IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004384

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Trevor Henry McKie
Date of birth:	27 March 1972
Date of death:	11 August 2020
Cause of death:	1(a) CORONARY ARTERY ATHEROSCLEROSIS IN THE SETTING OF IMMERSION
Place of death:	Bull Point, Lake Wellington, Victoria, 3851

INTRODUCTION

1. On 11 August 2020, Trevor Henry McKie was 48 years old when he was located deceased at Bull Point in Lake Wellington.

2. At the time of his death, Trevor resided in Golden Beach Victoria with his partner of 15 years, Ms Kate Grummisch. He is also survived by his parents, Mr Stuart McKie and Mrs Angela McKie.

3. Trevor was described by his family as a strong and fit individual. He was an experienced mariner and held a Victorian Recreational Boat Licence.

THE CORONIAL INVESTIGATION

4. Trevor's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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. Victoria Police assigned Leading Senior Constable Graham Shoobert (**LSC Shoobert**) to be the Coroner's Investigator for the investigation of Trevor's death. Leading Senior Constable Shoobert conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Trevor Henry McKie 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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

9. On 17 August 2020, Trevor Henry McKie, born 27 March 1972, was identified via fingerprint identification at the Victorian Institute of Forensic Medicine (**VIFM**).

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

11. On 17 August 2020, Forensic Pathologist Dr Joanne Chi Yik Ho from the VIFM, conducted an autopsy on the body of Mr McKie and provided a written report of her findings dated 22 October 2020.

12. The autopsy revealed significant signs of decomposition as well as severe atherosclerosis of the left anterior descending coronary artery. Coronary atherosclerosis causes a condition known as ischaemic which predisposes to the development of cardiac arrhythmias and sudden death. Risk factors for coronary atherosclerosis include increasing age, hypertension, family history, obesity, gender, and other factors.

13. Dr Ho stated that Trevor was located off-shore, after spending time in the water, raising the possibility of a drowning. The diagnosis of drowning is largely based on circumstances and nonspecific findings, and they may be absent after the onset of decomposition, as in this case. Dr Ho opined circumstances reported that Trevor fell overboard, which deceases the likelihood of a drowning. It is likely that he suffered a cardiac arrhythmia from his coronary artery disease (a heart attack).

14. Toxicological analysis of post-mortem samples identified the presence of mirtazapine (0.02mg/L), and delta-9-tetrahydrocannabinol (~137 ng/mL) which indicates recent usage. Ethanol was detected at 0.06g/100mL, some (or all) may have been from ingestion of alcohol,

[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.

or a by-product of decompositional bacterial action. Isopropanol (~ 114 mg/L) was also detected which Dr Ho considered was likely secondary to decompositional change.

15. The onset of decomposition can change the concentration of any drugs and poisons if they were present at death and may even prevent the detection of drugs and poisons by the presence of decomposition substances. Drugs such as cannabis are subject to post mortem redistribution making interpretation of the concentrations difficult. Isopropanol may also be produced due to decomposition.

16. Having regard to Trevor's young age and severity of coronary artery atherosclerosis, a referral to the VIFM Family Health Genetic Service was made.

17. There was no post-mortem evidence of any injuries, which may have caused or contributed to the death.

18. Dr Ho was of the opinion that the death was due to natural causes with the medical cause of death being *coronary artery atherosclerosis in the setting of immersion*.

19. I accept Dr Ho's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

20. In March 2020, Richard McKie (Trevor's uncle) offered Trevor his 9.1 metre timber cruiser known as the 'Alliance'. Richard had owned and maintained Alliance for over 12 years but during the past five years, he had stopped maintaining the vessel. The Alliance required work and needed to be towed. Trevor agreed to take on the Alliance as he and his father had grown up boating around the Gippsland lakes.

