Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Nuth, a prisoner at HMP Pentonville, on 24 September 2025

A report by the Prisons and Probation Ombudsman

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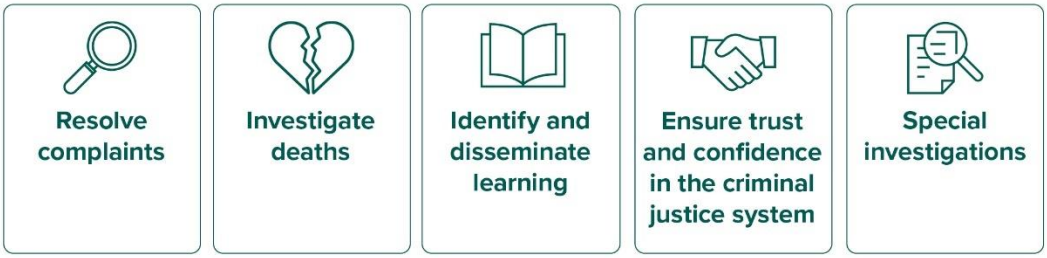
OUR VISION

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 Stephen Nuth was found hanged in his cell on 24 September 2025, at HMP Pentonville. He was 51 years old. I offer my condolences to Mr Nuth's family and friends.

Mr Nuth had a history of suicide attempts and several known risk factors for suicide when he arrived at Pentonville in April 2025. He did not inform staff of any initial concerns but later disclosed to healthcare staff paranoid thoughts, hallucinations and intrusive thoughts which involved tying things around his neck and jumping from the landing. Healthcare staff did not start suicide and self-harm prevention procedures, known as ACCT, as they should have done. The investigation found that healthcare staff relied too heavily on Mr Nuth's presentation and did not consider all his risk factors.

The clinical reviewer concluded that there were some good elements to Mr Nuth's healthcare including the ADHD clinic and his substance misuse care. However, his mental and physical healthcare were not equivalent to that he could have expected to receive in the community. Staff did not adequately review his previous records, speak to him about missed medication or ensure he was reviewed by a GP as he should have been. These were all potential missed opportunities to further assess the risk Mr Nuth posed to himself.

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 **March 2026**

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Summary

Events

1. Mr Stephen Nuth had a history of drug use including heroin, crack cocaine, cannabis and benzodiazepines. He was prescribed buprenorphine (a weekly or monthly injection used to treat opioid dependence).

2. On 19 April 2025, Mr Nuth was remanded to prison after being charged with robbery and taken to HMP Pentonville. Mr Nuth had been in prison before.

3. Mr Nuth had attention deficit hyperactivity disorder (ADHD – traits include impulsivity, difficulty concentrating and hyperactivity), depression, traits of autism (autistic people may find it hard to communicate and interact with others and understand how others think and feel), post-traumatic stress disorder (PTSD – symptoms include flashbacks and nightmares) and ankylosing spondylitis (chronic arthritis that affects the spine and can cause considerable pain). He also had a history of attempted suicide and self-harm. In prison, Mr Nuth was prescribed medication for his ADHD and depression but did not always take it.

4. During Mr Nuth's healthcare screenings staff referred him to the substance misuse service and to the ADHD clinic. He engaged regularly with both.

5. On 18 August, Mr Nuth disclosed to his drug recovery worker that he had been experiencing paranoid thoughts. They referred Mr Nuth to the mental health team and he also referred himself. On 23 August, Mr Nuth began sharing a cell with his son.

6. Three days later, a nurse assessed Mr Nuth's mental health while he was working at the textile workshop. He said he had paranoid thoughts, hallucinations and intrusive thoughts which involved tying things around his neck and jumping from the landing. The same day, Mr Nuth also voiced similar thoughts to healthcare staff in the ADHD clinic. Neither member of staff started suicide and self-harm support measures, known as ACCT.

7. On 2 September, a multidisciplinary mental health team meeting took place. The team discussed Mr Nuth and agreed a mood review should take place. They also tasked a mental health nurse with opening an ACCT due to his clinical presentation. Neither action was completed.

8. On 22 September, healthcare staff realised that Mr Nuth's ACCT had not been opened. A mental health nurse reviewed Mr Nuth, noted no concerns and did not begin ACCT procedures. On 23 September a pharmacy technician realised Mr Nuth had not taken his medication for five days and tasked a GP to review him.

