IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003682

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Amended pursuant to Section 76 of the Coroners Act 2008 on 6/10/2023[1]

Findings of:	Coroner Leveasque Peterson
Deceased:	Mary Veronica Morrow
Date of birth:	6 June 1953
Date of death:	6 July 2021
Cause of death:	1(a) Pulmonary Embolism 1(b) Deep Venous Thrombosis 1(c) Fractures of the left distal tibia and fibula
Place of death:	Wodonga Hospital, 69 Vermont Street, Wodonga, Victoria, 3690
Keywords:	Deep Venous Thrombosis (DVT), Venous thromboembolism (VTE), Pulmonary Embolism (PE) Anticoagulation, Prophylaxis

INTRODUCTION

1. Mary Veronica Morrow (**Mary**) was 68 years old at the time of her death. She is survived by her sisters Anne Morrow and Kathryn Woods, and her son Michael Guest. She had a medical history of hypertension and obstructive sleep apnoea syndrome and resided in West Wodonga.

2. On 23 June 2021, Mary suffered a fracture to her left ankle whilst on holiday in Queensland.

3. She attended a local hospital and received initial treatment for this.

4. Upon her return to Victoria, she booked into surgery for her ankle however this was cancelled on several subsequent occasions.

5. On 6 July 2021, Mary collapsed at home and was transported to Albury Wodonga Health (**AWH**) where she sadly passed away.

THE CORONIAL INVESTIGATION

6. Mary's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mary's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

10. The Court obtained copies of Mary's medical records and patient file from AWH and Federation Clinic.

11. In the later part of the investigation, the Court also obtained a statement from Safer Care Victoria (**SCV**).

12. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**) was also asked to review the statement from SCV and the appropriateness of the care provided to Mary proximate to her death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

13. This finding draws on the totality of the coronial investigation into Mary's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

14. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[3] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

15. On 23 June 2021, Mary sustained an ankle fracture whilst holidaying in Queensland. She received initial treatment whilst in Queensland, including prophylactic treatment for venous thromboembolism (**VTE**).

16. Orthopaedic opinion at Robina Hospital in Queensland was that the fracture required open reduction and internal fixation and this was offered to Mary. She preferred to return to Victoria

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

to have her surgery and so was placed in a backslab and commenced on enoxaparin (an anticoagulant) for VTE prophylaxis by emergency department (**ED**) staff at Robina Hospital. She returned to Victoria and presented to the ED at AWH on 26 June 2021.

17. A discharge letter from Robina Hospital was provided to staff at AWH. Mary appeared to have been seen by orthopaedic staff in the fracture clinic on that day and booked for surgery on 28 June 2021, however this was later cancelled and rescheduled for 1 July 2021.

18. Mary attended for surgery on 1 July 2021 but the procedure was cancelled and rescheduled. Over the following week, the surgery was cancelled several more times and was not completed prior to Mary's death.

19. On 6 July 2021, Mary collapsed at home and went into cardiac arrest. She was transferred to the ED at AWH. Despite resuscitation efforts, including the administration of thrombolytic medication, she could not be assisted and she passed away.

20. Police commenced an investigation and collected photographic evidence, which formed part of the coronial brief.

Identity of the deceased

21. On 13 July 2021, Mary Veronica Morrow, born 6 June 1953, was visually identified by her son, Michael Guest.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 15 July 2021 and provided a written report of his findings dated 25 August 2021.

24. Dr de Boer opined that death was caused by pulmonary thromboembolism; thrombotic occlusion of main pulmonary vessels by a detached thrombo-embolism from elsewhere in the body. He explained that this causes severe build-up of pressure in the lung circulation, with eventual loss of cardiac function and death. Thromboemboli usually form in the deep veins of the calves, as was seen in the left leg in this case.

25. Dr de Boer stated that various risk factors for developing thromboembolism are known. In general, anything that affects the so-called 'triad of Virchow' alter the risk of thromboembolism. This triad refers to alterations in blood flow, vessel wall integrity and blood coagulability. General acquired risk factors are prolonged bed rest or immobilisation; severe trauma, burns, fracture or surgery; congestive heart failure; malignancy (cancer); obesity and smoking. Some risk factors for thromboembolism are inherited.

26. He observed that of the above-mentioned risk factors, at least the following were identified in this case: recent severe trauma (fracture), immobilisation and obesity. The location of deep vein thrombosis, in the same region of the trauma, is additional evidence for a relation between the two.

