IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1400

AMENDED FINDING INTO DEATH FOLLOWING INQUEST

Amended pursuant to s.76 and s.76A of the *Coroners Act 2008* (Vic) on 17 March 2021 by order of State Coroner Judge Cain.*

Form 37 Rule 63(1)

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

Inquest into the death of Colleen Elizabeth Fermanian

Delivered on:	29 June 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	29 June 2020
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Ms Sonja Mileska, Senior Solicitor to the State Coroner
Catchwords	Suspected homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest.

*Paragraph 5 has been amended from, '*In 2014, Ms Fermian and Mr Cross were living at a residence in Frankston with her three children. They had various relationship issues and Ms Fermanian kicked Mr Cross out of the house several times*' to 'In 2014, Ms Fermanian and Mr Cross would regularly see each other on weekends. They had various relationship issues and Ms Fermanian's children were concerned about their mother.'

*Paragraph 29 has been amended from '*Mr Cross subsequently attended a residence in Daly Street Frankston*' to 'Mr Cross subsequently attended a residence in Frawley Street Frankston.'

HIS HONOUR:

BACKGROUND:

1. Colleen Elizabeth Fermanian **(Ms Fermanian)** was 45-years-old at the time of her death. She resided in Frankston and is survived by her parents, Ms Glenice Thomson and Mr Gary Wilson.

2. In 2004, Ms Fermanian married Mr Richard Fermanian **(Mr Fermanian)** with whom she had three children.

3. Ms Fermanian was a heavy drinker, and this caused significant strain on her marriage.[1] The Fermanians divorced in 2014. Around the time of the divorce, Ms Fermanian became critically ill with liver disease and was hospitalised for a lengthy period.[2]

4. Following the breakdown of her marriage, Ms Fermanian had an initial brief relationship with Nathan Cross **(Mr Cross)**. Mr Cross has two daughters, IDC and BDC from a previous relationship. Ms Fermanian and Mr Cross met through their children as they attended the same school.

5. In 2014, Ms Fermanian and Mr Cross would regularly see each other on weekends. They had various relationship issues[3] and Ms Fermanian's children were concerned about their mother. They informed Mr Fermanian about the fighting that was occurring. Mr Fermanian applied for full custody of the children and this was granted, with Ms Fermanian only having supervised access.[4]

6. In early 2016, Ms Fermanian moved to Mildura for a period before returning to Melbourne in November 2016.[5] She commenced communicating with Mr Cross again and subsequently moved in with him and his daughters at 11 Daly Street Frankston around January 2017.[6]

7. The property at 11 Daly Street Frankston is a registered rooming/boarding house which provides accommodation for up to seven persons in the main house. There is also a second detached dwelling at the rear of the property, described by Mr Cross as a "bungalow" which is where he and his children resided, along with Ms Fermanian.

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[1] Coronial brief, Statement of Richard Fermanian dated 28 March 2017, 363.
[2] Coronial brief, Statement of Glenice Thomson dated 9 May 2017, 377.
[3] Coronial brief, Statemen of Richard Fermanian dated 28 March 2017, 364.
[4] Coronial brief, Statement of Richard Fermanian dated 28 March 2017, 364.
[5] Coronial brief, Statement of Ian Lang dated 17 April 2017, 140.
[6] Coronial brief, Statement of Richard Fermanian dated 28 March 2017, 363.

8. On 25 March 2017, paramedics were called to 11 Daly Street Frankston as Ms Fermanian was unconscious and bleeding from the mouth. She subsequently died on 29 March 2017 due to blunt force trauma to the head.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Ms Fermanian's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria,[7] was unexpected and as a result of an injury.[8]

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[9] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[10]

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[11] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[12] or to determine disciplinary matters.