21. At 6:00pm on 18 July 2020, Trevor and Richard met at Hollands Landing in Gippsland. The Alliance was tied parallel to the bank and the rear duckboard was down, making it easier to step on board. They agreed to meet the following morning as Trevor was intending to tow the Alliance across Lake Wellington to Sale using his father's boat, the 'Dolphin,' an open fibre glass run-about.

22. Lake Wellington is a large lake which is 3.2m deep at its deepest part. The lake is isolated, with Sale being the closest town. The lake is vulnerable to strong winds.

23. At approximately 2:00pm on 19 July 2020, Trevor and his father met Richard on Lake Wellington, near the channel marker Number 8. There was a light breeze at this time, and it was sunny.

24. The Bureau of Meteorology forecast for local waters on this day was issued at 10.03am and indicated northerly winds of 10-15 knots, turning west to north westerly at 15-20 knots during the afternoon and evening. The weather was mostly sunny with a 50% chance of showers and chance of thunderstorm at night.

25. Trevor and his father boarded the Alliance and prepared the tow lines. It took Trevor approximately half an hour to rig Alliance to be towed by Dolphin. The tow was rigged so that Alliance would be towed from the front of the boat to the rear of the Dolphin, which would then be motoring froward whilst towing.

26. At the time Trevor rigged the Alliance to be towed by the Dolphin, the duckboard was in the down position. Richard knew that there was adverse weather coming later that day and asked Trevor on two occasions if he wanted him to take the tow all the way to Sale. Richard recalled that Trevor said they would be fine.

27. At 2.30pm, Trevor and Stuart set off for Sale. Richard recalled Trevor giving him a hug and two thumbs up, with Stuart at the helm of the Alliance. Trevor stated that they would catch up for a beer in a few days.

28. Sometime thereafter, Trevor contacted his mother and advised that he needed more fuel. They arranged to meet at Hearts Landing. When Trevor arrived at Hearts Landing in the Dolphin, Angela recalled that he was wearing a bright yellow high-vis top. He was not wearing a life jacket at the time. Trevor advised Angela that he had tied the Alliance (with Stuart on board) to the Number 14 channel marker. Trevor advised that the water was getting rough, and Angela offered to call the SES for him when she returned to Sale. Trevor indicated that this was a good idea.

29. At approximately 4:54pm, Trevor called Angela to advise that he was back at the Alliance. The phone dropped out and Angela contacted the SES and was put through to police. Trevor’s phone records indicate that his phone in fact ceased transmission at 4.13pm, earlier than Angela’s recollection.

30. Police advised Angela to tell Trevor that they should moor up for the night, however, Angela had already lost contact with Trevor. The call was directed to the Rescue Coordination Centre in Melbourne (Melbourne Water Police Squad).

31. Trevor had also contacted his partner, Kate throughout the day. In their last phone call, Trevor told Kate that he required assistance and Kate indicated that she would make some calls to see if someone could go to assist him. Kate presumed that Trevor meant he was having trouble due to the weather and made several calls to friends who were unfortunately unable to assist.

32. Police Air Wing (**PAW**) were tasked, and Gippsland Water Police were called. Both search and rescue assets arrived at Lake Wellington at 7:00pm.

33. PAW located the Alliance tied off to the Number 14 channel marker with Stuart on board. The duckboard was in the up position. The weather conditions were adverse, with seas to two metres. The Alliance was pitched and rolled about, making communication between Stuart and police difficult. They asked Stuart if any other persons were on board, to which he responded no. No other vessels were detected on the FLIR (thermal imagining system) or by radar.

34. Shortly thereafter, the Alliance suddenly snapped the bow line and was cast adrift. Stuart fell inside the cabin of the boat. The Alliance was subsequently towed to the nearest safe haven, in Seacombe.

35. On arrival at Seacombe, the Alliance was met by police who took care of Stuart. He advised police that Trevor had been with him at the channel marker but had fallen into the water and was then gone. Stuart could not remember what Trevor was wearing or any other particulars. He was found to be suffering from hypothermia and confirmed that he suffered from dementia, making recall difficult.

