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Date: 15th July 2026

Office of the Chief Medical Officer
Trust Headquarters
New Alderley House
Macclesfield District General Hospital
Victoria Road
Macclesfield
Cheshire
SK10 3BL

[redacted]

Ms Victoria Davies
Area Coroner
Cheshire Coroner's Court
Museum Street
Warrington
WA1 1JX

Dear Ms Davies

Re: Inquest into the death of Mr Isaac Arrowsmith

I write regarding the inquest into the death of Mr Arrowsmith which concluded on 20th May 2026 in which you issued a Regulation 28 Report to Prevent Future Deaths.

May we take this opportunity to express our sincere condolences to the family of Mr Arrowsmith.

I understand that the Regulation 28 Report was issued to East Cheshire NHS Trust because of your concerns in two distinct but related areas. The first relates to the recognition and consideration of the thrombotic risk in patients with Haemoglobin Rainier disease. The second relates to the Trust's investigation, review and learning processes, specifically the failure to identify the key contributory issue prior to the inquest, raising concerns regarding the effectiveness of internal investigation arrangements in identifying, capturing and acting upon learning from patient safety incidents.

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In collaboration with the acute medical team and the Patient Safety team, the Trust has carefully considered your report. We have outlined below our response and the actions which the Trust will undertake to reduce the risk of further harm. For clarity these are presented below in two subsections:

1. Lack of knowledge, or recognition of the same, in relation to the risk of a clot when a patient has haemoglobin Rainier disease.

2. Failure to identify the key causative issue in the Trust's internal investigation or internal processes

Lack of knowledge, or recognition of the same, in relation to the risk of a clot when a patient has haemoglobin Rainier disease.

The Trust has carefully considered the Coroner's concern regarding the recognition of thrombotic risk in patients with rare haematological conditions, and the evidence that clinicians were reassured by factors including normal haemoglobin and haematocrit levels, recent venesection and aspirin therapy. The Trust recognises that clinicians will inevitably encounter uncommon conditions during their practice and that safe care depends upon recognising when a patient's presentation, underlying diagnosis or risk profile should prompt escalation, specialist consultation or further investigation.

The Trust recognises that a specific learning point from this case relates to awareness of thrombotic risks associated with rare haematological disorders. On further review of Isaac's case, the Trust considers that this extends beyond knowledge of a single condition and relates to the cognitive processes that influence diagnostic reasoning when patients present with uncommon or complex underlying disorders. This is reflective of a broader patient safety issue relating to diagnostic overshadowing and cognitive bias in clinical decision-making. Diagnostic overshadowing occurs when a clinician misattributes new signs and symptoms to a patient's pre-existing condition or illness. This influences clinical judgement in a way that can unintentionally limit the active consideration of alternative explanations for symptoms, reassessment of ongoing risks, thereby reducing the likelihood that an alternative diagnosis will be identified.

The Trust has therefore taken a systems-based approach to identifying improvement actions that improve awareness amongst clinicians of diagnostic overshadowing and reinforcing the importance of seeking specialist advice when caring for patients with uncommon or complex disorders. Along with the need for systems and processes to support healthcare professionals with their decision-making where possible.

Improvement actions involve the following:

1. Awareness raising campaign: To raise awareness of diagnostic overshadowing and provide staff with a practical strategy to challenge assumptions and consider alternative diagnoses, this includes the following;

