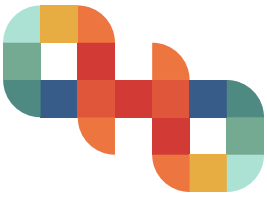
Systemic Investigation into health services provided by Robina Hospital to Mr Stewart Kelly

December 2025



OFFICE OF THE
HEALTH
OMBUDSMAN

Contents

Acknowledgement

The Office of the Health Ombudsman acknowledges the traditional Aboriginal and Torres Strait Islander custodians of the lands and seas on which we support the provision of safe and quality healthcare and pays respect to Elders past, present and emerging.

The Office of the Health Ombudsman recognises, respects and values Aboriginal peoples' and Torres Strait Islander peoples' cultures and is committed to providing a culturally safe and sensitive complaint management service.

This report contains detailed information about a critical clinical incident involving the death of a patient. Some readers may find the content distressing. Reader discretion is advised. If you are affected by the content, support is available through community support organisations and counselling services.

The Office of the Health Ombudsman acknowledges the profound loss suffered by Mr Kelly's family and would like to extend its condolences.

1 Executive summary

The following report provides findings and recommendations from the investigation conducted by the Office of the Health Ombudsman (OHO) into healthcare provided to Mr Stewart Kelly, a consumer with neurodevelopmental disorders, during his two admissions to Robina Hospital in 2022. Robina Hospital is a service of the Gold Coast Hospital and Health Service (GCHHS).

The investigation was initiated by the OHO at the direction of the then Minister for Health, Mental Health and Ambulance Services and Minister for Women to examine the circumstances surrounding the care and treatment of the consumer and to identify possible systemic areas of improvement in service delivery. Mr Kelly tragically passed away in Robina Hospital on 23 August 2022 during his second admission.

During the investigation, the OHO conducted interviews with Mr Kelly's parents and staff, and obtained relevant information including:

- copies of clinical records
- clinical incident reports
- the hospital investigation
- staff training records
- audit data
- governance documents
- relevant guidelines, policies and procedures.

The OHO investigation also referred to national and state standards, frameworks and guidelines that apply to and influence the provision of healthcare to consumers with neurodevelopmental disorders. The information obtained assisted with identifying the issues, informing the scope and findings of the investigation. A complete list of documents can be found at Appendix 2.

1.1 Key findings

The key findings highlight systemic failures in recognising and responding to the complex needs of consumers with neurodevelopmental disorders, including inadequate communication between treating teams, delays in specialist input, and missed opportunities for proactive management which resulted in Mr Kelly's continued deterioration, and ultimately lead to his death. The key findings are:

- **Inadequate staff training:** Clinical staff lacked training in recognising and managing the complex needs of Mr Kelly's neurodevelopmental disorders. This gap contributed to missed opportunities for appropriate care and intervention.

- **Deficiencies in policies, procedures and guidelines:** The investigation into Mr Kelly's care identified inadequate consideration of the unique needs of consumers with neurodevelopment disorders within relevant policies, procedures and guidelines.
- **Inadequate assessment and intervention:** Mr Kelly did not receive timely or comprehensive medical, psychiatric or nursing assessment, leading to delays in diagnosis and treatment. Key clinical indicators, including observations, weight loss and behavioural changes, were not adequately assessed, reported or managed.
- **Failure to recognise and act on deterioration:** Despite clear signs of clinical and behavioural deterioration, there was a failure to escalate care appropriately. This lack of escalation resulted in critical delays in intervention, ultimately contributing to Mr Kelly's deterioration and death.
- **Inadequate patient advocacy and protection of patient rights:** Mr Kelly's right to appropriate care was not upheld, with insufficient advocacy from hospital staff to ensure he received the necessary medical and psychiatric attention. This highlighted broader concerns about the protection of vulnerable patients and the hospital's ability to provide patient-centred care for these consumers.
- **Diagnostic overshadowing and interdisciplinary disconnect**: Mr Kelly's physical symptoms were largely attributed to his neurodevelopmental disorder, leading to diagnostic overshadowing and a failure to investigate potential underlying medical causes. Additionally, a lack of effective collaboration between medical, psychiatric, nursing and allied health teams contributed to fragmented and inadequate care.
- **Failure to make reasonable adjustments:** The hospital did not implement reasonable adjustments to accommodate Mr Kelly's specific needs, such as tailored communication strategies, development of a behaviour management plan and accommodation in a single patient room.
- **Failure to enact Ryan's Rule process:** Concerns raised by Mr Kelly's mother, which ought to have been managed through the Ryan's Rule process, were not appropriately managed.

In a submission to the OHO, GCHHS asserts that 'consideration of a single case cannot lead to a conclusion that there are systemic failures in recognising and responding to the complex needs of consumers with intellectual disabilities or neurodevelopmental disorders and therefore question the hospital's commitment to patient-centred care'.[1]

The OHO has considered this assertion; however, it notes that systemic concerns reflect weaknesses or risks in the broader systems, processes, culture, or governance of a health service. These often relate to policies, procedures, communication pathways, oversight, training, resource allocation or organisational culture that, if not addressed, could lead to repeated or widespread impacts on patient safety and quality of care.

[1] GCHHS Submission (June 2025).

Where these weaknesses exist, the ability of staff to provide safe, responsive, and individualised care is compromised. GCHHS by its own admission in its submission and the Root Cause Analysis Report acknowledges inadequate staff training and education related to consumers with neurodiversity and a lack of access to specialised clinicians to assist with developing strategies to support Mr Kelly as contributing to the outcome. Addressing these systemic concerns noted above is therefore essential to ensure that the health service consistently delivers patient-centred care that is respectful, coordinated, and responsive to the unique needs and values of each patient and their family.

The report below contains fulsome consideration of the adverse comment submissions received.

1.2 Recommendations

These findings underscore the urgent need for GCHHS to make systemic improvements at Robina Hospital to ensure consumers with neurodevelopmental disorders receive appropriate, timely, and coordinated care while safeguarding their rights and well-being. The OHO investigation makes the following recommendations:

- **Enhanced staff training**: Implement comprehensive training programs for all clinical staff addressing the specific needs of consumers with neurodevelopmental disorders, including communication strategies, behaviour management and recognising clinical deterioration.
- **Policy and procedure reform**: Review and revise relevant hospital policies and procedures to ensure they explicitly address the care requirements of neurodevelopmentally diverse consumers, including clear escalation pathways and interdisciplinary coordination.
- **Improved assessment and clinical pathways:** Develop standardised assessment protocols to ensure timely and thorough nursing, medical and psychiatric evaluations.
- **Strengthened recognition and response to deterioration processes**.
- **Stronger patient advocacy and rights protection:** Establish dedicated advocacy roles or processes to ensure the rights of consumers with disabilities are upheld, including proactive engagement with families, carers and substitute decision makers.
- **Address diagnostic overshadowing and enhance interdisciplinary collaboration**: Develop education and guidelines to reduce diagnostic overshadowing, and improve communication and case coordination between medical, psychiatric, nursing and allied health teams.
- **Reasonable adjustments and effective use of Ryan's Rule:** Implement formal processes for reasonable adjustments tailored to the needs of neurodevelopmentally diverse consumers. Ensure that concerns raised through the Ryan's Rule process are identified, taken seriously, acted upon promptly, and lead to appropriate clinical reviews.

These recommendations aim to strengthen GCHHS/Robina Hospital's ability to provide safe, equitable, and high-quality care for vulnerable consumers, ensuring a system-wide commitment to improvement and accountability.

2 Background information

On 5 December 2023, the OHO received a direction from the Queensland Minister for Health, Mental Health and Ambulance Service and Minister for Women to undertake an investigation into the care provided to Mr Stewart Adam Kelly at Robina Hospital during 2022, under section 81(1) of the *Health Ombudsman Act 2013* (Qld) (the Act).

Mr Kelly had been admitted to Robina Hospital in May and July 2022 after periods of restrictive eating and notable changes in his behaviour. Mr Kelly died in Robina Hospital on 23 August 2022 during his second admission.

On 12 December 2023, the OHO commenced an investigation into the care and treatment Mr Kelly received while an inpatient at Robina Hospital in 2022, and the circumstances leading to his death.

3 Facility

Located in Robina, the Robina Hospital is a public hospital servicing the southern suburbs of the Gold Coast, Queensland. The hospital is a service of the Gold Coast Hospital and Health Service (GCHHS) and governed by the Gold Coast Hospital and Health Board. It is also affiliated as a teaching hospital with Bond University and Griffith University.

Robina Hospital is a major regional health facility; it has 403 beds with mainly single rooms. Services offered at Robina Hospital include emergency, surgical, medical, palliative care, children's services and mental health.[2]

4 Consumer background

Mr Kelly was a 45-year-old male with a history of autism spectrum disorder (ASD), intellectual disability, depression, and post-traumatic stress disorder (PTSD). He lived at home with his mother and her partner and had regular contact and a supportive relationship with his father, sister and brother.

According to his mother, he led a full and happy life and had many friends. His challenges did not prevent him from participating in life activities, attending a supported school environment and later holding a part time job. Mr Kelly attended to his own activities of daily living (ADL) and personal care. From the age of 12 years, Mr Kelly had been supported by his National Disability Insurance Scheme (NDIS) service provider, Gold Coast Recreation and

[2] Queensland Government, Gold Coast Health, Robina Hospital.

Sport (GCRS).[3] Mr Kelly had established great relationships with his support workers, one of whom had worked with him since he was 18 years old and spent shifts of up to six hours with him while in the hospital. He regularly played golf and enjoyed ten-pin bowling and other activities with his day support worker (see Appendix 13.1 for photos of Mr Kelly prior to his illness). Mr Kelly had a love of animals and sports, and he had an incredible memory for sporting and music information. Despite his difficulties with literacy and numeracy, Mr Kelly was reportedly a whiz with computers and gaming machines. He had taken holidays with his mother, travelling to Hawaii twice and to Los Angeles Disneyland for his 40th birthday.

Mr Kelly's mother reported that when he felt distress and disturbance, this was often manifested by an upset stomach and he used the bathroom regularly as a place of refuge when stressed or upset. He did not ordinarily show any aggressive traits and was always polite and calm.

Mr Kelly was 187 cm tall and normally maintained a weight of 115 kg. He had never been admitted to hospital prior to his first admission to Robina Hospital in May 2022. At age 21 years, Mr Kelly was witness to an armed robbery and as a result began to suffer from anxiety. At that time, he sought support from a psychologist and was prescribed Sertraline by his doctor enabling him to recover his normal level of functioning.

An enduring power of attorney (EPoA) was held by Mr Kelly's mother as he did not have the mental capacity to make complex decisions, self-manage his affairs or make decisions relating to health matters.[4]

5 Investigation

5.1 Investigation scope

The investigation was conducted in accordance with the Act, and considered whether:

- the care and treatment provided to Mr Kelly during his two admissions to Robina Hospital in 2022 was adequate and appropriate
- during Mr Kelly's second admission to Robina Hospital, his treating team appropriately acknowledged and responded to requests related to his care made by his mother, who held EPoA related to health matters.

5.2 Investigation methodology

The OHO undertook the following investigation processes:

- Correspondence and requests for information made by the OHO to:
  - Robina Hospital, Gold Coast Hospital and Health Service

[3] Gold Coast Recreation and Sport Inc is a community-based organisation providing support to people with a disability and is registered to provide services under the National Disability Insurance Scheme (NDIS).
[4] RD\24\7018 Recording 1: meeting with Mr Kelly's mother; RD\24\7020 Recording 2: meeting with Mr Kelly's mother and father.

  - Mr Kelly's General Practitioner (GP)
  - Mr Kelly's Community Psychologist
- Receipt and review of information provided by Robina Hospital, Gold Coast Hospital and Health Service, GP and Community Psychologist.
- Interview with Mr Kelly's parents
- Staff interviews
- Research relating to relevant clinical guidelines, frameworks and literature
- Clinical expert opinion sought by the OHO on various aspects of Mr Kelly's care from the following practitioners:
  - Expert 1, a consultant psychiatrist with over 20 years of experience working in the health systems of Australia and England in general psychiatry and specialist fields including psychiatry of learning difficulties, early psychosis, community psychiatry, substance dependence and the area of dual disability (mental illness in people with intellectual disability)[5]
  - Expert 2, a General Physician with expertise in the medical management of eating disorders[6]
  - Expert 3, a Registered Nurse with over 40 years of diverse clinical nursing experience, and clinical teaching and academic appointments[7]
- Analysis and development of findings.

All evidence was considered that was obtained during the investigation and related to the care provided to Mr Kelly for the relevant period of 2022.

According to the American Psychiatric Association, publisher of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) neurodevelopmental disorders include intellectual disability, communication disorders, autism spectrum disorder, attention deficit hyperactivity disorder, specific learning disorder and motor disorders.[8] [9]

[5] Expert 1 BSc (Hons), MB, BS (London), MRC Psych, FRANZCP. GCHHS submission questioned the experience of this OHO expert advisor given his qualifications and experience from the United Kingdom. The OHO notes this expert has clinical experience in Australia from 1992, is a member of RANZCP holding both leadership and accredited supervisor roles within the college and has held Board positions in a State Disability Service in Australia.
[6] Expert 2 MBBS (Hons) MPH FRACP.
[7] Expert 3 RN, PhD.
[8] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders* (5th ed, 2013).
[9] GCHHS Submission (June 2025) noted that although the DSM 5 is a universally accepted manual, in Australia the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD10) is followed. The OHO notes that the Royal Australian and New Zealand College of Psychiatrists position statement related to diagnostic manuals indicates that both the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) are both used in Australia.

This report references the neurodevelopmental disorders of intellectual disability,[10] and autism (a type of neurodivergent condition),[11] as Mr Kelly had been diagnosed with both of these conditions.

6 National and state frameworks and guidelines

There are national and state standards, policies, frameworks and guidelines that apply and influence the provision of the safety and quality of health services provided by public hospitals in Queensland to the community. These include but are not limited to:

- Australia's Disability Strategy 2021-2031
- National Roadmap for Improving the Health of People with Intellectual Disability (2021)
- National Roadmap to Improve the Health and Mental Health of Autistic People 2025-2035 (2025)
- National Safety and Quality Health Service Standards 2017 (2nd edition)
- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards User Guide for health care of people with intellectual disability (2024)
- *Human Rights Act 2019* (Qld)
- *Powers of Attorney Act 1998* (Qld)
- Australian Charter of Healthcare Rights 2020
- Queensland's Disability Plan 2022-2027: Together, a better Queensland
- Department of Health Disability Service Plan 2025-2028.

7 Consumer health journey 2022

7.1 Admission one

On Sunday 22 May 2022, Mr Kelly was bought into the emergency department (ED) at Robina Hospital by Queensland Ambulance Service (QAS) with a two-day history of abdominal pain, diarrhoea, not eating and taking only sips of water.

[10] Intellectual disabilities are defined as neurodevelopmental disorders that begin in childhood and are characterised by intellectual difficulties as well as difficulties in conceptual, social, and practical areas of living according to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) published by the American Psychiatric Association.
[11] Annio Posar, Federica Resca and Paola Vicsonti, 'Autism according to diagnostic and statistical manual of mental disorders. 5th edition: The need for further improvements' (2015) 10(2) *Journal of Pediatric Neurosciences* 146-148: Autism, or autism spectrum disorder (ASD), refers to a broad range of conditions characterised by persisting deficits of social communication and interaction, and restricted and repetitive behaviours, interests, activities.

Mr Kelly's mother reported in the days before he stopped eating, he had been suffering from low mood, exhibited suicidal ideation and had a 10-day history of behavioural disturbance and anxiety, possibly associated with being told by a NDIS support worker that he could not live at home with his mother forever.

Mr Kelly was admitted to a single room on the Medical Assessment Unit (MAU), during this admission. On admission, his blood results were within normal limits and electrolytes were within normal range. His weight as recorded on admission was 106.6 kg; no other weight was recorded during this admission (22-30 May 2022). The abdominal pain was investigated, and tests conducted revealed no identifiable medical cause for the abdominal pain. Medical staff noted the abdominal pain was likely due to a manifestation of behavioural disturbance.

Dietitians reviewed Mr Kelly regularly during this admission and offered support with planning for oral intake. Clinical notes recorded by the dietician indicated the ongoing poor oral intake was discussed with the treating medical team and there was no plan currently for nasogastric (NG) tube feeding. Mr Kelly refused to see the dietician face to face on most occasions and reviews were undertaken via chart review and discussion with his mother.

The medical team noted Mr Kelly was resistant to cares, reluctant to take any oral intake and refused intravenous fluids. Noting there may have been a component of psychological distress contributing to these behaviours and lack of oral intake, an urgent referral was emailed to Consultation-Liaison Psychiatry (CLP) on 23 May 2022 requesting a mental health review for Mr Kelly.

A review by psychiatry was undertaken at a CLP multidisciplinary team meeting on 24 May 2022 via a review of his clinical notes. It was recommended a psychology and social work referral be considered in the first instance before the involvement of psychiatry.[12]

Clinical records indicate a social worker from Robina Hospital reviewed Mr Kelly on 23 May 2022, noting he was well supported in the community through both formal and informal support, and did not require any further input from social work.

On 24 May 2022, a psychology review was undertaken at Mr Kelly's bedside. The psychologist noted, based on assessment of Mr Kelly and information obtained from his mother, that his mental state was guarded, and he was highly objectively anxious, with blunted affect and restricted range. Associated triggers for this were identified as difficulties processing grief and possibly anticipatory grief at not being able to live with his mother forever and his stepfather's health issues. The psychologist recommended Mr Kelly may benefit from CLP input for further assessment, including the risk of self-harm and suicide.

On 26 May 2022, the treating team contacted the CLP team regarding a second referral, and a second request for urgent review was emailed the same day. The CLP team advised the treating team by phone on 27 May 2022 that Mr Kelly had been reviewed, and for these types

[12] GCHHS Submission (June 2025) suggested the date for this psychiatry review was incorrect and the OHO's suggestion that there was no physical attendance with Mr Kelly for this review was incorrect. The information in the report is taken from Mr Kelly's ieMR records (pages 584-585) from an entry made by the psychiatry registrar on 24 May 2022 referring to a CLP meeting that occurred on the morning of that date.

of behaviour issues they usually prescribe Lorazepam.[13] During that conversation the CLP team apologised for not reviewing Mr Kelly in person due to time constraints.[14] No record of this review was recorded by CLP in Mr Kelly's integrated electronic medical record (ieMR). There was a focused assessment and summary of CLP care recorded in Mr Kelly's Consumer Integrated Mental Health and Addiction (CIMHA) record on 30 May 2022. These indicated the psychiatry assessment of Mr Kelly during this admission was conducted using collateral information obtained from his mother and review of his medical record. Following this assessment a primary mental health diagnosis of 'childhood autism' and secondary mental health diagnosis of 'reaction to severe stress' was documented.

It was also noted that at the time, psychiatry opinion was that Mr Kelly did not have a depressive or psychotic disorder which required further treatment.[15] The clinical notes suggested Mr Kelly's mother discuss with the NDIS the possibility for re-allocation of some of his funding for psychology services.[16]

As well as his regular medication,[17] Mr Kelly was prescribed a daily oral multivitamin tablet, thiamine and Pantoprazole.[18] On 27 May 2022, he was also commenced on Lorazepam twice daily following the recommendation from CLP.

During this admission, Mr Kelly was somewhat agreeable to receiving care, allowing nursing staff to take his vital observations at least once per day. There was minimal documentation of his food or fluid intake recorded in the clinical records during this admission. However, behaviour related to food and fluid, the taking of vital signs and assistance with activities of daily living was documented in the progress notes. Over the course of the admission the notes indicate Mr Kelly was consuming small amounts of fluids and minimal amounts of food offered by staff or brought in by family. Blood tests taken on 26 May 2022 were noted to show mild derangement of liver function tests and the clinical records indicated no follow up was required.

On 30 May 2022, the treating medical team reviewed Mr Kelly and had a discussion with his mother, advising her that as there were no ongoing medical concerns, and after review by CLP and the dietician, they were happy for him to be discharged home. On the same day clinical records indicate CLP reviewed Mr Kelly's clinical records and spoke to his mother, noting there did not appear to be any barriers to discharge as there was no ongoing depressive or psychotic disorder requiring treatment. CLP also documented instructions for weaning Mr Kelly off the prescribed Lorazepam over three days following discharge.

[13] Lorazepam is in a class of medications called benzodiazepines and is used to relieve anxiety (NPS MedicineWise).
[14] RD\24\16048 Gold Coast University Hospital, Consultation Liaison Psychiatry – Intake and Patient Review Process, Work Instruction v3 2023 for processes for new assessments and reviews.
[15] GCHHS Submission (June 2025) noted that the diagnosis of 'reaction to severe stress' is included in the diagnosis of adjustment disorder with anxiety and depressed mood in the ICD 10 code F43.23. CLP recommended that a psychological therapy approach would be the preferred approach as this condition is primarily treated with psychological intervention. This was conveyed to Mr Kelly's mother and the referring team.
[16] RD\23\55400 CIMHA (Consumer Integrated Mental Health and Addiction) Clinical Records.
[17] Sertraline 50mgs daily, Salbutamol prn (when required) and Antihistamine prn.
[18] Pantoprazole: medication used to treat gastroesophageal reflux disease.

The dietician attempted to review Mr Kelly however, this was unsuccessful as he refused to speak to the dietician. Collateral information was obtained from his mother and the dietician noted ongoing grossly inadequate oral intake, no barriers to discharge from a dietetics point of view and discharge planning for follow up in the community with a Home Enteral Nutrition (HEN) outpatient's clinic appointment booked for September,[19] and a script for high protein/high calorie drink was provided.

Mr Kelly was discharged home on 30 May 2022.[20]

7.2 Period between hospital admissions

Mr Kelly's mother reported some improvement in his intake initially after he was commenced on Lorazepam, although he was mainly eating low nutritional food like chips and ice cream after discharge. Following discharge, he returned to his support program at Gold Coast Recreation and Sport, and while not eating properly his mother was able to get him to drink fluids, including high calorie smoothies, and to eat ice cream.

By mid July 2022, Mr Kelly again refused to eat or drink, he had retreated to his room, refused to engage in his usual activities, would not shower or attend to other self-care activities and began talking about dying.[21]

After discharge from hospital, Mr Kelly attended weekly to fortnightly visits with his GP and psychologist.[22] His weight recorded by the GP on 26 June 2022 was 91.5 kg. On 11 July 2022 when Mr Kelly visited the GP he was noted to still be in his pyjamas, his weight was recorded as 84 kg and his mother reported he had deteriorated and refused to have a blood test.

An emergency crisis support meeting was held at Mr Kelly's home on 20 July 2022 to discuss and support Mr Kelly's parents in planning his care. The meeting was attended by his psychologist, support co-ordinator, support worker and GP (via telehealth). During the meeting there was discussion about Mr Kelly's significant weight loss (26 kg since discharge from hospital in May), general deterioration and refusal to eat or go to hospital. During that meeting, after consultation with his mother and psychologist, Mr Kelly's GP placed him under an Emergency Examination Authority (EEA),[23] for potential health impacts from not eating, depressed mood, suicidal ideation and his lack of response to medication or psychological counselling that he had been attending. Mr Kelly became angry and violent, smashing a glass when told he would need to go to hospital for care.

---

[19] HEN: Home Enteral Nutrition Clinic runs weekly at Robina Hospital and supports consumers requiring or receiving supplemented nutrition support.

[20] RD\23\55395 ieMR (Integrated Electronic Medical Record) Clinical Records; RD\23\55398 EDS (Electronic Discharge Summary) Clinical Records.

[21] RD\24\7018 20240116 Recording 1 meeting with Mr Kelly's parents; RD\24\7020 20240116 Recording 2 meeting with Mr Kelly's parents.

[22] RD\24\29630 Clinical Records Mr Kelly – GP; RD\24\34271 Clinical Psychology Records Mr Kelly.

[23] Emergency Examination Authority is a legal mechanism by which a person whose behaviour indicates that they are at immediate risk of serious harm, which appears to be a result of a major disturbance in the person's mental capacity, and may be taken against their will to a public sector health service facility. See Queensland Health, Clinical Excellence Queensland, Emergency Examination Authorities and *Public Health Act 2005* (Qld) ch 4a.

An ambulance was called, and Mr Kelly was restrained and transported to Robina Hospital with the assistance of the Queensland Police Service.

7.3 Admission two

7.3.1 Emergency Department

At approximately 5 pm on Wednesday 20 July 2022, Mr Kelly was taken to the ED at Robina Hospital by QAS, with the assistance of the Queensland Police Service (see Appendix 13.1 for photo of Mr Kelly in the ED on 21 July 2022).

On arrival to the ED, Mr Kelly was uncooperative and refusing healthcare interventions including pathology tests, recording of observations and being weighed.

His mother provided a history of what had been happening with her son since his previous admission in May 2022 and gave consent for physical and chemical restraint to allow for his medical assessment and treatment as required.

In the early hours of Thursday 21 July 2022, Mr Kelly was physically restrained by security officers and given an intramuscular sedative. Following this he had an intravenous (IV) cannula inserted, blood tests, observations, an electrocardiograph taken, and he was given IV fluids.

Overnight in the ED there were two code black incidents involving Mr Kelly,[24] these were called after he reportedly became aggressive and combative towards staff. On each of these occasions his behaviour was unable to be de-escalated, and he was given intramuscular (IM) sedation to calm his behaviour. On the morning of 21 July 2022, Mr Kelly again became agitated and tried to leave the ED. His mother was present at that time and neither she nor staff were able to de-escalate the situation. Mr Kelly was again restrained and given IM sedation to manage his escalating behaviour.

Initially the Medical Decision Unit (MDU) declined care of Mr Kelly, indicating that they believed he was better suited to psychiatric care. The clinical records indicate the Early Psychosis Service was contacted to request assistance with Mr Kelly due to ongoing mental health concerns and his escalating behaviour;[25] however, the service declined to assess him and recommended sedation.

While in the ED, Mr Kelly had visual observations recorded every 15 minutes between his admission at 1700 hrs on 20 July 2022 and 0545 hrs on 21 July 2022. During this period Mr Kelly was reported to have been in the bathroom on 14 occasions and for the remaining occasions was observed in bed. His clinical observations were recorded at intervals between one and four hourly during his time in the ED. On four consecutive occasions overnight, his observations fell within the Medical Emergency Team (MET) call criteria according to his Early Warning Score (EWS), triggered by low blood pressure combined with either low

[24] Code Black: call for emergency assistance when a patient, or other person, poses a serious safety risk to themselves or others in the organisation.
[25] Queensland Government, Gold Coast Health, Early Psychosis Team (15-25 years).

temperature, elevated heart rate, pain or oxygen requirements. Clinical records indicate that during this time he was connected to monitoring including telemetry, and visual observations were being taken every 15 minutes.[26]

A social worker reviewed Mr Kelly in the ED on 21 July 2022, and the clinical notes indicate a history was obtained through chart review and speaking with nursing staff and his mother. Mr Kelly's NDIS plan and other community supports were documented, and it was noted that emotional support was provided to his mother and that his case was closed to ED social work.

On the afternoon of 21 July 2022, after consultation between ED medical staff and the Medical Consultant, Mr Kelly was admitted to the Medical Assessment Unit (MAU)[27] under the medical team for malnutrition, dehydration and general self-neglect with a risk of refeeding syndrome.[28]

7.3.2 Summary of clinical care medical units

On the evening of 21 July 2022, Mr Kelly was transferred from the ED to a single room in MAU with a nurse special and a patient safety officer in close proximity due to the risks associated with his exit seeking behaviour, agitation and aggressiveness. The table below is a summarised timeline of the care documented in Mr Kelly's clinical record by members of the multidisciplinary healthcare team from his admission to the Medical Ward until his transfer to Intensive Care.

DATE	ieMR documentation summary
21 July 2022	**Medical:** MAU Resident Medical Officer (RMO) noted history (as taken from his mother), investigation findings, discussion with Medical Consultant and plan of care in the clinical records. Plan of care included encouraging food and fluid, providing a low stimulus environment, strategies for de-escalation of behaviour and sedation if required, blood tests and formal review by Consultant Liaison Psychiatry (CLP) the following day.
	Nursing PM: Admitted to MAU for risk of refeeding. Registered nurse caring for Mr Kelly documented he had slept mostly since admission but was easily rousable. The plan after discussion with medical officer was to allow Mr Kelly to sleep, not to wake for vital signs, and to monitor respiratory rate and visual observations. **Nursing Night:** Recommendations for supportive and safe care and strategies to calm Mr Kelly were documented. He was cared for in a single room by a Registered Nurse Special due to the acute agitation and behaviours he exhibited in the ED. A security special was also present. Mr Kelly was reported to have refused all offers of food or fluids but allowed staff to do his observations. Independently mobilised to the toilet

[26] Telemetry monitoring allows continuous electrocardiograph, respiratory rate, and oxygen saturation measurement.
[27] The Medical Assessment Unit provides rapid assessment of internal medical patients presenting to Emergency Department by the General Internal Medical Team. Early discharge is facilitated for suitable patients and rapid referral occurs where inpatient medical care is required.
[28] Refeeding syndrome results in metabolic changes with the reintroduction of nutrition to those who are malnourished or in the starved state. If untreated, the condition can be serious, causing fluid and electrolyte imbalances that can result in death. See Hisham Mehanna, Jamil Molendina and Jane Travis, 'Refeeding syndrome: what it is, and how to prevent and treat it' (2008) 336(7659) *British Medical Journal* 1495-8.

