Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Michael Lunt, a prisoner at HMP Liverpool, on 17 July 2023

## 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 I 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

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 Michael Lunt died on 17 July 2023, having been found hanged in his cell at HMP Liverpool. He was 40 years old. I offer my condolences to Mr Lunt's family and friends.

Mr Lunt's presentation throughout his time at Liverpool was unusual and complex, leading mental health professionals to question whether he was suffering from an acute mental illness. However, his presentation fluctuated meaning that staff faced obstacles and delays when deciding how best to diagnose and treat him. Sadly, this also meant prison staff were unable to gain an accurate picture of the risk that he posed to himself.

I am satisfied that overall, Liverpool took appropriate measures to manage the risks associated with Mr Lunt's presentation. However, there were missed opportunities to assess whether Mr Lunt was fit for court and share information about his mental health with court staff.

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** **January 2025**

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# Summary

## Events

1. On 16 January 2023, Mr Michael Lunt was charged with robbery and was remanded to prison and taken to HMP Altcourse. It was his first time in prison. On 13 February, Mr Lunt transferred to HMP Liverpool.

2. On 17 March, Mr Lunt spoke to a nurse about his anxiety who advised him to make an appointment with the GP. Over the next few months, Mr Lunt asked to talk to someone about his mental health on several occasions and each time, he was seen promptly by the duty worker. Concerns were also raised by prison staff and his family during this time and again, Mr Lunt was seen promptly, and appropriate action was taken. Records show that Mr Lunt's mental health fluctuated, and it was therefore difficult for healthcare staff to accurately assess his mental state. On some days he was rational and coherent but on others he was suspicious, paranoid and showing symptoms associated with psychosis. The mental health team arranged for Mr Lunt to be assessed by a psychiatrist.

3. On 25 May, a psychiatrist assessed Mr Lunt. He concluded that although Mr Lunt had disordered speaking and appeared suspicious and guarded, he had no obvious symptoms of psychosis. The psychiatrist saw Mr Lunt for a follow up appointment two weeks later at which he found Mr Lunt's presentation to be more concerning.

4. On 2 July, Mr Lunt's mother telephoned the prison, concerned about her son. An officer spoke to Mr Lunt who said he had no thoughts of suicide or self-harm, and that he was just having a difficult day and missing his daughter. Over the next few days, Mr Lunt's mother contacted the prison's welfare line twice more with further concerns for her son's mental wellbeing. Mr Lunt was seen by both mental health and prison staff but was adamant that he was fine and did not want any additional support.

5. On 10 July, Mr Lunt attended court for the first day of his trial. There is no record of him being seen by healthcare staff or his medical record being reviewed to ensure he was fit to attend court. Mr Lunt returned to Liverpool that day.

6. On the morning of 11 July, Mr Lunt went to court. Again, there is no record that Mr Lunt was seen by healthcare staff prior to attending court and there is no reference to his ongoing mental health concerns in the digital prison escort record (dPER). That same morning, unaware that Mr Lunt had again attended court, the psychiatrist telephoned Mr Lunt's mother. It was at this point that the psychiatrist realised that Mr Lunt was showing clear signs of psychotic mental illness and needed further assessment and treatment.

7. After the phone call, the psychiatrist wrote a letter to the Judge stating that he did not feel Mr Lunt was fit to plead at his trial and requested that Mr Lunt be detained in an acute mental health facility for further assessment. However, Mr Lunt had already pleaded guilty in court and had been convicted of the offence. The psychiatrist arranged for Mr Lunt to be assessed for detainment under the Mental Health Act. The assessment was arranged for 17 July.

8. Mr Lunt returned from court later that day with a suicide and self-harm warning form noting that he was withdrawn, tearful, disorientated and was refusing to speak to court staff. Reception staff started prison suicide and self-harm procedures, known as ACCT. On 12 July, Mr Lunt was guarded, suspicious, and paranoid but said he had no thoughts of suicide or self-harm. Staff decided that Mr Lunt would be moved to the prison healthcare unit once a space was available.

9. On 17 July at approximately 5.12am, an officer found Mr Lunt in his cell in a seated position with a ligature tied around his neck. She immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Moments later, three prison officers responded, cut through the ligature, lowered Mr Lunt to the floor and started chest compressions. Healthcare staff arrived and continued CPR. At approximately 5.26am, paramedics arrived at Mr Lunt's cell and, at 5.36am, pronounced that Mr Lunt had died.

## Findings

10. Whilst at Liverpool, staff were concerned about Mr Lunt's mental wellbeing. His presentation was complex, unusual and it fluctuated daily. This made it difficult for staff to accurately assess the risk he posed to himself. We are satisfied that this was managed well by prison staff and mental health professionals.

11. In the week before he died, staff identified that Mr Lunt may be at risk of suicide and correctly started ACCT monitoring procedures. Mr Lunt repeatedly said that he did not want help from the mental health team and had no thoughts of suicide or self-harm but, despite this, staff made the decision to monitor him on an hourly basis. We are satisfied that, given the limited information staff had available to them to accurately assess the risk Mr Lunt posed to himself, this frequency of observations was proportionate. Staff did not record any checks in the two hours before Mr Lunt was found unresponsive and CCTV footage did not conclusively show whether the checks were undertaken. The staff involved told police that they had conducted these checks. The Governor will want to assure himself that ACCT checks are being done as required.

