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 Darren STEWART OBE, HM Area Coroner, for the coroner area of Suffolk.
2.	**DATE OF REPORT** 06 July 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. [redacted], Chief Executive Officer, Cambridge University Hospitals NHS Foundation Trust (CUH). 2. [redacted]Group Chief Executive, Ashford and St Peter's and Royal Surrey NHS Foundation Trusts (RSCH). 3. [redacted], Chief Executive Officer, NHS England. 4. [redacted]Chief Executive Officer, East of England Ambulance Service NHS Trust (EEAST). You are under a duty to respond to this report within 56 days of the date of this report, namely by August 25, 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 planning and management of Indy Storm MASON-KIDD's care and treatment, including record keeping relating to important conversations between clinicians, the effectiveness of clinician knowledge and use of electronic records and the efficacy of handover communications. The timeliness of the ambulance response to the 999-call made by Indy Storm MASON-KIDD on the evening of 20th October 2023. Several concerns have national implications. These are; access to patient electronic clinical records in cases where multiple NHS Trusts are involved in their care and treatment, and the use of location identifiers to assist in the response to calls within high density residential locations in the scripts used by ambulance service call handlers.
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 05 August 2024 I commenced an investigation into the death of Indy Storm MASON-KIDD aged 24. The investigation concluded at the end of the inquest on 19 June 2026. The conclusion of the inquest was that: Narrative Conclusion - Indy Storm MASON-KIDD is remembered by his Family as the kindest, caring and most gentle man. A person with incredible determination and grit, someone who experienced and tolerated great physical and mental pain yet maintained a positive outlook on life. It is clear that Indy was a significantly positive force touching a great many people during his relatively short life and which was cut so tragically short. Indy suffered from Immunoglobin A nephropathy and associated hypertensive heart disease which resulted in him receiving a renal transplant in May 2020. Indy had previously undergone several biopsy procedures prior to his transplant, the last of which was performed on 24th June 2019. During this biopsy Indy sustained an injury to his native left kidney that subsequently developed into a vascular lesion. On the 27th May 2021 Indy presented to the Royal Surrey County Hospital complaining of headache and was diagnosed with accelerated hypertension which was treated. An ultrasound scan taken at this time identified a vascular lesion to the lower pole of the left native kidney. There was a missed opportunity to effectively treat this condition as no follow up action was taken

	in relation to this finding at Royal Surrey County Hospital, the treating clinician being under the mistaken impression that this would be followed up at Addenbrookes Hospital where Indy was under the care of the Renal Department. Indy subsequently underwent a further ultrasound scan of his transplanted kidney on the 22nd June 2021 at the Renal Department at Addenbrookes Hospital. The scan did not identify any abnormality because it did not include the native kidneys. An entry in Indy's patient clinical records recording a telephone consultation between a consultant at Addenbrookes Hospital and the Royal Surrey County Hospital and which referred to the ultrasound findings from a scan undertaken at Royal Surrey County Hospital in May 2021, was not considered by the treating clinician and did not inform Indy's ongoing care and treatment. As a consequence, there was a further missed opportunity to effectively treat the vascular lesion due to the fact that no investigation was carried out at Addenbrookes Hospital concerning the ultrasound findings reported by Royal Surrey County Hospital including consideration of undertaking a CT scan. In June 2022 Indy was transferred to East Suffolk and North Essex NHS Foundation Trust (Ipswich Hospital) for ongoing care and treatment. A summary of the care and treatment provided and the plan for Indy's ongoing care and treatment was handed over at the time. No mention was made, or records provided which referred to the vascular lesions identified by the Royal Surrey County Hospital ultrasound scan in May 2021, or the plan for further investigation of this recorded in the telephone note recorded in the Addenbrookes Hospital patient records for Indy. The fact that this important information was not included as part of the handover between hospitals represented a further missed opportunity to effectively deal with the vascular lesion through further investigation and treatment. On the evening of the 20th October 2023 Indy suffered a period of haematuria and general unwellness. He presented to Ipswich Hospital Accident and Emergency Department where he was triaged and placed in a cubicle awaiting further assessment. At around 0150 hours on the morning of the 21st October 2023 he suffered a catastrophic internal bleed and collapsed. An emergency alarm was sounded and extensive attempts were made to resuscitate him. Sadly these were unsuccessful and he died at 0258 hours on the 21st October 2023. Indy Storm MASON-KIDD died due to either a ruptured arteriovenous fistula or pseudoaneurysm in the lower pole of his left kidney which is a recognised but rare complication arising from a biopsy procedure performed on 24th June 2019. The medical cause of death was confirmed as: 1a Retroperitoneal Haematoma 1b Ruptured Arteriovenous Fistula or Pseudoaneurysm in the Lower Pole of the Left Kidney

	2 Renal Transplant for IgA Nephropathy, Hypertensive Heart Disease
9.	**CIRCUMSTANCES OF DEATH** A narrative conclusion was recorded. See above for the circumstances of the 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: <u>Cambridge University Hospitals NHS Foundation Trust and Ashford and St. Peter's and Royal Surrey NHS Foundation Trusts</u> The failure by Royal Surrey County Hospital and Addenbrookes Hospital to; a. 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, b. 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. The effect of these failures contributed to the subsequent confusion and misunderstanding relating to the scan undertaken at Addenbrookes in June 2021 and which focused solely on the transplanted kidney. <u>Cambridge University Hospitals NHS Foundation Trust</u> a. 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. b. 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. <u>NHS England</u> a. Lack of access to a patient's full clinical record in circumstances where multiple NHS Trusts are involved in the care and treatment of patients,

	including the sharing of information such as scan results. b. The ability of NHS Ambulance Services to identify the location of patients within high density residential locations. This includes the effectiveness of call handler scripts used by NHS Ambulance Services, whether this be NHS Pathways or MPDS to provide precise locations and whether the incorporation of systems such as 'what three words' may afford greater accuracy. East of England Ambulance Service NHS Trust (EEAST) a. The persistent delays in relation to EEAST meeting target response timings across all categories of calls. In Indy's case his call was categorised as a category 2 call with a target of an 8-minute response. In fact, an ambulance was not dispatched until 53 minutes after the call, some three times the target response time. The evidence before the Court is that such delays are chronic, with few effective measures capable of addressing the problem.
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: The Family of Indy Storm Mason-Kidd. East Suffolk and North East Essex NHS Foundation Trust. 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**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**