

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Taras Nykolyn, a prisoner at HMP Woodhill, on 5 June 2018**

**A report by the Prisons and Probation Ombudsman**

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://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



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Taras Nykolyn died on 5 June 2018 after he was attacked by three other prisoners in the exercise yard of a special unit for dangerous and challenging prisoners at HMP Woodhill. Mr Nykolyn was 49 years old. I offer my condolences to Nykolyn's family and friends.

This was an extended and extremely brutal attack. Although it seems to have been pre-planned, I am satisfied that there was no information available to staff to suggest that Mr Nykolyn was at risk. However, I am concerned that while the mix of prisoners on the unit was clearly a dangerous one, all four prisoners exercised together, unlike the practice at other special units. In addition, there were weaknesses in some other aspects of security and risk assessment in the unit.

I am also very concerned at the lack of co-ordination and urgency in the response once the attack on Mr Nykolyn began, and the fact that there was no contingency plan for an incident in the exercise yard.

The production of this report has been delayed by a number of factors, some of which were outside our control. I am very sorry for the additional distress this has caused Mr Nykolyn's family.

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**September 2024**

# Contents

Summary.....	1
The Investigation Process.....	4
Background Information.....	5
Prisoner Backgrounds.....	8
Key Events.....	10
Findings.....	18

## Summary

### Events

1. Mr Taras Nykolyn was first remanded into custody in June 2014 for wounding with intent to cause grievous bodily harm. In May 2015, Mr Nykolyn killed his cellmate and was convicted of manslaughter and sentenced to life imprisonment for a minimum term of seven and a half years.
2. On 24 January 2018, Mr Nykolyn moved to the Managing Challenging Behaviour Strategy (MCBS) unit at HMP Woodhill: a small specialist unit for dangerous, disruptive and challenging prisoners. The prisoners at the unit were split into two association groups, and by June 2018, Mr Nykolyn was in an association group with three other prisoners, all three of whom had a history of violence, both in and out of custody.
3. At just after 3.00pm on 5 June, the four prisoners went into the exercise yard. The gate was locked and two officers supervised from outside. Around ten minutes later, a prisoner punched Mr Nykolyn to the floor and all three prisoners continued the attack by kicking him, punching him, cutting him with improvised weapons and tying a ligature round his neck.
4. The prisoners threatened to attack any officers who came into the yard. The attack continued for just over 30 minutes until officers entered the yard, dressed in protective clothing, and the prisoners surrendered.
5. Mr Nykolyn was examined by healthcare staff and ambulance paramedics and efforts were made to try to resuscitate him. He was pronounced dead at 4.23pm while being taken to hospital in an air ambulance.
6. All three prisoners were convicted of murder and given life sentences.
7. The special unit at Woodhill was closed following Mr Nykolyn's death. This was a long-planned closure unconnected with his death.

### Findings

8. We do not consider that staff could reasonably have anticipated that the other prisoners would attack and murder Mr Nykolyn.
9. However, we are concerned that management of the prisoners in the unit was insufficiently proactive and robust, with insufficient recognition of potential risk.
10. We are concerned that in the week before Mr Nykolyn's death, prisoners on the unit apparently received full packs of six razors, some of which were allegedly used to manufacture the weapons used in the attack.
11. We are also concerned that further weapons – sharpened metal spikes – were found in two of the perpetrators' cells after the attack, apparently made from shelf dividers taken from the prison library, and that cells in the MCBS unit do not seem to have been searched as frequently as local policy required.

12. We are very concerned that four prisoners were locked into the exercise yard for communal exercise, in contrast to similar units at other prisons where prisoners exercise alone. It appears that this was not in line with a local risk assessment.
13. Managers and staff working in MCBS units need to guard against becoming complacent about risks and security.
14. We are very concerned that around 32 minutes elapsed between the start of the attack on Mr Nykolyn and staff entering the exercise yard to rescue him and that the perpetrators continued to assault him during this time. It appears that there was no contingency plan for dealing with any incidents in the exercise yard. We cannot say whether the delay affected the outcome for Mr Nykolyn, but we consider that it was unacceptably long.
15. We are concerned that the Silver Commander in charge on 5 June did not make immediate contact with the national Gold Commander and did not consider all available options for an earlier entry by staff onto the exercise yard.
16. The clinical reviewer considered that the mental health care provided to Mr Nykolyn and his three attackers was satisfactory. She was, however, concerned that Mr Nykolyn had to wait seven weeks for urgent dental surgery and she said that the significant pain he suffered during this time may have contributed to his strange behaviour.

