Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thanweer Asharaf, a prisoner at HMP Wandsworth, on 23 June 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Thanweer Asharaf died from aspiration of gastric contents (inhalation of vomit into the lungs) on 23 June 2024 at HMP Wandsworth. He was 26 years old. I offer my condolences to Mr Asharaf's family and friends.

The post-mortem examination was unable to establish what had caused Mr Asharaf to vomit. Toxicology tests did not identify the presence of any illicit substances in Mr Asharaf's system, though the circumstances of his death point strongly to illicit drug use.

Apart from a letter sent to Mr Asharaf a few days before his death that tested positive for psychoactive substances, there were no suspicions that Mr Asharaf was taking drugs at Wandsworth.

Easy availability of drugs is a known issue at Wandsworth, recently highlighted by HM Inspectorate of Prisons following their inspection in May. The prison is taking steps to tackle it.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Contents

Summary

Events

1. Mr Thanweer Asharaf was remanded to HMP Wandsworth on 9 November 2023, charged with grievous bodily harm (GBH).

2. Mr Asharaf had a history of psychosis and drug use, including 'Spice' (psychoactive substances, PS), in the community. When he arrived at Wandsworth, he denied using drugs. He was prescribed antipsychotic medication but did not always take it.

3. Mr Asharaf spent two periods in the prison's mental health unit and was seen frequently by mental health staff and psychiatrists. In February 2024, he was accepted for a place at a secure mental health unit and was put on the waiting list.

4. On 20 June, a letter addressed to Mr Asharaf tested positive for PS.

5. During the early morning roll count on 23 June, an operational support grade was unable to get a response from Mr Asharaf, so she radioed for staff assistance. Other staff arrived, entered the cell and found Mr Asharaf unresponsive, with blood and vomit around his mouth. A vape pen was beside him.

6. Staff started CPR, which was continued by healthcare staff and ambulance paramedics. Resuscitation attempts were unsuccessful and at 4.30am, paramedics declared that Mr Asharaf had died.

7. After Mr Asharaf's death, prisoners said that Mr Asharaf had been using PS at Wandsworth.

8. The post-mortem examination found that Mr Asharaf died due to aspiration of gastric contents (inhalation of vomit into the lungs). No illicit substances were identified in toxicology tests. The pathologist could not establish the underlying cause of the vomiting.

Findings

9. It is unclear what caused Mr Asharaf's death. While toxicology tests found no trace of illicit substances in Mr Asharaf's system, the circumstances of his death point strongly to illicit drug use, probably PS. Apart from the incident on 20 June, when a letter addressed to Mr Asharaf tested positive for PS, there were no other incidents of suspected PS use by Mr Asharaf at Wandsworth.

10. The easy availability of drugs is a known issue at Wandsworth, recently highlighted by HM Inspectorate of Prisons during their inspection in April and May 2024. The prison has reviewed its drug strategy and is undertaking various actions to tackle the drug problem at Wandsworth.

11. The clinical reviewer concluded that the care Mr Asharaf received at Wandsworth was equivalent to that which he could have expected to receive in the community.

12. We make no recommendations.

The Investigation Process

13. HMPPS notified us of Mr Asharaf's death on 23 June 2024.

14. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. Five prisoners contacted the investigator and four had information relevant to Mr Asharaf's death.

15. The investigator visited Wandsworth on 1 July 2023. He obtained copies of relevant extracts from Mr Asharaf's prison and medical records, CCTV, and the HMPPS Early Learning Review.

16. The investigator interviewed four prisoners at Wandsworth on 1 July. He conducted interviews with four members of staff in July and October by telephone and video call.

17. NHS England commissioned an independent clinical reviewer to review Mr Asharaf's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with one member of healthcare staff on 3 October by video call.

18. We informed HM Coroner for London Inner West of the investigation. The Coroner sent us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Asharaf's parents to explain the investigation and ask if they had any matters they wanted us to consider. They did not respond.