DATE	ieMR documentation summary
	overnight. The plan of care noted was for a dietician review, single room with one-on-one special and request mental health review. Staff noted hourly rounding, and visual observations were attended overnight.
22 July 2022	**Medical AM:** RMO noted Mr Kelly's history and medications. Impression was he had a behavioural disturbance associated with severe autism and intellectual impairment. Plan of care was for dietician review and could eat and drink anything he likes.
	Nursing AM: Nursing special and patient safety officer remained in place on the morning shift. Mr Kelly was observed frequently attending the bathroom. No behavioural concerns were identified, although he was noted to become agitated when there was noise coming from outside. Both parents visited. Mr Kelly was weighed on his bed after he refused to stand on the scales, his weight was recorded as 78.9 kg. **Nursing PM:** Noted one-on-one nursing special and patient safety officer remained in place. Mother visited for most of the day. Encouragement was required with activities of daily living (ADLs) and his mother assisted with changing into clothes for bed. Continuously going to the bathroom and running the tap, mother advised this was his safe place. Hourly rounding attended to. **Nursing Night:** Mr Kelly was noted to be up to the toilet several times. He declined offers of a blanket and a warm drink.
	Dietetics: Initial assessment noted Mr Kelly had been admitted with risk of refeeding syndrome, aggression and suicidal ideation, and his history was obtained from his mother. The dietician documented he was suffering from severe malnutrition with a weight loss of 28kgs over the two months since the previous admission, and there was evidence of severe wastage. The treating team had advised Mr Kelly was not suitable for nasogastric tube as it was likely he would self-remove. Opinion was that he would not eat enough to refeed given his refusal of intake. The plan was for a high protein diet and high calorie supplements, to encourage the family to bring foods he likes, nursing staff to commence a food chart and set-up and assist at mealtimes, recommended monitoring electrolytes and replacement as required and weigh when safe to do so.
	Psychiatry: CLP registrar reviewed Mr Kelly at 1.28 pm on 22 July 2022. The clinical records indicate the referral was requested for advice regarding pharmacological management of behaviour. Clinical records written by the CLP registrar indicate Mr Kelly's clinical notes were reviewed, a history was obtained from his mother, and his case was discussed with the CLP Psychiatrist. There was no evidence Mr Kelly was examined. Recommendations for pharmacological management were documented, and it was noted that no further CLP input was required unless requested.[29]

[29] GCHHS Submission (June 2025): This was based on the understanding that Mr Kelly did not have a primary mental health disorder (the neurodevelopmental disorder was noted by both the CLP and medical team). With hindsight, this was incorrect.

DATE	ieMR documentation summary
23 July 2022	**Medical:** Medical Registrar noted continued minimal intake, that he could eat and drink whatever he wished, and that Mr Kelly had agreed to have a blood test which was ordered with the refeeding risk in mind.
	Nursing AM: Mr Kelly only allowed one set of observations to be taken. He refused any food, even that brought in by his family. Patient safety officer and nursing special remained in place. Recommendations for care included hourly rounding, regular observations and continue to monitor. **Nursing PM:** Nursing special and patient safety officer remain in place for shift. Refused observations, meals and a blood test. Mother brought in drinks which he did not touch. Mr Kelly was observed going in and out of the bathroom during the shift. Recommendations for care were to continue observations and monitor for early signs of deterioration. **Nursing Night:** Overnight assistant in nursing special and patient safety officer in place. Observed with a cup in his hands, unsure if he had anything to drink. Declined offers of food and fluid and refused to have observations taken. Frequently observed going to the bathroom. Refused to have a blood test at 6.00 am. Recommendations for care recorded as maintain hourly rounds, care as per treating team and food and fluid chart.
	Social work: Noted Mr Kelly's presenting situation, and that there was an NDIS plan in place which now included Supported Independent Living Accommodation. Noted liaison with multidisciplinary team, chart review and CLP and ED Social Work input. Social work advised there were no barriers to discharge from their point of view post-medical clearance.
24 July 2022	**Nursing AM:** Nursing special and patient safety officer remained in place. Refused observations despite multiple attempts. Mother brought in a banana smoothie. She advised staff the drinks in the room had been opened, and Mr Kelly had possibly been drinking small amounts of fluid. Noted to be repeatedly mobilising to the bathroom, unsure whether bowels opened. **Nursing PM:** Nursing special remained in place. Refusing all oral intake, including favourite foods brought in by mother, but did swallow medications whole. Mr Kelly appeared comfortable and there were no signs of distress. Care to continue as per treating team and care plans. **Nursing Night:** Noted to have been awake most of the time overnight and was observed going to toilet numerous times. He refused to have observations taken and refused offers of food and fluids.
25 July 2022	**Medical:** RMO documented ongoing restriction of eating and drinking and declining of all cares. Discussion with his mother who raised concerns that she felt he was going to die if he continued to restrict his intake. Medical staff opinion indicated that nasogastric tube feeding was not an appropriate course of action, and the plan was for ongoing

DATE	ieMR documentation summary
	dietician review, food charts, CLP advice regarding appetite stimulation, referral to psychology and to attempt oral sedation for blood work.
	Nursing AM: Noted to have declined observations, stating 'I'm ok'. Nursing staff attempted to let mother use observation machine; he would not allow her to put the blood pressure cuff on. Refused diet and fluids, would not allow nursing staff to bring breakfast or lunch trays to room. Refused diet and fluids brought in by family. Mother reported urine appeared to be normal colour and consistency. Recommendations for care to encourage oral intake, hourly rounding, encourage set of observations and continue to monitor. **Nursing PM:** Noted visual observations were taken as Mr Kelly was refusing for his blood pressure to be taken. He also refused medications, blood tests and evening meal. Staff observed Mr Kelly drinking a sports drink on one occasion and noted he was in the bathroom several times during the shift. **Nursing Night:** Observed sleeping and visiting the bathroom. Staff saw him standing by the bed pouring water but were unsure if he consumed any. He refused to have vital signs or blood tests taken.
	Psychology: Psychologist noted Mr Kelly's referral to the service in the clinical record and planned to review him on 26 July 2022.
	Dietetics: Noted discussion that occurred with Mr Kelly's mother and treating medical consultant. Weight on 22 July 78.9 kg and approximately 30 kg weight loss in two months. Observed evidence of severe wasting, nil biochemistry as unable without sedation, and refusing medication. Mother asked treating team to check renal function, reports patient urinated yesterday and likely consuming water behind closed door in bathroom. Refusing food/fluid offered. Discussion with Medical Consultant and mother noted, explained not appropriate for nasogastric tube; can insert under sedation but patient will remove once alert, and this is not sustainable long term. Phone call made to CLP regarding further advice, mentioned unable to provide further support. Mum has consented to psychology input while in hospital; she mentioned he had been seeing a private psychologist in the community through NDIS but this had recently stopped as he was too complex, and the psychologist was unable to provide further support. Plan for family to bring in favourite food and encourage oral intake, nursing staff to continue with food chart and to provide set-up and assist at mealtimes as required.
26 July 2022	**Medical:** RMO noted nursing staff had advised Mr Kelly was observed eating left over lollies in his room and drinking water in the bathroom; he was still refusing observations and medications. Observed by staff exploring cheesecake brought in by his father, although he was not seen eating any. RMO acknowledged psychologist's review and impression regarding Mr Kelly. Discussion with CLP had taken place, suggestion was oral disintegrating sedative, with a plan to raise this with the Medical Consultant.

DATE	ieMR documentation summary
	Nursing AM: Mr Kelly refused observations, hospital supplied meals and drink supplements. Mother visited and noted some of the sports drink had been consumed since yesterday; this was not observed by staff. Refused medications on this shift. **Nursing PM:** Mr Kelly's mother visited, she was noted to be teary and was provided with support and a cup of tea. Mr Kelly was noted to have eaten small amount of yoghurt and drinking sports drink. He refused to have observations or blood tests taken. Plan of care was to continue as per treating team. **Nursing Night:** Staff noted the rubbish bin in Mr Kelly's room contained empty drink cans and bottles and a hot chip container. Observed sleeping and intermittently up to the bathroom overnight. Refused to have observations or blood tests taken and declined the offer of chocolate.
	Psychology: Attempts to review Mr Kelly on 26 July 2022 were largely unsuccessful as he would not engage. The psychologist noted he seemed more engaged with his mother, accepting a high energy drink she had brought in and was observed consuming a lolly from a bag offered to him. Notes were made regarding the discussion with Mr Kelly's mother about his decline and her ongoing concerns. The clinical impression was that there appeared to be an element of anxiety and preoccupation with death and dying and possibly other emotional vulnerabilities not yet explored. The psychologist noted Mr Kelly may benefit from Psychiatry Clinical Liaison review and requested the medical team to consider this suggesting a low threshold for CLP referral if concerned about his mental state, risks and behaviours. The psychologist planned to continue to attempt to build rapport with Mr Kelly, support his mother, review NDIS funded psychologist report and liaise with the medical team. It was also suggested that a Behavioural Support Plan be considered, and that staff should be guided by mother's suggestions regarding how best to communicate and engage Mr Kelly.
27 July 2022	**Medical:** RMO acknowledged nursing notes indicating the rubbish bin in Mr Kelly's room was full of empty food and drink containers and that he appeared to be beginning to eat and drink. Other evidence he had been eating including half eaten food by the bedside, water jug one third empty and visible food in his mouth and teeth. Impression was restrictive eating was resolving. Plan to continue and for escalation if any oedema, ataxia or seizures were observed.
	Nursing AM: Mr Kelly continued to refuse observations, medications and hospital food. Mother advised staff he possibly ate a chocolate bar overnight and drank some sports drink; this was not witnessed by staff. Plan of care was as per medical team, for transfer to C1 with belongings. Mr Kelly was transferred from MAU to the Acute Medical Unit (AMU) midmorning on 27 July 2022. Staff in AMU noted Mr Kelly refused all cares, observations, food and medications. Resting in bed most of the time and when offered a supplement drink he was observed by a student pouring it down the sink. Plan of care was as per treating team.

DATE	ieMR documentation summary
	Nursing PM: Staff observed Mr Kelly regularly going to the bathroom, but they were unsure if he was voiding or moving his bowels. He was also seen tipping drinks into cups but not eating or drinking. Noted build-up of food on his teeth which was unable to be removed. Patient advised he had opened his bowels but was unable to give details. Unable to take observations despite using approach suggested by Mr Kelly's mother but noted patient 'appears visually asymptomatic of any abnormalities with regard to vital signs'. Difficult to communicate due to unclear speech. **Nursing Night:** Mr Kelly refused vital signs and assistance with ADLs.
	Dietetics: History noted. No biochemistry since 21 July. Patient observed to have consumed very small amounts of food/fluids. Nursing staff noted overnight the bin had empty lemonade cans, hot chip container and Gatorade. Mother happy patient starting to show interest in food and having small amounts. Noted psychology input and limited engagement from patient. Plan for family to bring in favourite food and encourage oral intake; nursing staff to continue with food chart and to provide set-up and assist with eating at mealtimes as required.
28 July 2022	**Medical AM:** RMO reviewed Mr Kelly noting he appeared uncomfortable in a four-bed bay and the computer on wheels in the room was causing him visible distress. He continued to refuse observations, examination and blood tests. Noted slow improvement in interest in food and that he was drinking small amounts. Risk of refeeding remained; however, unable to monitor. Treating team noted the hospital environment was not conducive to resolving the issue and felt community support in a familiar environment would likely be more successful. Medically clear and the plan was to discharge him home with NDIS dietetics and community psychology support. **Medical PM:** Documentation of meeting held with the Medical Consultant, Social Worker, Patient Flow Manager and Mr Kelly's mother. At that meeting Mr Kelly's mother expressed her stress about potential discharge given his recent cessation of eating again and insisted she was unable to take him home as she felt she was unable to care for him. She declined additional support at home and expressed concern about him becoming aggressive when he needed to be transferred from home to new accommodation when it was available. Her views were that it would be best for Mr Kelly to remain an inpatient until his preferred respite accommodation became available. The issue of his discomfort in the four-bed bay and the risks of the hospital environment to Mr Kelly's recovery were raised by the treating team. A multidisciplinary team meeting with NDIS was to be held the following day to evaluate his ongoing needs package and discuss a potential alternative discharge destination besides home.
	Nursing AM: Hourly rounding attended. Breathing, level of consciousness and capillary refill assessed, and patient noted to be saturating on room air. Mr Kelly refused observations, medications and assistance with ADLs. He declined food and fluids offered by staff and mother. Nursing staff noted Mr Kelly's mother was visiting and was very upset and stressed. Father also visited in the morning. Plan of care was for NDIS

DATE	ieMR documentation summary
	dietetic support and community psychology, possible discharge home if family comfortable and community services organised. Encourage food and fluid intake. **Nursing PM:** Staff noted they were unsure if Mr Kelly mobilised or used the toilet during the shift. He continued to refuse meals and supplement drinks offered. **Nursing Night:** Regular visual observations attended, and Mr Kelly was observed sleeping on and off. He refused to have his vital signs taken and declined any cares offered and was noted to be continent.
	Dietetics: History noted. Nil intake in last day despite encouragement. Assessment remains unchanged. At risk of refeeding, refusing food and fluid last five days on background of poor oral intake for two months, although electrolytes were normal as per bloods on 21 July 2022. However, likely not to eat enough to refeed given refusal. Discussion with mother re NDIS, inappropriate to go into at the time as mum teary and upset. Mother advised they did not have dietetics support with NDIS. Informed mother outpatient's department appointment booked for September with HEN clinic, again inappropriate to discuss as Mr Kelly not eating anything. Plan to keep HEN appointment in place, liaise with treating team re conversation with mother and carer stress, continue with current diet.
	Social Work: Met with Mr Kelly's mother after she was referred due to carer stress. Mr Kelly's mother expressed her distress at the possibility of his discharge, when her son was continuing to refuse food and fluid intake or take his medications, and she was worried that he was going to die as he continued to deteriorate, and she felt no-one was doing anything to help. According to the notes Mr Kelly's mother felt the best outcome for her son was for him to remain in hospital in a single room until his preferred respite accommodation is approved and ready as this will make him want to eat. It was explained that this would not be possible, and he would not be able to have a single room due to 'high amount of patients with illness/infections'. There was also discussion about the planned meeting regarding NDIS funding requirements for therapy, behaviour support and respite accommodation. Mr Kelly's mother advised the social worker she was a family in crisis and insisted she would not be taking him home to care for him. The Social Worker subsequently attempted unsuccessfully to seek emergency respite. When Mr Kelly's mother was advised of this, she was teary and said she felt her son was dying. The Social Worker deferred to the medical team to advise of his medical status and again reiterated that he could not remain in hospital until his desired respite facility became available. The Social Worker handed over the details of this conversation to the Medical Consultant and the Nursing Patient Flow Manager.
29 July 2022	**Medical AM:** RMO documented Mr Kelly's mother's wishes for him to remain in hospital in a single room to rest until respite accommodation was available because the new accommodation will make him want to eat. No observations were able to be taken, and he was observed to be lying in bed and breakfast tray was untouched. His admission was noted as a maintenance admission with a plan to discharge later that day after the outcome of a planned emergency NDIS meeting was known.

DATE	ieMR documentation summary
	Medical PM: Medical Consultant documented in clinical record details about Mr Kelly's admission. It was clear he had lost a significant amount of weight over the last two months, and this was clearly the effect of behavioural dysregulation related to his autism. The notes indicated Mr Kelly's bloodwork on admission was unremarkable despite his history of poor intake; however, admission was necessitated by the fact that he required heavy sedation in the ED to perform tests to assess his health status. Once admitted to a single quiet room he required no further sedation. The taking of vital signs, blood tests and enteral feeding options were not possible without significant risk to Mr Kelly and staff. Observed Mr Kelly walking back and forth from his ensuite with a cup, presumably drinking water from the tap, and in the days after admission he began eating small amounts of food. This stopped when he was transferred to a four-bed bay. He opined that an inpatient hospital ward was not an appropriate environment to treat Mr Kelly's behavioural disturbances of severe autism and was likely to be more harmful than managing him in the home environment. He had not received any correspondence from his care providers in the community citing what the medical issue was or suggested treatment, nor was he aware of any steps taken by Mr Kelly's care provider, NDIS, to address his behavioural disturbance in the past two months. It was his opinion that it was in Mr Kelly's best interests to be discharged home, or to another environment arranged by NDIS, 'because every day he spends in hospital delays appropriate specific treatment which should already have been implemented and is placing him at significant risk'.[30] RMO recorded his interaction with Mr Kelly's mother and brother on the afternoon of 29 July 2022, noting that the NDIS meeting had confirmed accommodation for discharge; however, it would not be available until Monday. Family expressed they were not comfortable taking Mr Kelly home over the weekend. The RMO noted discussion that the hospital environment was not conducive to encouraging him to eat. Notes indicate there was an agreement Mr Kelly would remain in hospital until Monday, even though he was medically clear and unlikely to make any significant progress as an inpatient.
	Nursing AM: Mr Kelly refused medications, observations and offers of food or fluid. Offered towels for a shower which he also refused. Visited by mother who requested social work contact a behavioural therapist to be involved in Mr Kelly's care and requested to speak with her son's medical team. Nursing staff noted the treating team were contacted regarding this. **Nursing PM:** Mr Kelly remained in bed the entire shift and refused to get changed. He refused offers of food and fluid and any assistance from nursing staff. Overnight Mr Kelly became incontinent of urine; he declined offers of assistance to go to the toilet and refused to have his pad changed or any observations recorded. Staff also noted he remained in bed overnight. Mother was noted to be visiting until the afternoon. Plan of care was to continue as per the treating team.

[30] GCHHS Submission (June 2025): 'GCHHS staff ensured that the treatment plans and goals and clinical interventions were flexible and reasonably tailored to the needs of Mr Kelly. This was done following discussion and collateral from Mr Kelly's mother who was frequently involved in the care of Mr Kelly and consulted on issues of consent and capacity'.

DATE	ieMR documentation summary
	Nursing Night: Nursing staff noted they conducted regular visual observations, and that Mr Kelly appeared comfortable but was awake on all rounds during the night. Mr Kelly was incontinent of urine overnight; he was given a clean top sheet but declined for nursing staff to change his pad or assist him to the toilet. He did not get out of bed overnight.
	Psychology: Psychology reviewed again o on 29 July 2022, as a follow up to initial consultation. Clinical records indicate the psychologist was present at a family meeting to discuss discharge planning and barriers. Short-term emergency accommodation was being sought from Monday 1 August 2022; however, details were unclear. Social work was to follow up and assist with planning. The plan was for Mr Kelly to continue to be seen post-discharge by NDIS psychologist who has previously been seeing him in the community. Report from community psychologist, provided by Mr Kelly's mother, recommends sourcing a suitable Behaviour Support Specialist to be involved in his care. This had been done, and arrangements were being made for this to be included in his NDIS care package post-discharge.
	Social Work: Was approached by Mr Kelly's mother while on AMU; she advised she had felt bullied during the family meeting held the day before and that she was in disbelief that her son did not require medical attention and does not have mental health issues. The social worker offered an apology that she felt bullied, that it was nobody's intention to make her feel this way and acknowledged the frustration she was currently feeling. Social work made some follow up calls regarding emergency accommodation; the acting support coordinator advised there is no confirmed accommodation and that she did not feel comfortable facilitating or supporting discharge for Mr Kelly while he was still refusing to eat or drink and take medication. When questioned about this, her opinion was that he should be in an inpatient mental health ward as his ASD and anxiety was contributing to his lack of desire to eat, and that is a mental health condition. It was documented that the acting support coordinator advised Mr Kelly had been seeing a psychologist in the community who was significantly concerned about his mental health and had recommended a psychiatric assessment and admission to a mental health ward. She suggested a disability specialist psychiatrist assess Mr Kelly. Social worker noted this would need permission which she would follow up. The social worker acknowledged in the clinical record that the treating team had medically discharged Mr Kelly and she was unable to further discharge plan; however, she would continue to monitor and support the treating team as indicated.
30 July 2022	**Nursing AM:** Mr Kelly refused any assistance from nursing staff and was reportedly observed going to the toilet three times. He refused to shower or change out of wet clothes, including when his mother offered to help. His bed linen was changed four times due to incontinence. Plan of care was to continue as per the treating team. **Nursing PM:** Noted Mr Kelly was alert and confused. He remained incontinent on this shift and refused to have his pad or bed changed. He refused all cares offered by nursing staff, medications, vital signs and any oral intake. His plan of care was to continue plan as per the treating team and aiming for discharge on Monday.

DATE	ieMR documentation summary
	Nursing Night: Mr Kelly was incontinent overnight and unsettled repeatedly saying 'no'. He refused observations and declined to have his clothing or bed linen changed after he was incontinent of urine. Staff put a bed alarm in place to alert when he got out of bed so they could change the linen; the alarm was not activated indicating he did not get out of bed overnight. Night staff were able to record some vital signs (which were abnormal) and it was noted that the nurse in charge was made aware.
31 July 2022	**Nursing AM:** Mr Kelly was alert. He refused all care, food and fluid offered, and to have his observations taken. He continued to be incontinent, and his mother and sister were unable to convince him to change his clothing. The plan of care was noted to continue as per the treating team. **Nursing PM:** Staff were able to give Mr Kelly a sponge bath and change his sheets and clothes with assistance from his brother. He was noted to become agitated when offered anything to eat or drink and threw drinks on the floor. Staff documented he refused to have observations taken, although noted his respirations were shallow and rapid, at a rate of 39-42 breaths per minute (bpm), and his oxygen saturations were recorded as 95%. The nurse in charge was made aware of these observations and the staff documented recommendations were to continue as per management plans, continue to monitor and the bed alarm was to always remain on. **Nursing Night:** Staff noted Mr Kelly was still hyperventilating at a rate of 29-30 bpm; he was awake during rounds but refused observations or to have his pad changed. He slept intermittently and was noted to have wet pants in the morning but declined any assistance. The care plan was documented as awaiting discharge with NDIS support.
1 August 2022	**Medical AM:** RMO reviewed Mr Kelly while his mother and NDIS support worker were present. RMO documented Mr Kelly was still refusing cares, had not been seen eating and drinking although urine output was noted. His breathing was shallow but other observations, allowed to be taken, were otherwise fine. Conversation with Mr Kelly's mother documented; she requested a private psychiatrist to come and do an assessment and was advised that private specialists don't generally become involved in inpatient care. She advised she did not think he was well enough to discharge, and NDIS support worker advised he was unlikely to be accepted into care if he was refusing his medication. There was discussion about Ryan's Rule, GCH psychiatry performing an inpatient review, and the family requested for Mr Kelly to be sedated, examined, blood tests performed and be tube fed. The RMO noted he informed Mr Kelly's mother these were poor options given his behaviour and past and current status and was likely to further alienate him from healthcare. Mr Kelly reportedly declined to talk or be examined during this interaction, although the RMO noted he was 'laying in a puddle of his own urine' and was tachypnoeic with a respiration rate of 30 bpm. The RMO noted Mr Kelly had further deteriorated secondary to his refusal to eat and drink and documented a plan to have further discussions with CLP and the Medical Consultant regarding his management. The option for private health service review was noted as not available as he was an inpatient.

DATE	ieMR documentation summary
	Medical Registrar recorded in the ieMR that Mr Kelly's mother and a friend from Gold Coast Recreation and Sport were present at the time of the round and his mother asked for short-term sedation to facilitate bloods. The events that occurred in ED when sedation was administered were discussed including the distress this caused. According to the notes bloods were able to be obtained with the assistance of Mr Kelly's friend from Gold Coast Recreation and Sport, and with redirection and reassurance. The Registrar's examination noted Mr Kelly's breathing was shallow and tachypnoeic (rate 39 bpm); he was tachycardic (heart rate 110 bpm), lethargic and had been incontinent of urine. His opinion was Mr Kelly was clinically dehydrated, and this was likely related to him not likely accessing water from the bathroom tap as he had been in a single room, and that his family had stopped bringing in food and fluids. A plan was documented for fluid replacement via the peripheral intravenous cannula (PIVC), bloods to be taken, attempt bladder scan and await further progress from patient flow and social work regarding discharge plans. **Medical PM:** Reviewed by Medical Registrar, blood results indicated he was 'profoundly dry' and his case had been discussed with the Intensive Care Unit (ICU) Registrar. The ICU Registrar indicated that if Mr Kelly was currently agreeable to blood tests and IV fluids there was no additional support that could be offered by ICU currently. The plan documented was for IV fluids, strict monitoring of fluid balance and follow up blood tests. The Medical Consultant was aware of Mr Kelly's condition and gave advice regarding the fluid replacement regime. ICU Registrar review noted Mr Kelly's history, profound dehydration and pathology results indicating severe electrolyte derangement. His submission to venipuncture and IV fluids, increased respiratory rate and lethargy were also noted. There was a discussion with Mr Kelly's mother at the bedside; she was advised he was unwell with highly abnormal electrolytes and severe renal impairment and the current treatment he was receiving was optimal. His short-term trajectory was uncertain, and he could deteriorate, requiring frequent blood tests to inform progress and dictate appropriate treatment. Medical staff were seeking to avoid unnecessary invasive measures such as forced nasogastric feeding and sedation at this stage, all of which were against his wishes and could cause further harm. Intensive care treatment was not required at this stage; however, they were happy to provide advice and assistance as needed. It was suggested a peripherally inserted central catheter (PICC) would be useful and this could be arranged through radiology the following day. The ICU Registrar agreed with the current treatment plan as per the home team notes, made suggestions for frequency of blood tests, for the home team to formalise an acute resuscitation plan, one on one nursing care and strict fluid balance records (input/output).
	Nursing AM: Mr Kelly was noted to be alert but disoriented, was refusing diet and fluids and nursing care, and remained incontinent staying in bed for the shift. Nurse documented early warning score – error. He remained incontinent of urine and rejected all offers to change his clothing. His family tried to assist him to the bathroom, but it was documented he was unable to mobilise. At approximately 11:45 am Mr Kelly had a peripheral intravenous cannula (PIVC) inserted, bloods were taken, and he was ordered

DATE	ieMR documentation summary
	some IV fluids. The insertion of the PIVC and taking of bloods was achieved with the assistance of his NDIS support worker's encouragement. Nursing notes indicated that pathology called the ward to notify medical staff that Mr Kelly's sodium (Na) level was high at 190 (normal 135-145). Medical staff were made aware and advised they would follow up. There was a further call from pathology at 12:35 pm updating medical staff that Mr Kelly's coagulant results were also abnormal. Plan of care was to continue as per the treating team. **Nursing PM:** At 3.00 pm the patient flow nurse recorded retrospective notes in the ieMR from the meeting with medical staff, social work and Mr Kelly's family held on 28 July 2022. Notes indicate Mr Kelly's mother was not happy to take him home as she did not think she was able to manage, and wished for him to remain in hospital in a single room until emergency respite was available. The patient flow nurse explained the limited availability of single rooms; these were reserved for patients who are infectious or have respiratory illnesses, and reiterated the expected discharge date was Friday 29 July 2022, explaining Mr Kelly had a safe home to discharge to and could be cared for by his mother with increased support as already discussed. Mr Kelly's circumstances were discussed with the NDIS coordinator who advised the options for discharge were to return home into the care of his mother with additional support (previously declined by his mother) or discharge to medium term accommodation for maximum of 12 weeks where assessments could be completed and complex care team support given. Patient flow nurse discussed this with medical consultant who advised Mr Kelly was currently unwell, but he agreed with potential options for discharge. Patient flow nurse and social work were to have further discussions with Mr Kelly's mother regarding discharge planning. Ward nursing staff documented Mr Kelly was more compliant with interventions and cares. He continued to refuse oral intake and remained in bed. He had attempted to get up to use the commode; however, he was too weak to transfer. He allowed staff to put a uridome in place to collect his urine output,[31] and have his observations recorded which indicated he had low oxygen saturations (94%) and shallow rapid breathing (34 bpm). Mr Kelly was receiving intravenous (IV) fluids and allowed staff to conduct a bladder scan. Plan of care was to continue as per management plans. **Nursing Night:** Mr Kelly continued to have IV fluids administered, refused for vital signs to be taken but noted his respiratory rate was 32 bpm at 12:07 am.
	Social Work: Meeting held with Mr Kelly's mother and discussion about options for discharge, should Mr Kelly be medically stable for discharge in the future. Mr Kelly's mother expressed she was unsure of what to do and requested input from GCSR, this was followed up by the social worker. During the meeting the Medical Consultant attended to provide an update that Mr Kelly had deteriorated, his mother became distressed, and the social work intervention became about providing emotional support and reassurance.

