REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Governor, HMP Wandsworth, Heathfield Road, Wandsworth, London
1	**CORONER** I am Paul Rogers, HM Assistant Coroner, for the Coroner Area of Inner West London
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** Between 24th and 27th June 2024 evidence was heard touching the death of Brandon Valrick JOHNSON who died on 12th September 2019 aged 40 years. **Medical Cause of Death** I (a) Cardio-Respiratory Failure 1(b) Ischaemic Heart Disease 1(c) Coronary artery atheroma and left ventricular hypertrophy 1(d) Chronic cocaine misuse 2 Schizophrenia, chronic substance misuse **How, when, where Brandon Valrick JOHNSON came by his death:** On 12th September 2019, Brandon Valrick Johnson suffered cardio-respiratory failure at cell 29, HMP Wandsworth, Heathfield Road, Wandsworth, London. **Conclusion of the Jury as to the death:** He died from cardio-respiratory failure as a result of poor heart health. Chronic cocaine misuse more than minimally contributed to his poor heart health.

(b)	**Circumstances of the death:** Extensive evidence was heard by the court in the form of written and oral evidence, including expert evidence. Of particular significance for the purpose of this report are the following matters: I heard evidence that Brandon was not discovered as deceased until the late afternoon of 12th September 2019 despite a number of attendances at his cell by prison officers and other staff. Rigor mortis and pooling of the blood had been identified. I was told various checks had been undertaken since 0430. I heard evidence that whilst staff knew they needed to obtain positive responses from prisoners and should asess whether the peson is alive and breathing, they had little time in which to do this when combined with other duties.
5	**Matters of Concern:** I am concerned about the robustness of the procedures and processes for checking that prisoners are alive within their cells. My concern arises because I heard evidence that Brandon was not discovered as deceased until the late afternoon of 12th September 2019 despite a number of attendances at his cell by prison officers and other staff. Rigor mortis and pooling of the blood had been identified. I was told various checks had been undertaken since 0430. I was not confident, having heard and assessed the evidence as a whole that staff had sufficient time to properly check on inmates and obtain positive responses or note obvious signs of life. The checks that were made were for a matter of seconds, and I was not satisfied that the signs of life said to have been noted were sufficiently obvious or reliable to have given appropriate reassurance, or that signs of life were actually being looked for rather than as being incidental to other observations. I am concerned whether all appropriate measures are being taken to perform robust checks at appropriate times that elicit positive responses to indicate that a prisoner remains alive. In addition, I am concerned about how the prison satisfies itself that staff know how and when to perform these checks, what that consists of, and in relation to signs of life/positive response what those are meant to be and where that is set out in the training of staff. Further if checks are performed which elicit a positive life response how are those recorded, who checks this is being done, in what form and how often.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: The Family of Brandon Johnson Ministry of Justice 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	**1st October 2024** **Paul Rogers** **HM Assistant Coroner Inner West London** **Inner West London Coroner's Court** **33 Tachbrook Street** **London SW1P 2ED**