CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Brontë Haskins**
Citation:	**[2023] ACTCD 4**
Hearing Dates:	31 January 2022, 1-4 February 2022, 5 August 2022
Decision Date:	**8 March 2023**
Before:	**Coroner Stewart**
Decision:	Comments and recommendations are made throughout these reasons
Catchwords:	**CORONIAL LAW** - cause and manner of death - death by suicide – death of person on bail and subject to supervision and monitoring conditions.
Legislation Cited:	*Coroners Act 1997* (ACT), s 34, s 34A, s 52 *Bail Act* 1992 (ACT), s 56A *Bail Act 1982* (WA), s 24, s 24A *Bail Act 1985* (SA), s 9 *Practice Direction Criminal 1 of 2020* *Mental Health Act 2015* (ACT), s 80
Representation:	**Counsel Assisting** Mr A. Muller **Counsel for the Australian Capital Territory** Ms V. Thomas **Counsel for the Australian Federal Police** Ms I. Sekler **Counsel for the Family** Mr S. Tierney
File Number(s):	CD 65 of 2020

CORONER STEWART

Introduction

1. This inquest relates to the untimely death of a much-loved young woman named Brontë Haskins. Brontë passed away three days after hanging herself outside the residence of her ex-partner on 18 February 2020.

2. This court previously made findings pursuant to s 52 of the *Coroners Act 1997* (the Coroners Act) about Brontë's death:

   (a) Identity of the deceased:

   Brontë Elouise Haskins

   (b) When and where the death happened:

   Calvary Public Hospital, Hayden Drive, Bruce in the Australian Capital Territory on 21 February 2020

   (c) The manner and cause of death:

   Hypoxic-ischaemic brain damage (due to) self-inflicted hanging with the intention of taking her own life.

3. A hearing was originally dispensed with by me pursuant to s 34A of the *Coroners Act 1997* (ACT), but after receiving written submissions from Brontë's family I resolved to convene a hearing pursuant to s 34 to deal with the following issues surrounding Brontë's death:

   (a) Brontë's incarceration at the Alexander McConachie Centre (AMC) immediately prior to her release on 13 February 2020.
   (b) Implementation of the conditions of bail, including but not limited to:
      (i) Supervision by delegates of ACT Corrective Services.
      (ii) Giving of any directions to Brontë by delegates of ACT Corrective Services;
      (iii) Preparation of court ordered reports; and
      (iv) The actions of CADAS.
   (c) The actions of the AFP in responding to Brontë in the period 13 to 18 February 2020, including consideration of whether a PACER response was appropriate and or available.
   (d) Any involvement of mental health workers with Brontë during the period 13 to 18 February 2020.
   (e) Brontë's interactions with any persons located at [an address] at Higgins on 18 February 2020.

Absence of blame

4. This hearing has identified no-one that can be blamed for Brontë taking her own life. With the benefit of hindsight, I have no doubt that every person involved with Brontë in the days and weeks prior to her death would have availed themselves of any opportunity to do something more to try and stop her death.

5. The Court is thankful for all of the written and oral submissions provided and for the manner of conduct of the hearing. All of the submissions have been considered.

6. The hearing itself was terribly sad. The grief that is still suffered by Brontë's family, friends and people associated with her is obvious and is recognised by the Court. It serves as yet another reminder of the deep and long-lasting effect that suicide has on the community.

7. The contents of this decision refer to death following attempted suicide by hanging. They also refer to illicit drug use, crime, imprisonment, and other negative aspects of life. Seek help if the words in this decision affect you negatively. Read them with someone who can support you. I ask you to take care when you do so.

Brontë Elouise Haskins

8. Whilst there was a premature and sorrowful end to the story of Brontë's life, the Court saw through photographs and heard in evidence that there is much about Brontë to celebrate. It was undisputed that there were many positive facets to Brontë's personality. She brought light to many people and, apparently, to many animals as well.

9. Brontë was born in Canberra on 06 July 1996 and schooled locally. She had a positive childhood in a family that loved her and cared for her. Sadly, the experience of the Coroner's Courts Australia-wide is that suicide as a manner of death visits families indiscriminately.

10. There are some aspects of the evidence that provided the Court with an insight into Brontë's suicidality. They are not itemised to cause shame, rather, they painted a picture of a deeply troubled young woman, who was exposed to multiple negative and harmful experiences and suicide risk factors and who was no stranger to suicide and suicide attempts. Brontë:

    (a) had experienced a friend commit suicide at a young age;
    (b) she became involved in illicit drugs in her teens;
    (c) made her first known suicide attempt aged 17;
    (d) isolated herself from her family at about the same time;
    (e) formed intimate relationships with men involved in outlaw motorcycle gangs;
    (f) formed intimate relationships with other drug users who supplied her with illicit drugs;
    (g) required psychological and psychiatric care;
    (h) was possibly fearful of being sentenced to imprisonment in relation to charges of driving whilst suspended and driving with a prescribed drug in her oral fluid;
    (i) made several suicide attempts in the months prior to her incarceration on 30 January 2020;
    (j) viewed the failure of those attempts in a negative light;[1]
    (k) had a friend die on 29 January 2020[2]; and
    (l) lapsed into illicit drug use post release from the AMC on 13 February 2020;

11. There were also some aspects of the evidence that pointed to Brontë having what was called a "future orientated outlook":

    (a) Brontë expressed interest in joining the army;
    (b) she had filled her flat with healthy food;
    (c) in the hours prior to hanging herself she had her hair done and had paid for another visit the following week. She did not seem depressed or upset during that hair appointment and spoke of having been recently released from prison, being clean and

[1] Statement of Hannah Parkin dated 26 September 2021 [Exhibit B]
[2] Ibid.

wanting to set up a café;
(d) On the drive to that hair appointment she had been initially erratic but had settled into her 'old self' behaviourally with an old friend.

12. It is unclear whether Brontë had pre-planned her death. It may well be that the future orientated outlook was a sham, but I cannot form any conclusion about that. I did form the view from the whole of the evidence that Brontë was skilled at covering up what she did not want people to know, so if her death was pre-planned then I am not surprised that no-one expected it.

13. I also formed the view that Brontë's family were stuck in a terrible situation. They believed that in the days between 13 and 18 February that Brontë had become mentally unwell and had re-commenced using illicit drugs. They did not want to harm a newly emerging relationship of trust with Brontë by incessantly involving authorities with Brontë or attempting a hospital admission themselves.