9. On 24 September at 3.21pm, Mr Nuth's son returned to their cell but could not open it. An officer arrived and tried to open the cell door but could see Mr Nuth had barricaded the door and hanged himself from the top bunk with a belt. The officer radioed an emergency code and staff arrived, entered the cell, cut the ligature and began CPR.

10. At 3.36pm, paramedics arrived at Mr Nuth's cell and continued with resuscitation attempts. At 4.17pm the paramedics pronounced life extinct.

Findings

11. Mr Nuth had several risk factors for suicide and self-harm including previous attempts to take his life, being diagnosed with depression, a history of substance use, a diagnosis of ADHD and being on remand. He had also been made homeless after losing his bedspace at his supported temporary accommodation.

12. The clinical reviewer found that the clinical care that Mr Nuth received was not equivalent to that which he could have expected to receive in the community. She found that although there were very good elements of his care, such as the ADHD clinic and his substance misuse care, there were concerns in relation to his physical and mental health care.

13. Healthcare staff at Pentonville did not appropriately manage Mr Nuth's risk to himself. They appeared to over rely on Mr Nuth's presentation rather than also assessing his risk factors. There were three occasions when he should have seen a GP and did not. Staff did not adequately review his medical record and they did not discuss his missed medication with him in a timely manner.

14. Mr Nuth appeared to have minimal interactions with prison staff and during his time at Pentonville he did not receive any key work sessions.

Recommendations

- The Head of Healthcare should introduce a robust process to ensure that outcomes and actions from clinical meetings are completed.

- The Head of Healthcare should ensure that all healthcare staff review medication and compliance as part of any mental health assessment.

- The Head of Healthcare should undertake a review of GP task allocation to understand why GP tasks are not always completed and implement any necessary improvements to practice.

The Investigation Process

15. HMPPS notified us of Mr Nuth's death on 24 September.

16. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

17. The investigator visited Pentonville on 6 October. She obtained copies of relevant extracts from Mr Nuth's prison and medical records.

18. The investigator interviewed four members of staff and one prisoner at Pentonville in November. She interviewed a further two members of staff on Microsoft Teams in January 2026.

19. NHS England commissioned an independent clinical reviewer to review Mr Nuth's clinical care at the prison. The clinical reviewer jointly conducted all interviews.

20. We informed HM Coroner for London Inner North of the investigation. The Coroner provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

21. The Ombudsman's office contacted Mr Nuth's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Nuth's brother wanted to know why Mr Nuth was not being monitored when he had attempted suicide before, why he was sharing a cell with his son and whether his phone calls were being monitored. These questions are answered in this report, the clinical review and separate correspondence.

22. We shared the initial report with Mr Nuth's brother. He did not make any comments.

23. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

Background Information

HMP Pentonville

24. HMP Pentonville is a local prison in London that primarily serves the courts of North and East London. Practice Plus Group, in partnership with North London NHS Foundation Trust, provides physical and mental healthcare services and Phoenix Futures provides substance misuse treatment.

HM Inspectorate of Prisons (HMIP)

25. The most recent inspection of HMP Pentonville was in June and July 2025. Inspectors reported that the prison had seriously deteriorated. As a result of the very worrying findings, an Urgent Notification to the Secretary of State was issued. (This is the process where HMIP identifies serious and immediate concerns during an inspection requiring the Secretary of State to respond publicly to their findings within 28 days).

26. Inspectors found that the care and support offered to new prisoners during their first few days in prison was wholly inadequate. The care for some of the most vulnerable was appalling and support for those who were at risk of suicide and self-harm was cursory at best. Many of the wings were chaotic and noisy. Levels of violence were high, often fuelled by the ingress of drugs into the jail, and inspectors frequently smelt cannabis on the wings. Relationships between prisoners and staff were often poor and prisoners complained that staff seemed to be indifferent to them or their needs. While there were many dedicated staff members at the prison, inspectors witnessed an apparent lack of care from too many officers. The key worker scheme was not operating effectively and those deemed a priority rarely received a keywork session.

27. There were some more positive findings. A dedicated healthcare team managed to deliver a good service, with some particularly good levels of care for some very unwell men on the inpatient unit. The incentivised substance free living (ISFL) unit was better than inspectors often found, with men given good support to address their addiction.

Independent Monitoring Board

28. 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 March 2025, the IMB reported that there had been some improvements in the management of safety and welcomed the increased focus on violence reduction. However, first night cells lacked basic equipment, safer custody was understaffed, and accurate completion of ACCT documents remained an issue. There was an insufficient number of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and the Board was concerned by an increase in the availability of psychoactive substances.

