CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kate Manley
Hearing dates:	28 July 2026 to 5 August 2026, Albury Court House
Date of findings:	31 August 2026
Place of findings:	Coroners Court, Lidcombe
Findings of:	Judge R. Hosking, Deputy State Coroner
Catchwords:	Cause of death; pulmonary embolism; assessment of risk of venous thromboembolism in a psychiatric ward; impact of the delineation of treatment for physical and mental health symptoms
File number:	2022/344827
Representation:	Counsel Assisting the Inquest: Patrick Rooney of Counsel instructed by Zoe Carter, NSW Crown Solicitor's Office. Albury Wodonga Health: Lorna McFee and Marco Nesbeth of Counsel, instructed by Mark O'Sullivan, Moray & Agnew. Dr Jagath Bandara: Matthew Hutchings of Counsel instructed by Joanne Hayes, Meridian Lawyers.
Findings:	Kate Manley died at 2.15am on 16 November 2022 from a pulmonary embolism while an inpatient at Albury Base Hospital receiving care for unspecified catatonia in circumstances where she was not administered chemical prophylaxis to reduce her risk of venous thromboembolism notwithstanding her deteriorating condition, reduced mobility and dehydration.

Recommendations: To the Chief Executive Officer, Albury Wodonga Health:

(1) That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across Albury Wodonga Health services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.

(2) That consideration be given to advocate with NSW Health and the Department of Health Victoria, for the implementation of a treatment pathway for patients diagnosed with catatonia.

(3) That consideration be given to using the (de-identified) facts and circumstances of Kate Manley's death as a case study for educational purposes and training.

(4) That consideration be given to carrying out additional audits of the Venous Thromboembolism Risk Management Procedure AWH0221276 and, if required, take all steps necessary to ensure appropriate levels of compliance.

Publication orders: Non-publication orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Hosking are available upon request from the Court Registry.

Introduction

1 Kate Manley was born on 16 September 1976 and died aged 46 on 16 November 2022 at ABH.

2 These are my findings following the inquest into Kate's death which was held at the Albury Court between 28 July and 5 August 2026.

3 A glossary of defined terms and abbreviations can be found at **Annexure A** to these findings.

The role of the coroner

4 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

The issues examined at the inquest

5 The issues below were identified in the coronial investigation for examination at the inquest.

(1) Determination of the statutory findings as required by s 81(1) of the Act, namely: the identity of the deceased, and the date, place, manner and cause of death.

(2) Whether Kate received adequate care and appropriate treatment while admitted at:

(a) Nolan House; and

[1] S 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[2] S 82 of the Act.

(b) ABH

from 11 November 2022 to 16 November 2022.

(3) Was the diagnosis made for Kate's mental health condition appropriate, and were any alternative diagnoses considered?

(4) Was there an appropriate assessment and investigation of Kate's physical health, including:

(a) DVT assessment upon admission, and

(b) whether Kate's treating psychiatrists were alive to the risk of thromboembolism associated with catatonia. If so, was this risk properly addressed and/or treated?

(5) Whether Kate's health was monitored and treated in accordance with applicable standards and policies while admitted at the ABH and Nolan House.

(6) Nolan House is based in NSW but is also subject to Victorian health oversight, policy, and guidelines; did that have any impact on the nature and quality of care provided to Kate during her admission?

(7) Whether any recommendations are considered necessary or desirable in relation to any matter connected with Kate's death.

(8) Whether there should be a referral of any medical practitioners involved in Kate's care and treatment to the Medical Council of NSW, the Health Care Complaints Commission and/or any other relevant body.

6 As the inquest progressed, it was apparent that some of the issues identified were more relevant than others.

The evidence

7 A 4 volume brief of evidence[3] was tendered at the inquest and marked Exhibit 1. In addition, updated policies were tendered in the course of the inquest and marked Exhibits 2-4.

8 A list of the witnesses that gave evidence at the inquest including their titles can be found at **Annexure B.**

Findings

9 Having considered the evidence and submissions in this inquest I make the findings outlined below.

(1) I find that Kate died at 2.15am on 16 November 2022 from a PE while an inpatient at ABH receiving care for unspecified catatonia in circumstances where she was not administered chemical prophylaxis to reduce her risk of VTE notwithstanding her deteriorating condition, reduced mobility and dehydration.

(2) Kate's ED assessment and admission to ABH (and Nolan House) pursuant to s 12 of the *Mental Health Act (NSW)* 2007 was appropriate. Kate was admitted promptly, appropriately managed in a HDU and subject to high levels of observations.

(3) While in Nolan House, Kate was appropriately cared for and treated with respect to her mental health. However, one of the symptoms of the delineation between psychiatric care and physical treatment was that her VTE risk was not appropriately assessed, she was not given prophylaxis and her VTE risk increased as her mobility and hydration decreased. The intertwining of physical and psychological symptoms was such that

[3] Prepared by the officer in charge (**OIC**) of the coronial investigation, Constable Benjamin Sutton, and supplemented by the Assisting team.

Nolan House could not provide Kate with the holistic treatment she required.

(4) The need for Kate to be transferred from Nolan House was appropriately recognised. However, given the level of deterioration, her transfer ought to have been undertaken more quickly.

(5) I accept A/P Sullivan's opinion that Kate was suffering from unspecified catatonia. However, appropriately, Kate's treating team considered alternative diagnoses such as NMS and a re-lapse of her schizophrenia when treating her in a hospital environment.

