IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 004070

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Alan Edward Stewart

Delivered on:	8 August 2024
Delivered at:	Southbank, Victoria
Hearing Dates:	22 and 23 April 2024
Findings of:	Coroner Paul Lawrie
Representation:	Ms A. de Souza – Counsel for the family of Alan Stewart instructed by Maurice Blackburn Mr S. Reid – Counsel for the Royal Melbourne Hospital instructed by HWL Ebsworth Lawyers
Counsel Assisting:	Ms S. Locke of Counsel
Keywords:	Colonoscopy, splenic injury, day procedure, patient discharge information, Nurse-on-Call

I, Coroner Paul Lawrie, having investigated the death of Alan Edward Stewart, and having held an inquest in relation to this death on 22 and 23 April 2024 –

at Southbank, Victoria

find that the identity of the deceased was Alan Edward Stewart born on 20 June 1948

and the death occurred on 16 or 17 August 2018

at 22 Whitton Road, Coburg North, Victoria

from:

1a: HAEMOPERITONEUM

1b: RUPTURED SPLEEN

1c: COLONOSCOPY

INTRODUCTION

1. Alan Stewart passed away at home at some time between 11.00pm on 16 August and 1.30am on 17 August, approximately one and a half days after an elective colonoscopy performed at the Royal Melbourne Hospital (RMH). Mr Stewart was 70 years of age.

2. In July 2018, Mr Stewart was referred for the colonoscopy after he returned a faecal occult blood test as part of the national bowel cancer screening program. The colonoscopy was performed on the afternoon of 15 August 2018. The procedure lasted approximately 20 minutes and involved the removal of a small polyp. Mr Stewart was discharged at 4.25pm – within the usual timeframe of two to four hours.

3. On the evening of 16 August 2018, Mr Stewart was suffering abdominal pain, dizziness and shortness of breath. At 10.44pm, his wife, Sherrilyn Stewart, called the main number for RMH and was transferred a short time later to Nurse-on-Call. This is a service funded by the Victorian Department of Health and provided by Medibank Health Solutions Telehealth Pty Ltd ("Medibank").

4. Mrs Stewart spoke with a triage nurse at the Nurse-on-Call service and detailed her husband's symptoms. Mr Stewart also spoke with the nurse and complained of being giddy, hot and short of breath. He was unable to continue the conversation and he handed the phone back to his wife.

5. The triage nurse ultimately advised that Mr Stewart should maintain hydration, take Panadol for the abdominal pain, and see a doctor within the next 12 hours. Also, that Mr Stewart should call the Nurse-on-Call service again or see a doctor sooner if symptoms persisted. Mr Stewart took Panadol and went to bed at approximately 11.00pm, in a room separate from his wife.

6. Shortly after 3.15am on 17 August 2018, Mrs Stewart checked on her husband and discovered him half out of bed and unresponsive. At 3.23am she called 000 Emergency and ambulance paramedics arrived at 3.30am.[1] Mr Stewart was declared deceased a short time later.

7. On 21 August 2018, an autopsy was performed by Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Parsons observed that there had been a parenchymal tear or avulsion at the spleen and provided an opinion that Mr Stewart's cause of death was: haemoperitoneum, ruptured spleen and colonoscopy.

CORONIAL INVESTIGATION AND INQUEST

8. I took carriage of the investigation in October 2022 and determined that it was appropriate to proceed as an inquest. The scope of the inquest was set as follows:

   (a) The significance of Alan Stewart's high platelet count prior to the colonoscopy.

   (b) The appropriateness of the instrument used for the colonoscopy.

   (c) The cause of the splenic injury.

[1] Ambulance Victoria Patient Care Record – CB155

(d) The likely impact of emergency medical treatment if it had been delivered in response to the call made to the Nurse-on-Call service at 10.44pm on 16 August 2018 being transferred to 000.

