STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Katrina Lee McGrady
Hearing dates:	14 – 16 October 2024 and 4 – 5 September 2025
Date of findings:	8 December 2025
Place of findings:	State Coroners Court of New South Wales at Moree
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of First Nations woman - ruptured berry aneurysm – subarachnoid haemorrhage – endovascular flow diversion - informed consent – communication with family – cultural safety and competency – failure to identify and escalate increasing headaches – multidisciplinary reviews – specialist consultation – health outcomes for First Nations persons – organ donation protocols – end of life care
File number:	2020/00287551

Representation:	**Counsel Assisting:** Gillian Mahony SC instructed by Kathleen McKinlay, DCJ Legal **Counsel for Hunter New England Local Health District:** Stuart Kettle, instructed by Jennifer Casperson, Uldouz Van Eenoo, and Ashley Lister of the Crown Solicitor's Office **Counsel for Dr Michael Edger and Dr Vijeth Bhat:** Stephen Barnes, instructed by Paul Tsaousidis of Avant Mutual
Non-publication orders:	The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009*. Details of these orders can be found on the Registry file.
Findings:	**The identity of the deceased** The person who died was Katrina (Trina) Lee McGrady. **Date of Death** Trina died on 15 September 2020. **Place of Death** Trina died at the John Hunter Hospital, Newcastle. **Cause of Death** The cause of Trina's death was a subarachnoid haemorrhage due to a ruptured berry aneurysm. **Manner of Death** Natural causes.

Recommendations:	To the Hunter New England Local Health District (HNELHD): 1. That the HNELHD consider whether the practice of obtaining informed consent is appropriately adhered to within its surgical units. This recommendation is made within the circumstances of Katrina McGrady's case, namely the commencement of medication required for a specific procedure in circumstances where all treatment options had not been sufficiently explored with or communicated to the patient, and whether the commenced medication was counter to those other treatment options. 2. That the HNELHD review its Comprehensive Care: Adult Inpatient Multidisciplinary Care Plan for the purposes of de a) Whether it is appropriate and fit for purpose for each neurosurgical team or unit; and b) Whether it has been sufficiently rolled out to the John Hunter Hospital (JHH) 3. That the HNELHD recommend to the JHH that it review its practices of raising end of life and organ donation with First Nations families to ensure a discussion of the clinical team occurs as a first step, wherever possible, prior to the issue being raised with the family.

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Introduction

1 This inquest concerns the death of Ms Katrina Lee McGrady.

2 Ms McGrady was born on 31 August 1977. She died at the John Hunter Hospital (JHH) in Newcastle, in the state of New South Wales at the age of 43 years.

3 Ms McGrady was a proud Goomeroi woman.

4 Ms McGrady died from a subarachnoid haemorrhage due to a ruptured berry aneurysm.

5 The identity and place of Ms McGrady's death are not in dispute. This inquest has focused on the date, cause and manner of Ms McGrady's death and the relevant contributing circumstances, including her care and treatment at the JHH.

6 Ms McGrady was the much-loved mother of her four children and partner to Craig. Ms McGrady was also a daughter, sister, aunty, cousin and a loyal and supportive friend and member of the Toomelah community.

7 Members of her family have been constant advocates for her and have been unwavering in their determination to ascertain the reasons for her unnecessary death. Various family members and friends have participated and contributed during these proceedings, and I acknowledge the profound loss and anguish felt and experienced by her family and friends.

8 In these findings I have referred to Ms McGrady as Trina. This has been at the request of her family members. Trina's good friend Brooke McGrady stated that:

> "Trina made us all very proud. She understood from an early age that knowledge was the key to understanding people, our community, the social dynamics and the world in which we live. Trina was inquisitive. She loved to research. If something was new to her, she would always have to find out how it worked, what made things the way they were, and why. I guess this is how Trina developed the understanding of people and the attributes we all saw in Trina."

9 I would like to express my sincere condolences to Trina's family for the loss of the strong and considerate woman Trina was to her family and community. I hope that Ms McGrady's memory had been honoured by the careful examination of the circumstances surrounding her death and the lessons that have been learned from the circumstances of her passing.

The role of the Coroner and the scope of the inquest

10 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and how the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence presented during the inquest, which may improve public health and safety.

11 During these proceedings, a brief of evidence containing statements, photographs and other documentation, was tendered in court and admitted into evidence. In addition, oral evidence was received from numerous witnesses. Written and oral expert evidence was received from Professor Michael Besser and Associate Professor Tony Goldschlager.

12 All the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Ms Gillian Mahony of Senior Counsel, and Mr Stuart Kettle, counsel on behalf of the Hunter New England Local Health District, as well as oral submissions delivered by Mr Stephen Barnes on behalf of Dr Bhat. At times, I have embraced their descriptions in these findings.

Background

13 Trina was the youngest child in her family. Trina grew up with her 14 siblings, and they have remained close throughout their lives.

14 Trina and her partner Craig were in a personal relationship for approximately seventeen years, and together they have three children. Trina has another child from an earlier relationship.

15 Trina attended university and completed a degree in business, as well as undertaking Indigenous leadership programs. Trina then worked in a number of roles, including as an Education Assistant, childcare worker, administration officer, youth and family support worker, child protection program worker and Chief Executive Officer of the Toomelah Land Council.

16 Prior to 2019, Trina had a very limited medical history, with the only known medical issue being chronic hypertension, which was managed with prescribed medication. She had undergone an uneventful appendicectomy in July 2020. Katrina was a non-smoker.

17 In late 2019, Trina was diagnosed with Cholesteatoma, a middle ear condition which can result in hearing loss if untreated. Trina was due to have corrective surgery in September 2020.

18 In May 2020, Trina went to visit her close friend, Brooke, and spoke to her about increasing headache pain. Brooke encouraged Trina to follow up with medical scans as she perceived that the headaches may be indicative of a more serious diagnosis.

19 On 24 August 2020, Trina visited her GP, Dr Gazy. Dr Gazy recommended that Trina undergo a CT Petrous Temporal Bone scan as part of a diagnostic workup for the forthcoming surgery to remove the cholesteatoma.

20 On 27 August 2020, Trina underwent the CT scan. The scan detected an abnormality, noting: "There is no acute intracranial pathology however note is made of a right-sided parasellar abnormality as described. Although this may represent a meningioma, large aneurysm involving right side of circle of Willis requires exclusion if not previously known. CT Circle of Willis angiogram would clarify."

21 The CT Circle of Willis was performed later that day. The CT scan report noted:

> "There is a saccular aneurysm demonstrated. It measures 2.0cm maximal span, pointing superiorly/posteriorly/laterally. It appears to originate from the terminal portion of the right internal carotid artery, slightly above clinoid process level with neck width of 0.4cm.
>
> On the left at similar distribution, just below clinoid process level, there is appearance of further saccular aneurysm involving distal left internal carotid artery, projecting posteriorly measuring 0.5cm and broad neck of 0.35cm (Serlas 502 Image 143, Series 5 !mag 90-92). Tortuosity of the carotid siphon is also noted but no further aneurysm or focal arterial vessel finding is detected on this stud.
>
> No further intracranial abnormal enhancement is identified. There is preserved grey/white matter differentiation. No hydrocephalus or extra-axial collection.
>
> Conclusion:
>
> Large aneurysm identified at the distal right internal carotid artery. Smaller aneurysm also noted at similar level at distal left internal carotid artery."

22 Trina was advised to attend Moree District Hospital (MDH) urgently.

23 Trina was reviewed by Dr Omar, shortly after her presentation to MDH emergency department (ED). Dr Omar arranged for her to be referred to the

John Hunter Hospital (JHH) in Newcastle for specialist assessment and treatment.

24 On 29 August 2020, Trina was transported by air ambulance to the JHH and admitted under the care of Dr Michael Edger, Neurosurgeon. At this time, all hospitals in NSW were operating under COVID 19 protocols, which significantly impacted the usual care and treatment protocols, including those at JHH.

25 Later that same day, Trina contacted her friend Brooke by text message and told her that "my head hasn't stopped aching since I woke up on Thursday morning," which would have been on 27 August 2020.

26 On 30 August 2020, Dr Edger attended on Trina. The clinical notes indicate that they "discussed aneurysm" and "DSA", being a Digital Subtraction Angiography. A DSA is a procedure used to view the inner surface of blood vessels. A plan was proposed for Trina to undergo a DSA and an MRI. It appears from a review of the clinical notes that the MRI was not performed.

27 On 1 September 2020, Trina underwent the DSA which confirmed the presence of a "23 mm partially thrombosed aneurysm originated midway between the ophthalmic artery and the posterior communicating artery at the posterior aspect of the right internal carotid artery. A 6 mm aneurysm in an identical position on the left internal carotid artery was also demonstrated."

28 Dr Miteff, the specialist endovascular interventional neurologist, who performed the angiogram (DSA) noted "The internal carotid artery aneurysms would be amenable to endovascular flow diversion."

29 Later that day, Trina sent a text to Brooke stating, "Had the procedure. They've located where the aneurysm is sitting and going to operate next Tuesday" (meaning 8 September 2020).

30 In preparation for the endovascular flow diversion surgery, Trina was placed on anticoagulant dual antiplatelet therapy, which consisted of her being given aspirin and Plavix. Trina's surgery was scheduled for 8 September 2020.

31 On 3 September 2020, Dr Miteff ordered a multiplate aggregometry test to determine if her platelets were adequately suppressed in preparation for the endovascular flow diversion. The test was scheduled for 4 September 2020. At this time, it appears that Trina had not been spoken to about her treatment options, nor given an opportunity to be involved in that decision-making process.

32 Trina was being prescribed medications to address her headaches and nausea. It does not appear that there were any other specific reviews of her

headaches and nausea. The fact that her headaches were varying in presentation and severity was not reported to either Dr Edger or Dr Miteff.

33 At 8.37pm, Trina was prescribed pain relief for headaches and nausea.

34 At 1.15am on 4 September 2020, Trina used the call button and complained of a 10/10 headache. As the staff sourced the codeine, Trina became unresponsive and was rushed to the ICU, where she was intubated and ventilated. Her blood pressure was 210/112.