12. The clinical reviewer found that most of the mental health care Mr Lunt received at Liverpool was equivalent to that which he could have expected to receive in the community. However, healthcare staff did not assess Mr Lunt before he went to court or after he came back, and opportunities were missed to share information with court staff about his mental health.

13. We make no recommendations.

# The Investigation Process

14. HMPPS notified us of Mr Michael Lunt's death on 17 July 2023.

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

16. The investigator obtained copies of relevant extracts from Mr Lunt's prison and medical records. The disc the prison provided of Mr Lunt's telephone calls did not work and the prison had no other recordings, so we were unable to listen to them.

17. NHS England commissioned a clinical reviewer to review Mr Lunt's clinical care at the prison. The investigator and clinical reviewer conducted six joint interviews with members of staff at Liverpool in August and November 2023. They also interviewed two mental health practitioners from the Liaison and Diversion Team at Liverpool Crown Court in November and December. In April 2024, the investigation was reallocated to another investigator.

18. We informed HM Coroner for Liverpool and Wirral of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Lunt's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked how Mr Lunt was able to attend his court trial after he had been assessed as being unfit for trial by a prison psychiatrist. Mr Lunt's friend also wrote to us with some concerns about Mr Lunt's mental ill health and the treatment he received for this at Liverpool. These concerns have been addressed within our report and the clinical review.

20. Mr Lunt's mother received a copy of the initial report. She did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Liverpool

22. HMP Liverpool is a category B local reception and resettlement prison for adult males. There is a healthcare inpatient facility. Primary healthcare services are provided by Spectrum Healthcare UK Limited. Mersey Care National Health Service Foundation Trust provides mental health services.

## HM Inspectorate of Prisons

23. The most recent inspection of HMP Liverpool was in July 2022. Inspectors reported that it was an encouraging inspection and that there was a positive and caring culture at the prison. Recorded levels of self-harm had fallen by 60% since the last inspection and were now lower than most comparator prisons. Prisoners in crisis were supported through the ACCT process, and those inspectors spoke to were positive about the care they had received from staff. Staff had a good understanding of individuals' risks and triggers, and daily entries by wing staff indicated that they built constructive and supportive relationships with the prisoners in their care.

24. Inspectors reported that the mental health provider, Mersey Care NHS Foundation Trust, delivered a seven-day mental health service, including assessment, low intensity psychological interventions and trauma-informed support. Nurses screened all prisoners on arrival at the prison and a duty nurse reviewed any new referrals each day, responding to acute concerns and prioritising clinical need and risk. Nurses referred patients, including those with complex needs, for further assessment or specialist mental health input through a regular single point referral meeting. The service worked well with safer custody and attended all ACCT meetings. The care programme approach was used consistently for patients with complex or severe and enduring mental health conditions and involved a range of professionals, including independent advocates.

## Independent Monitoring Board

25. 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 2022 to 2023, the IMB reported that healthcare staff generally responded quickly to concerns raised and that the prisoner was often seen on the same day or within 24 hours. The healthcare team and the safer custody team worked collaboratively, and lessons had been learned following recent self-inflicted deaths. The IMB found that some prisoners housed in the segregation unit had serious mental health issues and considered that they should be accommodated in more suitable conditions or mental health facilities.

## Previous deaths at HMP Liverpool

26. Mr Lunt was the nineteenth prisoner to die at Liverpool since August 2020. Of the previous deaths, 12 were from natural causes, three were drug-related, one was unascertained, and two were self-inflicted. None of these investigations raised

issues relevant to the death of Mr Lunt. Since the death of Mr Lunt up until the end of September 2024, there have been seven further deaths at Liverpool. Two of these were self-inflicted, four were from natural causes, and one is awaiting classification.

## Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

28. As part of the process, staff put in place a care plan (plan of care, support, and intervention). The ACCT plan should not be closed until all the actions of the care map have been completed. 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 Prison Service Instruction (PSI) 64/2011

# Key Events

## Background

29. Mr Michael Lunt did not have a significant history of mental ill health. However, during the year before being remanded to prison, Mr Lunt experienced major life changes which included the breakdown of his marriage and the closure of his business. This caused Mr Lunt a significant amount of distress and marked the beginning of a rapid deterioration in his mental health.

30. On 14 January 2023, Mr Lunt attempted to steal a bike from a member of the public. He was quickly apprehended by police and arrested. At the police station, he told police that he had tried to steal the bike to get away from the people who were chasing him. He said that people had been following him and were trying to steal his identity. Mr Lunt was seen by a mental health nurse in police custody, but Mr Lunt denied any issues with his mental health and said he did not want any help from their services.

31. On 16 January 2023, Mr Lunt was charged with robbery. Crown Prosecution Service (CPS) records note that Mr Lunt was of no fixed abode, had a history of failing to comply with bail conditions, and was evidently experiencing a decline in his mental health. It was deemed that if bailed, Mr Lunt could become transient and commit further offences. He was denied bail and taken to HMP Altcourse. This was Mr Lunt's first time in prison.