[31] A uridome is an externally worn device designed to collect urine.

DATE	ieMR documentation summary
2 August 2022	**Medical AM:** At 0520 hrs and 0745 hrs on 2 August 2022, medical staff attended Medical Emergency Team (MET) calls for Mr Kelly due to him being tachypnoeic (respiration rate 40bpm) and hypoxic (oxygen saturations 90%). On examination he was noted to be more drowsy, only able to answer yes/no to questions, was less combative and allowing for more interventions and assessments. The impression was he was suffering from severe dehydration resulting in significant metabolic derangement, profound uraemia, hypernatremia, stage three acute kidney injury and hypoxia. Mr Kelly's condition was discussed with the ICU Registrar who suggested continuing with IV rehydration using IV Glucose 5%; he was not an urgent dialysis candidate due to severe hypernatremia. The plan was made for repeat blood tests, commence on IV antibiotics and Heparin for venous thromboembolism prophylaxis. After the second MET call there was discussion with the Medical Consultant who advised the ceiling of care had been established with Mr Kelly's mother, under (EPoA), and she wished for all interventions except cardiopulmonary resuscitation (CPR). However, this unfortunately may be a terminal admission for Mr Kelly. The information related to the MET calls was relayed to the ICU team. Medical Consultant noted in the record the events of the past 24 hours, Mr Kelly's renal impairment and severe electrolyte disturbance and a discussion with his mother regarding the implications of his condition for his survival of this admission. The limits of care were discussed with Mr Kelly's mother, and she expressed her wishes for all interventions except CPR, given there was a reasonable chance of recovery, and that despite his disability he had a relatively good quality of life. Medical Consultant opined Mr Kelly's current condition was related to him no longer drinking fluids after being transferred to a four-bed bay, as the bathroom was reported by his mother as being a refuge for him when stressed. Nursing staff reported no witnessed drinking over the weekend. Medical Consultant wrote, 'This would have been avoided had his behaviour been appropriately treated in the community or been taken home into an environment where he was drinking'. RMO reviewed Mr Kelly on this morning, noting the events overnight and a discussion with his mother regarding cares sought. He documented Mr Kelly was not for CPR but for all other life prolonging measures. There was discussion regarding ICU and that there was nil likely benefit and that the deterioration, 'is due to poor environment/inpatient and reluctance to drink whilst here'. Noting Mr Kelly's mother 'appears to understand' and said, 'maybe it was a mistake we didn't take him home'. The RMO wrote that Mr Kelly's mother was quite thankful of service and care being provided currently, wanted to know if he significantly deteriorates and understood the guarded prognosis and that progress in the next 24 hours was critical in his survival of this admission. The plan was to increase IV fluids, attempt more blood tests, finalise the acute resuscitation plan (ARP) and for PICC line. Meeting held with Mr Kelly's parents, the ICU Senior Medical Officer and Medical Consultant in attendance. The ICU SMO documented there was discussion regarding Mr Kelly's current condition and treatment, the family's understanding that medical staff were trying to optimise therapy in the ward and all agreed that he is not currently for

DATE	ieMR documentation summary
	ICU; however, the ICU team will continue to visit and provide input as requested. He also noted he is not for ICU, intubation, ventilation or dialysis although this could be rediscussed in future dependent on recovery from current critical metabolic catastrophe. **Medical PM:** Reviewed by second ICU Consultant who noted a summary of his history, current status on examination and previous discussions regarding Mr Kelly's consent or refusal of treatment. The ICU Consultant thought this was now 'moot' because of Mr Kelly's level of biochemical derangement. Discussion with the family was documented including the risk of death, possible modes of death and that all sensible options for therapy were appropriate, and accordingly his opinion was that for the best chances of survival an admission to ICU was warranted. The variable timeframe for the course of care was raised and there was an agreement with the family that any issues that arose along the way would be discussed at that time and a plan made rather than having a blanket ARP in place. After discussion with the treating team and hospital administration Mr Kelly was transferred to ICU.
	Nursing Night (documented at 7:04 am): Mr Kelly's vital signs at 0520 hrs were documented as respiration rate was 40 bpm and oxygen saturations were 90% on room air and he was complaining of shortness of breath. At 0525 hrs a Medical Emergency Team (MET) call was activated and staff applied oxygen via nasal prongs. When the Medical Registrar arrived the oxygen therapy was increased, an Electrocardiograph (ECG) and blood tests were taken, and a chest x-ray was attended at the bedside. The MET call was ceased at 0550 hrs, and it was noted that Mr Kelly continued to be monitored. **Nursing AM:** Second MET call was activated at 0725 hrs when Mr Kelly's respiratory rate was recorded at 41 bpm, and his oxygen saturations were 93% on four litres of oxygen delivered via nasal prongs. A Clinical Team Coordinator (CTC) nurse attended the two MET calls activated. The plan following the second MET call was to wait for blood gas results, chest x-ray and for discussion with ICU. Nursing plan was to await treating team review of Mr Kelly for further management and assessment and to consider moving him back to a single room and notify CTC if concerned. Student nurse documented midmorning that Mr Kelly was noted to be hyperventilating from the start of the shift, and he appeared tired, unenergetic and unusually compliant. Following the second MET call Mr Kelly became agitated, refused food or fluids and observations and was constantly removing nasal prongs. He also became agitated when staff attempted to perform oral hygiene measures, attempting to snap the swab being used. At 10.00 am Mr Kelly was moved to a private room which, according to the notes, seemed to relax him slightly. At 1110 hrs, Mr Kelly's respiratory rate of 39 bpm and oxygen saturations of 95% on four litres of oxygen per minute via nasal prongs. Mr Kelly's family reported he was having chest pain as he was grimacing and touching his chest; an ECG was taken which was normal. The team leader was notified, and the CTC was present when the ECG was taken. He continued to refuse any food or fluid orally and his family were present. Nursing staff documented that an hourly fluid balance was maintained, noting Mr Kelly

DATE	ieMR documentation summary
	had a uridome insitu and it was draining well. The plan of care was as per the treating team; he was for transfer to ICU. Mr Kelly's care was handed over to ICU nursing staff at 2.00 pm.
	Social Work: Reviewed, noted the current situation and that Mr Kelly was not currently appropriate for discharge planning and would be referred back to acute social work who could monitor the situation and provide emotional support to the family.
2 August – 23 August 2022	Mr Kelly's care was managed in ICU until he passed away on 23 August 2022. The ICU Consultant noted in the ieMR on that date that Mr Kelly had suffered from severe hypernatremia and the subsequent resuscitation caused severe brain injury, pontine myelosis (sic),[32] and thrombolytic/embolic cerebral infarcts. In addition to this he had severe renal, hepatic, cardiovascular, respiratory, and bone marrow impairment during the ICU course.

7.3.3 Medical Consultant's account of events[33]

Emergency Department

Topic	Comment
21 July 2022	*'... received a call from an emergency department physician requesting a medical admission for Mr Kelly. The case was made for a 45 year old gentleman who had lost a significant amount of weight over the last few months secondary to a presumed behavioural disturbance, on a background of severe autism, intellectual impairment and PTSD. The emergency doctor added that Mr Kelly had been heavily sedated, owing to his behaviour, and was not in a condition to be discharged. Also, a referral to the Emergency Psychiatry Service had been made prior to referring to general medicine, but was denied ...'.* *'... the presentation appeared to be psychiatric in nature. Blood results were normal and the emergency physician was satisfied an acute medical condition wasn't underlying the presentation. It isn't ordinary practice to visit the emergency department for referrals in Robina Hospital given the model of care at the time'.* The Medical Consultant saw Mr Kelly in the Emergency Department to clarify details of the presentation and determine the most appropriate service to admit him. After consulting with psychiatry regarding admission and being advised his presentation did not require psychiatry involvement, the Medical Consultant considered there was no option but to admit Mr Kelly as a medical patient due to his sedated state at the time and felt he would be able to advocate for psychiatry review once Mr Kelly had been admitted.

[32] Referring to Pontine Myelinolysis, an acquired life-threatening neurologic disorder which can occur as a consequence of too rapid correction of hyponatremia. See B.K. Kleinschmidt-DeMasters and M.D. Norenberg, 'Rapid correction of hyponatremia causes demyelination: relation to central pontine myelinolysis' (1981) *Science* 1068–70.
[33] RD\25\79110 Letter to the OHO from Medical Consultant,11 June 2025; RD\25\160991 Recorded Practitioner Interview

Topic	Comment
Information provided to Medical Consultant by Mr Kelly's mother	*'Mr Kelly hadn't eaten or drunk anything in the last 2 months.*[34] *At this point, Mr Kelly had bloodwork done, which demonstrated normal renal function, electrolytes and protein levels'.* The Medical Consultant noted that *'this wasn't in keeping with the history obtained regarding his oral intake'* and sought to obtain further details. *'… he normally used the bathroom to regulate his emotions and she would see him going to and from the bathroom with a cup, saying he could have been drinking without her actually witnessing. Without dismissing it entirely, this history combined with his normal renal function [suggested] that his oral intake perhaps wasn't as diminished as reported'.""* *'[Mr Kelly's mother] said Mr Kelly had not displayed combative behaviour at home until he was told to come to hospital. Queensland Police and Ambulance services were involved in getting him to hospital. So far, Mr Kelly's Emergency Department stay was predominated by attempts to moderate his behaviour, physically and chemically. Behaviour escalated when he was told he had to stay in hospital. This [suggested] that the hospital environment itself was an adverse trigger and source of distress for Mr Kelly. And this should be kept in mind when considering what could be achieved with admission versus outpatient strategies'.* *'Mr Kelly had been preoccupied with thoughts of mortality, asking questions about death and dying. [Mr Kelly's mother] reported that recent events had cultivated this behaviour. Including the deaths of two famous cricketers (of which Mr Kelly was a fan), Ukraine crisis, and allegedly a NDIS worker telling Mr Kelly that he wouldn't be able to live with his mother forever because she would die before he does. The latter provoked an acute reaction in Mr Kelly, where he was found at 5am on the front porch of his house with his bags packed. This [suggested] his presentation may be of a psychiatric disorder, and that his reduced oral intake was a symptom of same'.*
Psychiatric involvement	The Medical Consultant reported direct contact with the psychiatric department; however, there were challenges in facilitating a referral while Mr Kelly remained in the Emergency Department. Following admission to the medical ward, the Medical Consultant submitted a referral to the CLP team and was assured that Mr Kelly would be reviewed. Subsequently, psychiatry documented entries in Mr Kelly's progress notes, which led the Medical Consultant to believe that an in-person assessment had occurred. It was only after Mr Kelly's death that the Medical Consultant became aware that no physical review had taken place and that the progress note had been recorded remotely.
Behavioural challenges	The Medical Consultant reported that they *'… witnessed Mr Kelly become extremely agitated. He'd just been told he wasn't going home that morning. He was physically restrained by several security personnel, pinning him to his trolley and intramuscular*

[34] It is not clear to the OHO whether this is a transcribing error or an error in the information provided by Mr Kelly's mother or a misunderstanding of the same.

Topic	Comment
	sedation was forcefully administered. Within 10 minutes following the sedation, Mr Kelly rose from his trolley and fell heavily onto the floor of the department. He appeared deeply sedated, eyes half open and could not walk unaided'. *"... He had normal bloodwork and observations, and was being further sedated by emergency staff to keep him in hospital ... [it was clear] a least restrictive path should be adopted."* As the Psychiatry team did not conduct an assessment in the Emergency Department, the Medical Consultant determined that admission to the general medical ward was necessary due to Mr Kelly's sedated state. The Medical Consultant intended to seek further psychiatric review following admission to determine the appropriate management of Mr Kelly.

Medical Ward Stay

Topic	Comment
Admission to Medical Ward	*'Mr Kelly was admitted to a single room on the medical ward where he would have access to his own ensuite. A registered nurse special and security personnel special were present. Behavioural plans were in place, both non-pharmacological (first line) and pharmacological measures'.* The Medical Consultant reported that Mr Kelly's mother provided advice on the optimal approach to Mr Kelly's behaviour. '*Examples include reorientation with use of soft music and low stimulus environment, turning on TV, topics of interest include ten pin bowling, football and cricket. Favourite foods, McDonald's fries and ice-cream. Allowing Mr Kelly use of the bathroom for long periods of time as he uses this for emotional self regulation. This approach was reinforced by the ward psychologist who recommended the Behaviour support plan be guided by [Mr Kelly's mother's] suggestions on how to engage Mr Kelly. However, there was no access to a formal Positive Behaviour Support Plan (PBSP)'.* The Medical Consultant acknowledges that this may have been useful. *'Pharmacological measures were also documented (Olanzapine 5-10mg IM) as PRN orders'.* The Medical Consultant noted that pharmacological measures were to be avoided unless Mr Kelly was at imminent risk.
Consideration of NGT feeding	*'On the first day, ... [the Medical Consultant and treating] team and the ward dietitian had a meeting with [Mr Kelly's mother] to discuss nasogastric tube (NGT) feeding. ... At the end of the discussion, all agreed keeping an NGT down was untenable, and the risk/benefit balance not being in Mr Kelly's best interest. The risks involved the amount of sedation required to insert the tube, and further maintaining sedation to prevent him pulling the tube out. He had already pulled out an IV cannula. This decision was*

Topic	Comment
	considered in the light of what happened in the emergency department, his normal bloods, and now being in a quieter, more stable environment with his own bathroom'.
Recording observations	*'Over the course of the week, there had been documentation of partially eaten food at Mr Kelly's bedside, food visible in his mouth and teeth, water jug 1/3 empty, observed to drink Powerade and walking to bathroom with a cup. Family were bringing him foods they knew he enjoyed. … He [Mr Kelly] was still not allowing observations or blood tests. Nursing staff had voiced concerns for their safety with taking [his] observations. He appeared alert, well perfused, ambulating around his room, … it was much more of a risk to sedate him for blood tests and observations'.*
Consultation with senior colleagues	The Medical Consultant noted that discussions were held with two senior colleagues about Mr Kelly's case during his admission. Consideration was given to '*… weighing risks and benefits of sedation, and the adverse effects of the hospital environment'.* An alternative preferred path of action could not be determined.
Considerations re discharge	*'Later in the week, a decision to plan for discharge was made. … [It appeared that] Mr Kelly wasn't suffering from an acute [sic] psychiatric disorder, but rather emotional dysregulation from recent events. He was at risk of this worsening again due to the hospital environment. Mr Kelly had made apparent gains in oral intake during the first week'.* Consideration was given to Mr Kelly recovering at home. '[Mr Kelly's mother] mentioned her son was not combative at home'. The Medical Consultant considered that Mr Kelly would be less agitated away from the hospital environment and where the staff '*… knew he was drinking adequately'.* Following discussions with Mr Kelly's family, a decision was made for him to remain in hospital. The Medical Consultant advised that the discharge plan was not supported by Mr Kelly's family or his NDIS support network, and this was taken into account when determining that discharge was not appropriate. The Medical Consultant confirmed that Mr Kelly would not be discharged without unanimous agreement from his family, care providers, and medical team. The Medical Consultant further clarified that the consideration of discharge was not influenced by bed availability or expedience at the expense of care. Rather, the rationale was based on concerns that the hospital environment might be causing undue stress for Mr Kelly. It was noted that, while at home, Mr Kelly had at least been maintaining some oral intake, which was viewed as a positive factor in his overall wellbeing.
Deterioration	*'Mr Kelly had been moved [without the knowledge of the Medical Consultant] from his ensuited single room to a four bed bay with a shared bathroom. [Mr Kelly's mother] had mentioned at the beginning, Mr Kelly used his bathroom to self regulate and he would drink from the bathroom'.*

Topic	Comment
	'[On Saturday] Mr Kelly was noted by nursing staff to have been incontinent in bed. This was new, he would normally toilet himself and had been doing so till this point in the admission. On the following day, Sunday, he was again incontinent, and observations were able to be taken. The latter [signalled] that there was a significant change in his clinical state, as this was not achieved previously without sedation'. *[On Monday] … Mr Kelly [was] obviously unwell, drowsy, with deranged vital signs'.* The Medical Consultant advised he was not aware of the plan to move Mr Kelly to a four-bed bay. Given Mr Kelly's need for a low-stimulus environment, he felt this change contributed significantly to his deterioration, noting that while in the single room Mr Kelly had been able to use the bathroom to self-regulate and likely access water to drink. The Medical Consultant noted pre-emptive discussions regarding resuscitative measures of Mr Kelly with his mother and the possibility of transfer to ICU. *'[There was indication that] Mr Kelly had become septic, bloodwork returned with hypernatraemia and acute renal failure, indicating dehydration. … Referral was made immediately to ICU and treatment was initiated on the ward to correct the abnormalities'.* *'In the early hours of the next day, Tuesday, two emergency calls were initiated for deranged vital signs. ICU were present at both and had organised another family meeting …. The outcome was to optimise therapy at the ward level … with the addition of a PICC line and low rate Total Parenteral Nutrition'.* Following a meeting, Mr Kelly was accepted into ICU.

7.3.4 Intensive Care Consultant's account of events[35]

DATE	Comment
1 August 2022	*'2.2 Mr Kelly was first referred [to the ICU Consultant] on 1st August 2022 at approximately 02.30pm for hypernatremia of 188 mmol/L and acute renal failure.* *2.3 Mr Kelly was initially admitted 11 days earlier for weight loss, poor oral intake and difficulty managing in his home situation. During this time in hospital, he had minimal enteral intake, and the last blood test was performed on 21st July 2022 at which stage his sodium was 146 mmol/L and he had normal renal function.* *2.4 Clinically, his observations where stable, he did not require oxygen and did not appear fluid overloaded. He had an acute kidney injury with a creatinine of 396 and urea of 53 but the pH and potassium 4.2 were normal. It was noted that this was a newly diagnosed event secondary to severe dehydration, and he had been started on the fluid*

[35] RD\25\80808 Letter to OHO from ICU Consultant, 12 June 2025.

DATE	Comment
	therapy in the last 1 hour. It was noted that he was not refusing any treatment at that point of time. *2.5 [The ICU Consultant's] overall conclusion was that he was hemodynamically stable and, as we had just started him on new treatment, it was worth assessing his response to it. Noting, this treatment stayed the main line of treatment even after 24-36 hours post ICU admission.* *2.6 [The ICU Consultant] advised the home team to proceed with slow re-hydration and careful correction of the hypernatremic and hypertonic state, accurate urine output measurement using an IDC and placement of a PICC line for ongoing IV access and TPN. [The ICU Consultant] advised against early dialysis because of the risks of rapid serum sodium fluctuation. [The ICU Consultant] considered him high risk for refeeding and hence did not advise aggressive feeding at this stage. [The] plan was to reassess his clinical progression and biochemistry in 6-8 hours.* *2.7 [The ICU Consultant reported Mr Kelly was] re-reviewed at 7:00pm that evening. His observations had remained stable during this time. On reassessment it was noted that on repeat bloods his sodium had improved to 185 mmol/L. [The ICU Consultant] would normally aim that correction would not exceed 10 mmol/24 hours. Bladder scan showed 300 ml urine in bladder, but an IDC had not yet been placed. It was noted that the patient had not been moved to the private room and the home team was requested to do so. There is a note written in retrospect the next morning, as this was an afterhours review.* *2.8 [The ICU Consultant] met Mr Kelly's mother, at this stage and expressed overall clinical concern. [Mr Kelly's mother] told [the ICU Consultant] that he had a reasonable quality of life, but she also expressed that, in her opinion, Mr Kelly 'would not want all this'. [The ICU Consultant] documented this the next morning and referred to comments made by Mr Kelly's mother] as 'patient's wishes'. [The ICU Consultant] did not pursue any limitation of care at that stage and the decisions made were on the basis of clinical assessment of Mr Kelly.* *2.9 Mr Kelly had 2 MET [Medical Emergency Team] calls overnight for hypoxemia with a CXR [Chest x-ray] showing new infiltrates and he was started on antibiotic treatment and low flow oxygen therapy via nasal prong. It was noted that the trigger for the MET call was a new pathology which was unrelated to the problems referred to [the ICU Consultant] on 1st August. Mr Kelly was catheterised and was making good urine. Based on the sequence of events, the home team contacted Mr Kelly's mother, and she was made aware that this could be a terminal admission. [Mr Kelly's mother] was advised of the guarded prognosis. The Acute Resuscitation Plan was established, and Mr Kelly was not for the CPR'.*

DATE	Comment
2 August 2022	*'2.10 The multi-disciplinary team meeting involving the General Medicine Physician, Mr Kelly's mother, father and [ICU Consultant], was conducted the next morning. Based on the clinical trajectory, new complication, and overall progression, the ceilings of care were established that intubation, dialysis and CPR will cause more harm than benefit. [The ICU Consultant] noted that the list of complications referred to in the cause of death substantiated concerns that the risk of ICU interventions outweighed the benefit. The home team was requested to get dietitian input and consider low rate TPN infusion considering that he was at a high risk of refeeding. [The ICU Consultant] was very well aware about his chronic malnutrition and tried to address this issue on higher priority. Even after setting up the limits of care, [the ICU Consultant] suggested that ICU admission should still be considered. By saying this, [the ICU Consultant] left the option open to discussion in a wide consultant group forum in ICU. The main reason for this was [the ICU Consultant's] concern based on the complexity of the case and to facilitate a group consensus'.*
4 August 2022	*'2.11 Reviewing my consultant colleague's notes from 4th August, it can be noted that Mr Kelly was discussed in the ICU cross campus meeting at 11.30am (this meeting happens every day) and was accepted for ICU admission even before his review. This was also discussed with hospital administration because of the overall complexity of the case. Mr Kelly stayed on the same line of management for more than 24 hours post ICU admission. It was a joint admission by [the ICU Consultant and his colleague].* *2.12 [Mr Kelly's mother] continued to raise her concerns about Mr Kelly's discomfort from the day he was intubated. The notes from 4th August highlight it as a primary concern rather than his metabolic issues and other complications. This again highlights [Mr Kelly's mother's] input during the previous meetings.* *2.13 Unfortunately, Mr Kelly developed barotrauma and shock status post intubation, cerebral pontine myelinolysis post sodium correction with dialysis, febrile neutropenia, agranulocytosis, LL DVT, ischemic hepatitis, ileus, HSV aphthous ulcers.* *2.14 [The ICU Consultant] did not agree that there was evidence of unconscious bias. [The ICU Consultant] noted that on initial assessment it was very obvious that Mr Kelly's overall prognosis was guarded, multidisciplinary input was appropriately considered, and ICU tried their best to help Mr Kelly'.*

8 Findings

8.1 Clinical care

The National Safety and Quality Health Service Standards (NSQHSS) highlight that coordinated care is fundamental to patient safety and quality outcomes. Coordinated care requires effective communication, collaboration and systems to manage care transitions, reduce fragmentation, and ensure patients receive the right care at the right time.[36] The NSQHSS outlines key elements to delivering comprehensive and coordinated care tailored to the needs of patients and these include multidisciplinary collaboration, effective communication, care planning and handover and transitions of care.

Comprehensive care is about delivering healthcare informed by a person's clinical and personal needs and preferences. It is shaped by shared decisions, planned and delivered in partnership with the multidisciplinary team, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate.[37] In this case medicine, psychiatry, nursing and allied health teams were involved in Mr Kelly's care. Although each of these teams reviewed Mr Kelly and recorded information in the progress notes, it was evident there was an absence of a cohesive, patient-centred comprehensive care plan available at point of care. This clearly contributed to the lack of recognition and appropriate response to the severity of his condition and subsequent deterioration.[38]

8.2 Analysis of issues

Mr Kelly's medical records indicated he presented to Robina Hospital ED on two occasions in 2022. On both occasions he was noted to have been suffering from behavioural disturbance resulting in inadequate oral intake with a background of ASD and intellectual disability. On his first presentation in May 2022, he was also exhibiting gastrointestinal symptoms. On presenting in June 2022, he was noted to have had rapid weight loss, be a high refeeding risk and was not responding to treatment in the community. On both occasions Mr Kelly was admitted under a Medical Consultant to a medical ward in the hospital.

His admission to a medical ward was appropriate as outlined in the *Queensland Eating Disorder Service Guide to Admission and Inpatient Treatment (QuEDS Guide),* which informs admission decisions for cases involving overlapping medicine and psychiatry issues by outlining medical parameters to guide admission pathways.[39] According to the *QuEDS Guide*, medical monitoring is the cornerstone of treatment in both inpatient and community settings. For those patients admitted to a medical ward, CLP teams are available to provide

[36] Australian Commission on Safety and Quality in Health Care (ACSQHC), 'National Safety and Quality Health Service Standards' (2nd ed.2021). See particularly Standard 5 Comprehensive Care Standard, Standard 2 Partnering with Consumers Standard and Standard 8 Recognising and Responding to Acute Deterioration Standard.
[37] Australian Commission on Safety and Quality in Health Care, 'National Safety and Quality Health Service Standards' (2nd ed. 2021). See Standard 5 Comprehensive Care Standard.
[38] Ibid.
[39] 'QuEDS Guide to Admission and Inpatient Treatment', Queensland Health (Guideline, July 2020). Document referenced in GCHHS Policy/Procedure documents provided to OHO.

adequate, regular and frequent support to medical teams to assist with patients' behavioural and psychological management.

The investigation raised concerns regarding the medical monitoring of Mr Kelly's condition and the adequacy of the involvement of the CLP and allied health teams in his care and treatment.

8.2.1 Medical team

First admission

During Mr Kelly's first admission medical staff appropriately undertook investigations to exclude medical causes of his refusal to eat and drink and reported gastrointestinal symptoms. He underwent clinical examination, observations, abdominal x-ray (which was reported as normal) and blood tests which ruled out any signs of infection and any other physical cause for his restricted eating pattern. Recognising the need for mental health involvement, the General Medical team completed the necessary referrals to the CLP service for review on two occasions during this first admission.

The General Medical team's assessment of Mr Kelly on this admission concluded that there was no medical cause for his behavioural disturbance and refusal of oral intake. He was assessed as medically stable and suitable for discharge after review by psychiatry and the dietician on 30 May 2022. The only follow up care arranged was a dietician referral requesting review in 3-4 months by the Home Enteral Nutrition Support Dietician. Records obtained indicated Mr Kelly's GP received a medical discharge summary which did not contain any documented plan for follow up.

Second admission

On Mr Kelly's second presentation, the Medical Consultant reviewed him in ED and requested a CLP review via phone. This review occurred the day after Mr Kelly's admission and the Psychiatry Registrar noted the review was for advice regarding pharmacological management of behaviour. There was no evidence that any further formal requests for CLP involvement in Mr Kelly's care were made during this admission, nor that any service requests were opened by the psychiatry team.[40]

The investigation identified concerns regarding the plan of care documented for Mr Kelly during his second admission. Over the period Mr Kelly was admitted to the acute medical units on his second admission, his plan of care was not clear despite the ED documentation outlining his significant weight loss since last admission, refusal to eat or drink, changes in his behaviour and attention to self-care, and note that he appeared moderately dehydrated.

[40] GCHHS Submission (June 2025): 'This assessment was based on the clinical understanding that Mr Kelly did not have a mental health condition and that his presentation was a consequence of behavioural disturbances of severe autism – a reflection of the training of GCHHS staff in relation to this cohort of patients (training that represents the norm in Australia). In addition, it was on the background of an initial assessment by the CLP services and a psychologist who had provided advice on impression and management'.

Medical staff focused care initially on minimising stimulation and managing the aggressive behaviour he had displayed in the ED (with medications if necessary). Over the course of his stay the focus shifted to encouraging food and fluid intake, seeking allied health input from dietetics, social work and psychology, and planning for discharge. There were no records indicating any investigations performed on Mr Kelly for the first 10 days after he was admitted to an acute medical ward and no clear diagnosis or documented treatment plan incorporating strategies to increase oral intake.

Mr Kelly had pathology collected on 21 July 2022 in the ED which was noted to be largely unremarkable. Although blood tests appear to have been ordered by medical staff during his admission period on the medical wards, nursing staff consistently noted he refused to have bloods collected. Medical staff also requested for Mr Kelly to be administered an oral sedative to assist with blood collection; however, he refused to take the medication. No further pathology was collected until 1 August 2022, by which time his results were severely deranged.

Mr Kelly's admission status was changed from acute to maintenance on 29 July 2022, with a plan to await discharge destination. The medical staff reportedly persisted with the plan for discharge believing that Mr Kelly's admission to hospital was exacerbating his issues with restrictive eating and drinking by contributing to his stressors. The clinical problem leading to his admission was unchanged and there was an absence of documentation of any reassuring evidence such as a physical examination, observations or blood work in the clinical record indicating he was fit for discharge. It was evident in the clinical records that the medical team were focused on discharge planning and increasing community support and not on his nutritional status. There was no plan to provide emergency nutritional support as an inpatient, even when the family actively requested this. The clinical records indicated that Mr Kelly lacked capacity, and that his mother was his substitute decision maker under the *Guardianship and Administration Act 2000* (Qld) and was appointed under an EPoA to make decisions on his behalf.

