IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004552

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Reginald Desmond Benham
Date of birth:	02 October 1933
Date of death:	25 August 2019
Cause of death:	1(a) Intracranial haemorrhage in the setting of a fall in a man with multiple comorbidities (palliated)
Place of death:	Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3677
Keywords:	Fall; hospital; medical; stroke; medication administration error

INTRODUCTION

1. On 25 August 2019, Reginald Desmond Benham was 85 years old when he died at Wangaratta Hospital. At the time of his death, Mr Benham lived in Yarrawonga with his wife, Judith Benham.

2. Mr Benham is remembered by his family as a strong-willed man who never gave up without a fight.

3. Mr Benham had a complex medical history including multiple myeloma with multiple bony metastases, recurrent deep venous thrombosis and pulmonary emboli, atrial fibrillation, depression, chronic airways disease, coronary artery bypass grafting for ischaemic heart disease and anaemia. Mr Benham was not treated with anticoagulation due to an additional history of bleeding.

THE CORONIAL INVESTIGATION

4. Mr Benham'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.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Reginald Desmond Benham 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.[1]

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

Circumstances in which the death occurred

8. At 7:46pm on 24 August 2019, Ambulance Victoria (**AV**) received an urgent call to attend at Mr Benham's home in Yarrawonga. Mrs Benham had located Mr Benham collapsed on the floor after hearing a 'thud', and it appeared he had suffered a fall.

9. At 8pm AV paramedics arrived at the scene and observed Mr Benham had a right facial droop, paralysis of his right side and a bleeding laceration around his right ear. He was unable to speak.

10. He was transferred to Wangaratta Hospital Emergency Department (**ED**) as an urgent 'Code Stroke',[2] arriving at 9pm. At the ED, clinicians observed that Mr Benham had right sided weakness consistent with a stroke, and a computed tomography (**CT**) brain scan was immediately performed at 9:03pm.[3]

11. At 9:39pm clinicians consulted with the Victorian Stroke Telemedicine Service[4] (**VST**), a division of Ambulance Victoria, via two telephone calls lasting 30 minutes in total. According to VST consultation records, the consultant neurologist advised that the results of the CT scan were normal and confirmed the diagnosis of ischaemic stroke. They recommended that intravenous thrombolysis with Alteplase[5] be administered.

12. At 10:45pm, after obtaining consent from Mr Benham's family, thrombolysis was commenced.[6]

13. At some time between the commencement of thrombolysis and 11:23pm, ED clinicians were made aware of the report of results of the CT scan. The report stated *"c/w recent small volume*

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[1] 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.

[2] A Code Stroke is activated for patients presenting with symptoms and/or signs of a stroke to allow for rapid assessment so that the patient can receive the most timely and appropriate treatment.

[3] Coronial Brief (**CB**), Statement of Dr David Cooper, dated 29 May 2020.

[4] The VST is a virtual service which links regional hospitals to a network of stroke consultants who can provide urgent treatment advice about patients with acute stroke symptoms. https://www.ambulance.vic.gov.au/about-us/our-services/victorian-stroke-telemedicine/.

[5] Thrombolysis protocol uses a tissue plasminogen activator with the trade name Alteplase that dissolves clots within the body. The most immediate risk is of bleeding including fatal intracranial bleeding.

[6] CB, Medical records of Northeast Health.

haemorrhage in the subarachnoid space". Thrombolysis is contraindicated in traumatic intracranial haemorrhage.[7]

14. At 11:23pm clinicians again consulted with the VST consultant neurologist via two telephone calls lasting a total of 15 minutes. The clinicians advised the neurologist of the radiologist's finding of subtle subarachnoid blood, which the neurologist agreed was correct. Clinicians were advised to cease thrombolysis. Approximately half of the infusion had been administered at this time.

15. Unfortunately, Mr Benham deteriorated rapidly. A second CT brain scan showed a large subarachnoid haemorrhage which was deemed to be non-survivable. Following discussion with Mr Benham's family, the decision was made to palliate. Mr Benham died at 8:15pm on 25 August 2019.[8]

Identity of the deceased

16. On 25 August 2019, Reginald Desmond Benham, born 2 October 1933, was visually identified by his son, Craig Benham, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Reginald Benham on 29 August 2019 and provided a written report of his findings dated 19 September 2019. Dr Bouwer had available to him the following materials:

    a) Victoria Police Report of Death (Form 83)

    b) E-Medical Deposition Form

    c) Northeast Health medical records

    d) Denis Medical group records

    e) Post mortem CT scan

    f) Ante mortem perfusion and CT brain scans from Wangaratta Hospital

[7] Court File (**CF**), Medical Examiner's Report of Dr Heinrich Bouwer.
[8] CF, E-Medical Deposition Form.

19. The post mortem CT scan showed a large convexity right subdural haemorrhage with minor convexity subarachnoid haemorrhage and intravascular extension, Duret haemorrhage and significant mass effect.

20. Radiologist Dr Chris O'Donnell at the VIFM reviewed the ante-mortem perfusion and CT brain scans taken on 24 August 2019. The perfusion scan showed acute left middle cerebral artery territory perfusion defect, consistent with an acute stroke. The CT scan showed subtle right occipito-parietal cortical and traumatic subarachnoid haemorrhage.

21. Dr Bouwer noted that Mr Benham was given tissue plasminogen activator (Alteplase) for thrombolysis which caused a massive cerebral haemorrhage and subsequent death.

22. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) INTRACRANIAL HAEMORRHAGE IN THE SETTING OF A FALL IN A MAN WITH MULTIPLE COMORBIDITIES (PALLIATED).

FURTHER INVESTIGATIONS

CPU Review

23. After perusing the evidence available to me at the early stages of the investigation and noting that the incorrect treatment protocol may have been implemented, I referred the matter to the Health and Medical Investigation Team within the Coroners Prevention Unit (**CPU**) for a preliminary clinical review.[9]

24. The CPU advised me that they had identified two areas which warranted further examination.

    a) It appeared that an error was made by the VST consultant neurologist in the interpretation of the CT scan; and

    b) It appeared that the subtle findings of sub-arachnoid haemorrhage were not immediately communicated by the reporting radiologist to the clinical staff, representing a delay in ceasing the thrombolysis.

25. Having received the preliminary advice of the CPU, I requested that they further investigate these issues. As part of their investigation, the CPU requested and received statements from Professor Christopher Bladin, Director, Victorian Stroke Telemedicine and Director of Stroke

[9] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Services in Ambulance Victoria, and Dr David Cooper, Director of Medical Services, Northeast Health.

Was an error made by the VST consultant neurologist in the interpretation of the CT scan?

26. In his statement to the Court, Professor Bladin described the process by which VST consultant neurologists interpret CT scan results. He advised that the neurologist reviews all imaging remotely via the Picture Archiving and Communication System (PACS) and the assessments made by the VST consultant are then used to guide treatment.

27. According to Professor Bladin, ordinarily the report of the radiologist would follow some hours later and would not be appropriate for time critical therapy. He further noted that this was typical of most acute stroke treatment settings, including metropolitan hospitals. I accept this explanation and the need for urgent treatment for patients with a stroke diagnosis.

28. This is supported by Northeast Health's Thrombolysis Protocol which includes the checklist item 'Confirm CT head has excluded haemorrhage […] (verbal report from radiology/consultant physician is reasonable. There is no requirement for VRC written report)'.[10]

29. Professor Bladin conceded that the VST consultant neurologist made an error while interpreting the CT scan, stating *"at the time a small (subtle) area of haemorrhage was missed on the non-contrast CT."*[11] He further admitted that in such a time critical scenario, subtle changes on the CT scan that may influence therapeutic decision making "may be overlooked".

30. On 2 September 2019 Professor Bladin undertook a major clinical case review of Mr Benham's matter, finding that other than the missed subarachnoid haemorrhage, the VST neurologist acted appropriately.

    "In this case the CT perfusion scan was favourable to quickly commencing stroke thrombolysis, but in doing so a very small Subarachnoid haemorrhage (SAH) was overlooked. Importantly, as soon as it was discovered, the tPA infusion was ceased." [12]

31. I accept both the concession that an error was made by the VST consultant neurologist, and the assessment that they otherwise acted appropriately in providing clinical advice.

[10] CB, Medical records of Northeast Health, Thrombolysis Protocol for use in acute stroke.
[11] CB, Statement of Professor Christopher Bladin, dated 24 April 2020.
[12] CB, Statement of Professor Christopher Bladin, dated 24 April 2020.