12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the phrase "*circumstances in which death occurred,*"[13] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

14. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

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[7] Section 4 *Coroners Act 2008*
[8] Section 4(2)(a) *Coroners Act 2008*
[9] *Coroners Act 2008* (Vic) s 89(4)
[10] *Coroners Act 2008* (Vic) preamble and s 67.
[11] *Keown v Khan* (1999) 1 VR 69.
[12] *Coroners Act 2008* (Vic) s 69 (1).
[13] *Coroners Act 2008* (Vic) s 67(1)(c).

15. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[14]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[15] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[16] These powers are the vehicles by which the prevention role may be advanced.

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[17] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[18] 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 that they caused or contributed to the death.

17. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

18. I note the observations of the Victorian Court of Appeal in *Priest v West*, where it was stated:

    "*If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause, and those circumstances will not have been discharged.*"

19. Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind

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[14] *Coroners Act 2008* (Vic) s 72(1).
[15] *Coroners Act 2008* (Vic) s 67(3).
[16] *Coroners Act 2008* (Vic) s 72(2).
[17] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[18] (1938) 60 CLR 336.

that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[19]

20. In conducting this investigation, I have made a thorough forensic examination of the evidence, including reading and considering the witness statements and other documents in the coronial brief.

21. In this instance, I consider Ms Fermanian's death may be due to homicide, as investigators have been unable to determine the cause of her injuries. No person or persons have been charged in respect of the death at this stage.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

22. On the afternoon of 24 March 2017, Ms Fermanian was at home. IDC and BDC returned home from school and spoke briefly with her.[20] They were excited about an open-air movie night which was being held that evening at IDC's school.

23. Mr Cross arrived home from work at approximately 6pm. He decided to have a brief nap before also attending the movie night.[21] BDC and IDC were to walk to the school, and he would join them later.

24. At approximately 6:30pm, IDC and BDC left home and walked the short distance to the primary school for the movie night.[22] Mr Cross and Ms Fermanian were alone at home and he stated that he had half a glass of wine at this time.[23]

25. At 6:51pm, Ms Fermanian had a phone conversation with her friend, Mr Paul Koshir **(Mr Koshir)** which lasted 27 minutes. Mr Koshir stated that the conversation started as normal, but he noted that Ms Fermanian did not appear to sound good.[24] She asked him to attend the movie night with her and her children, but Mr Koshir did not think this was a good idea.

26. During the conversation, Mr Koshir could hear Mr Cross in the background talking to Ms Fermanian. On several occasions Ms Fermanian spoke directly to Mr Cross.[25] Mr Cross

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[19] *Perre v Chivell* (2000) 77SASR 282.
[20] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017 Q283.
[21] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q325.
[22] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q332.
[23] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q152.
[24] Coronial brief, Statement of Paul Koshir dated 29 March 2017, 209.
[25] Ibid.

stated that she sounded '*a bit dopey*'[26] and he asked her if she felt ok and if she had been drinking.[27] According to Mr Cross, Ms Fermanian appeared offended by this and stated she had not been drinking.[28]

27. At one point towards the end of the conversation with Mr Koshir, Ms Fermanian indicated that Mr Cross had left. She started to speak about her own children but subsequently became upset and hung up the phone.[29]

28. At approximately 7:30pm, Mr Cross stated that he left Ms Fermanian to attend the movie night.[30] He approached Principal Tonia Flanagan who was working on the move night ticket desk. He spoke with her with respect to his daughters before walking off.[31]

29. At approximately 8:15pm, Mr Cross briefly approached Ms Flanagan again before walking off onto Jayne Street.[32] Mr Cross subsequently attended a residence in Frawley Street Frankston to visit his friend, Mr Stuart Morgan. They commenced drinking wine together.[33]

30. At approximately 8:30pm, BDC returned home from the movie night to grab some blankets for IDC and herself, as the evening was getting cold. BDC spoke with Ms Fermanian who was lying in bed. She appeared fine to BDC at this stage.[34] BDC then returned to the school.