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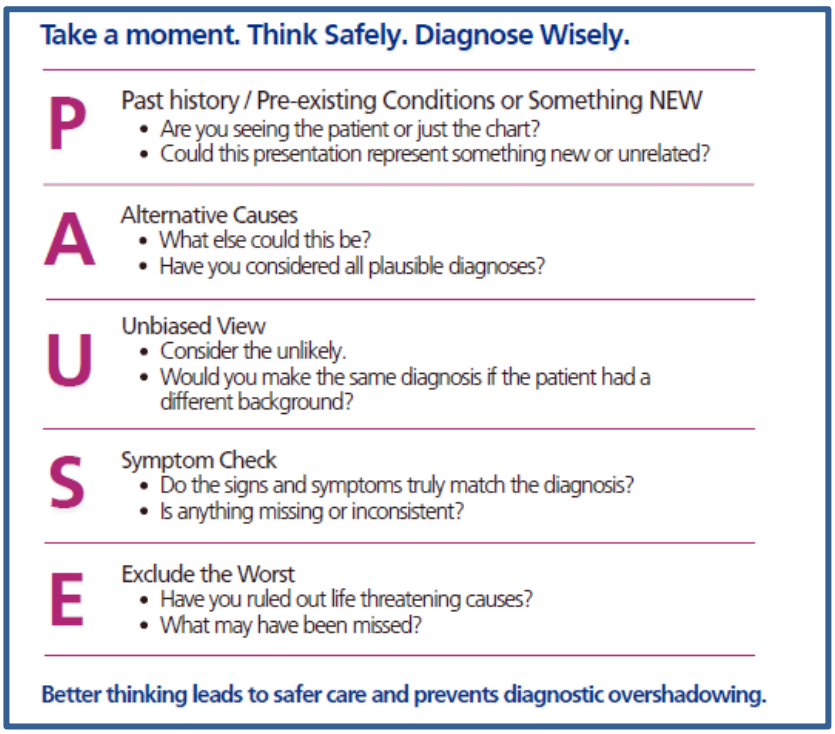
- Learning article in the staff electronic newsletter – summarising Isaac's case and the main learning points, linking into the 'PAUSE before you Diagnose' initiative. This article was published in the electronic newsletter on 6th July 2026.
- Screen saver - Display of the *'PAUSE Before You Diagnose'* message across Trust devices to reinforce the campaign and encourage staff to apply the mnemonic in daily clinical practice. This screensaver is scheduled to be published across all trust devices for a week on 20 July 2026.
- Video podcast - Development of a short educational podcast bringing together the learning from Isaac's case as an example of diagnostic overshadowing, the principles of the '*PAUSE* Before You Diagnose' initiative, and guidance on when clinicians should seek specialist advice or expert opinion when assessing patients with uncommon, complex or rare conditions. This will be available on the Trust intranet CONNECT and sent out in a general email communication to all staff. This podcast was filmed on 10 July 2026 and shared with staff in the electronic newsletter on 13th July 2026
- Poster campaign - Trust-wide promotion of the *'PAUSE Before You Diagnose'* initiative, encouraging staff to consciously pause and reflect before attributing symptoms to a patient's existing diagnosis or condition. The campaign incorporates the *PAUSE* mnemonic as a type of cognitive debiasing tool, (see picture below)



The mnemonic is designed to promote diagnostic curiosity, reduce cognitive bias and diagnostic overshadowing, and provide a structured approach to clinical reasoning that helps facilitate safer clinical decision-making. These posters were put up in the Emergency Department and all ward areas on 26 June 2026.

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2. Strengthening education: The learning from this case extends beyond knowledge of a single rare condition and highlights the importance of supporting clinicians to recognise potential cognitive biases that may influence clinical decision-making. The Trust is therefore strengthening its current continuing education programme by;
    - Providing a dedicated educational session on the Trust's Grand Round programme, to be delivered jointly with a Consultant Haematologist from The Christie. This session will focus on haematological conditions (including Haemoglobin Rainier Disease) associated with increased thrombotic risk, with learning from Isaac's case being used as an example to illustrate the challenges associated with recognising and managing uncommon but clinically significant risks. This session has been booked for 21 October 2026.
    - Developing and delivering a focused cognitive bias awareness and debiasing session for Emergency Department clinicians. This training will explore the impact of cognitive bias on clinical decision-making, including diagnostic overshadowing, false reassurance and the influence these factors can have on risk assessment, escalation and diagnostic reasoning. This session is aimed to be delivered by 30 September 2026.
    - Incorporating education relating to cognitive bias, diagnostic overshadowing and clinical debiasing strategies within its local undergraduate medical education programme. Isaac's case will be used as a learning example to demonstrate how systems factors, human factors and cognitive processes can influence clinical decision-making, reinforcing the importance of maintaining diagnostic curiosity and seeking specialist advice when managing patients with rare, complex or high-risk conditions. This education will be added to the undergraduate medical education programme by 30 September 2026.

3. Digital Clinical System (DCS) / Electronic Patient Record (EPR) optimisation in relation to VTE:

As part of the Trust's systems-based response to this case, consideration was given to how the functionality of the DCS could be further optimised to support clinicians in identifying and managing patients with an increased risk of venous thromboembolism (VTE). This review extended beyond the feasibility of implementing electronic alerts and included consideration of the existing VTE risk assessment process, the visibility of VTE-related information within the EPR, and opportunities to strengthen clinical prompts that support decision-making.

The Trust therefore undertook a review with the Lead Digital Nurse and the Trust VTE Group.

During this review, the feasibility of introducing an electronic alert for patients deemed to be at increased risk of VTE was also explored. However, it was concluded that implementation of such an alert was not feasible. This is due to there being a wide range of medical conditions, comorbidities and clinical factors that may increase an individual's risk of thrombosis, often in varying combinations and with different levels of significance. As a result, it would be challenging to define clear and reliable criteria that would accurately identify all relevant patients who would require an ‘increased risk of VTE’ alert to be added to their EPR.

Furthermore, the Trust was mindful of the recognised risk of alert fatigue, whereby excessive numbers of electronic alerts may result in important alerts receiving less attention from clinicians. The Trust

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therefore concluded that introducing a broad VTE risk alert could inadvertently reduce the overall effectiveness of the system to support clinical decision-making in this context.