Was there a delay in communicating the subtle findings of sub-arachnoid haemorrhage by the reporting radiologist to the clinical staff at the Wangaratta ED?

32. At the time of Mr Benham's death, I-MED Radiology Network Ltd (**I-MED**) provided radiology services to Wangaratta Hospital.

33. Dr Cooper and Professor Bladin provided conflicting evidence as to whether there was a delay in communicating the finding of sub-arachnoid haemorrhage.

34. Dr Cooper advised the Court that a health service investigation following Mr Benham's death found that the I-MED radiologist's report was available on the hospital's electronic system 'Orion' at 10:42pm and checked by ED staff 10:43pm. However, the medical registrar undertaking the thrombolysis treatment did not become aware of the report until sometime around 11:23pm when the VST was again contacted. [13] This represents a delay of at least 40 minutes in communicating findings to treating clinicians.[14]

35. Dr Cooper provided with his statement a copy of I-MED's Clinical Reports Procedure. Section 4.8 Critical, Urgent and non-Urgent Significant Unexpected Findings provides that significant radiological findings must be phoned to the referring doctor.

    The results must also be phoned through to the referring doctor and a note made in the Radiologist's report that this was done including the time and date of the call. In a case where the referrer is not available, another doctor at the practice or the admitting doctor in the emergency department must be contacted -whatever is applicable- and their names must be notated in the report.[15]

36. I note also that The Royal Australian and New Zealand College of Radiologists (**RANZCR**) Standards of Practice for Clinical Radiology provides minimum standards for the provision of safe radiology services. Section 5.5.2 Communication of Imaging Findings and Reports provides an indicator that

[13] CB, Statement of Dr David Cooper, dated 29 May 2020.

[14] I note a discrepancy in the statement of Dr Cooper and subsequent submissions on behalf of Northeast health that state the time of thrombolysis commencement as 10:25pm while medication charts state the commencement time as 10:45pm. I rely on the contemporaneous medical record as being the true time of commencement and assume that 10:25pm is a typographical error.

[15] Section 4.8, I-MED Radiology Network Clinical Reports Procedure Reporting & Recording of Imaging Findings, Version 1.1 December 2019, adopted September 2018.

"The practice has a protocol for urgent and significant unexpected findings that ensures [...] the reporting radiologist uses all reasonable endeavours to communicate directly with the referrer or an appropriate representative who will be providing clinical follow up."[16]

37. There is no evidence that the radiologist phoned through their findings in accordance with I-MED policy, or RANZCR standards.

38. Whilst the statement and annexures of Dr Cooper appear to point to I-MED as the source of the delay in communicating the findings, Dr Cooper did not provide an explanation as to why ED staff that accessed the report at 10:42pm did not advise Mr Benham's treating clinicians that the report was available.

39. In contrast with the evidence provided by Dr Cooper, Professor Bladin stated that *"in this case, the radiologist was able to communicate promptly with the ED staff and VST consultant about the presence of haemorrhage so that the thrombolytic therapy could be stopped."*[17]

40. Conversely, the evidence indicates that the reporting radiologist failed to telephone through the finding of sub-arachnoid haemorrhage, and Wangaratta Hospital ED staff failed to advise Mr Benham's treating clinicians that the report was available. In the circumstances, I cannot reconcile the statement of Professor Bladin that the radiologist "communicate[d] promptly".

41. At the time of CPU's review, it was unclear at exactly what time the radiologist reviewed the CT scan and identified the sub-arachnoid haemorrhage. However, assuming it was at some time between the scan's commencement at 9:03pm and the report being viewed at 10:42pm, had this been immediately communicated, thrombolysis treatment may not have commenced.

42. The exact reasons for the communication delay notwithstanding, it remains that by not informing Mr Benham's treating clinicians of the availability of the report, an opportunity was lost to either not commence or to cease the thrombolysis treatment.

Mention Hearing

43. On 28 May 2021 I convened a Mention Hearing to allow interested parties an opportunity to respond to potential adverse comments and/or findings in relation to their engagement with Mr Benham.

[16] https://www.ranzcr.com/search/standards-of-practice-for-clinical-radiology
[17] CB, Statement of Professor Christopher Bladin, dated 24 April 2020.

44. The coronial brief containing the statements of Professor Bladin and Dr Cooper, Northeast Health medical records and CPU's memorandum of advice was provided to interested parties prior to the hearing.