35 At 2.05am, a CT imaging scan was performed, indicating:

a. A large volume subarachnoid haemorrhage primarily on the right outlining the large previously demonstrated right ICA aneurysm in keeping with acute aneurysm rupture;

b. Associated interventricular haemorrhage extension;

c. Evidence of mass effect and elevated intracranial pressure with developing hydrocephalus; and

d. Cerebellar tonsillar herniation and midline shift of 10 mm towards the left.

36 At 2.45am, Trina was taken to the operating theatre for an insertion of a right frontal external ventricular drain (EVD). An EVD procedure is intended to drain bloody cerebrospinal fluid (CSF), as well as evacuate the subarachnoid haemorrhage, and to control the high intercranial pressure (ICP) in her head. This was performed in an effort to prevent brain death from central herniation.

37 The right EVD was commenced at 3.30am and performed by Dr Kate Poulgrain. The Surgical Consult and observer was Dr Edger. The surgery concluded at 4.30am and the medical team discussed the fact that shortly after the right EVD was inserted it became clotted with blood. It was agreed that a left EVD should be inserted. Dr Poulgrain commenced the left EVD procedure at 4.40am.

38 The left EVD insertion procedure was completed at 5.40am, however, that drain also became clotted with blood and brain tissue. During the left EVD, arrangements were being made for further urgent surgery, being a cerebral angiogram and the treatment of the aneurysm.

39 At 6.30am, a repeat DSA was performed which showed the giant right carotid artery aneurysm was partially thrombosed and there was poor perfusion of her entire brain.

40 At 7.15am, a cerebral examination concluded that there was "significant global cerebral perfusion defect suggesting sinister prognosis." Trina was placed on life support and was treated conservatively with Nimodipine and paracetamol. She remained on life support until her death.

41 Trina's family were advised that her prognosis was poor and that it was likely that she no longer had any brain function. The family requested a delay in the brain function testing as their cultural and spiritual beliefs suggested that Trina was still responsive, and her spirit remained present.

42 Over the ensuing 12 days, numerous meetings were held between family members and medical practitioners, social workers and First Nations health liaison officers to discuss Trina's further medical management.

43 During those 12 days, Trina began developing pressure sores, ventilator associated pneumonia, sepsis, and electrolyte and neuro-hormonal disturbances causing fluctuating heart and blood pressure rates.

44 On 11 September 2020, Trina's family provided a directive to hospital staff, which stated that they did not consent to any kind of testing except for testing necessary for the preservation of life. In addition, fluids and other life support measures were to be continued to ensure the preservation of Trina's life.

45 On 15 September 2020, Dr Bhat directed that the administration of Vasopressin cease. Vasopressin assists in constricting blood vessels to assist with the control of blood pressure, together with controlling the amount of water and salt that is processed by the kidneys.

46 On 16 September 2020, Trina's family insisted that the Vasopressin should be recommenced.

47 On 16 September 2020, a second opinion was sought from Dr Celia Bradford, an ICU Intensivist at Royal North Shore Hospital (RNSH). Dr Bradford provided an independent opinion regarding Trina's treatment and her prospects of improvement. Dr Bradford agreed with the plan for Trina's management and stated that at RNSH they would make sure the family was updated and change goals of care towards dignity and palliation.

48 At 6.30pm on 16 September 2020, Trina suffered circulatory arrest, and all life support was removed. Trina's family accepted that her heart had stopped beating and that she could not be revived.

49 Dr Adelaide Charlton, an ICU Fellow, completed the Medical Certificate of Cause of Death (MCCD), stating that the direct cause of Trina's death was due to a "Subarachnoid Haemorrhage" with an antecedent cause of death being "Internal Carotid Artery Aneurysms."

50 Trina's family did not accept the MCCD prepared by Dr Charlton and raised care and treatment issues with the JHH team, regarding her care at both the JHH and Moree District Hospital. One area of concern that was raised was the inappropriate use of opioids or other medications which may have advanced Trina's death.

51 Trina's family approached the Moree Local Court Registrar, requesting an investigation into Trina's death. Police reported Trina's death to the Coroner on 2 October 2020. An autopsy was conducted by Dr Allan Cala on 6 October 2020.

List of issues considered during the inquest

52 The following list of issues was prepared before the proceedings commenced, circulated to the interested parties, and were considered and provided focus during the inquest:

i. What was the cause of Trina's death?

ii. Whether there was any delay in transferring Trina from Moree District Hospital to John Hunter Hospital, and if so, whether such delay was reasonable in the circumstances.

iii. Whether the medical care and treatment Trina received at John Hunter Hospital was adequate and appropriate, including:

a. Whether Trina's headaches and nausea, in the days leading up to the rupture of the aneurysm were adequately recognised and escalated by treating staff;

b. Whether the decision to treat Trina's condition with endovascular flow diversion and anticoagulant dual antiplatelet therapy was appropriate in the circumstances, including whether consideration was given to alternative treatments such as a craniotomy or direct microsurgical clipping of the aneurysm neck;

c. Whether an MRI was conducted, and if not, whether an MRI should have been conducted in order to better understand and inform any urgency in treatment;

d. Whether a multidisciplinary review(s) was/were conducted in relation to Trina's care and treatment, and if not, whether a multidisciplinary review should have been conducted at any stage;

e. Whether a Specialist Consultation occurred in relation to Trina's care and treatment, and if not, whether a Specialist Consultation should have been conducted at any stage.

f. Whether Trina gave informed consent to treating her condition with endovascular flow diversion and anticoagulant dual antiplatelet therapy, including whether she received adequate information about alternative treatment modalities.

iv. Whether staff at John Hunter Hospital breached NSW Health and Hunter New England Local Health District policy in failing to record all clinical documentation in relation to Trina's care and treatment.

v. Whether informed consent from Trina's family was required to cease medications including vasopressin, and if so, whether that informed consent was given.

vi. Whether communication with Trina's family at John Hunter Hospital was culturally safe and responsive

vii. Whether Trina's family were appropriately counselled on treatment decisions surrounding Trina's ongoing life support.

Issue 1 - Cause of and date of Trina's death

53 The evidence disclosed that on 4 September 2020, the treating medical team first raised the possibility with Trina's family that Trina had sustained irreversible brain death that day.

54 On 7 September 2020, after further consultation with the family, it was agreed by the treating medical team that clinical or radiological testing regarding brain death would not be conducted at that time.

55 On 15 September 2020, Dr Bhat commenced the Brain Death Certification process, together with Dr Yee Yong Lee. Both doctors conducted a clinical examination and concluded that each of the seven preconditions were met and each of the eight clinical testing factors were satisfied. They both confirmed that they had determined that "according to the above procedures, that irreversible cessation of all function of the person's brain has occurred."

56 Trina's family were sceptical that she had suffered irreversible brain death on 4 September 2020. They also strongly believed that Trina would speak to them by way of a sign, indicating that she was ready to transit to death.

During the period from 4 – 16 September 2020, the family did not receive any sign from Trina.

57 Her family were also cognisant of a relative's experience who had been declared 'brain' dead,' only to make a subsequent recovery.

58 In addition, her family did not accept that her date of death could be attributed to the declaration of brain death on 15 September 2020 and contended that her date of death should be documented to reflect the time of the cessation of her circulatory system on 16 September 2020.

59 As referred to above, Dr Charlton concluded that the cause of Trina's death was due to a "Subarachnoid Haemorrhage" due to an "Internal Carotid Artery Aneurysm."

60 Dr Charlton recorded Trina's date of death as 15 September 2020, rather than 16 September 2020, as Trina required mechanical assistance to breathe and maintain life after the formal certification of brain death was declared at 1.20pm on 15 September 2020.

61 Section 81 of the *Coroners Act 2009*, states:

> "(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:
>
> (a) the person's identity, and
>
> (b) the date and place of the person's death, and
>
> (c) in the case of an inquest that is being concluded - the manner and cause of the person's death."

62 The *Coroners Act 2009* does not define "death," nor does it provide a statutory basis for determining the date and place of the person's death.

63 In New South Wales, the only legislation that provides for a definition of the death of a person is found in section 33 of the *Human Tissue* Act 1983. Section 33 provides:

> "For the purposes of the law of New South Wales, a person has died when there has occurred –
>
> (a) irreversible cessation of all function of the person's brain, or
>
> (b) irreversible cessation of circulation of blood in the person's body."

64 This Court is bound by section 33 of the *Human Tissue* Act 1983, and is required to apply this definition, as section 33 is a general provision and has an application for the "purposes of the law of New South Wales."

65 The NSW Supreme Court considered an application for an injunction in similar circumstances in the case of *Ibrahim v South Eastern Sydney Local Health District* [2018] NSWSC 913. The Court held that in light of the evidence of a senior staff specialist at the hospital and having regard to the definition of death in section 33 of the *Human Tissue* Act and to the relevant protocols, the Court came to the 'regrettable conclusion that (the plaintiff's wife) is deceased."

66 Trina's circumstances, and the circumstances outlined above in *Ibrahim*'s case are not readily distinguishable. As such, the application of the law as stated in *Ibrahim*'s case must be applied to these circumstances, meaning that Trina's date of death is required to be stated as having occurred on 15 September 2020.

67 Dr Allan Cala, a Senior Staff Specialist in Forensic Pathology, prepared a postmortem report dated 24 November 2020, outlining the results of the external examination that he conducted on 6 October 2020.

68 Dr Cala recommended that the cause of Trina's death be recorded as being due to a subarachnoid haemorrhage due to a ruptured berry aneurysm.

69 On the balance of probabilities, Trina's cause and date of death will be recorded as being due to a subarachnoid haemorrhage due to a ruptured berry aneurysm, which occurred on 15 September 2020.

Issue 2: Whether there was any delay in transferring Trina from Moree District Hospital to John Hunter Hospital, and if so, whether such delay was reasonable in the circumstances.

70 On 27 August 2020, Trina attended Moree Diagnostic Imaging at 11.50am. The CT Petrous Temporal Bone scan detected an abnormality and at 3.51pm, a CT Circle of Willis angiogram was performed. The CT angiogram detected a large aneurysm at the distal right internal carotid artery and a smaller aneurysm at a similar level at the distal left internal carotid artery.