14. It was also clear on the evidence that Brontë was likely to be resistant to voluntary intervention with her mental health.

15. Thus, if Brontë had determined to take her own life during those days in February 2020, it would seem that involuntary detention was the only step that might have stopped that ideation.

ISSUE A – BRONTË'S INCARCERATION AT THE AMC PRIOR TO 13 FEBRUARY 2020

16. Brontë was remanded in custody after being refused bail on 30 January 2020.[3] She was assessed as requiring a risk assessment by forensic mental health staff at the AMC. She was teary and told Christopher Davis that she had unsuccessfully attempted suicide by heroin use in the previous 72 hours.[4]

17. Brontë was reviewed at the AMC and told staff that she had used heroin daily for the previous 12 months including on the previous day.[5] She was placed on hourly observations and staff commenced benzodiazepine and opiate withdrawal charts.[6] Her review the following day indicated continuing suicidal ideation and the hourly observations remained in place.[7]

18. Brontë was reviewed on 02 February 2020. She was flat in effect and in a low mood and requested to be moved to the women's unit. Hourly observations were ceased, and the move took place the following day.[8]

19. On 05 February 2020 Brontë's symptoms on the withdrawal charts were recorded as being minimal.[9]

20. Brontë appeared in court on 10 February 2020 and her matters were adjourned to 12 February 2020 for a bail application. She was reviewed on 11 February 2020 and reportedly looked better and brighter. She was reported to be hoping to be granted bail

[3] Bench sheet for charge CC2019/10022
[4] Statement of Christopher Davis dated 02 September 2020 at [19]
[5] Statement of Fernandez dated 26 August 2021 at [9]
[6] Ibid at [28]
[7] Statement of Parkin dated 26 September 2021 at [44-45]
[8] Ibid [46]
[9] Statement of Fernandez ibid [32]

the following day and denied suicidal ideation or any intention of illicit drug use upon release. Brontë appeared future focussed. [10]

21. Brontë was granted conditional bail on 13 February 2020. Both of her parents gave evidence that Brontë appeared to be better than they had seen her for some years on that day.

22. I find that there are no recommendations or comments for me to make on this topic.

ISSUE B – THE IMPLEMENTATION OF THE CONDITIONS OF BAIL ON WHICH BRONTË WAS RELEASED FROM CUSTODY ON 13 FEBRUARY 2020, INCLDUING BUT NOT LIMITED TO:

i. SUPERVISION BY DELEGATES OF THE ACT CORRECTIVE SERVICES

23. Court files show that as of February 2020 Brontë was charged with three counts of driving whilst suspended, three counts of driving with a prescribed drug in her oral fluid and one count of failing to stop for a stop sign. She was granted bail on 13 February 2020 with the following conditions:

    (i) Reside at [an address], Cook with Janine Haskins.

    (ii) Accept supervision of ACT Corrective Services (as delegated by the director-general) and comply with all reasonable directions.

    (iii) Report immediately to ACT Corrective Services Court Duty Officer.

    (iv) Accept monitoring by CADAS and consent to the provision of information by CADAS to ACT Corrective Services.

    (v) Undertake treatment as recommended by CADAS.

    (vi) Do all things necessary to facilitate the preparation of Court ordered reports.

    (vii) Not use illegal drugs, including cannabis, or any other drug illegally obtained.

    (viii) Undertake urinalysis as directed by ACT Corrective Services.

    (ix) Not drive, or be in the driver's seat of, a motor vehicle.

24. There was a further oral undertaking given by Brontë's mother, Janine Haskins, to inform police of any breaches.

25. As a general start point it should be noted that the bail provisions of the ACT are not designed to implement a therapeutic purpose. Bail at its heart is a defendant's signed commitment to the court to reappear on a certain date at a certain time. Conditions are often imposed to attempt to reduce the risk of re-offending or for the safety of the defendant or other persons.

26. Bail is generally granted to those facing charges who have not entered pleas of guilty or had those findings made. As such, someone on bail generally has the presumption of innocence in their favour.

[10] Statement of Parkin ibid [59]

27. Sarah Karchinsky was Brontë's bail officer from 2019 to 2020. She was one of two bail officers in the ACT and she managed between 120 and 130 cases by herself.[11]

28. I pause to make some arithmetical calculations. Based on a 37.5 hour working week, there are 2,250 possible effective working minutes in each working week. Presuming Ms Karchinsky had 120 defendants to supervise then she had an average of 18.75 minutes per defendant each week to do so.

29. Despite the pressure of this workload, Ms Karchinsky had a telephone conversation with Brontë on 13 February 2020 and scheduled an appointment for 25 February 2020. She also received a copy of Bronte's bail conditions at 1803 hrs the same day.[12]

30. No other action that could possibly equate to an act of supervision took place prior to Bronte's death on 21 February 2020.

31. In fact, no other interaction at all took place between ACTCS and Brontë during the time spanning her release on 13 February 2020 and her death on 21 February 2020

32. None of this should be seen as a negative reflection on or comment about Ms Karchinsky. To do so would be contrary to her obvious work ethic and professionalism in circumstances of extraordinary and extreme workload.

33. In Brontë's case there was a professional history between the two women and there was no absence of knowledge about Brontë's personal issues and situation.

34. Brontë had previously submitted two urine samples for testing in accordance with earlier bail conditions in place in 2019. Those dates were 15 November 2019 and 19 December 2019. Both of those samples produced positive results for opiates and amphetamines and placed Brontë in breach of a condition of bail in place at those times.

35. The second positive result had not been actioned as a breach of bail by Ms Karchinsky and would, therefore, probably not have been known to the learned magistrate who granted bail to Brontë on 13 February 2020. I'm not sure that much turns on that point, but it does go to show that the overstretched resources of the bail officers probably did not allow the Court to be provided with the full picture about Brontë's drug use in the months prior to being granted bail on 13 February 2020.

36. Brontë had attended a bail compliance interview with Ms Karchinsky on 17 January 2020 during which she disclosed that she had experienced six overdoses in six weeks.[13] Brontë was not emotional and seemed future focussed during that interview.[14]

37. But, despite this level of knowledge of Brontë no greater level of supervision was apparently available to her.

38. Ms Karchinsky acknowledged that she had not been trained in identifying suicidality or suicidal ideation.[15] I note that Mental Health First Aid Training and access to an online Responding to Suicidal Thoughts and Behaviours Practice Guideline is now available to all Community Corrections staff.[16]

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[11] TX 134.45-46

[12] Statement of Ms Karchinsky dated 26 August 2021 pp 12-13.

