IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000641

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to section 76(a) of the Coroners Act 2008, as at 13 August 2024[i]

Findings of:	Coroner David Ryan
Deceased:	Angus Gordon Carruthers Collins
Date of birth:	1 September 2000
Date of death:	2 February 2023
Cause of death:	1(a) Injuries sustained in a motor vehicle collision (cyclist)
Place of death:	Footscray Road, West Melbourne, Victoria
Keywords:	Cyclist – traffic signals – intersection design

[i] Page 13, paragraph 53, last sentence: "*almost 3 months*" is amended to read "*almost 15 months*".

INTRODUCTION

1. On 2 February 2023, Angus Gordon Carruthers Collins was 22 years old when he died from injuries sustained when he was hit by a truck while riding his bicycle. At the time of his death, Angus lived in Williamstown, Victoria, with his mother, Ailsa Carruthers. He is also survived by his father, Ian Collins and his sisters, Adelaide and Ella.

BACKGROUND

The Intersection and the West Gate Tunnel Project

2. The collision which caused Angus's death occurred at the southeast corner of the intersection of Dock Link Road and a Shared Use Path (**SUP**) running parallel to Footscray Road in West Melbourne (**the Intersection**). There had been a number of construction and traffic management changes made at the Intersection in the preceding years as part of the West Gate Tunnel Project (**the Project**).

3. Transurban WGT Co Pty Ltd (**Transurban**) have been contracted by the Victorian government to design, construct, operate and maintain the Project. CPB Contractors and John Holland Pty Ltd have been subcontracted by Transurban as an unincorporated joint venture (**CPBJH**) to design and construct the Project. The Project is expected to be completed and opened to the public in late 2025.

4. CPBJH are required to prepare a Worksite Traffic Management Plan (**WTMP**) whenever components of construction for the Project may have an impact on roads, SUPs, footpaths and public transport facilities (or users of those facilities). A WTMP must include detailed drawings identifying the nature and location of all temporary measures contemplated including line marking, traffic barriers and signs and, among other matters, must address vehicle, bicycle and pedestrian movements.

5. Before submitting a WTMP to the Major Transport Infrastructure Authority (**MTIA**)[1] for approval, CPBJH must engage an independent contractor to conduct a Road Safety Audit (**RSA**). RSAs are completed by independent road safety auditors to identify and assess risks to road users that may arise from the temporary traffic arrangements outlined in a WTMP and may identify solutions for risk mitigation that may be appropriate to be implemented. CPBJH

[1] The MTIA is an administrative office within the Department of Transport and Planning.

are required to review RSAs and promptly address all corrective actions identified. They are responsible for determining whether any identified risks have been appropriately mitigated and can be "*closed*".[2]

6. Generally, RSAs are completed before the approval of a WTMP (**desktop RSA**) and within 48 hours of the implementation of a WTMP (**post-implementation RSA**).

7. Between November 2018 and Angus's death, a number of WTMPs were approved which affected the Intersection and provided for a number of changed traffic management conditions. In that process, a number of risks to road and SUP users were identified in RSAs and were sought to be addressed by CPBJH.

8. In November 2018, prior to the commencement of construction works, the road layout at the Intersection included slip lanes for vehicles entering and exiting Dock Link Road to the south of Footscray Road. Pedestrians and cyclists were required to give way to vehicles at the slip lanes.

9. In late 2018/early 2019, pursuant to a WTMP, the left turn slip lane from Footscray Road into Dock Link Road was removed. The slip lane had formed a chicane which operated to restrict cyclists to lower speeds. The removal of the slip lane effected a change to the vehicle/pedestrian give way arrangement, requiring left turning traffic to give way to cyclists on a concurrent green signal. Cyclists travelling west on the SUP were able to cross Dock Link Road on a green bicycle signal while vehicles travelling west and turning into Dock Link Road from Footscray Road on a green signal were required to give way to cyclists. There was no dedicated lane along Footscray Road for vehicles turning left into Dock Link Road, and no green arrow signal to give turning traffic right of way over SUP users.

