

Action Plan in response to the PPO Report into the death of Mr James Glendenning on 29 October 2023 at HMP Manchester

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should review the care pathways for dementia and ensure the care provided is in line with NICE clinical guideline: Dementia: assessment, management and support for people living with dementia and their carers and RCN Dementia Care Principles for People Living in Prison.	Accepted	Mr Glendenning had an established diagnosis of Dementia and had been in prison for many years. During his stay at HMP Manchester, Mr Glendenning was nursed in line with NICE clinical guidance and RCN 5 principles of care (SPACE) Staff who are skilled to provide care for their patients with Dementia. Mr Glendenning was nursed by our highly skilled social care nurses every day. These nurses were able to provide the care which he had been assessed for. Mr Glendenning had a personalised care-plan in place. Partnership in working within a prison community. The prison allows the enablement of H1 wing to allow the care and support to be provided. Assessment, Early identification & post diagnostic support – Mr Glendenning continued to be assessed daily, he was reviewed regularly	Head of Healthcare Greater Manchester Mental Health Trust	February 2025

			by professionals, prescribed relevant medications & had ongoing support from the social care team. Care & support plans – person centred & Individual. Mr Glendenning had person centred care plans in place. These were reviewed daily & accordingly by the social care nurses. Environment that is dementia friendly. Mr Glendenning was located on our social care wing. This wing holds 12 patients who are mainly elderly & predominantly have a diagnosis of Dementia. The care provided clinically is from our social care team. Officers are based on the wing to allow the care to be delivered efficiently and effectively. Pathway currently being developed.		
2	The Head of Healthcare should ensure that ongoing prevention, planning, and management of falls is undertaken for patients who are not located within the inpatient healthcare unit in line with NICE clinical guideline: Falls in older people: assessing risk and prevention and GMMH Prevention and management of patient falls policy.	Accepted	Falls risk assessments (FRAT) are completed for all patients who have social care needs or who are deemed to have mobility concerns. However, if there was a patient who had not fallen previously but then had a fall, a FRAT would be immediately completed, and ongoing updates would be completed. We have a trust Falls prevention policy which is reviewed regularly. All staff complete their training on Falls prevention & are made aware of the further implications should any patient be on anti-coagulant medications.	Head of Healthcare Greater Manchester Mental Health Trust	Completed