9. The coronial brief included the RMH patient records, the Nurse-on-Call transcript and patient history report, and the autopsy report by Forensic Pathologist Dr Sarah Parsons. Also included were statements and materials from:

(a) Sherrilyn Stewart;

(b) Dr Cate Kelly – Executive Director, Clinical Governance and Medical Services, RMH;

(c) Dr Robert Feller – Director Medical Services RMH;

(d) Dr Bronwen Ross – Director Medical Services RMH;

(e) Louise McKinlay – Safer Care Victoria;

(f) Dr Robert McGrath – Senior Executive Director of Health Services and Health Infomatics at Medibank Private Pty Ltd (for Medibank Health Solutions Telehealth Pty Ltd and Nurse-on-Call);

(g) Dr Janette Randall – Chief Medical Officer Medibank;

(h) Professor Johan Duflou – Consulting Forensic Pathologist;

(i) Dr Christopher Vickers – Consultant Gastroenterologist and Hepatologist; and

(j) Dr Andrew Jakobovits – Gastroenterologist

10. The last subject within the scope of inquest concerned the advice provided to Mr and Mrs Stewart from the Nurse-on-Call service and the likely consequences if an emergency medical response had been initiated instead. Dr McGrath provided a statement dated 26 June 2020 which, among other matters, detailed how the Nurse-on-Call triage nurse had failed to follow the appropriate pathway given the information from Mr and Mrs Stewart.

In short, given Mr Stewart's complaint of breathlessness, the call should have been transferred to Ambulance Victoria via 000. Dr McGrath also detailed the internal review process and remedial steps taken following these events.

11. Medibank provided a report by Professor Duflou which principally addressed Mr Stewart's likely time of death and hence whether earlier emergency medical attention was likely to have altered his clinical course. Professor Duflou's conclusion was that Mr Stewart most likely died at least 2 hours prior to examination by attending paramedics, that is, up to 1.30am on 17 August. As Mr Stewart had last been seen alive when he went to bed at approximately 11.00pm on 16 August, these times set the start and end of the likely interval during which he passed away.

12. Consequent upon Professor Duflou's conclusion, Dr Randall provided a statement on behalf of Medicare dated 20 December 2023 which accepted that the incorrect advice from the triage nurse resulted in a lost opportunity for emergency medical assessment and care which, subject to Mr Stewart's clinical presentation at the time of the emergency treatment, may have prevented his death.

13. This approach by Medicare to the issues surrounding the advice given by the triage nurse effectively provided all the material necessary to fully canvass the last subject of the scope of inquest. Moreover, this direct and candid approach meant that the viva voce evidence was focussed on the first three subjects and, to this end, Dr Parsons, Dr Vickers and Dr Jakobovits gave evidence together as an expert panel.

14. Following a directions hearing on 25 August 2023, Medicare[2] sought to be excused from the substantive hearing of the inquest, and was excused.

[2] Represented at that time by Ms R. Ellyard of Counsel, instructed by Barry Nilsson Lawyers.

FINDINGS

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

Mechanism of splenic injury and haemorrhage

15. It was agreed amongst all three expert witnesses that the cause of the splenic injury was mechanical and attributable to the use of the colonoscope on 15 August 2018.

16. Mr Stewart's colonoscopy was performed by a nurse colonoscopist at RMH who had been trained to perform routine colonoscopies under the auspices of the State Endoscopy Training Centre. The nurse commenced training in June 2015 and performed 316 colonoscopies under supervision until the completion of her training in July 2016. She then performed 483 unsupervised colonoscopies in the two years to August 2018. There was no suggestion that the nurse was not properly trained or qualified. In respect of Mr Stewart's procedure, the nurse reported no complications. [3]

17. The autopsy revealed adhesions between the mesentery and the spleen with splenic tissue identified firmly adherent to the mesentery. It was further observed that there was 1,000 mls of liquid blood surrounding the spleen and approximately 500 mls of clotted blood and the splenic capsule was deficient over an area of 5 cm x 3 cm.[4] The deficiency was the result of either a small tear leading to bleeding or a sub-capsular haematoma which has ruptured.[5] In either event, the consequence was significant internal bleeding from the spleen leading to Mr Stewart's death.

