

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation
into the death of
Mr Christopher Flaherty, a
resident at Ascot House Approved
Premises, on 29 April 2025**

A report by the Prisons and Probation Ombudsman

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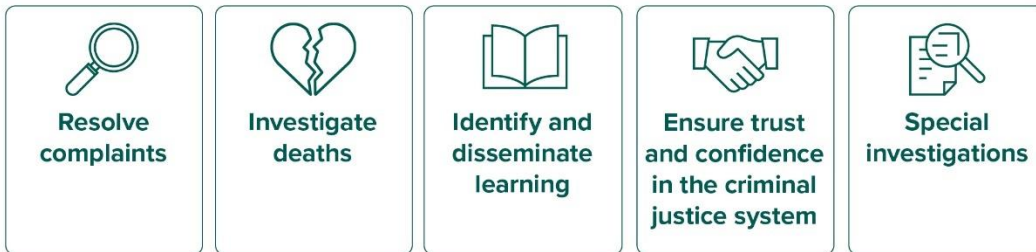
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OUR VISION

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



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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 Christopher Flaherty died in Ascot House Approved Premises (AP) of drug toxicity (cocaine) on 29 April 2025. He was 44 years old. I offer my condolences to Mr Flaherty's family and friends.

Mr Flaherty had been released from prison two months earlier and had been residing at Ascot House since then. Although he had a history of substance use, AP staff did not suspect him to be under the influence of drugs during his time there. Other residents said he regularly used drugs. I accept that it is often harder for staff to be aware of residents taking drugs but am not convinced that staff are sufficiently trained to recognise the signs or empowered to act appropriately if a resident is under the influence of drugs or alcohol. Staff also did not drug test Mr Flaherty as they should have or monitor his missed medication.

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

November 2025

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Summary

Events

1. On 3 January 2025, Mr Christopher Flaherty was sentenced to four months imprisonment for breaching a restraining order and sent to HMP Forest Bank. On 20 January, Mr Flaherty transferred to HMP Berwyn. He denied any substance use issues and staff informed him about drug support and overdose risks.
2. Mr Flaherty was released on 27 February and went to live at Ascot House Approved Premises (AP). During his stay he provided three negative drug tests, though he was not drug tested halfway through his stay as per AP policy.
3. After release, Mr Flaherty was prescribed several medications, but he missed doses on 18 occasions from late March, and staff only followed up once.
4. On 6 April, Mr Flaherty returned to the AP after drinking alcohol. Staff responded appropriately in the moment, but his keyworker did not follow up afterwards as required.
5. In the evening of 29 April, another resident told staff that Mr Flaherty was behaving strangely and was distressed. They immediately went to see him and Mr Flaherty was agitated and confused. Staff requested an ambulance and while they were on the phone to the 999-operator, Mr Flaherty stopped breathing. Staff started CPR. Paramedics arrived and took over Mr Flaherty's treatment. They pronounced his life extinct at 10.55pm.

Findings

6. The post-mortem found Mr Flaherty died of drug toxicity, with a potentially fatal level of cocaine in his system.
7. Staff did not always drug test Mr Flaherty in line with requirements. They also did not follow up his missed medication as they should have. The AP Manager has already addressed these issues.
8. Staff did not suspect Mr Flaherty was under the influence of drugs during his time at the AP. We question whether staff are sufficiently trained and empowered to act effectively if someone is under the influence of drugs or alcohol.
9. We make no recommendations.

The Investigation Process

10. HMPPS notified us of Mr Flaherty's death on 30 April 2025.
11. The investigator issued notices to staff and residents at Ascot House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Flaherty's prison, probation, and medical records. She also obtained CCTV video footage for the emergency response as well as North-West Ambulance service records.
13. The investigator interviewed one member of staff on 14 July 2025 on MS Teams.
14. We informed HM Coroner for Stockport of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's office wrote to Mr Flaherty's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

Ascot House Approved Premises (AP)

17. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.
18. Ascot House, in Stockport, is managed by HM Prison and Probation Service (HMPPS). The AP accommodates up to 25 residents. Residents are required to sign in and out of the building and follow agreed curfews. Each resident is allocated a keyworker to oversee their progress and wellbeing, and to ensure that they adhere to licence conditions and the rules of the AP. HMPPS employees are on duty at Ascot House 24 hours a day.