10. The post-implementation RSA dated 14 February 2019, conducted by the road safety auditor (**RSA Engineers**) identified the following risks to cyclists:

    a) "*Cyclists speeds entering and crossing intersection were high. This was not possible previously because of the geometric layout of the crossing forced… cyclists to slow*

[2] The responsibility of a contractor being responsible for *"closing"* the risks identified in an RSA is consistent with guidance provided in the Austroads Guide to Road Safety and the VicRoads Standard. As at 15 April 2024, over 900 RSAs had been completed by independent road safety auditors on the Project and assessed and closed by CPBJH.

for the "*chicane*". *Also, cyclists would slow to check along the slip lane (an obvious conflict point) for drivers;*

b) The slip lane has been removed but the chicane remained immediately before the crossing;

c) Now, with this setup, the chicane geometry is less effective at leading to cyclist speed-shedding and is located away from the conflict point at the intersection. Cyclists were observed to regain speed between the chicane and the intersection.

d) Cyclists were also observed to cross with the green bicycle symbol without looking or considering possible turning vehicle conflicts.

e) Cyclists and motorists, both share a green phase across Dock Link Rd. Drivers are faced with a 'give way to pedestrians' sign. However, it is difficult for a driver to see path users approaching the crossing from the same direction, especially at higher cyclist speeds".

11. The RSA classified the risk as "*high*" and made the following comment/suggestion:

"*This should be addressed. The 'Give way to Peds' sign is not considered sufficient. Some measures might include:*

- *ensure sightlines between turning vehicles and cyclists are as clear as possible.*
- *cyclists need to be warned of the potential conflict and slowed*".

12. CPBJH's relevant response to the risk identified in the RSA was as follows:

a) "*To improve sightlines between turning vehicles and SUP users, site materials will be relocated. Additionally, gawk screen mesh*[3] *adjacent to the SUP diversion will be removed from concrete barriers to enhance sightlines along the path.*

b) A 'PED/bike Stop Here On Red Signal' and a 'Watch For Entering Traffic' sign will be secured to the traffic lantern post adjacent to redundant slip lane to further warn SUP users. Additionally, a 'Look Right' will be painted on the redundant slip lane to further warn SUP users of vehicles making the left turn. To slow cyclist's, temporary

[3] Anti-gawk screens are sheets of mesh designed to provide extra privacy when attached to construction sites and barriers.

rumble strips will be installed on the approach to the chicane and intersection to enhance the presence of the signalised crossing point.

c) *A general clean of the site will be performed to remove redundant Klemmfix[4] and bollards*".

13. The Project included construction of a new elevated roadway above Footscray Road which would be supported by piles and piers. Two piers (Piers 19 & 20) would be constructed between the SUP and Footscray Road on the east side of the Intersection. In a desktop RSA dated 17 September 2018, RSA Engineers identified a risk that visibility (sight lines) between vehicles and SUP users at the Intersection would be reduced due to the construction of the piers. The RSA stated:

> "*Piers and barriers will obstruct sightlines between drivers and path users – increasing the importance of the warning signs. Two different warning message sign combinations are proposed on the westbound approach to Dock Link Rd. The amount of information for drivers to take in is considerable. If filtering left turns are occurring, legal give way requirements are unclear. It is important that vehicle speeds and sightlines are such that drivers and path users are able to give way to each other*".

14. The RSA identified the risk as "*high risk if a truck and a path user collide*" and made the following comment/suggestion:

- "*Do not install gawk screens on barriers near the corner.*
- *A symbolic NSW sign…may be easier to understand than the SUP/On Side Road combination.*
- *Monitor driver turning speeds and path user speeds. Consider measures to slow turning vehicles or path users if necessary*".

