Walsall Healthcare NHS
NHS Trust

[redacted]

Manor Hospital
Moat Road
Walsall
West Midlands
WS2 9PS

19 June 2026

Private & Confidential
Ms I Thistlethwaite
Assistant Coroner

[redacted]

Dear Assistant Coroner Ms Thistlethwaite

Re: In the matter of Regulation 28, Prevention of Future Death Report, Death of Mrs M Dawes

Thank you for your Regulation 28 Prevention of Future Deaths report following the inquest into the death of Mrs. Dawes. This letter sets out the Trust's response to the Regulation 28 notice received on 24 April 2026.

First and foremost, we wish to express our sincere condolences to Mrs Dawes' family. We fully acknowledge the concerns raised and recognise the findings, conclusions and concerns as stipulated within the notice, following evidence heard relating to learning, at the inquest held.

Following the inquest on 15 April 2026, the concerns within the notice received you raised in relation to this Trust were as follows:

1. I am concerned about the fact that the Trust accepted there were missed opportunities and delays in the care provided to Mrs Dawes and despite the fact they have identified changes required to improve care being delivered to their patients, those changes are yet to be implemented and embedded at the Trust.

2. The failure to take swift action to implement change undermines the process of identifying learning from deaths, there is little point knowing what needs to be done to improve patient safety if steps are not taken to implement those changes swiftly and effectively.

3. In this case we are nine months after Mrs Dawes' death and the evidence heard at inquest was that it could take another three months to implement the changes required. I am concerned that it is going to take the Trust a period of twelve months to implement the changes identified as required as a result of Mrs Dawes' death and the risk of future deaths continues in the absence of any interim measures being put in place.

For context:

Mrs. Dawes was reviewed on 12 July 2025, when a raised INR was identified, delaying chest drain insertion due to the risk of bleeding. Vitamin K was prescribed, with a plan to proceed with the chest drain insertion after the weekend. Evidence at the inquest confirmed that the INR should have been checked earlier on 8 July 2025; had this occurred, treatment could have allowed the chest drain insertion from 10 July onwards.

Over the weekend, Mrs Dawes sadly deteriorated but was not escalated for a consultant review despite multiple assessments by junior doctors. She was considered stable, and treatment focused on correcting her INR before proceeding with the chest drain insertion.

Mrs Dawes suffered a cardiac arrest on 14 July 2025 and died. A chest drain was never inserted.

You raised concerns that although the Trust acknowledged delays and missed opportunities in Mrs Dawes' care and had identified necessary improvements, these changes had not yet been implemented or embedded. The delay in taking action undermines patient safety, as known risks remained unaddressed. During the hearing you were told that nine months after Mrs Dawes' death, implementation was still incomplete, with a further three months anticipated, creating a prolonged period where the risk of similar incidents and future deaths remains due to the absence of timely action and interim safety measures.

Control measures and procedures in place at the time the incident occurred

Concern	Control Measures in place at the time of the incident.	How this mitigates risk
1. Delays and missed opportunities in care, with improvements not yet embedded	24/7 Emergency Department Consultant and Registrar presence with chest drain insertion competency. Designated Pleural Consultant Lead and Clinical Nurse Specialist (CNS) team. Operational (Flow and Capacity) Team prioritising patient transfers to specialist wards. Resident doctor induction and structured clinical supervision (monthly 1:1 meetings).	Ensures continuous access to skilled clinicians, specialist expertise, and clear oversight of patient pathways. Supports timely decision-making, escalation, and embedding of improved clinical practice.
2. Failure to implement learning promptly, undermining patient safety improvements	GIM Consultant rota for escalation of deteriorating patients out of normal working hours. 24/7 ICU on-call team (Anaesthetics and Surgical	Embeds learning into daily practice through senior oversight and structured training, ensuring staff act on identified risks promptly rather than relying solely on policy changes.

	staff). Structured induction programmes for resident doctors and clinical supervisors. Ongoing supervision with regular performance and escalation reviews. Weekly Divisional Safety Huddles to review reported incidents/complaints for shared learning.	
3. Delays in implementation and lack of interim safety measures, leading to ongoing risk	Immediate senior escalation routes (ED Consultants, GIM rota, ICU team). Operational Team oversight of capacity management and patient flow. Real-time communication and referral pathways. Access to specialist respiratory and pleural service input.	Provides immediate safety controls while longer-term changes are embedded, ensuring deteriorating patients are identified early, escalated appropriately, and prioritised for specialist care, reducing risk of recurrence.

Trust Response following learning and required actions

1. **Delays in treatment and missed opportunities including failure to insert a chest drain.**

A Standard Operating Procedure (SOP) aligned with the British Thoracic Society guidance ensuring clear escalation and senior involvement was already in place; following review of the incident learning has been undertaken since Mrs Dawes's death. This means that amendments to the policy to further strengthen practice in undertaking pleural effusion drainage, has been carried out with the aim and objective being to ensure clear escalation and senior involvement, an amendment has been made to the policy to include guidance on pleural procedures when there is bleeding risk due to medications or coagulopathy (reference page 9 and 10 of the policy).