36. Police returned to Lake Wellington to continue the search for Trevor. Conditions continued to worsen with the seas up to three metres and winds of 50 knots. The air and sea search continued until 2:00am on 20 July 2020 before recommencing at 7.50am.

37. At 9.10am on 20 July 2020, police located the Dolphin between Tucker Point and Bull (Bluff) Point. The location was 3.7km south-east of the Number 14 channel marker at Lake Wellington. The vessel was facing bow into the shore with no lines holding it up. The vessel engines were not running but it was in gear. A wallet and car keys belonging to

Trevor were located and a foam lifejacket was sitting of the floor of the boat towards the bow. A foot search was conducted in the vicinity. The terrain was harsh and small trees were tightly positioned, making it difficult to penetrate. Nothing was located at this position and the on-water search continued.

38. Over the following two and a half weeks, land, sea, air, and underwater searches for Trevor continued. On 11 August 2020, police re-attended Lake Wellington, arriving at midday. The conditions on the lake were good, with smooth water and little wind. The water level had dropped about half a metre.

39. A search was commenced on the south-eastern shoreline from McLennan Strait with plans to search to Tucker Point. At 1.45pm, police arrived at Bull Point and located a deflated lifejacket and a fluorescent green item of clothing entwined in the roots of some trees that were exposed above the low water mark. The items were a self-inflating lifejacket type one and a lime green vest. Police began to search the immediate area, which was heavily wooded on the shoreline, wet and marshy.

40. At 1.50pm, police located a black pair of tracksuit pants which was about 10 metres to the west of location from where the self-inflating lifejacket and vest were located. The item was also entwined in the root system of a tree that was exposed.

41. At about 1.55pm, police located a male person lying face-down approximately 60 metres to the west of where the tracksuit pants were located. Police stated that this was an open area of beach, and the water level had dropped enough to expose the body. It was apparent that the person had been deceased for some time and police believed that it was Trevor.

42. Arrangements were made to recover Trevor's body and it was transported to the Hollands Landing Boat Ramp which was then nearest and most easily accessible place launching ramp.

FURTHER INVESTIGATIONS

Investigation by Victoria Police

43. Following Trevor's death, Victoria Police conducted inspections of the vessels Dolphin and Alliance as well as the self-inflating lifejacket that Trevor had been wearing. They noted the following:

PFD Lifejacket

44. Police located a Personal Flotation Device type 1 (**PFD**) (manual inflation device) which had not been activated. The gas cylinder was inspected and found to be intact and at the correct weight. The trigger mechanism was in the stowed position and the plastic retaining indicator was intact. There was a white line connecting the trigger level and this line was missing its plastic toggle (used for hand grip).

45. The trigger mechanism was tested and found to be extremely hard to pull all the way out. The internal pin was intact and moved as required. There was sand and corrosion in this mechanism. The oral inflating mouthpiece on this PFD was broken with the top section missing. Police advised that without the fill tube, it would render the jacket useless.

46. The jacket had water and sand inside the bladder which would have entered through the broken mouthpiece. It is not known when the mouthpiece was broken, and the jacket appeared to be old and well used. There was no indication that this PFD had ever been serviced.

Dolphin

47. On 14 August 2020, the Dolphin was inspected at the Gippsland Water Police Office. The vessel was intact and watertight and there were no apparent cracks or holes on the hull or deck. The engine appeared to be in good condition and was in forward gear, raised to the first shallow drive position. There was a red fuel cell on the floor with a small amount of fuel in it. The engine was started and ran and when placed in forward and reverse gears, the engine reached smoothly, and the propeller moved in the correct direction. The vessel contained two foam PFD lifejackets. These were in good condition and complied with current standards.