71 Trina was advised to urgently attend Moree District Hospital (MDH).

72 Trina attended the hospital and was triaged into the Emergency Department (ED) at 5.09pm. An ED triage note recorded that Trina presented with "mild headache onset today 2/10" but no nausea, vomiting, no blurred vision or decreased weakness in limbs.

73 At 5.30pm, Trina was reviewed by Dr Omar. Dr Omar noted that Trina was "asymptomatic" with no family history of stroke and observed her to be neurologically fine. It was noted that Trina did present with elevated blood pressure, recorded as 160/110, and was provided with medication in response to that reading.

74 Following her admission, Trina underwent a CT cerebral angiogram. According to the clinical notes, the angiogram confirmed that the large right distal carotid aneurysm measured 2 cm in diameter, but with a relatively narrow neck width of 4mm. The smaller aneurysm located in the left carotid artery measured 0.5cm with a broad neck width.

75 At 8.30pm, Trina's patient plan stated that she was to be admitted under the care of Dr Edger, neurosurgeon at John Hunter Hospital (JHH) in the "next two days."

76 Nursing notes from MDH confirmed that Trina was complaining of headache, with observations confirming that they were within the patient's acceptable range during observation rounds. Trina was administered Paracetamol 1000mg for her headache symptoms on 28 and 29 August 2020.

77 At 8.15am on 28 August 2020, nursing staff confirmed that the air ambulance booking had been made, however, no bed was available at the JHH. At 10.25am, the air ambulance booking was confirmed for the following day.

78 At 8.30am on 29 August 2020, Trina was transported to the JHH by air ambulance, arriving at 12.45pm.

79 The evidence does not disclose that Trina's medical presentation from 27 August until 29 August 2020 required a more urgent response or an earlier transfer to the JHH.

80 On the available evidence, Trina's transfer to the JHH was appropriate and facilitated within a reasonable period of time that was consistent with her recent diagnosis and clinical presentation.

Trina's admission to the John Hunter Hospital (JHH)

81 At the time of Trina's referral and admission to the JHH, COVID-19 lockdowns were in place at the hospital.

82 The Department of Neurosurgery at the JHH, consisted of five consultants and approximately six registrars. In August 2020, the Department was divided into two teams. The intention was that the two teams would work independently of each other and not meet at the hospital, due to the risk of COVID-19 spreading through the entire Neurosurgery Department. The effect

of this decision was that there were no regular meetings or discussions occurring onsite. Meetings between consultants and registrars occurred online or by telephone.

83 On her admission to the JHH, Trina was seen by a neurosurgery Resident Medical Officer (RMO). The RMO then spoke with the neurosurgery Registrar and a treatment plan was devised. This plan included performing a digital subtraction angiogram (DSA), to further assess her two aneurysms.

84 On 30 August, Dr Michael Edger, Specialist Neurosurgeon, reviewed Trina and discussed with her the diagnosis of the two aneurysms and the need for a DSA to delineate them further. Dr Edger noted that at that time, Trina did not complain of headaches. He noted that "she had experienced a headache since her admission to Moree Hospital, but it had been stable and unchanged over the previous few days."

85 Dr Edger reviewed Trina again on 31 August 2020 and noted that "no mention of headaches was made." He stated that "Unfortunately, no record of this attendance was made."

86 On 1 September 2020, Dr Ferdi Miteff, Consultant Neurologist and Interventional Neuroradiologist (INR) performed the DSA. After the completion of the DSA, Dr Miteff discussed the DSA findings with Dr Edger.

87 The evidence of both Dr Edger and Dr Miteff was that they were not aware of Trina's ongoing complaints of increasing headaches and nausea during her admission.

Issue 3. Whether the medical care and treatment Ms McGrady received at John Hunter Hospital was adequate and appropriate, including:

a. Whether Trina's headaches and nausea in the days leading up to the rupture of the aneurysm were adequately recognised and escalated by treating staff.

88 The detection of Trina's bilateral intercranial aneurysms was described as being incidental to her 'work-up' for her forthcoming cholesteatoma at St Vincent's Hospital later in the year. The aneurysms were present on each of the internal carotid arteries that supply blood to the anterior part of the brain. In the evidence before the inquest, an aneurysm was described as an "out-pouching of the normal wall of an artery. So, it's like a balloon which is inflated, if you like, arising from the side of an artery, and so they're filled with arterial pressure blood, and they usually arise as a weakness in the arterial wall for often unknown reasons."

89 Aneurysms are divided into two groups. The first is a ruptured aneurysm, which is a bulge in a blood vessel in the brain that bursts, causing a subarachnoid haemorrhage, which is the bleeding into the subarachnoid space between the brain and its protective membranes. The second is an elective or incidental aneurysm, where the aneurysm is detected during a CT scan. Trina presented to both MDH and JHH with two unruptured aneurysms. One of Trina's aneurysms was described as a large aneurysm which was partially thrombosed, which places the patient at a high risk.

90 Trina reported that she was experiencing headache symptoms at MDH on 28 August 2020. She was treated with Paracetamol 1000mg at 4.24am, 6.42am and 11.41pm.

91 Trina continued to experience headaches up to and after her transfer to JHH.

92 The JHH and MDH clinical notes recorded Trina reporting continuing headaches over a number of days. These complaints included the following:

a. On 27 August 2020, Trina reported a mild headache that started that day with an intensity of 2/10 but no report of nausea.

b. On 28 August 2020, Trina complained of headaches and feeling a bit nauseated.

c. At 8pm on 29 August 2020, Trina reported a headache over the temporal region and the back of her head, with an intensity of 5/10 and associated with nausea and vomiting. The clinical notes documented the headache "Hasn't gotten significantly better or worse over last few days." It was recommended to "Contact ?MO if headache gets significantly worse or focal neurological changes that increased in intensity and required significant pain relief."

d. At 11.35am on 1 September 2020, Trina reported a headache with a severity of 7/10.

e. At 11.35am on 2 September 2020, Trina reported a headache with a severity of 7/10.

f. On 2 September 2020, at 8pm, Trina reported headaches fluctuating in intensity between 4/10 and 8/10, with Endone helping but making it worse in some cases and she also feels "funny".

g. At 1.10am on 4 September 2020, Trina buzzed for a nurse, complaining of a 10/10 headache. Nursing staff went to access the schedule 8 cupboard to retrieve medication and found Trina unresponsive ten minutes later.

93 Trina received ongoing medication to assist with the management of her headaches. The medication included:

a. On 30 August 2020, Trina was administered Paracetamol 1000mg at 5.17am, 11.18am, 5.36pm and 11.31pm. She was also administered Endone 5mg at 4.53pm, 8.39pm and 11.32pm.

b. On 31 August 2020, Trina was administered Paracetamol 1000mg at 8.44am and 5.50pm. She was also given Endone 5mg at 4.45am and 11.45pm.

c. On 1 September 2020, Trina was administered Paracetamol 1000mg at 3.37am, 11.51am and 6.29pm. She was also administered Endone 5mg at 7.44am, 11.51am, 4.29pm and 9.43pm, together with a clopidogrel tablet at 3.30pm.

d. On 2 September 2020, Trina was administered Endone 5mg at 3.21am, 8.06am, and 3.47pm. She was also given codeine phosphate hemihydrate 60mg at 8.30pm. This variation was administered in an attempt to address Trina's concerns that the ingestion of the Endone was making the headaches worse in some cases.

e. On 3 September 2020, Trina was administered codeine phosphate hemihydrate 60mg at 00.20am, 7.57am, 12.01pm and 8.37pm.

94 In addition, Trina was also prescribed Aspirin 100mg EC tab and Plavix on 2 September 2020 as part of the dual-platelet therapy, in preparation for the intended endovascular flow diversion procedure on 8 September 2020.

95 Dr Edger gave oral evidence confirming that the sudden onset of a severe headache would be indicative of an aneurysm rupturing and causing a subarachnoid haemorrhage. He noted that an aneurysm is not "necessarily related to a headache if the aneurysm hasn't ruptured."

96 Dr Edger was asked to comment on the differing degrees of rupture of an aneurysm, and stated "so you can have a small amount of blood, or you can have a much larger amount of blood, and usually the headache is related to the amount of blood which has ruptured, and there are various methods of categorising – describing how much blood there is present on a CT scan."

97 Dr Edger stated that for a sudden onset of a severe headache, "it would be indicative of an aneurysm rupturing, and causing a subarachnoid haemorrhage." He further noted that if there is a rupture of an aneurysm, there is usually "associated vomiting," and that a non-contrast CT scan would be the usual method of diagnosing if there was a subarachnoid haemorrhage.

98 Dr Edger confirmed that at the time Trina was admitted to JHH, there was not "a history of a concerning headache", and there was "nothing in the history to suggest that this was anything other than an incidental unruptured aneurysm at the time she presented." He stated that "if a headache was escalating and wasn't responding to analgesia, then that would be a reason to question whether there was any change in the aneurysm."

99 Dr Edger stated that he was unaware when he first saw her on his rounds on 30 August 2020, that Trina had been making complaints of experiencing headaches she assessed as being 4 out of 10 whilst at MDH. He indicated that "a headache, a degree of headache is present on every patient on the neurosurgical ward, so a mild headache which responds to analgesia would not raise any concerns," and he would "rely on relevant information being passed to (him) by (his) junior medical staff."

100 Dr Edger was asked the following question:

> Q. "Doctor, on 29 August at 8pm, that's the evening that Trina was admitted to (JH) hospital, there's a history recorded that reports a headache over the temporal region and the back of the head with an intensity of 5 out of 10, "hasn't gotten significantly better or worse over the last few days. First started Thursday. Intermittent, associated with nausea and vomiting," and moving over the page, it states "nil neck pain, nil SOB, nil visual changes, nil weakness, nil speech challenges. On examination, patient alert but drowsy." The fact of that headache being rated by Trina as a 5 out of 10 intensity, would that elevate to beyond being a mild headache?
>
> A. "I think it would still be an expected headache in a hypertensive person who'd been diagnosed with an aneurysm and had all the stress of being retrieved from Moree to John Hunter and not knowing what was going to happen."

