

	Report to Prevent Future Deaths Regulation 28 of The Coroners (Investigations) Regulations 2013 Stephen Andrew Christopher NUTH (died 24.09.25)
1	CORONER I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court
2	DATE OF REPORT Monday, 3 August 2026
3	CORONER'S LEGAL POWERS I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
4	THIS REPORT IS BEING SENT TO: 1. The Chief Executive North London NHS Foundation Trust (NLFT) You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 September 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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.

	I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that you have the power to take such action.
7	INVESTIGATION AND INQUEST On 2 October 2025, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Stephen Nuth, aged 51 years. I concluded the inquest on Friday, 31 July 2026.
8	CIRCUMSTANCES OF DEATH Mr Nuth was found hanging in his cell at HM Prison Pentonville on 24 September 2025. His medical cause of death was: 1a ligature compression to the neck. The jury made a determination of suicide and gave a narrative conclusion, a copy of which I attach.
9	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The MATTERS OF CONCERN are as follows: The failures to open an ACCT (assessment care in custody and teamwork) on 26 August and 2 September 2026 recorded by the jury in their conclusion had already been identified by the PPO (Prisons and Probation Ombudsman) and I heard evidence that NLFT has undertaken remedial work to avoid this happening in the future. I write to you now concerning the failure of the NLFT mental health nurse who conducted an assessment of Mr Nuth two days before Mr Nuth's death, to read his medical records. This meant that the mental health nurse did not know that Mr Nuth had disclosed to another mental health nurse that he had heard voices telling him to tie a ligature and jump off a landing, and he did not know that there had been a failure on two occasions since to open an ACCT. The mental health nurse and the then service manager both readily accepted at inquest that the medical records should have been read before an assessment was conducted. However, both were candid that, in a busy prison, without immediate access to the records on the wing (mobile devices are not permitted in prison), it may well be the case that an assessing mental healthcare professional will not necessarily do that. Aside from the individual, this seems to be a systems issue.
10	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I have sent the report to: • the family of Stephen Nuth • HM Prison Pentonville • the Ministry of Justice (MoJ) • Practice Plus Group (PPG) • Phoenix Futures • HM Inspectorate of Prisons (HMI Prisons) • HM Prison and Probation Service (HMPPS) • Prisons and Probation Ombudsman (PPO) • Independent Advisory Panel on Deaths in Custody (IAPDC). I also have a duty to send a copy of the report to the Chief Coroner.

	You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 5 above for additional information relating to the publication of reports and responses.
	SIGNATURE <i>ME Hassell</i>