27. Dr de Boer stated that trauma patients ordinarily receive therapy to decrease the risk of thrombo-embolism. From the received information it was unclear whether the decedent received such therapy in the period prior to death.

28. Toxicological analysis of post-mortem samples identified the presence of Citalopram and Paracetamol. Dr de Boer commented that there were no relevant toxicological findings in relation to the cause of death.

29. Dr de Boer provided an opinion that the medical cause of death was 1(a) pulmonary embolism, 1(b) deep venous thrombosis, 1(c) fractures of the left distal tibia and fibula.

30. I accept and adopt Dr de Boer's opinion.

FURTHER INVESTIGATIONS

Mary's clinical treatment at AWH

31. In a statement dated February 2022, Dr Barbara Robertson, Director of Anaesthetics, provided details of Mary's clinical treatment whilst at AWH.

32. Dr Robertston stated that Mary presented on 26 June 2021 with a discharge letter from ED at Robina Hospital in Queensland which confirmed she was offered surgery at the time and prescribed analgesia and a Clexane injection every morning. She was wheelchair-bound at the time and reported mild pain.

33. Following an x-ray, the ankle fracture was confirmed, and the orthopaedic registrar considered surgery appropriate. This was scheduled for 28 June 2021. The orthopaedic registrar noted that

Mary was taking VTE prophylaxis medication and considered she had an adequate supply of analgesic and Clexane medication. Overall, he assessed her to be reasonably fit, well, active and had reasonable supports at home.

34. The surgery on 28 June 2021 was cancelled and rescheduled for 1 July 2021, with Mary attending AWH that day. That surgery was also cancelled and rescheduled for 2 July 2021. Surgery was cancelled a further three times.

35. It appears that during this period, anti-coagulation treatments were ceased. Mary's sister stated that she administered a Clexane injection on each of 25 and 26 June 2021. A calendar entry on Mary's phone indicates that the last Clexane injection was due on 28 June 2021, although it is unclear whether Mary administered doses beyond 26 June 2021.

36. Dr Robertson stated that the reason for the cancellations was due to a full emergency/urgent theatre list and/or no bed being available at AWH. She conceded that there was insufficient documentation in relation to the rescheduling, including any factors that were considered and any communication with Mrs Morrow.

37. In this respect, Dr Robertson explained that, at the time, there was no documented process to oversee the management of potential clinical risks of patients awaiting urgent theatre at home, and no policies guiding the management of patients who awaited rescheduled surgeries.

38. On 6 July 2021, Mary arrived by ambulance and was non-responsive and not breathing. Resuscitation attempts were unsuccessful, and she was declared deceased later that afternoon.

Internal review

39. Following Mary's death, AWH undertook a Root Cause Analysis (**RCA**) and notified SCV.

40. Regarding managing the risks of VTE, the RCA found that:

    a) There was a lack of documentation regarding the ongoing management of, and discussion with, Mary about continuing anti-coagulation following her presentation to the AWH emergency department on 26 June 2021.

    b) Given the multiple cancellations of theatre, a referral to Occupational Therapy, Fracture Clinic and /or more comprehensive review and management of Mary's needs while awaiting theatre at home would have been warranted.

c) There was no documented process to comprehensively oversee the management of potential clinical risks of the patient while awaiting urgent theatre at home. For example, the Emergency Theatre Booking System (**ETBS**):

i. Did not flag patients whose surgeries had been cancelled multiple times;

ii. Did not display a running tally of days waiting for surgical procedure for ease of review; and

iii. Did not enable reports to be generated, as it was not supported by up-to-date IT applications.

d) While the Orthopaedic Registrars had developed a tracking system to monitor patients, this was not transparent to the wider perioperative team, was not secure and was over-written daily meaning that there was no ability to track and report previous entries.

e) There was no clear communication nor a policy or procedure requiring the Orthopaedic team to consult with the Access and Flow Unit to book a bed for urgent theatre patients.

f) Inadequate documentation by the Orthopaedic Registrars made it difficult to track Mary's care and the advice and instructions given to her.

41. The RCA Review Panel made the following recommendations, and Dr Barbara noted the progress of each as of February 2022:

a) A more structured and transparent process to manage patients in the community while awaiting urgent theatre that addresses and manages clinical risk.

A new process was commenced which includes oversight of orthopaedic patients waiting in the community by the Consultant. Further, a new orthopaedic liaison position is being developed to assist with the ongoing management of such patients.

b) The ETBS is fully reviewed to determine best practice models.