[13] TX 143 LL42-43

[14] TX 143 LL43-46.

[15] TX 142 LL14-16

[16] Letter from ACT Corrective Services to the Court dated 11 July 2022

39. The family has sought a recommendation that all breaches are reported within seven days of notification. That would be ideal, but I expect that it may be hampered by the overstretched resources already imposed upon the bail supervisors.

40. The family also sought a recommendation that bail supervisors receive mental health training. If the intention is for training beyond the administration of basic suicidality assessments and what has been put in place already, then I think that is beyond the scope of the inquest. Further, I cannot see how in the present system of supervision, there would be any time to utilise such deeper psychological training. I decline to make such a recommendation, but I do think that there is utility in bail supervisors being able to administer basic suicide assessments.

41. There was some helpful cross-examination of Ms Karchinsky in relation to access to information between services. Ms Karchinsky, as part of all ACT Corrective Services, was not able to access the Mental Health, Alcohol, Justice Health Integrated Care Electronic Record (MAJICER) notes held by ACT Health. Privacy considerations are obvious here, but there could have been potential for Brontë to consent to information sharing.

42. There is no basis for me to recommend over-riding ACT Health policy on privacy

43. I should make it clear that counsel for the Territory has been critical of the advance version of the findings under this heading and is of the view that they are, essentially, unfair and unbased and might cause reputational harm. I disagree.

44. I remind the reader that my comments and findings are not to be read as criticism of Ms Karchinsky. To do so would be obtuse and against the weight and intent of my written words.

45. **Comment:** As a judicial officer who often sits in the ACT Magistrates Court bail list I am genuinely shocked by the under-resourcing that allowed for the scant supervision of Brontë. This inquest has changed my whole view of the utility of supervision by ACTCS as a bail condition and left me in shocked awe at the workload put upon the bail supervisors.

46. The community is entitled to form their own view of whether the actual level of bail 'supervision' matches their own expectation and the usual meaning of the word.

    Comment: The resources allocated to bail supervision in the ACT as of February 2020 were inadequate and did not allow for an acceptable level of bail supervision.

    Comment: The "hands off" approach to supervising Brontë made her bail agreement little more than a paper tiger for the most part of it.

    Recommendation: The Minister for Corrections and the Attorney-General be made aware of the evidence and my findings on the actual (rather than perceived) manner and level of supervision provided to Brontë and presumably other defendants granted bail in the ACT.

    Recommendation: That bail officers be trained in administering basic suicidality assessments.

ii. GIVING OF ANY DIRECTIONS TO BRONTË BY DELEGATES OF ACT CORRECTIVE SERVICES

47. There were no directions given to Brontë other than to attend on 25 February 2020 for a supervision appointment. Thus, despite the level of knowledge of Brontë's personal issues and situation, no direction for urinalysis took place, no referrals for any health,

mental health, alcohol and drug or any other support services were made and nothing else was done by way of any directions at all.

iii. PREPARATION OF COURT ORDERED REPORTS

48. A pre-sentence report had been ordered by the Court on 13 February 2020 but no action had been taken to commence that report.

49. Despite all of the corporate knowledge about Brontë, the Court was not provided any material by ACTCS prior to Brontë being granted bail. This is because there is presently no mechanism for the provision of such information for bail applications in the ACT.

50. There were no conditions relating to mental health in Brontë's bail agreement. This is probably because the learned Magistrate who granted bail was not appraised of Brontë's mental health issues. Had there been a bail assessment report of some type this may have informed the Court of further conditions that may have supported Brontë's release on bail.

51. By virtue of *Practice Direction Criminal 1 of 2020* bail applications for those not fresh in custody may be listed with 48 hours' notice being given to the prosecution[17]. This would provide ample time for properly funded ACTCS staff to produce bail assessment reports. Such reports might access records from custodial and other ACTCS resources. That would have allowed for the learned Magistrate to have been made aware of the suicide vulnerability assessment tools ("SVAT"s) administered to Brontë at the AMC.

52. ACT Health may consider their policy position on disclosing relevant information to the court for this type of report. Even if input is limited to recommendations based on ACT Health records, this would provide some enlightenment to the court.

53. In Brontë's situation such a report, might, after considering the suicidality of Brontë upon and during her admission to the AMC and some input from ACT Health have recommended bail conditions that ensured engagement with mental health service providers.

54. The *Bail Act* 1992 does not prescribe limits on the number of or types of conditions of bail, however, as a matter of common sense and practice bail conditions must be lawful and practically workable.

55. Although it was not an issue in this inquest, these types of reports are (elsewhere in Australia) able to be utilised for broader bail issues such as:

    (a) homelessness;

    (b) residence suitability;

    (c) confirmation of employment status and offers of employment pending release;

    (d) assessing or recording physical and mental health issues;

    (e) drug and alcohol use assessment;

    (f) risk assessment for re-offending (such as family violence or general re-offending risk);

[17] Paragraph 50

(g) previous bail compliance;

(h) ability to provide a cash surety;

(i) consideration of non-association conditions;

(j) requirement for a curfew or other restrictive conditions;

(k) suitability and eligibility for rehabilitation or other forms of assistance;

(l) willingness to engage with service providers such as mental health teams or bail assistance programs; and

(m) willingness to comply with bail conditions.

56. This is not a definitive list. The tremendous utility of such reports is obvious.

57. This type of bail report is not exceptional in Australia. New South Wales trialled a bail assessment officer program extensively in the last decade[18] that included the production of short reports for the purpose of bail applications. South Australian Courts utilise bail assessment reports that can assess general bail suitability issues including suitability for supervision, suitability for intensive supervision, suitable accommodation, community supports and home detention release[19]. Western Australia also has provision for bail reports to be prepared by community corrections officers.[20]

58. Bail assessment reports were not raised during the hearing. I provided an advance copy of this section of my findings to the parties to allow them respond to my recommendations below and the rationale behind them. Only the Territory chose to respond by setting out a list of perceived difficulties in implementing bail assessment reports:

(a) *Because of the presumption of innocence, ACTCS personnel would be limited in the investigations and assessments*. I note that the same presumption does not provide a barrier to reports in other jurisdictions in Australia.