15. CPBJH's response to the risk identified in the RSA was as follows:

a) "*No gawk screens are proposed to be installed along the barriers which abut pier C2-P19 & C2-P20.*

[4] Klemmfix are a low cost, highly visible barrier used to help regulate traffic.

b) It is noted that the Pedestrian & Cyclists/On Side Road sign is more prevalent in Victoria and relevant to the SUP.

c) *Signage will be adjusted on the TGS*[5] *to ensure it is not obscured by the piers/barriers. Additionally, flashing give way to pedestrian signs will be installed at the Dock Link Road intersection to further enhance the present of SUP users*".

16. In a desktop RSA dated 29 April 2019, RSA Engineers identified the following risk to cyclists at the Intersection:

> *The SUP is aligned with the crossing. When bike lanterns are green cyclists may cross here at reasonably high speeds without considering possible conflicts with turning trucks.*

17. The RSA recommended adding a pavement warning facing westbound cyclists which stated "BEWARE – TURNING TRUCKS". CPBJH's response was as follows:

> *A 'Watch for Entering Traffic' sign has been shown on the updated TGS to warn approaching cyclists of the crossing point. Additionally, a 'Watch for Traffic' pavement marking will be installed at this location to reinforce the presence of the existing crossing.*

18. CPBJH have advised that *"Watch for Traffic"* pavement markings were installed and present as of August 2019, but there is no evidence that they were present on the day of the collision.

19. Pier 20 was constructed in October 2019 and Pier 19 was constructed in November 2020. The desktop and post-implementation RSAs conducted in October 2019 did not identify any additional risks to cyclists arising from the configuration of the intersection.

Complaints and near misses

20. The MTIA received a number of complaints and messages of concern from cyclists and road users in relation to the risks associated with the Intersection which were created by the ongoing Project works.

[5] Traffic Guidance Schemes (TGS) are included in a WTMP and are plans of the traffic signs and devices to be installed to direct traffic, pedestrian, cyclist and worker movements.

21. In March 2019, a cyclist posted a message on the Project Facebook page to express their concern about the risks associated with the Intersection. They stated:

> "*Can you do something to protect cyclists and pedestrians from almost being collected by cars turning left into dock link road?*
>
> *The current works and removal of the slip lane previously used by motorists has made it dangerous for cyclists. This morning I was crossing with the green light for cyclists and pedestrians and two vehicles turned left without stopping for me, one almost collecting me. I'd suggest putting something in place while the works continue before a pedestrian or cyclist gets killed*".

22. The MTIA responded to the post advising that they would follow it up with "*the builder*". Transurban has confirmed that this matter had been communicated to CPBJH.

23. In May 2019, the same cyclist posted a further message warning the MTIA that the risk that they had earlier identified was continuing to persist. They stated:

> "*Another day, someone almost got hit. When will you wake up???? I'll be sure that the coroner gets a copy of these messages of me pleading with you to do something about it!*".

24. The MTIA responded to the post by offering to put the cyclist in direct contact with the builder so they could discuss their concerns with them directly. The MTIA has confirmed that this matter was communicated to CPBJH.

25. On 18 November 2021, a transport company manager sent the following email to the MTIA expressing his serious concern about a dangerous incident that occurred between a cyclist and one of his drivers at the Intersection:

> "*I have already called up today to let you know that I have an extreme safety concern with the sequencing of the lights on Footscray Road.*
>
> *One of my trucks had an accident which could have ended in a fatality last night at the intersection of Footscray Road and Dock Link Road. Thankfully this was not the case.*

Both the cyclist and the traffic have a green light and there is a small box light that says give way to pedestrians…

A cyclist was behind the concrete pole last night as the truck was driving past and the truck driver did not see the cyclist. The Left Hand Side is a blind spot for trucks and the pole is very wide and close to the crossing.

The lady jumped off her bike and the bike ended up under underneath the trailers – seconds either side of this she would have been killed.

