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 Victoria DAVIES, Area Coroner, for the coroner area of Cheshire.
2.	**DATE OF REPORT** 20 May 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.
4.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive, East Cheshire NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by July 16, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**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.

6.	**SUMMARY OF CORONER'S CONCERN** The circumstances of Isaac's death gave rise to concerns that learning from his death has not been appropriately captured and acted upon. These concerns are detailed below.
7.	**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.
8.	**INVESTIGATION AND INQUEST** On 5 January 2026 I commenced an investigation into the death of Isaac Charles ARROWSMITH aged 19, who died on 2 January 2026. The investigation concluded at the end of the inquest on 20 May 2026. The conclusion of the inquest was: *Died as a result of natural causes. Had Isaac been in hospital at the time of his deterioration, as he should have been, he would not have died when he did.* The cause of death was 1a pulmonary embolus due to 1b deep vein thrombus and in part 2 haemoglobin Rainier disease.
9.	**CIRCUMSTANCES OF DEATH** Isaac Arrowsmith, age 19, had a background medical condition of haemoglobin Rainier disease which put him at higher risk of developing blood clots. On 19 December 2025 Isaac was taken to Macclesfield District General Hospital by ambulance with chest pain and finding it difficult to breathe. His symptoms were largely consistent with either a chest infection or a pulmonary embolism. He was assessed and diagnosed with pneumonia, before being discharged home with antibiotics. No testing was done to exclude a pulmonary embolism. He reattended later that day as he had begun coughing up blood and was again discharged. On 31 December Isaac saw his GP who felt that a chest infection did not fully explain his ongoing symptoms, particularly given his background medical condition, and referred him for further tests. Before these could be undertaken, Isaac attended hospital again, as he was now coughing up more significant amounts of blood. He was assessed and again was felt to have a chest infection, but the doctor wanted additional investigations to assist given his lack of improvement despite treatment. A decision was made to send Isaac home, under the care of the respiratory virtual ward team for follow up in 48 hours. No referral was made to the virtual ward team that day and, had it been, it would not have been accepted and Isaac would have been admitted to hospital. Later that evening Isaac attended hospital for the fourth time as he again was

	coughing up further amounts of blood, and had been advised to return if this was the case. He remained in the emergency department for several hours before being clerked by the medical team in the early hours of 1 January 2026, and was sent back to the emergency department waiting room, awaiting consultant review on the ward round. Isaac was not made aware of the plan, or updated on when he would be seen. He was not seen on 1 January before he left the department at 20.45. On 2 January, Isaac deteriorated at home, becoming confused, struggling to breathe and incomprehensible. On arrival of his father, an ambulance was called and, whilst awaiting an ambulance, Isaac stopped breathing. Full resuscitation was given by attending paramedics but sadly this was unsuccessful and Isaac's death was confirmed at 15.57. Had Isaac been admitted to hospital on 31 December, he would have been in hospital at the time of his deterioration on 2 January and would have been successfully resuscitated. The lack of referral to the virtual ward team and misunderstanding as to suitability for the team caused or contributed to Isaac's death. I made findings that there was a lack of weight given to Isaac's underlying haematological condition and the linked risk of a clot and as such a lack of appropriate consideration of a blood clot, but it cannot be said on balance of probabilities that this caused or contributed to Isaac's death.
10.	**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. Lack of knowledge, or recognition of the same, in relation to the risk of a clot when a patient has haemoglobin Rainier disease.* I heard evidence that there was a base level of understanding amongst the emergency department team at the hospital, whereby they knew it was high red blood cells and this increased the risk of clots, but all were falsely reassured by Isaac's almost normal haemoglobin and haematocrit, the recent venesection and that Isaac was on aspirin. I heard evidence that these are false reassurance and I have not heard any evidence from the trust as to how they are going to share this learning. Clearly, all clinicians cannot know the ins and outs of all rare conditions, but I was not assured or any process whereby they are aware that they need to seek further advice. I heard evidence from the Christie Hospital that they are producing an alert card for their patients to give to clinicians in emergency department settings which will assist, but not all patients will be under the Christie or have the alert card in all circumstances. *2. Failure to identify the key causative issue in the Trust's internal investigation or internal processes*

	The court, and most importantly Isaac's parents, became aware for the first time during the course of the evidence that the referral to the virtual ward had not been made on 31 December, and that had it been, Isaac would not have been accepted and he would have therefore remained in hospital. He would have been in hospital when he deteriorated on 2 January and would therefore have been given full, successful, resuscitation at the time, such that he would not have died when he did. There had been an internal multi disciplinary review tool undertaken which had not identified this issue. This was not a complex issue to identify, and was identified very quickly by the trust's legal team when asked during the course of the evidence. I have received a statement which suggests this was a genuine mistake, made on the back of an assumption. As well as showing lack of critical analysis, it shows a lack of understanding of the virtual ward service. The latter I understand is being addressed by the trust in light of the evidence heard at the inquest but I heard no evidence to suggest that the quality of investigation or analysis is being improved. Whilst the inquest investigation is distinct to the trust investigation, the court is reliant to a large extent on the findings and disclosures made by the trust, taking into account they have a duty of candour and a duty to the court. I am concerned that the investigation process has failed to highlight a very important issue in care, and, if this is the case for other investigations, the opportunity to learn from issues and put in place action to prevent future deaths is lost. My concern has been compounded by details of an inquest I heard on 18 May, the day before Isaac's inquest, in which questions arose about the trust's internal processes, transparency and learning and the trust legal team is aware of those details. That inquest is not the subject of this report but is additional context to the concern raised.
11.	**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 Isaac’s parents, and the Care Quality Commission. 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.
12.	**SIGNATURE**

	[redacted] **Victoria DAVIES** **Area Coroner for** **Cheshire**