(b) *There would be major resourcing implications*. This is noted as a budgetary constraint only.

(c) *There would be privacy issues*. I note that the Court is already provided brief mental health reports. It would seem that the same privacy implications apply to these reports. The ACT has proved that it has been able to overcome these very difficulties within the PACER mutli-disciplinary team.

(d) *Bail officers do not presently have access to MAJICER*. This could be remedied with interdepartmental will.

(e) *Concerns were raised about access to mental health records in the absence of clinicians*. I do not recommend this – I suggest that clinicians have an input into bail assessment reports where required.

(f) *48 hours would limit and potentially compromise detail in reports*. This is noted.

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[18] *"Evaluation of the Bail Assessment Officer (BAO) intervention"* Crime and Justice Bulletin Number 209 January 2018 NSW Bureau of Crime Statistics and Research

[19] See s9 *Bail Act* (SA) 1985 and "Bail" Legal Services Commission South Australia (undated online resource)

[20] See ss 24 and 24A *Bail Act* (WA) 1982

(g) *48 hours would not allow time for victim input*. I note this but do not understand why this would be the case other than a function of resource limitation. It does not prevent victim input in Bail Consideration Forms that are provided by ACT police to the Court on bail applications.

(h) *It would not be appropriate to impose mental health reporting responsibility on bail officers*. I note this response and note that I have not suggested this.

(i) *Current requests for mental health records can take up to 30 days*. This is noted.

59. Despite the surprisingly negative response from counsel for the Territory, I remain of the view that bail assessment reports are properly recommended.

Recommendation: Consideration be given to funding 48 hour turn-around bail assessment reports for those applying for bail or bail variations.

Recommendation: ACT Health consider what, if any, input it can provide to bail assessment reports from a policy perspective.

iv. THE ACTIONS OF CADAS

60. CADAS or Court Alcohol and Drug Assessment Service is an organisation within the purvey of Police and Court Drug Diversion Services provided by Mental Health Justice Health and Drug Services for the ACT.[21]

61. Brontë spoke to Ms Caesar, a CADAS officer, on the day prior to her release on 12 February 2020. Brontë said that she was "doing okay" and an appointment was made for 20 February 2020. CADAS received a copy of Brontë's bail agreement and sent her an appointment reminder message on 13 February 2020.[22]

62. There were no other interaction between CADAS and Brontë in the six days between her release from the AMC and Brontë attempting suicide.

63. There was a prior history of involvement with CADAS and a significant level of knowledge about Bronte. A previous CADAS assessment had been undertaken with Brontë on 18 November 2019 by Ms Caesar.

64. Despite this history and the knowledge held by CADAS about her, (in the context of her bail conditions) Brontë did not:

(a) Receive any monitoring by CADAS other than the fixing of an appointment a week after her release;
(b) Have any opportunity to consent to the provision of information by CADAS to ACT Corrective Services;
(c) Have the opportunity to undertake any treatment as recommended by CADAS (let alone have any such treatment recommended).

65. Importantly, the week's delay in a further CADAS assessment after her release from custody on 13 February 2020 meant that Brontë did not receive the following standard assessment procedures:

(a) Brontë did not receive a reminder explanation about the role of CADAS;

[21] Statement of Kylie Caesar dated 20 September 2021 p 1.
[22] Ibid pp12-13

(b) Brontë was not spoken to about consent regarding information sharing – although bail condition (iv) was related to consent;

(c) Brontë did not have her current alcohol or drug use discussed and recent history taken;

(d) Brontë did not receive an assessment around issues that might have affected her ability to access treatment;

(e) Brontë did not receive an SVAT which would have been another opportunity to assess her suicidality at that crucial time;

(f) Brontë did not have treatment recommendations made; and

(g) Brontë was not requested to allow inter-agency information release.

66. This was a further lost opportunity to independently assess whether Brontë had slipped back into illicit drug use by face-to-face assessment, but in a more therapeutic setting than with a bail officer. It was also a lost opportunity to observe any warning signs in relation to Brontë 's deteriorating mental health.

67. The reality is that an earlier assessment appointment would have given rise to several possible circuit breakers for drug use and suicide for Brontë.

68. None of this should be seen as a negative reflection on or comment about Ms Caesar. To do so would be contrary to her obvious work ethic and professionalism. Once again, the issue is one of resourcing.

69. Counsel for the Territory has been critical of the advance version of the findings under this heading and is of the view that they are, essentially, unfair and unbased, that there was no delay in monitoring Brontë and that they might cause reputational harm. I disagree. My comments in the preceding paragraph about Ms Caesar are clear enough.

70. **Comment:** I was underwhelmed by what CADAS monitoring meant for Brontë in real, rather than paper, terms. This inquest has changed my whole view of what the meaning of 'monitoring' is in the context of CADAS resourcing and dramatically reduced my expectation of what such a bail condition will achieve when I impose it.

71. Hopefully this inquest will enlighten to the public as to what the term 'monitoring' amounts to in the context of CADAS.

72. It is important to note that Ms Caesar and Katie McKenzie, Executive Director of MHJADS have both provided statements in response to this portion of my decision and in doing so disagree with my comment and recommendation below. As a matter of fairness their statements are attached to this decision. Any reader of this decision should also read those statements.

Comment: The delay in commencing CADAS assessment and monitoring meant that there were lost opportunities for the assessment of and intervention in Brontë's drug use, mental health issues and suicidality.

Recommendation: The Attorney-General and the Minister for Justice Health and Mental Health be made aware of the evidence and my findings on the timing, manner and level of CADAS assessment and monitoring provided to Brontë.

ISSUE C - THE ACTIONS OF THE AFP IN RESPONDING TO BRONTË IN THE PERIOD 13 TO 18 FEBRUARY 2020, INCLUDING CONSIDERATION OF WHETHER A PACER RESPONSE WAS APPROPRIATE AND/OR AVAILABLE.

73. The evidence from the two teams that attended on Brontë at her home on two separate occasions impressed the Court. The officers were highly trained including an officer on each team holding a degree in psychology.

74. ACT police have no powers to direct drug testing for defendants on bail. If officers believe on reasonable grounds that a condition of bail has not been complied with pursuant to s56A of the *Bail Act* 1992 (the *Bail Act*) they may arrest a defendant without a warrant for failing to comply with a bail condition.