101 Dr Edger indicated that "I would have said if it was a headache that was 5 out of 10 and responded to simple analgesia, then that was not a concern."

102 He further stated that "an ongoing headache on a patient on the neurosurgical ward would not be a concern. An escalating headache or a sudden change in the headache, I would expect to be notified."

103 In his statement dated 7 September 2023, he stated that when he reviewed Trina for the first time on his rounds on 31 August 2020, she did not complain to him that she was experiencing headache.

104 In his oral evidence, Dr Edger was examined about some of the entries in the JHH clinical notes from 29 August to 2 September 2020, specifically referencing Trina's pain medication and reported headaches.

105 On 31 August 2020, Trina was given paracetamol on two occasions and Endone on one occasion.

106 Dr Edger was not rostered on duty at JHH on either 1 or 2 September 2020.

107 On 1 September 2020, Trina was given paracetamol on four occasions, and Endone on four occasions. Dr Edger commented that Trina underwent her angiogram (DSA) on 1 September 2020:

> "which can give pain in the groin and can give a headache, so an escalation of the headache around the angiogram, where there's fasting time, would not be unexpected."

108 Dr Edger was asked how long the discomfort from the angiogram would be expected to last, and he responded that:

> "the groin discomfort should settle down and the headache, if the headache was aggravated by the – the angiogram, then I would have thought by, again, within about 12 hours it should go back to its previous baseline."

109 Dr Edger was taken to a notation recorded at 11.35am on 1 September 2020, which was prior to the DSA procedure. At this time, Trina complained of a 7 out of 10 headache. Dr Edger gave oral evidence that:

> "A seven out of 10 headache is obviously more significant for the patient than a five out of 10 headache, but in a patient that's anxious, that's waiting for an angiogram, that's been fasting since the morning, an escalation of headache would not be unexpected."

110 Dr Edger was then taken to the clinical notes recorded on 2 September 2020. At 11.35am, Trina was given 5mg of Endone and 1g of Panadol for her headache and subsequently reported some relief. Trina later complained of a seven out of ten headache and was given a further 5mg of Endone and Panadol. Dr Edger responded:

> "I gather it was rated at seven out of ten prior to the DSA. I would have been happier if it hadn't reached seven out of ten again the following day."

111 Dr Edger was referred to the clinical notes, recorded at 8pm the same day by a Junior Medical Officer (JMO):

Q. "So [the JMO] did a review of Trina for pain. The medical officer notes the following: "Ongoing headaches, same in nature, intensity fluctuating between four out of ten to eight out of ten, Endone helps initially, but seems to make it worse in some cases. She feels 'funny.' Has taken Panadeine Forte before to good effect." So then it's, "New neurology – changing in headaches' nature," and then their plan is "One – cease Endone, two – commence codeine 30 to 60 milligram PRN, and reassess pain tomorrow unless changed." The fact that that's now being reported, a headache at eight out of ten, before talking about what the junior medical officer's assessment and plan was, the fact that it's reached eight out of ten, though, at that point in time, do you say that it should have been escalated to you?"

A. "If the headache was worse, intensifying, then an escalation to myself or the registrar initially would not have been out of the question." Dr Edger indicated that he would then have ordered a CT scan.

112 Associate Professor Tony Goldschlager, a neurosurgeon and Head of Endoscopic Skull Base Surgery, and Head of Spine Surgery, in the Department of Neurosurgery at Monash University, was retained on behalf of Dr Edger to provide an expert opinion regarding Trina's care and treatment. Associate Professor Goldschlager prepared two reports, dated 12 April 2024 and 22 July 2024. He also gave oral evidence during these proceedings on 15 October 2024.

113 In his statement dated 12 April 2024, he noted that:

"It is important to consider whether Ms McGrady's aneurysm had in fact ruptured prior to her ictus on 4 September 2020. She did have headaches during her admission. These, however, were episodic. There was no 'thunderclap headache' and there was no neck pain or stiffness, which are pathognomonic features of subarachnoid haemorrhage. The headaches improved, which is typically not the case in a patient with subarachnoid haemorrhage due to the irritating nature of the blood products in the subarachnoid space. There was also no evidence of bleeding or rupture on the imaging prior to 4 September 2020."

114 Associate Professor Goldschlager indicated that a patient that is experiencing some kind of leak of an aneurysm may experience 'sentinel' headaches, which are a lesser intensity headache as compared to a 'thunderclap' headache. He noted that these headaches are constant and not episodic.

115 Associate Professor Goldschlager was asked about Trina's need for Endone to treat the symptoms of her headaches at the JHH and agreed that it would be "a more significant headache if it required Endone." In addition, he agreed that the amount of Endone dispensed to Trina from 30 August 2020 until 3 September 20202, was "quite a lot of Endone, I agree with that."

116 He went on to state:

> "I believe, I don't have the file in front of me but I believe there were times that she didn't have a headache, which is why I called it episodic. I'm not saying that there wasn't a severe period of headaches when she was taking a lot of Endone, but there were times in the notes that she didn't have headache."

117 Associate Professor Goldschlager was asked about the clinical notes made by the JMO at 8pm on 2 September 2020. He was asked the following:

> Q "The fact that there's these escalating headaches that aren't being reported to Dr Edger, that aren't being reported to Dr Miteff, is there a problem that there are these headaches being treated and managed through pain relief and nothing's being done about that. Is that not a concern based on your experience?
>
> A. "I think, I think if there was an escalation then it should have been reported, yes".
>
> Q. "If there's an escalation being reported as up to 8 out of 10, should it have been reported on that date?"
>
> A. "Yes".

118 Professor Michael Besser, a consultant neurosurgeon, provided two reports dated 25 March 2021 and 9 August 2023. He also gave oral evidence during these proceedings on 15 October 2024.

119 Professor Besser noted that Trina had a history of fluctuating high blood pressure and was being medicated for this condition. He also noted that she had been diagnosed with "a near-giant aneurysm with thrombus in it, so it's – thrombus in aneurysms don't just occur unless there's something else going on. So, there's blood flowing into the aneurysm. Clot is forming inside it. It's big, and that put together is concerning."

120 Professor Besser confirmed that in his opinion a seven out of ten headache pain reference in the context of an aneurysm would be a significant headache. He particularly noted that the angiogram had been performed the

previous day, so a person may have "pain at their groin site, but there's no reason the next day that they would have headache."

121 Professor Besser was taken to the JMO's entry in the clinical notes dated 2 September 2020 and was asked if this would be of concern to him regarding Trina's presentation at the time. Professor Besser confirmed that this would be of concern and that the JMO should have reported these clinical findings to the JMO's consultant, most likely Dr Edger.

122 In his first report, Professor Besser was of the opinion that "the increasing headache complained of by Ms McGrady warranted repeat brain imaging, either by CT or MRI scan. The likely cause of these headaches is increasing size of the aneurysm although a minor, subclinical SAH (subarachnoid haemorrhage) is possible."

123 I am of the view that the evidence indicates that it would have been reasonable and medically prudent for Dr Edger to have been notified of the increasing intensity of Trina's headaches on 2 September 2020. This would have allowed a CT scan to have been undertaken at that time.

b. Whether the decision to treat Trina's condition with endovascular flow diversion and anticoagulant dual antiplatelet therapy was appropriate in the circumstances, including whether consideration was given to alternative treatments such as a craniotomy or direct microsurgical clipping of the aneurysm neck.

124 A digital subtraction angiogram (DSA) was scheduled to be performed by Dr Ferdi Miteff, Consultant Neurologist and Interventional Neuroradiologist (INR) on 1 September 2020. The purpose of the DSA was to further assess Trina's two aneurysms.

125 The DSA confirmed the presence of a "23 millimetre partially thrombosed ICA aneurysm situated between the ophthalmic and PCOM arterial branches on the right, and a mirror 6mm aneurysm on the left."

126 After the conclusion of a DSA, it was customary that the INR specialist would contact the neurosurgeon, (in Trina's case, Dr Edger) and discuss the DSA results, noting that the aim of aneurysm treatment is to "exclude the aneurysm from the circulation, such that it is secure and there is no further risk of rupture."

127 In his statement, Dr Edger recalled Dr Miteff contacting him to discuss Trina's test results. He stated that Dr Miteff informed him that he was:

> "of the opinion that the aneurysms were amenable to endovascular treatment, with a flow-diverting stent for the large right-sided aneurysm, and coiling of the left-sided mirror, but smaller, aneurysm…Whilst alternative treatment such as craniotomy and direct surgical repair was considered, Dr Miteff and I agreed that the endovascular approach would be less invasive. This approach also had a quicker recovery time for the patient. Bilateral craniotomies for the clipping of bilateral aneurysms, particularly the giant 2cm aneurysm, would have been significant surgery with a risk of intraoperative aneurysm rupture, surgical morbidity, and death."

128 As indicated above, there were two treatment options available for Trina at JHH. The first option was to surgically perform separate bilateral craniotomies for the clipping of bilateral aneurysms. The second option, being endovascular treatment involved the aneurysm being "coiled (sometimes with stent assisted coiling) via an endovascular route."

129 A craniotomy is a surgical procedure which requires an incision being made to the patient's head and the scalp being retracted so that several burr holes can be drilled to elevate a bone flap. The dura, or lining of the brain, is then elevated. The surgeon then dissects tissue between the temporal lobe and the frontal lobe until the aneurysm is located. A clip is then placed over the neck of the aneurysm to exclude it from the arterial circulation.

130 Dr Edger gave oral evidence that a craniotomy on the larger of Trina's two aneurysms would take around four to five hours. He also noted that only one of the aneurysms could be operated on at one time and that the patient would need a recovery period of two to three months before the second aneurysm could be operated on.

131 Dr Edger noted that the risks to a patient from a craniotomy may include some form of brain damage if bleeding was to "occur when you're trying to approach the aneurysm. Damage to small, what are called, perforating arteries in the course of exposing the aneurysm can occur which can cause strokes. If the aneurysm ruptures on the approach then that can cause a large intracranial haemorrhage."