The policy that was in existence at the time of the incident has been strengthened and this is in a working draft format. It is currently going through the final stages of re-ratification through the Trust governance process, and the revised policy will be ratified by the end of June 2026, the amendments made, implemented and communicated through the divisional governance structure are:

1. *4.2.1 For patients who require chest drain insertion for these non-urgent conditions, it is the responsibility of the patient's team to ensure chest drain insertion in a safe and timely manner. If the team cannot arrange or do not have the necessary competency, they can request*

the respiratory registrar / ward, who will arrange transfer of the patient to the respiratory ward if appropriate.

2. *4.2.2 Urgent chest drain insertion in 'Medicine' at WHT – in the event the respiratory registrar or the on call GIM registrar does not have the required competencies to insert a chest drain, the following will apply:*
    - *Request on call anaesthetic registrar to insert drain. If unavailable:*
    - *Request assistance from general surgical on call team. If unavailable:*
    - *Respiratory Consultant / GIM Consultant on call to discuss with ED*
    - *Consultant on call to request support from ED.*

3. 9.0 Audit Process
   The Trust will participate annually in the BTS National Audit of Pleural Procedures. The standards measured are those set out by the BTS Pleural Disease guideline and Pleural Procedures statement (2023) and ICB, on which this policy has been based. This audit tool can be found within appendix 19.

2. Failure to manage elevated INR in a timely manner.

Processes have been strengthened in the amended policy as above to ensure early contact with the Haematology team in cases of an emergency procedure needing to be undertaken (reference to page 8-10 of the attached policy). The amendments to the policy stipulate the following:

1. 14.3 Clotting Disorders and Anticoagulation
   Due to the increased risk of bleeding and additional complications arising during the procedure, non-urgent pleural aspirations and chest drain insertions should be avoided in patients taking anticoagulation medications until a recent International Normalised Ratio (INR) result is <1.5 and Platelet count >50 is obtained.

2. BTS 2023 – Bleeding Risk Classification of Pleural Procedures

Risk Category	Procedures Included
Low Risk	• Diagnostic thoracentesis (pleural fluid aspiration)
Moderate Risk	• Chest drain insertion (Seldinger and surgical drains) • Indwelling pleural catheter (IPC) insertion or removal
Moderate–High Risk	• Pleural biopsy (e.g., Abrams, cutting needle) • Medical thoracoscopy

Medication/Class	Low Risk (Elective)	High Risk (Elective)	Emergency (Any Risk)
Aspirin	**Continue**	**Continue**	**Proceed**
$P2Y_{12}$ inhibitors (clopidogrel, prasugrel)	**Withhold 5 days**	**Withhold 5 days**	**Proceed with caution if life-saving**
Ticagrelor	**Withhold 7 days**	**Withhold 7 days**	**Proceed with caution if life-saving**
Dipyridamole	**Withhold 24h**	**Withhold 24h**	**Proceed with caution if life-saving**
Warfarin	**Stop 5 days prior; confirm INR < 1.5**	**Stop 5 days prior; confirm INR < 1.5; bridge if high risk**	**Proceed if INR < 1.5; consider reversal if needed**
LMWH (therapeutic)	**Withhold 24 h**	**Withhold 24 h**	**Proceed only if essential; omit next dose**
LMWH (prophylactic)	Acceptable if last dose ≥12 h ago	Acceptable if last dose ≥12 h ago	Proceed
DOACs (dabigatran, rivaroxaban, apixaban, edoxaban)	Withhold 48 h	Withhold 48 h	Proceed with caution if urgent
UFH (IV infusion)	Stop infusion 4–6 h before	Stop infusion 4–6 h before	Stop infusion and proceed once PTT normalizes
Fondaparinux	Withhold 24–48 h	Withhold 24–48 h	Proceed only if essential; reversal limited
Lab Checks	INR < 1.5; platelets > 50 000/µL	INR < 1.5; platelets > 50 000/µL	Use INR/platelets if time allows
Renal Failure (eGFR <30)	Extend LMWH to 36–48 h, DOACs to 72–96 h, Fondaparinux to 72 h	Extend LMWH to 36–48 h, DOACs to 72–96 h, Fondaparinux to 72 h	Same emergency rules; proceed only if life-saving
Restarting Therapy	Resume 24 h post-procedure if no bleeding	Resume 48–72 h post-procedure if no bleeding	Resume when hemostasis is secured

- *However, in emergency situations such as a tension pneumothorax, it may not be possible to correct an abnormal INR or platelet count prior to the performing procedure. If this arises, it is appropriate for the medical team to contact a Haematologist on call for further advice regarding the correct action needed to normalise the clotting factors.*

- *The risks and benefits of interrupting medication and/or the need for bridging therapy before the procedure should be discussed with the patient. For those with high thrombotic risk (e.g. cardiac stents), the discussion may need to include other relevant specialty teams.*

- *DOAC should be recommended 1 day after a low-risk procedure and 2-3 days after a high-risk procedure. Daily prophylactic heparin should be considered for patients at high risk of venous thrombosis prior to DOAC recommencement.*

3. Delays in transfer to a specialist respiratory ward.

The Trust has always had an Emergency Department Referral Policy which includes details of the Inter and Intra patient transfer process.

