Executive Offices

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07 September 2026

HM Area Coroner Darren Stewart OBE
HM Coroner's Court,
Beacon House,
White House Road,
Ipswich, IP1 5PB

Dear HM Coroner,

Re: Regulation 28 Report to Prevent Future Deaths- Mr Indy Storm Mason-Kidd who died on 21 October 2023

Thank you for your Report to Prevent Future Deaths dated 06 July 2026 concerning the death of Mr Indy Storm Mason-Kidd on 21 October 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Indy's parents and family. Cambridge University Hospitals NHS Foundation Trust ('the Trust') are keen to assure the family and the Coroner that the concerns raised about Indy's care have been listened to and reflected upon.

We have considered your concerns and set out our formal response to each matter using your numbering as follows.

Matters of Concern

Failure to record in Indy's medical record and then implement a clear plan concerning the follow up of the vascular lesion findings from the ultrasound undertaken at Royal Surrey County Hospital in May 2021;

I understand that the discussion between the two Trusts was recorded within the 'Telephone Encounter' section of Indy's medical records. It is recorded that there was agreement between the two Trusts that there was agreement that a CT scan would be arranged locally, however there appears to have been a miscommunication as to the Trust responsible for following this up. The above has been relayed to clinicians responsible for taking phone calls from referring hospitals and the importance of confirming responsibilities in communication.

The adequacy of the notes recorded by clinicians from Royal Surrey County Hospital and Addenbrookes Hospital concerning their telephone communications relating to Indy's presentation at Royal Surrey County Hospital in May 2021;

Please see above.

The management of electronic patient clinical records at Addenbrookes Hospital. Clinical practice in June 2021 led to a failure by the treating clinician to have regard to an important note made by another clinician concerning the 27th May 2021 telephone communication with a Royal Surrey County Hospital clinician.

At the time of Indy's care, clinicians using Epic could access information through a number of different views and encounter records. I understand that the clinician who reviewed Indy on 22 June 2021 accessed a specific patient encounter and, as a result, did not identify the earlier telephone encounter documenting the discussion with Royal Surrey County Hospital.

Since that time, the Trust has introduced and reinforced a number of measures to improve the visibility of clinically significant information:

1. Reinforcement of use of the Problem List

Clinicians have been reminded of the importance of using the Epic Problem List to record significant issues and agreed management plans.

The Problem List is one of the most visible sections of the electronic patient record and appears when a patient chart is opened.

The importance of reviewing all relevant entries within the patient record before outpatient appointments has also been reinforced within the team.

2. Redesign of outpatient summary reports

In 2025, the Trust redesigned its outpatient summary reports so that clinicians are presented with a consolidated view of previous notes from the relevant specialty when opening a patient record.

Following consideration of the issues identified in this case, the summary view has now been expanded to include telephone encounter notes from the same specialty across all patient encounters.

This means that, were the same circumstances to arise today, the relevant telephone encounter would be visible within the clinician's summary view.

3. Introduction of an outpatient note summary tool

The Trust is progressing implementation of an AI-supported outpatient note-summary tool.

This tool will provide clinicians with a summary of relevant clinical information from the preceding three years, including telephone consultation notes, helping to improve the visibility of important historical information.

Testing has been completed and further customisation is being undertaken before implementation.

4. Ongoing digital training and professional development

The Trust is introducing an annual Digital Continuing Professional Development requirement for staff. This will support clinicians in maintaining knowledge of digital systems and their optimal use, with compliance reviewed through the appraisal process.

How patient information was provided, both in terms of the level of detail and manner of provision as part of the handover of Indy's care and treatment between Addenbrookes Hospital and Ipswich Hospital. The full patient record was not handed over and a summary letter provided which omitted important information that was available within the Addenbrookes Hospital records

I understand that because the clinician reviewing Indy on 22 June 2021 did not identify the earlier telephone encounter, the subsequent correspondence to Ipswich Hospital did not include reference to the discussion that had taken place with Royal Surrey County Hospital in May 2021. Had that information been identified, it would have been included within the clinical correspondence sent to Ipswich Hospital.

The Trust recognises the importance of ensuring that significant clinical information is readily identifiable and therefore incorporated into correspondence shared with other organisations. The improvements outlined above, particularly the enhanced outpatient summary view, inclusion of telephone encounter notes within specialty summaries, reinforcement of Problem List usage, and development of the outpatient note-summary tool, are intended to improve clinicians' access to relevant historical information when reviewing patients and preparing clinical correspondence.

While NHS organisations continue to operate different electronic record systems, the Trust believes these changes significantly reduce the risk of important historical information not being identified and subsequently communicated to receiving organisations. Our teams have reflected deeply on Indy's experience and the findings of the Coroner as evidence by the changes and improvements set out above.

We hope that these actions will assure the Court that we are committed to ongoing learning and improvement from this tragic case.

If I can assist further with these matters, please do not hesitate to contact me.

Yours sincerely

Chief Medical Officer