20. We shared our initial report with HMPPS. They pointed out a factual inaccuracy which has been amended in this report.

Background Information

HMP Wandsworth

21. HMP Wandsworth is a local category B/C prison in London. It holds men in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. There is an inpatient unit which accommodates up to six prisoners with physical health needs and up to 12 prisoners with mental health needs.

HM Inspectorate of Prisons

22. The most recent inspection of Wandsworth was in April and May 2024. Following the inspection, the Chief Inspector invoked the Urgent Notification process because of multiple concerns, including weaknesses in security, high levels of self-harm and violence, overcrowding, poor living conditions, lack of purposeful activity and easy availability of drugs.

23. In a survey, over half (51%) of prisoners said it was easy to get illicit drugs, and inspectors reported that the smell of cannabis was everywhere. Despite identifying this issue as a high security risk, drug testing was suspended between August 2023 and January 2024. In February 2024, 44% of prisoners tested positive in random drug tests.

24. Inspectors found that there had been a high level of investment in mental health services since the last inspection. The team was well led and made up of a range of skilled clinicians that were able to offer a full range of interventions in supporting prisoners with mild to moderate problems through to major ill-health and complex needs. For prisoners needing assessment under the Mental Health Act, the mental health inpatient unit was able to support patients reasonably well before any potential transfer to hospital. A transfer coordinator was assigned specifically to oversee the referral and transfer system and although there were some long delays in transfers, mostly for those needing highly specialised beds, the process was well managed and most waits were relatively short.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2024, the IMB reported that the prison was not safe, with high levels of assaults and self-harm. Access to contraband remained alarmingly easy. Cell searches frequently uncovered phones, drugs, improvised weapons, and illicit alcohol.

26. The Board expressed concern that the 12-bed Addison unit was unfit for purpose. It had insufficient beds with cells frequently out of use for long periods awaiting repair.

Previous deaths at HMP Wandsworth

27. Mr Asharaf was the 22nd prisoner to die at Wandsworth since June 2021. Of the previous deaths, 13 were self-inflicted, six were from natural causes, one was drug related, and in the other, the cause of death was unascertained.

Psychoactive substances (PS)

28. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

29. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key worker scheme

30. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
    - Key workers must have completed the required training.
    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

31. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

32. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression

Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

33. On 9 November 2023, Mr Thanweer Asharaf, an Indian national, was remanded in prison, charged with grievous bodily harm (GBH), and sent to HMP Wandsworth. It was his first time in prison.

34. Mr Asharaf had a history of psychosis. Before being sent to prison, he had spent two weeks in Goodmayes Hospital under Section 2 of the Mental Health Act. During that time, his urine tested positive for cannabis, diazepam and 'Spice' (psychoactive substances, PS). He was discharged on 3 October and then received ongoing psychiatric support at home. He was prescribed antipsychotic medication in hospital but stopped taking it after his discharge.

35. Mr Asharaf arrived at Wandsworth with a suicide and self-harm warning as he had jumped off a bridge a week earlier. He said he did not use drugs. The nurse referred Mr Asharaf to the mental health in-reach team (MHIRT) and started suicide and self-harm prevention procedures (known as ACCT).

36. Staff monitored Mr Asharaf under ACCT for the next two weeks. During that time, Mr Asharaf told staff that he was hearing voices that were making him scared. He displayed violent and abusive behaviour. Staff arranged for him to be able to make international calls to his family in India and he spoke to his mother frequently. Staff stopped ACCT monitoring on 24 November. By then, Mr Asharaf had been moved to the prison's mental health unit, Addison unit, was taking antipsychotic medication and was more settled.

37. In late November and early December, Mr Asharaf's behaviour deteriorated again. He told staff he was stressed and depressed as he wanted to see his family in India. He was also hallucinating as he said he saw his father outside his door and was hearing voices. However, from mid-December, Mr Asharaf's behaviour improved again. He was taking his medication and participating fully in the regime. He said he still heard voices but this was improving.