## HMP Altcourse, 16 January 2023 – 13 February 2023

32. During his reception screening, a nurse noted that Mr Lunt appeared anxious. However, he denied having any history of mental health issues and said he did not have thoughts of suicide or self-harm.

33. The next day, wing staff asked the mental health team to see Mr Lunt as he was acting in a bizarre and paranoid manner. A mental health nurse completed an initial assessment and noted that Mr Lunt was unable to hold a conversation, appeared paranoid and had disordered and delayed responses. His medical records showed a history of anxiety and depression, and she noted that he required further assessment from mental health professionals. She referred him to the mental health team.

34. On 24 January, staff discussed Mr Lunt at the mental health multi-disciplinary meeting and agreed that he needed to be assessed by the secondary mental health team (specialists who manage those with severe and enduring mental health conditions).

35. On 27 January, a mental health nurse completed the secondary assessment in which she noted that Mr Lunt was coherent, oriented and engaged effectively throughout. She asked Mr Lunt about the concerns staff had raised and Mr Lunt said that his behaviour was due to feeling anxious and overwhelmed at being in prison for the first time. Mr Lunt assured the nurse that he had no thoughts of suicide or self-harm. The nurse noted that Mr Lunt appeared stable and had no obvious symptoms of psychosis. (Psychosis is where an individual sees or hears

things that are not there (hallucinations) or believes things that are not true (delusions)). The nurse discharged Mr Lunt back to the care of the primary healthcare team (for those with less complex mental health conditions, managed by the prison GP).

36. The next day, a nurse saw Mr Lunt for a follow up appointment. She described Mr Lunt's presentation as completely different from the first time she had met him on 17 January. She noted that he appeared relaxed and was able to engage in conversation with her. Mr Lunt said that he was happy on his wing and was feeling much more settled in prison. The nurse scheduled a follow-up appointment with a plan to discharge Mr Lunt from mental health services, if appropriate.

## HMP Liverpool, 13 February 2023 onwards

37. On 13 February, Mr Lunt transferred to HMP Liverpool. During his reception screening, Mr Lunt said he had no thoughts of suicide or self-harm. Reception staff noted that he had a history of anxiety and depression. A few hours later, an officer noted that Mr Lunt was polite and coherent and said that although he felt a little vulnerable in custody, he had no thoughts of suicide or self-harm.

38. The next day, a registered mental health nurse (RMN) completed Mr Lunt's initial health assessment. Mr Lunt asked if he could be prescribed sertraline, an antidepressant he had been prescribed while in the community. She said she would add Mr Lunt to the GP's waiting list and told Mr Lunt about the mental health support available to him at Liverpool.

39. On 21 February, Mr Lunt moved from the induction wing to a shared cell on G wing.

40. On 17 March, Mr Lunt asked to speak to healthcare staff. Later that day, a mental health nurse saw Mr Lunt in his cell. Mr Lunt said that he would like to see a GP to discuss medication options for anxiety. The nurse advised Mr Lunt to make an appointment to see the GP (he was unaware that he was already on the GP's waiting list).

41. On 23 March, a workshop instructor raised concerns to wing staff about Mr Lunt's presentation. He told them that Mr Lunt appeared anxious, stressed, and was having difficulty following basic instructions. Wing staff contacted the mental health team who agreed to see Mr Lunt later that day. A few hours later, a mental health nurse saw Mr Lunt in his cell. Mr Lunt told the nurse that he was feeling low and anxious but that he had no thoughts of suicide or self-harm. The nurse booked Mr Lunt an appointment for a depression review with the GP (in addition to the appointment he was already waiting for) and referred him for psychotherapy.

42. On 7 April, a nurse went to see Mr Lunt after he was brought back early from his shift in the kitchens. He told her that he was feeling overwhelmed as it was his first day in the kitchens. He said that he wanted to keep this job and that he felt he would be able to cope once he was on the right anxiety medication. She noticed that he was nineteenth on the GP's waiting list, so she moved him up to be seen as a priority.

43. On 10 April, a Custodial Manager (CM) requested that Mr Lunt was discussed at the next Safety Intervention Meeting (SIM), due to him presenting with paranoid and

bizarre behaviour on the wing. (The SIM is a multi-disciplinary safety risk management meeting, chaired by a senior manager. It focuses on those who are deemed to pose a significant risk of harming themselves or others and should ensure that individuals are managed and supported appropriately.)

44. On 11 April, a psychotherapist completed an initial talking therapies assessment with Mr Lunt. They agreed that Mr Lunt would benefit from engaging in therapy and he was added to the waiting list. Mr Lunt also asked to be removed from working in the kitchens until his anxiety lessened to which staff agreed.

45. The next day, Mr Lunt rang his emergency cell bell and told an officer that he was having thoughts of harming himself. The officer started suicide and self-harm prevention procedures (known as ACCT) and Mr Lunt was temporarily monitored on an hourly basis. Later that day, a multi-disciplinary ACCT review chaired by a CM was completed in which Mr Lunt denied having any thoughts of suicide or self-harm. The CM noted that Mr Lunt appeared confused as to why the ACCT had been opened and presented in a bizarre manner, with delayed responses and intermittent eye contact. As the CM felt she did not have an accurate picture of the risk Mr Lunt posed to himself, the ACCT remained open.