Following learning from Mrs Dawes's death we are acting on the principles of the right patient being cared for in the right clinical area and we have introduced a new formal process of patient referrals to specialty ward areas – based on urgency and clinical need. An amendment to the policy has been developed and is in draft format (whilst consultation process is completed).

The amendments made, implemented and communicated through the divisional governance structure are:

1. *4.1. Identification of Patients*
   Patients requiring either Specialty care or SDS admission must be identified promptly by the ward teams. Following identification of the need for a specialty or SDS bed there are two pathways;
   - *Specialty Bed pathway (for patients awaiting beds on Cardiology, Gastroenterology, Respiratory, Endocrinology/Renal).*
   - *SDS pathway (for patients awaiting a bed on the Sister Dora Suite).*

2. *4.2. Specialty Bed Pathway*

   Step 1 – Referral to specialty
   The patient must be referred to the relevant specialty via e-handover.

   Step 2 – Clinical Review
   The patient will be reviewed by a Senior Specialty Medic (Consultant or Registrar) and a decision will be made regarding the patient's clinical need/suitability for specialty care

   Step 3 – Recording
   If it is determined that the patient has been formally accepted for a transfer to a specialty ward the patient will then be added the relevant Specialty Microsoft Teams tracking sheet. The entry onto the sheet is the responsibility of the Consultant/Registrar or the Specialty Ward Manager.

   Step 4 – Daily Review
   The waiting list must be reviewed daily by the Consultant/Registrar or the Specialty Ward Manager to determine/assess prioritisation of all the patients waiting for a specialty bed.

   Step 5 – Bed Allocation
   When a specialty bed becomes available the Operations Centre will review the specialty waiting list and identify the highest priority patient, considering gender of the available bed. They will then communicate

the available bed space to the ward where the patient is currently being cared for.

Step 6 – Escalation (if required)
If there is no suitable patient identified the bed will be allocated in list with the specialty usual criteria.

In addition, there is a shared SharePoint database already in operation, in which nursing and medical teams have access to, to operationalise the clarity and referral process. The Operations Centre views this daily with the nursing and medical teams to ensure prioritisation of patients who are required to transfer into a specialty ward.

3. 4.5. Management of Patients Waiting ≥7 Days

Patients who remain on the specialty or Sister Dora Suite (SDS) waiting list for seven (7) consecutive days or more must be subject to enhanced review and escalation to ensure patient safety, ongoing clinical appropriateness and timely patient flow.

Patients must not remain on the waiting list beyond 7 days without senior clinical review, clear documentation, and active management towards an outcome.

<u>Identification</u>
The Specialty Ward Manager or Nurse in Charge (NIC) must review the waiting list daily. Any patients approaching or exceeding 7 days must be clearly identified on the Microsoft Teams tracking system and escalated to the Consultant/Registrar and the Specialty Matron.
Senior Clinical Review

A Consultant or Senior Registrar must review all patients at the 7-day point. The review must confirm the ongoing clinical requirement for specialty/SDS bed, current clinical priority and any change in the patient's condition or pathway.

<u>Reassessment and Action</u>
Following review, the patient must be re-prioritised where appropriate, have a clearly documented clinical plan, be considered for alternative care pathways, including:

- *Transfer to an alternative suitable ward*
- *Optimisation for discharge*
- *Outpatient or community-based management*

<u>Escalation</u>
All patients waiting ≥7 days must be escalated to the Operations Centre.
These patients must be included in daily patient flow meetings and bed management and escalation discussions.

Ongoing Review
Patients exceeding 7 days must have daily senior oversight until a definitive outcome is achieved.
The patient must not remain on the waiting list without evidence documented in the patients' medical notes of active review and progression planning.

Governance and Monitoring
Any patients waiting ≥7 days will be monitored through the daily reviews of the specialty waiting list. Any delays or risks identified must be escalated in line with Trust escalation procedures and recorded via the Trust incident reporting system.

4. Delayed implementation of identified learning: Pleural Services:

The Patient Safety Incident Response Framework (PSIRF) patient safety framework is well embedded into the organisational governance processes utilising the rapid review, and after-action review processes. Learning is distributed through the divisional governance structures feeding into corporate patient safety committees (as was the case with this incident).
Immediate actions were taken in response to the learning from review of this incident:

- Poster created to advertise the plural services supported by our illustrations department. This poster has been delivered to all wards and departments. Increasing staff knowledgebase of the availability of the pleural service and how to access this service.
- Immediate amendments to the existing policies shared across the division and organisation, ensuring existing pleural procedure guidelines review and updated to reflect current best practices and ensure alignment with national standards.
- Learning incorporated into the Resident and Registrar doctors' induction and clinical supervisor discussions.
- Shared specialty patient referral 'SharePoint database process implemented.

Action Plan

The plan and timescales are set out in this letter and implementation of the actions will be monitored through the existing Trust governance and patient safety process.

We believe the implementation of the action plan and learning by the teams involved brings recognition and reassurance to the family of Mrs Dawes and avoids the potential of similar incidents occurring in the future.

Yours sincerely

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Group Chief Executive