

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Managing Director of International Scientific Supplies Ltd

1 CORONER

I am Rebecca SUTTON, Assistant Coroner for the coroner area of County Durham and Darlington

2 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.

3 INVESTIGATION and INQUEST

On 28/07/2025 09:11an investigation was commenced into the death of Anthony Jonathon LODGE 03/08/1974. The investigation concluded at the end of the inquest on 10/12/2025 15:30. The conclusion of the inquest was that On 24 July 2025 at his home address of, the deceased died as a consequence of a severe urinary tract infection. On 18 July 2025 the deceased had been prescribed antibiotics to treat a suspected urinary tract infection and a urine sample had been taken on the same date to send to the laboratory for testing. Due to the sample container being out of date, it was not possible for the laboratory to process the sample and the deceased died before a further sample was taken. It is unlikely that the out-of-date container contributed to the deceased's death..

4 CIRCUMSTANCES OF THE DEATH

The cause of death was a severe urinary tract infection.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters 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:

(brief summary of matters of concern)

I heard evidence that the red-topped urine sample bottles containing boric acid (for preservation of the urine) used by the County Durham and Darlington NHS Foundation Trust district nursing team were not stamped with an expiry date, making it impossible for the district nursing team to know whether or not they were using an out of date sample bottle. The laboratory were unable to process the urine sample in this case because the red top sample bottle was out of date. Although it appears that the resulting delay in this case probably did not contribute to the deceased's death, I am concerned that there may be cases in the future where the delay caused by the use of an an out of date specimen bottle could cause or contribute to death. I understand that your company is the manufacturer of the urine specimen bottles used by the district nursing team.

6 ACTION SHOULD BE TAKEN



In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by February 09, 2026. I, the coroner, may extend the period.

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.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

I have also sent it to

CDDFT Legal Services

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

9 Dated: 15/12/2025



Rebecca SUTTON
Assistant Coroner for
County Durham and Darlington