The treating team maintained the belief that Mr Kelly was suffering from behavioural disturbances of severe autism, which were exacerbated by the hospital environment, and discharge was the best course of action for improvement. Despite pleas from his mother that she was not able to cope with caring for Mr Kelly in the community with his medical and psychological decline, the plan remained to progress towards discharging him to her care. The Medical Consultant's opinion, documented in the clinical record, was that keeping Mr Kelly in hospital was delaying appropriate specific treatment which should have already been implemented in the community, although he did not document what that treatment was. The Medical Consultant also noted he was unaware of any steps taken by Mr Kelly's care provider, NDIS, to address his behavioural disturbance, despite knowing about it for two months. There was no record that contact was made with Mr Kelly's GP seeking information related to his care in the community since his previous admission or what prompted the decision for referral to the ED prior to this admission.

The clinical record did contain a letter, dated 22 July 2022, from the clinical psychologist who had been providing support to Mr Kelly in the community. This letter outlined Mr Kelly's decline in physical and mental health and the impact of this on his mother as care giver. The psychologist documented recommendations to assist Mr Kelly and his family upon his discharge from hospital and included review by a suitably qualified Behavioural Support Specialist and a dietician to assist with meal planning and weight tracking. The emergency examination authority signed by Mr Kelly's GP,[41] was also in the clinical record and outlined that Mr Kelly was refusing to eat, had lost 24 kgs in past weeks, was non-communicative, and was suffering from depressed mood, suicidal ideation and anxiety. The document indicated Mr Kelly was not responding to medication or psychological counselling undertaken in the community and was at risk of medical and psychological decline.

The measures undertaken to monitor Mr Kelly's health status while he was a patient on the medical wards at Robina Hospital during his second admission were grossly inadequate. There was a lack of observations recorded, inadequate monitoring of his food and fluid intake, no pathology tests for more than 10 days and no formal referral for psychiatry review. This may be attributed to the treating team's wish not to cause Mr Kelly distress, escalate his behaviour and further alienate him from healthcare providers as recorded in the clinical notes. However, this lack of clinical information and assessment arguably led to a failure of medical staff to recognise the severity of his medical compromise and adequately act. Mr Kelly was referred to CLP for advice regarding pharmacological management of behaviour early on in his second admission; however, there was no other evidence of any follow up referral being made for psychiatry input during the admission.

After Mr Kelly's significant deterioration on 2 August 2022, the admitting Medical Consultant wrote in the record that Mr Kelly's situation would have been avoided 'had his behaviour been appropriately addressed in the community or if he had been taken home to an environment where he was eating'.[42]

8.2.1.1 Clinical expert – physician

Clinical advice was sought by the OHO from a physician with experience in managing patients with eating disorders. The following represents a summary of the expert's opinion on the care provided to Mr Kelly by the medical team:

- Mr Kelly was appropriately admitted to hospital on both presentations to the ED. General medicine units often manage cases where primary carers are experiencing difficulties with their role due to challenging behaviours. In this case Mr Kelly had failed to improve in the outpatient setting, had suffered significant weight loss and behavioural disturbance.

[41] RD\23\55395 ieMR Clinical Record pages 1124-1126.
[42] Ibid pages 447-448.

First admission

- The medical team undertook appropriate measures on the first admission in May to exclude any medical causes of the behavioural disturbance and gastrointestinal symptoms Mr Kelly was exhibiting. He was appropriately referred for a mental health review. This would be the standard of care for a complex patient with a history of autism, depression and PTSD who is refusing oral intake, particularly where the psychology notes reported blunted affect and catastrophic thinking. Patients with autism are known to have a higher incidence of mental health issues including eating disorders (in particular Avoidant Refusal Food Intake Disorder).
- The CLP review of patient notes in the multidisciplinary team meeting seemed inadequate in such a complex patient with a known mental health history. As a general medicine physician, the expert expected an acute medical patient would be seen in person by the CLP team if a consult had been requested. The patient was not reviewed for either of the referrals sent, the notes only referring to collateral from his mother. The notes indicate that a phone call was received from a psychiatrist who had reviewed Mr Kelly, but no notes are recorded in the ieMR.
- Mr Kelly's discharge after the first admission was appropriate from the point of view that the medical causes of the behavioural disturbance and limited oral intake had been investigated and he was assessed as being medically stable.
- While the discharge summary recommended ongoing psychological follow up, there was no information addressing the monitoring of ongoing nutrition or potential risk of ongoing malnutrition on behavioural disturbance. Opinion was that Mr Kelly's grossly inadequate intake was underestimated and not emphasised in the discharge plan. There were no recommendations regarding the behaviour support plan or referral to behaviour support specialist based on the recommendation from the psychologist review. Mr Kelly needed weekly reviews of his weight, oral intake, behaviour disturbance and mental health, bloods and assessment of his mother's coping levels with his GP, similar to any patient with an eating disorder. The summary of care generated following review by CLP on 30 May 2022 did not provide any advice on how the GP might refer for acute mental health support if needed in the future as per policy advice.[43] A general medicine outpatient clinic follow up appointment may have benefited the patient and his family if arranged on discharge.

Second admission

- During Mr Kelly's second admission there was no clear plan by the medical team to provide emergency nutritional support as an inpatient (even where family had actively requested this) or in the community setting where this strategy had already failed following the first admission. The clinical expert acknowledged the difficulties of

[43] RD\24\16048 GCHHS Consultation Liaison Psychiatry – Intake and Patient Review Process Work Instruction (Ver 3) effective 28/11/2023.

managing complex patients with behavioural issues on a medical ward, where the unfamiliar environment may be believed to exacerbate behaviours. However, from an acute medical perspective this patient was suffering severe malnutrition and was medically unstable (in the absence of information such as bloods or observations that would otherwise provide reassurance). Inadequate measures were undertaken to monitor Mr Kelly's health status on the medical ward. Mr Kelly was refusing blood tests, observations, and to be weighed. He had been assessed on admission as lacking capacity and his EPoA, his mother, had become his substitute decision maker under the Guardianship Act. The records indicate she wished for measures to be undertaken to monitor and treat Mr Kelly. While acknowledging the treating team's wish not to cause Mr Kelly any distress or further alienate him from his healthcare providers, the expert physician felt that given his presentation with significant weight loss and the lack of oral intake during his admission, he should have had bloods taken at least every 2-3 days with the least invasive restraint required and daily observations similarly.[44]

- Acknowledging the difficulties that would have been encountered, the expert opined that further consideration should also have been given to supplemental feeding via nasogastric given Mr Kelly's significant weight loss, and the trial of oral intake on the ward was not working resulting in continued inadequate intake. Had this occurred, his deterioration may have been detected and managed prior to an ICU admission being required.
- Mr Kelly's clinical records show evidence of adequate communication and collaboration. Members of the individual teams including medical, psychiatric, allied health and nursing teams communicated with each other and acknowledged the recordings by others by referencing the relevant teams in their notes. It was difficult to determine whether individual department's concerns were escalated appropriately via the ieMR records, for example the inability of the nursing staff to do observations.
- The medical treating team's focus remained on Mr Kelly's discharge and management in the community. The major factor that needed to be addressed aside from his deteriorating behaviour and refusal to engage was his extreme malnutrition and ongoing lack of oral intake. The opinion of the treating team that Mr Kelly should be managed in the community and the continued focus on discharge planning seemed to fracture the therapeutic relationship with the family as it did not address their concerns regarding his physical status and did not treat his ongoing starvation. The clinical expert opined that the decision to aim to discharge Mr Kelly on 29 July 2022 was not based on adequate clinical assessment and was not clinically appropriate.
- During the second admission Mr Kelly was referred to CLP and it seemed from the medical record that he was not examined. The concerns regarding a complex patient with autism and a background of mental health challenges including depression and

[44] RD\24\158501 GL1673 GCHHS, Identification and Management of Refeeding Syndrome in Adults Guideline, (Version 2) effective 12/7/2021.

anxiety not being thoroughly assessed were again noted by the clinical expert, while also noting request for advice on this occasion was specifically for medication advice. Mr Kelly had notable changes in behaviour, significant weight loss of which the association between rigid thinking, personality changes, depression and anxiety are known to be clear in the mental health space (regarding eating disorders). Autism spectrum disorders are known to be associated with a lesser-known eating disorder called Avoidant Refusal Food Intake Disorder (ARFID), which is a psychiatric diagnosis, and there was no evidence in the notes this was considered.

- The clinical expert noted that ASD is not a mental health condition, although it is in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).[45] Patients with autism are often affected by concurrent mental health issues such as depression and anxiety and are often managed by a psychiatrist with a special interest in this area given the complexity of presentations, behavioural difficulties, emotional dysregulation and in Mr Kelly's case concurrent intellectual disability. A review by a psychiatrist with a specific interest in ASD and complex behaviour would have been appropriate, acknowledging that this may not have been available.

8.2.1.2 Recommendations

1. Within six months GCHHS/Robina Hospital will complete an organisation training needs analysis by comparing current available education and competencies related to care of consumers with neurodevelopmental disorders against training requirements arising from the NSQHSS Guide for Health Care of people with intellectual disability. This should include a staff survey allowing staff to self-assess their confidence, skills, knowledge and attitudes in caring for consumers with neurodevelopmental disorders.
2. Within 12 months GCHHS/Robina Hospital will develop and provide access to relevant training and additional resources (best practice guidelines, integrated care pathways, clinical pathways and decision support tools) to:
    a. improve disability awareness among health providers and increase understanding about barriers people with intellectual disability experience when accessing healthcare. Training should address disability awareness, complex care needs, safety and quality risks, reasonable adjustments, legal and ethical considerations (capacity, decision making, human rights considerations, etc.), patient advocacy and increasing awareness of the role of NDIS service providers.[46]
    b. enable staff to recognise when a consumer with neurodevelopmental disorders requires specialist support beyond the health service's scope and ensure awareness of relevant referral pathways.

[45] DSM-5 or Diagnostic and Statistical Manual of Mental Disorders is the American Psychiatric Association's professional reference book on mental health and brain related conditions.
[46] See resources available at: Queensland Government, Queensland Health – People with disability, CheckUp, Australian Government, DoHAC Intellectual Disability Health Capacity Framework and ID Health Education – Health Professionals.

c. educate staff regarding requirements in circumstances when a person's physical, emotional or behavioural state affects their ability to participate in shared decision making and consent to treatment. Ensure information includes how and when to engage substitute decision makers or nominated persons, and guidance on EPoA, Advanced Health Directives and Statutory Health Attorney Frameworks.

3. Within 18 months GCHHS/Robina Hospital will provide the OHO with details of training resources developed and implemented, and data detailing staff attendance/participation in training from each area of the clinical workforce including nursing, medical and allied health.

8.2.2 Psychiatry

First admission

On Mr Kelly's first admission an urgent request for review by CLP was sent by the medical treating team on 23 May 2022. In the request the treating team detailed concerns regarding his risk of deterioration, his flat affect and ongoing behavioural disturbances. Progress notes in clinical records written by the Psychiatry Registrar, on 24 May 2022, indicated Mr Kelly's notes were reviewed and his case was discussed at the MDT meeting (three Psychiatry Consultants were present), where it was recommended referral to social work and psychology in the first instance before CLP involvement.

Mr Kelly was again referred for urgent CLP review on 26 May 2022 by the treating team. The second referral provided details about Mr Kelly's stressors, current medication and behavioural disturbances and indicated the treating team were unsure of what next steps to take.

On 27 May 2022, the Medical Intern documented that a phone call was taken from the Psychiatry Consultant who advised Mr Kelly had been reviewed and for the types of behaviour issues being exhibited Lorazepam is usually prescribed. The Psychiatry Consultant apologised for the Psychiatry Registrar being unable to review Mr Kelly in person due to time constraints.

Clinical notes indicate the Psychiatry Registrar reviewed Mr Kelly on 30 May 2022 by undertaking a chart review and discussion with his mother. There was no evidence in the progress notes of any attempt made to assess Mr Kelly, nor that any assessment took place. The notes outlined Mr Kelly's behavioural disturbance was 'reactionary and secondary' to several identifiable factors and that his oral intake had improved. A primary mental health diagnosis of 'childhood autism' and a secondary diagnosis of 'reaction to severe stress' was recorded following this assessment.[47] Mr Kelly was deemed suitable for discharge from a CLP perspective, and was to continue his regular antidepressants, and be given a three-day

[47] RD\23\55400 CIMHA Clinical Records.

supply of Lorazepam on discharge. It was also suggested his mother seek NDIS support to reassess current funding and consider adding psychology.

The GCHHS CLP intake and patient review process work instruction outlines the process for CLP to accept and action new referral requests. Actions required include:[48]

- Clinicians or registrars allocated to complete newly referred consumer assessments generally review consumers ieMR and CIHMA records to gain an overview of current needs and status as well as history and potential risks prior to assessment.
- Following review, the CLP staff member will inform the treating team, primary nurse or nurse in charge that they have been assessed by CLP, noting any immediate risks or alerts.
- On returning to the CLP office following new assessments, the CLP staff member must attempt to gather relevant information from collateral sources (e.g. family, next of kin, GP) if possible, prior to discussing case with CLP Consultant Psychiatrist.
- The CLP staff member will complete outcomes, diagnosis and smoking status for the consumer in CIMHA to comply with KPI standards.
- The closing process for CLP consumers notes that all consumers must have one of the following: GP letter, Electronic Discharge Summary or Summary of Care.
  - Summary of Care should be completed for consumers who are discharged with ongoing support from Private MH Specialists (Psychiatrists, Psychologists or NGOs) or who are discharging to an out of area address. This must include a summary of CLP involvement, and include diagnosis, risk, medication dispensing concerns, change of medications and advice on how they can refer for acute mental health support if needed in the future.

This work instruction is ambiguous; where it states, 'following review', it is not clear whether it is referring to review of the consumer or review of the appropriate clinical records.

CIMHA records indicate Mr Kelly was not reviewed in person during his first admission; the information documented was recorded as having been obtained through collateral sources including his mother and his clinical record. The focused assessment document contained in Mr Kelly's CIMHA records, dated 30 May 2022, was incomplete and did not include his health-related history, medications, a mental state examination or a risk assessment. The Summary of Care document in Mr Kelly's CIMHA record was incomplete. It contained no information in the risk assessment section or advice on how he could be referred for acute mental health support if needed in the future. Both Mr Kelly's GP and community Psychologist received a copy of the discharge summary from his CLP encounter.

[48] RD\24\16048 GCHHS Consultation Liaison Psychiatry – Intake and Patient Review Process Work Instruction (Ver 3) effective 28/11/2023.

Second admission

During Mr Kelly's second admission to Robina Hospital in July 2022, clinical records indicate that during initial review in the ED the admitting Medical Consultant approached the Acute Care ED mental health team to review Mr Kelly. This request was declined, and the Medical Consultant was directed to contact the CLP Psychiatric Registrar. On 22 July 2022, the CLP Psychiatric Registrar documented in Mr Kelly's clinical record noting the referral received from the Medical Consultant the previous day for advice regarding pharmacological management of behaviour. A review of clinical notes was undertaken, and the CLP Psychiatric Registrar acknowledged Mr Kelly's weight loss of approximately 25 kg in the last two months. The CLP Psychiatric Registrar recorded Mr Kelly's history as discussed with his mother, including his withdrawal and minimal engagement, restrictive eating, psychologist care in the community and behavioural disturbance in the ED which was attributed to overstimulation while in ED and 'not being able to get his way', resulting in aggressive behaviours. Suggestions for pharmacological management, as discussed with the CLP Psychiatrist, were documented and it was noted that if further CLP input was needed a formal referral would be required. In their submission dated 30 June 2025, GCHHS noted the contact made for CLP input on 22 July 2022 was very specific to pharmacological management of behaviour. The response provided to the referring officer was within scope of a CLP service and appropriate to the question posed by the medical team.

There was evidence in the clinical record that the CLP team provided advice over the phone on other occasions during this admission, although there was no evidence of a formal referral, or that any assessment of Mr Kelly occurred. On 25 July 2022, the RMO documented as part of the plan of care CLP advice would be sought regarding possible appetite stimulation. On 26 July 2022, the RMO noted in the clinical records he had discussed Mr Kelly with the Psychiatry Registrar who advised that oral disintegrating Olanzapine could be considered. The RMO noted he would discuss this with the Medical Consultant. On 1 August 2022, the RMO noted there had been a discussion about GCH psychiatry performing an inpatient review after Mr Kelly's family requested a private disability specialist psychiatrist to come and perform an assessment. There was no evidence in the clinical record that this occurred.

The GCHHS submission, dated 30 June 2025, acknowledged that 'no subsequent referrals were made to CLP and hence for further input from a psychiatry perspective. This was based on the understanding that Mr Kelly did not have a primary mental health disorder (the neurodevelopmental disorder noted by both CLP and the medical team)'. GCHHS acknowledged that with hindsight this was incorrect.

Provision of comprehensive healthcare relies on clinicians to appropriately assess patients' conditions and risks.[49] The decision by psychiatry to passively assess Mr Kelly by obtaining collateral information from his mother and conducting a chart review without directly

[49] Australian Commission on Safety and Quality in Health Care, 'National Safety and Quality Health Service Standards' (2nd ed. 2021). See Standard 5 Comprehensive Care Standard.

evaluating his condition demonstrated a lack of proper consideration of his complex medical and psychiatric needs. Arguably this resulted in missed critical signs required to develop a full picture of his presenting issues and determine appropriate intervention in collaboration with the treating team.

8.2.2.1 Clinical expert – psychiatry

Clinical expert opinion was sought from a specialist psychiatrist [50] regarding aspects of care provided to Mr Kelly during his admissions to Robina Hospital. The following is a summary of the expert's opinion in relation to relevant aspects of Mr Kelly's care:

First admission

- Mr Kelly's admission to hospital was appropriate. On presentation in May 2022, he needed admission for investigation to determine the reason for his recent deterioration and because his mother was at risk due to his aggression, and she was unable to provide the care needed.
- Mr Kelly's referral for psychiatric review on his first presentation was appropriate in the context of being unable to identify a medical problem that could explain his presentation, or advise about management of his behaviour and any specific treatment indicated. Additionally, he had two significant mental disorders (autism and intellectual disability) putting him at higher risk of developing mental illness. He presented with change in his usual self and behaviour that involved a degree of risk. Although CLP assessment was appropriate, Mr Kelly was not seen, the assessment form was incomplete, and a full psychiatric history and mental state examination was not recorded and presumably not undertaken. The incomplete assessment meant there was insufficient data to support the formulation and subsequent management planning process. The initial management plan and follow up recommendations were inadequate as they did not address the presenting problems, consider the risks or address the need for ongoing monitoring and review.
- It is unclear why Lorazepam was recommended other than for behaviour issues, although it is not clear what behaviours were being referred to. Evidence is that medication is ineffective for managing problem behaviours in the absence of a specific diagnosis but can be tried when other measures have failed. The reasons for recommending referral to dietician and psychology were not identified.
- The decision to discharge Mr Kelly was based on the opinion that he did not have a medical or psychiatric illness, and his problems were behavioural. This was a failure to recognise that illness can present as behaviours in people with an intellectual disability and a lack of understanding of the capacity of NDIS funded services to manage and safely monitor Mr Kelly's issues. Mr Kelly's discharge after his first admission was not

[50] Note: This clinical expert is a consultant psychiatrist with over 20 years of experience working in the health systems of Australia and England in general psychiatry and specialist fields including psychiatry of learning difficulties, early psychosis, community psychiatry, substance dependence and the area of dual disability (mental illness in people with intellectual disability).

appropriate without adequate follow up including support for his mother, monitoring his oral intake and weight, review of his mental state and risk management plan.

Second admission

- On his second presentation in July 2022, Mr Kelly's admission was necessary based on his significant symptoms, his mother's inability to provide the care needed, and the significant risks due to his loss of weight and dehydration. It was not clear why he was admitted as a medical patient and not a mental health patient. He presented with significant mental health symptoms, as documented in the clinical record including suicidal ideation, self-injury, depression, refusal to eat and drink, decline in personal care, and in social interaction and participation, obsession with death and dying and low mood. He also required management responses to his escalating behaviour in the ED. Given this, a mental health admission was more appropriate than a medical admission however his problems were not identified as being mental health related and his admission was noted as a 'social admission'.[51]

- Referral to a mental health service may not have occurred as these services are reluctant to treat people with an intellectual disability who do not meet traditional criteria for 'serious mental illness' and an acute psychiatric inpatient unit can present an extremely difficult environment for people with neurodevelopmental disorders. In the absence of a suitable specialised unit, it is arguable that admission to a medical ward was the 'least worst option' and probably presented as the best compromise and is not an uncommon occurrence. Irrespective of where he was admitted, psychiatric oversight would have been appropriate.

- CLP involvement in Mr Kelly's care was inadequate; significant psychotropic medication was recommended prior to any assessment and in the absence of any specific diagnosis. At no time did he have a comprehensive assessment to establish a diagnosis or develop a treatment plan, despite presenting with significant symptoms of mental illness.

  The information in Mr Kelly's file detailing his presenting symptoms as depressed mood and negative thoughts, significant weight loss due to not eating and drinking, loss of interest in his usual activities, thinking of suicide and death, agitation, social withdrawal, ceasing usual activities, somatic symptoms of anxiety and decreased self-care was sufficient to determine he would meet the DSM-5 criteria for major depressive disorder.[52]

- With respect to the clinical notes referencing that he was suffering from a behavioural disturbance of severe autism, this was not the case. Autism is a lifelong disorder and is not progressive, and in Mr Kelly's case his autism appeared to have been mild and had limited his opportunities but had not in itself presented a problem. The changes in his behaviour were indicative of the onset of an additional problem that was modified in its

[51] RD\23\55395 ieMR Clinical Records page 71.
[52] DSM-5 or Diagnostic and Statistical Manual of Mental Disorders is the American Psychiatric Association's professional reference book on mental health and brain related conditions.

presentation by his autism and intellectual disability. Believing he was suffering from a behavioural disturbance of severe autism would have limited the opportunity to consider other explanations that may have led to appropriate treatment. This was an example of diagnostic overshadowing when new problems are attributed to a known diagnosis.

- Planning for discharge during Mr Kelly's second admission was inappropriate due to the lack of an appropriate diagnosis and the fact that the clinical problem leading to his admission was unchanged. Discharge planning began based on a misunderstanding that there were no treatment options that could be offered to Mr Kelly. Medical assessment was extremely limited by Mr Kelly's lack of cooperation, and his physical status was unclear. He had not had a comprehensive mental health assessment, and this was inadequate given his presentation with symptoms of mental illness.
- The clinical approach and conclusions demonstrate a lack of understanding and knowledge about the presentation and treatment of mental illness in people with intellectual disability, and the disability system and what it can provide. There appeared to be high levels of frustration that there was nowhere for Mr Kelly to be discharged to and that he was inappropriately placed in a medical setting, presenting difficulties to the medical team who did not know how to manage and treat him. The advice they received from mental health services did not indicate he needed treatment for mental illness. The response from the mental health team was inadequate but the reasons for this cannot be determined by review of the notes.[53]

8.2.2.2 Recommendations

See recommendations 1-3 above at 8.2.1.2 regarding training.

4. Within six months review the *GCHHS CLP intake and patient review process work instruction* and make appropriate amendments to*:*

    a. ensure where a consumer is triaged as appropriate for an in-person assessment by the CLP team, but the mental state examination is unable to be completed, the clinical documentation in the consumer's ieMR must clearly outline attempts made to undertake the assessment and reasons it was unsuccessful. This includes but is not limited to, for example, where the consumer refuses to engage or other barriers preventing the assessment from proceeding. In such cases, this information must also be communicated to the referring team, along with a clear plan of action moving forward to support the consumer's ongoing care.

[53] GCHHS submission (June 2025) suggested the insights provided by this clinical expert are indicative of their background and experience from the UK, something a psychiatrist with qualifications and experience in the Australian system would not be able to provide. The OHO notes the expert has extensive experience in the Australian healthcare system since 1992 and considers that they are well qualified to provide informed comment on contemporary psychiatric practice, particularly in relation to the care and management of consumers with neurodevelopmental conditions in Australia.

b. ensure the outcome of any assessment undertaken, recommendations for treatment made or advice given by CLP is documented in the patient's ieMR.

Within 12 months, GCHHS will conduct a targeted audit of a sample of inpatient referral review documentation to ensure the process is being undertaken appropriately. Findings from the audit should inform any required improvements to documentation practices.

5. It is recommended that GCHHS engage proactively with Queensland Health to explore and implement strategies and pathways that ensure timely and equitable access to specialist mental health advice, assessment and treatment for patients with neurodevelopmental disorders and intellectual disability. This collaboration should focus on developing clear referral pathways, expanding specialist outreach services, and enhancing the capacity of local teams through shared care models and targeted training.

   This engagement should assist GCHHS with:

   a. mapping approved available local and regional resources with expertise in neurodevelopmental disorders including approved external specialists and services, such as intellectual disability services, specialised mental health providers and social services.

   b. developing a directory of available resources that is accessible and known to staff.

   c. developing clear referral pathways for consumers with neurodevelopmental disorders and intellectual disability who require additional specialist services and embed these into existing processes.

   d. developing a pathway for engaging clinical expertise and resources not included on the GCHHS local list of recognised providers.

8.2.3 Allied health support

During both Mr Kelly's admissions to Robina Hospital, he was supported by members of the allied health team, including dietetics, social work and psychology.

Mr Kelly was regularly reviewed by the dietician who noted his severe malnutrition, weight loss and risk of refeeding syndrome. In the clinical records it was documented that the dietetics team were following refeeding guidelines.[54] Plans were made for a high protein diet with calorie supplements; however, during each review of Mr Kelly the dietician noted the ongoing limited oral intake. The dietetics team support for Mr Kelly was limited without the ability to offer alternative feeding options such as nasogastric feeding, which was raised with medical staff and declined. It was not evident in the clinical records whether the ongoing concerns held about the severity of the malnutrition, or the ongoing limited intake were

[54] RD\24\158501 GL1673 GCHHS, Identification and Management of Refeeding Syndrome in Adults Guideline (Version 2) effective 12/7/2021.

adequately raised with the medical team after initial discussion about nasogastric feeding. It is also unclear from the records whether the dietetics team escalated concerns regarding the lack of accurate recording of Mr Kelly's intake.

The psychologist who reviewed Mr Kelly and performed a mental state examination during his first presentation was able to effectively engage with him and gain insight into the mental health concerns that were present and identify possible triggers. Subsequent reviews during both admissions were less successful in engaging with Mr Kelly; however, the psychologist did note and escalate to medical staff that he may benefit from referral to CLP during his second admission.

Social work supported Mr Kelly and his family throughout both of his admissions. Mr Kelly's mother raised concerns about her son's deterioration with the social worker and according to clinical records this was escalated to medical staff. The social work team appropriately escalated concerns raised by Mr Kelly's mother regarding her son's deterioration to the relevant medical staff. Despite his mother's repeated expressions of concern, social workers ultimately relied on the clinical assessment and decision of the medical professionals, who deemed he was suitable for discharge. While the social work team maintained communication with both Mr Kelly's mother and the medical team, they did not challenge the medical judgement or escalate further any concerns they may have had, instead deferring to the expertise of the medical team in determining discharge readiness. During the second admission the social worker was involved in planning for Mr Kelly's discharge as directed by the medical treating team; however, records indicate this approach taken by the social work team may have fractured the relationship between the family and social worker as Mr Kelly's mother did not feel her concerns with his ongoing deterioration were being addressed.

The review of the records relating to allied health involvement, and the clinical expert's comments on the lack of clarity of the extent to which concerns by any of allied health professionals were appropriately escalated, raises the question of the adequacy of pathways and processes for allied health staff escalating concerns about patient safety and wellbeing. Queensland Health's Patient Safety Net program,[55] developed to provide staff with a process for raising a patient safety concern they feel has not been addressed adequately through standard reporting processes, should be considered as a potential way to facilitate the escalation and review of concerns for allied staff such as dieticians who identify the risk of medical compromise or social workers who identify patient wellbeing risks in inadequate discharge planning. The availability of such processes is particularly important for staff such as social workers who may be following orders of the medical treating team to arrange for discharge of a patient despite the protests of a family member, as in Mr Kelly's case.

[55] Queensland Health: Patient Safety Net (October 2024).

8.2.3.1 Clinical expert – physician re allied health

Mr Kelly was appropriately identified at admission through screening procedures as at risk of malnutrition due to his history, presenting complaint and poor oral intake. There was a reasonable plan for nutritional support and follow up was enacted. Overall, the level of dietetic support provided for Mr Kelly was adequate. Without access to parenteral feeding options, such as nasogastric feeding, the support provided was limited. An escalation of the concerns regarding the severity of malnutrition, ongoing inadequate or lack of oral intake and impending medical compromise (or potential presence of medical compromise) could have been raised, and this was not clear to have occurred in the ieMR notes.