Previous deaths at HMP Pentonville

29. Mr Nuth was the ninth prisoner to die at Pentonville since September 2022. Of the previous deaths, five were self-inflicted with four of these deaths in 2025, two were due to natural causes and two were drug related. Since the death of Mr Nuth and up to mid-March 2026, there had been one further death due to natural causes.

30. In our investigation into a self-inflicted death in 2025, we noted some issues with prison staff identifying prisoners' risk factors and basing their assessment of a prisoner's risk of suicide solely on their presentation.

Assessment, Care in Custody and Teamwork (ACCT)

31. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

32. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed, the closure has been discussed with the prisoner and a post closure review date has been set. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in the Prison Safety Policy Framework.

Key work scheme

33. The key work scheme is a key part of HMPPS' 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' Manage the Custodial Sentence Policy Framework issued in 2018.

34. In recent years, 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

Background

35. Mr Stephen Nuth had attention deficit hyperactivity disorder (ADHD), depression, traits of autism, post-traumatic stress disorder (PTSD) and ankylosing spondylitis. He also had a history of self-harm and attempted suicide by tying a ligature around his neck. He was prescribed methylphenidate (a central nervous stimulant for ADHD) and mirtazapine (an antidepressant).

36. Mr Nuth had a history of drug use including heroin, crack cocaine, cannabis and benzodiazepines (sedatives). He was prescribed buprenorphine (an injectable medication used to treat opioid dependence). Mr Nuth received his injection monthly throughout his time in prison.

HMP Pentonville

37. On 19 April 2025, Mr Nuth was charged with robbery, remanded to prison and taken to HMP Pentonville. Mr Nuth had been to Pentonville several times before.

38. Officer A completed Mr Nuth's reception screening. Mr Nuth told him that he had autism and that he had no intention of self-harming in prison. He raised no concerns and Officer A completed his cell sharing risk assessment (CSRA - assesses the risk posed by a prisoner to another in a locked cell.) He assessed Mr Nuth as standard risk, meaning Mr Nuth could share a cell with other prisoners.

39. The same day, a nurse completed Mr Nuth's initial healthcare screening. Mr Nuth told her that he had attempted suicide around 18 months earlier by tying a ligature around his neck because he was so distressed from having his sleep disturbed. However, he said he had no current thoughts of suicide. Mr Nuth tested positive for benzodiazepines, cannabis, cocaine and buprenorphine. The nurse referred Mr Nuth to the substance misuse service (Phoenix Futures). The nurse noted that Mr Nuth had a diagnosis of ADHD and depression. She also completed a medicine in possession risk assessment (this considers whether a prisoner can safely keep their medication in their cell). She assessed Mr Nuth as being unsuitable meaning he would have to collect any prescribed medication from the medication hatch on the wing.

40. The following day, during his secondary healthcare screening, staff referred Mr Nuth to the ADHD clinic. (The ADHD clinic is run by Dr A. She told the investigator that it runs every Tuesday, and she sees six or seven prisoners in a day. This means appointments are not that frequent, sometimes taking weeks.)

41. On 24 April, Ms A, substance misuse service recovery worker, assessed Mr Nuth. He told her that since coming to Pentonville he had experienced three seizures. He also said he had not received his mirtazapine, methylphenidate, pain relief for his ankylosing spondylitis and omeprazole (reduces stomach acid). Ms A passed this information onto healthcare staff and the GP to review his medication.

42. Later that day, a nurse assessed Mr Nuth. They confirmed it was unlikely that he had experienced seizures based on his symptoms and what Mr Nuth had

described. Mr Nuth's clinical observations appeared fine and the nurse noted no concerns.

43. On 3 June, Dr A reviewed Mr Nuth in the ADHD clinic. Dr A said Mr Nuth presented with prominent ADHD symptoms and he told her that he was not sleeping well. He told her that he had stopped taking medication in the community and used cocaine instead as it made him feel calm. Mr Nuth told Dr A that he had been screened for autism and wanted an assessment. Dr A told the investigator that she prescribed Mr Nuth methylphenidate and mirtazapine following the review. (Mr Nuth had still not seen a GP despite the referral for a medication review made on 24 April.) She then added Mr Nuth to the autism diagnosis pathway following a discussion with his community offender manager (COM), who confirmed his screening in the community. Dr A told the investigator that there was a long waiting list for the autism pathway and Mr Nuth did not access it before he died.

