Royal Cornwall Hospitals
NHS Trust

Chief Medical officer's office
Royal Cornwall Hospital
Truro
Cornwall
TR1 3LJ

[redacted]

Date: 25 March 2026

Private and Confidential
Mr. Guy Davies
H.M Assistant Coroner for Cornwall and the Isles of Scilly
Pydar House
Pydar Street
Truro
Cornwall
TR1 1XU

Dear Mr Davies

Re: The Late Mrs Janet Tripp – Regulation 28 PFD Report and Response

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated 09 February 2026 and received on the 12 February 2026 This was issued following the inquest into the death of Mrs Janet Tripp which was heard on 18 December 2026. I understand the Matron who provided a report was unavailable to attend the hearing on 18 December 2026 due to pre-planned annual leave.

I would like to take this opportunity to express my sincerest condolences to the family of Mrs Tripp for their tragic loss.

During the inquest, the evidence revealed matters giving rise to concern. Which are as follows:

1. *There was in sufficient evidence before the Court to indicate that the following failings found at inquest had been addressed by the Hospital:*
    - *Lack of care rounds by staff*
    - *Lack of training regarding basic patient care for some staff working in the discharge lounge*
    - *Janet was not re-positioned every 2 hours as is required to avoid pressure sores*
    - *No risk assessment was conducted in the duration of Janet's stay in the discharge lounge or following the discovery of the pressure sores when Janet was still in the discharge lounge*
    - *No documentation that dressings were required following the discovery of Janet's pressure sore*
    - *No handover notes to the ambulance service or Helston hospital warning of the development of pressure sores and the need for protective measures.*

Please find below the response from the Trust and details of the actions taken in relation to the above concerns.

Response:

I reiterate the contents of paragraph 8 – 11 of Matron Keogh's statement dated 13 November 2025 which confirmed the following:

- Nursing documentation indicated that care rounding had been carried out every two hours in line with RCHT policy whilst Mrs Tripp was on the Trauma Unit and this continued in the Discharge Lounge.
- Whilst on the Discharge Lounge, a healthcare professional identified a blister on Mrs Tripp's right heel. The issue was raised, and appropriate pressure care was initiated by elevating the foot on a pillow. This had been documented in the notes on the 22.07.2024 @ 17:15 hours.
- The following Learning Point has been taken from Mrs. Tripp's case. While skin bundles were completed as per protocol, there is an important learning outcome regarding the need to ensure documentation and reassessment are undertaken whenever new clinical findings arise, particularly prior to any patient transfer. Nursing documentation indicates that staff had elevated the patient's heels on a pillow in order to relieve additional pressure. However, there was no documentation to suggest that dressings were required. The identified learning points will focus on the importance of timely reassessment and identification of required needs, to include repositioning advice if required. All new findings, reflections and learning are discussed during our safety briefing and subsequently shared with nursing staff through the monthly newsletter
- In addition to the information provided by Matron Keogh, to support good communication on the discharge lounge, a verbal 'safety brief' in held at each shift handover to ensure patients who are in the Discharge Lounge have their care rounds and other needs completed and ensure this is correctly documented.
- Training concerns – All staff working within the Discharge Lounge are required to complete the organisation's essential mandatory training programme, alongside any role-specific clinical skills competencies.

  Compliance with mandatory training is monitored by the Unit Leader, with additional oversight and support provided by the Clinical Practice Educator (CPE) team. Any gaps in compliance are actively followed up on to ensure that staff maintain the required level of knowledge and competence for safe patient care.

In addition, the Division has recently increased its focus on pressure ulcer prevention and on the fundamentals of patient assessment. Targeted education sessions have been delivered to reinforce the importance of timely and accurate assessments, clear documentation, and proactive risk identification. Staff are being supported in developing a stronger understanding of their responsibilities for escalating concerns and communicating identified risks effectively to all members of the multidisciplinary team.

The Unit Leader, in collaboration with the CPE team, will continue to monitor training compliance and practice standards to ensure that all staff in the Discharge Lounge maintain the skills and confidence required to provide safe, high-quality basic care to all patients. As of 28th February 2026, the overall training compliance for the discharge lounge is 84.5%, including all non-registered staff who are compliant with the HCSW (Band 3) Clinical Skills Core Competencies. The updated training figures from March 2026 will be available from early April 2026 and can be provided if required.

- Handover concerns re SWAST/Community Hospital - We acknowledge the concerns raised regarding the absence of documented handover to both the ambulance crew and Helston Hospital, particularly regarding the development of pressure damage and the need for protective measures. We also recognise that the SBARD forms completed at the point of transfer were not signed by a registered nurse and did not include timings, which falls below expected standards of documentation and governance.

  Following internal review, it was identified that while Helston Hospital's SBARD did include reference to a "blister to the right heel," this information was not formally or consistently communicated as part of a structured handover from the Discharge Lounge. The lack of a clearly identifiable RN signature and the absence of time-stamping on the SBARD documentation further hindered continuity of care and compromised clarity regarding the patient's condition at the point of transfer.

  We also acknowledge the concern regarding the retrospective documentation recorded by the registered nurse at 17:15 hours, noting Mrs Tripp's arrival in the Discharge Lounge that morning and her discharge at 18:43 after a total stay of over seven hours. While the medication handover was appropriately completed in line with EMPA requirements and TTOs were provided to the transport team, the delay and retrospective nature of the clinical record did not meet the required standards for real-time documentation and handover completeness.

  In summary, the Division has implemented the following actions:

- **Reinforcement of SBARD standards:** All staff in the Discharge Lounge have received updated guidance and education on the requirement for SBARD forms to be fully completed, including mandatory timing and a registered nurse's signature. Compliance will be reviewed through monthly documentation audits.
- **Structured handover expectations:** A standardised handover process has been introduced for all patient transfers from the Discharge Lounge, including mandatory communication of any identified risks—particularly pressure damage or vulnerability—and confirmation that this has been verbally acknowledged by the receiving team.
- **Real-time documentation reminder process:** Unit leadership has reinforced with all registered staff the requirement to document care contemporaneously. Spot checks of nursing notes are being undertaken to ensure improvements and identify any additional training needs.
- **Focused education on pressure ulcer risks:** In conjunction with the Clinical Practice Educator team, staff have been trained on the importance of recognising early skin changes, documenting these accurately, and escalating them promptly to the multidisciplinary team and receiving services.

These measures aim to ensure that all future handovers from the Discharge Lounge are accurate, timely, and complete, thereby supporting continuity of care and reducing the risk of avoidable harm.

I hope that this letter provides both you and Mrs Tripp's family with assurance that the Trust has taken seriously the concerns raised in your report and that the Trust has taken the appropriate action to prevent future deaths.

Yours Sincerely

Chief Medical Officer
Royal Cornwall Hospitals NHS Trust