REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

HM Area Coroner, Darren Stewart OBE for the Coroner Area Suffolk in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Indy Storm MASON-KIDD**, and an inquest that concluded on **19 June 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted] **Medical Director – Royal Surrey NHS Foundation Trust** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE 21.08.2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: a. The failure of a clear plan to be recorded in Indy's notes at either the Royal Surrey County Hospital or Addenbrookes Hospital concerning the follow up of the vascular lesion findings from the ultrasound undertaken at RSCH in May 2021; b. Adequacy of the notes recorded by both [redacted] concerning their telephone communications and subsequent plan concerning the care and treatment of Indy; c. The practice at Addenbrookes Hospital in managing electronic patient clinical records and the failure of [redacted] to have regard to the important telephone note made by [redacted] concerning the 27th May 21 telephone communication with [redacted] d. Handover between Addenbrookes Hospital and Ipswich Hospital, the extent of the information provided and how it is provided; e. Lack of access to patient records where multiple trusts involved in the care and treatment of patients are involved, including the sharing of information such as scan results; f. The ability for EEAST and ambulance services more widely to identify the location of students or others within high density residential locations g. The delays that were experienced and which are a common occurrence,

	in relation to EEAST response to category 2 calls.
4.	**DETAILS OF ACTION TAKEN,** I have reminded all clinicians at the Royal Surrey County Hospital to clearly record any conversation that they have with clinicians at another organisation in the medical record. I have also reminded them that if it is expected that the patients care be continued at another organisation and there are relevant findings from clinical investigations undertaken at the Royal Surrey that this should be included within the discharge summary, provided to the patient and their General Practitioner, including any expectations around follow up and who that follow up should be managed by. If this follow up should be with another secondary care provider, Addenbrookes Hospital in this case, a formal letter should be sent to that organisation transferring the care of the patient and documenting any relevant investigation findings and expected follow up.
5.	**DETAILS OF FURTHER ACTION PROPOSED**
6.	**SIGNATURE**