OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation into the care, discharge and follow up provided by two hospitals to a consumer living with developmental conditions (July 2026).

Wider learnings and recommendations for service improvements

The investigation identified opportunities for improvement and proposed recommendations relating to:

- Reviewing the relevant seizure management procedure in relation to any required observation period/s, referrals for Electroencephalogram (EEG) testing and additional considerations to be undertaken in relation to people who may be at increased risk of harm, recurrent seizures or otherwise present with conditions making it more difficult to accurately diagnose seizures (such as those with developmental disability).
- Sourcing or developing communication aids to support patients with communication difficulties arising from developmental disabilities, which could include visual schedules, picture cards or assistive communication devices such as electronic tablets.
- Development of communication tools for staff to assist in managing delays in care caused by emergency department workload pressures.

Background

The Office of the Health Ombudsman (OHO) commenced systemic investigations following a complaint in relation to the care provided to a consumer who lived with developmental conditions and presented to two hospitals in Queensland following seizures. The complaint raised the following concerns:

- Delays in review and treatment following presentation at the facilities, including the consumer's extended wait time for review at an outpatient appointment.
- Concerns regarding the consumer's discharge, including that the consumer had not received a confirmed diagnosis or reason for the seizures and the consumer's family's belief that the consumer had not returned to baseline function before being discharged.
- Communication issues with health staff, including that the family's concerns about the consumer were dismissed.
- That there was a failure to recognise that consumers living with developmental conditions are at an increased risk of harm.
- Concerns relating to the follow up care provided to the consumer, including referral processes for outpatient appointments and clinical investigations that should have been conducted for the consumer.

Issues investigated

The investigation considered whether the relevant facilities adequately and appropriately assessed and treated the consumer, including whether:

- Clinical guidelines were followed and clinical prioritisation was appropriate.

- The consumer's discharge was appropriate.
- The consumer's follow up and referrals were appropriate.
- The communication with the consumer and their family was adequate and appropriate.

Key findings

The investigation found that:

- The consumer was appropriately categorised upon presentation according to the Australasian Triage Scale in Emergency Departments.
- In one of the two facilities, the consumer was not seen within the clinically recommended timeframe of 30 minutes according to their triage category.
- The consumer's treatment plan at the first facility was consistent with relevant Australian clinical guidelines and the Hospital and Health Service's procedures, except that the consumer should have been referred for an outpatient EEG.
- It was difficult from the records to establish when the consumer returned to their 'baseline' function. There is no required observation period in national guidelines or the relevant Hospital and Health Service's procedures. An unpublished work instruction in one of the facilities – which was not followed - described a 6-hour observation period.
- Where a patient has returned to baseline following a short-term, self-resolving seizure, with no concerns from examination or assessment, discharge is consistent with clinical guidelines.
- The consumer's referral for a specialist outpatient department appointment was appropriately categorised and was consistent with local practice and the Hospital and Health Service's procedure.
- The consumer was not seen within the recommended 30 calendar days at the specialist departments. The OHO notes that waiting times are influenced by a range of factors, and prioritisation decisions affecting individual consumers are best made by Hospital and Health Services taking into account relevant considerations including risk of adverse consumer impact.
- The consumer's presentation at the second hospital should have been discussed with the Neurology Department as per the Hospital and Health Service's procedures. A consultation with Neurology could potentially have provided an opportunity for a different management approach, which may have had particular significance given the consumer's increased risk of recurrent seizures and the difficulties in diagnosing seizure type and/or epilepsy. However in the absence of certainty about this, it is not possible to draw conclusions about its influence on the consumer's passing.
- The attempts to expedite the consumer's referral to the specialist outpatient department following their presentation to the second hospital were consistent with local practice and clinical guidelines.
- The consumer should have been referred for an outpatient EEG following this presentation at the second hospital, especially as it had not been arranged following discharge from the first hospital.
- The Hospital and Health Service's internal review of the consumer's care found that the consumer's extended period in emergency departments over 2 days, failure to organise an EEG in anticipation of an upcoming outpatient appointment, and a 56 day wait for an opportunity to be reviewed by a clinician with expertise in seizures, did not represent effective or efficient care.

- Patients with developmental disability face additional hurdles in navigating health care and communicating as part of their episodes of care.
- Ongoing attention should be given to identifying, and striving to address, the difficulties that patients with developmental disability and their carers experience when receiving health care, including the challenges presented by noisy and stressful health care environments.

Recommendations

The OHO made a number of recommendations (which were strengthened through collaborative input from the provider):

- Evaluation and review of the existing seizure management procedure to ensure it addresses required observation periods, referrals for Electroencephalogram (EEG) testing, and specific considerations for individuals at higher risk.
- Development of communication aids to support patients with developmental disabilities who experience communication difficulties. These aids may include visual schedules, picture cards, or assistive communication devices such as electronic tablets.
- Implementation of recommendations from an internal clinical review, particularly the development of communication tools for staff. These tools should assist in managing delays in care caused by emergency department workload pressures, ensuring effective communication and continuity of care.

The OHO will be monitoring the work being undertaken.