(6) There was no formal DVT assessment performed on Kate's admission or over the weekend. While this was inappropriate, in context, Kate was able to self-mobilise when she entered ABH, her mobility was variable while in Nolan House and she was appropriately transferred to a medical ward (albeit her transfer was delayed) when she deteriorated and her mobility and hydration were diminished. The evidence does not suggest that a swifter transfer would have impacted the tragic outcome.

(7) Consistent with the opinion of A/P Grabs, Kate ought to have been prescribed a prophylactic anticoagulant (such as Clexane) from admission to manage her VTE risk notwithstanding that she was able to mobilise on admission.

(8) Kate's treating psychiatrists were alive to the risk of VTE associated with catatonia. However, the evidence indicated that amongst the treating psychiatrists there was a reluctance to prescribe Clexane on the basis that this role was for the medical team. A/P Sullivan and Professor Large did not support that distinction. On the evidence adduced, chemical prophylaxis could have been prescribed and administered to Kate in Nolan House and this may have positively impacted the outcome.

(9) While Kate's health was largely treated appropriately it did not appear that this occurred based on applicable standards and policies rather it appeared to be based on clinical decisions and experience.

(10) The evidence did not establish that Nolan House being based in NSW had any impact on the nature and quality of Kate's care although I note that ABH will not have the benefit of the SDPR when introduced in NSW because it is operated by AWH and not NSW Health.

(11) I do not consider it appropriate to refer any individual medical practitioner involved in Kate's care based on the evidence adduced in the inquest.

Recommendations

10 Having considered the evidence and submissions in this inquest I make the recommendations outlined below.

11 To the Chief Executive Officer, AWH:

(1) That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across AWH services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.

(2) That consideration be given to advocate with NSW Health and the Department of Health Victoria, for the implementation of a treatment pathway for patients diagnosed with catatonia.

(3) That consideration be given to using the (de-identified) facts and circumstances of Kate's death as a case study for educational purposes and training.

(4) That consideration be given to carrying out additional audits of the Venous Thromboembolism Risk Management Procedure AWH0221276 and, if required, take all steps necessary to ensure appropriate levels of compliance.

Background

12 In consultation with the participants, the Assisting Team provided as an *aide memoire* a Statement of Agreed Facts. I have drawn from these documents and Counsels' submissions in the preparation of these findings and I am grateful for this assistance.

Kate's life

13 Kate was born on 16 September 1976. She is survived by her partner, Jason and their daughter, her greatest pride. Jason attended the inquest via audio visual link as did Kate's twin brother, Alex. I am grateful to Alex for sharing with us a family statement about Kate.

14 Kate was a much loved partner, daughter, sister, aunty, niece, cousin and friend. Her family describe her as independent, strong, beautiful and full of energy with a wicked sense of humour and unforgettable laugh.

15 Kate made lasting friendships wherever she went. Her life was meaningful and those that loved her continue to feel a profound loss.

16 Kate worked as a chef at the Mercy Hospital in Albury for several years. Kate also loved to cook for her family and friends always making special meals for those with dietary issues. She was able to bring together her love of food and people on social occasions.

Medical history

17 Kate had a complex medical history which included diagnoses of schizophrenia and depression. She also had a history of hypercholesterolaemia, elevated BMI

and anxiety. In Alex's words, these challenges form part of Kate's life but did not define her.

18 Kate did not regularly drink alcohol but was considered a chain smoker, consuming about half a packet of cigarettes a day.

19 Kate had been seeing Dr Katherina Ebert at the 'Doctors on Lavington' for many years however she was not a frequent visitor.

20 In 2001, Kate was diagnosed with schizophrenia and commenced on treatment.

21 Following this diagnosis, Kate had multiple presentations and admissions between 2006 and 2017 often receiving treatment as both an inpatient and outpatient at Nolan House. She would often become unwell (sometimes rapidly), withdrawn, and uncommunicative, cease self-care, and not consume any food or fluids. When this occurred, Kate was treated with therapeutic agents including antipsychotics, antidepressants, benzodiazepines, and ECT.

22 Kate responded well to therapy but compliance with her medication regime would often be problematic, resulting in her being changed from depot treatment to CTOs. While on a CTO Kate would often be well. When the CTO would lapse compliance with medication would again become an issue and a relapse of symptoms would follow.

23 Kate's predominant symptoms when experiencing a relapse of schizophrenia were documented as being catatonic, becoming non-verbal, resistive to examination, and irritable.

24 On 9 November 2022, Kate saw Dr Ebert, regarding her mental health issues. Dr Ebert records that Kate informed her that she was in a '*bad way mentally*' and had not been sleeping. Dr Ebert prescribed Kate quetiapine and reduced her amitriptyline dosage. A referral was sent to Yulia Hruz, psychologist, for review and Dr Ebert provided a medical certificate for two weeks of leave.

Events leading to Kate's death

25 Kate was admitted to the ED of ABH on 11 November 2022 at around 6.40pm due to concerns about an acute decline in her mental health. On arrival, the triage assessment stated that Kate was in a catatonic state, tachycardic, making no eye contact or having verbal interactions.

26 At 7.05pm, Kate was assessed by Dr Vishal Bhargava in the ED. Dr Bhargava evaluated Kate's risk to herself and others and assessed her overall health. During this assessment, Kate's vital signs were within normal limits, save for mild tachycardia. Dr Bhargava considered that Kate appeared to be exhibiting negative symptoms of schizophrenia, with a risk of developing catatonia.