Previous deaths at Ascot House

19. Mr Flaherty was the second resident to die at Ascot House since 2022. The previous death was self-inflicted and there are no significant similarities between Mr Flaherty's death and that of the previous resident. Up to mid-October 2025, there have been no further deaths since that of Mr Flaherty.

HM Inspectorate of Probation

20. The most recent inspection of Manchester North Probation Delivery Unit (PDU) was published in May 2023. The inspection concluded that the PDU required improvement and made nine recommendations. The recommendations included improving the quality of work to assess and manage risk of harm ensuring that all available information is accessed and utilised. Another recommendation looked at reviewing the efficacy of work with people on probation both before leaving custody and upon release.

Key Events

21. On 3 January 2025, Mr Christopher Flaherty was sentenced to four months imprisonment for breaching a restraining order. He was taken to HMP Forest Bank and had two healthcare screenings, during which he said he had no current substance use issues. Records show that previously Mr Flaherty had a history of misusing cocaine and benzodiazepines (sedatives).
22. On 8 January, Mr Flaherty asked to see someone about his mental health via a digital kiosk application. Healthcare staff asked him for further information to triage his needs.
23. On 10 January, a probation service officer (PSO) in prison spoke to Mr Flaherty to complete a risk assessment. Mr Flaherty said that he did not have any substance misuse issues. The PSO shared her risk assessment with Mr Flaherty's Community Offender Manager (COM).
24. On 15 January, Mr Flaherty asked again to see mental health staff because he was struggling after being released from prison homeless three times in a seven-month period. Healthcare staff suggested that he spoke to staff in the offender management unit (OMU) and Ingeus who support people transition from prison to the community.
25. On 20 January, Mr Flaherty transferred to HMP Berwyn and had two healthcare reception screenings, where he was asked about alcohol use but not drugs. However, healthcare staff told him how he could get support for drug use within prison and about the risks of overdose.
26. The same day, the COM referred Mr Flaherty to approved premises. The referral said he had no known health conditions and did not include any information about medication. Mr Flaherty's referral was accepted and he was given a place at Ascot House.
27. On 14 February, substance misuse staff reviewed Mr Flaherty's records and noted that he did not have a history of opiate, heroin or methadone use and he had not engaged with the substance misuse team during his current sentence so there was no need for a referral.
28. On 27 February, a nurse saw Mr Flaherty before he was released from prison. He told her he had a GP appointment the following day. He was not issued any medication to take with him on release.

Ascot House Approved Premises

29. On 27 February, Mr Flaherty arrived at Ascot House following his release from prison. The Ascot House Manager, told us that, based on Mr Flaherty's history of drug use, she placed him on a three-week rouse response. The rouse response required staff to check on Mr Flaherty at 1.00am and 4.00am each night to ensure he was responsive. They had to wake him and confirm he was well, not just breathing, in line with national policy to reduce the risk of drug-related deaths. Mr Flaherty also provided a negative drug test the same day.

30. Mr Flaherty's licence conditions required him to have an alcohol tag (which detects and monitors alcohol use through sweat). This was fitted on 5 March and removed on 3 April. During this time, the tag did not detect alcohol use.
31. Mr Flaherty's licence conditions also required him to be drug tested, which he was on 10 March and 20 March, with both tests returning negative results.
32. According to AP policy, residents should be drug tested halfway through their stay, so Mr Flaherty should have been drug tested on 27 March. This did not happen due to a staff oversight. The AP's lead practitioner, who was responsible for scheduling drug tests, did not add the test to the staff rota.
33. Mr Flaherty was prescribed several medications by a community GP soon after release, including statins, antibiotics, anti-inflammatories and mirtazapine (an antidepressant), for several conditions such as elbow pain, ear pain, depression and anxiety.
34. Staff considered that it was not appropriate for Mr Flaherty to have his medication in his possession, due to his history of drug and alcohol use. This meant staff were responsible for giving him his medication when he asked for it and monitoring if he took it when he should.
35. Mr Flaherty's mirtazapine prescription ran out on 2 April and he did not request a repeat prescription. This would have been Mr Flaherty's responsibility, although staff could have supported him if he needed help.
36. Mr Flaherty missed doses of some of his medication on 18 separate days between 28 March and when he died. Staff followed up with him only once, despite policy requiring that they should do so each time and note this on his record. His missed medication mainly related to statins and medication for reflux but also included mirtazapine on five days and naproxen (a strong painkiller) on six days.
37. On 6 April, Mr Flaherty returned to the Ascot House under the influence of alcohol. He told staff he had been out for a meal with family and had drunk too much. Staff placed him under observation in a room on the ground floor and contacted the on-call Manager. The incident was recorded and shared with the team and his COM. The AP keyworker did not speak to Mr Flaherty about this at a later date as they should have.
38. Other than this this, there were no records of staff suspecting Mr Flaherty to be under the influence of alcohol or drugs. During his supervision appointments with the COM, Mr Flaherty denied using drugs. However, after Mr Flaherty's death, several residents told the police that Mr Flaherty was taking drugs, including cocaine, at the AP.
39. Staff described Mr Flaherty as cooperative and well-liked. They believed he was doing well, except for not attending his supervision appointments in person a few times because he had no money for the journey. He remained in close contact via phone, text, email and videocalls with his COM.
40. Mr Flaherty's licence conditions ended on 24 April and he was due to leave the AP then. However, since his move on accommodation was not ready, and there was a