44. On 18 June, Ms A completed a substance use session with Mr Nuth. No issues were raised.

45. On 2 July, a GP prescribed Mr Nuth naproxen (pain relief) for his ankylosing spondylitis and omeprazole for the side effects of this medication. (Mr Nuth had been referred to the GP in April for this).

46. On 4 July, Mr Nuth attended court where they set a trial date for December. Prison and healthcare staff did not review Mr Nuth following his court appearance.

47. Four days later, Dr A saw Mr Nuth in the ADHD clinic. She increased his methylphenidate as Mr Nuth felt the initial effects had worn off. Mr Nuth spoke positively of his employment and how much he enjoyed the routine it gave him.

48. On 15 August, Mr Nuth appeared at court via video link. Again, prison staff did not speak to him after this.

49. On 18 August, Ms A saw Mr Nuth for another session. Mr Nuth said he had no thoughts of suicide or self-harm but had paranoid thoughts. His cellmate told Ms A that Mr Nuth had been acting erratically. Ms A referred Mr Nuth to the mental health team. Mr Nuth also self-referred the next day.

50. Two days later, a planned care meeting took place following the mental health referrals. Healthcare staff noted that Mr Nuth already had a pre-existing review booked with Dr A in six days' time. They referred Mr Nuth for a review with the mental health team.

51. On 23 August, Mr Nuth's son, Prisoner A, moved into his cell. Prisoner A told the investigator that Mr Nuth had asked him if he wanted to share. Prisoner A told the investigator that while sharing a cell with his father, he noticed a change in Mr Nuth during the evenings when he appeared paranoid and his mood changed. (Prisoner A had previously not seen this as they were locked up for the evening in different cells). Prisoner A said he did not explicitly share his concerns with prison staff.

52. The next day Mental Health Nurse A (employed temporarily as an agency nurse) attempted to see Mr Nuth for a mental health review. It is not clear why he was unable to, and Nurse A was not available for interview. (He has since left his role at

Pentonville and is not in the country but provided us with a statement sent via email).

53. On 26 August, Nurse A saw Mr Nuth briefly in the textile workshop. He said Mr Nuth told him he had paranoid thoughts, hallucinations and intrusive thoughts which involved tying things around his neck and jumping from the landing. Nurse A said he did not start suicide and self-harm prevention procedures, known as ACCT, as Mr Nuth said he had no plans to act on these thoughts. Nurse A did not record that he had seen Mr Nuth. We became aware of the details of this interaction as the nurse included it in his email to us after Mr Nuth had died. Prison staff were unaware of the exchange.

54. Later that afternoon, Dr A saw Mr Nuth in the ADHD clinic. Mr Nuth told Dr A about the paranoia and voices he was hearing, and how he found noise overwhelming. Mr Nuth said he had some thoughts of suicide and self-harm but would not act on them and had felt better since his son had moved into his cell. Dr A agreed to reduce his medication due to the side effects of the higher dose being the potential cause of these thoughts. She told the investigator that she planned to review Mr Nuth again the following month and reduced Mr Nuth's medication.

55. The same day prison staff moved Mr Nuth to the incentivised substance free living (ISFL) wing. (The ISFL is a designated wing for prisoners who wish to live drug free. These wings provide a structured environment where prisoners agree to a behavioural compact which includes working with Phoenix Futures, undergo regular drug testing and receive incentives that they otherwise would not get. The aim is to create a safe and stable environment where prisoners can focus on recovery.)

56. Two days later, Catch22, a voluntary organisation working with prisoners on remand at Pentonville, visited Mr Nuth. He declined support from them.

57. On 2 September, a multidisciplinary mental health team meeting took place which Nurse A attended. Nurse A told staff that on the 26 August Mr Nuth had appeared anxious and said he was not sleeping. The team discussed Mr Nuth and tasked Nurse A with opening an ACCT due to Mr Nuth's clinical presentation. Nurse A did not open the ACCT. He told us this was due to workload pressures. Other actions included a mood review. There is no evidence indicating that the mood review was completed and it remains unclear who should have completed it. Healthcare staff at the meeting noted Mr Nuth would be seen in the ADHD clinic on 16 September.

58. On the 11 September, Mr Nuth's son, Prisoner A, moved to the ISFL wing. They began sharing a cell again.

59. The next day Mr A, pharmacy technician, spoke with Mr Nuth as he had missed four doses of medication across the week. Mr Nuth told him he had lost his prison ID and had been hearing voices. Mr A referred Mr Nuth to the GP and the mental health team.