27 Dr Bhargava's oral evidence was that VTE risk was to be assessed on admission to ABH and because Kate was ambulatory on arrival, he was not concerned about her VTE risk. Assessment for VTE risk on admission was consistent with AWH's policy in place at the time and its current policy which requires an assessment to take place within 24 hours of admission.

28 Significantly, Kate was not prescribed prophylactic medication on admission.

29 At around 9.30pm, RN Mohammed checked in on Kate. RN Mohammed attempted to communicate with Kate but Kate did not verbally respond and appeared to be asleep. The plan was for Kate to continue to wait for an assessment by the ACIS.

30 While awaiting medical review, Kate was placed in a BAR with her partner and their daughter.

31 At around 10.40pm following review by ACIS clinician, Shaju Pathrose, Kate was admitted to the HDU at Nolan House for mental health treatment pursuant to s 12(1) of the *Mental Health Act 2007* (NSW) on the basis that she was determined to be a 'mentally ill person.'

32 Pathrose suggested that an ECG and pathology be completed prior to transfer from ED to Nolan House. RN Mohammed attempted to complete these tests; however, Kate was resistant. This culminated in a physical interaction occurring between Kate and her partner, which did not appear to cause any serious injuries. Consequently, however, her partner was asked to leave the facility. Kate refused to speak to staff about the incident and it is recorded that she also became agitated and aggressive.

33 At around 11.50pm, Kate was taken to the HDU at Nolan House via a wheelchair. Kate was not happy with this transfer and said she would '*freak*' if admitted there. Kate was reassured and then entered the HDU of her own volition.

34 On 12 November 2022, at around 4am, RN Goeth-Kearney noted that Kate was lying in bed, with her arms and legs appearing stiff. She was not responding verbally, and physical observations were closely monitored throughout the day. Kate's fluid intake was poor and she was not eating meals. Her presentation was escalated to the treating team and team leader, and 1mg of intra-muscular lorazepam was administered in the afternoon.

35 Kate was also noted to display some irritability. She was not happy to be in the HDU. RN Goeth-Kearney noted that care should include monitoring observations closely, monitoring food and fluid, and monitoring pressure area, and to turn and reposition to reduce the risk of pressure sores.

36 At around 9am, Kate was reviewed by Dr Ntokwane. Dr Ntokwane formed the view that Kate's symptoms were caused by a schizophrenic relapse, and that her clinical presentation appeared consistent with her past presentations to ABH. Kate was prescribed olanzapine (5mg) at night.

37 Later that same day, nursing staff documented that Kate was responding with slight movements but had not eaten that day. She was administered lorazepam for her catatonia; however, Kate refused to take the prescribed olanzapine

dose. Kate ultimately took the olanzapine at around 2.20am and showered later that morning.

38 On 13 November 2022, at around 7am, RN Moon commenced her shift and introduced herself to Kate. On review of Kate's medical records, RN Moon requested that Kate's treating team complete an assessment of Kate's mental state and risk.

39 At around 9am, Kate was reviewed by Dr Abbaro, with RN Moon. Dr Abbaro discussed Kate's progress with Dr Ntokwane and they agreed that her mental state had improved. It was recorded that she was calm and cooperative, but still irritable, and her oral intake was adequate. Kate's risk of VTE, including DVT or PE, was not assessed during this review. Dr Abbaro and Dr Ntokwane arranged for Kate to be transferred from the HDU to the LDU with continued monitoring of her mental state and vital signs. Kate was keen to be discharged.

40 At around midday, and following her transfer to the LDU, Kate was seen by RN who performed a risk assessment.

41 On this same day, Kate was visited by her partner and their daughter. Nursing staff described Kate as polite and pleasant, and laughing during the visit with family. Following their visit, Kate showered, ate in the lounge area and then went to bed.

42 On Monday, 14 November 2022, at around 10.30am, Dr Bandara was allocated as Kate's treating psychiatrist.

43 At around 11.45am, Dr Bandara, Dr Amal Elabbas, and Dr Ng (collectively, the treating psychiatric team) met with Kate's case manager, Claire.

44 Following this meeting, Kate was reviewed by Dr Bandara, Dr Elabbas and Dr Ng. She was observed to be in experiencing a catatonic episode and to be not responding verbally. She had also developed a low-grade fever of 37.8ºC with mild tachycardia. Blood tests were performed which were unremarkable. Kate

was diagnosed with catatonic episode, and prescribed lorazepam (2mg) BD for two days and then, in substitution, Kate was medicated with clonazepam 1mg BD.

45 At around 2.05pm, Kate had a slightly elevated temperature coupled with catatonia. A referral was made for the medical registrar to review her.

46 At around 2.30pm, Dr Banatwalla reviewed Kate. Her observations were documented as being 'normal', save for a temperature of 37.8^{o}C; there was no cardiac murmur and her chest was clear. Dr Banatwalla assessed Kate's lower limbs for DVT that could lead to a PE. No evidence was found of this condition.

47 Dr Banatwalla requested routine blood tests, including full blood count, renal functions test, liver function test, and thyroid functions test. Tests were also ordered to check for infection, including COVID-19, blood and urine cultures, venous blood gases and a chest x-ray. A beta HCG test was ordered to ascertain if Kate was pregnant.

48 At around 8pm hrs, Dr Banatwalla contacted Nolan House to find out if the ordered tests had been undertaken and she was informed they had not. Dr Banatwalla asked the evening general medical team to follow-up these results. The blood test results were available the following morning and on review appeared to be within normal limits.