While no specific questions were asked of the clinical expert with respect to social work or psychology, the following information was provided in response to other questions put to the clinical expert:

- The social work team reviewed Mr Kelly's informal and formal supports in the community, including those offered through NDIS.
- The psychologist reviews during his inpatient stay noted on at least two occasions that a behaviour support plan would benefit Mr Kelly (and his family and carers in how to best support his behaviour and improve his oral intake). This was not enacted or reflected in the discharge summary. This may reflect an overall lack of awareness regarding the role of behaviour support plans for complex patients with difficult behaviours in the community and in the hospital. These plans need to be developed by professional behaviour support plan specialists.

8.2.3.2 Recommendation

See recommendations 1-3 above at 8.2.1.2 regarding training.

6. It is recommended that GCHHS undertake a comprehensive evaluation of the implementation of Patient Safety Net. This should include an assessment of clinician awareness of the program across all departments, as well as a detailed analysis of program usage since its inception. The evaluation should specifically capture the frequency and nature of concerns raised, disaggregated by clinical stream, to identify patterns of use and any underutilised areas. Findings should inform targeted communication, education strategies, and system refinements to support broader engagement and sustained integration into clinical practice if required.

8.2.4 Managing clinical risk

Clinical assessment and monitoring of patients in acute healthcare settings is critical for ensuring the delivery of safe, effective healthcare. Comprehensive and ongoing assessments allow healthcare providers to understand a patient's baseline condition, identify changes and

implement appropriate interventions.[56] The NSQHSS, particularly Standard 5 Comprehensive Care and Standard 8 Recognising and Responding to Acute Deterioration, emphasises the importance of providing coordinated care tailored to the individual consumer's needs and highlights the importance of monitoring and timely escalation to prevent adverse outcomes.[57] The investigation identified significant concerns related to the monitoring of Mr Kelly's condition while he was an inpatient, which highlighted failures in patient safety and compliance with both regulatory standards and hospital policies that impacted his overall care and management during his admissions to Robina Hospital in 2022.

Recognition of deterioration and effective escalation pathways are critical components to the delivery of safe, high-quality healthcare. Early identification of clinical deterioration through ongoing assessment allows for timely intervention, which can significantly improve patient outcomes and reduce preventable harm. Routine observations, weight, dietary intake, hydration and biochemical markers are critical for detecting early signs of malnutrition and dehydration. It is clear that staff failed to sufficiently assess and monitor Mr Kelly's physical and mental condition, recognise the signals of decline he was exhibiting, and act on the concerns about his condition raised by his family.

8.2.4.1 Vital signs

Early recognition of acute deterioration, followed by prompt and effective action, may mean that a person can be stabilised with less intervention. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state. Early intervention can minimise adverse events and improve patient safety outcomes. Hospitals have a critical responsibility to ensure clinicians are equipped to effectively recognise and manage patient deterioration and understand and adhere to their obligations for recording observations, documenting and escalating concerns. The NSQHSS Standard 8: Recognising and Responding to Acute Deterioration[58] requires health services to establish and maintain systems recognising and responding to clinical deterioration. The Queensland Health vital signs recording tools and Early Warning Alert and Response System (EWARS), if used as intended, meets the requirements of this standard. The first iteration of the Queensland Adult Deterioration Detection System (Q-ADDS), a track and trigger early warning system for adult patients, was introduced in 2013 and is embedded in Queensland Health facilities.[59]

The GCHHS procedure Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (GCHHS Vital Signs Procedure) outlines steps to be undertaken for recording, reviewing and actioning patient vital signs and other observations to ensure timely recognition and management of patients who are clinically deteriorating.[60]

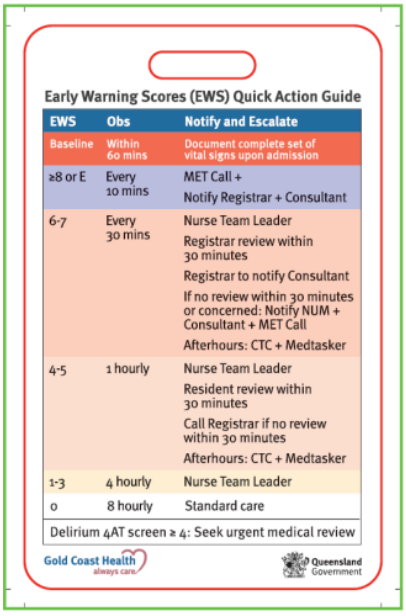
---

[56] Australian Commission on Safety and Quality in Health Care (ACSQHC), 'National Safety and Quality Health Service Standards' (2nd ed.2021). See Standard 5 Comprehensive Care and Standard 8 Recognising and Responding to Acute Deterioration.
[57] Ibid.
[58] Australian Commission on Safety and Quality in Health Care (ACSQHC), 'National Safety and Quality Health Service Standards' (2nd ed.2021). Standard 8 Recognising and Responding to Acute Deterioration.
[59] Clinical Excellence Queensland, *RTI # 5284 Release Notes: A copy of the review of the Queensland Adult Deterioration Detection System, including any documents commenting about the research* (no date).
[60] RD\24\16347PRO0514 GCHHS Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (version 5) effective 31/8/2021.

The policy aligns with the NSQHSS Standard 8: Recognising and Responding to Acute Deterioration[61] and the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration.[62]

The GCHHS Vital Signs procedure outlines that guidance on the frequency of vital signs and escalation is based on the total Early Warning, Alert and Response System (EWARS) score which must be calculated each time a set of vital signs is performed. Baseline observations for adults are respiratory rate, oxygen saturations, oxygen flow rate, blood pressure, temperature, and level of consciousness.[63] Patients must have observations taken within 60 minutes of admission and at minimum inpatients are to have their vital signs assessed and documented once per eight-hour shift. Further guidance on frequency of observations may also be derived from action plans, clinical pathways and from senior medical and/or nursing staff e.g. team leader. All vital signs must be recorded in ieMR to facilitate the identification of trends.

The GCHHS Vital Signs Procedure outlines the minimal actions required based on the EWAR score, including observation frequency and notification/escalation of clinical concerns; see Figure 1.



Early Warning Scores (EWS) Quick Action Guide

EWS	Obs	Notify and Escalate
Baseline	Within 60 mins	Document complete set of vital signs upon admission
≥8 or E	Every 10 mins	MET Call + Notify Registrar + Consultant
6-7	Every 30 mins	Nurse Team Leader Registrar review within 30 minutes Registrar to notify Consultant If no review within 30 minutes or concerned: Notify NUM + Consultant + MET Call Afterhours: CTC + Medtasker
4-5	1 hourly	Nurse Team Leader Resident review within 30 minutes Call Registrar if no review within 30 minutes Afterhours: CTC + Medtasker
1-3	4 hourly	Nurse Team Leader
0	8 hourly	Standard care
Delirium 4AT screen ≥ 4: Seek urgent medical review		

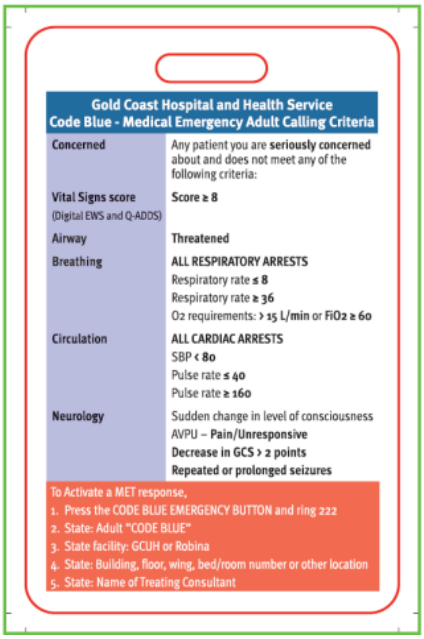
Gold Coast Health always care

Queensland Government

Figure 1: Adults EWAR score Quick Action Guide.[64]

The GCHHS Vital Signs Procedure also outlines criteria for activation of a Medical Emergency Team (MET) call; that is, an EWAR score equal to or more than 8, or where a single parameter which reaches MET criteria threshold, and where staff are seriously concerned about a patient who does not meet these MET criteria; see Figure 2.

[61] Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (2nd ed. 2021), see Standard 8 Recognising and Responding to Acute Deterioration.
[62] Australian Commission on Safety and Quality in Health Care, 'National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration (3rd ed. 2021).
[63] RD\24\16347PRO0514 GCHHS Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (version 5) effective 31/8/2021, see 4.2.1.
[64] Ibid, see 6.3.



Gold Coast Hospital and Health Service
Code Blue - Medical Emergency Adult Calling Criteria

Concerned	Any patient you are **seriously concerned** about and does not meet any of the following criteria:
Vital Signs score (Digital EWS and Q-ADDS)	**Score ≥ 8**
Airway	**Threatened**
Breathing	**ALL RESPIRATORY ARRESTS** Respiratory rate **≤ 8** Respiratory rate **≥ 36** O2 requirements: **> 15 L/min** or **FiO2 ≥ 60**
Circulation	**ALL CARDIAC ARRESTS** SBP **< 80** Pulse rate **≤ 40** Pulse rate **≥ 160**
Neurology	Sudden change in level of consciousness AVPU – **Pain/Unresponsive** **Decrease in GCS > 2 points** **Repeated or prolonged seizures**

To Activate a MET response,
1. Press the CODE BLUE EMERGENCY BUTTON and ring 222
2. State: Adult "CODE BLUE"
3. State facility: GCUH or Robina
4. State: Building, floor, wing, bed/room number or other location
5. State: Name of Treating Consultant

Figure 2: MET Calling Criteria.[65]

On both admissions to Robina Hospital Mr Kelly's observations were recorded irregularly and incompletely.

During Mr Kelly's first admission to Robina Hospital in May 2022, his vital signs were recorded at least daily for the period of this admission. On some occasions nursing staff recorded when Mr Kelly refused observations in the clinical record; however, there was no record of how often recording of observations was attempted, details of any strategies used to try and obtain observations or any escalation when observations were unable to be taken.

The most notable omission with recording Mr Kelly's vital signs was during his second admission, for the period between 23 July 2022 and 1 August 2022. There was a full set of vital signs recorded on the morning of 23 July 2022 and there was no further documentation of vital signs until 30 July 2022 when Mr Kelly's respiration rate was documented twice and noted to be elevated. The next full set of vital signs was not documented until the afternoon of 1 August 2022.

By 31 July 2022, Mr Kelly was noted to have rapid shallow breathing (respiratory rate >34 bpm), and his oxygen saturations were 95% on room air. On three occasions on this date Mr Kelly's early warning score was recorded as 'E' (emergency) requiring a MET response be activated, staff to notify the treating Registrar and Consultant, and observations be recorded every 10 minutes.[66] According to the nursing progress notes this was escalated to the nurse in charge on two occasions, and Mr Kelly's observations were not recorded as required by the EWAR score. No MET response was activated.

[65] RD\24\16347PRO0514 GCHHS Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (version 5) effective 31/8/2021, see 6.4.
[66] Ibid, see 6.3.

Between 31 July 2022 and 2 August 2022 at 5:20 am, observations recorded for Mr Kelly triggered an emergency on the early warning score six times. Despite this, his observations continued to be taken infrequently and at times incompletely; the documented response to these scores was to notify the nurse in charge, continue treatment as per management plan and continue to monitor. The first MET response activated for Mr Kelly was on 2 August 2022 at 5:50 am.

A primary responsibility for acute care nurses is to assess patients and recognise clinical change to detect deterioration and escalate concerns. It is important that nurses use appropriately targeted clinical cues to detect changes in clinical status. The most common cues used to recognise clinical change are a patient's vital signs.[67] The clinical records reflect that nursing staff experienced difficulty measuring Mr Kelly's vital signs due to his resistance. At times nursing staff documented strategies implemented to try and gain compliance with measuring vital signs. The clinical records reflect that nursing staff continued to ask Mr Kelly's permission to take his vital signs despite clearly documented instruction from his mother that this was not the appropriate way to approach her son as this would always be met with a negative response.

The OHO conducted interviews with staff involved in Mr Kelly's care. One staff member stated that the clinical records reflected that nursing staff often recorded "refused observations" but did not appear to attempt alternative assessments that could have been performed and recorded without physical contact, such as counting the respiratory rate from a distance or noting visible signs of perfusion.[68]

It is acknowledged that on initial presentation to the ED Mr Kelly triggered three code black responses due to aggressive behaviour and required sedation.[69] Outside these code black events, there was no documented evidence of aggressive behaviour during the remainder of Mr Kelly's admission, or any concerns regarding staff safety when providing care for him. The OHO has considered the medical officer's account that staff had voiced concerns for their safety while caring for Mr Kelly. However, a review of the clinical record indicates that while staff documented Mr Kelly's refusal to have observations taken and receive care at times, there was no evidence recorded to suggest he displayed aggression or behaviour escalation outside the Code Black incidents that occurred in the ED. Furthermore, there is no documentation in the clinical record to reflect that staff formally recorded their concerns or fears regarding potential escalation of the consumer's behaviour, either before or after his one-to-one nursing and security special were removed several days after his admission to the ward. A Workplace Health and Safety Patient Risk Assessment was conducted on Mr Kelly while he was in the ED. At that time, he was displaying clear signs of aggression and escalating behaviour and was assessed to be high risk of occupational violence.

[67] Gabriel Burdeu et al, 'Clinical cues used by nurses to recognize changes in patients' clinical states: A systematic review' (2021) 23 *Nursing and Health Sciences* 9-28.
[68] RD\25\162511 Recorded Practitioner Interview
[69] Code black is a situation involving a personal threat, typically related to violence or aggression, where staff, patients, or visitors may be at risk of physical harm.

However, this risk assessment was not subsequently updated, despite there being no evidence of any further signs of escalation or violent behaviour after that time and the removal of the security special and one-on-one nursing care several days after admission. The failure to review and update the risk assessment may have contributed to nursing staff maintaining an elevated perception of risk associated with caring for Mr Kelly, despite the absence of documented behaviours indicating ongoing aggression or threat and removal of security special.[70]

During interviews, staff were asked to clarify observations of the consumer's behaviour. One staff member reported at the time of their initial involvement with Mr Kelly he appeared stable, and no concerns were raised by nursing or security staff on the ward about his behaviour. Upon later reviewing the clinical notes, the staff member observed that the patient had previously refused observations, food, and drink, and had declined routine care such as bed changes. These behaviours suggested withdrawal and refusal, but there were no reports of overt aggression during the period leading up to, or after the MET call.[71] The staff member noted the only reference to aggression in the clinical records was historical, relating to earlier episodes in the ED when security intervention had been required.[72]

Another staff member recalled that Mr Kelly declined most care interventions during the period they were providing care, including vital signs and other routine assessments. Whilst reporting Mr Kelly resisted observations, the staff member could not provide details on how this resistance was expressed beyond him declining to offer his arms for blood pressure monitoring and other observations by holding his arms up in front of him to prevent staff from proceeding. The staff member did not remember any specific occasions when Mr Kelly displayed agitation or aggression and described the patient as generally quiet when speaking. There was no recollection of staff discussions about behavioural concerns, agitation, or aggression being reported.[73]

While acknowledging GCHHS's comments in the submission regarding staff concerns for their workplace safety, as well as the plan to minimise controllable environmental stimuli and avoid unnecessary clinical interruptions, it is noted that there was little evidence in the clinical record that nursing staff attempted to obtain vital signs that could be measured outside the use of monitoring equipment such as respirations, capillary refill, temperature of skin to touch, skin turgor, level of alertness, and mental status.

For all patients it is necessary to understand the clinical risks and develop systems to ensure that vital signs and other parameters for detecting deterioration in the patient's physical, mental or cognitive condition are being measured and documented.[74]

---

[70] GCHHS Submission (30 June 2025) asserted that fear of violence against staff, and the perceived risk of Mr Kelly's behaviour escalating, was relevant to his treatment.
[71] RD\25\162511 Recorded Practitioner Interview.
[72] Ibid.
[73] RD\25\163251 Recorded Practitioner Interview.
[74] Australian Commission on Safety and Quality in Health Care, 'Detecting and recognising acute deterioration, and escalating care', (web Page) <Detecting and recognising acute deterioration, and escalating care | Australian Commission on Safety and Quality in Health Care>.

Outside of his vital signs, Mr Kelly was arguably showing signs of deterioration which were noted in the clinical record including:

- On 27 July 2022, noted changes in his behaviour when moved from a single room to a four-bed bay. He had been eating small amounts of food while in the single room; this stopped when he was transferred to the four-bed bay, and he again refused any oral intake.
- On 29 July 2022, nursing staff noted he was no longer mobilising to the bathroom and remained in bed for the whole shift. This was unusual for him as he had been mobilising to the toilet frequently during shifts prior to this.
- On 30 July 2022, Mr Kelly had become incontinent of urine and refused to change out of wet clothes. He was also noted to be alert and confused.
- On 31 July 2022, Mr Kelly was agitated and threw drinks onto the floor, he continued to be incontinent of urine and refused any assistance with getting changed or showering. He had gone from mobilising to the toilet regularly to not getting out of bed at all; staff had put a bed alarm in place to be alerted if he got out of bed which was not activated at all. His breathing was noted as shallow and rapid on this date.
- On 1 August 2022, Mr Kelly was noted to appear 'clinically dehydrated', was too weak to transfer from bed to chair to use the commode and became more cooperative, allowing staff to put on a uridome to measure urine output.

Although these changes were documented, there appeared insufficient attention paid to these soft signals for deterioration and a lack of awareness of the significance of these changes, leading to missed opportunities for staff to respond to these early warning signs by escalating concern regarding the changes in Mr Kelly's condition.

The lack of observations and recognition and escalation of Mr Kelly's deterioration represents a clear breach of policies, procedures and standards associated with assessment of the patient's condition and identification and management of patient deterioration.[75] By failing to track basic physiological parameters, despite Mr Kelly's known vulnerability and history, there was a delay in the recognition of signs of systemic decline. This was a critical lapse in basic nursing responsibilities and monitoring practices. Further, when observations were conducted after a delay of seven days, and reflected that Mr Kelly's condition was deteriorating, nursing staff failed to appropriately escalate his clinical deterioration as required by hospital policy. On 31 July 2022, when Mr Kelly's vital signs indicated on several occasions that a MET response ought to have been activated,[76] nursing staff documented

[75] RD\24\16347PRO0514 GCHHS Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (version 5) effective 31/8/2021; Australian Commission on Safety and Quality in Health Care (ACSQHC), 'National Safety and Quality Health Service Standards' (2nd ed.2021). See Standard 5 Comprehensive Care and Standard 8 Recognising and Responding to Acute Deterioration.
[76] RD\24\16347PRO0514 GCHHS Vital Signs and Observations: Performing, Frequency, Documenting, Responsibilities and Escalating Concerns (version 5) effective 31/8/2021.

their response was to notify the nurse in charge, continue treatment as per management plan and continue to monitor.

Staff also failed to recognise or act upon the soft signs of Mr Kelly's decline, such as his complete lack of oral intake, lethargy, incontinence and other subtle indicators of clinical deterioration. It is also unclear if the inability to record vital signs was escalated beyond what was recorded in the clinical record.

These failures underscore lack of adherence to clinical protocols, insufficient training in clinical assessment and recognising early signs of deterioration, and a failure to uphold Mr Kelly's healthcare right to 'Receive safe and high-quality health care that meets national standards' under the Australian Charter of Health Care Rights.[77]

8.2.4.2 Escalation of deterioration

The investigation highlighted the devastating consequences that can occur when staff fail to activate the appropriate response as indicated by the early warning system or recognise and escalate concerns with soft signals of patient deterioration. Even if nursing staff did not understand the significance of Mr Kelly's emergency trigger on the EWAR score, it is difficult to understand why they did not follow the corresponding actions mandated by the early warning response system, developed specifically to assist clinicians to better detect and manage clinical deterioration.[78]

Mandatory training records requested from Robina Hospital for the year 2022 indicated that all nursing and medical staff involved in Mr Kelly's care, except for two medical officers, had currency with the speaking up for safety mandatory education.[79] Clinical records indicated that any specific concerns related to Mr Kelly's condition raised by nursing staff were documented and escalated to the team leader on shift in relation to nursing concerns. There was no evidence of any escalation from any other members of the multidisciplinary team related to Mr Kelly's condition.

GCHHS undertook an audit related to Early Warning Signs in the first quarter of 2023. The results of this audit, which included review of 419 patient records across the service, indicated 58% of patients that met any criteria for notification and escalation of care (including clinical concern) were not appropriately escalated in accordance with local procedure. The report noted this was a 10% increase from the quarter four 2022 results. Medical officer review (41%) and team leader notification (17%) were the most common aspects of notification or escalation of care that were not followed, consistent with results obtained in quarter four 2022. The audit was repeated in quarter two of 2023 with 510 patient records reviewed for the audit period. The audit data at that time indicated that 64% of patients who met any criteria for notification and escalation of care (including clinical concern) were not appropriately escalated in accordance with local procedure. Medical

[77] Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights (Second Ed)' (2020).
[78] Ibid.
[79] Cognitive Institute Speaking up for Safety Program is an organisation wide program to build a culture of safety by empowering staff to raise concerns.

officer review was reported as the most common aspect of notification or escalation that did not follow local procedure (62% - a significant increase from the previous quarter). This data is indicative of a systemic issue with staff failing to understand and adhere to escalation protocols across the HHS at that time.[80] It also highlights the importance of the implementation of Queensland Health's Patient Safety Net Guidelines for all staff at GCHHS.[81]

8.2.4.3 Dietary intake/output and weight

The physician clinical expert who reviewed the case concluded that Mr Kelly's discharge on his first admission was appropriate, as no medical cause for his behavioural disturbance had been identified. However, concerns were noted regarding Mr Kelly's weight loss, particularly given only one weight measurement was taken during that admission. The physician clinical expert believed if his weight had been taken again during the admission and demonstrated further weight loss, he would not have been suitable for discharge.

GCHHS Malnutrition Risk Screening for Adult Inpatients procedure requires patients to be screened for malnutrition risk within eight hours of admission and rescreened weekly for malnutrition risk.[82] On Mr Kelly's second presentation he was appropriately screened for malnutrition risk on 21 July 2022 and his score was recorded as five, which automatically generated a referral through ieMR to the ward dietician.[83] Mr Kelly was not rescreened until 31 July 2022, which was outside the documented timeframe; at that time his score was recorded as three. The weight loss recorded on this entry did not correlate with Mr Kelly's actual weight loss over the past six months, as required by Queensland Health Malnutrition Screening Tool.[84] The Malnutrition Screening Tool, noting the six-month time period over which the weight loss should be considered, is not referenced or included in the GCHHS Malnutrition Risk Screening for Adult Inpatients procedure or ieMR.[85]

The dietician reviewed Mr Kelly on 22 July 2022 and documented a plan which included encouraging his family to bring in his favourite foods and drinks, a nutrition supplement, and nursing staff were to assist with meals,[86] record a food chart and weigh him when safe to do so.

---

[80] GCHHS Submission (June 2025) noted the audit referenced 'used blunt measures to assess the documentation of escalation in ieMR. It was not a direct measure of whether or not the escalation occurred. It considered record keeping in relation to medical officer review, observation frequency and team leader notification. This data was reviewed during the accreditation process and GCHHS was given a "Met" outcome against Standard 8 of the National Safety and Quality Health Service Standards. If the issue was considered to be systemic, GCHHS would not have passed this criterion'.

[81] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/patient-safety-staff-escalation.

[82] RD\24\16368 PRO1277 GCHHS Malnutrition Risk Screening for Adult Inpatients (version 4) effective from 6/1/22. The Malnutrition Screening Tool (MST) is a simple, evidenced based and validated tool designed to rapidly identify patients at risk of malnutrition (Shaw et al., 2014).

[83] Ibid.

[84] Queensland Government, 'Malnutrition Screening Tool' (no date).

[85] Gold Coast Hospital and Health Service Procedure PRO1277: GCHHS Malnutrition risk screening for adult inpatients, version 4 effective from 6/1/22.

[86] Gold Coast Hospital and Health Service Procedure: Patient Mealtime Preparation, Provision and Assistance, version 4 effective from 24/6/2024. Procedure requires nursing staff to assist patients preparing for mealtimes and encouragement and assistance with food and fluid intake.

During this admission Mr Kelly's nursing progress notes consistently recorded his refusal to eat and drink, noted empty food and drink containers in his rubbish bin, occasions when family brought in food for him, occasions when he was observed eating, and when he was thought to be drinking water while in the bathroom. Some attempts were made to record food and fluid offered to Mr Kelly and what he consumed, although this was recorded inconsistently and under a variety of headings in the ieMR including Nutrition ADLs, Newborn-Infant Feeding and Diabetes/Endocrine.

Mr Kelly's mother and father advised that they visited Mr Kelly every day and did not witness staff assist him with preparation for meals at any time. They explained that they witnessed staff deliver meals and come back to collect them when they had not been touched and did not recall the staff asking them about what he had been offered or consumed.

Mr Kelly's bowel motions were recorded daily from 27 July 2022 to 2 August 2022 under the Gastrointestinal Assessment. Nursing staff documented in the progress notes occasions when Mr Kelly was passing urine in the toilet. During the period when Mr Kelly had a uridome, and then an Indwelling Catheter, staff regularly recorded the output in the progress notes.

From 1 August 2022, when Mr Kelly began to deteriorate medical staff requested a strict fluid balance chart be kept for Mr Kelly, there was no evidence found in the clinical records received that this occurred.[87]

The GCHHS Malnutrition risk screening for adult inpatients procedure also requires patient's weight and height are recorded within 24 hours of admission and weekly throughout admission. Mr Kelly's weight was recoded on 22 July 2022 and was not recorded again until after his admission to ICU on 2 August 2022.[88] He was initially weighed on his bed after refusing to stand on the scales, indicating there was capacity to weigh him on the bed and comply with the requirements of the procedure.

The lack of fluid and nutrition monitoring over this period is a fundamental lapse in care, particularly where the care plan requested recording food and fluid intake and Mr Kelly was at high risk of malnutrition, dehydration and refeeding syndrome due to his reported restrictive intake. This also represented a failure to follow the clinical care plan outlined by both the dietician and medical staff in the clinical record. When staff did record Mr Kelly's intake and output in the ieMR there was also a lack of standardised approach leaving staff ill-equipped to monitor Mr Kelly's nutritional status over time. Clinical staff relied on incomplete information recorded in progress notes in relation to Mr Kelly's intake and output, including observing empty food containers in the rubbish bin and unconfirmed assumptions of him consuming water while in the bathroom.

These failures may have resulted from systemic shortcomings related to training, communication and monitoring protocols.

---

[87] 'QuEDS Guide to Admission and Inpatient Treatment', Queensland Health (Guideline, July 2020). Document referenced in GCHHS Policy/Procedure documents provided to OHO, requires fluid balance chart to be recorded for duration of the admission.
[88] RD\23\55395 ieMR, see page 433.

8.2.4.4 Clinical expert – nursing

Clinical expert opinion was sought from a Registered Nurse regarding aspects of nursing care provided to Mr Kelly during his second admission to Robina Hospital. The following is a summary of the expert's opinion in relation to relevant aspects of Mr Kelly's care:

- The frequency of observations recorded for Mr Kelly during his second admission was not sufficient to ensure his safety and wellbeing. There was a complete lack of vital signs from 22 July 2022 at 6:37pm until 30 July 2022 at 1:38pm, apart from one set recorded on 23 July 2022 at 9:59am. At 1:38pm on 30 July 2022, the only observation recorded was a respiratory rate which was high and remained so through until 2 August 2022 at 2.00 pm. The Early Warning score was recorded as E on ten occasions during this period. No MET call was activated until 2 August 2022. If more frequent observations or recording of soft signals had occurred, closer attention been paid to providing an environment to support Mr Kelly's special needs, and a carer appointed who was known to him, it is more likely than not, that his deterioration would have been identified earlier leading to a more timely and appropriate response.
- While the difficulties with performing certain tasks such as obtaining observations was appreciated, the clinical expert opined that nurses caring for Mr Kelly should have gained an understanding of how best to support him during his hospitalisation by discussing communication techniques, what distressed him, what calmed him and how best to approach him to obtain vital signs with those closest to him. The strategies used by staff to obtain observations, perform other nursing care and encourage food and fluid intake did not align with the strategies which had been explained by his mother and documented early on in his admission. Nursing records show nurses continued to ask for consent to perform tasks, despite clear recommendations from his mother that these requests would always be met with a negative response. Time taken to understand what would have calmed Mr Kelly may have resulted in him being more compliant with nursing and medical staff.[89] One nurse caring for Mr Kelly on the day of his admission to MAU documented an excellent list of strategies to assist with calming Mr Kelly.[90]
- Mr Kelly's dire situation required nurses to implement strategies as advised by his mother along with urgent specialist input to address psychological and/or psychiatric issues before any attempt at general nursing care could be implemented to support his recovery.
- It was clearly apparent that Mr Kelly was suffering from severe wastage. His weight was only recorded once during his second admission prior to transfer to ICU. The patient could have been weighed on his bed if equipped with an inbuilt scale, or the bed moved to a weighing scale if available.