132 Professor Besser raised his concerns that Trina was required to be placed on dual antiplatelet medication, which was:

> "a significant anticoagulant manoeuvre, required for the elected treatment modality of endovascular flow diversion.

The dual anti-platelet medication would have adversely contributed to her subarachnoid and intracerebral haemorrhage from her giant aneurysm.

On the information supplied a reasonable alternative treatment strategy was craniotomy and direct microsurgical clipping of the aneurysm neck considering it was quite small on measurement in comparison to the overall diameter of the aneurysm. The aneurysm mass could then have been decompressed with presumed relief of headache.

Obviously open microsurgical neck clipping and aneurysm debulking also carries some risk. A multidisciplinary discussion between the neurosurgeon and INR specialists is appropriate before a final decision on the best treatment recommendation is made."

133 The second treatment option was an interventional neuroradiology procedure, referred to as a "endovascular treatment, with a flow-diverting stent for the large right-sided aneurysm, and coiling of the left-sided mirror, but smaller aneurysm."

134 This treatment was perceived to be a less invasive treatment, requiring the insertion of a catheter into the femoral artery in the groin, which is then threaded into the cranial artery. In addition, both of the aneurysms identified on Trina's DSA would have been able to be treated during the one procedure, and a patient's recovery time would be lessened to approximately a 24 hour period.

135 Prior to the commencement of a flow diversion coil or stent, the patient is required to be placed on anticoagulant medication to reduce the risk of a thrombus clot forming on the end of the catheter during the stenting or coiling procedure.

136 Associate Professor Goldschlager noted that the "main treatment of an aneurysm endovascularly is coiling, which is putting little titanium coils into the aneurysm, and it occludes the aneurysm. But a complicated aneurysm they do a stent to assist with coiling. So they put a stent in the parent vessel to keep the coil in place," which enables an endovascular surgeon to treat more complex aneurysms.

137 In Trina's case, the large aneurysm was defined as a complicated aneurysm which was too large to be treated by 'coiling,' as it was "too large to try to pack full of coils because the coils are very small. Dr Edger described the process that Dr Miteff was planning was to "put a stent across the back of the aneurysm which avoids having to actually enter the aneurysm dome, so

there's a reduced risk of rupture of the aneurysms when you put a stent in place."

138 Professor Besser gave oral evidence that:

> "The coils have to go through the narrow neck, and you keep putting the coils in to try and fill the aneurysm, right? So, in that way you exclude it from the circulation and prevent it from rupturing, and in this particular matter I believe the endovascular radiologist was going to use a flow diversion stent. In other words, not putting coils, but put in a mechanical device that causes the blood not to flow into the aneurysm, but to flow along the vessel past the aneurysm. So, that's a newer technique. I think it's a good technique in certain cases. It does not replace craniotomy and clipping of the neck, and if you follow these people up in the longer term, a significant number will still flow into the aneurysm, the aneurysm can continue to grow and rupture, in a small number of cases. So, you know, these are things that you have to weigh up, and it depends on the patient, it depends on the architecture of the aneurysm, it depends on the individual anatomy."

139 Dr Edger, Dr Miteff, Professor Besser and Associate Professor Goldachlager all agreed that both treatments were available for Trina, however, there were differing views as to which treatment was the most appropriate in the circumstances.

140 Professor Besser preferred to treat Trina's aneurysms, particularly the larger aneurysm, with a craniotomy, whereas Dr Edger, Dr Miteff and Associate Professor Goldschlager maintained that the endovascular flow diversion was the better treatment option for Trina.

141 The expert evidence confirms that both Dr Edger and Dr Miteff gave appropriate consideration to the best treatment and surgical options available to manage and treat Trina's significant aneurysms. The expert evidence also confirms that the decision to proceed by way of the endovascular flow diversion approach was one of two appropriate treatment options available.

Issue 3(c) Whether an MRI was conducted, and if not, whether an MRI should have been conducted in order to better understand and inform any urgency in treatment.

142 At 8am on 30 August 2020, Dr Edger attended on Trina for the first time. The clinical notes of this consultation indicate that Dr Edger discussed with Trina

her “aneurysm and DSA”, being the Digital Subtraction Angiography. A further note indicates

> “Plan
>
> 1. DSA
>
> 2. MRI A”

143 On 30 August 2020, Trina sent a text message to her friend Brooke stating: “They’re going to do an angiogram through my groin to have another look.”

144 In another text, Trina messaged Brooke:

> “He said they’re going to do the angiogram to double-check and go from there, he said… He said they grow at a certain rate per year, but my case is serious because of the size. I think the angiograms will determine the blood flow and compressions… They said it will take about an hour for the angiogram and they’re also doing an MRI tomorrow as well.”

145 Another clinical note, recorded at 7am on 31 August 2020, recorded the following:

> “42 (F) aneurysm - 2cm R MCA - unruptured. Likely for DSA + MRI A.”

146 Dr Edger gave oral evidence that an:

> “MRI A is an MRI scan to look at the aneurysms and often that is not necessary and in this case I think once we got a good quality DSA that delineated the aneurysms then an MRI was not required. I don’t recall saying that I wanted an MRI because it wouldn’t be standard workup for a presentation like Trina’s.”

147 Dr Edger indicated that “a CT and a DSA is all that you would normally require to look at intracranial aneurysms,” and “I don’t think an MRI would have added anything to it.”

148 The evidence confirms that the DSA was conducted on 1 September 2020, however, there is no indication that Trina underwent an MRI at any time.

149 Both the clinical notes and Trina’s text messages supports the contention that an MRI was considered and discussed with Trina on 30 or 31 August 2020. It is unclear why the MRI was not conducted.

150 Associate Professor Goldschlager noted in his statement dated 12 April 2024:

> “I note that there was mention of obtaining an MRI Brain, however I could not see that an MRI was performed. An MRI in this situation, with T2 hyperintense signal in the brain parenchyma surrounding the aneurysm

dome on the FLAIR sequences, would be suggestive of higher risk of impending rupture. These MRI changes suggest venous congestion and dynamic aneurysmal growth."

151 In his oral evidence, he explained that:

"What I'm referring to is when the aneurysm is sitting against the brain parenchyma, like the brain substance, if it's, if it's active or if there's little microhaemorrhages or it's thrombosing, it could cause some oedema or swelling in the brain. An MRI is very sensitive at seeing that. So, like, it would suggest that even, that an unruptured aneurysm is more, there's more likely impending rupture a short period of time."

152 Associate Professor Goldschlager confirmed that "the DSA will just show you the vessels, and the MRI will show you the vessels in relation to the brain."

153 He continued, stating:

"If the patient had an MRI when the headaches were getting worse and it showed there was some changes there, that would have prompted more urgent, more urgent treatment."

154 He confirmed that when Trina complained of 8 out of 10 headaches,

"It would have been helpful to perform it at the time. It would be possible that they wouldn't approve it. They would say, 'well, we don't need to do an MRI. We already know what the problem is.' Like, the radiologist might not approve the MRI. But I think it would be, it would have been helpful to have done an MRI scan."

155 Professor Besser opined that:

"The digital subtraction angiogram (DSA) is an injection of dye into the blood vessels, and it shows the internal aspect of the aneurysm, but you'll appreciate that if there is clot in the aneurysm – that is, it's partially thrombosed – then it's hard to appreciate the full size of the aneurysm just with a digital subtraction angiogram. I think a CT or an MRI with the correct sequences gives a better impression of the effect of the aneurysm on the surrounding brain, and it's my belief, and I think your literature confirms it, that it's more accurate in giving you the size of a partially thrombosed, very large aneurysm."

156 Professor Besser indicated that for a CT scan you need to use a T2 sequence to give contrast, whereas with an MRI, you use a flare sequence, which provides better imaging where you can see more detail in terms of the brain. Both an MRI and a CT scan will demonstrate swelling in the surrounding brain

and allow you to see any leakage against the aneurysm wall and determine whether the aneurysm is active, including whether there is growth or microleakage around the wall into the surrounding brain. The scans demonstrate a change in the brain architecture around the aneurysm, which is "important information."

157 Professor Besser was of the opinion that an MRI gives a clearer picture than a CT scan, however, either a CT scan or an MRI should have been performed given Trina's large aneurysm and increasing headaches.

158 A review of the evidence indicates that either an MRI or CT scan should have been undertaken when Trina was complaining of increasing headaches with escalating severity, particularly by 1 – 2 September 2020.

159 The evidence indicates that Dr Edger was not made aware of this information regarding Trina's escalating headaches.

160 Dr Edger gave oral evidence that had he been made aware of the escalating nature of Trina's headaches he would have ordered a CT scan, which was a straightforward procedure at the JHH, and could have been performed irrespective of the time of day or night.

161 The failure to obtain a CT scan or MRI was a lost opportunity and should have been undertaken.

Issue 3(d) Whether a multidisciplinary review(s) was/were conducted in relation to Trina's care and treatment, and if not, whether a multidisciplinary review should have been conducted at any stage.

Issue 3(e) Whether a Specialist Consultation occurred in relation to Trina's care and treatment, and if not, whether a Specialist Consultation should have been conducted at any stage.

162 Prior to the COVID-19 pandemic, JHH neurosurgical staff would undertake a multidisciplinary review of patients. The reviews would be conducted at a meeting each Monday morning at 7.45am, with the entire neurosurgical medical staff present to discuss each patient that had been admitted for neurosurgery care, including management planning. Each Tuesday afternoon, a meeting was convened with the radiology specialist to review the relevant imaging.

163 During Trina's admission at the JHH, staffing arrangements were impacted by the pandemic and the neurosurgical unit was divided into two teams of consultants and registrars.

164 The intention was that the two teams would work independently of each other and not meet, due to the risk of COVID-19 spreading through the entire Neurosurgery Department.

165 The effect of this arrangement meant that the neurosurgical teams did not attend regular meetings onsite to discuss their patients.

166 Patient handovers were conducted twice weekly, and ward rounds were not conducted with both a consultant and registrar present. Meetings between consultants and registrar would occur online or by telephone.