49 On Tuesday, 15 November 2022, Kate had regressed to a catatonic state and was unresponsive.

50 Dr Bandara said that at around 10am he reviewed Kate with Dr Elabbas. Dr Elabbas denied being present and she is not identified in the notes made by Dr Bandara as being present. Nothing turns on this inconsistency and I make no finding in relation to it. Kate was reported to be awake with minimal interaction, resistant to having observations taken, but having taken water and juice. Kate was content for Dr Bandara to speak to her husband and her daughter. Kate told Dr Bandara that she would speak to him at 4pm. Dr Bandara formed the

view that Kate's catatonic state was not effectively responding to clonazepam, and he considered that she had schizoaffective disorder and was depressed with catatonic symptoms. He also noted that Kate's disposition seemed different than when he saw her the previous day, and her movements were abnormal, and so he sought a second opinion.

51 At around midday, Dr Flynn was asked by Dr Bandara to review Kate and provide a second opinion. At around 1.30pm Dr Flynn attended Kate's room for the purpose of reviewing her. Kate was asleep and could not be roused. Dr Flynn briefly reviewed Kate's file and formed the view that Kate's symptoms for that admission may have been related to the trauma she experienced while in ED or mutism from a non-catatonic schizophrenia.

52 At around 4.45pm, Dr Bandara reviewed Kate a second time, along with Dr Elabbas. Kate was asleep. Her temperature was 38.1ºC, her heart rate was slightly elevated at 127bpm and her blood pressure normal.

53 On rousing, Kate complained of neck pain. She had consumed minimal (if any) food or fluids for almost 48 hours and Dr Bandara was concerned that she might have an infection.

54 At 5.04pm, clonazepam was ceased and a MET call was initiated by Dr Bandara.

55 At around 6pm, Dr Ong and Dr Tagell responded and a medical review was performed. Dr Bandara remained present.

56 Kate's temperature was documented to be between 37.8ºC and 37.5ºC, her blood glucose level was 6.4 and she was tachycardic (her heart rate was 125 beats per minute). Kate's blood pressure and oxygen saturation were within normal limits. It is recorded that Kate's legs were rigid but that this was because she was resistant rather than due to increased tone. Kate was resistant to the insertion of an IV canula, having bloods drawn, bladder scan and an ECG. Dr

Ong and Dr Bandara were concerned that Kate had minimal oral intake, had not passed urine, and required IV fluids[4].

57 Kate otherwise moved all four limbs spontaneously, however, was distressed when she turned or moved her head. Kate continued to complain of neck pain.

58 Dr Ong documented that during her review Kate had soft calves and no pedal oedema,[5] no signs of respiratory distress and her chest sounds were normal.

59 Having regard to her symptoms, Dr Ong and Kate's treating psychiatry team agreed that a transfer from the inpatient psychiatric ward to an acute medical ward was needed for closer monitoring and medical treatment such as IV fluids for rehydration.

60 A medical bed was requested. However, transfer was delayed due to lack of available medical beds. Anti-psychotics were ceased and lorazepam and diazepam were prescribed for agitation. IV fluids were charted. Dr Bandara recalled that IV fluids were commenced. The balance of the evidence indicated that IV fluids could not be administered in Nolan House. I accept that proposition and consider it likely that Dr Bandara was simply mistaken in that regard.

61 Prior to concluding his shift, Dr Bandara handed over care of Kate to Dr Mafaz and requested that Dr Mafaz not leave until Kate had been transferred to a medical ward. In A/P Grady's view, the medical team should have assumed responsibility for Kate immediately following the MET call.

62 At around 8.40pm, Dr Mafaz reviewed Kate. He reported that Kate was mute and not responding. At around, 9.10pm Dr Mafaz informed Dr Bandara of his review and Kate's pending transfer to a medical ward.

[4] Which could not be provided in Nolan House.
[5] Fluid build-up which can suggest a DVT.

63 At around 10pm, Dr Mafaz reviewed Kate a second time. Kate's condition had not changed.

64 At approximately 11.20pm, Kate was transferred from Nolan House to Medical Ward 2 due to her condition deteriorating. RN Perry performed a bedside assessment of Kate. Of note, Kate's temperature was 36.7^{o}C, she had tachycardia, and slightly reduced oxygen saturations. At 11.30pm, IV fluids were commenced. During transfer, Kate was not responding, had her eyes closed, and she needed to be manually transferred onto the medical ward bed with a 'sliding sheet'.

65 At around 12.20am on 16 November 2022, RN Jyoti and RN Perry attempted to collect blood samples from Kate. While doing so, both nurses agreed Kate did not look well and, on checking her pupils, RN Jyoti saw they were fixed and non-reactive to light.

66 At around 12.35am, medical staff observed Kate to be unresponsive and not breathing. A MET call was initiated and Dr Huang attended Kate's room. Kate's oxygen saturation was 55% on room air, and her respiratory rate was unknown as her breathing was abnormal. The MET call was escalated to a Code Blue and CPR was initiated.

67 Dr Reid and Dr Fitzpatrick, along with RN Thompson, responded to the Code Blue. Dr Reid assessed Kate and initiated Advanced Life Support. A total of fifteen cycles of CPR were completed with Kate's cardiac rhythm varying between asystole and PEA. No shocks were administered, and adrenaline was given every second cycle.

68 Kate could not be revived. Resuscitation attempts were ceased at 1.20am and, at 2.15am, Kate was declared deceased.

69 During her admission, Kate did not receive any DVT prophylaxis parenterally and was not documented to have worn anti-thromboembolic stockings.

