

Inquest into the death of Joshua Jai Plumb

Joshua Plumb, a seven year old boy with epilepsy and spastic quadriplegia, died unexpectedly at the Ipswich Hospital on 16 December 2010 after nurses found him to have become entrapped in the railings of his hospital bed.

The then Deputy State Coroner Christine Clements delivered her findings on 18 October 2012.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Concluding comments, page 23

Standards for care of children with special needs should apply across the state. While it is acknowledged changes have been implemented in Ipswich Hospital to increase staffing levels to provide 'specialling' by a designated nurse for disabled children, reviewing the regime of observations and to consider the appropriate bed for each child, the evidence at the inquest could not establish this was a Queensland Health-wide safety improvement.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Patient Safety Unit issued a patient safety notice to all hospital and health services in 2013 summarising the findings and recommendations of the coroner in this case and providing information on the range of entrapment and suffocation risks associated with beds for both adult and paediatric patients. The patient safety notice suggested a range of risk management actions for local consideration and action, including reviewing or developing 'specialling' procedures for high dependency patients.

The coroner's comments were also considered by the Statewide Child and Youth Clinical Network. In the context of health reform and accountability for health services resting with local hospital and health boards, the Statewide Child and Youth Clinical Network endorsed the bed safety advice issued in the patient safety notice and felt this was appropriate to support the safe management of care of children with special needs across the state, customised for each hospital's local circumstances.

No specific further action is required in relation to the findings of this inquest. However, the Patient Safety Unit and the Statewide Child and Youth Clinical Network will continue with their ongoing programs of work for the continual improvement of standards of care for children, including children with special needs.