38. On 27 December, Mr Asharaf was discharged from Addison unit and moved to a shared cell on D Wing.

2024

39. In January 2024, Mr Asharaf asked for his antipsychotic medication to be reduced and a psychiatrist agreed. Mr Asharaf subsequently stopped taking his medication and a period of poor behaviour followed, which included an attack on his cellmate and trying to punch officers. He told a psychiatrist that he was hearing voices. He was moved back to Addison unit. He started taking his medication again but his behaviour remained unpredictable.

40. In early February, Mr Asharaf agreed to a depot injection (a slow-release form of medication) to help with medication compliance and was prescribed this injection every two weeks for two months. Mr Asharaf told staff he wanted to be moved to a psychiatric hospital; however, there was a long waiting list. Mr Asharaf was reluctant to increase the dosage of his medication due to the side effects. It was suggested that another medication, Risperidone, be explored for Mr Asharaf. Mr

Asharaf generally engaged with the regime and played pool. He told an officer the voices he heard increased when he was on a main prison wing.

41. On 15 February, a psychiatrist saw Mr Asharaf for a psychiatric review. Mr Asharaf told him that he was no longer hearing voices and wanted to remain on his normal medication instead of the depot injection or Risperidone.

42. Between 16 February and 8 March, Mr Asharaf's behaviour continued to improve. Mr Asharaf appeared stable and was not hearing voices. Mr Asharaf had been accepted for a transfer to John Howard Medium Secure Unit (MSU) and was on the waiting list.

43. On 8 March, Mr Asharaf was discharged from Addison unit and moved to a single cell on Trinity Wing.

44. On 11 March, Mr Asharaf requested an appointment with the MHIRT via the wing kiosk, stating that he felt depressed. He asked to go back to Addison unit until he was taken to hospital. He repeated this request a week later.

45. On 25 March, a worker from Catch 22, an organisation that supports foreign nationals, saw Mr Asharaf. She noted Mr Asharaf said he wanted to return to India. She told Mr Asharaf that after he was sentenced, he would be able to speak to immigration staff.

ACCT: 29 March to 16 April

46. On 29 March, an officer from the Safer Custody Team saw Mr Asharaf for a welfare check following an email from PACT (a prison charity). Mr Asharaf told her he was feeling depressed and had had suicidal thoughts over the past week. He found it noisy on the wing and wanted to go back to Addison unit. Mr Asharaf asked if he could speak to his family by video call. The officer explained the process for arranging a video call and she started ACCT monitoring. (Subsequently staff tried to arrange a family video call but then Mr Asharaf said his family would not be able to use the technology. He continued to speak to them frequently by phone.)

47. Healthcare staff noted that Mr Asharaf had not been taking his medication as he was fasting during Ramadan. They altered his medication times to avoid fasting times.

48. On 16 April, staff stopped ACCT monitoring. Mr Asharaf was engaging more with the regime and other prisoners and getting involved with activities such as chess club and being a wing cleaner. Mr Asharaf told staff he was feeling much better mentally because of the activities and no longer had thoughts of suicide or self-harm.

May to June

49. Mr Asharaf had a fairly settled period in May and early June. He was taking his medication, attending chess club and working well as a wing cleaner. He said he missed his family and wanted to go back to India. He also said he had friends in the

UK who wanted to visit him but he struggled to use the kiosk. (It is unclear why as Mr Asharaf's English was good.)

50. On 17 June, a nurse and an officer saw Mr Asharaf after he had sent a letter to the Safer Custody Department. Mr Asharaf wanted to know for certain if he was still due to be transferred to hospital. The nurse told Mr Asharaf he was still on the waiting list. Mr Asharaf said he was hearing voices telling him to harm himself, but that he had not acted on these. He said he did not intend to harm himself or take his life. The nurse told Mr Asharaf he would be discussed at the mental health team meeting the next day.