18. Dr Parsons explained that adhesions between Mr Stewart's colon and the spleen may have resulted in tearing of the splenic capsule as the colonoscope passed through the colon. An alternative mechanism was tension created in splenocolic ligament or

[3] Dr Kelly – CB019; RMH records – CB116
[4] Dr Parsons – T010
[5] Dr Parsons – T018-019

preexisting adhesions (or both) due to manipulation of the sigmoid, descending and transverse colon during the procedure. Either mechanism can result in a parenchymal tear or avulsion at the spleen.[6]

19. Dr Vickers explained that splenic injury associated with colonoscopy was extremely rare and he had heard of only two cases in Sydney in the preceding 12 months.[7] This was against a backdrop of a very high number of colonoscopies performed each year.[8] Dr Jakobovits agreed and noted that he had never seen a case in 40 years of practice, even working at the Alfred Hospital with approximately 100 colonoscopies per week.[9]

20. Dr Vickers further explained that the precise cause or causes of splenic injury in this setting were unknown. Insofar as a cause could be described, it arose from forward or rotational pressure from the colonoscope as it moved past the splenic flexure. There was also a possible association with previous trauma (such as abdominal surgery) which can result in adhesions so that these forces may be abnormally distributed in the surrounding anatomy.[10]

21. Injury was not necessarily the result of excessive force used in the procedure. Tellingly, Dr Vickers revealed that a splenic injury had occurred during a procedure he conducted and which he described as "very gentle".[11] Dr Jacobovits recalled anecdotally that a colleague gastroenterologist had chosen who he thought to be the best in Melbourne to perform his colonoscopy, yet he had suffered a ruptured spleen. His conclusion was, "it can happen to anybody."[12] Dr Vickers agreed saying, "Well, it's happened to me, so it can happen to anyone."[13]

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6 Dr Parsons – T010
7 Dr Vickers – T023
8 According to the Australian Commission on Safety and Quality in Heath Care there are more than 900,000 colonoscopies performed in Australia annually – www.safetyandquality.gov.au/standards
9 Dr Jakobovits – T023
10 Dr Vickers – T022-023
11 Dr Vickers – T023
12 Dr Jakobovits – T060
13 Dr Vickers – T060

22. I am satisfied that the cause of the splenic injury was tear or avulsion of the splenic capsule associated with an abnormal transmission of tension via an adhesion between the spleen and the mesentery and/or the splenocolic ligament – such force arising from the forward and/or rotational movement of the colonoscope.

23. I also find that the haemorrhage at the spleen arose from a parenchymal tear or a sub-capsular haematoma that eventually ruptured and resulted in significant internal haemorrhage which, in turn, led to Mr Stewart's death.

24. I am satisfied that splenic injury associated with routine colonoscopy is exceeding rare but may occur notwithstanding the degree of expertise and care exercised by the colonoscopist. I further note that there is no evidence to suggest that Mr Stewart's procedure was anything other than routine or that inappropriate force was used at any stage.

<u>High platelet count</u>

25. When Dr Vickers considered the likely cause of the splenic injury, he noted Mr Stewart's pre-operative platelet count was 506,000 (tested on 12 July 2018)[14] – above the normal range of 150,000 to 450,000. He opined that this was suggestive of a pre-existing haematological disease that could have involved the spleen.[15] Dr Jacobovits characterised the platelet count as "slightly elevated" and not amounting to a contraindication for proceeding with the colonoscopy.[16]

26. In evidence, Dr Vickers highlighted that the platelet count was 10% above the top of the normal range (which should capture 97% of individuals) and warranted investigation. He explained that the platelet count might have been indicative of a haematological disease[17] with an associated risk of bleeding. It might also mean that the spleen was involved with

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14 The platelet count was in the context of normal haemoglobin at 158g/L.
15 CB054
16 CB072
17 Specifically, the myeloproliferative disease thrombocythemia.

the haematological disease.[18] Alternatively, the high platelet count might be associated with a chronic inflammatory disease such as Crohn's disease or ulcerative colitis.[19] There was however no evidence at autopsy of any chronic inflammatory condition affecting the bowel.[20] Moreover, there was no evidence of splenic disease and the spleen itself was of a normal size.[21]

27. Dr Parsons explained that the autopsy included an examination of the bone marrow[22] which appeared normal. Dr Vickers agreed that this meant there was no histological evidence of haematological disease, but it still may have been present at a sub-clinical level and detectable on blood tests.[23] Further, that the cell lineage and the bone marrow may harbour a mutation[24] which makes the platelets functionally abnormal with an increased propensity for bleeding.[25]