60. On 16 September, Dr A reviewed Mr Nuth as planned. She said Mr Nuth presented as less paranoid but appeared overwhelmed. Mr Nuth told her that he struggled to take his medication daily because he kept losing his prison ID and he found the wing noisy. Mr Nuth told Dr A that he wanted his own cell as he found it challenging sharing. Dr A referred Mr Nuth to occupational therapy for help with practical tasks

and added him to the medical single cell discussion list. Healthcare staff discussed this a few days later and agreed Mr Nuth did not meet the medical requirements for a single cell.

61. The following day a planned care meeting took place. Healthcare staff noted Mr Nuth had been referred to occupational therapy and remained on the waiting list for an autism assessment. They added Mr Nuth to the voices and visions group, speech and language therapist support (to support with the pre-screening process for the autism assessment) and requested ear plugs to block out noise. Healthcare staff did not appear to notice that the actions from the meeting on the 2 September had not been completed.

62. On 18 September, Ms A saw Mr Nuth. He presented with a low mood and said he had a lot on his mind but did not want to discuss it. Mr Nuth said he had no thoughts of suicide or self-harm. Ms A did not share Mr Nuth's low mood with any other healthcare or prison staff.

63. On 22 September, healthcare staff reviewed Mr Nuth during a multidisciplinary complex case clinic (MPCCC). Staff noted that an ACCT had not been opened following the meeting on 2 September. As a result, Mental Health Nurse B reviewed Mr Nuth later that day. Mr Nuth said he had no thoughts of suicide or self-harm, so Nurse B did not open an ACCT. He told Nurse B that his mood had improved, although poor sleep remained an issue, and that he would contact the mental health team should anything change. Nurse B did not appear to follow up on Mr Nuth's missed medication and that he had not been taking it regularly. He referred Mr Nuth to the GP regarding his sleep.

64. The next day Mr A discussed Mr Nuth's missed medication with him again as he had not taken it for five consecutive days. Mr Nuth told Mr A that some days he did not feel like taking it. Mr A referred Mr Nuth to the GP (again) and the mental health team but a review did not take place before Mr Nuth died.

65. During his time at Pentonville, Mr Nuth did not receive any key work sessions and did not have any visits. His phone records indicate that he maintained contact with his partner and in the month before his death, he spoke with her several times. Unfortunately, we have not been able to listen to these calls. The investigator requested a recording of Mr Nuth's phone calls at the start of the investigation but the prison did not provide them and they were subsequently deleted from records. There is no evidence that staff listened to Mr Nuth's calls before he died.

Events of 23 and 24 September

66. The investigator watched CCTV and body worn video camera (BWVC) footage. She also obtained information from London Ambulance Service. The following account has been taken from these sources, staff statements and interviews.

67. On 23 September, Mr Nuth made three phone calls to his solicitor. The first at 5.31pm, then at 5.47pm and finally at 6.20pm. We do not know the nature of these calls due to the confidentiality of Mr Nuth's legal communications. Mr Nuth made another call at 5.34pm to Conway House (a supported housing provider who had previously provided Mr Nuth with hostel accommodation). Mr Nuth's COM said that

Mr Nuth knew Conway House were unable to hold his bedspace past July 2025, leaving him homeless again.

68. On 24 September at 2.22am, Mr Nuth pressed his cell bell. Prisoner A told the investigator that Mr Nuth woke him up during the night complaining of breathing difficulties. At 3.38am, Operational Support Grade (OSG) A went to Mr Nuth's cell. Prisoner A said that by the time staff arrived, Mr Nuth's breathing had returned to normal.

69. OSG A told the investigator that she remembered attending the cell but did not recall the bell had been ringing for over an hour before she responded. OSG A said Mr Nuth requested paracetamol for a headache. She said she collected four paracetamol tablets from the medication hatch, took them to his cell and passed them under the cell door. OSG A said she knew Mr Nuth as he worked in the kitchens and that his mood seemed no different to usual.

70. In the morning, Prisoner A said that he woke up to find Mr Nuth crying. He said he told Mr Nuth that they would talk after his social visit that afternoon. Prisoner A told the investigator that Mr Nuth appeared down, but he did not mention suicide or self-harm. However, he also told the investigator that Mr Nuth would not disclose these thoughts to him anyway.