31. At approximately 10pm, IDC and BDC left the school grounds at the conclusion of the movie night and walked the short distance home.[35] On arrival, they located Ms Fermanian lying on her bed, with her feet hanging off to the side. She had one eye partially open and had her mobile phone in her hands.[36]

32. It was apparent to IDC and BDC that Ms Fermanian had wet herself and the bed.[37] They were concerned about the way she was snoring, and it was clear that she had been drinking. BDC moved Ms Fermanian's legs up onto the bed and placed a pillow beneath her head.[38] She subsequently contacted Mr Cross at approximately 10pm and asked him to come home.

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[26] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q163.
[27] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q162-3.
[28] Ibid, Q413.
[29] Coronial brief, Statement of Paul Koshir dated 29 March 2017, 210.
[30] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q421-422.
[31] Coronial brief, Statement of Tonia Flanagan dated 9 May 2017, 241.
[32] Ibid, 242.
[33] Coronial brief, Statement of Stuart Morgan dated 25 March 2017, 259.
[34] Coronial brief Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q287, Q364.
[35] Coronial brief Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q378, Coronial brief, Exhibit 33-VARE 1 Transcript of IDC dated 25 March 2017, Q142.
[36] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q401.
[37] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q39, Coronial brief, Exhibit 33-VARE 1 Transcript of IDC dated 25 March 2017, Q159.
[38] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q409.

Mr Cross stated that BDC had informed him that Ms Fermanian had fallen off the bed.[39] However, in BDC's statement to police, she does not mention a potential fall.

33. Mr Cross left Mr Morgan's residence and arrived home between 10.30-11pm.[40] He observed Ms Fermanian lying on the bed and proceeded to take video footage of her on his mobile phone.[41] He stated to police that he did not make further enquiries of BDC as to the circumstances of Ms Fermanian's alleged fall from the bed.[42] According to BDC, he then sat in the lounge room, drinking wine and listening to music.[43]

34. At approximately 11pm, Ms Lia King, a resident of 11 Daly Street was involved in an argument with another resident at the premises.[44] Mr Cross heard the commotion and went to see what had happened. Ms King had injured herself and an ambulance had been called. However, due to the length of time it was taking for the ambulance to arrive, Mr Cross, his daughters and another resident, Mr Trevor Sagor, drove Ms King to the Frankston Hospital for treatment.[45]

35. Ms King was dropped out the front of the Frankston Emergency Department. Mr Cross, his daughters and Mr Sagor returned to Daly Street.

36. At 11:37pm and 11.46pm respectively, Mr Cross took further short videos of Ms Fermanian snoring.[46] He later stated to police that he took this footage as Ms Fermanian often referred to him as being a '*piggy*' when he snores. He wanted to have something which would show her that she also snores.[47]

37. BDC stated that she went to bed close to 1:00am on 25 March 2017, leaving Mr Cross up drinking.[48] He then went to bed a short time later, next to Ms Fermanian.

38. Sometime between 3.30-4am that morning, Ms Kirsty Ward (another resident of 11 Daly Street) woke up as she could hear crashing, banging and yelling. She believed she could hear Mr Cross and another person whom she believed to be Ms Fermanian.[49] Ms Ward stated that

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[39] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q401, Q451.
[40] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q172-173.
[41] Coronial brief, Exhibit 54-Video Recordings of Colleen Fermanian.
[42] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q456, Q459.
[43] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q429.
[44] Coronial brief, Statement of Lia King dated 25 March 2017, 268.
[45] Coronial brief, Statement of Lia King dated 25 March 2017, 269. Coronial brief, Statement of Trevor Sagor dated 25 March 2017, 282.
[46] Coronial brief Exhibit 54-Video Recordings of Colleen Fermanian.
[47] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q87-90.
[48] Coronial brief, Exhibit 30-VARE 1 Transcript of BDC dated 25 March 2017, Q452.
[49] Coronial brief, Statement of Kirsty Ward dated 25 March 2017, 297.

this went on for an hour or so, however she was in and out of sleep during this time.[50] No other residents indicated hearing a disturbance of this kind at the time.