28. Dr Jakobovits considered that a low platelet count would be more of a concern with an increased tendency for bleeding. He further commented that his experience included many patients with liver disease, large spleens and low platelet counts where normal colonoscopies were routinely performed without complication.[26] Furthermore there was no evidence in the (admittedly sparse) medical literature that the size of the spleen or any haematological disorder was associated with an increased risk of splenic rupture.[27]

29. Dr Vickers stated that if he saw a platelet count of 506,000, he would want to speak with the patient and further investigate.[28] He regarded it as an abnormality that warranted

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18 Dr Vickers – T046
19 Dr Vickers – T027
20 Dr Parsons – T047
21 Dr Parsons – T033
22 This was a histological examination of sections of the bone marrow which were unremarkable: Autopsy Report at CB010.
23 Dr Vickers – T051, T054
24 Potentially leading to polycythemia or thrombocytosis.
25 Dr Vickers – T054-055
26 Dr Vickers – T049
27 Dr Jakobovits – T036
28 Dr Vickers – T034

examination and evaluation before the colonoscopy.[29] It is important to note however that this approach was described in the context of Dr Vickers' usual clinical practice where he consulted with his patient prior to the colonoscopy. The context in which Mr Stewart presented for the procedure at RMH was very different – it was the result of a faecal occult blood test under the national bowel screening program and not did not involve a consultation with a gastroenterologist or other specialist beforehand.

30. Ultimately, Dr Vickers did not go so far as to say that he would have postponed the colonoscopy had Mr Stewart presented ready to undergo the procedure in all other respects. Dr Jakobovits explicitly stated that he would not have postponed.[30]

31. There is no sufficient evidential basis upon which to conclude that Mr Stewart's high platelet count, or any undetected haematological disease impacted his clinical course after the injury to his spleen. Moreover, I am not satisfied that Mr Stewart's high platelet count indicated that the colonoscopy should have been postponed.

Choice of colonoscope

32. The were differing opinions offered by Dr Vickers and Dr Jackobovits concerning the question whether the use of a paediatric colonoscope was indicated for Mr Stewart's procedure. The issue itself arose from the proposition that Mr Stewart's elevated platelet count may have indicated the presence of a haematological disease.

33. Dr Vickers opined in his written statement:

> *Knowledge of haematological disease would make a colonoscopist particularly careful in negotiating the splenic flexure of the colon with the most minimal of forward pressure and rotation. Myself, and likely my colleagues, would have used a paediatric colonoscope in this situation rather than the larger diameter adult colonoscope. However, there is no firm data on this as splenic trauma is such a rarely reported complication of colonoscopy.*[31]

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29 Dr Vickers – T029
30 Dr Jacobovits – T028
31 CB058

34. Whereas Dr Jakobovits considered:

> *... and although Dr Vickers states that he would have used a paediatric colonoscope, there would be no evidence upon which to base this opinion. Most colonoscopists would have probably used the colonoscope which they regularly use.*[32]

35. Dr Jakobovits went on to say in evidence that the clinician would use the instrument (that is, either a standard or paediatric colonoscope) that they are comfortable using.[33] Dr Vickers agreed that there was no published literature to indicate which instrument might be best in circumstances where a haematological disorder was suspected, although he suggested that clinical judgement may still call for the use of the paediatric instrument.[34]

36. The issue of the choice of colonoscope is inextricably tied to the significance of Mr Stewart's high platelet count and, having found that the high platelet count was not linked to any clinically observable haematological disorder or his risk of splenic injury, the controversy becomes less pertinent. In any event, I am satisfied that there was nothing in Mr Stewart's presentation which indicated that the use of a paediatric colonoscope should have been preferred.