Alliance

48. Alliance was inspected on 23 July 2020 which was in poor condition on the topsides. The duckboard was made of Merbau timber and was able to be raised or lowered as required. It was hinged and when in the lowered position, it was low enough to the water for a person to be able to climb onto it. To raise or lower the duckboard took some effort and would be hard to do in adverse conditions.

49. The duckboard had been in the up and secure position when Water Police had first arrived on scene, and they believe that it was in the up position when Trevor was attempting to transfer from the Dolphin. Police noted that if the duckboard was down, Trevor could have been able to get onto this platform and board the Alliance. The wave action at the time would have also assisted him in boarding the vessel from the water as the boat would have been pitching, making the duckboard go under water.

50. Police concluded that when Trevor met his mother to obtain fuel, this may have taken longer than planned and the weather had become more inclement when he returned to the cabin cruiser. Nonetheless, police also concluded that the weather forecast for the day of the incident was as forecast by the Bureau of Meteorology and this should have been taken into consideration by Trevor before undertaking to tow the Alliance.

51. Trevor's telephone records revealed that his phone stopped transmitting at 4.13pm, as he may have been attempting to transfer from the Dolphin and back onto Alliance. It appears that he did not get a proper hand grip or footing and slipped and fell into the water. Stuart had told Richard that Trevor said, *I can't hold on anymore, I love you dad*, before drifting away from the vessel. Due to Stuart's medical condition, a formal statement was not obtained by police.

52. When Trevor fell into the water, he was wearing black tracksuit pants and a black hoodie, a green, fluorescent vest, and a self-inflating life jacket. These items of clothing were heavy when water sodden. The jacket that Trevor was wearing was not deployed, possibly because of its condition or through omission, and therefore could not assist him in staying afloat.

53. It is the opinion of police that the mixture of drugs and alcohol in Trevor's system may have explained his decision making on the day of the incident and effected his ability to manoeuvre between boats and to deploy the PFD once he was immersed in the cold water.

54. I am satisfied that Victoria Police have conducted a comprehensive investigation into Mr McKie's death and agree with their conclusions. Having reviewed the available evidence in depth, I am satisfied that no further investigation into the circumstances of Trevor's death is required.

Information provided by Safe Transport Victoria

55. In investigating the circumstances surrounding Trevor's death, LSC Shoobert made recommendations regarding the need for Martine Safe Victoria (now known as Safe

Transport Victoria) implementing additional education initiatives for mariners on the use of PFD's, checking weather forecasts and contacting emergency services.

56. In considering these issues, I wrote to and consulted with Safe Transport Victoria (**ST Vic**). I have included a summary of the information provided by ST Vic below.

PFDs

57. At the time of Trevor's death, ST Vic had a number of educational resources available to mariners regarding the use of PFDs, as follows:

- wearalifejacket.vic.gov.au[2]: a ST Vic owned microsite that outlines what type of lifejacket to wear in different situations and how to maintain inflatable lifejackets.

- Recreational Boating Safety Handbook[3] (**Safety Handbook**): this document is produced by ST Vic and contains a comprehensive range of topics to inform and educate boaters with more knowledge beyond that required to simply pass the marine licence test. Pages 37 to 40 of the Safety Handbook set out the requirements for carrying safety equipment for each type of vessel, including the requirement to carry an appropriate size and type of PFD for each person on board a vessel. The current version was released in 2021, however it remains substantially the same as the previous version.

- The Skippers Manual[4] (**the Manual**): a concise version of the Safety Handbook in a spiral bound and waterproof page format for quick reference and to be kept on board vessels. Pages 8 and 9 of the Manual contain information about lifejacket carriage requirements for each category of vessel. The Manual is also printed in languages other than English.