The operating theatre list was realigned to allow a dedicated orthopaedic emergency list every day of the week. This new model has meant that emergency cases are being expedited due to an emergency session allocated every day, and cases requiring long operations are booked ahead in a semi elective list as required.

c) *A review of the alternate process utilised by Registrars to track emergency urgent surgery to determine a secure IT solution to meet the needs of the organisation.*

An Urgent Cases theatre schedule is being developed by IT to facilitate firm scheduling of the urgent cases on ETBS.

d) *A procedure to be determined and implemented that ensures the Access and Flow unit are aware of pending admissions for emergency/ urgent surgical interventions.*

The Urgent Cases theatre schedule, referred to above, will be visible to all AWH staff, including Access and Flow.

e) *Feedback to be provided to the Orthopaedic Registrar group regarding the expectation and medico legal requirement of adequate documentation.*

Feedback has been provided to the Orthopaedic Team, with ongoing discussions each week. Specifically, feedback has also been provided to the Registrars.

CPU Review

42. I requested the CPU review all materials and provide advice regarding the adequacy of medical care provided and any prevention opportunities.

43. The CPU confirmed that VTE prophylaxis treatment Mary received in Queensland was appropriate and in accordance with both:

a) the *Australian Commission on Safety and Quality in Healthcare: Venous Thromboembolism Prevention Clinical Care Standard* (October 2018) (**National Standard**); and

b) local (Queensland) guidelines.

44. However, the CPU raised significant concerns regarding the adequacy of care provided to Mary by AWH, following her discharge from the emergency department on 26 June 2021 and over the course of her numerous surgery cancellations.

45. In particular, the CPU was concerned that clinicians did not adequately manage those risks of VTE which apply to patients being discharged from Emergency Departments with a significant reduction of their mobility compared to their normal state.

46. Overall, the CPU considered that Mary's death was preventable had the National Standard regarding VTE prophylaxis been consistently followed after her return to Victoria and VTE prophylaxis maintained over the period prior to surgery.

47. The CPU noted that due to inadequate medical documentation, the extent to which the risks of VTE prophylaxis were considered or communicated to Mary could not be known which was, in and of itself, a significant concern. Further, as was conceded by Dr Robertson, it was clear that no clinician caring for Mary at AHW took overall responsibility for this aspect of her care.

48. The CPU considered that certain aspects of the National Standard which relate to patients discharged from an emergency department are not widely appreciated in Victoria, due to the absence of a state-based guideline as exists in Queensland or NSW.

Previous consideration of VTE risk management in patients discharged from Emergency Department with reduced mobility

49. A number of previous coronial findings have recommended the need for improved Victorian guidance to support clinicians to undertake VTE risk management appropriately.[4]

50. On 7 June 2019, Coroner Jacqui Hawkins published a finding without inquest into the death of Maria Kerr (COR 2017 006132).[5] That matter concerned a 60-year-old woman who suffered a fracture to her ankle and there was a delay in surgery, resulting in her developing deep vein thrombosis, VTE, pulmonary embolism and eventually death. The medical cause of death at autopsy was pulmonary thromboembolism in a woman recovering from a fractured right ankle.

51. The finding included the following recommendation to Safer Care Victoria – Emergency Care Clinical Network (**ECCN**):

    a) to develop, implement and disseminate an Emergency Department Practice Update to be distributed to all Victorian health service Emergency Departments advising of the new clinical standard *Venous Thromboembolism Prevention Clinical Care Standard* (October 2018) and their need to ensure their policies and procedures are up-to-date, specifically

[4] See Finding into the death of Eoghan Jerome Arnold (COR 2018 5766), https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202018%205766%20-%20E.Arnold%20-%20Finding.pdf; Finding into the death of Ann-Maree Manno (COR 2019 1589), https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202019%20001598%20Manno%20Finding.pdf; Finding into the death of Maria Kerr (COR 2017 006132), https://www.coronerscourt.vic.gov.au/sites/default/files/2019-07/MariaKerr_613217.pdf.

[5] See https://www.coronerscourt.vic.gov.au/sites/default/files/2019-07/MariaKerr_613217.pdf.

in relation to VTE risk management of patients who are discharged from an Emergency Department with significantly reduced mobility compared to their normal state.