Expert evidence

Post-mortem examination

70 Dr Bernard l'Ons conducted a coronial post-mortem examination on 21 November 2022 and concluded that Kate's cause of death was a pulmonary thromboembolism.

71 Dr l'Ons reported:

(1) Kate's external examination was unremarkable save for minor injuries consistent with resuscitation. Her internal examination revealed a saddle embolus in the pulmonary trunk.

(2) At the time of her death, Kate was prescribed amitriptyline, quetiapine and olanzapine. Kate's post-mortem toxicology analysis detected amino clonazepam[6] and amitriptyline.

(3) Kate's medical history included hypercholesterolaemia, depression and anxiety, schizophrenia and Covid-19 3 months prior.

(4) Kate's mental health appeared to have made her assessment and treatment extremely complex. Her symptoms were compatible with either pulmonary thromboembolism or NMS. NMS is a clinical diagnosis which cannot be confirmed via a laboratory test.

(5) NMS affected patients have recent exposure to a dopamine antagonist (such as an antipsychotic or antiemetic agent) or dopamine agonist withdrawal. Such patients could demonstrate a range of symptoms including, mental status change which may manifest as an agitated or hypoactive delirium, muscular rigidity that is generalised and 'lead pipe' in nature, hyperthermia with temperatures greater than 38 degrees Celsius, sometimes higher. He also noted that autonomic instability

[6] A metabolite of clonazepam.

> manifesting as tachycardia, labile blood pressure, tachypnoea and arrhythmias may occur.

A/P McGrady, cardiologist, report dated 22 August 2024

72 A/P McGrady opined that Kate's cause of death was a saddle PE in the pulmonary trunk. She reported that while Kate had several risk factors for cardiovascular disease, her heart was normal in size and there was no obstructive atheroma in the coronary arteries noted on her post-mortem examination.

73 A/P McGrady did not consider that Kate met the criteria for NMS.

74 Kate's risks for PE included her elevated BMI and her smoking. Her oral intake was reduced, she had received no DVT prophylaxis and it does not appear she was wearing anti-thromboembolic stockings.

75 A/P McGrady opined:

> The embolisation of the thrombus likely occurred on transfer to the Medical Ward bed. The saddle PE in the pulmonary trunk would have obstructed cardiac output and caused the catastrophic chain of events and led to a pulseless electrical activity cardiac arrest from which [she] was unable to be resuscitated. Thrombolysis was not given and no comment of [its] consideration was noted in medical records.

76 A/P McGrady considered that Kate's death was a complication of bedrest which was avoidable with DVT prophylaxis. She also commented that the delay in transferring Kate, an acutely deteriorating patient, to a medical bed was of concern particularly in circumstances where she was not receiving IV fluids.

77 A/P McGrady considered that the cause of Kate's deterioration at Nolan House is unclear – the PE that caused her death was an acute event. She concluded that Kate's deterioration may have been caused by a combination of events, her fever was indicative of a UTI or chest infection though there was no significant infection found on her post-mortem examination.

A/P Grabs, vascular and general surgeon, report dated 29 September 2024

78 A/P Grabs concluded that Kate's death was caused by a saddle PE. He considered that the PE caused an acute obstruction of the pulmonary arteries leading to acute right heart failure.

79 A/P Grabs' view was that Kate's mobility on admission indicated she was possibly in a 'grey area' regarding risk of DVT but based on her BMI the administration of Clexane was probably warranted.

80 He reported that the risk profile of prophylactic use of Clexane (0.5mg per kg of bodyweight) was typically lower than the risk of DVT or PE. He considered that within Australia this is poorly understood and even more so in psychiatric care units. He opined that prophylactic Clexane would likely have improved Kate's position though it would not necessarily have changed the outcome.

Kate's cause of death

81 Consistent with the opinions of Dr I'Ons, A/P McGrady and A/P Grabs, I find that Kate died from a PE.

Issues

Whether Kate's care & treatment at ABH (including Nolan House) was appropriate?

82 A/P Sullivan and Professor Large's opined that Kate's ED assessment and admission to ABH (and Nolan House) pursuant to s 12 of the *Mental Health Act (NSW)* 2007 was appropriate. A/P Sullivan opined that Kate was admitted promptly, appropriately managed in a HDU and subject to high levels of observations.

83 For the period in which Kate was in Nolan House, A/P Sullivan distinguished between 'adequate and appropriate care and treatment' and 'optimal care.' Similarly, Professor Large applied the lens of what was 'broadly within the acceptable standard of care in NSW' at the time.

84 While the care and treatment Kate was provided in respect of her mental health may have been adequate and appropriate, it was not optimal in respect of the examples described below.

(1) Kate was not given an ECG or pathology tests at admission (because of her aggression and restrictive behaviour). That said, it is unlikely this would have included tests to diagnose thrombosis risk or PE as these are generally ordered when differential diagnosis is sought. As such, even if these tests were undertaken it would not have impacted the tragic outcome.

(2) A further ECG was not obtained following the MET call. However, A/P Sullivan noted this may have been because the priority was to transfer Kate to a medical ward.

(3) A risk screening chart was not completed on 11 November 2022.

(4) A/P Sullivan and Professor Large agree that Kate could have received higher and more frequent doses of benzodiazepine which may have led to more rapid mental state improvement. However, A/P Sullivan also notes that increasing malaise due to pulmonary thromboembolism may have been the cause of ongoing impairment.

(5) A fluid chart was not commenced until 15 November 2022.

(6) It appears that a pressure risk screen (using the Braden tool) was not performed.

