Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karim Simi, on 22 July 2025, following his release from HMP Pentonville

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

Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Karim Simi was found hanging in a car park on 12 July 2025, five days after his release from HMP Pentonville. He was taken to hospital but died ten days later due to lack of oxygen to the brain. He was 45 years old. We offer our condolences to those who knew him.

5. Mr Simi should have been referred to community mental health services or the homelessness outreach service before his release, but the prison's mental health team were unaware of his release date. Since Mr Simi's death, Pentonville has changed the release checklist, which now ensures that healthcare staff are notified.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Simi's death on 1 August 2025.

8. The PPO investigator obtained copies of relevant extracts from Mr Simi's prison and probation records.

9. We informed HM Coroner for Camden of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Simi's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why Mr Simi went to prison, how long he was there, and how long he had been released before his death. We have addressed these questions within our report.

11. We shared our initial report with HMPPS and the prison's healthcare provider, North London NHS Foundation Trust. They found no factual inaccuracies.

12. We sent a copy of our initial report to Mr Simi's brother. He did not notify us of any factual inaccuracies.

13. We identified one factual inaccuracy and have amended this report accordingly.

Background Information

HMP Pentonville

14. HMP Pentonville is a category B men's prison, managed by HMPPS. It holds men remanded by local courts, and those serving short sentences or beginning longer sentences. North London NHS Foundation Trust provides physical and mental healthcare services.

Probation Service

15. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Pentonville was in June 2025. Inspectors reported that the inpatient mental health delivered particularly good levels of care. However, there were serious failures in release planning and sentence management. They found a lack of planning and release errors meant many prisoners were released without proper support for housing employment or benefits.

Key Events

Background

17. On 28 December 2024, Mr Karim Simi, whose nationality was unknown by the Home Office but who claimed to be Palestinian, was sentenced to six months in prison for possession of a knife. He was sent to HMP Brixton.

18. On 10 March 2025, Mr Simi was released homeless from Brixton. Because he had no lawful basis to stay in the UK, he could not access public funds, or CAS3 accommodation (temporary accommodation for people leaving prison) or local authority housing.

19. On 24 April, Mr Simi did not attend his probation appointment. He also failed to attend on 29 April. Mr Simi's community offender manager (COM) was unable to contact him and so started recall proceedings.

20. On 21 May, Mr Simi was arrested and taken to HMP Pentonville. Mr Simi went into RESET (where active supervision and Rehabilitation Activity Requirements (RARs) are suspended in the final third of a Community Order or licence).

Pre-release planning

Housing

21. On 22 May, during his reception screening, Mr Simi told staff that he was homeless and had been rough sleeping.

22. On 30 May, staff at Pentonville completed the Basic Custody Screening Tool with him and referred him to a housing charity through Commissioned Rehabilitative Services (CRS).

Mental health

23. On 23 May, a nurse from the mental health team assessed Mr Simi. He said he was hearing voices, but they were "all right" at that time. He said he had no thoughts of suicide or self-harm. He said he had schizophrenia and was previously prescribed olanzapine (antipsychotic medication). The nurse referred him to the Mental Health In-Reach Team (MHIRT) and restarted olanzapine.

24. On 17 June, staff found Mr Simi in his cell with a ligature around his neck. An officer started suicide and self-harm prevention procedures (known as ACCT) and set checks at one an hour.

25. At the first ACCT review later that day, Mr Simi said he had tied the ligature because he wanted more medication and was struggling with voices. He also said he had not been sleeping for several days. A healthcare worker noticed cuts on his left arm. The case review team agreed to refer him to the GP for a medication review and to continue ACCT monitoring.

26. Later that evening, a GP reviewed Mr Simi's medication and prescribed him sertraline (an antidepressant) and zopiclone (medicine to aid sleep).

27. On 19 June, officers again found Mr Simi with a ligature around his neck. They entered the cell, cut the ligature, and placed him in the recovery position. Healthcare staff checked his airway and breathing were normal. Mr Simi then became aggressive, so staff could not complete further observations. Officers found two modified vapes in his cell, which suggested he had used psychoactive substances (PS). ACCT checks continued at one an hour, and a mental health worker reviewed him three times that day.

28. On 23 June, during a routine check, an officer saw Mr Simi tightening and loosening a ligature around his neck. The officer removed the ligature and asked healthcare staff to review him. Healthcare staff checked him and were content he was not injured.

29. On 27 June, a GP reviewed Mr Simi's mental health medication. He increased his sertraline and noted that he was looking well.

30. On 2 July, a senior officer tried to hold an ACCT review with Mr Simi and his mental health key worker. Mr Simi initially agreed to engage but refused once the senior officer told him he could not give him a vape. The senior officer rescheduled the review for the next day.

31. On 3 July, Mr Simi's mental health key worker was unavailable, so the senior officer asked a chaplain to attend in their place.

32. On 7 July, before release, Mr Simi had a final ACCT review with an officer in reception. He said he was pleased to be returning home and spoke positively about the future. He said he had no thoughts of suicide or self-harm. MHIRT were not aware of his release.

Substance misuse

33. At reception, Mr Simi told a healthcare worker that he had previously used cocaine and crystal methamphetamine. He said his most recent crystal methamphetamine use was 21 May, before his arrest.

