

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Peter Lunt, on 23 February 2025 following his release from HMP Altcourse**

**A report by the Prisons and Probation Ombudsman**

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. 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.
3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
4. Mr Peter Lunt died from cardiorespiratory failure on 23 February 2025, following his release from HMP Altcourse on 20 February 2025. He was 55 years old. We offer our condolences to those who knew him.
5. Mr Lunt did not have any diagnosed cardiac issues documented in his medical records. He had a history of drug and alcohol issues, and he was supported by the substance misuse team in prison. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Lunt.
6. We make no recommendations.

## The Investigation Process

7. HMPPS notified us of Mr Lunt's death on 25 February 2025.
8. The PPO investigator obtained copies of relevant extracts from Mr Lunt's prison and probation records.
9. We informed HM Coroner for Cheshire of the investigation. She gave us the results of the post-mortem examination. The Coroner informed us that they were not holding an inquest. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Lunt's next of kin to explain the investigation and to ask they had any matters they wanted us to consider. They did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Altcourse

12. HMP Altcourse is a category B prison which holds male prisoners who have either been convicted or are on remand. It is managed by Sodexo. Practice Plus Group provides physical health services, Mersey Care NHS Foundation Trust provides mental health services and Phoenix Futures provides substance misuse services.

### Probation Service

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

## Key Events

14. On 20 January 2025, Mr Peter Lunt was charged with threatening behaviour and sentenced to 12 weeks in prison. He was sent to HMP Altcourse. Mr Lunt was due to be released one month later on 20 February.
15. Prior to entering prison, Mr Lunt was diagnosed with epilepsy (a condition that affects your brain and causes seizures) and was prescribed clonazepam. His community GP had commenced treatment for heartburn following investigations of chest pain in 2021.
16. Mr Lunt had a history of drug and alcohol use. While in the community, Mr Lunt had been assessed for an Acquired Brain Injury. However, it could not be officially diagnosed until he had stopped using drugs and alcohol for three months. Mr Lunt did not have a period of abstinence so he was unable to get a formal diagnosis.
17. During his initial healthcare reception screen at Altcourse, Mr Lunt said that he had epilepsy, asthma, depression and a heart condition, however he did not specify what heart condition he had. There is no record of Mr Lunt being diagnosed with a heart condition in his medical notes, communication letters or on his GP summary sheet. Mr Lunt was prescribed clonazepam and pregabalin in prison to manage his seizures and mirtazapine to manage his depression.
18. On 22 January, a nurse completed Mr Lunt's secondary reception screen, and noted he reported that he had suspected heart disease, but the nurse found no supporting information to confirm any cardiac issues in his medical record. During his most recent time in prison, there were no recorded seizures in Mr Lunt's medical record. His last reported seizure was on 30 September 2024. However, this was an unwitnessed seizure and therefore limited information was recorded about the incident.
19. Mr Lunt was prescribed 50ml methadone (opioid substitution medication) and was placed on a diazepam detoxification programme for alcohol withdrawal. He was located on Furlong wing, the drug and alcohol wing, where he received support from the substance misuse team.
20. On 30 January, a member of the substance misuse team and a nurse, completed an initial assessment with Mr Lunt. They discussed harm minimisation and tolerance levels and trained him on the use of naloxone (medication that reverses the effects of an opioid overdose).
21. Mr Lunt had regular keyworker sessions at Altcourse. He consistently told officers that he had no issues with his physical health and that he felt okay.
22. On 3 February, a member of the substance misuse team saw Mr Lunt. He said that he was being released later that month. She told Mr Lunt that she would provide him with an appointment for CGL Halton (Change, Grow, Live - community drug and alcohol team). Mr Lunt asked that CGL pick him up from prison on the day of his release.
23. On 19 February, two workers from CGL completed Mr Lunt's assessment in preparation for his release for the following day. They confirmed with Mr Lunt that

CGL staff were going to collect him from the prison and take him to his induction appointment with the Probation Service and CGL. They noted that Mr Lunt was eager to engage with CGL.

24. On 20 February, Mr Lunt was released from Altcourse. CGL met him at the gate and accompanied him to his appointments. He was released with a naloxone kit and seven days' supply of his prescribed medication.
25. During his probation appointment, his Community Offender Manager (COM), noted that Mr Lunt appeared tired and was constantly being prompted to stay awake. She asked him why he was so tired and he said he was given his medication in the early hours of the morning, then he was woken up early to be released, and that he was still feeling the effects of the medication.
26. Mr Lunt then attended his initial appointment with CGL Halton. The Safeguarding Lead at CGL contacted his COM after the appointment because they were concerned about Mr Lunt's presentation as he again appeared tired and he was struggling to stay awake. CGL informed his COM that they were going to arrange a post-prison release meeting with partner agencies the following week to ensure Mr Lunt would receive all the support he needed in the community. Unfortunately, Mr Lunt died before this meeting took place.

### **Circumstances of Mr Lunt's death**

27. On 22 February, Mr Lunt stayed at his friend's house. At approximately 7.46pm his friend called 999, when she realised he had been lying in the same position on the bed for several hours. She told the paramedics that Mr Lunt had become incontinent at some point, and she tried to wake him up, but he was unresponsive and rigid. She said that Mr Lunt had not taken any drugs, but that he had consumed alcohol earlier that day. She did not recall Mr Lunt complaining of feeling unwell prior to his death.
28. At 7.53pm, the paramedics arrived and at 7.58pm, they pronounced life extinct.

### **Post-mortem report**

29. The post-mortem report gave Mr Lunt's cause of death as cardiorespiratory failure, caused by ischaemic heart disease due to coronary artery atheroma, left ventricular hypertrophy, and acute bronchitis. Epilepsy contributed to but did not cause Mr Lunt's death.

## Findings

### Healthcare

30. During his healthcare screens on arrival at Altcourse, Mr Lunt said that he had a heart condition. The healthcare team could not find any evidence in his medical record of him having a history of cardiac issues and he did not report any heart problems while in prison.
31. We make no recommendations.

### Director and Head of Healthcare to note

32. According to the 'Follow up to Deaths in Custody Policy Framework', staff must comply with requests for information from the PPO. The investigator asked the healthcare team at Altcourse if they had sought clarification from Mr Lunt's community GP about any history of heart problems. They did not respond.
33. The regional safety lead emailed all relevant parties and asked them for a response to the PPO's query, but the healthcare provider still failed to respond. We find the lack of response both concerning and disrespectful and we bring the matter to the attention of the Director and the Head of Healthcare.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2025**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100