I believe that the sequence of lights should be that whilst the cyclist has a green light the traffic should have a red, or a no left hand turn into Dock Link Road whilst the cyclist has a green.

The blind spot of the trucks and the closeness of the pole to the crossing is a recipe for disaster and death and we are all very lucky that this did not eventuate last night.

Thousands of trucks use this road daily and the risk of recurrence is extremely high."

26. The MTIA recorded that the manager's complaint had been referred to CPBJH. The MTIA has also confirmed that the manager's complaint was communicated to CPBJH.

THE CORONIAL INVESTIGATION

27. Angus'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.

28. 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.

29. 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.

30. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Angus's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

31. A mention hearing was held in Court on 14 April 2023 and a number of the safety risks associated with the Intersection where Angus died were identified. I encouraged the Department of Transport and Planning (**the Department**) not to wait for the coronial process to be completed before it took steps that it considered necessary and appropriate to eliminate the risks associated with the intersection.

32. After the mention hearing, the Court obtained further evidence directly from the Department and CPBJH.

33. This finding draws on the totality of the coronial investigation into Angus's death including evidence contained in the coronial brief. While 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.[6]

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

Circumstances in which the death occurred

34. On 2 February 2023 at around 12.20pm, Angus was riding his bicycle west along the SUP parallel to Footscray Road, and approaching the Intersection. Witnesses estimated that he was travelling at around 40 kilometres per hour. As he approached the Intersection, Angus had an illuminated green bicycle signal which gave him right of way to cross the Intersection.[7]

35. At the same time, Mr Arthur Kalaitzis was driving a cement mixer truck (YVR 016) west along Footscray Road, and approaching the Intersection with the intention of turning left into Dock Link Road. As he approached the Intersection, he had an illuminated green light which, as it was combined with a green bicycle signal along the SUP, required him to give way to

[6] 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.

[7] *Road Safety Rules 2017*, Reg 62(1(b).

cyclists. There was also a sign approaching the Intersection, between Piers 19 & 20, which alerted drivers to watch for cyclists on the SUP.

36. Mr Kalaitzis turned his truck left into Dock Link Road into the path of Angus and his bicycle. Angus braked hard but was unable to stop in time to avoid a collision and he lost control of his bicycle and slid underneath the truck, between the first and second axles, and was run over. He was killed instantly.

37. Emergency services were contacted and Victoria Police and Ambulance Victoria attended the scene. Angus was pronounced deceased by paramedics at 1.00pm.

38. Mr Kalaitzis was cooperative with Victoria Police although he was not interviewed and did not make a statement. They confirmed that he had a valid licence to drive the truck and a blood sample obtained from him returned a negative result for alcohol and other drugs. Further, his phone was analysed and there was no evidence that he was using it at the time of the collision.

39. Victoria Police observed that visibility from the driver's seat of the truck was restricted by the design of the cabin but that all side mirrors were intact and positioned correctly.

40. It is clear that the configuration of the Intersection, including the location of the concrete piers at the southeast corner, significantly compromised the ability of drivers of turning vehicles to see bicycles approaching from the east, particularly if travelling at speed.

41. Mr Kalaitzis was not charged with any criminal offences as a result of the incident. The Coronial Investigator requested that he provide a statement for the purpose of the investigation but he declined after being advised of his rights under section 50 of the Act. It is also clear that he is understandably still traumatised by the incident.

Identity of the deceased

42. On 8 February 2023, Angus Gordon Carruthers Collins, born 1 September 2000, was identified via DNA comparison.

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

Medical cause of death

44. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine performed an examination on 6 February 2023 and provided a written report of his findings dated 7 February 2023.