(7) DVT prophylaxis includes consideration of pressure stockings and low molecular weight heparin which reduces the risk of DVT and PE.

(8) Given her history of catatonia episodes, catatonia complications warranted preventative care. She could have been operationalised into a clinical pathway involving:

(a) administration of benzodiazepines, consideration of ECT, and

(b) physical healthcare to prevent complications including in relation to hydration, nutrition, prevention of aspiration, urinary retention of constipation, prevention of pressure injury and prophylaxis for DVT.

85 A/P Sullivan acknowledged that Kate's presentation was complex and variable. For example:

(1) she was not completely immobile on 12 and 13 November 2022, she was showering and she was shifting position in bed

(2) in the early days of her admission, she had adequate oral intake and her vital signs were 'within the flags'

(3) by 14 November 2022 she was less responsive

(4) the features of pulmonary thromboembolism are non-specific and Kate would not have been considered high risk until she became tachycardic, and

(5) catatonia may be mimicked by serious medical conditions and result in uncertainty as to whether a patient should be looked after in a medical ward or a psychiatric unit.

86 A/P Sullivan and Professor Large highlight that the complexity of Kate's case and her varied presentation contextualise the areas in which the treatment provided was less than optimal.

Findings

87 Kate's ED assessment and admission to ABH (and Nolan House) pursuant to s 12 of the *Mental Health Act (NSW)* 2007 was appropriate. Kate was admitted

promptly, appropriately managed in a HDU and subject to high levels of observations.

88 While in Nolan House, Kate was appropriately cared for and treated with respect to her mental health. However, one of the symptoms of the delineation between psychiatric care and physical treatment was that her VTE risk was not appropriately assessed, she was not given prophylaxis and her VTE risk increased as her mobility and hydration decreased. The intertwining of physical and psychological symptoms was such that Nolan House could not provide Kate with the holistic treatment she required.

89 The need for Kate to be transferred from Nolan House was appropriately recognised, given the level of deterioration, her transfer ought to have been undertaken more quickly.

Was Kate appropriately diagnosed?

90 A/P Sullivan considered Kate's primary diagnosis to be unspecified catatonia. It is a clinical diagnosis which no tests can confirm.

91 However, appropriately, Kate's treating team considered alternative diagnoses such as NMS and a re-lapse of her schizophrenia when treating her in a hospital environment.

Was Kate's physical health appropriated assessed and investigated?

DVT assessment

92 A/P Grabs considered that all patients require a DVT risk assessment to be undertaken by a medical practitioner. While Kate was aggressive shortly after her admission, A/P Grabs did not consider that her behaviour should have been a barrier for this to occur.

93 A/P Sullivan considered that clinicians needed to balance benefit of investigations against any risk of conducting these. He did not consider that these investigations ought to have been forcibly conducted against Kate's

wishes as there was no clear evidence that her clinical state was so deteriorated that this approach was warranted on admission. However, he considered that Kate's decision-making capacity was compromised during her admission and that in retrospect her catatonia warranted anticoagulants.

94 A/P McGrady:

(1) considered that Kate was high risk for DVT and PE

(2) found no documentation regarding DVT/PE risk in the medical records, no prescription for DVT prophylaxis and no record of Kate wearing compression stockings

(3) noted that DVT was considered during the MET call and it was noted that Kate had soft calves and no pedal oedema

(4) considered that other investigations may have helped to assess for DVT/PE such as blood tests for D-dimer[7]

(5) considered that ongoing review may have been helpful to gain Kate's co-operation to reduce her resistance and involving her family in assessments may have helped, and

(6) considered that if subcutaneous therapies were not suitable, oral anticoagulants may have been considered in the alternative, though would have been impossible if Kate refused.

95 Professor Large reported that all patients entering a NSW hospital, including a psychiatric hospital, should have an assessment for DVT prophylaxis; the relevant policy in 2022 being 'Prevention of Thromboembolism PD2019_057'.

[7] In contrast, A/P Grabs did not readily consider that such a D-dimer test would be utilised rather than prescribing a dose of Clexane as a preventative measure.

96 In recent years, he noted that mandatory risk assessments have been embedded into eMr in some (but maybe not all) public hospitals. Had Kate been assessed, he thought that she might have been prescribed measures to reduce her VTE risk.

97 In broad terms, it was accepted by the expert psychiatrists that the respective AWH procedure was compatible with the NSW equivalent policy directive.

98 AWH tendered its updated VTE policy which now adopts the relevant timings of the NSW Policy (and the requisite clinical care standards of the ACSQHC).

Was the thromboembolism risk associated with catatonia appropriately managed?

99 The psychiatric team requested Kate be reviewed by the medical team on 14 November 2022, given concerns such as her high temperature.

100 Dr Banatwalla assessed (amongst other things) Kate's lower limbs looking for DVT for a potential PE and did not find any evidence of this condition (given her oxygen saturation was also at 97% on room air at the time of her clinical assessment). Additional tests were recommended.

101 On 15 November 2022, Dr Bandara sought a second opinion from Dr Flynn as to Kate's psychiatric condition. This was unable to be undertaken by Dr Flynn as Kate was asleep when she sought to assess her.

102 At around 5pm on 15 November 2022 Dr Bandara activated a MET call.

103 During the MET call, Dr Ong examined Kate for a DVT and concluded that she did not have a DVT issue.

104 The above reflects that the psychiatric team were aware of the risk of thromboembolism but the evidence indicated a reluctance by that team to prescribe low molecular weight heparin as a prophylaxis. This highlights the risks associated with the delineation between Nolan House as the psychiatric ward and the medical wards within ABH.