71. Later that day, prison staff removed Mr Nuth from the print workshop as he had not attended work all week. There is no evidence to suggest that wing staff spoke to him about his non-attendance. Officer B told the investigator that Mr Nuth did not like this job and had another job in the kitchen which he attended regularly. OSG A confirmed Mr Nuth appeared to enjoy working in the kitchens.

72. At 1.27pm, Prisoner A left their cell for a social visit. Mr Nuth remained in the cell.

73. At 1.57pm, Officer B unlocked Mr Nuth's cell for association (when prisoners can socialise with each other). Mr Nuth told Officer B that Prisoner A was on a social visit. Staff did not speak to Mr Nuth again.

74. Around a minute later, Mr Nuth left his cell with a green bag. He returned approximately a minute later, without the bag and went back in his cell. We do not know what was in the bag or where he took it. He did not leave his cell again after this.

75. At 3.21pm, Prisoner A returned to the cell. He could not open the cell door and spoke with another prisoner just outside of the cell. A minute later, Prisoner A walked down the landing and returned with Officer C. Officer C unlocked the cell door, without looking in, and walked away.

76. Prisoner A told the investigator that the cell door appeared barricaded and would not push open. He said he left the cell to ask for help. Officer C told him to ask Officer B for help and he did so.

77. At 3.26pm, Officer B arrived at the cell. She tried to push open the door but could not. She looked through the observation panel and could see a barricade behind the door and Mr Nuth suspended from the top bunk bed, having used a belt to hang himself.

78. Officer B called out for Officer C and Officer D to assist her. Both made their way to the cell. At 3.30pm, Officer B radioed a code blue (an emergency code used to indicate when someone is unresponsive or not breathing). Control room staff requested an ambulance.

79. Officer B managed to move the cupboard which had blocked the door. Staff went into the cell. Custodial Manager (CM) A arrived and supported Mr Nuth while Officer D used his anti-ligature knife to cut the ligature and remove it from Mr Nuth's neck. Staff lowered Mr Nuth to the floor, laid him on his back and checked his airways. Officer D immediately began cardio-pulmonary resuscitation (CPR).

80. Nurse C arrived a minute after the code blue radio call and soon after more healthcare staff arrived. Nurse C requested that staff continue with CPR. Staff attached a defibrillator. Initially it appeared not to be working but healthcare staff quickly resolved the issue and attached the defibrillator correctly.

81. Staff moved Prisoner A downstairs to the wing office. CM B remained with him. All other prisoners were locked in their cells.

82. At 3.36pm, paramedics arrived at Mr Nuth's cell. They asked for the cell to be cleared and continued with resuscitation attempts. At 4.17pm paramedics pronounced life extinct.

Contact with Mr Nuth's family

83. The prison appointed Ms B as family liaison officer. Mr Nuth did not have a recorded next of kin on the prison system. However, CM B, another trained family liaison officer, broke the news to Prisoner A and he provided details of Mr Nuth's brother.

84. Ms B and CM B visited Mr Nuth's brother at his home address later that evening, broke the news of Mr Nuth's death and offered their condolences. At the request of Mr Nuth's brother, they then attended the address of Prisoner A's grandmother and broke the news to her.

85. In line with national guidance, the prison offered a financial contribution to Mr Nuth's funeral costs. The also arranged for Prisoner A to attend the funeral with a prison escort.

Support for prisoners and staff

86. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

87. After Mr Nuth's death, Deputy Governor Mr B 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.

88. The prison posted notices informing other prisoners of Mr Nuth's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nuth's death. Listeners were also provided. They also appropriately supported Prisoner A.

Post-mortem report

89. The Pathologist concluded that the cause of death was hanging.

Findings

Assessment and management of suicide and self-harm

90. The Prison Safety Policy Framework lists risks factors and potential triggers for suicide and self-harm. It requires all staff to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Mr Nuth had several risk factors for suicide and self-harm including previous attempts to take his life, being diagnosed with depression, a history of substance misuse, a diagnosis of ADHD and being on remand. He had also been made homeless after losing his bedspace at his supported temporary accommodation, which possibly acted as a trigger.