167 In Trina's case, Dr Miteff provided Dr Edger with a copy of the DSA imaging, which Dr Edger could review on his computer. Dr Miteff and Dr Edger discussed the feasibility of proceeding with an endovascular flow diversion procedure rather than a craniotomy and direct surgical repair of the large aneurysm via telecommunication devices. Whilst such an approach was not ideal, it appeared to be a satisfactory alternative in the circumstances of the pandemic.

168 Professor Besser indicated that under ordinary circumstances (not during a COVID response), a multidisciplinary team meeting would involve the endovascular interventionist, the cerebrovascular neurosurgeon, the nursing staff and the junior medical staff. The benefit of such an arrangement is that all members of the neurosurgical team are provided with a clinical overview of the patient, and given an understanding of the decision-making, the reason for the intervention, the risks involved, and any relevant consent from the patient.

169 The evidence suggests that there was an absence of communication within Trina's treating and care teams, as described by Professor Besser. This appears to be at least partly reflective of the COVID arrangements in place at the time. The impact of those arrangements appeared to result in the medical staff failing to appropriately escalate the reported increase in severity of Trina's headaches to Dr Edger.

170 Dr Peter Choi, the Director of Medical Services at JHH provided a statement dated 6 February 2024.

171 Dr Choi stated that:

> "An informal multidisciplinary review may arise in any clinical situation, where more than one clinician discusses and plans a patient's care.
>
> However, clinicians most often refer to a multidisciplinary review as being a formal scheduled meeting of clinicians, with a terms of reference,

agenda of cases for discussion, meeting minutes and correspondence, to plan the management of elective cases.

Admitted inpatients and non-elective patients, as in the case of Ms McGrady, are usually discussed in unscheduled, informal multidisciplinary discussion because of the unpredictable timeline of presentation."

172 Dr Choi indicated that:

"As of August and September 2020, I am not aware that any specific policy or guideline was in place to direct the use of multidisciplinary reviews in HNELHD (Hunter New England Local Health District).

I also note as at August and September 2020, usual clinical practices were significantly modified across NSW Health, as a response to the COVID-19 pandemic."

173 Dr Choi confirmed that the HNELHD had developed a policy called the *Comprehensive Care: Adult Inpatient Multidisciplinary Care Plan*, which was introduced on 24 February 2023. The new policy required all multidisciplinary team members "to review, update and add to the care plan after care delivery, clinical assessment and discussion with patient/carer/family."

174 The policy also states that "Clear communication between the multidisciplinary team and patient/carer enables a collaborative and proactive approach to patient-centred care planning."

175 Dr Miteff gave oral evidence that he was not aware of the new 2023 policy and that it had not been implemented in his department at the hospital. He indicated that his department consists of two consultants, and they rely "heavily on the consulting neurosurgical or neurology team with regards to day-to-day ward care for the patients."

176 Dr Miteff confirmed that his multidisciplinary meetings continue to be conducted mainly by telephone as "most of those procedures are an emergency, unless they are outpatients."

177 It remains unclear as to whether the 2023 *Comprehensive Care – Adult Inpatient Multidisciplinary Car Plan* policy is both fit for purpose and being complied with by all relevant surgical teams or units to which it is meant to apply.

Issue 3(f) Whether Trina gave informed consent to treating her condition with endovascular flow diversion and anticoagulant dual antiplatelet therapy,

including whether she received adequate information about alternative treatment modalities.

178 In preparation for the endovascular flow diversion procedure, Trina was prescribed antiplatelet treatment, consisting of aspirin and clopidogrel medications.

179 Dr Miteff gave oral evidence indicating that in his experience, all that is required to ascertain a patient's consent to anticoagulant medication is to ensure that the patient is aware that they are being prescribed the medications for a particular reason.

180 The evidence confirms that Trina was aware that she was being prescribed an anticoagulant dual antiplatelet therapy and understood the general reason for the medication, particularly given the text message she sent to her friend Brooke, stating that she had "to have the blood thinners for the surgery."

181 The evidence is less clear as to the information provided to Trina regarding her available treatment options, including the risks and benefits associated with those options.

182 Dr Miteff gave oral evidence, recalling his usual approach to patients who were undergoing a DSA procedure. He stated:

> "And also it's the opportunity to show the patient the pictures, because in the angiographic lab, we have a screen that's two by one metre in size, the patient is on the table, or we are performing usually pressure on their femoral artery for ten minutes, and during that time, all the imaging appears on the screen and it's possible to show, "These are the pictures we have acquired the aneurysm, the aneurysm, as you can see, is a round structure that, you know, is coming out of your artery, that is your artery, and we will have to work up a plan to try to manage it because it appears to be a large aneurysm. And those treatment strategies are, mainly two types – one is open surgery, which patients usually understand, and the other is minimally invasive surgery, which is very similar to the angiogram that I performed. But I don't really go into much greater detail than that."

183 It is clear that it was incumbent on the specialist medical staff at the neurosurgical department at JHH to clearly explain the three treatment options available for the treatment of Trina's two aneurysms, being the craniotomy, and the endovascular flow diversion coiling and stenting procedures. In addition, the patient should be advised of the possibility of complications, adverse outcomes, such as a stroke or brain damage and the chance of death.

184 Dr Miteff gave oral evidence that:

> "Well, if she was going to have a – if – if – a platelet suppression appeared to be sufficient, and if she was going to have endovascular procedure on the Tuesday as planned, then it would have been my responsibility to sit down with her and the family the day prior to the surgery, when I know that it would be the safest point for her and it's almost certainly going to go ahead with regards to stenting, to explain all of these things to her at that stage."

185 Trina's situation was additionally complicated in terms of her informed consent given the endovascular flow diversion procedure could not proceed for at least 7 – 10 days to allow the administration of the antiplatelet medication regime.

186 There remained a possibility that Trina may have objected to proceeding with the endovascular flow diversion procedure or alternatively elected to undergo a craniotomy. Additionally, the medication regime may not have been successful, requiring the abandonment of the endovascular procedure. Whilst the antiplatelet treatment could have been reversed reasonably quickly, it was important that Trina was provided with informed options prior to commencing the antiplatelet treatment.

187 This was particularly so in Trina's case given the dangers associated with her large aneurysm and the possibility that it may leak or rupture, necessitating an urgent medical intervention.

188 It is unclear whether Trina was made aware that a craniotomy could have been performed at an earlier time, as compared to the endovascular flow diversion.

189 The evidence suggests that Dr Miteff provided Trina with appropriate information regarding the endovascular flow diversion procedure after he had conducted the DSA on 1 September 2020, however, Trina should have also been provided with further information regarding the details of the procedures and the alternatives by the neurosurgical team well prior to the proposed procedure on 8 September 2020.

Issue 4. Whether staff at John Hunter Hospital breached NSW Health and Hunter New England Local Health District policy in failing to record all clinical documentation in relation to Trina's care and treatment.

190 The clinical and nursing notes regarding Trina's admission generally appear to be comprehensive and contemporaneous.

191 The evidence suggests that there was no documentation of any meetings conducted between specialist medical staff relating to Trina's care and treatment. Additionally, as noted above, Dr Edger did not record his attendance on Trina on 31 August 2020.

192 It is noted that the hospital was functioning under unusual circumstances of the COVID pandemic and has now implemented new policy which confirms and clarifies the need for clear and consistent documentation of these types of specialist meetings.

Communication on and from 4 September 2020

5. Whether informed consent from Trina's family was required to cease medications including vasopressin, and if so, whether that informed consent was given.

6. Whether communication with Trina's family at John Hunter Hospital was culturally safe and responsive.

7. Whether Trina's family were appropriately counselled on treatment decisions surrounding Trina's ongoing life support.

193 On 4 September 2020, an angiography was performed which indicated that Trina did have some blood flow to one side of her brain. Dr Moynihan gave oral evidence that:

> "However, given the catastrophic nature, the signs of raised pressure inside the brain, it was my opinion and the opinion of everyone else that she would progress to brain death fairly quickly."

194 Dr Moynihan referred to brain death as the "irreversible cessation of flow." He confirmed that due to "how severe her imaging was," he anticipated that brain death would occur "relatively" quickly.

195 Dr Moynihan stated that Trina was provided:

> "With steps to keep everything as normal as we could be in those initial first days while we could get a bit more information. So that would have been medications to help with fluid balance, to, you know, give oxygen to her heart and lungs. But I guess the concern was that she'd already passed away in those first couple of days, so it's a bit hard to say if they were to preserve her life versus, you know, giving us a bit of time to – to get to the bottom of it".

196 Trina was placed on various medications following the rupture of the aneurysm on 4 September 2020. One of the medications was vasopressin.

197 Professor Besser explained that "vasopressin is an antidiuretic hormone produced normally in the posterior pituitary gland but can now be artificially manufactured."

198 After the rupture of the aneurysm, Trina was no longer able to produce vasopressin naturally due to the damage which had been occasioned to her brain.

199 Vasopressin was administered to Trina from 4 September until 14 September 2020. It was used to regulate and maintain her blood pressure and regulate her high output of urine and maintain fluid in Trina's body.

200 On 4 September 2020, a family meeting was convened with 15 members of Trina's family, including her partner Craig, two of her sisters and 3 of her brothers, Dr Moynihan, Intensivist, Dr Poulgrain, Neurosurgical Registrar, Aboriginal Liaison Officer, Ms Cheryl Cox, and a social worker and nurse. Clinical notes indicate that Dr Moynihan explained to the family members that Trina had suffered a catastrophic brain injury and was possibly already "brain dead." Dr Moynihan indicated to the family that the treating team were proposing to conduct formal brain testing the following day.

201 On 5 September 2020, a further family meeting was convened. A large number of Trina's family members were in attendance, together with Dr Moynihan and other medical staff. The clinical notes record that Trina's family had questions for Dr Moynihan surrounding initial delay in treatment when Trina was experiencing headaches. The notes record the family indicating that "our culture believes in harnessing the spirit without negativity so discussions around dying without hope are rarely accepted well."

202 At that meeting, it was agreed that Dr Moynihan would organise further radiology so that a limited family group would be able to visualise the extent of Trina's brain injury.