39. At some time between 4:30am to 5:00am, Mr Cross stated that he woke to the sound of Ms Fermanian gargling on the side of the bed.[51] There was red fluid coming from her mouth which Mr Cross believed was red wine. He stated; *'It was dripping out the side of her mouth. If you look at the end of the bed the bile and phlegm where her head was sitting...I put my fingers in her mouth there and got all the stuff out of her mouth and I put her on her side.'*[52]

40. Mr Cross ran to BDC's room and asked to use her phone to contact emergency services as his phone was dead.[53] He then contacted emergency services at 5:11am and requested an ambulance to attend.

41. BDC briefly entered the bedroom during this period and noted that Ms Fermanian appeared very pale.[54] She observed Mr Cross attempt cardiopulmonary resuscitation with instructions from the triple zero call taker.[55]

Arrival of Police and Paramedics:

42. Paramedics arrived at 11 Daly Street shortly thereafter and commenced treating Ms Fermanian. During this time, Mr Cross was requested to clear the driveway of vehicles to allow an ambulance to move up to the area near the bungalow. Mr Cross attended the room of resident Mr Colin Gorman and asked him to move his vehicle. They got into a verbal argument[56] and subsequently paramedics requested the attendance of police.

43. At 6:20am, Ms Fermanian was being prepared to be transported to the Frankston Hospital by Ambulance. Police spoke with Mr Cross who stated that Ms Fermanian had been coughing up blood and that he had tried to clear her mouth before calling emergency services. He further stated that she had been drinking heavily prior to him calling the ambulance.[57]

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[50] Ibid.
[51] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017 Q83, Q91.
[52] Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017 Q91.
[53] Ibid Q110, Q266.
[54] Coronial brief-VARE 2 Transcript of BDC dated 28 January 2019, Q127.
[55] Ibid Q121-125.
[56] Coronial brief, Statement of Colin Gorman dated 25 March 2017, 325-326. Coronial brief, Exhibit 77-Interview transcript of Nathan Cross dated 25 March 2017, Q684-689.
[57] Coronial brief, Statement of Senior Constable Jonathon Edwards dated 5 April 2017, 400.

Hospital attendance:

44. At approximately 6:35am, Ms Fermanian arrived at the Frankston Hospital and was admitted to the emergency ward. Further investigation into her condition identified that she was suffering from head trauma. A CT scan of her brain showed a large left heterogeneous bleed in keeping with acute on chronic subdural haemorrhage (bleeding around the brain).[58] Multiple bruises over her face and abdomen were also noted.[59]

45. A decision was made for Ms Fermanian to be urgently transferred to the Alfred Hospital for review by their neurosurgical team. At the Alfred, it was recognized that Ms Fermanian's head injury was non-survivable, and she was transferred to the intensive care unit **(ICU)** with a view to end of life care. [60]

46. Dr Lloyd Roberts, Intensivist at the Alfred Hospital detailed the visible injuries to Ms Fermanian which were identified whilst in the ICU. Dr Roberts stated that Ms Fermanian had a '*small laceration in front of her left ear, and multiple bruises which continued to evolve during her ICU stay. On 26 March these were documented by the trauma team to include a large sacral bruise, minor bruising of the left forearm, left hip bruising, left knee and lateral shin bruising, left lateral and posterior chest bruising and potentially a bite mark on the left lateral chest.*'[61]

47. Over the course of many family meetings, the prognosis of Ms Fermanian was discussed and a time of withdrawal of treatment was established. Ms Fermanian was declared brain dead at 1:23pm on 27 March 2017.[62]

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

48. On 26 March 2017, Ms Glenice Thomson visually identified her daughter, Colleen Elizabeth Fermanian born 12 August 1971.

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

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[58] Coronial brief Exhibit 72-Medical Records from Peninsula Health dated 25 March 2017, 10.
[59] Coronial brief, Statement of Dr Lloyd Roberts dated 9 June 2017, 356.
[60] Ibid, 357.
[61] Ibid, 357.
[62] Ibid, 357.

