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E-MAIL VERSION
received MAY 25/15

Honourable H. Wade MacLauchlan
Minister of Justice and Public Safety
Province of Prince Edward Island
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95 Rochford Street
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Minister: Re: Hennessey-Campbell Inquest

I am in receipt of the recommendations from the jury which sat in the inquest into the deaths of Patricia Lynn Hennessey and Nash David Campbell. Before I present their recommendations and my comments on each, let me make some general comments about the process of the inquest, which was conducted over 4 days of hearings in March, 2015.

While, in general, things went smoothly, there were some constraints placed on the process by the current legislation, which created some issues for the timely and judicious prosecution of the inquest by all involved. At the same time, it became apparent that the families of the deceased had a set of outcome expectations which were not going to be met. It appears that the family of Nash Campbell was expecting the inquest to assign blame for his death. In future, it would be prudent for the conducting Coroner and Crown attorney to be very sure that involved families are very clear about what an inquest is designed to accomplish and, equally importantly, not accomplish. The whole question of why and how a Coroner's inquest is to be conducted needs to be revisited and the process streamlined as much as possible.

The Coroner's Jury is comprised of lay persons, very few of whom would have been exposed to the graphic details of murder-suicide in their own lives, leaving them emotionally poorly equipped to handle the stark reality of the situation as presented. One of them was so stressed after the first day of testimony, having viewing photographic evidence from the scene, that he had great difficulty returning to the court room on the second day. Stress counseling wasn't offered to jury members, who were dismissed from duty without any post-inquest arrangements for emotional support having been put in place.

Here are the recommendations and my comments.

1. Health care workers should be provided additional education in recognizing risks for filicide and strategies for prevention. I agree. Responsibility for delivery of such

education should lie with Health PEI and other agencies involved in delivering child and family services.

2. Child protection policy and protocol [procedure] regarding the identification and management of high risk cases needs to be updated. I would agree and would add "and disseminated widely".
3. There needs more training for Child Protective Services [CPS] workers on parental engagement. I think it is important that Government understand the current training of CPS workers and receive a report from CPS outlining a plan to bring training up to standard if currently deficient.
4. There needs to be mandatory multidisciplinary training on domestic violence and child abuse. I agree. It should be required of all clinical health care and child and family services workers.
5. There should be better information sharing between families and the justice system. Apparently the family of Nash Campbell was unable to communicate with the family court judge their concerns about letting Patricia Hennessey take custody of her son, Nash Campbell, the day before she was to surrender custody to his father. Too frequently we work in silos where there is significant reluctance to share information with those outside our particular silo.
6. There needs to be judicial education on domestic violence and child abuse. Additional education is always a good thing.
7. There needs to be timelier access to child custody assessments in high risk family court cases. First we have to recognize high risk situations; then we have to remove any barriers to successful resolution of dangerous situations.
8. Develop supervised access services. The availability and adequacy of services and facilities to provide closer supervision of children in high risk family situations needs to be reviewed and changes made if necessary.
9. There needs to be a strategy in place to assure that employees who are dealing with domestic violence or mental health issues receive workplace support. I agree.
10. There needs to be a policy requiring a "cooling off period" before the spouse who has been assigned limited visitation rights resumes caring for the child. This makes sense to me.
11. There needs to be more aggressive enforcement of custody arrangements, with justice system consequences, such as criminal charges, available if the terms of child custody are violated. I am not sure that the creation of punitive consequences is an effective deterrent to non-compliance. We need to find better ways to understand non-compliance and minimize its occurrence.
12. Parents in child custody cases should be required to attend violence prevention and successful parenting programs. Failure to do so might result in visitation rights being

revoked. Again, this recommendation takes a punitive approach, which has never been shown to be an effective way to extinguish unacceptable behavior in the absence of other behavior modification strategies.

13. Every high risk family should have a 'Safety Circle". I agree. Ref: http://www.spconsultancy.com.au/family-safety-circles-booklet.html
14. Every family with child custody issues should have a "Peace Plan." I agree. Ref: http://thefamilylifeplan.com/gpage1.html
15. Government should consider creating a provincial position for "Child Advocate". I think that Government should assess the need for such a position and consider the best way to meet the intent of this recommendation.

Overall, I think that this inquest served a worthwhile purpose and provides us with an opportunity to critically examine the way we currently deliver child and family services.

Respectfully,

Desmond Colohan, MD, FRCPC

Chief Coroner, Prince Edward Island