Consequently, the Trust's improvement work has focused on enhancing the functionality of the existing VTE risk assessment within the Electronic Patient Record, including exploration of an additional assessment prompt relating to balancing the individual patient's clotting and bleeding risk and improving the visibility of VTE-related information within the patient record. This will strengthen system support for clinical decision-making without creating an alert burden. This work is currently being progressed with the Trust's Digital team in conjunction with Mid Cheshire Hospitals NHS Foundation Trust and the Digital Clinical System suppliers, Meditech. A meeting has been scheduled for 17th July 2026 to progress this.

Failure to identify the key causative issue in the Trust's internal investigation or internal processes.

The Trust acknowledges and has carefully considered the concerns raised by the Coroner regarding the identification of issues relating to the referral to the Virtual Ward service, the effectiveness of the Trust's internal review processes, and the potential implications for organisational learning. The Trust wishes to sincerely apologise to Isaac's family and the Coroner that the key causative issue was not identified in the investigation and that this was not communicated to them in advance of the inquest.

The Trust recognises the significance of these concerns, particularly in the context of ensuring that patients, families, staff, the Coroner and the wider public can have confidence in the Trust's ability to identify care delivery issues, undertake robust and objective investigations, learn from adverse events, and implement meaningful improvements. The Trust fully accepts its responsibilities under the Duty of Candour as set out within Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and its wider obligations to act in an open, honest and transparent manner with patients, families, regulators and the Coroner.

The Trust is committed to continually reviewing and strengthening its patient safety systems and recognises the valuable opportunity for learning presented through this Prevention of Future Deaths Report. The Trust is focused on ensuring that opportunities for learning are identified and acted upon so that care for patients continues to improve, risks are reduced wherever possible, and staff are supported to deliver safe and effective care.

In Isaac's case, an Initial Patient Safety Review was undertaken and presented to the Trust's Incident Investigation Check and Review Meeting. Following multidisciplinary discussion, it was agreed that the case met the criteria for a Patient Safety Review and that a multidisciplinary team (MDT) review would be the most appropriate methodology to further explore the circumstances of the case and identify any opportunities for learning.

The MDT review was subsequently completed and presented through the Trust's governance processes for executive review and approval.

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On reflection, the Trust notes that whilst the review included representation from the Emergency Department and Respiratory Medical teams, representation from the Virtual Ward team and nursing staff was not sought as part of the review process. The Trust recognises that the inclusion of all relevant professional groups and services involved in a patient safety event supports a more comprehensive understanding of the factors influencing care and the identification of learning opportunities. It is likely that had a member of the Virtual Ward clinical team been part of the MDT process that the lack of formal referral would have been identified. The following improvement actions have been put in place to address this:

1. The Trust will obtain and/or gain access to all relevant healthcare records as part of any patient safety investigation to ensure that all relevant information is considered as part of the review
2. The introduction of a standard MDT review commissioning email template which specifies the required clinical specialities and professional groups contributing to each review
3. Development of an MDT review quick-reference guide to provide staff with clear and consistent guidance on undertaking patient safety MDT reviews, which is due to be completed by 20 July 2026
4. The MDT review report template is being reviewed and will be updated to include specific prompts relating to the review of clinical referral processes and other key areas of enquiry, which is due to be completed by 20 July 2026
5. Delivering focused bitesize MDT review and After Action Review training through specialty and departmental meetings to strengthen staff knowledge and promote a consistent approach to reviews, complemented by the Trust's dedicated full-day Patient Safety Investigation training programme
6. Embed MDT review training as an ongoing educational resource and support Clinical Leads, Senior Sisters and Matrons to cascade learning throughout clinical teams

This will ensure that all appropriate specialties are in attendance at future MDT reviews enabling all issues to be identified and can be taken forward for analysis and identification of lesson learning.

The Trust has also taken steps to assure itself that learning opportunities are identified wherever care is delivered across healthcare organisational boundaries, for example with Virtual Ward and Telehealth services. This includes undertaking patient safety review and investigation work, in collaboration with partner organisations, where circumstances indicate there may be opportunities to strengthen shared learning and understanding across services and the wider integrated health system.

All of these actions have been incorporated into the enclosed formal action plan, which will be monitored through the Patient Safety Incident Oversight (PSIO) Meeting. The PSIO Meeting has executive oversight and will provide assurance regarding the implementation, progress, and effectiveness of the actions to support sustained improvement in patient safety review processes across the Trust.

The Trust welcomes the opportunity to learn from the circumstances surrounding Isaac's death and the concerns identified through the inquest process. We are committed to ensuring that the learning

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is embedded across the organisation, supporting improvements that benefit future patients, families and staff while strengthening the quality and safety of the services we provide. We hope the above offers you assurance of the Trust's ongoing commitment to managing patient safety risks and continually improve the services we provide.

Yours sincerely

Chief Medical Officer