[89] Using soft signs to identify early indications of physical deterioration.
[90] RD\23\55395 ieMR see page 537.

- Soft signals of deterioration are defined as non-numerical deterioration cues attained from observation rather than instrumentation. These important cues may have alerted staff to Mr Kelly's deterioration along with visual observations which could have been recorded. These include respiratory rate, skin colour, changes in eating and drinking habits, reduced mobility, confusion, agitation or sleeping more than usual. Listening to those closest to him could not be understated; they are the best people to recognise early signs or behaviours out of the ordinary. Observing urine output including colour, clarity and smell and any changes in bowel habits can be an early sign that may assist in providing a plan of care.

There was inconsistency in the clinical record regarding soft signals of clinical deterioration. There were entries recording Mr Kelly staying in bed, not eating or drinking, refusing medications, being incontinent and refusing to change or shower. Changes in Mr Kelly's behaviour were most apparent when he was moved from a single room to four-bed-bay. While in the single room it was reported he was settled and did not require sedation and was managing to eat and drink a little. By 31 July 2022, Mr Kelly was noted to have shallow breathing, was hyperventilating, agitated, declining assistance despite his bed being soaked in urine and he threw drinks onto the floor. By 1 August 2022, Mr Kelly was too weak to transfer out of bed to use the toilet. He declined to use a bottle but did allow staff to put a uridome on him. This yielded a volume of 150 ml of dark yellow urine, indicating dehydration.

8.2.4.5 Recommendations

See recommendations 1-3 above at 8.2.1.2 regarding training.

7. GCHHS/Robina Hospital undertake measures to improve staff awareness and compliance with requirements for recognising and responding to patient deterioration including:

    a. consider the development of a tool for recording behavioural changes and mental health status for patients with neurodevelopmental conditions as an instrument for objectively documenting improvement or deterioration in mental state and escalation protocols.

    b. undertake an audit of clinical handover processes (medical/nursing) to determine whether patients and/or their families/carers are given opportunity to be involved in handover, and to what extent early signs of patient deterioration and risk factors associated with this are included in the handover framework. Table results at the appropriate governance committee, develop an action plan for implementation of necessary improvements, ensure staff receive feedback, and implement training where required.

    c. enhance training and education related to patient assessment, recognition and responding to deterioration through inclusion in onboarding education, regular mandatory training and scenario-based simulations. Include education

on recognising soft signals for deterioration and the importance of gaining information and understanding consumer's baseline. Consider the development and inclusion of a training scenario based on Mr Kelly's story to reinforce the practical application of the importance of recognising and responding to clinical deterioration.

d. continue to monitor compliance with policies/procedures and guidelines associated with patient assessment and recognising and responding to patient deterioration, table at appropriate governance committees and undertake improvement actions where required. Develop feedback loops to ensure constructive feedback on non-compliance and recognition of excellence in practice is provided to clinical staff.

e. consider the introduction of tiered multidisciplinary safety huddles at various levels throughout the organisation (executive, service and unit level) which include discussion on patients of concern or with complex issues at risk of deterioration.

f. review current relevant policies/procedures/guidelines related to vital signs and observations to ensure there is a mandatory escalation process outlined for staff to follow when patients are unable to have vital signs and observations recorded as per the frequency required. Consider the introduction of a formal policy/mandatory escalation protocol, requiring staff to escalate concerns when they are unable to obtain the required observations for a defined period (e.g. within 24 hours). The protocol should include a tiered escalation process, ensuring timely intervention by senior clinical staff and mandatory documentation of all unsuccessful attempts to obtain observations.

8. After 12 months GCHHS/Robina Hospital are to provide a report to the OHO on Gold Coast Hospital and Health Service's progress in operationalising the Queensland Health Patient Safety Net initiative. This should include information on the implementation of the initiative, rollout of GCHHS Clinical Safety Escalation Pathway – Nursing and Midwifery, training provided to staff, evaluation and measures of success/areas for improvement.

9. Undertake organisation wide escalation mapping (see ACSQHC template) in relation to recognising and responding to deterioration in mental state and how the recognition of deteriorating patient (RODP) system works for consumers with neurodevelopmental conditions and address any barriers identified to recognising and responding to escalation. The mapping should include assessment of:

    a. training needs, including conducting an analysis of current workforce skills and availability of comprehensive contemporaneous and accessible information and training.

b. availability of context specific tools (in addition to Q-ADDs) for recording behavioural changes and mental health status for patients with neurodevelopmental conditions as an instrument for objectively documenting improvement or deterioration in mental state and associated escalation protocols.

c. measures in place to minimise the risk of harm including risk screening, comprehensive care plans, processes for escalation when mental health deteriorates and availability of additional response teams (CLP etc).

d. the use of Ryan's Rule to escalate concerns about care or condition by the patient, family and/or carers.

e. information and communication systems including what information is available at point of care about the patient.

f. assess whether environmental factors are likely to cause additional stress to consumers with a cognitive disability and are factors modifiable to minimise stress.

g. evaluation of the overall effectiveness of systems for recognising and responding to deterioration in a person's mental state.

Within 12 months, provide the OHO with an update on the progress of mapping and outcomes resulting from mapping process.

10. Within 6 months, GCHHS/Robina Hospital review the *GCHHS Malnutrition risk screening for adult inpatients procedure* to specify the time period for assessment of weight loss in the past six months. If possible, amend the ieMR where this information is recorded to include a prompt to reflect this.

8.2.5 Barriers to accessible care and failures to uphold healthcare rights

The Australian Institute of Health and Welfare (AIHW) (2024) reports that in 2018, the prevalence of disability in the Australian population is estimated at 18% (about 4.4 million people). Of these, 23% present with mental or behavioural conditions.[91] People with an intellectual disability present with higher rates of common mental ill-health, at a rate two to three times higher than the general population.[92]

[91] Australian Institute of Health and Welfare (2024) People with disability in Australia 2024, catalogue number DIS 72, AIHW, Australian Government.
[92] Sally-Ann Cooper et al, 'Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors' (2007) 190 *British Journal of Psychiatry* 27–35

People with intellectual disability often experience significant barriers in accessing safe and quality care as evidenced by a higher mortality rate, increased incidence of preventable illness and more frequent hospital admissions.[93]

Intellectual disability is a neurodevelopmental disorder that begins in childhood and is 'characterised by intellectual difficulties as well as difficulties in conceptual, social and practical areas of living'.[94] When compared with the general population, people with intellectual disability have significantly higher physical and psychiatric morbidities.[95]

Professional knowledge about neurodiversity, sensory issues, communication issues, lack of focus on person centred care and environmental factors have all been found to contribute to the significant barriers to accessing healthcare for individuals diagnosed with these conditions.[96]

Limited understanding of neurodevelopmental conditions may lead to misdiagnosis or delayed diagnosis if a person's physical symptoms or behaviours are attributed to their intellectual disability.[97] Consequently, these individuals may not receive the same level of health care as the general population.[98]

Complex healthcare needs, communication difficulties and reliance on others for support may also have significant implications for the delivery of healthcare to people with neurodevelopmental conditions. Patient advocacy in healthcare is critical for individuals with neurodevelopmental conditions such as Mr Kelly. It is aimed at promoting and safeguarding the rights and well-being of patients, ensuring their dignity and health outcomes are prioritised in a system that may not always account for their specific needs. It involves advocating for patients' rights, providing support and information, and ensuring that patients have access to safe, quality healthcare services. Clinical staff act as patient advocates in various ways, demonstrating their commitment to ethical patient-centred care. Common cognitive biases toward people with intellectual disability include assumptions about a person's quality of life, their ability to gain new skills and their capacity to participate in healthcare planning, and these may significantly influence clinical decisions related to

[93] C. Salomon and J. Trollor, 'A scoping review of the causes and contributors to the deaths of people with disability in Australia' Sydney: Department of Developmental Disability Neuropsychiatry UNSW; 2019; World Health Organization, 'Global report on health equity for persons with disabilities' Geneva: 2022; Jullian Trollor et al., 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data', *BMJ Open* (2017) 7(2).
[94] Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards, User Guide for the Health Care of People with Intellectual Disability, 2024; American Psychiatric Association. Diagnostic and statistical manual of mental disorders 5-TR Washington, DC2022.
[95] Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards, User Guide for the Health Care of People with Intellectual Disability, 2024; P. White et al, 'Prevalence of intellectual disability and comorbid mental illness in an Australian community sample' (2005) 39(5) *Australian & New Zealand Journal of Psychiatry* 395-400; Cooper et al, 'Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors' (2007) 190 *British Journal of Psychiatry,* 27-35.
[96] Samuel Arnold et al, 'Barriers to healthcare for Australian autistic adults' (2024) 28(2) *Autism*, 301-315; Sophia Duckert et al, 'Barriers and needs in mental healthcare of adults with autism spectrum disorder in Germany: A qualitative study in autistic adults, relatives, and healthcare providers' (2023) 23 *Biomed Central Psychiatry*, 528.
[97] Australian Commission on Safety and Quality in Health Care, User Guide for the Health Care of People with Intellectual Disability, 2024; Christina Nicolaidis et al, 'Respect the way I need to communicate with you': Healthcare experiences of adults on the autism spectrum' (2015) 19(7) *Autism*, 824–831.
[98] Janelle Weise et al, 'Who provides primary health care for people with an intellectual disability: General practitioner and general practice characteristics from the BEACH dataset' (2107) 42(4) *Journal of Intellectual & Developmental Disability*, 416-421.

healthcare.[99] People with intellectual disability are included under the Australian Charter of Healthcare Rights and should be afforded the same right to access, safety, respect, partnership, information, privacy and ability to give feedback as any other member of the community requiring healthcare.[100]

During the investigation there was evidence that Mr Kelly experienced some of these barriers to safe and effective healthcare during his admissions to Robina Hospital and that there was a failure to uphold his rights under the Australian Charter of Healthcare Rights.[101]

8.2.5.1 Failure to assess and address individual needs

The intention of the NSQHSS Comprehensive Care Standard is to ensure patients receive comprehensive coordinated care that is aligned with patient goals and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing and is clinically appropriate.[102] Individuals with neurodevelopmental conditions may have difficulties expressing their symptoms, concerns, or preferences clearly. Advocacy helps bridge the gap ensuring their voices are heard, whether directly or through trusted family members. Families and caregivers have critical insights into individuals' baseline behaviours, health history and needs, and their input should be valued and integrated into care planning to enhance outcomes.

Mr Kelly's family, as his primary caregivers, had detailed knowledge of his daily functioning, communication methods, strategies for engagement and the triggers or calming strategies that could have informed a personalised approach to his care. The family's detailed knowledge of his typical behaviour, level of independence, and ways of expressing discomfort or distress was vital for distinguishing between his usual traits and the changes brought on by his illness and was essential information for healthcare providers. Accessing and recording this information was essential to ensure clinical staff were able to accurately assess his condition, develop a plan for communication and interaction and recognise the severity of any deterioration. Some information provided by Mr Kelly's family about his usual daily functioning and strategies to assist with providing care was recorded throughout his ieMR by members of the multidisciplinary team.

Similarly, Mr Kelly had been receiving care from his GP and a Psychologist in the community weekly in between admissions, each of whom provided important information about Mr Kelly's health status. The GP completed an Emergency Examination Authority which described Mr Kelly's recent behaviour, that he had failed to respond to treatment in the community and reasons why he required urgent examination.

---

[99] S. Bunbury, 'Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination' (2019) 19(1) *International Journal of Discrimination and the Law*, 26-47; C. Kripke, 'Patients with disabilities: Avoiding unconscious bias when discussing goals of care' (2017) 96(3) *American Family Physician* 192-195; Christian Möller et al, 'All inside our heads? A critical discursive review of unconscious bias training in the sciences' (2024) 31(3) *Gender, Work & Organization*, 797-820.

[100] Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights (Second Ed)' (2020).

[101] Ibid.

[102] Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards, Standard 5 Comprehensive Care, May 2021.

The community psychologist wrote a letter which summarised care provided to Mr Kelly, outlined his deterioration and made recommendations for care on discharge from hospital.

Although crucial information provided by Mr Kelly's family and health professionals providing services to him in the community was recorded in the ieMR, it was dispersed throughout the clinical record and not readily accessible. This lack of visibility and accessibility presented a barrier for the care team to be able to quickly access or comprehend essential details about Mr Kelly or specific considerations required to care for him effectively. As a result, clinicians providing care to Mr Kelly at Robina Hospital frequently operated without the context necessary to make informed decisions, leading to repeated errors or inconsistencies in care delivery. For example, staff consistently asked Mr Kelly if they could take his vital signs and documented in the clinical record his refusal, despite his mother recommending that rather than ask for permission or consent to provide care, which would always be met with a negative response, staff should be direct and advise what they intended to do to gain his cooperation.

There was no comprehensive care plan developed to meet Mr Kelly's needs, taking into consideration his autism and intellectual disability and accounting for his communication challenges and sensory sensitivities.[103] A comprehensive care plan reflecting agreed goals of care, and outlining planned medical, nursing and allied health activities was required and needed to be available at point of care. There was no agreed plan on how to monitor Mr Kelly's condition in terms of recording observations, recording his intake and output or taking blood tests. Access to a behaviour support team may have assisted with conducting a comprehensive patient assessment to understand fully Mr Kelly's unique abilities, preferences, and behavioural patterns, enabling the creation of tailored care strategies that addressed specific challenges and promoted his engagement with healthcare providers.

The situation highlights a systemic issue within the ieMR system, where critical information about complex, vulnerable patients is not easily flagged or prioritised. It is acknowledged that the ieMR system is a statewide electronic health record, and any changes to its design must be implemented at the state level. However, at the local level, there was a lack of clear workflows to ensure essential data was visible or consistently handed over, which exacerbated the problem. This breakdown not only compromised the quality of care but also placed undue stress on the patient, whose needs were overlooked, and on his family, who may have felt ignored. Addressing these issues requires improvements in both the design of electronic medical records and the processes for clinical handovers, ensuring that vital information is readily available at the point of care and actively shared among all members of the care team.

[103] Australian Commission on Safety and Quality in Health Care, 'National Safety and Quality Health Service Standards', May 2021, see Standard 1: Clinical Governance actions 1.16, 1.27 and Standard 2: Partnering with Consumers.

8.2.5.2 Reasonable adjustments

Mr Kelly's mother provided essential information on her son's sensory sensitivities and triggers for increased anxiety. An assessment of Mr Kelly in the ED on 21 July 2022 identified a lower sensory stimuli environment would be optimal for management of his agitation, distress and incidents of aggression. Mr Kelly was initially admitted to a single room on the medial ward, with his own bathroom, and was noted to have sought solace in the bathroom of the single room when he became distressed, something his mother had advised he would do to calm himself. Clinical records indicated that while he was in the single room Mr Kelly was drinking water and had begun to eat and drink small amounts of food and fluid offered. On 27 July 2022, the decision was made to transfer Mr Kelly to a four-bed bay. The treating team did not document the rationale for this. However, there was evidence in the progress notes recorded by allied health that provided some context for this decision. The social worker noted in the clinical record that during a conversation with Mr Kelly's mother, she was told that Mr Kelly remaining in a single room was not possible due to the high number of patients with illness/infections.

GCHHS notes that, 'Mr Kelly could not be moved into a single room because, at the relevant time, the COVID-19 pandemic was impacting on the availability of rooms and single rooms were reserved for those with the COVID-19 infectious disease'. The OHO acknowledges the challenges associated with the COVID-19 pandemic, including increased demands on bed availability and the allocation of single rooms. However, given the significance of the requirement for a single room noted at the time of Mr Kelly's admission and noting that the Gold Coast Health website indicates that the facility's 400 beds are predominantly single rooms,[104] the rationale for not prioritising Mr Kelly for a single room remains unclear.

Evidence of the distress this move caused him was recorded in the clinical notes. The RMO noted 'appears uncomfortable with 4 bed bay and as an inpatient' and that the 'computer on wheels caused visible distress'. The Consultant noted that Mr Kelly had begun to eat and drink small amounts, and this stopped when he was transferred to the four-bed bay. The GCHHS Bed Management Admission/Resource Co-ordination procedure outlines as one of the overarching principles that allocation of single rooms is based on clinical need and infection control status. The evidence in the clinical records indicated that Mr Kelly's sensory sensitivities justified that he be allocated a single room based on clinical need.

The physician clinical expert raised concerns regarding the fact that Mr Kelly had his initial needs documented as becoming distressed in a stimulating environment, and that as his oral intake and refusal to engage with the medical and nursing teams had not improved, it would not make sense to move him to an environment that would further distress him. The expert noted his clinical record indicated he was distressed by the new environment and his condition clearly deteriorated after he was transferred to the four-bed-bay, he refused to get out of bed, became incontinent of urine and threw drinks onto the floor.

[104] Queensland Government, Gold Coast Health, Hospitals and Centres: Robina Hospital (Sep 2017).

The clinical expert psychiatrist believed that Mr Kelly would have found the move to the four-bed bay very stressful, consistent with the clinical notes recorded. He explained that people with ASD have difficulty with social interaction and lack of predictability, which would have been issues in a shared room. Mr Kelly would also have had difficulties with sharing a toilet, which he used as a safe space.

The investigation found that there was a failure to give adequate consideration to Mr Kelly's specific needs and make reasonable adjustments to ensure his hospital environment accommodated his sensory sensitivities or minimised situations likely to cause agitation. This is demonstrated by the decision to transfer him from a single room to a shared four-bed bay, which was unlikely to support his best interests. Without these measures, Mr Kelly may have experienced heightened stress, exacerbated his condition and made it harder for staff to deliver care.[105]

Healthcare organisations must develop processes to ensure that the person receives care in the setting that best meets their needs.[106] When considering patient flow and placing a person in the right bed, it is important to ensure that the workforce is aware of the person's disability support needs so they can provide a person-centred approach and make reasonable adjustments to accommodate the patient's needs.[107] Ensuring Mr Kelly was able to be accommodated in a single room during his admission to accommodate his sensory needs by providing a low-stimulus environment would arguably be considered a reasonable adjustment. Such an adjustment would have reflected person-centred care, by ensuring Mr Kelly's individual needs were met to support his overall health and stability.

8.2.5.3 Protection of rights

Patient advocacy ensures healthcare providers respect the autonomy, preferences and humanity of individuals with neurodevelopmental conditions, but also to recognise when these individuals do not have capacity, other appointed decision makers can rightfully make decisions regarding their care and treatment. This is important in order to avoid paternalistic attitudes that can strip individuals and their appointed decision makers of agency in their care.

Both nursing and medical staff failed to recognise Mr Kelly's lack of capacity in respect to decision making about his care and treatment. Nursing staff documented his refusal to have vital signs taken and noted they did not want to persist with trying to record them without

[105] GCHHS Submission (June 2025) noted that Mr Kelly's needs were taken into consideration and that following the Code Black incidents on 22 July 2022 'collateral information was obtained from Mr Kelly's mother and NDIS to inform sensory changes to his room including noise and lighting preferences. This approach was a tailored adjustment strategy used to eliminate or reduce the severity of triggers which were exacerbating Mr Kelly's symptoms. Staff also tailored menu options in consultation with [Mr Kelly's mother] to encourage intake and involve carer engagement in treatment of malnutrition'.

[106] Australian Commission on Safety and Quality in Health Care, User Guide for the Health Care of People with Intellectual Disability (2024), see action 5.04.

[107] Australian Commission on Safety and Quality in Health Care, User Guide for the Health Care of People with Intellectual Disability (2024) defines a reasonable adjustment in healthcare as policies, processes, systems and communication aids that cater to the needs of the person with disability; Julian Trollor et al, 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data' (2017) 7(2) *British Medical Journal Open*; Pauline Heslop et al, 'Implementing reasonable adjustments for disabled people in healthcare services' (2019) 34(8) *Nursing Standard* 29-34; *Disability Discrimination Act 1992* (Cth) s 5.

his consent, despite his mother offering suggestions for how to gain cooperation for vital signs to be recorded. The medical team were hesitant to provide invasive treatment such as inserting a nasogastric tube for nutrition replacement or sedation to facilitate blood tests. This may be explained by the 'do no harm' principle, a cornerstone of medical ethics. Staff may have been concerned that this type of intervention might exacerbate Mr Kelly's condition, cause undue distress, further alienate him from healthcare providers or breach his right to refuse healthcare.

However, Mr Kelly was assessed as not having capacity to make decisions about his care during his presentation, rendering him unable to participate in discussions about his treatment. This placed the responsibility for decision-making on his appointed EPoA, his mother. Deeply distressed by her son's worsening condition, she strongly advocated for intervention such as insertion of a nasogastric tube and sedation to obtain blood tests, expressing her belief that her son was dying and required more aggressive treatment to have a chance at survival. At interview, Mr Kelly's mother explained that her rationale for this was to keep her son alive so that his mental health issues could then be addressed. The treating team appeared to disregard the information provided by Mr Kelly's mother regarding his baseline condition, the significant deterioration he had experienced over the period before both of his admissions to hospital, and the difficulties she was facing in providing care to Mr Kelly in the community since his decline. Despite his mother's intimate knowledge of his usual health and behaviour, her observations were clearly not adequately acknowledged or explored. Failure to adequately consider the firsthand perspective provided by Mr Kelly's mother and concerns raised by her and various members of his family likely impacted the treating team's ability to understand, recognise and address his worsening condition.[108]

Mr Kelly's condition continued to deteriorate despite the initial treatment plan. He was referred to ICU for review twice on 1 August 2022. The ICU Consultant was of the opinion Mr Kelly was receiving optimal treatment on the ward, and they would seek to avoid unnecessary invasive measures such as nasogastric tube and sedation as they were against Mr Kelly's wishes and could cause further harm. The ICU Consultant also suggested the medical team, who had admitted Mr Kelly, formalise his Acute Resuscitation Plan (ARP). No formal ARP was documented in the clinical records; however, on the morning of 2 August 2022, the progress notes reflect that after discussion regarding cares sought, Mr Kelly was not for CPR but for all other life prolonging measures. The professional opinion of the physician clinical expert was that Mr Kelly did not have capacity to make decisions about his healthcare and understand that at that time he was under the Guardianship Act with his mother acting as his EPoA and noted there was no evidence this was discussed with his mother in the clinical notes.[109]

[108] Australian Commission on Safety and Quality in Health Care, 'National Safety and Quality Health Service Standards', May 2021, see Standard 2 Partnering with consumers.
[109] *Guardianship and Administration Act 2000* (Qld).

Mr Kelly had two further MET calls overnight and on 2 August 2024, he was again clinically reviewed by his medical treating team and ICU medical staff and the decision was to continue to manage him on the ward within the capacity of his wishes. A second ICU consultant reviewed Mr Kelly on the afternoon of 2 August 2024 and believed Mr Kelly did not have the ability to consent to or refuse treatment due to the level of his biochemical derangement. The second ICU Consultant documented that after discussion with the family there was agreement that a blanket ARP was not appropriate and that each issue would be looked at as they came along and a decision would be made regarding what was sensible in the circumstances. He felt for the best chance of survival, Mr Kelly required an ICU admission, and he was subsequently transferred to ICU for care.

In relation to Mr Kelly's assessment on admission and subsequent transfer to ICU, the physician clinical expert opined that Mr Kelly did not have capacity to refuse oral intake, observations, examinations and blood tests and therefore should have been treated according to the gold standard for any 45-year-old male. He met the criteria for severe malnutrition on admission, and standard observations and blood tests would have alerted the treating team to the need for more aggressive nutrition support earlier in his admission. The physician clinical expert expressed concern that the earlier ICU reviews of Mr Kelly may have shown evidence of unconscious bias by underestimating his overall quality of life and assuming he required less ambitious care goals and/or exclusion from lifesaving therapies. The opinion was that unbiased care would have involved earlier transfer to ICU to facilitate nutritional support and intensive monitoring given his biochemical derangement and clinical status at the time.

During the investigation the health service demonstrated that clear information and guidance was available regarding consent,[110] EPoA,[111] Advanced Health Directives,[112] and Statutory Health Attorney frameworks.[113] However, the issue regarding the availability and accessibility of this information also underscores the responsibility to ensure staff are aware of the information and they actively seek and apply it in practice to ensure compliance with legal and ethical obligations.

The medical staff gave insufficient consideration to Mr Kelly's capacity and the legal authority of the EPoA held by his mother. This oversight raises significant ethical and legal concerns, particularly as Mr Kelly's mother was advocating for treatment in her role as the legally appointed decision-maker. Furthermore, their approach seemed to disregard Section 37 of the *Human Rights Act 2019* (Qld), which guarantees the right to access health services without discrimination and access to emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment.

[110] Gold Coast Hospital and Health Service, Informed Consent Procedure, version 5, effective from 24 August 2020.
[111] Queensland Government, FORM 9 — Enduring power of attorney explanatory guide, Version 1: approved for use from 30 November 2020; Office of the General Counsel – GCHHS, Information Sheet Enduring Power of Attorney, version 2.1, 30 July 2021; Queensland Health, Mental Health Act 2016, Guide to Advance Health Directives, Enduring Power of Attorney, Guardians and Administrators, April 2020.
[112] Office of the General Counsel – GCHHS, Information Sheet Advanced Health Directives, version 2.1, 27 July 2021.
[113] Office of the General Counsel – GCHHS, Information Sheet Statutory Health Attorney, version 3, 3 June 2022.

By failing to appropriately acknowledge the EPoA's authority and the patient's right to timely and effective medical care, the staff undermined the patient's legal protections and the ethical duty to respect his rights and dignity.[114] Medical staff seemed unfamiliar with the legislative framework underpinning healthcare decision making and failed to understand that the right to equal treatment does not mean the treatment should be the same but rather may need adapting to meet the patient's specific needs. This lack of compliance with established legal frameworks highlighted a concerning gap in their knowledge of the legal implications of EPoA documents and Human Rights legislation.

8.2.5.4 Diagnostic overshadowing and interdisciplinary disconnect

People with neurodevelopmental conditions present with higher rates of common mental ill-health, at a rate of two to three times higher than the general population.[115] A literature review and meta-analysis conducted by Lai et al. in 2019 reported that co-occurring mental health conditions are more prevalent in the autism population than in the general population. Interpretation of the findings noted that careful assessment of mental health is an essential component of care for all people on the autism spectrum and should be integrated into clinical practice.[116] Symptoms of mental health or physical illness in individuals with neurodevelopmental conditions may present atypically or be overlooked and attributed instead to their condition. This is known as diagnostic overshadowing, when new problems are attributed to a known diagnosis such as ASD.[117] Patient advocacy assists with ensuring these consumers have a thorough and unbiased assessment, preventing delays or errors in diagnosis.

In Mr Kelly's case, medical staff attributed his condition to behaviours associated with autism and failed to appropriately assess him and prioritise his immediate symptoms. This resulted in the failure to identify and address the underlying cause of his condition and develop a structured plan of care. His serious medical and mental health needs were overlooked when his behavioural disturbance, deterioration in mental health and restrictive eating were misinterpreted as inherent traits of ASD rather than indicators of a potentially treatable issue. Despite his condition not improving, the treating team continued to plan for discharge. This oversight highlights a systemic failure to prioritise the consumer safety and well-being, and may be attributed to diagnostic overshadowing and be suggestive of lack of knowledge or understanding among medical staff about how individuals with neurodevelopmental conditions may present with and experience health issues differently.

---

[114] GCHHS Submission (2025): 'GCHHS staff ensured that the treatment plans and goals and clinical interventions were flexible and reasonably tailored to the needs of Mr Kelly. This was done following discussion and collateral from his mother who was frequently involved in the care of Mr Kelly and consulted on issues of consent and capacity'.

[115] Einfeld et al, 'Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review' (2011) 36(2) *Journal of Intellectual and Developmental Disability*, 137–143; Cooper et al, 'Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors' (2007) 190 *British Journal of Psychiatry*, 27-35.

[116] Lai et al, 'Prevalence of co-occurring mental health diagnosis in the autism population: A systematic review and meta-analysis' (2019) 6(10) *The Lancet Psychiatry*, 819-829.

[117] Maire O'Dwyer et al, 'Medication use and potentially inappropriate prescribing in older adults with intellectual disabilities: A neglected area of research' (2018) 9(9) *Therapeutic Advances in Drug Safety* 535-557.

Further, potential unconscious bias against Mr Kelly's disabilities may have influenced clinical decisions, leading to delays in escalating his care to ICU, compromising his right to timely and adequate healthcare, a fundamental human right.[118] The lack of prompt intervention on Mr Kelly's deterioration highlighted systemic issues within the health service including the need for greater awareness and training on capacity assessment, disability rights, and the avoidance of discriminatory practices.

