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Media Release

Inquest into the death of Mr Paul Coventry - UPDATED

A nurse at the Royal United Hospital NHS Trust has today been removed from duty, pending the outcome of an investigation and following the conclusion yesterday of an inquest into a former patient.

The inquest recorded a verdict for Mr Paul Coventry of accidental death contributed to by neglect. In her summing up, the Coroner said there was conflicting evidence about who assembled the incorrect infusion of fluid prior to it being connected to Mr Coventry.

The inquest was informed that, following a thorough internal investigation by the Trust, a comprehensive action plan to address the failings highlighted by this incident was put in place immediately. The actions include; changing part of the infusion equipment to make the labeling on the fluid bags more visible, having a detailed care checklist for each patient that has to be completed at every shift change and senior nursing staff now cross check and sign to say that a correct bag of fluid has been selected and put up.

A similar incident in December 2010 was detected very quickly and caused no harm to the patient. However the Trust still took this matter very seriously and took immediate action to strengthen procedures. We recognize that despite these early actions the mistake sadly repeated itself.

Dr Andrew Hartle, a leading expert in patient safety and intensive care and witness at the inquest, praised the RUH for the high standards of care he found in the Intensive Care Unit.

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