51. On 20 June, an occupational therapy apprentice saw Mr Asharaf. She told us that normally he was very friendly but he presented differently that day. She said he was hunched, looking at the ground, and not really making eye contact with her. He seemed to be in a lower mood, and when they talked about his social interaction, he became disinterested and asked to end the conversation.

52. That day, a letter addressed to Mr Asharaf tested positive for PS.

53. CCTV footage shows Mr Asharaf walking around the wing on 22 June, occasionally talking to other prisoners, shaking hands, and bumping fists. At 4.40pm, an officer had a short conversation with Mr Asharaf outside his cell. The officer told us he could not recall what they talked about, but there was nothing of note.

54. At 4.52pm, an officer went to Mr Asharaf's cell to deliver dinner. He was at the cell door for a short time. The investigator tried to contact the officer to find out what he and Mr Asharaf discussed. However, the officer had left the Prison Service.

55. At 8.04pm, an officer went to Mr Asharaf's cell and appeared to look through the observation panel for a moment.

56. At 9.20pm, during a routine check, an operational support grade (OSG) went to Mr Asharaf's cell. She told us Mr Asharaf was sitting on his bed and acknowledged her.

Events of 23 June

57. At 4.12am on 23 June, during her early morning routine roll check, the OSG looked into Mr Asharaf's cell. She told us that Mr Asharaf was lying on his bed with his hand stretched out. The OSG called out to Mr Asharaf and knocked on his door, but he did not respond. At 4.14am, she radioed for staff assistance.

58. At 4.17am, Oscar 2, the second most senior officer on duty, and other staff tried to get a response from Mr Asharaf but were unsuccessful. Staff entered the cell. Oscar 2 said Mr Asharaf was stiff, pale, his eyes were open, and he had vomit and blood around his nose and mouth. He said that Mr Asharaf's vape pen was down the side of his bed near his hand, as if Mr Asharaf had been using it. (There was also a large amount of vomit on Mr Asharaf's bed.) Oscar 2 told us he thought Mr Asharaf was dead. More prison staff arrived.

59. At 4.19am, Oscar 2 radioed a Code Blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Prison staff moved Mr Asharaf to the floor and Oscar 2 started CPR.

60. Healthcare staff arrived a minute later and asked for Mr Asharaf to be moved out of the cell for better access. Staff moved him onto the landing. One nurse applied a defibrillator, while another nurse managed Mr Asharaf's airway, though she had difficulty as Mr Asharaf's jaw was stiff. Oscar 2 and healthcare staff continued CPR.

61. At 4.27am, ambulance paramedics arrived. Paramedics attached their own defibrillator and CPR continued.

62. Paramedics confirmed that Mr Asharaf had no electrical activity in his heart and informed staff that there was evidence that rigor mortis had set in. At 4.30am, they stopped CPR and pronounced that Mr Asharaf had died.

Contact with Mr Asharaf's family

63. Mr Asharaf's family lived in India and did not speak English. Prison staff Identified a family friend who agreed to assist as an interpreter. At 11.00am on 23 June, a prison manager telephoned Mr Asharaf's mother and father and with the support of the interpreter, informed them of Mr Asharaf's death.

64. A supervising officer and a prison manager took over as family liaison officers. Over the following weeks they kept in contact with the interpreter, and by extension Mr Asharaf's family, offering support and advice.

65. Mr Asharaf's body was repatriated to India. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

66. After Mr Asharaf's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr Asharaf's death and offering support.

Post-mortem report

68. The post-mortem report concluded that Mr Asharaf died by acute respiratory failure, due to air way obstruction and pneumonia, caused by aspiration of gastric contents (inhalation of stomach contents into the lungs). Toxicology tests showed no illicit substances in Mr Asharaf's system.

69. The pathologist concluded that Mr Asharaf had vomited, which had entered his lungs. He could not establish the underlying cause of the vomiting.