## Recommendations

17. The MCBS unit at Woodhill has closed since Mr Nykolyn's death. We have, therefore, addressed the majority of our recommendations to the Governors of prisons which currently house MCBS units, and not to Woodhill.
  - Governors should ensure that managers and staff in MCBS units:
    - are aware that certain personality traits and behaviours may make individual prisoners more vulnerable to assault;
    - are aware of potential conflicts between individuals; and
    - record, monitor and manage such issues proactively.
  - Governors should ensure that association and exercise groups in MCBS units are regularly risk assessed.
  - Governors should ensure that safe and appropriate practices are always followed in the supply of razors to prisoners in MCBS units.
  - Governors should ensure that:
    - there is an effective security and searching strategy in place in MCBS units, which reflects the specific risks of the prisoners housed there;
    - prisoners and cells are searched thoroughly and in line with the local policy; and

- measures are in place to guard against staff becoming complacent about security and staff are able to discuss these issues in a safe, non-judgmental and supportive environment.
- Governors should ensure that:
  - contingency plans are in place for a range of possible incidents in MCBS units; and
  - staff who may be called upon to act as Silver Commanders have received the appropriate training, including refresher training, and have a clear understanding of their role.
- The Governor of Woodhill should share this report with the Deputy Governor and CM A and discuss the Ombudsman's findings with them.
- The Governor and Head of Healthcare at Woodhill must ensure that urgent healthcare appointments are not delayed.

## The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
19. The investigator obtained copies of relevant extracts from Mr Nykolyn's and the perpetrators prison and medical records.
20. The investigator obtained relevant disclosure from the police investigation and reviewed statements and interviews taken from staff and prisoners involved in the incident. The investigator interviewed eight members of staff between November 2019 and March 2020. He also interviewed one of the perpetrators, but the other two perpetrators declined to be interviewed.
21. NHS England commissioned a clinical reviewer to review the clinical care provided by the prison to Mr Nykolyn and to the perpetrators. The investigator and clinical reviewer jointly interviewed healthcare staff. The investigator left the PPO in 2020 and the investigation was completed by another investigator.
22. Our investigation was initially suspended while we waited for the conclusion of the police investigation and the criminal trial. There was a further delay while the prison and the police tried to find the incident logs completed on the day of Mr Nykolyn's murder. (They were not found and we have had to complete this report without them.) The COVID-19 pandemic has also delayed the production of this report.
23. We informed HM Coroner for Milton Keynes of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
24. One of the Ombudsman's family liaison officers contacted Mr Nykolyn's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Nykolyn's partner wanted to know:
  - whether staff appropriately supervised the prisoners living in the MCBS unit;
  - whether the MCBS unit was an appropriate location for Mr Nykolyn; and
  - whether the perpetrators were adequately searched before going on to the exercise yard?
25. We shared our initial report with Mr Nykolyn's family and with HM Prison and Probation Service (HMPPS). Neither party identified any factual inaccuracies. The HMPPS action plan has been annexed to this report.
26. We apologise for the delay in issuing this report. The delay was due to extended communication with HMPPS on the action plan. This report is issued under the name of the previous Ombudsman as she issued the initial report.

## Background Information

### HMP Woodhill

27. HMP Woodhill in Milton Keynes is a complex institution known as a core local prison. It combines a local prison function for just over 600 men with a high security responsibility holding a small number of category A prisoners, most of whom are going through the court process or have been recently convicted. At the time of Mr Nykolyn's death, the prison also had a close supervision centre (CSC - a specialist facility for some of the country's most challenging, dangerous and disruptive prisoners) and a Managing Challenging Behaviour Strategy (MCBS) unit. (In July 2018, the MCBS unit was closed. The closure had been planned for some time and was not in response to Mr Nykolyn's death. The accommodation now houses a second CSC.)
28. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care.

### The close supervision centre (CSC) system

29. The aim of the close supervision centre (CSC) system is to remove the most significantly disruptive, challenging and dangerous prisoners from the ordinary prison location, and to manage them within small and highly supervised units. The units are managed by the Central Management Group (CMG), a group within the Long-Term and High Security Estate (LTHSE) Directorate in HMPPS, although the day to day running is the responsibility of the host prison.