105 A/P Grabs opined that Kate ought to have received chemical prophylaxis and this would have represented her 'best chance' to reduce development of DVT/PE. It is likely that this would have occurred if she were being treated in a 'medical ward.'

106 According to A/P Grabs, if it had been administered from start of her admission, her death from the saddle embolus 'may' have been avoided. In terms of whether Kate's death was preventable – that is the evidence at its highest.

107 There was evidence about consideration given to not administering Clexane given the potential for Kate needing a lumbar puncture (being a contradiction to using Clexane). A/P Grabs accepted that a therapeutic dose (1mg per kg) would present a contradiction if a lumbar puncture was being considered but that a lower dose for prophylaxis would still be acceptable in that context. He considered that notwithstanding the assessment of either Dr Banatwalla or Dr Ong, it was appropriate to give Kate a dose of Clexane.

Was Kate's transfer appropriate and timely?

108 A/P Grabs and A/P Sullivan considered that given Kate's fevers and rigidity, it was an appropriate decision to transfer her from Nolan House to a medical ward within ABH. That transfer took some 5 hours to occur. A/P McGrady considered that Kate would have benefited from immediate IV therapy for her hydration. While the experts agreed that the transfer could have occurred more swiftly though there was no evidence that this would have prevented Kate's death.

109 Professor Large considered that ideally patients such as Kate ought to be managed in medical-psychiatric setting; however, such areas are lacking.

Findings

110 There was no formal DVT assessment performed on Kate's admission or over the weekend. While this was inappropriate, in context, Kate was able to self-mobilise when she entered ABH, her mobility was variable while in Nolan House and she was appropriately transferred to a medical ward (albeit her transfer

was delayed) when she deteriorated and her mobility and hydration were diminished. The evidence does not suggest that a swifter transfer would have impacted the tragic outcome.

111 Consistent with the opinion of A/P Grabs, Kate ought to have been prescribed a prophylactic anticoagulant (such as Clexane) from admission to manage her VTE risk notwithstanding that she was able to mobilise on admission.

112 Kate's treating psychiatrists were alive to the risk of VTE associated with catatonia. However, the evidence indicated that amongst the treating psychiatrists there was a reluctance to prescribe Clexane on the basis that this role was for the medical team. A/P Sullivan and Professor Large did not support that distinction. On the evidence adduced, chemical prophylaxis could have been prescribed and administered to Kate in Nolan House and this may have positively impacted the outcome.

Were applicable standards and policies complied with?

113 The evidence demonstrated that standards and policies as at November 2022 were not well known for reasons that included medical practitioners missing orientation and/or the use of locums and agency staff.

114 While Kate's health was largely treated appropriately it did not appear that this occurred based on applicable standards and policies rather it appeared to be based on clinical decisions and experience.

Was there an impact because of the AWH oversight of a NSW located facility?

115 The evidence did not establish that Nolan House being based in NSW had any impact on the nature and quality of Kate's care.

Should there be a referral of any medical practitioner involved in Kate's care.

116 I do not consider it appropriate to refer any individual medical practitioner involved in Kate's care based on the evidence adduced in the inquest.

Is it necessary or desirable to make recommendations?

117 AWH described policy and procedural changes which address some of the risks identified following Kate's death as summarised below.

(1) The adoption of the ACSQHC 'Recognising and Responding to Acute Deterioration Standard'.

(2) The introduction of an Interdisciplinary Consultant led Safety Huddle which provides an opportunity to communicate critical information, alerts and risks in a timely way. The huddle must be convened when there is no clear working diagnosis, where there is an undifferentiated diagnosis which appears to require medical and psychiatric care, where clinical review criteria is constant and MET calls have been required and where there is any unexplained clinical or mental health deterioration or concern.

(3) The updating of the Clinical Risk Screening Procedure process which provides direction for expanded assessments, care-planning, specialist referrals and health promotion activities.

(4) The introduction of updated VTE assessment policies and risk management procedures consistent with NSW and Victorian legislation.

(5) Ongoing education and audits regarding risk assessments.

(6) Orientation education packages refresher courses which are monitored by clinical nurse educators.

(7) The role-based communication tool, Baret, introduced to ensure direct communication between all clinicians and consultants across departments.

118 These improvements are welcomed. However, additional areas warranting change identified in the inquest are presented below.

eMR

119 Professor Way reported that ABH and Nolan House would not have the benefit of the SDPR which is being introduced in NSW because they are managed by AWH. Professor Way also confirmed that there has been no funding allocated to a similar tool in AWH managed facilities.

120 While the absence of a single, readily accessible, electronic record of truth in this case was not a significant factor in Kate's death, it was an issue identified by clinicians as an ongoing inefficiency in patient management.

Case study

121 I consider there could be a public benefit in the circumstances in which Kate died being used as a case study particularly given the factors that follow.

(1) Kate's presentation was complex. Her symptoms initially presented as a mental health issue and she was appropriately transferred to Nolan House, however as her condition progressed and deteriorated, her physical symptoms (including immobility and dehydration) gave rise to a physical risk of VTE appropriately treated within a medical ward.

(2) As outlined by Ms McFee in her submissions for AWH:

> There was no formal model for physical and mental health shared care which contributed to physical assessments and tests either being delayed or not completed. There was transfer to Nolan House without medical clearance from ED.

(3) Professor Large considered that ideally patients such as Kate ought to be managed in medical-psychiatric setting; however, such areas are lacking.