46. Following the ACCT review, a nurse reviewed Mr Lunt's clinical records and found that in 2018, Mr Lunt was diagnosed with a brain cyst. She questioned whether this could be causing Mr Lunt's unusual behaviour and delayed responses, so she relayed her concerns to the GP.

47. On 14 April, Partners of Prisoners (POP, a scheme which supports the families of those in prison), contacted the prison after receiving concerns from Mr Lunt's family about his welfare. As a result, the duty mental health worker and a GP saw Mr Lunt to assess his mental and physical wellbeing. Medical records note that Mr Lunt appeared to be unaware of the concerns raised regarding the cyst and was confused as to why he was being reviewed. Staff noted that he displayed no psychotic symptoms, and his clinical observations (including blood pressure and pulse rate) were all within an acceptable range. Additional observations were completed a few days later, all of which came back within acceptable ranges.

48. On 18 April, staff discussed Mr Lunt at the SIM. Due to his unusual presentation, it was agreed that he would be moved to a single cell until the ongoing investigation into his brain cyst had been concluded.

49. On 19 April, a Supervising Officer (SO) held Mr Lunt's ACCT review alongside a nurse from the mental health team. Mr Lunt said he was feeling much more settled and less anxious now that he was in a single cell. It was noted that Mr Lunt presented well during the review and that healthcare staff were not concerned about any potential psychotic symptoms. However, he still appeared to be distracted at times with delayed responses and a fixed gaze. Mr Lunt said he had no thoughts of suicide or self-harm, and the only issues he raised were regarding his physical health. As Mr Lunt was due to see the GP the following day, it was agreed that Mr Lunt no longer needed to be monitored via the ACCT process. The ACCT was put into post-closure (a seven day period of review).

50. On 20 April, further concerns regarding Mr Lunt's mental wellbeing were raised by his family via the POP scheme. As a result, a mental health nurse visited Mr Lunt in

his cell. Mr Lunt told her that he had spoken to his mother about his physical health concerns connected to his digestion which he felt were causing his anxiety to increase. Mr Lunt said that he did not want to be referred to the GP regarding this. When asked, Mr Lunt said he had no thoughts of suicide or self-harm and did not want any further support from the mental health team. She referred Mr Lunt to the primary healthcare team regarding his physical health concerns and reminded him how he could access mental health support at Liverpool, should he need it in the future.

51. The following day, a nurse was carrying out her duties on G wing when wing staff alerted her to concerns regarding Mr Lunt's bizarre behaviour. They told her that he often stood staring blankly at walls and that it was hard to get his attention. They told her that when they tried to speak to him regarding his wellbeing and personal life, he became overly suspicious and often spent periods isolating himself in his cell. She placed Mr Lunt on the duty ledger to have a full mental health assessment the next day.

52. On 22 April, a nurse attempted to complete a full mental health assessment with Mr Lunt. However, she was unable to do so due to his increased confusion, paranoia and unwillingness to engage. She noted that Mr Lunt had no recollection of seeing her previously and that he became guarded when she tried to speak with him about the concerns raised by staff and family. Mr Lunt said that he did not want to discuss these issues with her and asked to return to his cell.

53. The next morning, the Mental Health Team Leader again attempted to complete a full mental health assessment with Mr Lunt. Mr Lunt did not wish to speak with him and abruptly ended their appointment. In their discussions at the multi-disciplinary team meeting the next day, the mental health team agreed that Mr Lunt needed to have a full psychiatric assessment with a consultant psychiatrist, as well as a CT scan to look for any changes in his neurological cyst. They booked an appointment with a psychiatrist for 25 May and referred Mr Lunt to the local neurology hospital.

54. On 25 May, a consultant forensic psychiatrist at Liverpool completed Mr Lunt's initial psychiatric assessment. He assessed that although Mr Lunt had disordered speaking and appeared suspicious and guarded, he had no obvious symptoms of psychosis. He recommended that Mr Lunt had a CT scan of his brain in case his symptoms were neurological and related to his previously diagnosed brain cyst. At interview, he told the investigator that he wanted to review the results of the brain scan before deciding on a treatment plan in case Mr Lunt's symptoms were not related to mental illness. He arranged to see Mr Lunt for a follow up appointment in two weeks' time.

55. On 8 June, the psychiatrist completed a follow-up review with Mr Lunt. At interview, he told us that Mr Lunt was significantly more guarded than in their previous meeting and was unwilling to answer any direct questions. He told us that Mr Lunt said that there was nothing wrong with his mental health and that he didn't need help from anyone. When he tried to discuss prescribing Mr Lunt antidepressants, he could not recall ever being prescribed or asking to be re-prescribed them. Mr Lunt hastily ended the conversation and said he wished to speak with his solicitor before answering any further questions from him.

56. Due to his concerns about Mr Lunt's presentation and his upcoming court case, the psychiatrist spoke to the Secondary Mental Health Team Lead. He proposed writing to the Judge and requesting that Mr Lunt had an independent Mental Health Act assessment to determine if he needed to be admitted to a secure hospital. She said that she did not think that Mr Lunt was acutely unwell and that he therefore would not meet the criteria for an urgent hospital admission. They agreed to monitor Mr Lunt and for the psychiatrist to review him in two weeks' time (they did not write to the judge at this point).

57. On 29 June, the psychiatrist attempted to review Mr Lunt. However, he said he had not yet spoken to his solicitor and did not want any help from mental health services. At interview, he told us that despite Mr Lunt's family continually expressing their concerns about his mental state, he was unable to speak with them without Mr Lunt's consent. As Mr Lunt had no significant history of mental illness, was not willing to engage, and would not consent to family involvement, he was still unable to make an accurate assessment of Mr Lunt's mental state. He told us that, at that stage, he still did not consider that Mr Lunt would meet the threshold for mental health detention. He asked Mr Lunt to speak to his solicitor to find out when his court date was and planned another review for 10 July.

58. On the evening of 2 July, Mr Lunt's mother telephoned the prison with concerns for Mr Lunt's welfare, stating that he had said, "I can't do this anymore" before hanging up the telephone. An officer immediately spoke to Mr Lunt about his mother's concerns. Mr Lunt assured the officer that he had no thoughts of suicide or self-harm, and that he was just having a difficult day and missing his daughter. The officer asked Mr Lunt if he would like to speak to a Listener (trained prisoners who offer confidential emotional support to their peers). Mr Lunt declined this offer and said that he was fine. He reminded Mr Lunt to press his cell bell if he needed anything during the night. He also suggested that Mr Lunt called his mother to reassure her, which he did.

59. The next day, Mr Lunt's mother again rang the prison's welfare line. As a result, another officer spoke to Mr Lunt, who seemed confused why his mother was concerned about him. Mr Lunt said he was fine, he had no thoughts of suicide or self-harm, and would ring his mother that day. The officer reminded Mr Lunt of support services available to him at Liverpool and Mr Lunt thanked her for checking on him.

60. On 5 July, a nurse saw Mr Lunt after his family contacted the prison with further concerns about his mental health. Mr Lunt told her that he just seen his family on a visit (this was true) and did not understand why they were concerned for his wellbeing. He said he had no thoughts of suicide or self-harm and was reluctant to engage in any meaningful conversation. The nurse was not overly concerned with his presentation and noted that he had an upcoming appointment with the psychiatrist.

61. On 10 July, Mr Lunt attended court for the first day of his trial. There is no record of him being seen by healthcare staff or his medical record being reviewed to ensure he was fit to attend court. The medical section of the digital Person Escort Record (dPER – a document containing relevant details about a prisoner, including any risks), completed by a nurse, did not reference any of the concerns regarding his presentation, or the ongoing intervention from the mental health team. In answer to

whether Mr Lunt had any mental health issues, the person completing the dPER clicked “no” from the drop down menu.

62. Before Mr Lunt’s court hearing, Mr Lunt’s mother spoke to a social worker from the Criminal Justice Liaison and Diversion (CJLD) team at Liverpool Crown Court. The CJLD team provides early identification, assessment and care for vulnerable people with mental health problems in the criminal justice system. Mr Lunt’s mother expressed her concerns regarding her son’s deteriorating mental health including that he was experiencing paranoid delusions. The social worker shared this information with Mr Lunt’s solicitor. He also spoke to the Secondary Mental Health Team Lead, who explained that Liverpool was exploring the possibility of having Mr Lunt detained under Section 35 of the Mental Health Act. (The purpose of Section 35 is for mental health professionals to establish if an individual with an upcoming court case has any potential diagnoses and to establish if that individual is fit to plead at court. Section 35 does not apply to individuals who have already been convicted.) It seems that neither Mr Lunt’s solicitor, nor the CJLD took any further action to explore with Mr Lunt whether he was mentally well enough to understand court proceedings.

63. The same day, the psychiatrist went to review Mr Lunt, but found that he was already at court. Mr Lunt returned to Liverpool that day.

64. The next morning, Mr Lunt went to court for his trial. Again, there is no record that Mr Lunt was seen by healthcare staff before going to court and, there was no reference to his ongoing mental health concerns in the dPER and the medical section of the form was left blank.

65. The same morning, unaware that Mr Lunt had again attended court, the psychiatrist telephoned Mr Lunt’s mother. Although the psychiatrist did not have Mr Lunt’s consent to disclose any details of his current condition, Mr Lunt had consented to him obtaining information from her about his past medical history. She gave the psychiatrist a detailed account of the events leading up to his arrest along with details of her concerns of the preceding 12 months. This included clear examples of delusions amongst other symptoms associated with psychotic illness. The psychiatrist told the investigator that it was at this point he realised that Mr Lunt was showing clear signs of a psychotic mental illness and needed timely further assessment and treatment. After the phone call, he wrote a letter to the Judge requesting that Mr Lunt be detained in an acute mental health facility under Section 35 of the Mental Health Act. The letter was forwarded to the Judge later that day.

66. However, unbeknownst to the psychiatrist, Mr Lunt had already pleaded guilty at court. This meant that Section 35 was no longer applicable, and he would need to be detained under a different section of the Mental Health Act. As the psychiatrist was due to go on annual leave, he telephoned another consultant psychiatrist working at Liverpool. He asked the other psychiatrist to complete a referral to the Psychiatric Intensive Care Unit, requesting that they assess Mr Lunt’s suitability for Section 48 of the Mental Health Act (hospital detainment for individuals who have been convicted but have not yet been sentenced). The other psychiatrist arranged to see Mr Lunt and complete the referral on 17 July. Mr Lunt was due back in court for sentencing on 15 August.