### The Managing Challenging Behaviour Strategy (MCBS)

30. The MCBS was launched in 2008 and is designed for men who do not meet the threshold for a CSC, but who nevertheless present with challenging behaviour in custody, including risk of harm to staff and other prisoners. Management under the MCBS is not a punitive measure, but is designed to assist selected prisoners to progress and to return safely to normal or more appropriate prison location. The policy governing the management of the MCBS was set out in a document dated 2012.
31. Most men subject to the MCBS are managed locally by their host prison with advice available from the CMG, but a few are managed centrally by the CMG and are held in what are known as central MCBS units.
32. At the time of Mr Nykolyn's death, the MCBS unit at Woodhill was a central MCBS unit and was overseen by the CMG, although its day-to-day running was the responsibility of Woodhill. The MCBS unit held up to ten prisoners who were subject to a care and management plan and mandatory fortnightly dynamic risk assessments. Although the prisoners were case managed by the CMG, their daily management on the unit (regime delivery, disciplinary procedures, Incentives and Earned Privileges level, meals, etc) was the responsibility of Woodhill staff and managers.

33. The regime in the Woodhill unit included exercise, association, library, in-cell education and employment, access to offending behaviour programmes and on unit gym. Prisoners could also access activities off the unit (such as gym, education, employment, substance misuse courses and religious services, subject to individual risk assessment).
34. Prisoners in the MCBS unit were automatically referred to the mental health team. At that time, the mental health service was provided separately to the prison's primary healthcare service. The mental health team working in the MCBS unit consisted of a mental health nurse, a forensic psychologist (who attended twice a week) and support from a forensic psychiatrist.
35. At the time of Mr Nykolyn's death, there were six prisoners in the unit.

### **HM Inspectorate of Prisons**

36. In December 2017, HM Inspectorate of Prisons carried out an inspection of the CSC system, including the centrally managed MCBS units, following up an earlier inspection in 2015. They commented, "This is extreme custody and its management raises complex operational challenges and profound ethical issues." They noted that all the units were psychologically informed, and all were on their way towards achieving Royal College of Psychiatry Enabling Environment accreditation. They said that the focus on giving men hope, and persevering even with those who were the most difficult to reach, was impressive.
37. Inspectors found that tangible progress had been made with the system since the previous inspection in 2015 and that the relationship between central MCBS units and CSCs had become clear. Inspectors found that regimes at most of the units had improved, although staffing shortages had hampered efforts at some units, especially at Woodhill. They noted that far more men than previously had progressed out of the central MCBS system, often to less restrictive special units and some to mainstream prison wings.
38. With regard to the Woodhill MCBS unit, inspectors noted that time out of cell at Woodhill was reasonable and that men could use mainstream facilities in the prison, subject to risk assessment.

### **Independent Monitoring Board**

39. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year to May 2019, the IMB reported that Woodhill had experienced another challenging year with a complex prisoner population and staffing shortfalls. The IMB referred to Mr Nykolyn's death, but made no further comment on it. (At the time the report was published, the perpetrators were still un-convicted.)

## **Previous deaths at HMP Woodhill**

40. Mr Nykolyn was the 13th prisoner to die at Woodhill since June 2016. Of the previous deaths, five were self-inflicted and seven were from natural causes. With one of the self-inflicted deaths, we found inadequate management of a prisoner who had been assaulted by other prisoners and who felt under threat.

## Prisoner Backgrounds

### Mr Nykolyn

41. On 20 June 2014, Mr Taras Nykolyn, was remanded to HMP Wandsworth charged with wounding with intent to cause grievous bodily harm after an unprovoked attack on a stranger. Mr Nykolyn was a Ukrainian national who said that he had lived in the UK since 2002 under an alias. There is evidence that he had applied for asylum, but his immigration status was unclear at the time of his death.
42. On 4 May 2015, while still on remand, Mr Nykolyn killed his cellmate by assaulting him with a television. Mr Nykolyn was subsequently convicted of manslaughter and sentenced to life imprisonment with a minimum term of seven and a half years. For his original offence of grievous bodily harm, he received a concurrent sentence of 16 months imprisonment.
43. On 12 August, Mr Nykolyn was admitted to Broadmoor Hospital for a mental health assessment. Doctors found no evidence that he was suffering from a psychotic disorder and on 27 November, he returned to Belmarsh.
44. On 11 February 2016, Mr Nykolyn was readmitted to Broadmoor Hospital after his mental health deteriorated. He was prescribed anti-psychotic medication and remained in Broadmoor for the next 16 months until doctors decided that, although Mr Nykolyn had a mental disorder - probable paranoid schizophrenia - he did not need hospital treatment. He returned to Belmarsh on 6 June 2017.
45. On 19 June, Belmarsh referred Mr Nykolyn for consideration to move to a close supervision centre (CSC). The Central Case Management Group assessed that a CSC was inappropriate for Mr Nykolyn, but decided that he was suitable for a MCBS unit.