203 On 6 September 2020, informal brain stem testing was conducted on Trina. Dr McVey conducted the testing and noted, "Story in keeping with irreversible brain death – imaging in keeping irreversible intracranial pathology."

204 On 7 September 2020, another family meeting was convened. The family raised concerns regarding the length of time between diagnosis of aneurysm, transfer to JHH and the surgical intervention. The clinical notes record the following:

> "One of the Aunties raised a number of concerns including racism, trust between family, aboriginal community members and medical staff. This was acknowledged, it was also acknowledged by myself, Gerard (Dr Moynihan) and Rosie (bedside nurse) that we did not understand aboriginal spirituality however we would endeavour to try and continue to support them. The family agreed that this is something that they were happy to discuss throughout ongoing conversations. Family stated that they felt they understood the medical discussion around end of life, they felt that discussion of clinical brain death testing was too soon as they were still receiving spiritual messages from Trina. We agreed to meet the following day to discuss clinical testing or radiological testing and end of life."

205 At this meeting, the Aboriginal Liaison Officer spoke with some members of Trina's family about the possibility of organ donation. This conversation caused significant upset to the family.

206 Dr Monihan explained that ordinarily:

> "The process of organ donation, I think, if you want me to take a step back, is – is about getting the family towards – first of all, to end of life. And we don't really go into detail about organ donation or anything like that until we're comfortable that the patient's family understand that this is a life ending event, or that the patient's already deceased. So I think in situations like this, the priority is to give the family time, and I think that is the majority – the main reasons why these things are kept in place."

207 Dr Moynihan commented that:

> "There's a national guideline that puts out what – how we're meant to go about raising donation at end of life, and there's a couple of different steps in it. And generally you do not progress to raising organ donation with the family until the clinicians involved are happy that they are ready to accept, for want of a better word, whether that be intellectually or emotionally that death has occurred, and then give the family some breathing room, some space, and then – then talk about the next steps, which includes things like coronial process, you know, organ donation, those kind of things."

208 Trina's family raised concerns that after some time in the ICU, the focus appeared to shift from providing appropriate treatment to Trina to preserve her life, to one of possible organ donation. Dr Moynihan responded, saying,

> "I think that there's a fine line between lying to a family and being, I guess, dishonest, and trying to apply the best – these best practice guidelines to every single situation. I try not to raise donation out of order, but I guess in this case, in that conversation I really felt the family just needed to know the next steps, and I think – my usual practice in that is to try, you know, a fairly generic talking about what's going on, and if the family push me then I will talk about, A, whether it will need to be coronial, B, you know, pulling out the endotracheal tube, letting her heart stop, and also talk about the process of organ donation. Because I think that in those situations if the family is asking you what will happen then – then I can't lie to them. So I just try and do what's best for the family in front of me."

209 Trina's family contend that Dr Moynihan had advised them that there would be no time limit placed on the maintenance of Trina's life support, and that support would not be removed until the family were comfortable and accepting that Trina's condition was terminal. Dr Moynihan gave oral evidence, stating:

> "So I sit with a lot of families who are trying to, I guess, understand the concept of brain death which a lot of families struggle to understand; the heart's still beating, the hands are still warm, it's a difficult, I guess, concept to understand that their loved one has passed on. And I think what I try not to do is actually pressure the family or put time limits on it. I think on the flip side, or alternatively what we do know is that once someone's declared dead – so their – their irreversible cessation of all brain function, they tend to – the other organs tend to – to stop functioning, there's a high risk of infections, which did occur in Trina's case as well. So the longer we are keeping the heart beating after the diagnosis of brain death, then I guess the more complications that can occur to the body. But also I think there's that ethical or moral or – you know, what is – what is the right thing to do for Trina. And I think that's always difficult because I think the families will have one view and the doctors will have another view, as was in this case. But it's about negotiating that together."

210 Dr Moynihan confirmed that it was his usual practice to convene a meeting of the clinicians prior to attending a family meeting, to discuss where we think the family is up to, what they're struggling with, including their 'ideals' and their 'hopes'. In that meeting, the clinicians plan what they will do and 'tailor' their approach as issues arise. He noted that during family meetings, he would particularly rely on the expertise of social workers, the bedside nurse and the Indigenous health officers.

211 On 11 September 2020, a further family meeting was convened. During this meeting Trina's family indicated to the hospital staff that they did not agree that any testing should be undertaken, with the exception of testing which was require for the preservation of Trina's life. The directive also referred to the maintenance of life support measures and supplementary fluid support. In addition, the family advised that meetings with the family should only be called if there were significant changes and updates on Trina's condition.

212 The evidence indicates that the JHH staff complied with these requests, particularly on 9 September and 11 September 2020.

213 On 9 September 2020, two arterial lines which were not functioning were removed only after consent was sought and given by the family.

214 On 11 September 2020, two External Ventricular Drains (EVDs) had become blocked. Ordinarily, blocked EVDs would be removed as they would be non-functional and may cause infection if left in situ. In Trina's case, the drains remained in place until the family had been consulted, and the situation explained to them. The family then agreed that the two drains should be removed.

215 On 14 September 2020 at 11.14pm, the vasopressin which had been administered since 4 September 2020, was ceased on the direction of Dr Bhat, an ICU intensivist. This was done without any consultation with Trina's family. The clinical notes indicate that the administration of the vasopressin had been gradually reduced over a number of days, commencing on 9 September 2020.

216 After the cessation of the vasopressin, Trina's urine output increased between 10 – 11am on 15 September 2020, however remained within acceptable range. Similarly, Trina's blood pressure readings remained within an acceptable range.

217 Dr Moynihan noted that if Trina had been dependent upon the vasopressin at the time it was discontinued, it would be expected that her urine output would have again increased, and her blood pressure would have fallen within one to two hours. This did not occur.

218 Professor Besser opined that:

> "Ms McGrady had been declared brain dead 12 days previously with official documentation following established protocol by two medical practitioners on the 4th September 2020. Under normal circumstances all life support, including vasopressin medication, would have been withdrawn at that stage. However the family did not accept the concept of

brain death despite explanation of the medical diagnosis of irreversible brain damage."

219 On 16 September 2020, Trina's condition deteriorated, with her blood pressure falling, and her family were upset that the vasopressin had been withdrawn and wanted it to be reinstated.

220 A second opinion was obtained from Dr Ceilia Bradford, an intensive care specialist from the Royal North Shore Hospital (RNSH), who provided her advice that the vasopressin should not be reinstated.

221 Professor Besser provided his advice regarding the ethical consideration associated with the vasopressin being withdrawn and not reinstated. He opined that:

> "From a medical viewpoint the main consideration was appropriate, ethical medical practice with irreversible brain damage and documented brain death. It was inevitable that organ failure would inevitably eventuate and all ethical guidelines were followed. The re-introduction of vasopressin after it had been ceased was inappropriate under these circumstances."

222 Trina's family strenuously believed that it was important for Trina to remain on the vasopressin, as it was vital to assist in her medical revival. Given the strenuous nature of their concerns, it became more imperative that the medical staff engage with the family members to explain why the decision had been made to cease the vasopressin. It appears that Dr Bhat did not engage in any discussions with the family regarding the removal of the vasopressin, either before or after its withdrawal.

223 Dr Bhat gave evidence that he was focused on implementing a treatment plan which focused on Trina's specific medical needs. In relation to the vasopressin, he commented in his oral evidence that "if it was not needed it should not be there."

224 Dr Bhat was asked what harm the vasopressin may cause if it was still being administered while Trina's family were engaged in conversation about its discontinuance. He indicated that "I don't know that, maybe next minute it would have caused harm."

225 In relation to Dr Bhat completing the certification of brain death on 15 September 2020, he gave oral evidence that he wanted to give Trina the best possible diagnosis, which included nursing considerations.

226 He remained anchored to this view during his evidence. It was unclear what he was referring to regarding nursing considerations, given that Trina had been nursed in a similar fashion for nearly two weeks.

227 It is clear that Dr Bhat was acting lawfully both when he ceased the administration of the vasopressin medication, as well as when he signed the certification of brain death.

228 It is less clear whether Dr Bhat was complying with the tenor of the relevant HNELHD policy, referred to above.

229 Dr Bhat conceded in his oral evidence that he should have discussed his decision to withdraw the vasopressin with Trina's family. After concluding his evidence, Dr Bhat's legal representatives conceded on his behalf that he should have consulted with Trina's family regarding his decision to undertake the brain death testing.

230 Mr Barnes, counsel for Dr Bhat, has urged the Court not to conclude that Dr Bhat was acting out of "some sort of wilful disdain for the various Local Health District policies…nor would your Honour form the view that Dr Bhat acted in a manner calculated to undermine the integrity of those policies." Dr Bhat was applying appropriate clinical decisions when he decided to remove the vasopressin and undertake brain death testing, however, it remains unclear what Dr Bhat's motivation was in not applying the LHD policy which is not onerous and is straightforward.

231 It is trite to observe that there is little benefit in implementing policies in a hospital or Local Health District, if policy is ignored by the persons to whom that policy applies.

232 I am not of the view that the brain death testing carried out by Dr Bhat was designed to allow or force the issue over any organ donation. Similarly, I am not of the view that Dr Bhat acted illegally or contrary to his medical obligations. I am of the view that Dr Bhat ignored the policy requirements and considerations that all the other staff at the JHH had previously considered and applied regarding cultural considerations and sensitivities.

Cultural beliefs

233 At the conclusion of the evidence, and before Trina's family members had provided their family statements to the Court, four of her family members spoke freely and passionately about their culture, their spirituality, their sense of disadvantage at the hands of government institutions and their ongoing connectedness to Trina.

234 Trina's sister, Glynnis, and her aunt, Aunty Madge provided information about their community in Toomelah and their people, the Goomeroi nation. They spoke of their community being forcefully resettled on three occasions, without consultation. They spoke about their community being deprived of appropriate access to water during these moves.

235 They spoke of their sense that each member of their community has a role to play for themselves and generationally. In relation to Trina, they described their desperate grief that her role had been cut short, affecting her living kin, but also her kin who are yet to be born, such as her grandson, Levi, who was born after her death.

