

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vasilev Pachev, a prisoner at HMP Wormwood Scrubs, on 25 January 2026

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

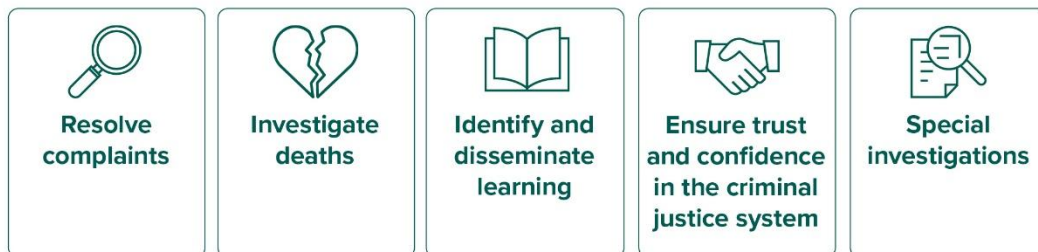
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



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1. 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.
2. 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.
3. On 5 January 2026, Mr Vasilev Pachev was remanded to HMP Wormwood Scrubs for sexual offences. He was admitted to hospital following a medical emergency two days later and did not return to prison.
4. On 25 January, Mr Pachev died in hospital of an intracranial haemorrhage (a bleed on the brain). He was 47 years old. We offer our condolences to Mr Pachev's family and friends.
5. The Ombudsman's office contacted Mr Pachev's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
6. NHS England commissioned an independent clinical reviewer, to review Mr Pachev's clinical care at Wormwood Scrubs. The clinical reviewer's report is attached as Annex 1.
7. The clinical reviewer concluded that the clinical care Mr Pachev received during the short time he was at Wormwood Scrubs was of a very good standard and was equivalent to that which he could have expected to receive in the wider community. The clinical reviewer found that the emergency response to Mr Pachev was appropriately escalated and that healthcare staff maintained regular contact with the hospital to obtain updates on his clinical condition following his transfer. The clinical reviewer made one recommendation not related to Mr Pachev's death that the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Pachev's care.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

July 2026

Inquest

At an inquest held on 2 July 2026, the coroner concluded that Mr Pachev died from natural causes.



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