75. Road traffic drug tests in this jurisdiction test for methylamphetamines, MDMA and cannabis only. There is no power to use those tests for bail compliance checks.

76. The attending officers had to rely on observations to determine whether or not Brontë had failed to comply with her bail conditions. They had no power under the *Bail Act* to search her premises for the purpose of ensuring bail compliance.

77. ACT Police are able to contact ACT Corrections in relation to requesting a drug test for bail compliance reasons. That did not occur in Brontë's case and I accept the evidence of the attending officers about them not forming a view that Brontë had breached bail.

78. Despite no doubt being "street-smart" I do not think that Brontë had sufficient "smarts" to "pull the wool over the eyes" of the two different sets of attending police.

79. The PACER (Police, Ambulance and Clinical Early Response) team was not on duty at the time of the calls made to ACT Policing by Brontë's family. The general duties officers who attended found no reason to notify the PACER team about Brontë.

80. Attending Police had not been informed of information from Brontë 's mother about her growing fascination with an oven in her residence and a connection (stated by Brontë) between that oven and Nazi Germany. That information may have enlivened further questioning with a view to apprehension pursuant to s80 of the *Mental Health Act 1983* (ACT), but, I think that this is highly speculative.

81. The attending police were well versed in mental health issues and their powers of detention. Any use of the mental health detention power had to be based on their own observations and assessments of Brontë. It required a reasonable belief that Brontë was suffering from a mental disorder or mental illness, had attempted or was likely to attempt suicide or likely to inflict serious harm on herself or another person. The officers determined that they had no basis for such a belief.

82. Attendance by a PACER team would have had the greater benefit of access to ACT Mental Health records through that organisation's own practitioner allocated to the PACER team.

83. If Brontë was assessed as not requiring detention under s 80 by the PACER team – and the weight of the evidence indicates to me that she did not require forced detention at the time of the two police attendances – then it would have been a situation where Brontë's consent and willing participation was required for any outpatient mental health referral or assistance.

84. Janine Haskins was of the view that Brontë would have been reluctant to attend Canberra Hospital voluntarily for treatment and possibly would have fled if taken there[23].

85. I accept the evidence of the Haskins family about Brontë's behaviour at the relevant time. The conclusions that might be drawn are that over the days of the police attendances Brontë was fleeting in and out of psychosis that was either drug induced or had it's origin in mental ill-health, or both. I also accept the evidence of the attending officers that at the time of their attendances there was no basis for them to exercise any power in relation to Brontë.

86. I do not agree with the Haskins family view that the inquest gave rise to a requirement for greater mental health training for ACT police officers. The weight of the evidence informed the court that the attending officers were well trained, quite experienced in mental health issues and knew the relevant law.

87. A recommendation about AFP access to the MAJICER system was also sought. This is beyond the scope of the inquest, however, it may be an issue that the AFP and the relevant ACT government departments wish to explore.

88. The Haskins family also seek a recommendation that body worn cameras should be worn for bail compliance checks. This is beyond the scope of the inquest, but I understood that this does now occur.

89. The family sought that I make a comment or 'encouragement[24]' about police listening to families.

90. The words used in that submission imply that the attending police did not listen to Brontë's family. When I reflect on the evidence I find there is no basis for such an implication or criticism. There is no basis for me to make any other comment.

91. Finally, the Haskins family have asked that I consider a request from Ms Haskins to meet with new AFP recruits to "hear the stories of families who have lost a loved one in circumstances such as Brontë's". This is well outside of the scope of the inquest.

92. I find that there are no recommendations or comments for me to make on this topic.

ISSUE D - ANY INVOLVEMENT OF MENTAL HEALTH WORKERS WITH BRONTË DURING THE PERIOD 13 TO 18 FEBRUARY 2020.

93. Janine Haskins attempted to obtain the involvement of ACT Mental Health in the relevant period. What would ultimately come from that attempt was another lost opportunity to assist Brontë.

94. Ms Haskins telephoned the Access Mental Health Triage Service in the early hours of 15 February. This was an hour or so after she had telephoned Police late the previous evening.

95. The subpoenaed MAJICER notes from that organisation show that the call commenced at 12.56 am and lasted seven minutes and 42 seconds.

96. Ms Haskins gave evidence that during the call she had spoken with Karina Boyd at that service. She had advised Ms Boyd that:

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[23] Affidavit of Janine Haskins dated 18 August 2022

[24] Haskins family submissions at para 140g

(a) Brontë was having delusional thoughts about World War II, the Jews and thinking that she was in a gas chamber;

(b) Brontë was experiencing hallucinations and had attempted to remove her oven;

(c) Brontë has taken methamphetamine and heroin and was now expressing delusions;

(d) Brontë was in breach of her bail conditions;

(e) Brontë was acutely unwell;

(f) Brontë needed to go to the Canberra Hospital and/or Access Mental Health Unit; and

(g) That she had contacted Belconnen Police and was waiting for them to arrive.

97. There was a dispute between the evidence of Ms Boyd and Ms Haskins about whether or not Ms Haskins had told Ms Boyd that Police had arrived at her home to conduct a bail check on Brontë. Little turns on that – the arrival of police did not alter the need for Ms Boyd to follow the procedures set down for her to follow.

98. Ms Boyd gave evidence that she used a red folder at work and that this folder contained a triage scale that set out standard operating procedures for dealing with people displaying various sequelae. There was no clarity about which historical version of the triage scale was in the folder that Ms Boyd used that morning, however, she was adamant that it would have been the most up to date version.

99. Bruno Aloisi gave evidence that he had circulated by e-mail a new draft triage scale on 11 December 2019. That email directed that the new draft triage scale had immediate effect.

100. The MAJICER notes contained the SVAT assessments from Brontë's remand in custody. They recorded her recent suicide attempts. Had those notes been read, the 11 December 2019 version triage scale should have had Brontë categorised in triage category C or D.

101. This meant that there would have been a mandatory follow up from Access Mental Health. Mr Aloisi properly conceded that the failure to follow up Ms Haskin's telephone call was an opportunity lost for Brontë.

102. Evidence provided at the hearing showed that steps have since been taken by ACT Health to improve the Access Mental Health Triage Service process and training of staff. At the time of the hearing the triage scale was the subject of a further review. These facts obviate the need for any comment or recommendations on those issues.