236 Most importantly, the family members were imploring to Court to slow down and to hear what Trina's family were saying about their culture and their cultural beliefs.

Family statements

237 In her family statement, Aunty Madge described the effects of the *Aborigines Protection Act 1909* (NSW) (the Act) on the community in Toomelah over the years. The Act granted the NSW government extensive control over the lives of First Nations persons, including the forced removal of families from land that they perceived as their spiritual homes, the removal of children from their families and the establishment of reserves, where First Nations persons were subjected to daily management by a manager appointed by the Aborigine Protection Board. The daily management included the provision of food rations, the limiting of free movement of residents, labour, education, health and policing. Although the Act was repealed in 1969, the mission manager continued to maintain control in Toomelah until 1979.

238 Residents were required to obtain permission from the mission manager to attend a GP in Goondiwindi if they felt unwell. If the request was denied, the resident was required to remain in Toomelah.

239 Aunty Madge spoke about wanting change to occur in the way that First Nations people are treated.

240 Trina's cousin, Ms Sandy McGrady, spoke eloquently about the "urgent need for empathy in the healthcare for Aboriginal people." Ms McGrady stated:

> "The empathy and understanding needed to address our unique needs are frequently lacking. We've had serious consequences for our health and wellbeing. For many Aboriginal people the healthcare system can feel alienated, unwelcoming, systematic inequality, biases and historical injustices contribute to a mistrust of health services, making it

challenging for us to access the care we deserve. When our experiences and cultural background are not acknowledged, it diminishes the quality of our care we receive and undermines invaluable relationships between patients and healthcare providers. The statistics are appalling. We have a life expectancy that is approximately 8.6 years shorter than that of non-Indigenous Australians, and the burden of disease is disproportionately higher in our community. These health disparities are not just numbers. They represent our family members, friends and community suffering needlessly due to the lack of compassion and understanding within the healthcare system."

241 Ms Sandy McGrady told the Court that:

> "To address the critical issues we need a genuine commitment to equity and healthcare that is reflected in compassionate practices. This means embracing our diversities, prioritising emotional and physical wellbeing of every Aboriginal individual. It requires healthcare professionals to undergo training that enhances cultural awareness and sensitivity, allowing them to be better – to better understand our experiences and challenges. By fostering an empathetic approach and actively working to close the gap in health outcomes we can build a healthcare system that truly serves us, one that uplifts and empowers Aboriginal people, ensuring we receive the care and respect we rightfully deserve."

242 A local health care worker and friend, Ms Ann-Marie Thomas, noted that:

> "For Aboriginal and Torres Strait Islander people, social and emotional wellbeing is the foundation of physical and mental health. Holistically, a connection to land, culture and spirituality all influence wellbeing. Social and emotional wellbeing views the self as inseparable from the embedded within family and community. The self is surrounding by seven overlapping domains that are sources of wellbeing and connection including connection to the body, mind and emotions, family and kinship, community, culture, country, spirituality and ancestors."

243 Trina's siblings provided a joint statement which was delivered by Trina's sisters Glynnis and Maxine. Glynnis provided the context of the concerns the family experienced with Trina's treatment after her aneurysm had ruptured. These included the historical treatment of the residents of Toomelah, particularly the experiences of dealing with hospitals and healthcare.

244 Glynnis spoke about a cousin from Bourke who had been diagnosed as being brain dead. The family sought a legal injunction to prevent the removal of his life support system, and subsequently the cousin survived, making a full

recovery. Glynnis also referred to another relative who was hit by a car in Boggabilla and placed on life support, who also made a full recovery.

245 Glynnis also spoke about the concerns the family had that Trina's treatment was provided for the sole purpose of facilitating organ removal for transplantation.

246 Glynnis noted that Trina felt culturally safe when she was provided with assistance from the Aboriginal liaison officers and other Indigenous medical staff.

247 Glynnis stated that "our belief is that while there is spirit in our body, there is still life." Glynnis commented that the cultural safety "frameworks are not optional, they are essential. They are built on the understanding that cultural safety is a fundamental right and that healing cannot care without respect for dignity, belief and connection".

Considerations

248 The medical treatment that Trina received at both Moree District Hospital and the John Hunter Hospital was appropriate and largely professional.

249 Her medical care was impacted by restrictions which were in force given the COVID-19 pandemic.

250 In particular, the separation of the treating specialist neurosurgeons into two teams resulted in a failure to alert Dr Edger of the increasing severity of Trina's headaches between 30 August until 4 September 2020.

251 The failure to escalate this information meant that an MRI was not performed on or around 1 – 2 September 2020, which may have disclosed changes in Trina's aneurysms.

252 The decision to proceed with an endovascular flow procedure was appropriate and it is accepted that Dr Miteff spoke with Trina about her options, although it remains unclear whether Trina was appropriately advised of the adverse consequences of each of the available procedures, and whether she had been able to provide her informed consent prior to her aneurysm rupturing.

253 It is clear that JHH had policies in place which acknowledged the importance of engaging with families of patients generally, as well as culturally appropriate engagement.

254 The medical staff at the JHH all appeared to appreciate the importance of recognising and implementing these policies, with the exception of Dr Bhat.

255 Dr Bhat has somewhat belatedly conceded that he should have engaged with Trina's family on 14 and 15 September 2020, regarding the cessation of the vasopressin and the brain death certification.

256 Many members of Trina's family recognise that various medical interventions are necessary for the treatment of a patient, and that medical practitioners are required to provide treatment which is lawfully permitted and necessary.

257 Some of Trina's family share a contrary view and strenuously maintain their position that the vasopressin should not have been withdrawn and that the brain death certification was performed in order to facilitate organ donations.

258 All of Trina's family submit that Dr Bhat should have engaged with the family in accordance with the LHD's written policy.

259 Medical experts have an obligation to provide appropriate medical care which cannot be overborne but must be permitted to be informed by cultural issues and sensitivities.

260 Trina's loss has resulted in a deep and ongoing grief for her family, her community and her culture.

261 Her family have been constant advocates for both Trina and her memory, and have meaningfully imparted the impact her death has had on the broader First Nations community. In addition, it is acknowledged that they perceived that the lack of sensitive communication at the hospital was an ongoing reflection of their disenfranchisement.

Recommendations

262 Senior Counsel assisting has circulated three draft Recommendations directed to the Hunter New England Local Health District (HNELHD).

263 The three draft Recommendations are:

> 1. That the HNELHD consider whether the practice of obtaining informed consent is appropriately adhered to within its surgical units. This recommendation is made within the circumstances of Katrina McGrady's case, namely the commencement of medication required for a specific procedure in circumstances where all treatment options had not been sufficiently explored with or communicated to the patient, and whether the commence medication was counter to those other treatment options."
>
> 2. That the HNELHD review its *Comprehensive Care: Adult Inpatient Multidisciplinary Care Plan* for the purposes of determining:

a. Whether it is appropriate and fit for purpose for each neurosurgical team or unit; and

b. Whether it has been sufficiently rolled out to the John Hunter Hospital (JHH).

3. That the HNELHD recommend to JHH that it review its practices of raising end of life and organ donation with First Nations families to ensure a discussion of the clinical team occurs as a first step, wherever possible, prior to the issue being raised with the family."

264 Mr Kettle of counsel, on behalf of the HNELHD, indicated that his client did not oppose the adoption of the Recommendations as drafted.

265 I am of the view that the three Recommendations are appropriate and should be made pursuant to section 82 of the *Coroners Act 2009* (NSW).

Conclusions

266 Trina McGrady was a well-educated and much-admired member of her community. She was clearly loved passionately by her family and friends. Her loss to her family and community was clearly palpable and far reaching, both in terms of her community's spiritual beliefs, as well as her importance as a supportive and wise mother and friend.

267 Trina's treatment at the John Hunter Hospital occurred during the pandemic, which altered the usual treatment protocols and medical procedures.

268 Trina's care and treatment at the John Hunter Hospital was largely clinically appropriate, with the exception of the failure to observe and escalate concerns about the increasing severity of headaches that she was experiencing. The decision to cease the administration of vasopressin and undertake brain death testing by Dr Bhat was clinically permissible but did not comply with the hospital's policies regarding First Nations patients.

269 Cultural sensitivity in the provision of health care should not be perceived as onerous or an imposition. It can clearly result in better health outcomes for a First Nations patient and their family.

270 Before turning to the findings that I am required to make, I would like to acknowledge my gratitude to Ms Gillian Mahony of senior counsel and Ms Kathleen McKinlay, solicitor, for their significant assistance, commitment, support and preparation of this case.

271 Finally, I would like to again record my most sincere condolences to Trina's family.

Findings pursuant to section 81(1) of the *Coroners Act 2009* (NSW)

272 I make the following findings pursuant to section 81(1) of the *Coroners Act 2009* (NSW).

The identity of the deceased

273 The person who died was Katrina (Trina) Lee McGrady.

Date of Death

274 Trina died on 15 September 2020.

Place of Death

275 Trina died at the John Hunter Hospital, Newcastle.

Cause of Death

276 The cause of Trina's death was a subarachnoid haemorrhage due to a ruptured berry aneurysm.

Manner of Death

277 Natural causes.

Recommendations

278 I make the following recommendations pursuant to section 82 of the *Coroners Act 2009* (NSW).

279 To the Hunter New England Local Health District (HNELHD):

> 1. That the HNELHD consider whether the practice of obtaining informed consent is appropriately adhered to within its surgical units. This recommendation is made within the circumstances of Katrina McGrady's case, namely the commencement of medication required for a specific procedure in circumstances where all treatment options had not been sufficiently explored with or communicated to the patient, and whether the commence medication was counter to those other treatment options."
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a. Whether it is appropriate and fit for purpose for each neurosurgical team or unit; and

b. Whether it has been sufficiently rolled out to the John Hunter Hospital (JHH).

3. That the HNELHD recommend to JHH that it review its practices of raising end of life and organ donation with First Nations families to ensure a discussion of the clinical team occurs as a first step, wherever possible, prior to the issue being raised with the family."

280 I now close this inquest.

Magistrate Joan Baptie

Deputy State Coroner

8 December 2025