67. Mr Lunt returned from court later that day with a suicide and self-harm warning form. The form noted that Mr Lunt was withdrawn, tearful, disorientated and had refused to speak to court staff. Reception staff started ACCT procedures and a senior prison manager completed the immediate action plan. Staff set Mr Lunt's observations at four per hour until his review the following day. Mr Lunt was not reviewed by healthcare staff as he should have been. When Mr Lunt returned to the wing, a SO completed a second immediate action plan. He reduced Mr Lunt's observations to one per hour and noted his decision for doing so as being 'due to having previous knowledge of Mr Lunt and his unusual behaviour'. It is not standard practice to complete a second immediate action plan without a review taking place. However, we recognise that this did not make any difference to the care Mr Lunt received in this instance or affect the outcome for him.

68. On 12 July, a SO chaired Mr Lunt's first ACCT review with the Secondary Mental Health Team Lead. The SO noted that Mr Lunt presented as guarded, suspicious, and paranoid. He was easily startled, unable to converse fluently and was reluctant to answer questions in any detail. When asked, Mr Lunt was unable to recall the outcome of his court case and became increasingly agitated and confused by their questions. The team discussed the psychiatrist's actions the previous day. Mr Lunt repeatedly said that he did not want help from the mental health team and had no thoughts of suicide or self-harm. The Team Lead asked Mr Lunt if he would like to move to the prison's healthcare unit where it was quieter, and he said he would.

69. Although there was no obvious indication that Mr Lunt presented a risk to himself, staff agreed that his presentation was concerning and that ACCT observations should remain at one per hour until his next review. His next review was set for 17 July.

70. At the Integrated Mental Health Team meeting the following day, staff agreed that Mr Lunt should be moved to the prison's healthcare unit where he could be closely monitored and have access to additional support from mental health staff. As the healthcare unit was full, he was added to the waiting list.

71. On 14 July, Mr Lunt spoke to his ex-partner and his daughter on the telephone for just over one minute. The early learning review conducted after Mr Lunt died, noted that although Mr Lunt spoke about being low in mood, there was nothing that indicated Mr Lunt was a risk to himself. This was his last recorded prison telephone call before he died (although he had phone credit remaining at the time). Prison records also show that Mr Lunt had placed a canteen order on 15 July, to be delivered the following week.

72. In the early hours of the morning on 16 July, Mr Lunt pressed his emergency cell bell and said that he was feeling very anxious and was having difficulty breathing. The Deputy Head of Healthcare spoke with Mr Lunt at his cell door, and, after a few minutes, Mr Lunt said he was feeling more relaxed. She advised Mr Lunt to try some deep breathing exercises and to contact staff again if his anxiety worsened. Prison records note that Mr Lunt slept through the rest of the night with no issues. Records also show that Mr Lunt raised no concerns throughout the day and collected both his lunch and dinner from the servery. Officer A documented that he was watching TV until approximately 9.30pm that evening. She noted that he said he was feeling better, smiled, and said he was going to get some sleep.

## Events of 17 July

73. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio communications from 17 July. She also obtained information from the Northwest Ambulance Service. The following account has been taken from all sources.

74. At approximately 3.35am, Officer A went to Mr Lunt's cell to complete an ACCT observation. She recorded that Mr Lunt was asleep in his bed. This is the last documented ACCT observation prior to Mr Lunt's death.

75. At approximately 5.12am, Officer B went to Mr Lunt's cell to complete an ACCT observation. Upon opening the observation panel, she saw Mr Lunt in a sitting position on the floor with a ligature (made from a blanket) around his neck and attached to the top bunk. She immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). She did not enter the cell straight away as she did not know Mr Lunt and therefore waited for other staff to attend.

76. CCTV shows Officer A and a CM attending the cell within one minute, followed by a nurse. As the control room did not acknowledge the initial code blue, the CM radioed a further code blue, in which he said that he needed an ambulance immediately. Staff went into the cell and the CM cut the ligature with his anti-ligature knife. They lowered Mr Lunt onto the floor, laid him on his back, checked for signs of life and started giving chest compressions. The nurse completed medical observations, applied a defibrillator (a device that gives shocks to the heart to restore a normal heartbeat) and continued resuscitation attempts.

77. At approximately 5.14am, control room staff phoned an ambulance. At 5.18am, a category 2 (for serious but non-life threatening situations) ambulance was dispatched to the prison with a wait time of 45 minutes. The control room relayed this information to those with Mr Lunt, who replied stating that they had a possible self-inflicted death and needed an ambulance immediately. At 5.19am, the control rang the emergency services and updated them on the condition of Mr Lunt. At 5.21am, a category 1 ambulance (for life-threatening situations) was dispatched to the prison.

78. At 5.26am, paramedics arrived at Mr Lunt's cell. Their notes confirm that Mr Lunt was showing clear signs of death including blood pooling and discolouration of the skin. At 5.36am, the paramedics pronounced that Mr Lunt had died.