room available in the AP, the Ascot House Manager extended his stay. Mr Flaherty was on a post-sentence supervision order from 25 April until 27 February 2027.

Events on 29 April

41. The investigator watched CCTV from 29 April. She also reviewed North-West Ambulance Service records, along with staff statements, police statements and interviewed the AP Manager. The following account is taken from all these sources of information.
42. On 29 April, Mr Flaherty left Ascot House at 8.30am. He told staff he was going to visit a property that he was planning to move into the following day. He returned briefly to the AP at 3.15pm and left two minutes later, telling staff he was going to the town centre.
43. Mr Flaherty returned to Ascot House at 4.50pm. Staff did not have any concerns about him and he went to his room. At 5.58pm, two residents tried to open his room door but could not and walked away. Two minutes later, one of them returned and went into Mr Flaherty's room briefly. In his police statement, he said he spoke to Mr Flaherty who said he was doing well.
44. At 8.00pm, a residential assistant, and a residential worker, started their evening shift. During their handover, staff did not pass on anything significant about Mr Flaherty.
45. At 8.20pm, Mr Flaherty went to the communal bathroom and then returned to his room. Around 9.00pm, he briefly opened his door a couple of times, but he remained inside. At 9.11pm, he went to the bathroom and then returned to his room.
46. At 9.15pm the residential assistant, and the residential worker, went to the garage to retrieve the air conditioner unit and started installing it as it was a hot evening.
47. From 9.16pm, Mr Flaherty went in and out of his bedroom, the communal bathroom, and the corridor several times. He looked at the floor and ceiling several times in fixated manner and jumped on his bed in an unusual way. (This could be seen from the CCTV in the corridor, there are no cameras in residents' rooms.)
48. At 9.33pm, Mr Flaherty went downstairs and into the kitchen on the ground floor. Another resident was in the kitchen. He told the police that Mr Flaherty said to him, "They are coming to me." He said that he asked Mr Flaherty if he was okay, but he did not respond. Mr Flaherty then left and went upstairs and into his room at 9.35pm.
49. The resident believed that Mr Flaherty was under the influence of drugs and alerted staff that he was behaving abnormally, but mistakenly referred to him as "X", which was the name of another resident. The residential worker and residential assistant immediately went to look for X on the second floor. They could not find X and were confused as his room was on the ground floor. In the meantime, the residential assistant, heard a noise from Mr Flaherty's room, so assumed that it was Mr Flaherty who needed assistance.