52. In a letter dated 11 September 2019, Professor Euan Wallace committed to implementation of this recommendation by:

    a) Distributing the new clinical standard Venous Thromboembolism Prevention Clinical Care Standard to Victorian health services, clinicians and consumers through the monthly Safer Care Victoria clinical newsletter; and

    b) Distributing information about the new clinical standard via email from the ECCN to Victorian emergency department directors, nurse unit managers, and urgent care centre directors of medicine and directors of nursing, encouraging alignment of policies and procedures by the end of the year; and

    c) The ECCN Insight sub-committee endeavouring to use the coroner's recommendation to inform the development of its suite of quality and safety indicators where applicable.[6]

Update from Safer Care Victoria

53. On 21 October 2022, I sought an update from SCV regarding the status of the implementation of the recommendations in the Kerr finding.

54. By letter dated 14 November 2022, SCV's Chief Executive Officer, Professor Mike Roberts, confirmed that on the 19 September 2019 the Emergency Care Clinical Network distributed information about the new clinical care standard (Venous Thromboembolism Prevention October 2018) to Victorian emergency department directors, nurse unit managers, and urgent care centre directors of medicine and directors of nursing, encouraging alignment of policies and procedures. They also provided links to the Commission's Consumer and Patient factsheets for use by health services. This information was also published in the SCV News in September 2019.

55. Professor Roberts further indicated that:

[6] See https://www.coronerscourt.vic.gov.au/sites/default/files/2019-09/2017%206132%20Response%20to%20recommendation%20from%20Safer%20Care%20Victoria_KERR.pdf.

a) SCV was currently reviewing local guidelines around VTE prophylaxis, in light of previous recommendations to create a guideline similar to the one used by Queensland Health.

b) There is a measure relating to venous thromboembolism currently included in SCV's list of priority measures for their Quality and Safety Signals (QASS) group. SCV is still determining how this measure informs iterative improvements in VTE safety monitoring.

c) While SCV "strongly urge" the use of the National Standard, they are not in a position to mandate adherence and do not audit the use of externally created guidelines. SCV is therefore unable to advise whether the measures have been implemented at Emergency Departments.

56. On 4 August 2023, SCV provided a further update that in response to two similar recommendations directed by Coroner English,[7] SCV has coordinated an expert working group to draft the Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients. SCV advised that the new guideline had been drafted to align with the National Standard and includes clear guidance for Thromboprophylaxis in patients leaving the Emergency Department with immobilised lower limb injury. SCV considered that the new Guideline would assist Victorian health services to develop and audit local VTE guidelines.

57. SCV indicated that the draft guideline had been endorsed and was scheduled for release in August 2023. However, I note that as at 15 September 2023, the guideline did not appear to have been published on the SCV website. To ensure this initiative is progressed as proposed, I have included a recommendation to this effect.

Response by Albury Wodonga Health

58. In accordance with procedural fairness, AWH was also afforded an opportunity to respond to draft findings and recommendations in this matter. In response, a statement was provided by Dr Annabel Martin, the Chief Medical Officer of AWH dated 8 September 2023.

[7] Finding into the death of Eoghan Jerome Arnold (COR 2018 5766), https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202018%205766%20-%20E.Arnold%20-%20Finding.pdf; and Finding into the death of Ann-Maree Manno (COR 2019 1589), https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202019%20001598%20Manno%20Finding.pdf.

59. Dr Martin conceded that had Mrs Morrow been clearly instructed and supported to take VTE prophylaxis (40 mg Enoxaparin daily), then her risk of developing DVT would have been "lower".[8] However, Dr Martin considered that it was ultimately "difficult to confirm" what would have been the outcome for Mrs Morrow had procedures been in place to ensure this occurred. In this respect, Dr Martin noted that as Mrs Morrow was planned to have surgery, she would have been instructed to withhold a dose of DVT prophylaxis 12-24 hours before the planned surgery due to the risk of bleeding, subsequently interrupting routine administration, and thus altering the risk again.

60. In response to the CPU's opinion that Mary's death was preventable had the National Standard regarding VTE prophylaxis been consistently followed, Dr Martin stated that:

    a) The National Standard is not intended to be a clinical practice guideline and does not provide the level of detail required to inform VTE risk assessments or the provision and management of VTE prophylaxis prescribing. There is no current Australian clinical practice guideline for the prevention of VTE acquired in hospital.

    b) The National Standard does not explicitly address patients such as Mrs Morrow who are temporarily discharged from the emergency department to await surgery in the community to be performed at the same hospital. Dr Martin recognised that the National Standard does explicitly provide in its scope that it applies to those who are "[d]ischarged home from the emergency department with significantly reduced mobility compared to their normal state (for example, due to a lower-limb injury requiring immobilisation with a plaster cast/brace)." However, she considered that this "appears to contemplate the coverage of those patients where they are discharged from the emergency department to receive care from other healthcare providers within the community."

