Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Walter Tideswell, a prisoner at HMP Risley, on 18 May 2025

## A report by the Prisons and Probation Ombudsman

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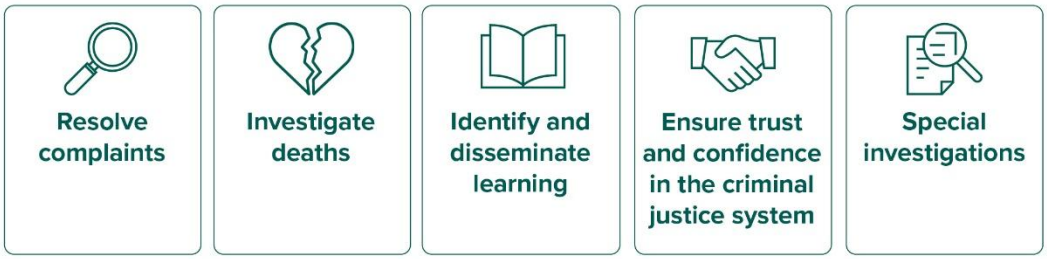
## OUR VISION

**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

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. On 19 September 2024, Mr Walter Tideswell was sentenced to three years in prison for sexual offences. He died from congestive cardiac failure caused by ischaemic and hypertensive heart disease, coronary artery atheroma, and hypertension on 18 May 2025, while a prisoner at HMP Risley. He was 84 years old. We offer our condolences to his family and friends.

4. The Ombudsman's office wrote to Mr Tideswell'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 to our letter.

5. NHS England commissioned an independent clinical reviewer, to review Mr Tideswell's clinical care at HMP Risley. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Tideswell received at HMP Risley was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Tideswell had care plans in place, appropriate and timely access to the healthcare team, and was provided with the equipment and support he needed to support him with his basic care needs. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Tideswell's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

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

**Inquest**

10. At the inquest held on 1 October 2025, the Coroner concluded that Mr Tideswell died of natural causes.

**Adrian Usher**
**Prisons and Probation Ombudsman** **December 2025**

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