

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Kaminsky, a prisoner at HMP/YOI Parc, on 4 October 2025

A report by the Prisons and Probation Ombudsman

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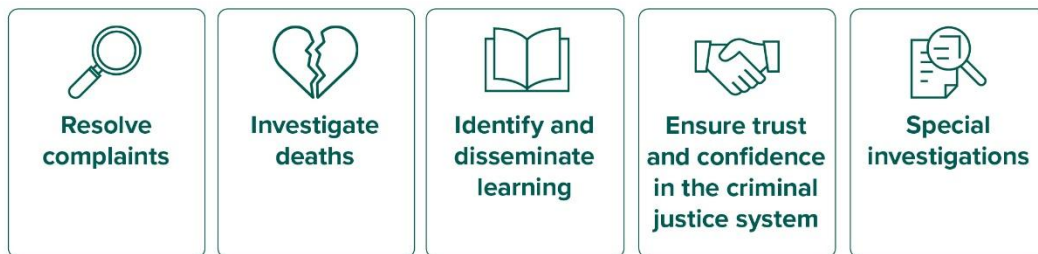
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OUR VISION

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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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 21 February 2025, Mr Peter Kaminsky was sentenced to 54 months in prison for arson. He died from metastatic pancreatic cancer on 4 October 2025, while a prisoner at HMP Parc. He was 57 years old. We offer our condolences to Mr Kaminsky's family and friends.
4. The Ombudsman's office wrote to Mr Kaminsky's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Kaminsky's clinical care at HMP Parc. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Kaminsky received at Parc was equivalent to what he could have expected to receive in the community. He found the healthcare team at Parc acted promptly to seek urgent care when requested, and the quality of palliative care delivered to Mr Kaminsky was exemplary.
7. The PPO investigator investigated the non-clinical issues relating to Mr Kaminsky's care. We did not find any non-clinical issues of concern.
8. The initial report was shared with HM Prison and Probation Service (HMPPS) and Cwn Taf Morgannwg University Health Board. They did not find any factual inaccuracies.
9. Mr Kaminsky's family received a copy of the draft report. They did not make any comments.
10. We informed HM Coroner for South Wales Central of our investigation. The Coroner informed us that they were not holding an inquest. We have sent the Coroner a copy of this report.

Adrian Usher
Prisons and Probation Ombudsman

May 2026



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