### Prisoner A

46. On 20 August 2012, prisoner A was remanded to HMP Belmarsh charged with attempted murder. He was found guilty on 15 July 2013 and was sentenced to 15 years in prison.
47. Prisoner A was initially considered for a move to the CSC system after he was charged with the murder of another prisoner at HMP Long Lartin. However, in March 2016 he was found not guilty of involvement in the murder. Prisoner A subsequently assaulted two prison officers and received an additional 15 months imprisonment for one of the assaults.
48. Prisoner A had been diagnosed with antisocial personality disorder, particularly with regard to having no empathy towards victims, a disregard for rules, and violence. As his violent behaviour in prison had not been deemed to be life-threatening, he did not meet the threshold for a CSC. However, senior managers decided that he would be better managed in an MCBS unit.

## **Prisoner B**

49. In September 2012, Prisoner B was remanded to HMP Holme House charged with murder. He pleaded guilty and in May 2013, was sentenced to life imprisonment with a minimum term of 29 years and six months. He had a long history of depression and was receiving anti-depressants.
50. In October 2015, Prisoner B assaulted a prison officer causing actual bodily harm. He was later sentenced to 20 months imprisonment.
51. In April 2017, Prisoner B attempted to strangle another prisoner at HMP Wakefield and he was later sentenced to a further four years imprisonment. He began to be managed under central MCBS in August 2017.

## **Prisoner C**

52. In May 2009, Prisoner C was convicted of robbery where he threatened the victim with a knife.
53. In October 2012, Prisoner C attacked another prisoner at HMYOI Rochester using an improvised weapon made from a razor blade melted into a plastic knife handle. He was found guilty of attempted murder and given an indeterminate sentence for public protection (IPP) with a tariff of 5 years and 6 months. This was later reduced to 4 years and 6 months on appeal. He was placed under central MCBS management in October 2015 for escalating violence in custody.

## Key Events

54. Prisoner A moved to the MCBS unit at Woodhill on 15 November 2017. His MCBS management plan included substance misuse interventions, engagement in wing association and wing-based work, improved anger management and engagement with mental health services. His records show that he engaged well in his initial management plan meeting and showed interest in progressing.
55. Prisoner B moved to the MCBS unit on 1 December 2017. He declined the offer of input from a psychiatrist or the mental health team, but he agreed to regular consultations with a psychologist to explore anger management techniques.
56. From January 2018, Prisoner A's initial interest in engaging with the MCBS programme waned. Officers and psychologists encouraged him, but increasingly he failed to attend sessions and would not engage with psychological interventions.
57. On 14 March, a psychologist spoke to Prisoner A about his poor engagement with the MCBS programme. She explained that he would have to participate in the programme for him to move to a standard location. The psychologist aimed to speak to him again two weeks later, but he did not go to the meeting.
58. Mr Nykolyn moved to the MCBS unit on 24 January 2018.
59. There were six prisoners in the MCBS unit at that time, who were divided into two groups for association. The reason for separate groups was to limit the number of prisoners out of their cells at any one time and to prevent prisoners associating who were at risk of violence towards each other. All of the prisoners on the unit were subject to two-officer unlock and on coming out of their cells would be subject to a rub down search and checked with a hand-held electronic metal detector. Prisoners could access the unit's TV room during association, which remained unlocked.
60. The prisoners and their allocation to association groups were reviewed every two weeks by a multidisciplinary team through dynamic risk assessment meetings (DRAMs). The DRAMs reviewed the prisoners' case notes and security reports before their assessments. The investigator was provided with copies of the DRAM minutes of the meetings on 6 February, 20 February, 6 March, 17 April, 1 May, 16 May and 29 May 2018, only.
61. On 14 February 2018, a forensic psychiatrist, reviewed Mr Nykolyn. He recorded that Mr Nykolyn had previously been treated with anti-psychotic medication at Broadmoor. He assessed that Mr Nykolyn's mental health was stable and he planned for him to have ongoing intervention from the mental health team.
62. At the DRAM on 20 February 2018, the team discussed Mr Nykolyn and recorded that they had no concerns. Mr Nykolyn was still not allocated an association group at that point.
63. On 28 February, Mr Nykolyn's progress in the MCBS system was reviewed at a routine quarterly review (separate to the DRAMs). The operational lead for the MCBS for the Long-term and High Security Estate at the time, chaired the review, which was attended by MCBS unit officers. They recorded that Mr

Nykolyn had been working well as a cleaner and that a psychiatrist had reviewed him and had not prescribed him any medication.