Discharge information

37. Mr Stewart was discharged from RMH at 4.25pm on 15 August 2018.[35] Mrs Stewart recalled in her written statement that she was not handed any documents at the time of discharge, nor did she see any documents being handed to her husband or carried by him. Moreover, Mrs Stewart stated that no one gave them any specific instructions in the event of complications or concerns.[36]

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32 CB072
33 Dr Jakobovits – T034-035
34 Dr Vickers – T036
35 CB121
36 CB016

38. When Mrs Stewart called RMH later that evening she obtained the telephone number from a document she recalled as the "Patient Information" document.[37] Examination of the RMH records suggests this was likely to be one of two documents: either the "Patient Election Form"[38] or the document titled "Patient Discharge Information".[39] According to Dr Kelly, the latter is provided to patients on discharge[40] but I note that no completed or signed version of the form was ever produced.

39. The relevant portion of the Patient Discharge Information form which advises in the event of post-procedure complications is found on the second page under the heading "What if I experience complications?" and reads:

- *If you require emergency assistance, call 000 or attend the Emergency Department. If you are concerned about any of the symptoms below, contact your local doctor or after hours GP service*
- *Severe pain which is not relieved by your prescribed medications*
- *Unrelieved vomiting and/or nausea*
- *Fever, sweats or chills with a temperature greater than 38 degrees*
- *Excessive redness, tenderness, and/or swelling around your wound or procedure site*
- *Heavy or ongoing bleeding from the wound or site*
- *Difficulty breathing*[41] (the "complications information")

40. Dr Vickers considered that the complications information did not seem to cover the symptoms of blood loss, which are dizziness, weakness, fatigue, and feeling cold. He also noted that day procedure patients are often discharged after only a short period of post-procedure observation and anything unusual within 24 hours after the procedure should be a prompt to contact the hospital or the doctor who performed the procedure.[42]

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37 CB016
38 CB124
39 CB027
40 CB020
41 CB028
42 Dr Vickers – T042-043

41. Dr Jakobovits agreed that the complications information was somewhat vague and opined that anything within 48 hours after a procedure should be assumed to be related to the procedure. Furthermore, if the discharged patient is worried and requires medical assistance, they should call 000 Emergency or go to the Emergency Department.[43]

42. The complications information is poorly presented. It does not appear to include some symptoms of significant internal haemorrhage. Moreover, on one interpretation, it appears to suggest that the action to be taken in the event of the very serious symptom of "difficulty breathing" should be to contact the person's local doctor or after hours GP service. This does not accord with the emergency action that should be taken, according to Nurse-on-Call, when there is new onset of breathlessness.[44] The deficiencies in the complications information warrant a recommendation aimed at improving this information for the patient after discharge.

43. Mrs Stewart was not called as a witness during the inquest, and it is not necessary to reach a conclusion whether she or her husband were provided with the Patient Discharge Information document. It is sufficient to observe that appropriate information and advice on discharge must be effectively communicated to the patient. To achieve this, it will often be necessary to include persons who may be assisting the patient at the time of discharge. The delivery of discharge information should also be recorded by the person providing the information. Such a requirement helps to ensure that this necessary step is not missed.

44. Whatever transpired during the discharge process, Mrs Stewart's account of events later that night reveals that there was inadequate communication concerning the appropriate actions to be taken if serious symptoms arose.

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43 Dr Jakobovits – T043-044

44 Dr McGrath – CB046

Post-discharge complications advice – Nurse on Call

45. Through the statement of Dr McGrath, Medibank identified at an early stage that the triage nurse with the Nurse-on-Call service failed to adopt the correct pathway following the information she received in the telephone call from Mr and Mrs Stewart at 10.44pm.

46. A triage nurse answering a call to the Nurse-on-Call service is guided by an algorithm which provides a structured response depending on the situation. In this case, the triage nurse used the appropriate algorithm (titled "Post-Operative Problems") but fell into error when assessing the answers to the "ABC (Airways Breathing Circulation) Compromise Evaluation" question. During the call Mrs Stewart described pallor, dizziness, abdominal pain, and new onset breathlessness. The presence of audible breathlessness was confirmed when Mr Stewart spoke to the triage nurse. Dr McGrath explained that this information should have caused the triage nurse to answer "yes" rather than "no" to the ABC Compromise Evaluation question which would have resulted in a transfer of the call to 000 Emergency.[45]

47. Medibank's internal review sought to identify the cause or causes of the triage nurse's error and concluded that the failure to answer the ABC Compromise Evaluation question correctly and her subsequent clinical decision making and advice were affected by the initial error. Consequently, she did not recognise the severity of the clinical presentation.