58. Since July 2020, ST Vic have implemented five (5) additional educational resources for mariners, as outlined below:

- an Inflatable Lifejacket maintenance brochure which was distributed at shows and events and displayed at retail outlets;

[2] https://wearalifejacket.transportsafety.vic.gov.au/
[3] https://transportsafety.vic.gov.au/_data/assets/pdf_file/0020/29540/Boating-Safety-Handbook.pdf
[4] https://transportsafety.vic.gov.au/_data/assets/pdf_file/0011/53300/Skippers-Manual-2021-BV-update-web.pdf

- a pilot program of FloatSafe Inflatable Lifejacket Self Inspection Clinics which commenced in December 2020. These clinics were designed to familiarise boaters with the inspection requirements and maintenance that should be undertaken regularly to ensure that their inflatable life jackets are functioning properly. Due to the COVID-19 pandemic these clinics have been limited.

- regular advertisements about the "Know the Five" campaign featured during the Talking Fishing program on the 3MP radio station in the first quarter of 2022; and

- ST Vic staff have coordinated FlareSafe sessions for boaters to dispose of expired flares in conjunction with WorkSafe Victoria. These sessions provide a touch point to promote best practice in emergency signalling and further reinforce emergency procedures on recreational boats. ST Vic staff frequently answer questions in relation to lifejacket servicing and safety at these sessions

59. The following resources are also available to mariners and emphasise the importance of regularly inspecting and professionally servicing lifejackets:

    - ST Vic staff released a video and an article for Boatsales, a popular boating website in April 2020 about how to inspect and self-service a lifejacket; and

    - ST Vic frequently post on the ST Vic Facebook page to promote the appropriate maintenance of lifejackets.

60. However, whilst ST Vic strongly encourage mariners to inspect and maintain their lifejackets every 12 months, manufacturers do not necessarily recommend that lifejackets are professionally serviced every year. ST Vic recommends that lifejackets are serviced by an accredited provider in line with the manufacturer's instructions.

Weather forecasts

61. In October 2019, ST Vic launched the Boating Vic mobile application (**the App**), and website were launched. Through the App, mariners are able to obtain live weather and boating launch site conditions to inform their decision making when determining whether or not to leave home and go boating. The App is designed to inform mariners of conditions likely to be encountered before they have committed to a day on the water and provides localised weather direct from the Bureau of Meteorology based on launching facility location.

62. In addition, ST Vic has been conducting a safety campaign called 'Know the Five' (**safety campaign**) since 2018. One of the key messages in the safety campaign is "Know the Weather". The purpose of this campaign is to highlight the importance of obtaining up to date local weather forecasts, as well as understanding the weather forecast prior to going on the water.

63. The Bureau of Meteorology also provide information about the '5 Vital Checks' for mariners to perform before entering the water which they can access through their smart phone. ST Vic continue to work directly with the Bureau of Meteorology and the Australia and New Zealand Safe Boating Education Group to identify products and channels to better inform mariners of the current and forecast weather conditions.

<u>Contacting emergency services</u>

64. In emergency situations, mariners are able to contact triple zero whilst they are within mobile phone coverage aeras. On the advice of Victoria Police, St Vic recommends that mariners call triple zero as opposed to contacting the Australian Maritime Safety Authority Joint Rescue Coordination Centre (**JRCC**) directly.

65. However, ST Vic have acknowledged that there is a limitation to this as mariners are only able to contact triple zero as long as they remain in mobile phone coverage areas. The JRCC is able to receive alerts through distress beacons, satellite emergency notification devices and maritime distress and safety systems.

66. At present, the reverse side of the marine licence card (required to be carried by all licensed operators of powered vessels) also includes advice for boaters to call Triple Zero in an emergency and the holding message which greets callers to ST Vic states that boaters should call triple zero in an emergency. The Safety Handbook also contains details of raising the alarm at time of distress and includes reference to calling Triple Zero.

67. ST Vic also produces a number of resources for mariners on the importance of carrying an emergency distress beacon or marine radio. The following resources were available to boaters as at July 2020:

- <u>Boat Safety Campaign</u> which includes five safety initiatives. The Campaign uses a media purchasing agent to enable key messages to appear in google searches, searches of Boatsales website, as well as online news outlets.

