IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of John Anthony Atkin
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Managing Director Millbrook Healthcare Limited
2	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INVESTIGATION and INQUEST** An investigation was commenced on 4 March 2016 and the inquest into the death of **John Atkin** was opened on 13 May 2016. It was resumed on 8 February 2017 with a jury. The jury returned their conclusion on the 13th February 2017, having been in retirement for 4 hours and 53 minutes. They found the medical cause of death to have been: 1a. Staphylococcal Septicaemia 1b. Dog bite wound of the hand II. Diabetes Mellitus They concluded with a short form conclusion of 'Accident'.

5	**CIRCUMSTANCES OF THE DEATH** John Atkin was a Driver/Technician for a company called Millbrook Healthcare Limited (Millbrook), a company that delivers and installs healthcare equipment at service-users' homes. Healthcare professionals use a web-based system to order equipment from Millbrook on behalf of their patients/clients. The court heard that, due to the nature of its business, a significant proportion of the people to whom Millbrook delivers have difficulties with their mobility. On 23 February 2016 Mr Atkin was tasked to deliver and to install an item of equipment at the home of an individual who had recently undergone an amputation of her leg. On the job sheet Mr Atkin received he was instructed to go directly into the service-user's home because she could not come to the door. On arrival he duly entered the premises where he was bitten by the service-user's spaniel dog. The court heard that Mr Atkin then returned to work and the wound was washed and dressed by the first aider. The first aider advised Mr Atkin to go to hospital but he declined. He continued to go to work over the next few days but began to feel increasingly unwell. On 26 February 2016 he left work early complaining of feeling ill. On 27 February 2016 he was found deceased at his home address.

6	**CORONER'S CONCERNS** The court heard evidence that Millbrook expects the healthcare professionals ordering a particular piece of equipment to assess whether the service-user's home poses any potential hazards to Millbrook's delivery drivers, and to inform Millbrook of any such hazards when they place an order. During the course of the inquest the court heard from the two occupational therapists who were involved in prescribing and ordering the piece of equipment that Mr Atkin delivered on 23 February 2016. They told the court that they do not always assess service-users at their home addresses and do not routinely ask service-users about the presence of pets in their homes. They were not aware that they were expected to assess potential hazards to Millbrook's delivery drivers, and said that they only passed on such information if they were aware of it. The court heard evidence that Millbrook is due to roll out a new system which will require healthcare professionals ordering equipment to specify whether or not there is a dog at a service-user's address. The company has not carried out any consultation with its clients regarding the introduction of the new system, and whether it is realistic to expect healthcare professionals to obtain this information from their patients/clients. The court also heard evidence from an inspector at the Health and Safety Executive. As part of his investigation into Mr Atkin's death he had carried out enquiries with the Royal Mail and a representative of the white goods industry with respect to industry practice. He told the court that members of the industry did not routinely ask in advance about potential hazards at addresses, but that it was accepted practice at both the Royal Mail and within the white good industry to have a policy in place to prevent employees from crossing the threshold into a person's home until they had made direct contact with the homeowner. The **MATTERS OF CONCERN** are: - Millbrook currently operates on the basis of an inaccurate assumption that enquiries with regard to whether there are any hazardous dogs at a service-user's address are carried out by the healthcare professionals who order the equipment from them. - There is no policy in place at Millbrook which prevents driver/ technicians from entering a service-user's address before they have made direct contact with the home owner. Consideration should be given to whether any steps can be taken to address the above concerns.

7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. [redacted] 2. Surrey County Council 3. St. George's University Hospitals NHS Foundation Trust 4. [redacted] 5. Health and Safety Executive 6. The Chief Coroner In addition to this report, I am under a duty to send the Chief Coroner a copy of your response. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
10	**Signed:** **ANNA CRAWFORD** **DATED this 6th day of March 2017**