34. On 29 May, a substance misuse service (SMS) worker spoke to Mr Simi through his cell door. He was unable to have a full key work session with Mr Simi as officers could not unlock the door due to staffing levels. Mr Simi said he had no current substance misuse issues. The SMS worker warned him about bad batches of hooch (illegally brewed alcohol) and PS reported on his wing. Mr Simi said he did not like either and had no plans to use them.

35. On 30 May, a SMS worker had a key work session with Mr Simi. They discussed harm reduction and how Mr Simi had taken positive steps by not using drugs since he had entered prison. Mr Simi said he wanted to stop using crystal methamphetamine once back in the community. The SMS worker agreed to refer him to Change Grow Live, the community substance misuse service, for support on release.

36. On 20 June, a SMS worker had a key work session with Mr Simi. Mr Simi said he had not used any substances, despite being found suspected under the influence the day before.

37. On 1 July, Mr Simi had a SMS key work session. His key worker noted Mr Simi looked well and felt more positive than the previous week. Mr Simi denied any substance use and asked for information about his immigration hold.

Release from HMP Pentonville

38. Mr Simi was due to be released from Pentonville on 11 June 2025. However, due to him being held under immigration detention powers, his release was delayed until immigration bail was granted.

39. On 25 June, Mr Simi was allocated a new community offender manager (COM), who was part of the RESET team.

40. On 26 June, Mr Simi's prison offender manager (POM) told him that they were awaiting confirmation from the Home Office on whether he would be released or detained under immigration powers.

41. On 3 July, Mr Simi's POM saw him on the wing. He told him that he had spoken to the Home Office, and they had told him that they were going to come and see Mr Simi with the paperwork for immigration bail in the next week. This meant Mr Simi would be released into the community, pending his deportation. Mr Simi said he was happy with the update.

42. On 7 July at 1.00pm, Mr Simi was released homeless from Pentonville on immigration bail and licence. Mr Simi declined support with GP registration and was given information on healthcare services. He was told his appointment with Change Grow Live, the community substance misuse service, was on 8 July.

43. Mr Simi had no contact details, and no phone. He did not attend his initial appointment with probation.

44. On 8 July, Mr Simi went to the probation office, but he had no appointment booked and his COM was not in. The COM asked reception staff to tell him to return the next day at 12.00pm, noting he had no phone.

45. The next day, Mr Simi did not attend the probation office. His COM could not send an enforcement letter because Mr Simi had no known address.

Circumstances of Mr Simi's death

46. On 12 July, a passer-by found Mr Simi hanging in a car park. They called emergency services and started CPR. After about 30 minutes, paramedics found a pulse and intubated him. They took him to hospital for further treatment.

47. Hospital staff continued to treat Mr Simi, but they concluded he had brain damage from which he would not recover. Doctors removed life support, and he died on 22 July.

Post-mortem report

48. The post-mortem report concluded that Mr Simi died from hypoxic brain injury (brain damage caused by the brain not getting enough oxygen) following successful resuscitation from cardiac arrest, caused by suspension by ligature.

49. The toxicology report showed Mr Simi was not under the influence of drugs or alcohol when he died. However, because he had been in hospital for ten days, it is not possible to say whether he had taken drugs or alcohol before admission.

Findings

Mental health

50. Mr Simi saw a mental health key worker regularly at Pentonville and had several medication reviews with a GP to help manage his symptoms.

51. We found that staff appropriately started suicide and self-harm monitoring for Mr Simi after he tied a ligature around his neck on 19 June. This support continued throughout his stay at Pentonville. We consider he received a good level of mental health support in custody.

Housing

52. Due to his immigration status, Mr Simi had no access to public funds which meant he could not access much of the accommodation available to people leaving prison homeless. Staff at Pentonville referred Mr Simi to a housing support charity, through CRS. However, no housing was found for him before his release.

Substance misuse

53. When Mr Simi arrived at Pentonville, he told staff that he had a history of cocaine and crystal methamphetamine use. He denied any use while in Pentonville and engaged well with substance misuse key work sessions. We consider that Mr Simi had good support with substance misuse in prison and was appropriately referred to community substance misuse services in the community release.

Release planning

54. Mr Simi was not referred to community mental health services before his release. The service lead for the mental health in-reach service at Pentonville told us that the service was not aware of Mr Simi's release date and only found out after his release. Had they known, they would have referred him to either the community mental health team (if he had an address) or the homelessness outreach team.

55. The Head of the Offender Management Unit (OMU) at Pentonville told us that at the time of Mr Simi's release, there was no formal process for OMU to inform healthcare staff about scheduled releases. The assumption was that if a prisoner was under the care of a healthcare team, they would have access to their release date without being told by OMU. Since Mr Simi's death, they have designed new release checklists that require staff to inform healthcare staff either on the day of release (for immediate releases), or 14 days before release (for standard releases).

56. We are satisfied that the prison has taken steps to address the issue and make no recommendation.

Adrian Usher
Prisons and Probation Ombudsman **March 2026**

Inquest

At the inquest, held on 7 July 2026, the Coroner reached a narrative conclusion:

“Mohamed Benmebarek, aka Karim Simi, died on 22 July 2025 at St Mary's Hospital, Paddington, London from a hypoxic brain injury he suffered as a result of suspending himself by a ligature on 12 July 2025. He had, on 7 July 2025, been released from HMP Pentonville on immigration bail. The prison had not made the prison's mental health team aware of his release date, such that the mental health team had not been involved in his release planning. This meant that there was no opportunity for provision to be made for ongoing assessment and care of Mr Benmebarek's mental health in the community.”

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