REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JANET MARY TRIPP

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive** **Royal Cornwall Hospital**
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15 January 2025 I commenced an investigation into the death of 85 year old Janet Mary Tripp. The investigation concluded at the end of the inquest on 18 December 2025. The medical cause of death was found to be as follows: *1a Ischaemic right foot and Frailty of Old Age* *1b Peripheral Vascular Disease* *2 Non heeling pressure Ulcer on Right Heel, Cerebrovascular Disease, Iron deficiency anaemia* The four statutory questions - who, when, where and how – were answered as follows: *Janet Mary TRIPP died on 28 December 2024 at Apartment 10 Ocean 1 Pentire Avenue NEWQUAY CORNWALL from Frailty of Old Age and an Ischaemic right foot caused by Peripheral Vascular Disease. The ischaemic right foot was contributed to by an avoidable pressure sore that developed on Janet's right heel*

	during a 7 hour stay in the Royal Cornwall Hospital discharge lounge. In that time there was an absence of protective measures that could have prevented that pressure sore. The right heel pressure sore more than minimally contributed to Janet's death. The conclusion of the inquest was as follows *Janet died from natural causes contributed to by an avoidable pressure sore.*
4	**CIRCUMSTANCES OF THE DEATH** 1. The circumstances are sufficiently explained in the answers to the four statutory questions set out above. 2. The following findings of fact were made in relation to failings in the provision of care whilst Janet was in the Royal Cornwall Hospital discharge lounge awaiting transport to Helson hospital. These failings likely caused the development of a pressure sore that contributed to Janet's death. • 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 pressure sores when Janet was still in the discharge lounge. • No documentation that dressings were required following the discovery of Janet's pressure sores • No handover notes to the ambulance service or Helston hospital warning of the development of pressure sores and the need for protective measures.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – There was insufficient evidence before the court to indicate that the above failings found at Inquest had been addressed by the hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 April 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to Janet's family. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**9 February 2026** **HMC Guy Davies**