



Trust Headquarters
4th Floor, East Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

Ms. ME Hassell
HM senior Coroner
Inner North London Coroner's Court

Date: 29 September 2026

By email only

Dear HM Senior Coroner Hassell,

Re: Inquest touching the death of Mr Stephen Nuth

I write on behalf of North London NHS Foundation Trust ('The Trust') in response to your Regulation 28 Prevention of Future Deaths Report received on 12th August 2026 and following the conclusion of the inquest touching the death of Mr Stephen Nuth. The Trust wishes to express its sincere condolences to Mr Nuth's family.

The Trust has carefully reviewed the matters you have identified and accepts your concern that the mental health assessment undertaken two days before Mr Nuth's death was conducted without review of the available electronic patient record. The Trust further acknowledges the evidence heard during the inquest that this failure represents a potential systems issue rather than solely an individual practitioner omission. The Trust acknowledges that where there is a failure to adequately review the available records, there is a significant risk that relevant clinical factors may not be considered during clinical decision-making, and this represents potential missed opportunities to strengthen risk management.

The New Model of Care Standard Operating Policy: London, Health in Justice Sites, HMP operated by Practice Plus Group ('PPG' - the lead provider of healthcare under which the mental health in reach provision is subcontracted to the Trust) sets out the framework for staff undertaking assessments throughout the early days in custody pathway. This policy describes the processes for gathering and sharing information to



support effective integrated working and to better understand patient needs. Whilst not expressly stated, it is implicit in this policy that patient records are appropriately maintained and referred to so that risks are identified and addressed thereby prioritising safety and promoting continuity of care. The formal induction process for staff employed (and engaged as agency staff) within the mental health in-reach service includes the requirement that all new staff read this policy prior to commencing work. The expectation that clinical staff must review a patient's notes prior to seeing them, is also communicated through overarching professional codes and the safety standards governing nursing (and other clinical) practice. It is the Trust's expectation that all clinical staff are familiar with their professional codes of conduct and that they refer to a patient's medical record where possible before conducting clinical assessments.

With respect to the mental health nurse who did not review the notes before assessing Mr Nuth, this member of staff was engaged via an agency – Medicure/Hunter and the Trust has referred this matter to Medicure/Hunter. In collaboration with the Trust, Medicure/Hunter has reviewed this matter. The Trust has been advised that this is the first time a concern has been received in respect of this individual and, on this basis, it has been agreed that the Trust will put additional clinical supervision in place. In addition, a copy of the PFD Report has been shared with this member of staff, and he has completed a written reflection.

To ensure wider learning, the concerns raised in this PFD will be shared across the wider prison mental health service staff group through the local clinical governance meetings. Emphasis will be placed upon the importance of reviewing relevant clinical records before undertaking mental health assessments where possible. All existing and new clinical staff within the prison mental health service will continue to be reminded of their professional responsibilities during the local induction process and at mandatory refresher intervals which are tracked as part of the yearly appraisal process. This expectation will be strengthened by revision of the New Model of Care Standard Operating Policy: London, Health in Justice Sites, HMP Pentonville, which will now include explicit guidance around the review of medical records prior to assessment. This policy is in the process of being revised and a copy of the revised version can be disclosed on finalisation, should you wish to receive this.

Whilst the Trust accepts that medical professionals should review a patient's medical records before conducting an assessment, it does recognise that within the busy and clinically acute environment of the prison, circumstances may arise that prevent this from happening. For example, in an emergency or otherwise clinically urgent situation, the reasonableness and proportionality of the assessor's actions should be considered in the context of the operational security constraints of the prison environment.

Although, ideally, for planned assessments a prisoner would be brought to a clinic room in the health-care wing, the security requirements and operational pressures may mean that clinicians must assess prisoners in their cells or elsewhere on the general wings, in a private and confidential setting where possible, for unplanned and emergency assessments, sometimes while coordinating security support, such as a prison guard escort. In some cases, assessments are referred via verbal handover and with prisoners requiring immediate face to face assessment, noting there is very limited access to medical records outside of the healthcare wing, for example, in Mr Nuth's case, where he was assessed as part of the Unscheduled Care pathway which deals with urgent or high-risk cases.



North London NHS Foundation Trust

Restrictions on the possession, availability and use of electronic devices within the custodial environment, together with the urgency of the clinical work, may also limit the assessor's ability to review records or complete contemporaneous documentation before or during the assessment. Where the records have not been reviewed prior to an assessment being undertaken, there is, in line with best practice, an expectation that they will be reviewed following the assessment, with a view to identifying any matters requiring further consideration and, where necessary, returning to the patient to address those matters. In addition, the Trust recognises that modern electronic healthcare records, such as SystmOne, may contain extensive documentation accumulated over many years, frequently including thousands of entries generated across multiple care settings. In such circumstances, appropriate discretion is afforded to the clinician, with due deference to their professional judgment, provided that the approach taken is reasonable and proportionate to the circumstances.

Action Plan

Action	Date for Completion	
Reflective Practice Supervision Mental Health Nurse.	09.10.26	Completed
Revision of NMOC Standard Operating Policy.	01.12.26	In progress
Dissemination of PFD learning in local clinical governance.	08.09.26	Completed

I hope that the above response provides assurance that the Trust is committed to providing high-quality care and that this response addresses the concerns you hold. Please contact me if you have any remaining queries.

Yours sincerely,



Chief Medical Officer

Chief Medical Officer
North London NHS Foundation Trust