Evidence suggests that people with cognitive impairment have poorer health outcomes than the rest of the population and are more likely to experience discrimination in the provision of healthcare.[119] Literature suggests that health professionals and health services may be underequipped to meet the complex and often unique needs of individuals with cognitive impairment, including autism.[120]

During their formative training health professionals have limited opportunities to learn about and experience how to work with people with cognitive disability.[121] This is of particular importance given in 2018, the prevalence of disability in the Australian population was estimated at 18% (about 4.4 million people), including approximately 1.8% of the population with an intellectual disability (about 450, 000 people).[122] People with intellectual disability present with higher rates of common mental ill-health at a rate of two to three times higher than the general population.[123] The investigation identified clinical staff appeared to have lacked specific skills required to adequately assess Mr Kelly and implement an appropriate care plan addressing his unique needs, including understanding sensory sensitivities, behavioural triggers, communication preferences and the importance of engagement with his family and supporters.

The clinical expert psychiatrist identified evidence of diagnostic overshadowing during Mr Kelly's admission to Robina Hospital. Evidence suggests the first step to preventing the occurrence of diagnostic overshadowing requires acknowledging that it exists, and recognising the occurrence of it can have serious implications.[124] Other recommendations for prevention of diagnostic overshadowing include training and education on trauma informed

---

[118] *Convention of the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008), article 25; Australian Commission on Safety and Quality in Health Care, 'Australian Charter of Healthcare Rights' (2nd ed, 2020).

[119] Australian Commission on Safety and Quality in Health Care, 'Health outcomes for adults with cognitive impairment: a national analysis of public hospital admitted care' (Report, August 2023); Jeromey B Temple et al, 'Discrimination and avoidance due to disability in Australia: evidence from a National Cross Sectional Survey' (2018) 18 *BMC Public Health*.

[120] Chloe Walsh et al, 'Barriers to healthcare for persons with autism: A systematic review of the literature and development of a taxonomy' (2020) 23(7) *Developmental Neurorehabilitation* 413-430.

[121] Michele Lee et al, 'Providing equitable access to health care for individuals with disabilities: An important challenge for medical education' (2021) 44, *Harvard Public Health Review*; Julian Trollor et al, 'Intellectual disability content within pre-registration nursing curriculum: how is it taught?' (2018) 69 *Nurse Education Today* 48-52; Julian Trollor et al, 'Has teaching about intellectual disability healthcare in Australian medical schools improved? A 20-year comparison of curricula audits' (2020) 20(1) *Biomed Central Medical Education* 321.

[122] Australian Institute of Health and Welfare, People with disability in Australia, (2024) catalogue number DIS 72, Australian Government.

[123] Stewart Einfeld et al, 'Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review' (2011) 36(2) *Journal of Intellectual and Developmental Disability*, 137–143; Sally-Ann Cooper et al, 'Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors' (2007) 190(1) *British Journal of Psychiatry,* 27-35.

[124] Ann Hallyburton, 'Diagnostic overshadowing: An evolutionary concept analysis on the misattribution of physical symptoms to pre-existing psychological illnesses' (2022) 31(6) *International Journal Mental Health Nursing* 1360-1372.

care,[125] engaging in self-critical evaluation,[126] and improved collaboration between physical and mental healthcare professionals.[127] Literature suggests training and awareness should not be limited to medical staff and acknowledges the critical role of nurses as hands on carers and lead advocates for patient care.[128] Empowering staff to identify and address the risks of diagnostic overshadowing can enhance the delivery of equitable care, improve patient outcomes, foster critical thinking, and support ongoing professional development. Additionally, this approach aligns with legal and ethical responsibilities, ensuring person-centred care.

This investigation highlighted the interdisciplinary disconnect between the medicine and psychiatry teams caring for Mr Kelly. The medicine team referred him to psychiatry to determine if the changes in his behaviour and restrictive eating could have been attributed to a mental health disorder. Undoubtedly the expectation would be that Mr Kelly would undergo a thorough assessment which would provide insights and inform his care plan. However, in this case, the psychiatry team limited their input to a chart review and obtained collateral information from Mr Kelly's mother, which is likely to have led to an incomplete understanding of his condition. This approach risks misdiagnosis and creates a barrier for the medical team to revisit or explore the patient's condition from a multidisciplinary perspective. When he was showing no signs of improvement, Mr Kelly would have benefited from an interdisciplinary case conference to ensure all contributing factors to his health were thoroughly explored in a holistic way, allowing for mutual accountability and prioritisation of patient-centred care.

The clinical expert psychiatrist consulted by the OHO noted that ASD is a lifelong disorder and is not progressive. Further, in Mr Kelly's case his autism appeared to be mild and while it had limited his opportunities, it had not in itself presented a problem. The changes in his behaviour were indicative of the onset of an additional problem that was modified in its presentation by his autism and intellectual disability. Believing that he was 'suffering from a behavioural disturbance of severe autism' would have limited the opportunity to consider other explanations that may have led to appropriate treatment. A thorough mental health assessment should have identified the likelihood of a major depressive illness leading to appropriate treatment and possibly preventing his subsequent death. The physician clinical expert noted that ASDs are known to be associated with a lesser known eating disorder called Avoidant Refusal Food Intake Disorder (ARFID) which is a psychiatric diagnosis. There were no clinical notes indicating this disorder was considered.

---

[125] Hanni Stoklosa et al, 'Human trafficking, mental illness, and addiction: Avoiding diagnostic overshadowing' (2017) 19(1) *American Medical Association Journal of Ethics* 23-34.
[126] David Wood and Terence Tracey, 'A brief feedback intervention for diagnostic overshadowing' (2009) 3(4) *Training and Education in Professional Psychology* 218-225.
[127] Guy Shefer et al, 'Improving the diagnosis of physical illness in patients with mental illness who present in emergency departments: Consensus study' (2015) 78(4) *Journal of Psychosomatic Research* 346-351; A van Nieuwenhuizen et al, 'Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness' (2013) 22(3) *Epidemiology and Psychiatric Sciences* 255-262.
[128] Lauren Chuttoo and Vijay Chuttoo, 'Supporting patients with serious mental illness during physical health treatment' (2019) 34(6) *Nursing Standard* 77-82; Concepcion Martinez-Martinez et al, 'A qualitative emancipatory inquiry into relationships between people with mental disorders and health professionals' (2021)28(4) *Journal Psychiatric Mental Health Nursing* 721-737.

This underscores the critical need for comprehensive evidence-based training to enhance healthcare professionals' competencies in communication, care planning, and the implementation of reasonable adjustments for cognitively impaired patients. Implementing disability focused training for healthcare providers can improve knowledge, attitudes and skills, leading to more equitable and effective healthcare for patients with cognitive impairment.[129]

8.2.5.5 Recommendations

See recommendations 1-3 above at 8.2.1.2 regarding training and recommendation 5 at 8.2.2.2 regarding strategies to improve access to specialist services as required for consumers with neurodevelopmental disorders and intellectual disabilities.

11. Conduct a review of current screening tools used for clinical assessment of consumers with intellectual disabilities. Where necessary standardise and update assessment tools to ensure essential baseline data is recorded, available at point of care and updated when required. Clinical assessment of consumers with intellectual disabilities should include cognitive, behavioural, mental and physical conditions, identifying any issues or risks of harm throughout admission and specific questions addressing communication abilities, cognitive functioning, sensory processing, and support needs and preferences.
12. Actively promote Queensland Health Julian's Key Health Passport[130] to raise awareness among staff and relevant consumers using the health service.[131] Develop a reliable method for ensuring consumer baseline information, relevant for each admission, can be effectively obtained, communicated and available. Consider whether this may be achieved through introducing the Health Passport Chart Summary,[132] a document designed to summarise key information from a consumer's Julian's Key Health Passport (if the consumer has one) and provided by the consumer/carers and family relevant to each admission.

8.2.6 Ryan's Rule

Mr Kelly's mother raised concerns about her son's condition to various members of the multidisciplinary team including social work, medical and nursing staff during his second admission. Throughout his second admission she explained to staff she felt her son was

[129] Gracie Hay et al, 'Educating the educated: The impact of educational interventions on knowledge, attitudes and confidence of healthcare professionals caring for patients with intellectual disability: A systematic review' (2023) 49(2) *Journal of Intellectual and Developmental Disability* 134-145; Rae Morris et al, 'Healthcare providers' experiences with autism: A scoping review' (2019) 49(6) *Journal of Autism and Developmental Disorders* 2374-2388.
[130] Julian's Key Health Passport is a consumer-controlled communication tool designed to improve accessibility of information relevant to communication and healthcare needs of consumers with intellectual and physical disabilities. It helps people with a disability communicate their needs and healthcare professionals to understand them.
[131] Information obtained from Qld Health: Updated version of Julian's Key Health Passport was released by Qld Health in December 2024; an implementation guide for hospitals and health services is available and other resources including online webinars and education workshops which will continue throughout 2025, and a Project Advisory Group commenced in February 2025; RD\25\14513 Julian's Key Health Passport Implementation Guide.
[132] RD\25\14515 Health Passport Chart Summary. Queensland Health have advised this form can be uploaded to the Viewer to support visibility across services including primary care and QAS.

going to die and requested sedation to enable him to receive nutrition and obtain blood tests to assess his health status. His mother was uncomfortable with plans for discharge as she felt his condition was worsening, that he had not eaten properly for months and was not showing any signs of improvement. When Mr Kelly was moved from a single room to a four-bed bay his mother made a plea with staff to allow him to stay in a single room and again expressed concern about her son's deterioration and the lack of a plan for his care. The clinical notes indicate she expressed disbelief at the medical opinion that her son did not require medical attention and did not have a mental health condition. On the day before Mr Kelly was admitted to ICU his mother requested a second opinion from an external private psychiatrist and behavioural therapist at her expense. Following this request, the RMO recorded in the progress notes that he had discussed Ryan's Rule and the possibility of Gold Coast Hospital Psychiatry performing an inpatient review with Mr Kelly's mother. The RMO noted that the request for private health service review was denied as Mr Kelly was an inpatient. There was no evidence that a Ryan's Rule was activated or any further involvement from Gold Coast Hospital Psychiatry was actioned.

Ryan's Rule is a three-step process for patients, families and carers to raise concerns if a patient's health condition is getting worse or not improving as expected and applies to all patients admitted to any Queensland Health public hospital.[133] The GCHHS Ryan's Rule Procedure[134] applies to all GCHHS employees, and outlines the premise for involving families in early recognition and response to clinical deterioration noting that although families have no responsibility for formal assessment of clinical changes in the patient condition, their familiarity with their relative places them at an advantage in recognising subtle changes that might suggest early stages of deterioration. The procedure also states that to better improve early detection and management of clinical deterioration, patients' families and carers engagement must be considered. Acknowledging concerns and fostering better communication between clinical staff and consumers provides an additional patient safety component of care.

GCHHS Ryan's Rule procedure requires that 'upon a patient's arrival on the admitting inpatient unit, nursing staff must raise awareness and inform the patient, their families and/or carers of the GCHHS Ryan's Rule process' and at handover of every shift, 'the incoming nursing staff should check with the patient whether they have any clinical concerns about their care and their awareness and understanding of Ryan's Rule'. This would extend to Mr Kelly's mother as his next of kin.

At interview Mrs Kelly recalled requesting a review by external experts including a neuropsychiatrist and a behavioural therapist; however, this request was denied by the treating team as it was a conflict of interest. She recalled speaking with her son's treating medical team raising concerns about his condition and explaining that the two experts were willing to come in and see him at her expense and all they needed was permission. She believed during that conversation she had raised Ryan's Rule; however, she was later advised

[133] Queensland Government, *Ryan's Rule,* November 2024 <Ryan's Rule | Health and wellbeing | Queensland Government>.
[134] RD\24\16364 PRO1264 GCHHS Ryan's Rule Procedure (version 3) effective 22 March 2021.

that this was not done as per the process required. Mr Kelly's mother advised during interview that she was aware of Ryan's Rule but denied ever being given any information on how to officially activate a Ryan's Rule response until she saw a brochure in the ICU waiting room.

Mr Kelly's mother had raised valid concerns about her son's condition on several occasions, which were not given due attention by the medical team. Her advocacy for her son was crucial, yet it was overlooked, arguably leading to a delay in appropriate diagnosis and treatment. She requested a second opinion from an external expert, a reasonable and often essential step when complex or unresolved medical issues persist. The refusal to facilitate this undermined the family's trust in the healthcare system and limited Mr Kelly's access to comprehensive care. The medical team documented a discussion regarding Ryan's Rule with Mr Kelly's mother in their clinical notes but failed to action it.

Additionally, while his mother was aware of Ryan's Rule she was not provided the requisite information on how to activate this response, contrary to hospital policy which mandates that families be informed of their rights, including the Ryan's Rule process. This lack of communication represents a systemic failure to empower Mr Kelly's mother with the tools necessary to advocate for her son's care effectively. It also represents a failure by the medical team to recognise and respond to concerns raised by Mr Kelly's mother as a request to activate Ryan's Rule.[135]

Both the clinical expert physician and psychiatrist opined that it would have been appropriate for a second opinion to be sought in relation to Mr Kelly's condition from a psychiatrist with a special interest in autism, as requested by his mother, given the complexity of his case.[136] Both experts noted the difficulties that can arise with credentialling of external experts and the process required to arrange consultation in the public hospital system; however, it would have been appropriate for the request to have been discussed with the local mental health service and or the CLP team. No evidence that this occurred was documented in the ieMR.

8.2.6.1 Recommendations

13. Conduct an evaluation of current information available across the organisation related to Ryan's Rule; assess staff and consumer awareness of Ryan's Rule and the steps involved in the process. Identify any areas for improvement and implement relevant actions to raise awareness of the Ryan's Rule process. In 12 months provide the OHO with a report outlining evaluation results and improvements identified and implemented in relation to Ryan's Rule.

[135] GCHHS Submission (June 2025) noted staff reported requests made by Mr Kelly's mother were all implemented and initiated in the care, until August 2022 when she sought to use more invasive practices (nasogastric tube) which the treating team considered would further deteriorate Mr Kelly's condition and alienate him from healthcare.
[136] GCHHS Submission (June 2025) noted due to credentialling, external clinicians could not be brought in to provide opinion as requested by Mr Kelly's mother in the timeframe required.

8.2.7 Governance

Effective governance systems within a health service play a crucial role in improving outcomes for consumers with intellectual disabilities. By ensuring accountability, consistency, and compliance with national standards, governance frameworks help deliver high-quality, person-centred care. By integrating effective governance systems through data collection, clear policies, disability service plans and strong leadership, health services can provide safe, inclusive, high-quality care to consumers with intellectual disability and ensure compliance with national standards and equitable healthcare access.

8.2.7.1 Recommendations

14. Within six months GCHHS/Robina Hospital undertake an organisation wide self-assessment to identify strengths and weaknesses in relation to the health service's capability to provide health services for people with neurodevelopmental disorders. Identify areas of action for the organisation to focus on to ensure the organisation has capacity to provide safe and high-quality healthcare to people with neurodevelopmental disorders.

    Guidance on how this might be undertaken can be found in other Australian jurisdictions, including, for example, NSW Health Intellectual Disability Essentials.

15. Within six months GCHHS/Robina Hospital develops and outlines a strategy to collect both qualitative and quantitative data related to consumers with neurodevelopmental disorders who use the health service. This should include, but not be limited to, numbers of consumers with neurodevelopmental disorders who use the hospital's services, which services are most utilised, the availability of accessible feedback tools for consumers/carers and family to provide feedback on individual experiences, barriers to access and unmet needs, and analysis of clinical outcomes. Analysis of the data must be completed to inform service planning and improve health outcomes. Within 12 months the hospital is to provide a report to the OHO on data collected, analysis and any actions arising from this, and where the information is tabled and discussed.

16. Recognise and consider people with neurodevelopmental disorders when reviewing and developing policies, procedures and guidelines. Ensure policies/procedures/guidelines support reasonable adjustments, disability inclusion and access strategies, allowing for flexibility of service delivery and focus on building workforce knowledge, neurodevelopmental disorder awareness, and confidence in communication and caring for people with neurodevelopmental disorders.[137] At 12 months provide a report to the OHO outlining policies, procedures and guidelines (clinical, administrative, and operational) which have been reviewed and amended, with explanation. The hospital should prioritise policies based on their relevance to

[137] Australian Commission on Safety and Quality in Health Care, User Guide for the Health Care of People with Intellectual Disability, 2024; The Royal Australian and New Zealand College of Psychiatrists, 'Intellectual disabilities: Addressing the mental health needs of people with ID', position statement (2022).

consumers with intellectual disability, for example patient communication and clinical handover, consent, clinical assessment and service access policies.

17. Within 12 months GCHHS/Robina Hospital must develop a Disability Service Plan, for example, see Metro South Health, and outline governance structures for oversight of this plan.
18. Review governance committees to identify those instances where consumers with an intellectual disability have family members or carers who might provide relevant insight and input. Assess the current level of consumer representation and consider recruitment and appointment of these consumers where appropriate. At 12 months, provide a progress report on this process and outline any evaluation undertaken to measuring the effectiveness of including these consumers on identified relevant committees.

9 Root Cause Analysis (RCA)

Details of the RCA investigation undertaken by Gold Coast Hospital and Health Service related to the care and treatment provided to Mr Kelly cannot be discussed in this report. Commissioned RCAs are confidential undertakings with protections on the contents of the investigation and recommendations made, pursuant to the *Hospital and Health Boards Act 2011* (Qld). This investigation considered the recommendations made in the RCA report and determined they did not sufficiently address the issues identified in this report. As a result, the Health Ombudsman has made the recommendations outlined below.

10 Recommendations

1. Within six months GCHHS/Robina Hospital will complete an organisation training needs analysis by comparing current available education and competencies related to care of consumers with neurodevelopmental disorders against training requirements arising from the NSQHSS Guide for Health Care of people with intellectual disability. This should include a staff survey allowing staff to self-assess their confidence, skills, knowledge and attitudes in caring for consumers with neurodevelopmental disorders.
2. Within 12 months GCHHS/Robina Hospital will develop and provide access to relevant training and additional resources (best practice guidelines, integrated care pathways, clinical pathways and decision support tools) to:
    a. improve disability awareness among health providers and increase understanding about barriers people with intellectual disability experience when accessing healthcare. Training should address disability awareness, complex care needs, safety and quality risks, reasonable adjustments, legal and ethical considerations (capacity,

decision making, human rights considerations, etc.), patient advocacy and increasing awareness of the role of NDIS service providers.[138]

b. enable staff to recognise when a consumer with neurodevelopmental disorders requires specialist support beyond the health service's scope and ensure awareness of relevant referral pathways.

c. educate staff regarding requirements in circumstances when a person's physical, emotional or behavioural state affects their ability to participate in shared decision making and consent to treatment. Ensure information includes how and when to engage substitute decision makers or nominated persons, and guidance on EPoA, Advanced Health Directives and Statutory Health Attorney Frameworks.

3. Within 18 months GCHHS/Robina Hospital will provide the OHO with details of training resources developed and implemented, and data detailing staff attendance/participation in training from each area of the clinical workforce including nursing, medical and allied health.

4. Within 6 months review the *GCHHS CLP intake and patient review process work instruction* and make appropriate amendments to*:*

   a. ensure where a consumer is triaged as appropriate for an in-person assessment by the CLP team, but the mental state examination is unable to be completed, the clinical documentation in the consumer's ieMR must clearly outline attempts made to undertake the assessment and reasons it was unsuccessful. This includes but is not limited to, for example, where the consumer refuses to engage or other barriers preventing the assessment from proceeding. In such cases, this information must also be communicated to the referring team, along with a clear plan of action moving forward to support the consumer's ongoing care.

   b. ensure the outcome of any assessment undertaken, recommendations for treatment made or advice given by CLP is documented in the patient's ieMR.

   Within 12 months, GCHHS will conduct a targeted audit of a sample of inpatient referral review documentation to ensure the process is being undertaken appropriately. Findings from the audit should inform any required improvements to documentation practices.

5. It is recommended that GCHHS engage proactively with Queensland Health to explore and implement strategies and pathways that ensure timely and equitable access to specialist mental health advice, assessment and treatment for patients with neurodevelopmental disorders and intellectual disability. This collaboration should focus on developing clear referral pathways, expanding specialist outreach services, and enhancing the capacity of local teams through shared care models and targeted training.

   This engagement should assist GCHHS with:

[138] See resources available at: Queensland Government, Queensland Health – People with disability, CheckUp, Australian Government, DoHAC Intellectual Disability Health Capacity Framework and ID Health Education – Health Professionals

a. mapping approved available local and regional resources with expertise in neurodevelopmental disorders including approved external specialist and services, such as intellectual disability services, specialised mental health providers and social services.

b. developing a directory of available resources that is accessible and known to staff.

c. developing clear referral pathways for consumers with neurodevelopmental disorders and intellectual disability who require additional specialist services and embed these into existing processes.

d. developing a pathway for engaging clinical expertise and resources not included on the GCHHS local list of recognised providers.

6. It is recommended that GCHHS undertake a comprehensive evaluation of the implementation of Patient Safety Net. This should include an assessment of clinician awareness of the program across all departments, as well as a detailed analysis of program usage since its inception. The evaluation should specifically capture the frequency and nature of concerns raised, disaggregated by clinical stream, to identify patterns of use and any underutilised areas. Findings should inform targeted communication, education strategies, and system refinements to support broader engagement and sustained integration into clinical practice if required.

7. GCHHS/Robina Hospital undertake measures to improve staff awareness and compliance with requirements for recognising and responding to patient deterioration including:

   a. consider the development of a tool for recording behavioural changes and mental health status for patients with neurodevelopmental conditions as an instrument for objectively documenting improvement or deterioration in mental state and escalation protocols.

   b. undertake an audit of clinical handover processes (medical/nursing) to determine whether patients and or their families/carers are given opportunity to be involved in handover, and to what extent early signs of patient deterioration and risk factors associated with this are included in the handover framework. Table results at the appropriate governance committee, develop an action plan for implementation of necessary improvements, ensure staff receive feedback, and implement training where required.

   c. enhance training and education related to patient assessment, recognition and responding to deterioration through inclusion in onboarding education, regular mandatory training and scenario-based simulations. Include education on recognising soft signals for deterioration and the importance of gaining information and understanding consumer's baseline. Consider the development and inclusion of a training scenario based on Mr Kelly's story to reinforce the practical application of the importance of recognising and responding to clinical deterioration.

d. continue to monitor compliance with policies/procedures and guidelines associated with patient assessment and recognising and responding to patient deterioration, table at appropriate governance committees and undertake improvement actions where required. Develop feedback loops to ensure constructive feedback on non-compliance and recognition of excellence in practice is provided to clinical staff.

e. consider the introduction of tiered multidisciplinary safety huddles at various levels throughout the organisation (executive, service and unit level) which include discussion on patients of concern or with complex issues at risk of deterioration.

f. review current relevant policies/procedures/guidelines related to vital signs and observations to ensure there is a mandatory escalation process outlined for staff to follow when patients are unable to have vital signs and observations recorded as per the frequency required. Consider the introduction of a formal policy/mandatory escalation protocol, requiring staff to escalate concerns when they are unable to obtain the required observations for a defined period (e.g. within 24 hours). The protocol should include a tiered escalation process, ensuring timely intervention by senior clinical staff and mandatory documentation of all unsuccessful attempts to obtain observations.

8. After 12 months GCHHS/Robina Hospital are to provide a report to the OHO on Gold Coast Hospital and Health Service's progress in operationalising the Queensland Health Patient Safety Net initiative. This should include information on the implementation of the initiative, rollout of GCHHS Clinical Safety Escalation Pathway – Nursing and Midwifery, training provided to staff, evaluation, and measures of success/areas for improvement.

9. Undertake organisation wide escalation mapping (see ACSQHC template) in relation to recognising and responding to deterioration in mental state and how the recognition of deteriorating patient (RODP) system works for consumers with neurodevelopmental conditions and address any barriers identified to recognising and responding to escalation. The mapping should include assessment of:

   a. training needs, including conducting an analysis of current workforce skills and availability of comprehensive contemporaneous and accessible information and training.

   b. availability of context specific tools (in addition to Q-ADDs) for recording behavioural changes and mental health status for patients with neurodevelopmental conditions as an instrument for objectively documenting improvement or deterioration in mental state and associated escalation protocols.

   c. measures in place to minimise the risk of harm including risk screening, comprehensive care plans, processes for escalation when mental health deteriorates and availability of additional response teams (CLP etc.).

d. the use of Ryan's Rule to escalate concerns about care or condition by the patient, family and/or carers.

e. information and communication systems including what information is available at point of care about the patient.

f. assess whether environmental factors are likely to cause additional stress to consumers with a cognitive disability and are factors modifiable to minimise stress.

g. evaluation of the overall effectiveness of systems for recognising and responding to deterioration in a person's mental state.

Within 12 months, provide the OHO with an update on the progress of mapping and outcomes resulting from mapping process.

10. Within 6 months, GCHHS/Robina Hospital) reviews the *GCHHS Malnutrition risk screening for adult inpatients procedure* to specify the time period for assessment of weight loss in the past six months. If possible, amend the ieMR where this information is recorded to include a prompt to reflect this.

11. Conduct a review of current screening tools used for clinical assessment of consumers with intellectual disabilities. Where necessary standardise and update assessment tools to ensure essential baseline data is recorded, available at point of care and updated when required. Clinical assessment of consumers with intellectual disabilities should include cognitive, behavioural, mental and physical conditions, identifying any issues or risks of harm throughout admission and specific questions addressing communication abilities, cognitive functioning, sensory processing, and support needs and preferences.

12. Actively promote Queensland Health Julian's Key Health Passport[139] to raise awareness among staff and relevant consumers using the health service.[140] Develop a reliable method for ensuring consumer baseline information, relevant for each admission, can be effectively obtained, communicated and available. Consider whether this may be achieved through introducing the Health Passport Chart Summary,[141] a document designed to summarise key information from a consumer's Julian's Key Health Passport (if the consumer has one) and provided by the consumer/carers and family relevant to each admission.

13. Conduct an evaluation of current information available across the organisation related to Ryan's Rule; assess staff and consumer awareness of Ryan's Rule and the steps involved in the process. Identify any areas for improvement and implement relevant actions to raise

[139] Julian's Key Health Passport is a consumer-controlled communication tool designed to improve accessibility of information relevant to communication and healthcare needs of consumers with intellectual and physical disabilities. It helps people with a disability communicate their needs and healthcare professionals to understand them.
[140] Information obtained from Qld Health: Updated version of Julian's Key Health Passport was released by Qld Health in December 2024, an implementation Guide for hospitals and health services is available and other resources including online webinars and education workshops which will continue throughout 2025, and a Project Advisory Group commenced in February 2025; RD\25\14513 Julian's Key Health Passport Implementation Guide.
[141] RD\25\14515 Health Passport Chart Summary. Queensland Health has advised this form can be uploaded to the Viewer to support visibility across services including primary care and QAS.

awareness of the Ryan's Rule process. In 12 months provide the OHO with a report outlining evaluation results and improvements identified and implemented in relation to Ryan's Rule.

14. Within six months GCHHS/Robina Hospital undertake an organisation wide self-assessment to identify strengths and weaknesses in relation to the health services capability to provide health services for people with neurodevelopmental disorders. Identify areas of action for the organisation to focus on to ensure the organisation has capacity to provide safe and high-quality healthcare to people with neurodevelopmental disorders.

    Guidance on how this might be undertaken can be found in other Australian jurisdictions, including, for example, NSW Health Intellectual Disability Essentials.

15. Within six months GCHHS/Robina Hospital develops and outlines a strategy to collect both qualitative and quantitative data related to consumers with neurodevelopmental disorders who use the health service. This should include, but not be limited to, numbers of consumers with neurodevelopmental disorders who use the hospital's services, which services are most utilised, the availability of accessible feedback tools for consumers/carers and family to provide feedback on individual experiences, barriers to access and unmet needs, and analysis of clinical outcomes. Analysis of the data must be completed to inform service planning and improve health outcomes. Within 12 months the hospital is to provide a report to the OHO on data collected, analysis and any actions arising from this, and where the information is tabled and discussed.

16. Recognise and consider people with neurodevelopmental disorders when reviewing and developing policies, procedures and guidelines. Ensure policies/procedures/guidelines support reasonable adjustments, disability inclusion and access strategies, allowing for flexibility of service delivery and focus on building workforce knowledge, neurodevelopmental disorder awareness, and confidence in communication and caring for people with neurodevelopmental disorders.[142] At 12 months provide a report to the OHO outlining policies, procedures and guidelines (clinical, administrative, and operational) which have been reviewed and amended, with explanation. The hospital should prioritise policies based on their relevance to consumers with intellectual disability, for example patient communication and clinical handover, consent, clinical assessment and service access policies.

17. Within 12 months GCHHS/Robina Hospital must develop a Disability Service Plan for example, see Metro South Health, and outline governance structures for oversight of this plan.