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

50. On 29 March 2017, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine **(VIFM)**, performed an autopsy on Ms Fermanian and provided a written report of her findings. Post-mortem examination revealed a right side acute subdural haemorrhage with associated mass effect. Also present were bilateral inferior frontal subarachnoid haemorrhage with a burst lobe and a subarachnoid haemorrhage about the right temporal lobe.[63] Ms Fermanian also had a number of fractured ribs[64] and a bite mark to the left lateral chest.[65]

51. Dr Parsons examined the post-mortem CT scans taken at the Frankston Hospital in conjunction with Radiologist Dr Chris O'Donnell of the VIFM. Their review of the report shows that there was no blood identified in the abdomen on the arrival of Ms Fermanian to the hospital.[66]

52. Dr Parsons was asked to comment on whether Ms Fermanian's injury could have been caused by a fall or assault. She stated; '*in this case, the injuries are consistent with blunt force trauma to the head. This may have occurred following a fall or due to an assault. The autopsy findings do not aid in answering this question.*'[67]

53. Dr Parsons was further asked by police to comment on whether Ms Fermanian's head injury was sustained in the previous 24-48 hours prior to the death or several weeks earlier. In a supplementary report, Dr Parsons stated; '*the head injury identified at autopsy is an acute injury, there is no evidence of perls staining or organisation, this could <u>not</u> have occurred 2 weeks previously. Exact timing of the injury is not possible, but it could fall into the previous 24-48-hour time period.*'[68]

54. Dr Parsons concluded that a reasonable cause of death was

1(a) Blunt force trauma to the head

55. Toxicological analysis of post-mortem specimens revealed the presence of Midazolam which was administered in a hospital setting. Also present was 0.04g/100mL of alcohol.

56. I accept the cause of death proposed by Dr Parsons.

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[63] Coronial brief, Medical Examiner's Report of Dr Sarah Parsons dated 29 June 2017, 97.
[64] Ibid, 95.
[65] Ibid, 91.
[66] Ibid, 98.
[67] Ibid, 98.
[68] Coronial brief, Supplementary Report of Dr Sarah Parsons dated 14 November 2017, 100.

VICTORIA POLICE INVESTIGATION

57. Following Ms Fermanian's death, the Homicide Squad commenced a criminal investigation due to the nature of the injuries she had sustained. However, despite an extensive investigation, police have been unable to establish how Ms Fermanian's injuries occurred and the surrounding circumstances. To date no person or persons have been charged with an indictable offence in connection with the death.

58. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence.

59. In making this finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Ms Fermanian's death may be the result of homicide.

60. Section 49 of the Act provides that the Principal Registrar must notify the Director of Public Prosecutions **(DPP)** if the coroner investigating a death forms the belief that an indictable offence may have been committed in connection with the death.[69]

61. On the basis of Ms Fermanina's injuries, being blunt force trauma to the head, and having reviewed the available evidence, I have formed the belief that on the balance of probabilities, an indictable offence may have been committed in connection with her death.

62. Accordingly, pursuant to s.49 of the Act, I direct the Court's Principal Registrar to notify the DPP of my determination that an indictable offence may have been committed.

63. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at that time.

[69] Section 49.

FINDINGS AND CONCLUSION:

64. Having held an inquest into the death of Ms Fermanian, I make the following findings, pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Colleen Elizabeth Fermanian, born on 12 August 1971;

    (b) That the death occurred on 29 March 2017 at the Alfred Hospital, 55 Commercial Road Melbourne, 3004 Victoria from blunt force trauma to the head and;

    (c) That the death occurred in the circumstances set out above.

65. I convey my sincerest sympathy to Ms Fermanian's family and friends.

66. Pursuant to s.73(1) of the Act, I order that this finding be published on the Internet.

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

    Ms Glenice Thomson, Senior Next of Kin

    Mr Gary Wilson, Senior Next of Kin

    Detective Leading Senior Constable Simon Florence

    Mr Nathan Cross

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 17 March 2021

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 inquest. 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.