- Boater information pamphlets which are regularly included in VicRoads Regulation annual renewal notices mailed out by VicRoads. These pamphlets are updated yearly.

- Boat Safety Information Signs which are present at all boat ramps. At the larger boat ramps the information signs set out safety equipment requirements, including lifejacket carriage, along with information about calling Triple Zero in the case of an emergency.

- ST Vic produces a range of safety stickers providing information to boaters about various topics, including the importance of carrying the correct safety equipment.

- ST Vic's Recreational Boating Safety Education Team regularly attends shows and events, such as boat shows, safety seminars, and field days at regional locations to promote boating safety. Primary messaging is related to wearing and servicing of life jackets as well as trip preparation, including obtaining accurate weather information and being able to raise the alarm in times of distress.

68. From my review of the information provided by ST Vic, there does not currently appear to be any practical resources available to mariners that specify the information that should be provided to triple zero in the case of an emergency on the water. This may include how to advise the emergency call taker of their location on the water, latitude and longitude and reference or a nearby landmark or some combination.

69. Whilst I am not critical of the work that is being done by ST Vic to educate mariners on contacting triple zero in the event of an emergency, ST Vic may wish to consider developing a practical resource or policy document, in conjunction with the Emergency Services Telecommunications Service for emergency call takers and/or dispatchers on the questions that should be asked, and information sought when a mariner contacts triple zero in an emergency situation.

70. ST Vic has acknowledged that there is additional work that can be done to address and further educate mariners on these issues. This is particularly true for mariners who are engaged with sailing or recreational boating clubs or those who regularly attend boat trade shows or check the ST Vic website.

71. ST Vic have advised that they would be supportive of recommendations to review their approach to addressing these issues.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Trevor Henry McKie, born 27 March 1972;

   b) the death occurred on 11 August 2020 at Bull Point, Lake Wellington, Victoria, 3851, from coronary artery atherosclerosis in the setting of immersion and;

   c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

73. Having regard to the circumstances of Mr McKie's death, and the information provided by ST Vic, I recommend that:

   (i) ST Vic consider reviewing the current information and safety material provided to mariners to ensure that it includes:

      a. information about the requirement to conduct an annual service and tests of an inflatable lifejacket to ensure that it is functional. The material should include a step-by-step guide as to how to conduct a check and service of the lifejacket if to be done by the owner, or in the alternative information about third-party contractors who provide do this service;

      b. information for mariners about the importance of checking and being up to date with the weather forecasts before they leave the shore and whilst on the water. This should include information about where to find the most up to date weather information and the availability of weather mobile applications (including the Boating Vic mobile application) that are available to mariners to check changing weather conditions while they are on the water; and

      c. information directed to mariners to contact triple zero in the event of an emergency and what information should be communicated to the triple zero

call tacker including location information which may be the position expressed by reference to the current latitude and longitude.

(ii) ST Vic consider providing this information with the annual renewal of the registration of a vessel to ensure that boat owners read and understand this information. Consideration should be given to the feasibility of developing an online test to be completed prior to renewal of registration.

74. I confirm that recommendations (i)(a) and (ii) above have been directed to ST Vic in the coronial investigation into the death of Peter Boyle (COR 2022 001498) in which I considered similar issues relating to the annual servicing and testing of inflatable life jackets and the distribution of relevant information and safety material to mariners.

I convey my sincere condolences to Trevor'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.

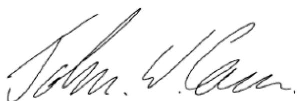
I direct that a copy of this finding be provided to the following:

Kate Grummisch, Senior Next of Kin

Leading Senior Constable Graham Shoobert, Coroner's Investigator

Safe Transport Victoria

Signature:



JUDGE JOHN CAIN
STATE CORONER
Date: 2 MAY 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.