45. The examination revealed extensive head injuries which would have caused instant death.

46. Toxicological analysis of post-mortem samples identified the presence of a small amount of paracetamol.

47. Dr Lynch provided an opinion that the medical cause of death was *1 (a) Injuries sustained in a motor vehicle collision (cyclist).*

48. I accept Dr Lynch's opinion.

INDEPENDENT SAFETY REVIEW

49. After an inspection at the Intersection on 8 February 2023, the Department conducted an Independent Safety Review (**ISR**). The following relevant observations were recorded in a report following the review:

    a) "*Sign and line marking - the general condition of the signage and line marking across the site is of poor quality, with faded line marking around the Dock Link Road and LED warning signage at the centre of the crossing is not operational.*

    b) Obstructed sight lines - Construction of a large concrete pier supporting the elevated section of the West Gate Tunnel Project has created a major visual obstruction. Approaching vehicles and bikes have diminished vision and awareness of each other.

    c) Right of way - Bike aspect lanterns operate as slave to general traffic phase, providing both vehicles and bikes concurrent through movement and may result in ambiguous right of way.

    d) Approach Speed - People on bikes have a straight approach with a clear line of sight to bike aspect lanterns at Dock Link Road. This may contribute to users approaching the intersection at high speed.

e) *Gravel accumulating in the kerb and SUP path can destabilise bikes and decrease the effectiveness of braking*".

50. The ISR made the following relevant recommendations until construction of the Project is completed and the ultimate traffic control scheme is in place:

a) A dedicated left turn lane from Footscray Road into Dock Link Road with a fully controlled left turn.[8] The rationale for this recommendation was that it provided the greatest degree of issue mitigation, by separating bikes and left turning vehicles in time.

b) The creation of a SUP chicane to the south of the Intersection to slow down cyclists. The rationale for this recommendation was that it slowed down cyclists, making them more aware of their surroundings and reducing instances of non-compliance at traffic signals.

51. The configuration of the Intersection has now been changed in line with the recommendations of the ISR and subsequent RSAs. Further, the SUP is now located on the north side of Piers 19 and 20, so that they no longer obstruct visibility between cyclists and traffic along Footscray Road.

CONTRIBUTING FACTORS

52. The RSAs conducted in relation to the construction works which altered the configuration of the Intersection identified a number of risks to cyclists. These risks were also clearly present at the time of Angus's death. The most significant risks were:

a) The sequencing of traffic lights which provided simultaneous green signals to cyclists travelling west along the SUP and traffic travelling west and turning left into Dock Link Road;

b) The removal of the chicane on the SUP to the east of the Intersection leading to high cyclist speeds on approach; and

c) The location and size of Piers 19 and 20 between the SUP and Footscray Road east of the Intersection which obstructed visibility between traffic and cyclists.

[8] As an interim measure it was recommended that left hand turns into Dock Link Road from Footscray Road be banned.

53. The corrective action taken by CPBJH in response to the RSAs was not sufficient to mitigate these risks. Further, CPBJH were aware that their mitigation measures were not effectively reducing the risks to cyclists at the Intersection as a result of being informed of various complaints by cyclists and road users. In one such complaint, almost 15 months before Angus's death, the manager of a transport company had alerted MTIA to his "*extreme safety concern*" after one of his drivers had a near miss with a cyclist in very similar circumstances.

SUBMISSION OF CPBJH

54. CPBJH were notified of my intention to make the adverse finding identified in the above paragraph and the evidentiary basis for it. They submitted that there is insufficient evidence to conclude that:

    a) The mitigation measures were *"not sufficient"* or *"not effectively reducing the risks to cyclists at the intersection"*; or

    b) CPBJH were aware that their mitigation measures were *"not sufficient"* or *"not effectively reducing the risks to cyclists at the intersection"*.

55. CPBJH emphasised that various RSAs applied at different stages of the development of the intersection with a different WTMP being considered by each RSA, noting that there were significant changes to the Intersection over time.

56. CPBJH noted that the RSAs I have referred to in the finding, which identified risks to cyclists presented by the configuration of the Intersection, were *"reviewing and considering arrangements for a different layout of the intersection compared to the layout in place at the time of the incident"*. Further, they note that the desktop and post-implementation RSAs conducted in relation to the specific intersection configuration at the time of the incident did not refer to the risks to cyclists that I have identified in paragraph 52. Accordingly, they submit that the earlier RSAs I have relied upon provide no evidentiary support for the adverse finding against CPBJH. This submission is rejected.