48. In response to the internal review, Medibank amended its induction and annual education program to place stronger emphasis on the importance of audible cues from callers. (In this case Mr Stewart's breathlessness could be heard.)

49. Medibank also reviewed the algorithms used by the triage nurses resulting in an amendment to include a question related to hospital discharge within the previous 48 hours. The new question is designed to address signs of potential deterioration post

[45] Dr McGrath – CB049

discharge and, if deterioration is apparent, the resulting advice is to attend an Emergency Department immediately.

50. I am satisfied that Medibank has conscientiously sought to analyse of the cause of the error. I am also satisfied that the remedial steps it has taken in response to the error by the triage nurse are appropriate. Consequently, no recommendation or further comment is required in this regard.

Potential impact of timely emergency medical care

51. Professor Duflou provided an opinion concerning Mr Stewart's likely time of death. The question whether earlier emergency medical care was likely to have altered Mr Stewart's clinical course depends on the rapidity of his decline following the call to Nurse-on-Call at 10.44pm and hence the opportunity for effective intervention.

52. Dr Vickers explained that, had Mr Stewart arrived at an Emergency Department, he would be assessed as being in shock and treated as an emergency case requiring resuscitation with oxygen, intravenous fluids and transfusion if necessary. Investigations would include an urgent CT scan of chest and abdomen and differential diagnosis would have included abdominal emergency related to sepsis or blood loss. A diagnosis of blood loss would have been made by a low haemoglobin, negative chest x-ray or CT, normal ECG trace, and the presence of splenic trauma on the CT scan.

53. Depending on the timing of the diagnosis and Mr Stewart's condition, it may have been possible to perform an angiographic embolization of the splenic artery. However, the timing of events meant that Mr Stewart probably would have required emergency resuscitation and blood transfusion before rapid transfer to an operating theatre.

54. Dr Vickers opined that, on balance, had Mr Stewart arrived promptly at an Emergency Department, he may have been saved. However there remained an outside chance that he

may have deteriorated so quickly from blood loss at home that he may not have made it to hospital.[46]

55. Professor Duflou analysed the available evidence, including Mr Stewart's temperature of 31°C recorded by paramedics on arrival, and concluded that he most likely died at least 2 beforehand, that is, between 11.00pm on 16 August and 1.30am on 17 August. I accept this to be the case.

56. Medicare accepted, via Dr Randall:

> *… that it would be open to find that the incorrect advice given by the triage nurse resulted in the loss of an opportunity for Mr Stewart to be taken to hospital in time to receive emergency assessment and care, which assessment and care may, subject to his clinical presentation on arrival at hospital, have prevented his death.*[47]

57. I commend Medicare for the consideration it has given to this concession.

58. I find that the incorrect advice given by the triage nurse resulted in the loss of an opportunity for Mr Stewart to be taken to hospital in time to receive emergency assessment and care, which assessment and care may, subject to his clinical presentation on arrival at hospital, have prevented his death.

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46 Dr Vickers – CB060

47 Dr Randall – CB AM4.2

RECOMMENDATIONS

59. I make the following recommendation(s) connected with the death to Melbourne Health – Royal Melbourne Hospital under section 72(2) of the Act:

Recommendation 1

That Melbourne Health review its written patient discharge information with the aim of:

(a) removing ambiguity concerning the appropriate emergency action to be taken in the event of serious symptoms such as breathing difficulties;

(b) including complete symptoms of significant internal haemorrhage among the group of serious symptoms requiring emergency action; and

(c) emphasising the significance of the post operative period when considering any symptoms.

Recommendation 2

That Melbourne Health review its patient discharge procedures to ensure a record is kept of the discharge information provided to the patient.

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

I extend my sincere condolences to Mr Stewart's family and friends for their loss.

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

Sherrilyn Stewart – Senior Next of Kin
Melbourne Health – Royal Melbourne Hospital
Medibank Health Solutions Telehealth Pty Ltd (Nurse-on-Call)
Victorian Department of Health

Signature:

Coroner Paul Lawrie

Date: 08 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 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.