64. At the DRAM on 6 March, staff recorded that Mr Nykolyn engaged well with staff and had been added to association group one, with Prisoner A and B.
65. On the same day, an officer submitted an intelligence report to say that Mr Nykolyn, Prisoner A and Prisoner B were attempting to manipulate and condition staff by splitting their attentions. Supplementary text to the same report referred to there being some tension between the prisoners: there was no explanation as to whether this was tension within the group or was tension between the group and staff. The same report was copied into Prisoner A's and Prisoner B's records. The report was evaluated by the security team, who concluded that no judgement could be reached on the matter.
66. At the DRAM on 17 April, the team recorded a deterioration in Mr Nykolyn's mental and physical state. His personal hygiene was poor and he was acting strangely and was in constant pain from his teeth. Staff were to chase up a referral for Mr Nykolyn to be seen by a doctor. The DRAM noted that Prisoner A spent a lot of time in his cell, although he associated positively with staff and his group when he did come out, and that he had not attended any psychology sessions. The DRAM noted that Prisoner B was settled and was engaging well with staff. The DRAM also noted that Prisoner B had asked to move to association group two, so the groups were modified for a trial period of two weeks.
67. Prisoner C moved to the MCBS unit at Woodhill on 17 April 2018 and was placed in association group one with Mr Nykolyn and Prisoner A (with Prisoner B temporarily moved to association group two).
68. On 18 April, an officer found a piece of sharpened battery casing in Prisoner C's right shoe using a metal detector. Prisoner C said that he had brought the item from his previous prison. He was warned that if any further items were found, he would be placed on a disciplinary charge.
69. On 23 April, the forensic psychiatrist reviewed Mr Nykolyn following the earlier referral in relation to his strange behaviour. He noted that Mr Nykolyn would not consider taking any anti-psychotic medication and that he showed significant thought disorder, which had not been evident at their previous consultation. He assessed that Mr Nykolyn's mental health was likely to deteriorate further without treatment. He also noted that Mr Nykolyn appeared to be in considerable distress from his dental problems. He found no evidence that Mr Nykolyn's risk of harm to himself or others had increased, but noted that if any such signs arose, referral to a high security mental health setting should be considered.
70. At the DRAM on 1 May, it was recorded that Mr Nykolyn had been seen by a doctor since the last DRAM who had reported there was 'nothing wrong with him' (this does not accord with forensic psychiatrist's assessment). However, the DRAM noted that staff were aware that Mr Nykolyn was not taking his anti-psychotic medication and they needed to be aware that this could be a 'trigger for him'. The DRAM noted that Prisoner A was not engaging with psychology and that he spent a lot of time in his cell. The DRAM advised that staff needed to interact and engage more with him. The DRAM noted that Prisoner B was

coming out for association with both association groups and that he should return to association group one. The DRAM noted that Prisoner C had settled since his arrival, but that he spent a lot of time in his cell and he had been spoken to about coming out more.