(4) The delineation between psychiatric and medical wards made it very difficult for Kate to be treated holistically.

Catatonia treatment pathway

122 Given the manner in which catatonia in particular crosses over between mental and physical health, the consensus from the treating and independent psychiatric experts was that the availability of a specific catatonia treatment pathway would assist in providing appropriate care to patients.

Policy compliance audit

123 Of significant concern was the evidence of A/P Grabs to the effect that ongoing audits reveal that within NSW (if not Australia), there is relatively poor compliance with VTE protocols.

Recommendations

124 To address the issues identified above, I make the following recommendations to the Chief Executive Officer, Albury Wodonga Health:

(1) That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across Albury Wodonga Health services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.

(2) That consideration be given to advocate with NSW Health and the Department of Health Victoria, for the implementation of a treatment pathway for patients diagnosed with catatonia.

(3) That consideration be given to using the (de-identified) facts and circumstances of Kate Manley's death as a case study for educational purposes and training.

(4) That consideration be given to carrying out additional audits of the Venous Thromboembolism Risk Management Procedure AWH0221276

and, if required, take all steps necessary to ensure appropriate levels of compliance.

Findings required by s 81(1) of the Act

125 I find that Kate died at 2.15am on 16 November 2022 from a PE while an inpatient at ABH receiving care for unspecified catatonia in circumstances where she was not administered chemical prophylaxis to reduce her risk of VTE notwithstanding her deteriorating condition, reduced mobility and dehydration.

Concluding remarks

126 I will close by conveying to Kate's family my sympathy for their tragic loss.

127 I thank the Assisting team for their outstanding support in the conduct of this inquest and to those appearing for AWH and Dr Bandara for their conduct during the inquest.

128 I thank the officers in charge, Constable Benjamin Sutton and Senior Constable Kerry Redshaw, for their work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

I close this inquest.

Judge R Hosking
Deputy State Coroner
Lidcombe

****

Annexure A

Glossary/definitions

Assisting team	Patrick Rooney of Counsel and Zoe Carter, NSW Crown Solicitor's Office
ABH	Albury Base Hospital
ACIS	Acute Crisis Intervention Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
Asystole	Ceasing of heart activity
AWH	Albury Wodonga Health
BAR	Behavioural Assessment Room
BD	*Bis in die* – twice daily
CTO	Community treatment order
DVT	Deep vein thrombosis
ECG	Electrocardiogram
ECT	Electroconvulsive therapy
ED	Emergency Department
EEN	Endorsed Enrolled Nurse
eMr	Electronic medical record
HDU	High dependency unit
ICU	Intensive care unit
IV	Intravenous
LDU	Low dependency unit
MET	Medical emergency team
NMS	Neuroleptic malignant syndrome.
Nolan House	A 24-bed specialist inpatient assessment and treatment service with a HDU based at ABH.
PE	Pulmonary embolism
PEA	Pulseless electric activity
PRN	Latin term *pro re nata* in relation to medication means administration of medication as required rather than at pre-scheduled times.
RMO	Registered Medical Practitioner
RN	Registered Nurse
SDPR	Single digital patient record
Tachycardia	Heart rate greater than 100 beats per minute at rest
VTE	Venous thromboembolism
WHV	Western Health Victoria

Annexure B

Witnesses	Expert Witness
1. Dr Tshepo Jackson Ntokwane, then locum Consultant Psychiatrist, AWH at Nolan House 2. Dr Amal Elabbas, then uncredited Psychiatry Registrar, AWH at Nolan House 3. Dr Caroline Flynn, then locum Consultant Psychiatrist for AWH at Nolan House, ABH 4. Dr Vishal Bhargava, then ED Registrar, AWH at Nolan House 5. Andrea Friswell, RN, AWH at Nolan House, ABH 6. Dr Rumaisa Banatwalla, then Medical Registrar, AWH, ABH 7. Dr Zhen Yee Ong, then RMO at WHV seconded to AWH, ABH 8. Trish Mohammed, RN, AWH, ABH 9. Dr Elwaleed Abbaro, then Psychiatry Registrar, AWH, Nolan House 10. Karen Hannon, EEN, AWH, Nolan House, 11. Dr Laura Tagell, then ICU Registrar, AWH, ABH 12. Shaju Pathrose, then Social Worker, AWH, ED, ABH 13. Janet Noveras Perry (nee Salvador), Agency RN, AWH, Medical Ward, ABH 14. Sheetal Shivaghni, Agency RN, AWH, Nolan House 15. Dr Leigh Fitzpatrick, Intensivist, AWH, ABH 16. Dr Jagath Bandara, then locum Consultant Psychiatrist, AWH, ABH 17. Danielle McLeish, Area Director Mental Health, Wellbeing and Alcohol Other Drugs, AWH 18. Professor Andrew Way, former interim CEO, AWH, currently a director of the Melbourne Primary Healthcare Board and Chair of the Latrobe Regional Health Board 19. Dr Quinton Smith, Staff Specialist, General Surgical Unit and Acting Director Medical Services, AWH	1. Associate Professor Michele McGrady, Cardiologist, reports dated 22 August 2024 and 4 October 2025 2. Associate Professor Anthony Grabs, Vascular Surgeon, reports dated 29 September 2024 and 16 October 2025 3. Associate Professor Danny Sullivan, Psychiatrist, reports dated 26 August 2024 and 24 October 2025 4. Professor Large, Psychiatrist, reports dated 22 November 2022 and 12 December 2025 obtained by AWH