REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Isobel Thistlethwaite, Assistant Coroner for The Black Country Jurisdiction.
2.	**DATE OF REPORT** 24 April 2026
3.	**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.
3.	**THIS REPORT IS BEING SENT TO** 1. **Walsall Healthcare NHS Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th June 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** I am concerned that despite the Trust acknowledging missed opportunities and delays and identifying required improvements, it will take up to twelve months after Mrs Dawes' death to fully implement those changes, with no interim measures in place, thereby undermining learning from deaths and leaving an ongoing risk to patient safety.

6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 18/7/25, I commenced an investigation into the death of Michelle DAWES, aged 55 years. **The medical cause of death was** Cause of death 1a Respiratory failure Cause of death 1b Granulomatous inflammatory disease **How, when and where** Mrs Dawes was a 55 year old female who presented to hospital on 3 June 2025, the working diagnosis at that time was community acquired pneumonia. She was discharged with antibiotics and a plan to have a repeat chest x-ray in six weeks. On 8 July 2025 she represented to hospital with worsening symptoms. A chest x-ray revealed a large right sided pleural effusion, she was treated with intravenous antibiotics and a plan was formed to move her to a respiratory ward to insert a chest drain. There was a delay moving Mrs Dawes to the respiratory ward, during that time Mrs Dawes deteriorated. She was transferred to the respiratory ward on 12 July 2025. A chest drain was not inserted and Mrs Dawes went on to suffer a cardiac arrest and died on 14 July 2026 at Walsall Manor Hospital. **Conclusion at inquest** Mrs Dawes died from respiratory failure, it is unlikely that she would have died when she did had a chest drain been inserted during the seven days she spent in hospital prior to death.
8.	**CIRCUMSTANCES OF DEATH** Mrs Dawes presented to hospital on 3 June 2025. The working diagnosis of the hospital at that time was Community Acquired Pneumonia, Mrs Dawes was discharged with antibiotics and a plan to have a repeat x-ray in six weeks time. The treatment received and discharge and plan formed as a result of that hospital attendance was appropriate. Mrs Dawes represented to hospital on 8 July 2025 with worsening symptoms including shortness of breath, lethargy and weight loss. A chest x-ray revealed a large right sided pleural effusion, Mrs Dawes also had raised inflammatory markers. She was treated with antibiotics and the plan was to move her to the respiratory ward where she could have a chest drain inserted. For reasons unknown Mrs Dawes was not moved to the respiratory ward, her move was delayed. She began to deteriorate, with acute kidney injury and deranged liver function noted before she was moved to the respiratory ward on Saturday 12 July 2025.

	On 12 July 2025 Mrs Dawes was reviewed on the respiratory ward and it was noted that she had a raised INR level which could increase the risk of her bleeding during the chest drain insertion. A plan was therefore formed to give Mrs Dawes vitamin K to decrease her INR and to insert the chest drain after the weekend. Evidence was heard at inquest to confirm INR levels should have been checked on 8 July 2025 when the plan was initially formed to insert chest drains. Had that check been done, Mrs Dawes' higher than appropriate INR would have been identified at that time and treated before she was moved to the respiratory ward, likely allowing the chest drain to be inserted on any date from 10 July 2025 onwards. During the weekend Mrs Dawes continued to deteriorate, she was reviewed on several occasions by resident Doctors but was not escalated up for Consultant input. The decision made during the weekend was that Mrs Dawes was stable and therefore the INR level was to be reduced with vitamin K before inserting the chest drain after the weekend. Mrs Dawes suffered a cardiac arrest on Monday 14 July 2025 and died. A chest drain was never inserted. The hospital Trust have identified learning as a result of Mrs Dawe's death, however, implementation of the changes required has not been fully undertaken.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. I am concerned about the fact that the Trust accept there were missed opportunities and delays in the care provided to Mrs Dawes and despite the fact they have identified changes required to improve the 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.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

	I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to the family of the deceased I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE