Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Cumiskey, a prisoner at HMP Doncaster, on 1 August 2024

A report by the Prisons and Probation Ombudsman

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

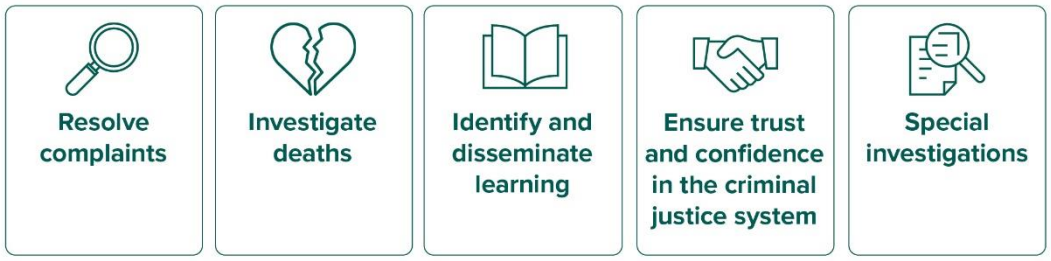
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 28 June 2016, Mr Martin Cumiskey was sentenced to nine years in prison for sexual offences. On 2 June 2017, Mr Cumiskey was transferred to HMP Doncaster.

4. Mr Cumiskey died at HMP Doncaster on 1 August 2024. His cause of death was bronchopneumonia (a severe lung infection). Contributing factors were chronic emphysema (long-term lung disease) and laryngeal cancer (cancer of the voice box). He was 61 years old. We offer our condolences to Mr Cumiskey's family and friends.

5. The Ombudsman's office contacted to Mr Cumiskey's family to explain the investigation and to ask if they had any matters she wanted us to consider. They had no questions.

6. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Cumiskey received at Doncaster.

7. The clinical reviewer concluded that the clinical care Mr Cumiskey received at Doncaster was of a good standard and was equivalent to that which he could expect to receive in the community. She found that that there was well-co-ordinated care with regular multi-disciplinary and social care meetings, good joined up multi-disciplinary team approach to palliative care, and that this was delivered in accordance with the Dying Well in Custody Charter and Gold Standards Framework.

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

9. We found one non-clinical issue of concern. On 3 February 2023, prison staff recorded that an application for Early Release on Compassionate Grounds had been started due to Mr Cumiskey's terminal illness. However, no significant progress was made with the application before Mr Cumiskey died.

10. In October, healthcare staff also requested that the process for Early Release on Compassionate Grounds should start. However, no progress was made and no one caring for Mr Cumiskey followed up on the request.

11. Since Mr Cumiskey died, the Head of Offender Management Services has made some changes to the process, including assigning a named member of staff to the case with a timeline of actions to follow. They have also established a multi-disciplinary meeting once an application is started, to identify actions and ensure it is clear who will take forward which action. As a result of these changes, we make no recommendation.

12. We shared the report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

13. The inquest into Mr Cumiskey's death concluded on 26 March 2025 and returned a verdict of natural causes.

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

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