50. At 9.37pm, the residential assistant and residential worker went into Mr Flaherty's room. Records show that Mr Flaherty was agitated, distressed, and confused. He kept pointing at something on the floor that was not there and staff could not make sense of what he was saying. The residential assistant went to get a mobile phone from the office and immediately returned. The residential worker called the emergency services at 9.38pm. She spoke to the ambulance services operator who said that a doctor would call them back in one hour to discuss the situation further. The call lasted 8 minutes and 56 seconds, ending at approximately 9.47pm. She then left the room at 9.47pm to get a fan for Mr Flaherty and returned at 9.49pm.
51. Mr Flaherty remained agitated for a few more minutes but then became quiet and still. Staff helped him to lie in bed. Mr Flaherty's breathing then became noisy and laboured, so the residential worker called the emergency services again at 9.51pm. During the call, Mr Flaherty stopped breathing and the operator told her to start CPR, which she did. At 9.54pm, the residential assistant left the room to collect the defibrillator and returned one minute later. They attached the defibrillator and followed its instructions. At 9.56pm, the residential assistant left the room to open the front door for the paramedics. At 9.58pm, he returned to the room with a paramedic.
52. Other paramedics also arrived, moved Mr Flaherty to the floor and took over his care. At 10.55pm, they stopped CPR and pronounced his life extinct. At 11.15pm, the residential worker called the on-call Manager who arrived at the AP at 11.50pm.

Contact with Mr Flaherty's family

53. The police attended Ascot House at 1.00am and staff gave them the contact details of Mr Flaherty's mother, so that they could inform her of his death which they did.
54. The Approved Premises Manager later contacted Mr Flaherty's mother and offered her assistance with funeral expenses, in line with national guidelines.

Support for prisoners and staff

55. The Approved Premises Manager briefed staff involved in the emergency response. She spoke with the night staff member who had responded and offered support. She also contacted the Sodexo worker's Manager to ensure he received appropriate support. On the morning of 30 April, she met with all residents to inform them of Mr Flaherty's death, explain the investigation process, and offer support. She held a follow-up meeting a few days later to answer questions and provide reassurance.

Post-mortem report

56. The post-mortem report concluded that Mr Flaherty died of drug toxicity. Mr Flaherty had a potentially fatal level of cocaine in his system. The toxicology report noted that there was evidence that Mr Flaherty had taken cocaine in the hours before his death.

Inquest

57. At the inquest hearing held on 2 and 3 of March 2026, the Coroner concluded that Mr Flaherty's death was drug related.

Findings

58. Mr Flaherty died of drug toxicity. He had a potentially fatal amount of cocaine in his system. While we cannot know for sure, we have found no evidence that he took cocaine with an intention to take his own life or that staff should have assessed him as a risk to himself. Mr Flaherty had denied that he had any substance use issues when most recently in prison and therefore was not referred to substance misuse services on release. This was reasonable, since engagement with substance misuse services is voluntary. Prison staff had spoken to him about the dangers of taking drugs and the risk of overdose.

Drug testing

59. Mr Flaherty provided two negative drug tests in March. He also should have had a drug test on 27 March but this did not occur due to an administrative error. The Ascot House Manager had already identified this oversight at the time of our investigation and was putting safeguards in place to ensure it did not happen again. We therefore make no further recommendation.

Missed medication

60. Mr Flaherty also did not take all his medication on 18 separate days between the end of March and when he died. AP policy notes that staff should follow up with the resident after each occasion and record the conversation. This only happened once. The AP Manager planned to send reminders to staff on the importance of following this process and also start a medication audit led by the AP's lead practitioner. We therefore make no further recommendation.

Area AP Manager to note

Staff awareness and training

61. On 6 April, Mr Flaherty returned to Ascot House under the influence of alcohol. Mr Flaherty's key worker did not speak to him about this afterwards as he should have to understand more about what had happened and raise any potential concerns. The AP Manager told us that his keyworker was inexperienced and was still learning the job.
62. During his time at Ascot House, staff did not suspect Mr Flaherty to be under the influence of drugs. However, other residents told police that Mr Flaherty took drugs, including cocaine, at the AP. We accept it might be more apparent to other residents than staff that a resident is taking drugs but we are not convinced that AP staff are sufficiently aware of the signs that someone might be under the influence.
63. Even when another prisoner raised concerns about Mr Flaherty's behaviour and he subsequently collapsed, staff did not seem to consider that he might be under the influence of drugs. Although staff have access to and are trained in administering naloxone (used to reverse the effect of opioid overdose), there is no evidence they considered administering this to Mr Flaherty. However, we accept that it would not

have made any difference to the outcome for Mr Flaherty as he did not die of an opioid overdose.

64. The Approved Premises Manager told us there was a lack of training for AP staff nationally. She had already reminded her team of the need to follow up with residents who had been under the influence of drugs or alcohol. The Area AP Manager will want to consider the training for AP staff, including awareness of signs that a resident may have taken drugs or alcohol and empowering them to act appropriately.

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