Comment: The failure to correctly categorise Brontë meant that a vital follow-up did not occur. That follow up should have taken place regardless of police attendance – hence my view that an opportunity to assist Brontë was lost.

ISSUE E - BRONTË'S INTERACTIONS WITH ANY PERSONS LOCATED AT [AN ADDRESS IN] HIGGINS, ACT ON 18 FEBRUARY 2020.

103. The evidence was that the only person present at this address at the relevant time on 18 February 2020 was Brett French. He had previously been in a relationship with Brontë, and she still kept a room at this residence.

104. There were CCTV cameras in place at the residence. They captured a fiery exchange at the door between Brontë and Mr French involving his ultimate refusal to allow her entry.

105. There is no evidence that Mr French had any suspicion that Brontë would then go and attempt suicide by hanging herself metres away from that door. It was Mr French who observed Brontë hanging when he looked outside about 30 minutes later. Brontë was unconscious and, with great physical difficulty, he removed her from her ligatures and telephoned 000 for assistance.

106. Brontë 's family hold a strong view that the relationship was entirely unhealthy and that it included the supply of illicit drugs to Brontë.

107. A gap in the footage captured by Mr French's CCTV recording system has only served to heighten that dislike and distrust.

108. I am left in no doubt that it is not lost on Mr French that his interaction with Brontë at his doorstep was the last conscious human interaction that Brontë experienced. I do not think that any comment is required in those circumstances.

109. Police reviewed Mr French's footage and two experts assessed the recording equipment. The evidence was that the relevant camera was motion activated. I find that the motion activation is the only explanation for the gap in footage capture.

110. There is no basis on the evidence to find that there was any tampering with CCTV footage by Mr French or anyone else.

111. Mr French gave evidence that there was no monitor inside the part of the residence that he was in that would have enabled him to have watched Brontë hang herself. His evidence is bolstered by my observation in the footage of the desperation showed in his behaviour when he was seen to go outside and observe Brontë hanging. There is no basis disclosed in the evidence to conclude otherwise.

112. Further, I cannot find a reason to criticise Mr French's manner of removing Brontë from her ligatures. It should be remembered that whilst Mr French was both attempting to lift and release Brontë that Brontë was suspended in the air by her neck, unconscious and an immobile weight.

113. I find that there are no recommendations or comments for me to make about Mr French.

FURTHER MATTERS ARISING

(i) Recording of telephone calls with access mental health

114. Counsel for the Haskins family submitted that this should be a recommendation and that this is within the scope of the hearing. Counsel for the ACT government made the following submissions:

(a) This would require legislative change;
(b) may have broader privacy implications; and
(c) may discourage openness in the calls.

115. I find that this matter is beyond the scope of the inquest.

(ii) There should be a clear explanation of triage services available on ACCESS Health telephone calls.

116. Counsel for the Haskins family submitted that this should be a recommendation and that this is within the scope of the hearing. Counsel for the ACT government submitted that the present procedure is appropriate.

117. I find that this matter is beyond the scope of the inquest.

(iii) Close family reports should be included on triage scales

118. The ACT government accepted that this is a matter that should be considered in the present review of the triage scale.

119. In those circumstances there is no need to make any comment or recommendation on this issue.

(iv) Access to or release of Quality Assurance Committee (QAC) protected information should be part of a legislative review of the *Mental Health Act* 1933 (ACT)

120. Counsel for the Haskins family submitted that this should be a recommendation and that this is within the scope of the hearing. I find that this matter is beyond the scope of the inquest.

(v) There should be a regular audit of mental health triage scales.

121. Counsel for the Haskins family submitted that this should be a recommendation and that this is within the scope of the hearing I find that this matter is beyond the scope of the inquest.

(vi) Return of the CCTV recorder.

122. Counsel for the Haskins family submitted that an adverse comment should be made in relation to the handling of the CCTV recorder (CCTV DVR) from Mr French's home.

123. I find the following facts established:

(a) Mr French voluntarily supplied the CCTV DVR to Police whilst Brontë was alive.

(b) There was no investigation on foot whilst Brontë was alive.

(c) Senior Constable (SENCON) James was allocated the role of informant in the coronial investigation when Brontë passed away.

(d) The CCTV DVR was provided to an AFP video technician specialist who retrieved data from the DVR.

(e) Once this process was completed SENCON James sought approval from coronial staff for the release of the CCTV DVR. That approval was given by email and the item was returned to Mr French a few days later by another officer.

124. I see no basis for adverse comment in the circumstances.

Closing remarks

125. The Court extends their condolences to the family and friends of Brontë Haskins and thanks the advocates for the parties for their efforts in assisting the Court and the respect shown for Brontë, Brontë's family and Brontë's loved ones during the hearing process.

I certify that the preceding one hundred and twenty-five [125] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Coroner Stewart.

Associate: Rebecca Hunter
Date: 08 March 2023

LIST OF ACRONYMS

ACT – Australian Capital Territory
ACTCS - ACT Corrective Services
AFP - Australian Federal Police
AMC - Alexander McConachie Centre
CADAS – Court Alcohol and Drug Assessment Service
CCTV – closed circuit television
DVR – digital video recorder
MAJICER – Mental Health, Alcohol, Justice Health Integrated Care Electronic Record
MDMA – methylenedioxymethamphetamine otherwise known as ecstasy, molly or pingers.
PACER – Police, Ambulance and Clinician Early Response
QAC – Quality Assurance Committee
SVAT - suicide vulnerability assessment tool

ACT Government | **Canberra Health Services**

ACT Coroners Court
Knowles Place
Canberra City ACT 2601

Katie McKenzie
Mental Health, Justice Health,
Alcohol & Drug Services
Canberra Health Services

Inquest into the death of Brontë Haskins

Statement of Katie McKenzie

1. This statement made by me sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false or not believe to be true.

2. My full name is Katie McKenzie.

3. I am currently employed as the Executive Director of Mental Health, Justice Health, Alcohol & Drug Services (**MHJHADS**) at Canberra Health Services (**CHS**) in the Australian Capital Territory. I have previously provided a written statement, dated 11 July 2022, to the Coroner in this inquest on behalf of MHJHADS and CADAS.

4. I now provide a second statement in response to a notice received under section 55 of the *Coroner's Act 1997*. The notice, issued to a Court Alcohol and Drug Assessment Service ('**CADAS**') CADAS worker, includes new proposed findings in relation to CADAS. This response is in relation to paragraphs 9, 11 and 12 of the notice. These paragraphs were not previously included in the section 55 notice issued to the Australian Capital Territory, which includes CADAS.