91. On 26 August, Mr Nuth told two members of healthcare staff that he had thoughts of suicide and self-harm. He first told Nurse A that he had paranoia, hallucinations and thoughts of ligaturing and jumping from the landing. He also said he had no plans to act on these thoughts. We do not know whether the nurse fully explored Mr Nuth's risk factors as he did not update Mr Nuth's medical notes. In his statement, Nurse A said that he did not believe that Mr Nuth's presentation indicated a need for an ACCT to be opened. (We note however, that Nurse A assessed Mr Nuth briefly in the textile workshop while he was working. This was inappropriate. Any mental health assessment should take place in a private and confidential space.)

92. The same day, Mr Nuth told Dr A that he had thoughts of suicide and self-harm but again said he would not act on these thoughts. Dr A appeared to know Mr Nuth well, having worked with him during a previous prison sentence. She did not consider ACCT procedures necessary and instead decided to review his medication and review him again later. She did not believe that Mr Nuth was a risk to himself. Neither member of staff advised prison staff of Mr Nuth's comments.

93. At the multi-disciplinary mental health meeting that took place on 2 September, healthcare staff agreed that Nurse A should open an ACCT. Nurse A said the volume and urgency of other clinical work meant that he did not do it. He did not notify anyone of this.

94. Mr C, Head of Healthcare, told the investigator that following the MPCCC on 22 September, Nurse A's contract was ended due to concerns around his practice. The nurse was told of these concerns both verbally and in writing and his employing agency was also informed. Pentonville said that Nurse A was covering a substantive position and after his contract terminated they recruited a permanent member of staff to cover the position.

95. In relation to high workloads, we were told that additional support was available through the leadership team but Nurse A had not raised any concerns with them at the time. The clinical reviewer is satisfied that these concerns related to one member of the team and were appropriately managed at the time.

96. On 22 September, healthcare staff noticed during the MPCCC that Nurse A had not opened an ACCT as agreed. It is concerning that healthcare staff had accessed Mr Nuth's health records prior to this at a planned care meeting and during the ADHD

clinic but did not notice that the ACCT had not been opened. We endorse the clinical reviewer's recommendation:

The Head of Healthcare should introduce a robust process to ensure that outcomes and actions from clinical meetings are completed.

97. On identifying the omission, staff acted promptly and another mental health nurse assessed Mr Nuth the same day. The nurse decided not to open an ACCT after Mr Nuth said he had no thoughts of suicide and self-harm. Mr Nuth's records show that poor sleep was something he struggled with and mentioned during his healthcare screening, then again on 3 June, 2 September and 22 September. Nurse B referred Mr Nuth to the GP for this. However, Nurse B did not appear to explore it further and we do not know if Nurse B knew that poor sleep had been a trigger for one of Mr Nuth's previous attempts to take his own life. Nurse B did not discuss Mr Nuth's missed medication with him either. (At this point he had not taken his antidepressants for several days.) We consider these examples of further missed opportunities to better understand Mr Nuth's risk and triggers. We make the recommendation:

The Head of Healthcare should ensure that all healthcare staff review medication and compliance as part of any mental health assessment.

98. We acknowledge that staff judgement is fundamental to the ACCT process, but we conclude that healthcare staff relied too heavily on what Mr Nuth was telling them rather than considering all his risk factors. Dr A had a positive working relationship with Mr Nuth and managed his ADHD well. However, there was a missed opportunity for her and the two nurses to fully explore Mr Nuth's suicidal intent.

99. The clinical reviewer noted that all healthcare staff, including agency staff, now receive an induction when they start working at Pentonville. This lasts for two to four weeks. They receive suicide and self-harm training during this induction as well as annual ACCT refresher training. We therefore make no recommendation.

Clinical care

100. The clinical reviewer concluded that there were very good elements to the care of Mr Nuth, notably the ADHD clinic and his substance misuse care. However, the mental and physical healthcare offered to Mr Nuth were not equivalent to that he would have received in the community. Much of this related to Mr Nuth's risk to himself and has been detailed above.

Mental healthcare

101. The clinical reviewer concluded that, given Mr Nuth's disclosure of previous suicide attempts and the number of risk factors he had for suicide, an assessment of his risk of suicide and self-harm should have taken place and a safety plan developed. For example, highlighting the contribution poor sleep made to his suicide risk and understanding that his symptoms of paranoia and hearing voices may have increased his impulsivity and suicide risk. This should have been done during a mental health assessment.

102. She also found that there were at least two occasions when Mr Nuth was referred to the GP in relation to his mental health but he was not subsequently seen. One of these requests was on 24 April, to review Mr Nuth's mental health medication. (This was subsequently prescribed around six weeks later by Dr A in the ADHD clinic.) The second was on 2 September, during the multi-disciplinary mental health meeting, those present agreed Mr Nuth would have a mood review. This was never done and the clinical reviewer notes they are usually completed by a GP or advanced clinical practitioner.