61. While I do not agree with Dr Martin's narrow interpretation of the National Standard's application, I support the need for improved and detailed guidance with regard to VTE risk management of patients who are discharged home, including in circumstances where they are temporarily discharged from the emergency department to await surgery in the community to be performed at the same hospital.

[8] Dr Martin noted that AWH understands that the Orthopaedic Registrar had in fact advised Mrs Morrow on 26 June 2021 to continue VTE prophylaxis. However, AWH has previously conceded that inadequate documentation by the Orthopaedic Registrars made it difficult to track Mary's care and the advice and instructions which were given to her.

62. Dr Martin stated that in response to this perceived gap, AWH had developed the Orthopaedic Outpatient Emergency Follow-up Procedure (PRO1873). This procedure was intended to ensure that patients discharged from the AWH Emergency Department who require surgery and are listed on the emergency theatre booking list, but are awaiting surgery in the community, have a VTE risk assessment and are provided VTE prophylaxis as per the VTE risk assessment tool (MR 104). These patients are now reviewed daily by telephone by the orthopaedic team to ensure the risk assessment stays current and any new concerns are addressed.

63. Further, Dr Martin noted that AWH has a local VTE Risk Management Procedure (PRO0006) which is concordant with the National Standard and in March 2022 adopted the Clinical Excellence Commission NSW VTE risk screening and management tools for local implementation.

64. Dr Martin noted that AWH will continue to review its system of VTE prevention to ensure compliance with standards, including the National Standard, and clinical guidance documents applicable. AWH would also continue to audit its compliance with its system of VTE prevention to ensure it continuously improves in this area and minimises the risk of preventable harm to its patients.

65. I commend AWH on the work it has undertaken to improve its practice in this regard.

66. Noting the imminent release of the new Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients, I have made a recommendation below that AWH continue to review its policies to ensure compliance.

FINDINGS AND CONCLUSION

67. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Mary Veronica Morrow, born 6 June 1953;

    b) the death occurred on 6 July 2021 at Albury Wodonga Health, Wodonga Hospital, 69 Vermont Street, Wodonga, Victoria, 3690, from 1(a) pulmonary embolism, 1(b) deep venous thrombosis, 1(c) fractures of the left distal tibia and fibula; and

    c) the death occurred in the circumstances described above.

68. Having considered all of the circumstances, I am satisfied to the requisite standard that Mary's death was preventable if there had been processes in place to adequately manage those risks of VTE which apply to patients being discharged from Emergency Departments with a significant reduction of their mobility compared to their normal state, including in circumstances where they are temporarily discharged from the emergency department to await surgery in the community to be performed at the same hospital.

69. I commend AWH on the work it has undertaken to improve practices in this regard and recognise that the gap in processes at the time of Mrs Morrow's death reflected a broader issue deriving from the absence of state-based guidelines with regard to the management of VTE prophylaxis in these circumstances.

70. In this respect, I commend SCV on its ongoing work to develop state-wide guidelines and increase clinician knowledge of these issues.

71. I am hopeful that these initiatives will prevent future deaths in similar circumstances and have made recommendations below which are intended to support ongoing work in this regard.

RECOMMENDATIONS

72. Pursuant to section 72(2) of the Act, I make the following recommendations:

    a) that SCV finalise and publish a Victorian guideline on VTE risk management of patients who are discharged from an Emergency Department with significantly reduced mobility compared to their normal state, having regard to the *Australian Commission on Safety and Quality in Healthcare: Venous Thromboembolism Prevention Clinical Care Standard* (October 2018) and other state-based guidelines.

    b) that Albury Wodonga Health continues to regularly review its system of VTE prevention to ensure compliance with applicable standards, including any newly-released Victorian Guideline for the Prevention of Venous Thromboembolism (VTE) in Adult Hospitalised Patients.

I convey my sincere condolences to Mary's family for their loss and acknowledge the grief you have endured.

I direct that a copy of this finding be provided to the following:

Michael Guest, Senior Next of Kin

Kate Woods, Family

Safer Care Victoria

Leading Senior Constable Mark Paynter, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date: 10 October 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.