5. By way of background, I note that bail conditions were imposed on Ms Haskins on 13 February 2020 which included that she "accept monitoring by CADAS" and "undertake treatment as recommended by CADAS". Her bail conditions of 26 September 2019 and/or 4 December 2019 did not contain any conditions relating to CADAS, although she had been referred by the Court for a CADAS assessment on 26 September 2019.

6. I believe that the proposed comments in paragraphs 9, 11 and 12 of the notice convey, quite clearly, that CADAS is under-resourced and that this has impacted on the extent to which the service is able to monitor a client, when a client is subject to bail conditions such as the ones imposed on Ms Haskins on 13 February 2020. For the reasons set out below, I consider that the comments proceed upon the basis of an incorrect assumption about the monitoring that CADAS is intended to provide and convey an unfair criticism of the service.

7. CADAS, is a voluntary and free service available to alleged offenders and sentenced offenders. CADAS does not have the power to require a client to undertake treatment. It is used by Courts in the Australian Capital Territory to attempt to engage clients in alcohol and drug treatment plans. This service can be used as a pre-sentencing initiative during Court proceedings, and/or as part of Court orders following a sentence. The primary aims of CADAS are to divert people away from the justice system to treatment and to reduce the risk of recidivism while an offender is on bail.

8. The CADAS Procedures Manual which was in place in February 2020 and is still in place, was in evidence at the inquest [Exhibit 1, part 2, 1, Court Alcohol and Drug Assessment Service, Procedures Manual]. In accordance with the manual and with standard practice, once a CADAS clinician has received a client's bail papers and the request for a report from the Court, they will arrange a CADAS assessment for the client.

9. At that assessment, the CADAS clinician will:

   (1) Explain the role of CADAS;

   (2) Obtain the client's consent to release and exchange information with other services or specific people;

   (3) Undertake an assessment of the client's current alcohol and drug use and their history;

   (4) Complete a Suicide Vulnerability Assessment Tool ('**SVAT**') form;

   (5) Make treatment recommendations; and

   (6) Request that the client sign a release of information form to allow contact with other service providers for the purposes of monitoring engagement with treatment.

10. Once the assessment has occurred the CADAS clinician then prepares a report for the Court. If the client has accepted treatment recommendations at the assessment, the report will specify that fact and set out the treatment that the client is willing to undergo. The CADAS clinician will also refer the client to the relevant treatment agency and notify the agency of the CADAS monitoring requirement.

11. A bail condition that requires a client to accept monitoring by CADAS, is understood by CADAS as meaning that the client is required, as a condition of bail, to allow CADAS to monitor the client's attendance and participation in treatment. This is clear from section 7 of the CADAS Procedures manual.

12. As set out in the CADAS Procedures manual, the frequency of CADAS monitoring depends on the treatment that the client has agreed to undertake. In most cases, it will involve weekly contact, with the client, provider of the treatment, and/or the

rehabilitation facility in which the client is residing, to ensure they are undertaking and participating the recommended treatment. The consent provided by the client at the initial assessment allows a CADAS clinician to contact treatment providers and rehabilitation facilities to monitor the client's attendance and participation in the recommended treatment.

13. CADAS clinicians prepare progress reports for the Court to indicate whether the client is engaging in the treatment recommended by CADAS and accepted by the client.

14. If a client fails to attend the agreed treatment, the CADAS clinician will contact the client by phone and remind the client of the requirement to complete the treatment. If after two contacts the client is still unwilling to engage in treatment, a non-compliance report is completed and provided to the Court.

15. We have four full time clinical staff who undertake CADAS assessments. I am not aware of any circumstances where the available CADAS staff have been unable to undertake regular monitoring of CADAS clients, engaged in treatment programs, due to other obligations due to resourcing issues.

16. I understand that, at the time of her release from the AMC, Brontë had not accepted treatment that had been recommended by Ms Caesar at a previous CADAS assessment. There was therefore nothing that CADAS was in a position to monitor. The proposed comment conveys that CADAS has some overarching role to monitor the mental health and drug and alcohol use of clients who have been referred to it by the Courts. For the reasons set out above, this is not the case. Ms Caesar had scheduled a further assessment for Brontë at which I assume she would have sought to negotiate an agreement with her to accept treatment, but Brontë tragically took her own life before it could occur.

17. I have read this statement before signing it.

Signed:

Date: 2/3/2023

Supplementary Statement of Kylie Caesar, Alcohol and Drug Worker

ACT Coroner's Office
Knowles Place
CANBERRA CITY ACT 2601

Inquest into the death of Brontë Haskins

1. I, Kylie Caesar, declare that this statement made by me is true and accurately sets out the evidence which I would be prepared, if necessary, to give in court as a witness in this matter.

2. This is my second statement in relation to the inquest into the death of Brontë Haskins. I provided my first statement, dated 20 September 2021 (**first statement**), to the Coroner for the purposes of the inquest in this matter. I also gave oral evidence at the inquest. I now provide a second statement in response to a notice received under section 55 of the *Coroner's Act 1997*. At the relevant time and at the time of the inquest, I was employed as an Alcohol and Other Drugs ('**AOD**') Worker with the Police and Court Drug Diversion Services with Mental Health Justice Health and Alcohol and Drug Services ('**MHJHADS**') in the Australian Capital Territory.

3. As explained in my first statement and at the inquest, I first saw Brontë for a Court Alcohol and Drug Assessment Service (**CADAS**) assessment on 18 November 2019 as ordered by the Court. The assessment on 18 November 2019 was scheduled following the receipt of a request for a CADAS report from the Magistrates Court on 26 September 2019.

4. At the time I received the request to undertake a CADAS assessment and at the time of the assessment with Brontë on 18 November 2019, there were no bail conditions in place which related to or involved CADAS. The request for a CADAS assessment was received from the Magistrates Court. Requests for CADAS assessments can be made by the Courts without specific bail conditions, regarding engagement with and/or monitoring by CADAS, being in place.