103. In addition, Mr Nuth was referred to the GP in relation to his back pain. However, he was not given an appointment for eight weeks (at which he was prescribed naproxen), potentially leaving him in unnecessary pain for some time.

104. Mr C said routine GP appointments should take two weeks. He could not tell us why this had not occurred on several occasions in Mr Nuth's time at Pentonville. We make the following recommendation:

The Head of Healthcare should undertake a review of GP task allocation to understand why GP tasks are not always completed and implement any necessary improvements to practice.

Missed medication

105. On 16 September, Mr Nuth told Dr A that he was struggling to take his medication every day. The pharmacy technician initially raised concern on 12 September after Mr Nuth had not collected his medication for four days and then again on 23 September after he had not collected it for five days. The clinical reviewer noted that National Institute for Health and Care Excellence (NICE) guidelines state that prisoners should be followed up after missing three doses of medication. She noted that this was another missed opportunity to review Mr Nuth's mental health in the days before his death. We bring this to the Head of Healthcare's attention

Key work

106. During his time at Pentonville, Mr Nuth had no recorded key work sessions and Pentonville has confirmed that Mr Nuth was never assigned a key worker.

107. At the time of Mr Nuth's death, Pentonville was using an adapted key work model and prioritising those deemed most vulnerable. Sessions were completed on an ad hoc basis and tended to be with prisoners who were managed under the ACCT process. We found there was a lack of key work sessions in an investigation into the death of a prisoner in 2024. HMIP also highlighted that the key work scheme was highly ineffective and even those deemed to be a priority rarely received a key work session.

108. Mr Nuth's records indicate that not only did he not have key work sessions, but also he had minimal recorded interactions with wing staff. Two members of staff who were interviewed both described Mr Nuth as quite introverted and quiet. It is likely that Mr Nuth went unnoticed on the wing and it is possible that there were missed opportunities to further understand his risk of suicide and self-harm.

109. Pentonville plan to relaunch their key work scheme in April 2026. This consists of a training day which will target approximately 50 officers and focus on training and upskilling staff to carry out these sessions. Pentonville will continue to prioritise those deemed most vulnerable and anticipate that this will include approximately 375 prisoners. The quality assurance process of these keywork sessions is still being finalised by senior managers. In recognition of this we make no recommendation but the Governor will want to ensure that the new key work scheme is effective and meets the needs of at least the most vulnerable prisoners.

Cell bells

110. On 24 September, OSG A took one hour and 16 minutes to respond to Mr Nuth's cell bell. She could not provide an explanation for the delay. HMIP's expectation is that staff answer cell bells within five minutes. During their most recent inspection, inspectors were concerned that cell bells were not being answered quickly enough.

111. Pentonville has confirmed that since Mr Nuth's death they complete daily assessments of cell bell records which are reviewed by senior managers. A weekly analysis is completed, and senior managers identify any concerns or trends and taking appropriate action. Mr D, Head of Safety and Equalities, told us that the average for the last 16 weeks had been that cell bells were answered within five minutes 66% of the time. They are committed to monitoring this and making incremental improvements, as well as reducing the number of significantly delayed responses. Given the quality assurance system that is in place, and the improvements that are being driven, we make no further recommendation.

Governor and Head of Healthcare to note

Welfare checks after court hearings

112. In July and August, Mr Nuth attended court both in person and via video link. The Prison Safety Policy Framework says that any court appearance, in person or video link, may mean that a prisoner is at a heightened risk of suicide or self-harm, and the Prison Service Instruction (PSI) 07/2015, *Early days in custody*, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link. Prison Service Order (PSO) 3050*, Continuity of healthcare for prisoners*, says that when prisoners pass through reception on their return from court, prisons are required to have protocols in place for risk assessing them to identify any potential suicide and self-harm issues. We found no record of staff engaging with Mr Nuth after either of his court hearings to establish whether his demeanour had changed and whether he would need further support.

113. We acknowledge that this was two months before Mr Nuth died and is unlikely to have had any impact on his death. The Governor and Head of Healthcare will want to ensure that staff engage with prisoners after they have appeared in court and record these interactions.

Inquest

114. The inquest into Mr Nuth's death ended on 31 July 2026 and concluded that Mr Nuth died as a result of suicide.

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