## Contact with Mr Lunt's family

79. At 8.50am, the Governor and a senior prison manager travelled to Mr Lunt's mother's home address and informed her of Mr Lunt's death and offered their condolences. The prison appointed a family liaison officer, who kept in touch with Mr Lunt's mother. The prison contributed to Mr Lunt's funeral costs in line with national guidance.

## Support for prisoners and staff

80. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners 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.

81. After Mr Lunt's death, staff held a debrief and those involved in the emergency response were given the opportunity to discuss any issues arising. They were also offered support by the staff care team and signposted to support services available to them. The staff directly involved in the incident were on their last night shift for that week and were all about to go on their rest week. As a result, their line managers kept in contact with them during the week to check on their welfare and offer additional support. Additionally, a member of the care team suggested that staff swap phone numbers so they could support each other.

82. The prison posted notices informing other prisoners of Mr Lunt'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 Lunt's death.

## Post-mortem report

83. The post-mortem concluded that Mr Lunt died of neck compression as a result of suspension by ligature (hanging). There were no significant toxicological findings to report.

84. The pathologist found a small cyst within Mr Lunt's brain. Although he did not find this to have directly contributed to Mr Lunt's death, he noted the potential for cysts to cause neurological symptoms and to contribute to psychiatric problems.

# Findings

## Assessment of risk of suicide and self-harm

85. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. Mr Lunt had several risk factors, including that it was his first time in prison, he had undiagnosed mental health issues, and he was awaiting sentencing. However, he had no recorded history of suicidal thoughts or attempts, or self-harm.

86. Mr Lunt was monitored under ACCT procedures on two occasions while at Liverpool. Firstly, for a week in mid-April, when he had expressed thoughts of self-harm. Secondly, when Mr Lunt returned from court on 11 July until he died. Overall, we are satisfied that the ACCT process was managed well. Mr Lunt was allocated an ACCT case co-ordinator in a timely manner, and his ACCT reviews were attended by a multi-disciplinary team, including those from the mental health department.

87. However, Mr Lunt's fluctuating complex mental presentation made it difficult for staff to accurately assess when this risk increased. Mr Lunt repeatedly said that he did not want help from the mental health team and had no thoughts of suicide or self-harm but, despite this, staff made the decision to monitor him on an hourly basis. We are satisfied that, given the limited information staff had available to them to accurately assess the risk Mr Lunt posed to himself, these observations were proportionate. We do not believe that staff could have foreseen his actions or should have assessed him as an imminent risk of suicide when he died.

### ACCT observations

88. PSI 64/2011 states that ACCT observations and conversations must be documented immediately after they take place. On the morning of Mr Lunt's death, CCTV shows that ACCT observations took place hourly as required up until 2am, and these observations were correctly recorded in the ACCT document. We found that the next observation at 3.35am was conducted outside of the 60-minute period, and we found no record of an hourly observation being completed between 4.00am and 5.00am.

89. CCTV does not cover Mr Lunt's cell door. There are two cameras covering parts of the landing outside Mr Lunt's cell, with views in both directions, but the landing outside his cell door is a CCTV blind spot. In addition, at the time that these checks were supposed to take place, the wing was extremely dark and CCTV footage is therefore not clear.

90. The night patrol officers, Officers A and B told the police that they had carried out Mr Lunt's hourly ACCT checks as required, but had not yet documented them in the

ACCT. Neither the investigator nor the police were able to verify if an hourly observation was indeed completed between 4.00am and 5.00am.

91. We spoke to the Head of Safety to ask why there was no internal investigation into this matter after Mr Lunt's death. She told us that she would have expected a local investigation to have been commissioned but, as she was not in post at the time, she was unsure why this was missed. We are satisfied that she has now highlighted this matter to the Governor at Liverpool, who is considering further action. Additionally, she explained that measures have been taken to ensure that ACCT procedures are completed to a high standard in line with national policy. This includes monthly upskilling days and ACCT refresher training for both operational and civilian staff. They have also introduced a process whereby wing supervising officers complete daily checks on all open ACCTS to ensure they are up-to-date, accurate, and to minimise the likelihood of anything being missed. Finally, Liverpool have introduced a robust ACCT quality assurance process whereby 100% of open ACCTS and 50% of ACCTS in post-closure are reviewed on a weekly basis. On that basis, we make no recommendation.

## Clinical care

92. The clinical reviewer concluded that much of the physical healthcare that Mr Lunt received was of a reasonable standard and equivalent to that he could have received in the community although she did find some exceptions to this which the Head of Healthcare will wish to address.

### Mental healthcare

93. The clinical reviewer also concluded that the mental healthcare Mr Lunt received was equivalent to that which he could have expected to receive in the wider community, although again she found some exceptions to this.

94. Mr Lunt first came to the attention of the mental health team at Liverpool on 17 March when he applied to speak to someone about his anxiety. Mr Lunt asked to see or talk to someone on several occasions after this and each time, he was seen promptly (usually the same day) by the duty mental health worker. When concerns were raised by prison staff and his family, Mr Lunt was seen promptly, and appropriate action was taken.