57. I am satisfied that the risks to cyclists identified in the earlier RSAs were clearly also present in the configuration of the Intersection that existed at the time of Angus's death. These risks had been acknowledged by CPBJH in their response to the earlier RSAs and they had been *"closed"* by them with the proposed implementation of mitigation measures which proved to be insufficient and ineffective. I also note that in their explanatory notes to their RSAs, the

road safety auditor stated*, "Once key issues have been initially raised, they will not necessarily be re-raised in future audits"*.

58. CPBJH further submits that the ISR does not support a finding that the mitigation measures prior to the incident were *"not sufficient"* or *"not effectively reducing the risks to cyclists at the intersection"*. I have referred to the ISR to document what changes were made to the Intersection after Angus's death to reduce the likelihood of deaths or injuries to cyclists. The evidence I have relied upon to support the finding is not the ISR, but rather the circumstances of Angus's death and the evidence of previous near misses.

59. CPBJH also submits that there is insufficient evidence for me to be satisfied to the *Briginshaw* standard that they were aware that its mitigation measures were *"not sufficient"* or *"not effectively reducing the risks to cyclists at the intersection"*. They contend that the evidence merely demonstrates complaints had been proposed to be referred to them by the MTIA and that it does not establish any state of knowledge attributable to them. This submission is also rejected.

60. I am comfortably satisfied that CPBJH were aware of the complaints referred to in this finding soon after they were submitted to the MTIA. Records and correspondence from MTIA and Transurban confirm that CPBJH were notified of the complaints very soon after they were submitted to the MTIA. Further, CPBJH does not deny that it was notified of the complaints and, despite being provided with an opportunity, they have submitted no evidence to support a finding that they were unaware of them.

61. It follows that I am comfortably satisfied on the evidence that it is appropriate to make the adverse finding against CPBJH.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Angus Gordon Carruthers Collins, born 1 September 2000;

b) the death occurred on 2 February 2023 at Footscray Road, West Melbourne, Victoria, from injuries sustained in a motor vehicle collision; and

c) the death occurred in the circumstances described above.

COMMENTS

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

63. Angus's death was a preventable tragedy which has devastated his family and caused significant distress to Mr Kalaitzis.

64. This case highlights the pernicious risk that exists at intersections between left turning vehicles and cyclists that are travelling straight ahead. The law as to who has right of way is not well understood. I consider that greater education of road users as to their respective obligations is required.

65. Further, I consider that serious risks to the safety of road users (including cyclists) which are identified in a Road Safety Audit ought to be "*closed*" by an independent road safety auditor, not the contractor that has been retained to carry out the works. The contractor is subject to significant commercial pressures which may cloud judgment when responding to safety risks.

RECOMMENDATIONS

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

(i) That the Department of Transport and Planning consult with relevant authorities to formulate and implement a public safety campaign to highlight the risks that exist at intersections between left turning vehicles and cyclists that are travelling straight ahead, and to clearly set out the law as to who has right of way.

(ii) That the Department of Transport and Planning consider amending its contract arrangements for road works carried out pursuant to a Worksite Traffic Management Plan so that serious risks to the safety of road users (including cyclists) which are identified in a Road Safety Audit are required to be "*closed*" by an independent road safety auditor, not the contractor that has been retained to carry out the works.

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

Pursuant to section 73(1A) 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:

Ian Collins, Senior Next of Kin

Ailsa Carruthers, Senior Next of Kin

Department of Transport and Planning, c/- MinterEllison

Transurban WGT Co Pty Ltd, c/- Holding Redlich

CPBJH JV, c/- Sparke Helmore

Senior Constable Stephen Warr, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 12 August 2024

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.