

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Glendenning, a prisoner at HMP Manchester, on 29 October 2023

A report by the Prisons and Probation Ombudsman

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

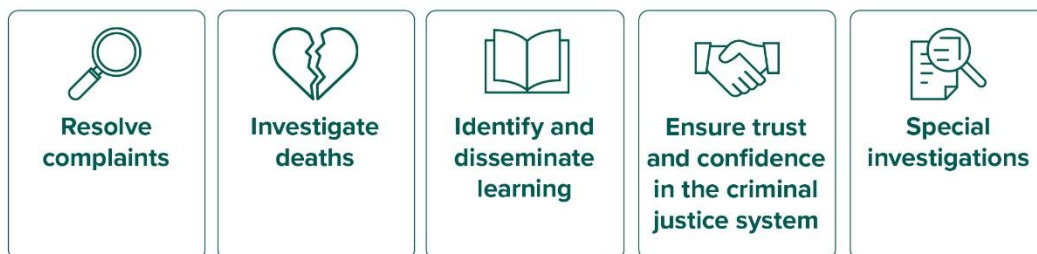
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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

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

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. In November 2018, Mr James Glendenning was sentenced to 23 years in prison for sexual offences. He died in hospital of a stroke on 29 October 2023, while a prisoner at HMP Manchester. He had been taken to hospital the day before, when he was found on the floor of his cell with a head wound. He was 93 years old. We offer our condolences to Mr Glendenning's family and friends.
4. The Ombudsman's office contacted Mr Glendenning'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.
5. The PPO investigator investigated the non-clinical issues relating to Mr Glendenning's care.
6. We did not find any non-clinical issues of concern.
7. NHS England commissioned an independent clinical reviewer to review Mr Glendenning's clinical care at HMP Manchester.
8. The clinical reviewer concluded that the clinical care Mr Glendenning received at Manchester was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community. She considered that the management of Mr Glendenning's cardiovascular disease and his social care was equivalent but that his dementia care and planning for his risk of falls was not. We make two recommendations:

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.

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.

9. We shared our initial report with HMPPS and with the prison's healthcare provider, Greater Manchester Mental Health NHS Foundation Trust. They found no factual inaccuracies. Greater Manchester Mental Health NHS Foundation Trust provided an action plan which is annexed to this report.

Adrian Usher
Prisons and Probation Ombudsman

November 2024

Inquest

At the inquest, held on 30 September 2026, the Coroner concluded that Mr Glendenning died from natural causes.



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

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

T | 020 7633 4100