45. Ms Hayley Challender appeared to assist me. Ms Katarina Bilandzic appeared for I-MED Radiology Network Ltd, Ms Rachel Ellyard appeared for Ambulance Victoria and Ms Deborah Foy appeared on behalf of Northeast Health.

46. I indicated that I would likely adopt the advice of the CPU, namely that there were opportunities lost with regards to Mr Benham's treatment. However, I could not say that his death would have been prevented had those opportunities been presented[18] – as the CPU advised, it is unknown whether Mr Benham would have subsequently succumbed to his large thromboembolic stroke if the thrombolysis was withheld.[19]

47. Ms Ellyard and Ms Foy indicated that they accepted this, noting in particular that the evidence could not permit a firm finding of the consequences of those opportunities lost. Ms Ellyard submitted that but for the subtle subarachnoid haemorrhage, the imaging suggested that Mr Benham was a good candidate for therapy.[20]

48. Ms Bilandzic for I-MED, having recently become an interested party, sought a further two weeks to provide a statement on behalf of her client, which I granted.

Submissions following Mention Hearing

I-MED Radiology Network Ltd

49. Following the Mention Hearing, the Court received a statement from Dr Murray Bartlett, Clinical Director of I-MED Radiology Network's teleradiology service. This statement was disseminated to interested parties.

50. Dr Bartlett provided clarification as to the timing of the CT scan and subsequent report.[21]

    a) Mr Benham underwent a CT scan of his brain at approximately 9:03 pm

    b) The scan was completed by approximately 9:35 pm

[18] Transcript of Proceedings (**TP**) at page 5.
[19] CB, Coroners Prevention Unit Health & Medical Consulation Memo.
[20] TP at page 7.
[21] Statement of Dr Murray Bartlett, dated 17 June 2021.

c) The scan was reviewed by a radiologist at approximately 9:43 pm and the report dictated

d) The report was typed at 10.14 pm, and verified by the radiologist at 10:27 pm

e) The verified radiology report was distributed to Wangaratta Hospital at 10:31pm

51. He confirmed that the phoning through of unexpected findings was I-MED's policy at the time of Mr Benham's death. He stated there was no evidence of this on Mr Benham's records, but that the reporting radiologist confirmed that their usual practice would be to phone through such findings.

52. I note that the thrombolysis was not administered until approximately 62 minutes after the I-MED radiologist had reviewed the CT scan and as such, had they called the referring doctor in accordance with I-MED policy, Mr Benham's treating clinicians would have had the opportunity to seek further advice from the VST prior to administering the treatment.

53. Dr Bartlett outlined the restorative measures implemented by I-MED, though it is unclear whether these were implemented as a result of Mr Benham's death. I-MED now utilises a voice recording software to instantaneously transcribe reports, which according to Dr Bartlett has significantly reduced the time between the imaging being reviewed and the report being distributed.

54. The same software is used to arrange telephone calls to referring doctors in accordance with I-MED policy. The policy requirement to phone through unexpected findings was reiterated to all radiologists in a newsletter dated 29 March 2021.

55. Further, Dr Bartlett advised that I-MED regularly audits around 5% of all CT reports to ensure compliance with policy. Radiologists who are found to be non-compliant are individually contacted and re-trained, and continued non-compliance is considered a disciplinary matter.

Northeast Health

56. Having received the statement of Dr Bartlett, Ms Foy provided submissions to the Court on behalf of Northeast Health.[22]

57. Ms Foy advised that following an audit of Wangaratta Hospital's IT system, it appeared that the radiologist's report had been opened at 10:43pm by a nursing student uninvolved in Mr Benham's care. However, Ms Foy did not address why the nursing student did not advise Mr

[22] CF, Submissions on behalf of Northeast Health, dated 26 July 2020.

Benham's treating clinicians, or what the Hospital's ordinary course would be in such a situation.

58. Ms Foy submitted that clinicians' reliance on the advice of the VST consultant neurologist in commencing thrombolysis was reasonable in the circumstances. Ms Foy pointed to the evidence of Professor Bladin as outlined in paragraph 31 of this Finding and stated that the scenario reflects the purpose of the VST in providing time critical specialist advice to regional hospitals to avoid delay.