5. As outlined in my first statement (paragraphs [22] to [29]), following the receipt of a request for a CADAS report from the Magistrates Court, I attempted to contact Brontë on 3, 24 and 29 October 2019 to arrange an assessment. These attempts were unsuccessful. I again contacted Brontë on 1 November 2019 and managed to speak to her on this occasion. I scheduled an assessment for 7 November 2019. On 7 November 2019 Brontë did not attend the scheduled appointment. On 13 November 2019 I scheduled a further appointment for Brontë to attend an assessment on 18 November 2019. Brontë did attend on 18 November 2019.

6. I prepared a CADAS report to the Court of my assessment. As set out in my first statement, I had formed the impression that Brontë did not want to undergo any treatment (paragraph [50]). I recommended brief intervention counselling as an introductory form of counselling at which she could work on strategies for reduction, lapses planning or for general support. While Brontë said that she might be open to this, she was not willing to give her consent to it at that point (paragraph 51).

7. Where a client has been referred to CADAS for an assessment but is not willing to accept treatment, usual practice would be that the clinician would close the file in relation to that client after preparing the report to the Court. I did not do this as I was still hopeful that Brontë might agree to accept at least the counselling I had recommended. My intention was to arrange another meeting with her to see if she would accept this or any other treatment.

8. I tried to speak to Brontë by phone on 9 December 2019 to arrange a further catch up. I left a message and received no response.

9. I was on leave for a five-week period from 22 December 2019 to 28 January 2020. When I returned from leave, I looked at Brontë's file on 30 January 2020 to follow up to arrange another meeting. I discovered that she was incarcerated at the AMC at the time. In February 2020, CADAS were not able to do face to face assessments when an individual was in custody due to safety reasons. CADAS could undertake assessment via AVL, which I could have organised for Bronte if she had remained incarcerated. The appointment being on the 20.02.2020 would have allowed enough time for me to arrange an AVL assessment with the relevant administrative staff at the AMC, and book the AVL room at the Legal Aid office in the city, which we use for AVL assessments.

10. The next time I spoke with Brontë was when she called me from the AMC on 12 February 2020.

11. While giving evidence at the inquest, and in paragraphs 60 to 63 of my first statement, I explained that during that call, Brontë told me that the Court had asked her to engage with CADAS. She said that she was at the AMC and that she was not sure when she was going to be released. She told me that she was "doing okay".

12. At the time of the call, I had not received Brontë's bail conditions, nor had I received any request from the Court for an assessment to be undertaken. Although it was not clear at that point when Brontë would be released and I had yet to receive a request from the Court, I arranged an appointment for her on 20 February 2020. I received the request for an assessment of Brontë from the Court on 13 February 2020. It would have come to me because, for the reasons set out above, I had decided not to close her file after the last assessment. I sent a text message on 13 February 2020 confirming her appointment for 20 February 2020.

13. My usual practice was to schedule an assessment with clients within 1 to 2 weeks of receiving a request from the Court for an assessment.

14. I have been notified that the Coroner proposes to comment that there was a delay in commencing a CADAS assessment of Brontë. I do not agree. I made the appointment 6 business days from the day of our phone call and 5 business days from the date when she was released from the AMC (CADAS does not operate on a weekend). This was well within the period in which I would usually schedule an appointment. I could not, in any event, have safely scheduled the appointment any earlier because, when she called me, Brontë was not certain when she would be released from the AMC and if she was not going to be released, it would take me several days to organise an AVL assessment via AVL. Furthermore, during my conversation with her on 12 February, we had a discussion about how she was feeling. Brontë told me she was doing "OK". I was not aware of any circumstances that suggested that I should have scheduled an appointment earlier.

15. I did not receive any information about Brontë between 12 February and 20 February 2020.

16. The Coroner proposes including a comment that there was a delay in monitoring Brontë, commenting that the inquest has "*changed [his] whole view of what the meaning of 'monitoring' is in the context of CADAS resourcing*".

17. CADAS is and was at the time, a voluntary service. It is reliant on a person's willingness to engage with the service and in treatment. We do not have powers to breach or force clients into treatment. To do so would be inconsistent with evidence-based practice in alcohol and drug treatment. Forcing treatment is ineffective and can be detrimental to treatment outcomes. I would not and could not have forced Brontë into any alcohol and drug treatment if she was not ready to do so. This would have irreparably broken any trust she may have had in me.

18. The only monitoring of Brontë that I could have undertaken as a CADAS clinician is monitoring her attendance at and participation in treatment that she had agreed to undergo. At the time of her release from the AMC, she had not agreed to undergo any treatment. The only thing I could do was arrange a further meeting with her to negotiate treatment options with her and determine whether she was willing to accept treatment. This is what I did.

19. In my role with CADAS, I applied the best practice and National Drug Strategy (2017 to 2026) to my work. This guided how I engaged people in alcohol and drug services, treatments, and conversation. As an alcohol and drug worker, I needed to be very person centred, trauma informed and willing to meet Brontë where she was at. I needed to build self-efficacy and a trust relationship with Brontë so that she felt empowered to choose and not forced into a type of treatment. Brontë's appointment and my engagement with her, dating back to November 2018, was negotiated with all

of this in mind. However, she had been reluctant to engage in treatment. I was hoping that she would accept at least brief intervention counselling when I met with her on 20 February 2020.

20. If, at the assessment I had scheduled, Brontë had been prepared to accept counselling or other treatment, I would have made the necessary referrals and would then have monitored her attendance and participation in that treatment. I would have prepared a report on her participation in the treatment for her next Court date. If she continued to be unwilling to accept treatment, I would have set this out in my report to the Court. It would then be up to the Magistrate to determine whether she had complied with the conditions of bail that she had accepted on 13 February 2020.

21. For these reasons, I reject the suggestion that there was any failure to monitor Brontë after her release from the AMC.

22. I do not believe the proposed recommendation – that the Attorney General and the Minister for Justice Health and Mental Health be made aware of the evidence and finding on the level of CADAS assessment and monitoring would do anything to assist persons engaged with Alcohol and Drug treatment.

23. As I indicated when I gave my oral evidence at the inquest, a recommendation that CADAS have offices and a physical presence in the Court building, like it did in the past, would assist CADAS workers to engage persons in Alcohol and drug treatment. This would allow workers to be present in person for initial face to face contacts to facilitate engagement with our service and treatment. In my view, this would be a more effective recommendation. I believe that proximity and access are key elements to engaging persons in alcohol and drug treatment.

24. It is incredibly sad that Brontë died under such awful circumstances, and I again wish to express my deepest condolences to Brontë's family.

Signed: 

Date: 03.03.2023