[142] Australian Commission on Safety and Quality in Health Care, User Guide for the Health Care of People with Intellectual Disability, 2024; The Royal Australian and New Zealand College of Psychiatrists, 'Intellectual disabilities: Addressing the mental health needs of people with ID', position statement (2022).

18. Review governance committees to identify those instances where consumers with an intellectual disability have family members or carers who might provide relevant insight and input. Assess the current level of consumer representation and consider recruitment and appointment of these consumers where appropriate. At 12 months, provide a progress report on this process and outline any evaluation undertaken to measuring the effectiveness of including these consumers on identified relevant committees.

11 Adverse comment phase

Under the *Health Ombudsman Act 2013* (Qld), an entity must be given an opportunity to respond to a report that makes adverse comment about the entity, and the entity is identifiable from the report.[143]

Adverse comment submissions were received from practitioners involved in Mr Kelly's care (see above at section 8). The submissions provided insight and explanation into events that occurred and clinical decisions made during Mr Kelly's admissions. These submissions were carefully considered as part of the investigation and contributed to the broader understanding of the context in which care was delivered

GCHHS submitted an adverse comment response on 30 June 2025. Relevant sections of this submission are referred to throughout the report above or extracted or summarised below.

Topic	Submission
Submission overview	'GCHHS acknowledges that there are important lessons for the medical, nursing and allied health professional streams, and inter-disciplinary coordination arising from management of the complex nature of Mr Kelly's diagnosis and treatment. GCHHS has taken a range of actions to make necessary improvements many of which overlap with the recommendations made by the Office of the Health Ombudsman (OHO) in the draft report'. 'This matter concerns a unique case with complexity that is rarely seen at GCHHS. It is a case that falls outside of routine clinical practice typically encountered within the health service'. 'The OHO report will potentially have an important role in making lasting improvements to inter-disciplinary and cross-divisional service delivery in complex cases such as this. For that to be the case, our staff need to feel that their perspectives have been considered'. 'GCHHS has learnt from this case and has been committed to embedding its learnings in its policies, practices and governance across the health service, implementing recommendations made in the Root Cause Analysis report and actioning additional measures to strengthen staff awareness and education of patients with intellectual and neurodevelopmental disorders'.

[143] *Health Ombudsman Act 2013* (Qld) s86(3)

Topic	Submission
Grounds of submission	GCHHS commented on the 'rarity of such cases in a district general hospital and … the extent of medical expertise or specialism in specific intellectual and developmental disability related disorders needed to manage such patients was generally not found in clinicians working in GCHHS hospitals and indeed across the Queensland health system, at least at the time'. 'While staff training at Robina Hospital in dealing with the complex needs of patients was lacking, it represented the norm in Australia at that time. The training undertaken by the staff represents the standard training in Australia provided to clinicians. It is also unrealistic to expect that the generalist adult or Consultation-Liaison Psychiatrists (CLP) at GCHHS would have specialised training and experience in intellectual disabilities and developmental disorders when the training for psychiatry in Australia does not include this component as part of the college curriculum (in 2022 or even now in 2025)'." GCHHS expressed concerns that the report did not address the impacts of the COVID-19 pandemic on the availability of single room accommodation at the time, this has been addressed at 8.2.5.2. 'Some of the recommendations being proposed are represent expectations for the health service to implement measures well above and beyond what is in existence in health services across Queensland, while many have been implemented by the health service in some shape or form. Importantly, there have been no presentations akin to this case since OHO's first review of this matter, even in the absence of the implementation of the raft of recommendations being proposed now'.
Environmental context	GCHHS in their submission raised concerns about assertions made within the report regarding inadequate assessments, diagnostic overshadowing, failures to make reasonable adjustments and failure to escalate without acknowledging the complexity of the case, limited clinical specialist knowledge across Australia for this type of consumer, and staff concerns about their work health and safety. 'The training deficit for clinical staff at the time was an issue not unique to GCHHS but an issue that requires a system wide solution … the staff were out of their depth, working beyond their level of confidence and capability'.
Systemic concerns	GCHHS commented that drawing conclusions about systemic failures from a single case may be misrepresentative. They emphasised the challenges identified reflect broader system-wide issues in caring for neurodiverse patients, rather than failings unique to GCHHS.
Clinical care	GCHHS emphasised that this was an exceptionally complex case. While acknowledging missed opportunities for nursing assessment and escalation, GCHHS highlighted that staff were working with a challenging clinical environment, including concerns about occupational violence.

Topic	Submission
Other observations	'Balancing competing clinical needs across a busy ward environment is inherently complex. While retrospective analysis may suggest a clear cause and effect relationship, this was not clinically apparent at the time. If the indicators of deterioration or complexity had been evident, appropriate nursing and multidisciplinary actions would have been initiated to meet the patient's needs. Decisions were made based on the information available at the time, the relevant training of the staff, within the constraints of a high acuity clinical setting and the requirements for single rooms for infectious patients'. GCHHS also noted that 'there was collaboration between teams but this was impacted by the complex presentation of a neurodevelopmental disorder which is less understood by GCHHS staff'.
Recommendations	'GCHHS acknowledges that there were failures in the care provided to Mr Kelly, including recognising and escalating clinical deterioration and maintaining a clearer clinical record of clinical considerations and decisions'. 'In response to Mr Kelly's case, GCHHS has implemented significant measures to ensure such a case does not occur again'.

The OHO acknowledges the comments provided in the GCHHS submission to adverse comment.

The OHO recognises this context and the broader system-wide challenges associated with caring for patients with neurodiversity and significant behavioural complexities within general hospital settings. However, the proportion of individuals in Australia living with disabilities, including those with neurodiverse conditions, is not insignificant (see 8.2.5). It is essential that this cohort is able to access mainstream healthcare services and is afforded the same standard of patient-centred care as all other consumers.

In relation to the allocation of a shared bay rather than a single room, the OHO notes GCHHS's explanation that the prioritisation of single rooms at that time was necessitated by COVID-19 isolation requirements. While operational pressures are acknowledged, the OHO also notes that the majority of rooms at Robina Hospital are single rooms and maintains that reasonable adjustments for vulnerable patients should be actively considered, to the extent practicable, alongside infection control measures.

The OHO accepts GCHHS's position that findings of systemic failings must be balanced against the volume and complexity of presentations managed safely and appropriately each year. The report is intended to highlight areas where lessons may be drawn to inform improvements for similarly complex cases in the future.

The OHO has extensively considered the submission from GCHHS to ensure the final findings and recommendations are fair, balanced and support continuous improvement. The information provided did not alter the overall findings or conclusions of the investigation, which were based on available evidence and informed by clinical expert opinion.

Recommendations outlined within this report have been shaped having regard to submissions provided by the GCHHS.

Recommendations

The OHO acknowledges the feedback provided in GCHHS submission regarding the recommendations made as a result of the investigation. The OHO notes and recognises the work that has been undertaken, or is currently in progress, to implement these recommendations, including broadly:

- staff education and training
- review of current service models and introduction of specialised services to enhance system-wide capacity to deliver safe, person-centred care to consumers with complex behavioural needs
- development of a service Disability Plan 2025-2030
- review roles of NDIS carers providing care in hospital setting
- review of relevant policies and procedures
- introduction of patient safety net framework.

While GCHHS indicated disagreement with a some of the recommendations, the OHO maintained that elements of these specific recommendations were necessary to fully address the issues identified during the investigation and minimise risks identified. The OHO has worked collaboratively with GCHHS to amend the recommendations to ensure they are appropriate and practicable, resulting in a final set of recommendations that will be accepted and implemented.[144] The OHO looks forward to working collaboratively with the HHS to monitor the ongoing progress of the implementation of the recommendations.

12 Conclusion

Mr Kelly's death remains a deep loss for his family and friends. His mother emphasised her desire to ensure that it was recognised that her son was deeply loved, valued and led a full and meaningful life. She expressed her hope that his tragic death would serve as a catalyst for change, helping to prevent similar circumstances from occurring in the future.

The findings of this report confirm and reinforce the strong evidence available in academic literature and government reports suggesting that people with intellectual disabilities often face poorer outcomes in Australia's healthcare system and that significant improvement is required to overcome this. The findings highlight systemic challenges and underlying contributors to poor safety and quality outcomes for these healthcare consumers including:

- limited training on the healthcare needs of people with neurodevelopmental disability

[144] RD\25\96707 Email to GCHHS summary meeting 14 July 2025; RD\25\102589 Email from GCHHS 23 July 2025.

- poor awareness of the barriers to accessing healthcare
- discrimination – both direct and indirect
- lack of available data to ensure:
  - visibility of these consumers
  - inform workforce planning
  - development of healthcare strategies and measure outcomes.

To address these critical issues, the recommendations outlined in this report focus on improving clinician knowledge, accessibility, communication and the delivery of person-centred care. By implementing these measures, GCHHS/Robina Hospital can work towards reducing disparities, enhancing patient outcomes and ensuring consumers with neurodevelopmental disorders receive the safe, quality care they deserve. A commitment to continuous improvement, staff training and policy reforms will be essential in bridging the gaps and fostering a more inclusive and effective health service.

It is recognised that the issues identified in this report have broader application for health services in ensuring that the healthcare rights of consumers with neurodevelopmental disorders are upheld and there is appropriate access to specialist mental health advice, assessment and treatment for these consumers. The learnings from this investigation will be raised separately with Queensland Health for consideration.

13 Appendices

13.1 Photos of Mr Kelly

Photo 1: Fishing June 2021

Photo 2: Coffee April 2022

Photo 3: Golf early 2022

Photo 4: Emergency Department 21 July 2022

13.2 Index of information relied upon to inform the report

RCA Documents /Riskman Reports		
OHO Reference	**Date**	**Title**
RD\24\5368	23-Feb-23	Gold Coast Hospital and Health Service RCA 3522
RD\23\59301	18-May-23	Riskman Reports RM 4439078; RM 4439142; RM4464027; RM4454455
RD\24\101452	30-Jul-24	Attachment A-RCA Recommendations Closure Evidence Summary
RD\24\101456	30-Jul-24	Attachment B-RCA Rec 1 Closure Report
RD\24\101458	30-Jul-24	Attachment C-RCA Rec 2 Closure Report
RD\24\101463	30-Jul-24	Attachment D-RCA Rec 3 Closure Report
RD\24\101474	30-Jul-24	Attachment E-RCA Rec 4 Closure Report
RD\24\101475	30-Jul-24	Attachment F-RCA Rec 5 Closure Report
RD\24\101477	30-Jul-24	Attachment G-RCA Rec 6 Closure Report
RD\24\101478	30-Jul-24	Attachment H-RCA Rec 7 Closure Report
RD\24\101479	30-Jul-24	Attachment I-RCA Rec 8 Closure Report
RD\24\101480	30-Jul-24	Attachment J-RCA Rec 9 Closure Report
RD\24\101484	30-Jul-24	Attachment K-RCA Rec 10 Closure Report
RD\24\101485	30-Jul-24	Attachment L-RCA Rec 11 Closure Report
RD\24\101489	30-Jul-24	Attachment M-Lessons Learnt Closure Evidence Summary
RD\24\101492	30-Jul-24	Attachment N-LL1 Closure Report Specific
RD\24\101494	30-Jul-24	Attachment O-LL2 Closure Report Specific
RD\24\101495	30-Jul-24	Attachment P-LL3 Closure Report Specific
RD\24\101497	30-Jul-24	Attachment Q-LL4 Closure Report Specific
RD\24\101501	30-Jul-24	Attachment R-LL5 Closure Report Specific
RD\24\101502	30-Jul-24	Attachment S-LL6 Closure Report Specific
RD\25\7550	16-Jan-25	Lesson Learn 1 MPRH23 Standard 5 Comp Care Report Oct 2023
RD\25\7552	16-Jan-25	Lesson Learn 2 Memo to Medical Staff 6.12.23
RD\25\7554	16-Jan-25	Submission from GCH - LL1 Standard comp care report
RD\25\7557	16-Jan-25	Submission from GCH - LL3 Memo to Medical Staff 6.12.23
RD\25\7558	16-Jan-25	Submission from GCH -LL4 Gold Coast Health PPM
RD\25\7559	16-Jan-25	Submission from GCH -LL5 RR Presentation appointment 2023-09-18
RD\25\7560	16-Jan-25	Submission from GCH - LL1 Email from S-5 Lead re MST 1.11.23
RD\25\7561	16-Jan-25	Submission from GCH - LL3 Available services for consumers open to MHSS in QLD
RD\25\7562	16-Jan-25	Submission from GCH - LL3 Email from Nursing 9.11.23
RD\25\7563	16-Jan-25	Submission from GCH - LL3 Memo to med staff 6.12.23
RD\25\7564	16-Jan-25	Submission from GCH - LL4 Response to RCA - 23.12.13
RD\25\7565	16-Jan-25	Submission from GCH - LL4 Core Capability Framework
RD\25\7566	16-Jan-25	Submission from GCH - LL4 GCH Professional Practice Model
RD\25\7567	16-Jan-25	Submission from GCH - LL4 Nursing & Midwifery PPM domain definitions
RD\25\7568	16-Jan-25	Submission from GCH - LL4 Professional Governance
RD\25\7569	16-Jan-25	Submission from GCH - LL5 CAG related updated email evidence
RD\25\7570	16-Jan-25	Submission from GCH - LL5 Ryan's Rule CAG presentation Sept 2023
RD\25\7571	16-Jan-25	Submission from GCH - LL5 Ryan's Rule awareness 7.12.23
RD\25\7572	16-Jan-25	Submission from GCH - LL6 Increased Patient Supervision – RN- RM and HCW Responsibilities
RD\25\7573	16-Jan-25	Submission from GCH - LL6 Increased Patient Supervision (Nurse Special) approval for Inpatient
RD\25\7574	16-Jan-25	Submission from GCH -LL6 Increased Patient Supervision Screening Tool

RCA Documents /Riskman Reports		
RD\25\7575	16-Jan-25	Submission from GCH - Rec 1 - Clinical Deterioration Dashboard
RD\25\7576	16-Jan-25	Submission from GCH - Rec 3 - Memo for RCA 3522
RD\25\7577	16-Jan-25	Submission from GCH - Rec 3 - Memo to DOH
RD\25\7578	16-Jan-25	Submission from GCH - Rec 4 - GCHHS Clinical Form Management Procedure
RD\25\7579	16-Jan-25	Submission from GCH - Rec 4 - Healthcare Records Governance - Overview
RD\25\7580	16-Jan-25	Submission from GCH - Rec 7 - Coomera Request for Change Form LSR_RCH signed
RD\25\7581	16-Jan-25	Submission from GCH - Rec 8 - Response to RCA 23.12.23
RD\25\7582	16-Jan-25	Submission from GCH - Rec 9 - Appendix 1 Multidisciplinary Team Costs
RD\25\7583	16-Jan-25	Submission from GCH - Rec 9 - Chief Psychiatrist Letter to GCHHS re Statewide Rec
RD\25\7584	16-Jan-25	Submission from GCH - Rec 9 - Learning and Cognitive Disability Brief
RD\25\7585	16-Jan-25	Submission from GCH - Rec 10 - CR3522_RM4464027_CLP MOS 2023
RD\25\19674	11-Feb-25	Recommendation 2 Professional Practice Model Domains
RD\25\19720	11-Feb-25	Recommendation 2 Core Capability Framework GCHHS
RD\25\19723	11-Feb-25	Rec 2 Nursing and Midwifery PPM Domain Definitions
RD\25\19727	11-Feb-25	Rec 2 Nursing and Midwifery Professional Governance
RD\25\19728	11-Feb-25	Rec 2 GCH Professional Practice Model
RD\25\19729	11-Feb-25	Rec 2 Allied Health Learning Model
RD\25\19730	11-Feb-25	Rec 2 Our Professional Values Program FAQ's
RD\25\19733	11-Feb-25	Rec 2 Our Professional Values Flow Chart
RD\25\19737	11-Feb-25	Rec 2 Our Professional Values EOI Peer messenger
RD\25\19769	11-Feb-25	Rec 2 Our Professional Values Guideline
RD\25\19812	11-Feb-25	Rec 2 Nurse Manager Role Description User Guide
RD\25\19818	11-Feb-25	Rec 5 Role Description SHO or JHO
RD\25\19824	11-Feb-25	Rec 5 Role Description Medical Director and Staff Specialist Combined
RD\25\19825	11-Feb-25	Rec 5 Nurse Manager Role Description User Guide
RD\25\19829	11-Feb-25	Rec 5 Allied Health Role Description Template
RD\25\19836	11-Feb-25	Rec 10 Presentation Consultant Liaison Psychiatry
RD\25\19842	11-Feb-25	Rec 10 Consultant Liaison Psychiatry Model of Service 2023
RD\25\19847	11-Feb-25	Rec 10 Extract from CLP Orientation Manual
RD\25\19849	11-Feb-25	Rec 10 CLP Referral Form
RD\25\19865	11-Feb-25	Rec 10 CLP Referral Flow chart
RD\25\19870	11-Feb-25	Rec 10 CLP Orientation Manual Updated August 2023
RD\25\19872	11-Feb-25	Rec 10 Acute deterioration in a person's mental state Policy 2024

Clinical Records		
OHO Reference	**Date**	**Title**
RD\23\55395	10-May-23	ieMR Clinical Record
RD\23\55398	10-May-23	EDS Clinical Records
RD\23\55400	10-May-23	CIMHA Clinical records
RD\24\16144	5-Feb-24	WHS Patient Risk Assessment Mr Kelly
RD\24\29630	4-Mar-24	GP Records Mr Kelly
RD\24\34251	12-Mar-24	Psychologist Records
RD\24\34259	12-Mar-24	Psychologist Records
RD\24\34263	12-Mar-24	Psychologist Records
RD\24\34266	12-Mar-24	Psychologist Records

RD\24\34267	12-Mar-24	Psychologist Records
RD\24\34268	12-Mar-24	Psychologist Records
RD\24\34270	12-Mar-24	Psychologist Records
RD\24\34271	12-Mar-24	Psychologist Records

Documents/Policies/Procedures/Guidelines/Work Instructions/Resources/ Governance Documents		
OHO Reference	**Date**	**Title**
RD\24\16048	5-Feb-24	WI2283 GCHHS Consultant Liaison Psychiatry – Intake and Patient Review Process Work Instruction
RD\24\16054	5-Feb-24	Qld Government Form 9 EPoA Explanatory Guide
RD\24\16055	5-Feb-24	PRO1789 GCHHS Advanced Health Directive and Less Restrictive Treatment
RD\24\16057	5-Feb-24	Office of General Counsel GCHHS Advance Health Directive Info.
RD\24\16059	5-Feb-24	Office of General Counsel GCHHS Enduring Power of Attorney Info.
RD\24\16060	5-Feb-24	Office of General Counsel GCHHS Statutory Health Attorney Info.
RD\24\16074	5-Feb-24	Qld Health Guide to Advance Health Directives, EPoA, Guardians and administrators (2020)
RD\24\16327	5-Feb-24	GL1727 GCHHS Enteral Feeding in Adult Intensive Care Guideline
RD\24\16330	5-Feb-24	PRO0103 GCHHS Pressure Injury Prevention and Management
RD\24\16335	5-Feb-24	PRO0195 GCHHS Bed Management Admission/Resource Co-ordination
RD\24\16337	5-Feb-24	PRO0393 GCHHS Home Enteral Nutrition
RD\24\16339	5-Feb-24	PRO0454 GCHHS Increased Patient Supervision
RD\24\16347	5-Feb-24	PRO0514 GCHHS Vital Signs and Observations
RD\24\16352	5-Feb-24	PRO0760 GCHHS Informed Consent
RD\24\16356	5-Feb-24	PRO0956 GCHHS Inpatient Discharge Planning
RD\24\16360	5-Feb-24	PRO1079 GCHHS Medication Policy Instrument
RD\24\16364	5-Feb-24	PRO1264 GCHHS Ryan's Rule
RD\24\16367	5-Feb-24	PRO1276 GCHHS Patient Mealtime Preparation
RD\24\16368	5-Feb-24	PRO1277 GCHHS Malnutrition Risk Screening for Adult Inpatients
RD\24\16369	5-Feb-24	PRO1278 GCHHS Food and Nutrition
RD\24\16372	5-Feb-24	PRO1823 GCHHS Enteral Feeding Adults
RD\24\16373	5-Feb-24	PRO2350 GCHHS Early Warning Signs Observations
RD\24\16376	5-Feb-24	WI1128 GCHHS Enteral Nutrition Prescription
RD\24\16379	5-Feb-24	GL1824 GCHHS Nutrition Clinical Prioritisation
RD\24\16382	5-Feb-24	GOV004610 GCHHS ieMR Inpatient Ward Business Rules
RD\24\16385	5-Feb-24	GOV004850 GCHHS ieMR General Business Rules
RD\24\16184	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee Nov 2022
RD\24\16185	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee May 2023
RD\24\16186	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee Feb 2023
RD\24\16188	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee Mar 2023
RD\24\16189	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee April 2023
RD\24\16190	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee June 2023
RD\24\16191	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee Jan 2023
RD\24\16193	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee July 2023

Documents/Policies/Procedures/Guidelines/Work Instructions/Resources/ Governance Documents		
RD\24\16194	5-Feb-24	GCHHS Minutes Minimising Patient Risk and Harm Committee Dec 2022
RD\24\16128	5-Feb-24	Australia/New Zealand Standard ISO 45001:2018 OHS Management Systems
RD\24\16129	5-Feb-24	GL1027 GCHHS Occupational Violence Prev and Mgt
RD\24\16130	5-Feb-24	GL1028 GCHHS Occupational Violence Prev Training
RD\24\16131	5-Feb-24	GL1029 GCHHS Occupational Violence Risk Ass Process
RD\24\16132	5-Feb-24	POL1381 GCHHS WHS Policy
RD\24\16135	5-Feb-24	PRO1850 GCHHS WHS Risk Management
RD\24\16136	5-Feb-24	PRO2000 GCHHS WHS Consultation
RD\24\16139	5-Feb-24	PRO2118 GCHHS Security Specials
RD\24\16143	5-Feb-24	GCHHS WHS Patient Risk Assess Template
RD\24\18260	6-Feb-24	PRO1001 GCHHS Open Disclosure Management
RD\24\101508	30-Jul-24	Attachment T Inpatient Physiotherapy Referral Priority Guideline
RD\24\101510	30-Jul-24	Attachment U Maternity Assessment Centre-MAC
RD\24\101513	30-Jul-24	Attachment V Rehabilitation Services Referral Management
RD\24\101518	30-Jul-24	Attachment W Adult Eating Disorders Program EDP Referral Process
RD\24\101522	30-Jul-24	Attachment X Inpatient Referrals to Physiotherapy
RD\24\101525	30-Jul-24	Attachment Y Robina MAU Nursing (GCH) Staff Survey Main Report
RD\24\101530	30-Jul-24	Attachment Z Robina AMU Nursing (GCH) Staff Survey Main Report
RD\24\101533	30-Jul-24	Attachment AA-Robina MAU Nursing-At A Glance Staff Survey
RD\24\101537	30-Jul-24	Attachment AB-Robina AMU Nursing-At A Glance Staff Survey
RD\24\101549	30-Jul-24	Attachment AC-Robina MAU Nursing-Top Drawer Report Staff Survey
RD\24\101550	30-Jul-24	Attachment AD-Robina AMU Nursing-Top Drawer Report Staff Survey
RD\24\101561	30-Jul-24	Attachment AE-AMU Nursing LOL Mandatory Training Records
RD\24\101564	30-Jul-24	Attachment AF-Gen Med Junior Mandatory Training Records
RD\24\101567	30-Jul-24	Attachment AG-Gen Med Reg Mandatory Training
RD\24\101569	30-Jul-24	Attachment AH-Gen Med Senior Mandatory training
RD\24\101571	30-Jul-24	Attachment AI-MAU Nursing LOL Mandatory Training
RD\24\101604	30-Jul-24	Attachment AJ-Autism Spectrum Disorder Screening Assessment
RD\24\101605	30-Jul-24	Attachment AK-Ryan's Rule Brochure
RD\24\101610	30-Jul-24	Attachment AL-Early Warning Signs Audit Form
RD\24\101614	30-Jul-24	Attachment AL-Early Warning Signs Audit Guide
RD\24\101622	30-Jul-24	Attachment AN-EWS Audit Report - April 2023
RD\24\101630	30-Jul-24	Attachment AO-CG GCH EWS Audit Paper - May 2023
RD\24\101634	30-Jul-24	Attachment AP-EWS Qtr Report MAU-AMU Q3 - 2023
RD\24\101636	30-Jul-24	Attachment AP-EWS Qtr Report MAU-AMU Q4 - 2023
RD\24\101637	30-Jul-24	Attachment AR-EWS Audit Report_Q1_2023 v1.0
RD\24\101638	30-Jul-24	Attachment AS-EWS Audit Report_Q2_2023 v1.1
RD\24\158500	4-Dec-24	PRO2015 GCHHS Treatment and Management of Adults with Eating Disorders
RD\24\158501	4-Dec-24	GL1673 GCHHS Identification and Management of Refeeding Syndrome Adults
RD\24\158502	4-Dec-24	PRO2040 GCHHS Adult Eating Disorders Program EDP Referral Process 2024
RD\24\158504	4-Dec-24	Queensland Eating Disorder Services (QuEDS) - A guide to admission and inpatient treatment
RD\24\158507	4-Dec-24	QuEDS - A guide for people admitted to a medical ward with an eating disorder

Documents/Policies/Procedures/Guidelines/Work Instructions/Resources/ Governance Documents		
RD\24\158508	4-Dec-24	QuEDS Family Support Guide - Medical admissions for an eating disorder
RD\24\158510	4-Dec-24	QuEDS - Nutrition Flowchart
RD\24\158513	4-Dec-24	QuEDS fact-sheet-eating-disorder.pdf
RD\24\158514	4-Dec-24	Metro North Mental Health QuEDS Ongoing meal plan
RD\24\158517	4-Dec-24	QuEDS edos-food-record chart
RD\24\158518	4-Dec-24	QuEDS Weight Chart
RD\25\14513	30-Jan-25	Julian's Key Health Passport Implementation Guide
RD\25\14515	30-Jan-25	Health Passport Chart Summary
RD\25\14517	30-Jan-25	Julian's Key Health Passport Resource Kit
RD\25\19671	11-Feb-25	GCHHS Clinical Safety Escalation Pathway DRAFT

Interview Records		
OHO Reference	**Date**	**Title**
RD\24\7018	16-Jan-24	Interview Recording 1 Mr Kelly's family 16 Jan 2024
RD\24\7020	16-Jan-24	Interview Recording 2 Mr Kelly's family 16 Jan 2024
RD\25\160991	11-Nov-25	Practitioner Interviews x 3
RD\25\162511	13-Nov-25	
RD\25\163251	14-Nov-25	

Clinical Advice		
OHO Reference	**Date**	**Title**
RD\24\98014	24-Jul-24	Clinical Advice – Psychiatrist
RD\24\117846	5-Sep-24	Clinical Advice – Registered Nurse
RD\24\122201	16-Sep-24	Clinical Advice – Physician

Emails		
OHO Reference	**Date**	**Title**
RD\24\137057	17-Oct-24	Email from Qld Health Mental Health Alcohol and Other Drugs Strategy and Planning Branch, Clinical Planning and Service Strategy Division re: Centre of Excellence Intellectual and Developmental Disability
RD\25\2431	7-Jan-25	Email from Mr Kelly's mother - photos
RD\25\4539	12-Jan-25	Email from Mr Kelly's mother – information
RD\25\19313	10-Feb-25	Email from Mr Kelly's mother - photos
RD\25\19314	10-Feb-25	Email from Mr Kelly's mother – information about photos
RD\25\102598	23-Jul-25	Email from GCHHS re recommendations

Submissions/Information received		
OHO Reference	**Date**	**Title**
RD\23\59305	18-May-23	Submission from GCHHS
RD\24\16198	5-Feb-24	Letter from GCHHS re information provided
RD\24\18265	6-Feb-24	Open Disclosure Documents provided by GCHHS
RD\24\18269	6-Feb-24	GCHHS Documents re Psychology assistance for family
RD\24\58142	2-May-24	Robina Hospital Staffing Information
RD\24\101446	30-Jul-24	Letter from GCHHS re information provided

RD\24\101857	31-Jul-24	Letter from GCHHS re information provided
RD\25\6535	15-Jan-25	Information from Qld Health Special Projects Branch
RD\25\14509	30-Jan-25	Information from Qld Government Disability Reform
RD\25\66477	19-May-25	Adverse comment submissions – various
RD\25\68929	22-May-25	
RD\25\73661	2-Jun-25	
RD\25\79110	11-Jun-25	
RD\25\80808	13-Jun-25	
RD\25\89835	30-Jun-25	Adverse comment submission GCHHS

Miscellaneous		
OHO Reference	**Date**	**Title**
RD\24\130093	3-Oct-24	Media article referencing Qld Gov initiative Qld Centre of Excellence in Intellectual and Developmental Disability dated 3 October 2024