	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **HIS MAJESTY'S PRISON AND PROBATION SERVICE**
1	**CORONER** I am Jonathan Dixey, assistant coroner, for the coroner area of Northamptonshire.
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 2nd October 2019 an investigation was commenced into the death of Sean Anthony Heeney, aged 34. The investigation concluded at the end of the inquest on 13th July 2023. The conclusion of the inquest was a narrative conclusion: Sean Heeney was found unconscious at Bridgewood House on 22nd September 2019 and passed away on 26th September 2019 at Northampton General Hospital. The initial call to 999 on 22nd September was incorrectly categorised, an admitted failure on EMAS' behalf, which made a material contribution to his death. Ambulance staff that attended did not properly appreciate the seriousness and urgency of Sean Heeney's condition and, as such, it was not escalated appropriately. The lack of proper monitoring by the ambulance staff made a contribution to his death. This was a drug-related death. The medical cause of death was: 1a Hypoxic brain injury 1b Cardiac arrest 1c Aspiration pneumonia 1d Use of heroin and cocaine
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death, Mr Heeney was a resident at Bridgewood House Approved Premises in Northampton. He had been released from prison on licence on 9th September 2019. Mr Heeney had a history of drug and alcohol misuse. At or around 06.00 on 22nd September Mr Heeney was found unresponsive on the floor of his first-floor bedroom. Shortly thereafter the residential worker who discovered Mr Heeney called 999. At 06.35 a technician-led ambulance crew arrived at Bridgewood House. Mr Heeney was found to have a Glasgow Coma Scale ("GCS") of 4 and with oxygen saturation levels of 28%. At 06.44 an ambulance technician called for paramedic assistance. At 06.51 a paramedic-led ambulance crew arrived at Bridgewood House.

	At 07.25 the East Midlands Ambulance Service ("EMAS") requested assistance from Northamptonshire Police in order to extricate Mr Heeney from his bedroom. At 07.36 two police officers arrived at Bridgewood House. They themselves requested additional support, with further officers arriving at 07.47. At or around 07.52 Mr Heeney was handcuffed to the rear by the police officers. They lifted Mr Heeney to his feet which caused postural hypotension which led to cardiac arrest. Advanced life support was commenced. A doctor attended and was able to intubate Mr Heeney with an endotracheal tube at or around 08.25. A return of spontaneous circulation was achieved at 08.36. Mr Heeney was eventually removed from his bedroom by means of a scoop stretcher. At 08.59 he departed from Bridgewood House to Northampton General Hospital. By the time that Mr Heeney arrived at Northampton General Hospital he was very unwell: his breathing was being managed by a ventilator. His oxygen saturations and blood pressure were very low. He was unconscious with a GCS of 3. Arterial blood gas measurements suggested a prolonged period of cardiac arrest. On 26th September 2019 Mr Heeney died.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. – Witnesses described the difficulties in extricating Mr Heeney from Bridgewood House. Those difficulties included: 1. The layout of the building. Witnesses described *inter alia*: (i) the corridors as being narrow and with 90 degree angle turns; (ii) the stairs as being narrow and steep; and (iii) Mr Heeney's bedroom as being small and with little space to manoeuvre. 2. Mr Heeney was very seriously unwell. He was described as non-compliant and agitated. When given Naloxone he became increasingly agitated. 3. Mr Heeney was described as heavy and therefore required more than one person to safely move him. The evidence suggested a lack of a clear or settled plan amongst the EMAS personnel and police officers as to how Mr Heeney was to be extricated. This caused a delay in removing Mr Heeney to hospital. Whilst I recognise that any extrication is unlikely to be something done by the Approved Premises staff on their own or at all, I am concerned that Bridgewood House did not and still does not have a plan on how to extricate from the first-floor of the building a person who is unable and/or unwilling to leave in the case of a medical emergency. In this respect, I note the following: 1. The layout of the building and the restrictions which that creates was and remains a known issue: a former manager of Bridgewood House described how it did not take "any residents with mobility issues, because of the stairs". 2. HMPPS have identified a requirement for Personal Emergency Evacuation Plans. I was referred to the 'Approved Premises Safe Working Practice

	Document' for Bridgewood House which provides: "Personal Emergency Evacuation Plans (PEEP) must be put in place for any building user who would encounter a problem and need assistance in exiting the building in an emergency. Staff must be aware of individual residents and colleagues who are on PEEP. Separate PEEP forms are for both staff and residents." 3. HMPPS have properly identified that individuals recently released from prison have a heightened risk of accidental overdose as they may have lost tolerance to drugs which they had previously used. This is reflected in the induction paperwork provided to residents at Approved Premises. 4. It is to be anticipated that residents within Approved Premises may be more reluctant to cooperate with emergency service personnel, in particular the police. This may make extrication more difficult. 5. It is to be anticipated that residents who have overdosed may be administered Naloxone. This is reflected in HMPPS' roll-out of Naloxone to all Approved Premises since Mr Heeney's death. As witnesses explained, a known side-effect of Naloxone is increased agitation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 8th September 2023. 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: 1. Sean Heeney's family. 2. East Midlands Ambulance Service. 3. Chief Constable of Northamptonshire Police. 4. Independent Office for Police Conduct. I have also sent it to the Prisons and Probation Ombudsman and the Northamptonshire Fire and Rescue Service who may find it useful or of interest. I am also 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, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14th July 2023** **JONATHAN DIXEY**