Findings

Cause of death

70. The toxicology report found no illicit substances in Mr Asharaf's system. However, the circumstances surrounding Mr Asharaf's death point strongly to illicit drug use. A few days before Mr Asharaf died a letter addressed to him tested positive for PS, he was found with a vape pen next to him (and vape pens are often tampered with in prison to allow for the smoking of drugs), he had vomited (the pathologist was unable to establish the cause of the vomiting) and prisoners reported that Mr Asharaf used PS at Wandsworth.

71. Apart from the incident with the letter, there was nothing in prison or healthcare records to suggest that Mr Asharaf was suspected of using illicit substances.

72. A prisoner told us that on the afternoon of 22 June, Mr Asharaf was unwell and told an officer who did not take his concerns seriously. We could not corroborate this account. CCTV footage from that day did not show Mr Asharaf exhibiting behaviour that might indicate he was unwell, prison staff who interacted with him did not recall any signs or reports of illness, and Mr Asharaf did not activate his cell bell to alert staff that he needed medical assistance.

73. HMIP and the IMB have raised concerns about prisoners' easy access to drugs at Wandsworth.

74. Between May and July, HMPPS made several changes to tackle the drug problem at Wandsworth. A permanent Drug Strategy Lead was appointed to drive improvements and enhance collaboration between security and safety teams.

75. The Regional and Local Drug Leads revised the drug strategy to better restrict supply and reduce demand. This included effective collaboration between the substance misuse team and health colleagues, using adjudications for referrals to drug support programmes, and regular mandatory drug testing (MDT). They also conducted a resilience assessment to ensure specialist advice, good practices were shared, and areas of improvement were identified.

76. The National Intelligence Unit (NIU) conducted a vulnerability assessment to understand conveyance routes and help reduce drug entry into the prison. We were told that regional searching and dog teams will increase support, maximising the use of search dogs and providing additional search training for local staff.

77. We make no recommendation.

Clinical care

78. The clinical reviewer concluded that the physical and mental health care Mr Asharaf received at Wandsworth was equivalent to that which he could have expected to receive in the community. She made several recommendations, not directly related to Mr Asharaf's death, which the Head of Healthcare will wish to address.

Key work

79. All prisoners in the male closed estate are supposed to have weekly key worker sessions. However, there were only four key worker sessions recorded in Mr Asharaf's prison record during his seven months at Wandsworth. All four were in November and December 2023. Three of these focused on whether Mr Asharaf had had a shower and participated in the regime, which is not, in our view, a key worker session. In addition, there were seven key worker entries in Mr Asharaf's record, but again, the majority of these focused on whether Mr Asharaf had participated in the regime. There was little evidence that the key worker was trying to understand Mr Asharaf's needs and build a relationship with him.

80. During its recent inspection of Wandsworth in April and May 2024, HM Inspectorate of Prisons found that key work at the prison had halted entirely since the last inspection. In its survey, just 23% of respondents said that a member of staff had talked to them about how they were getting on in the past week, evidencing a lack of regular, positive engagement. Inspectors reported that the failure to deliver any key work reduced the opportunity to develop meaningful relationships.

81. The Head of Reducing Reoffending at Wandsworth told us during a previous investigation that because of staffing levels, and to provide the best regime and access to purposeful activity, key work had been suspended since COVID-19. The reintroduction of keywork had been included in Wandsworth's 2024/25 business plan, but while staffing levels were reduced, only priority prisoners would receive key work. Once staffing levels allowed, all prisoners would receive key work.

82. It is difficult to say whether regular key worker sessions with Mr Asharaf would have made any difference to the outcome. Nevertheless, key worker sessions are important in establishing good relationships between prisoners and staff and should be resumed as soon as staffing levels allow.

Inquest

83. The inquest, held on 22 July 2025, concluded that Mr Asharaf died from natural causes.

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