95. Healthcare staff faced difficulties in accurately assessing Mr Lunt's mental state due to fluctuations in his presentation, him consistently denying thoughts of suicide or self-harm, denying disordered thinking, and being adamant that he did not want any help from the mental health team. Despite this, healthcare staff were evidently concerned about Mr Lunt and identified that his reluctance to engage may be attributable to a deterioration in his mental state. As a result, they continued to take measures to identify the cause of his unusual presentation, and he was appropriately assessed and reviewed regularly by mental health professionals, with serious mental illness being considered on multiple occasions.

96. A psychiatrist was responsible for Mr Lunt's mental healthcare at the time of his death. He told us that before Mr Lunt's court hearing, he did not have the evidence to conclusively diagnose Mr Lunt with an acute mental illness and therefore Mr Lunt

would not have met the criteria for detainment in a secure hospital. He said that it only became clear to him that Mr Lunt was likely to be experiencing a significant psychotic illness on 11 July, when he obtained a detailed account of Mr Lunt's mental health history from his mother. He made timely arrangements for Mr Lunt to be assessed for detainment in a secure psychiatric hospital. Sadly, the assessments were not completed before Mr Lunt's death six days later.

**Transfer to/from court**

97. Completion of medical and health risk information within the dPER is an essential requirement to ensure the safe movement and risk management of prisoners. It includes any relevant mental health concerns, current or historic. Prison healthcare staff are responsible for completing the health information section of the dPER when someone leaves prison. If healthcare staff decide that a prisoner is not fit to travel, then they must communicate this to prison staff and the move should be cancelled. It is not mandatory for the prisoner to be seen by healthcare staff before leaving the prison. However, it is recommended that the healthcare section is completed as close as possible to when the prisoner leaves to ensure it is accurate.

98. Mr Lunt attended court on 10 July and 11 July. Neither dPER contained any reference to the ongoing concerns regarding his behaviour, presentation, or mental health. We spoke to the Head of Healthcare, who told us that, typically, the nurse who completes the dPER consults the patient summary record which provides a list of established diagnoses and all current medications. This summary does not contain information about any ongoing assessments or concerns. As Mr Lunt had no formal mental health diagnosis and assessments were ongoing, this would not have been captured in the patient summary. He said that Mr Lunt's ongoing mental health concerns may not therefore have been obvious to the nurse filling in the dPER, especially if that nurse had no prior knowledge of him.

99. Since the death of Mr Lunt, there is now an allocated nurse in reception who is present from 6.30am to 9pm, to ensure that every prisoner who passes through reception has an appropriate assessment, and that this is documented on the prisoner's record. These screenings have also been reviewed to ensure they are completed comprehensively and include physical observations and a rapid review of any recent entries on the prisoner's record. We are satisfied that Liverpool has taken appropriate measures to ensure that all prisoners are assessed by a healthcare professional before leaving the prison. We therefore make no recommendation.

100. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events that require a prisoner to leave the prison and pass back through prison reception can have a significant impact on the prisoner: a court appearance is an example of such an event. The PSO says that prisons must have protocols in place for screening prisoners for any potential health or suicide/self-harm risks following such events.

101. Mr Lunt attended court and pleaded guilty on 11 July. His upcoming sentencing was likely to have caused additional worry, distress and anxiety. It also meant that the psychiatrist had to start a separate referral for him to be transferred to a mental health unit, so delaying this process further. Mr Lunt returned with a suicide and self-harm warning form and staff appropriately opened an ACCT. He should have

been seen by healthcare staff in reception, but this did not happen. However, we are satisfied that Mr Lunt was appropriately assessed by healthcare staff after this as part of the ACCT process. In addition, as already identified, the prison now has a nurse present in reception to screen those returning. We therefore make no recommendation.

102. The clinical reviewer has also identified several other issues relating to recording information, completing a mental capacity assessment and communication between staff which the Head of Healthcare will wish to consider.

## Emergency response

103. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, states that when a member of staff finds a prisoner unresponsive, they should alert the control room of this using a medical emergency code, without delay. The member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process. This is to ensure a timely, appropriate, and effective response to medical emergencies and to maximise the likelihood of a positive outcome for the prisoner.

104. There was a delay of approximately two minutes between the code blue being called and the control room ringing the emergency services. The first code blue was not acknowledged by the control room. That morning, there were some signal issues and disruption on the prison's radio network. This meant that some vital radio transmissions were inaudible. This issue has been resolved since that time. The CM then radioed a second code blue (in which he requested an ambulance but did not provide details of Mr Lunt's condition) and, having repeated the transmission as the control room could not hear it, they immediately rang an ambulance.

105. However, control room staff were unable to provide any information about the nature of the emergency or Mr Lunt's condition. As a result, the 999 call handler did not despatch a priority ambulance until they were provided further information in a second call from the control room a few minutes later.

106. We acknowledge that these issues did not affect the outcome for Mr Lunt given that when he was found he was showing clear, irreversible signs of death. However, such a delay could be critical for somebody in a life-threatening condition in a future medical emergency. We are aware that HMPPS and NHSE are currently considering further national guidance in relation to medical emergencies, so we make no recommendation.

## Inquest

107. Mr Lunt's inquest concluded on 5 March 2026 and found that he died as a result of suicide.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100