59. Ambulance Victoria did not make further submissions, as foreshadowed by Ms Ellyard at the Mention Hearing.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. I recently investigated the death of Mr Jeffrey Marsden[23] who died in January 2019 following a fall. Mr Marsden had sustained fractures to the C1 and C2 vertebrae and in similar circumstances to this matter, the I-MED radiologist reviewing Mr Marsden's CT scan did not phone through their significant findings to the referring doctor.

2. It is of concern that I have investigated two deaths in an eight-month period whose shared circumstances involve a radiologist failing to follow I-MED policy and RANZCR standards. I note that neither instance was necessarily causal to the deaths. However, in line with my prevention role[24] it would be remiss of me not to draw attention to these failings, whether they were coincidental or indicative of a wider pattern of non-adherence to accepted standards.

3. In my *Finding into death without inquest*[25] in the matter of Mr Marsden I made the following recommendation:

    i. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Royal Australian and New Zealand College of Radiologists consider using the death of Jeffrey Marsden as a case study in educational campaigns or materials highlighting the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.

[23] COR 2019 000142.
[24] The prevention role of the Coroner is articulated in the Preamble and Purposes of The Act.
[25] https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=jeffrey+marsden

4. I reiterate that same recommendation and implore RANZCR to carefully examine the rigorousness of the means they have to ensure that members of their college and radiologists widely are acting in accordance with their Standards of Practice.

5. I acknowledge the restorative measures implemented by I-MED and encourage the continued reminders to radiologists of their obligations under both I-MED policy and RANZCR standards. I note that while I-MED made no explicit concessions in relation to the death of Mr Benham, Dr Bartlett in his statement did concede that there were no records to suggest that the radiologist had complied with I-MED policy.

6. I acknowledge the concession made by Professor Bladin that the VST consultant neurologist made an error in reviewing the CT scan images of Mr Benham and as a result an opportunity was missed to provide Mr Benham with the appropriate treatment. Humans are not infallible and human error can never entirely be eliminated, even in a healthcare setting where the consequences may be tragic. As such, those working within our healthcare system rely on checks and balances such as those provided for in I-MED's policy and RANZCR standards.

7. I reiterate the comments I made at the Mention Hearing that the VST is a wonderful resource, particularly for regional clinicians.[26] The VST provides a critical service to regional hospitals across Victoria and Tasmania, allowing patients diagnosed with a stroke or presenting with suspected stroke symptoms to access the necessary treatment in the most timely manner. The VST overall has undoubtedly contributed to better patient outcomes at our regional hospitals.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

1. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Royal Australian and New Zealand College of Radiologists consider using the death of Reginald Benham as a case study in educational campaigns or materials highlighting the importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.

[26] TP at page 5.

FINDINGS AND CONCLUSION

1. 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.[27] 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.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Reginald Desmond Benham, born 02 October 1933;

   b) the death occurred on 25 August 2019 at Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3677;

   c) I accept and adopt the medical cause of death as ascribed by Dr Heinrich Bouwer and I find that Reginald Desmond Benham, a man with multiple comorbidities, died from intracranial haemorrhage following a fall.

3. I accept the evidence of Dr Bouwer and find that the thrombolysis caused a massive cerebral haemorrhage and the subsequent death of Reginald Desmond Benham. However, I am unable to determine with any certainty whether he would have succumbed to his large thromboembolic stroke if the thrombolysis was withheld. As such, I am unable to find whether the death of Reginald Desmond Benham was preventable.

4. AND, although I cannot find with any certainty that his death was preventable, I find that due to both the error in interpreting the CT scan and the delay in communicating the findings of sub-arachnoid haemorrhage, the opportunity to provide the appropriate medical care and treatment was lost to Reginald Desmond Benham.

5. AND FURTHER, I find that the clinicians at Wangaratta Hospital acted reasonably and appropriately in adopting the advice of the VST consultant neurologist and administering thrombolysis.

[27] *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…'.

I convey my sincere condolences to Mr Benham's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Judith Benham, Senior Next of Kin

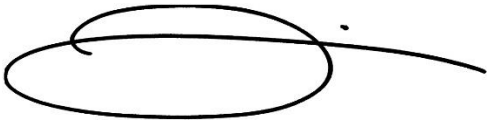
Ambulance Victoria

Northeast Health, Wangaratta Hospital

Hall and Wilcox on behalf of I-MED Radiology Network Ltd

First Constable Jordan Condron, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 July 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.