71. On the afternoon of 1 May, an officer opened Prisoner B's door for association, but he told her to close the door and go away before he hurt staff. The officer thought the reason for Prisoner B's response was because staff had stopped another prisoner passing him a vape. (Prisoner B's threat to assault staff was not discussed at any of the following DRAMs.)
72. On 8 May, Prisoner A did not attend his quarterly care management review. The operational lead for the MCBS recorded that Prisoner A remained limited in his engagement with the unit, its regime and staff.
73. At the DRAM on 16 May, it was noted that a referral was to be made for Mr Nykolyn to move back to Broadmoor. The DRAM noted that Prisoner A was not engaging with psychology services. The entry for Prisoner B, suggested that he was still coming out for association with both groups. Prisoner C was noted to have said that he wanted to progress, but would not speak to the psychology team as he felt they had broken his trust. It was also noted that Prisoner C did not like to be challenged by staff.
74. On the afternoon of 16 May, Mr Nykolyn was placed on report for throwing urine from his cell.
75. On 23 May, the prisoners were told that a long planned move for them to transfer to the MCBS unit at HMP Long Lartin had been delayed.
76. At the DRAM on 29 May, it was noted that Prisoner C had said that if he encountered a particular prisoner who lived on another wing at Woodhill, he would 'finish him'. Prisoner C was noted to have said that he had no intentions of engaging with anyone and would prefer to go to a segregation unit than a planned psychological environment. The only notes made for Mr Nykolyn and Prisoner A were in reference to the delay in the move to Long Lartin.
77. On 30 May, an officer recorded that Prisoner B had become very close to Prisoner A and they had been using 'lines' to pass items between their cells. Prisoner B had a random mandatory drugs test (MDT) the next day, which was negative. A security intelligence assessment described Prisoner A as the strongest character in the unit, who could incite other prisoners, in particular Prisoner B, to disengage with staff and to break rules.
78. On 1 June, an officer noted that Prisoner A had been unsettled and frustrated through the week due to the delay in his transfer to Long Lartin.
79. On the afternoon of 4 June 2018, Prisoner B's 'greased up' by covering himself with shaving gel (to make it difficult for staff to restrain him) and he threatened to assault staff with a metal bin. The reason for Prisoner Bs' behaviour was because he had not been given a charger for his vape. Another prisoner loaned Prisoner B his charger and he was locked back into his cell. An officer submitted an intelligence report and a disciplinary hearing was scheduled. No immediate changes were made to Prisoner Bs' unlock and association arrangements.

**5 June 2018**

80. CCTV shows that between 10.00am and 10.28am, Mr Nykolyn, along with Prisoner's A, B and C, were all unlocked for association. They variously spent time speaking to one another, visiting the TV room, making telephone calls and going back and forth between the TV room, the landing and their cells. Each time the prisoners returned to their cells they were locked in again and each time they came out, they were given rub down searches and were checked with a metal detector. These searches detected no inappropriate items.
81. From just before 11.00am, Prisoners A, B and C, were together talking in the TV room. At 11.23am, Prisoner B left the TV room and went to his cell. He came out of his cell a few minutes later and officers again checked him, including checking the sole of his shoes with a metal detector. Prisoner B then returned to the TV room where CCTV shows he removed his shoes and removed a small yellow package which he passed to Prisoner C. Prisoner C placed the package in his pocket. The three prisoners then continued talking.
82. At 11.36am, Mr Nykolyn returned to the TV room and appeared to speak to the other three prisoners. Between 11.41am and 11.46am, all four prisoners returned to their cells. Prisoner B briefly came out of his cell again at 11.51am and was escorted to the laundry room. All four prisoners then remained locked in their cells over lunch.
83. At 1.21pm, an officer visited the cells to ask the prisoners if they wanted to go to the library, but they all declined. At around 1.40pm, Prisoner B pressed his cell bell and asked to go to the library and Prisoners A and C also asked to do so. The three prisoners were unlocked, searched, and escorted to the library. They returned from the library at 2.13pm and returned to their cells. Prisoner B collected bed sheets from the laundry before he returned to his cell.
84. At just before 3.00pm, the prisoners were unlocked for exercise. Officers again conducted rub down searches and checked the prisoners with a metal detector, but found nothing. Prisoner C left his cell with a blue jumper in his hand, which officers did not check. Prisoner B left his cell with a bag which contained a green bed sheet and a yellow blanket. An officer said that she had a 'quick feel of the items', but found nothing: CCTV shows that she did not check the bag thoroughly. Prisoner B placed the bag outside the laundry room and then said he needed to use the toilet so he returned to his cell. He came out of his cell a minute later holding a blue jumper. Another officer carried out a rub down search on Prisoner B and used the metal detector. The officer said that he searched the jumper, but CCTV shows that the search was not thorough.

**The attack on Mr Nykolyn**

85. At 3.02pm, Mr Nykolyn, Prisoners A, B and C went onto the exercise yard, which was accessed by a single width door. The door was locked after the prisoners entered the yard and two officers observed the prisoners from outside as they began to exercise. Mr Nykolyn was walking on his own and did not interact with the other three prisoners.

86. At 3.13pm, CCTV shows that Prisoners A, B and C were standing at the top right-hand corner of the yard relative to the entrance gate, while Mr Nykolyn continued walking alone. As Mr Nykolyn walked past, Prisoner A punched him on his head and Mr Nykolyn fell to the floor face down, apparently unconscious. Prisoner A and B repeatedly kicked Mr Nykolyn's head.
87. As soon as she saw the attack, an officer radioed a general alarm and asked for urgent medical assistance. The alarm was sounded at 3.14pm and an emergency ambulance was called at around the same time.
88. The Deputy Governor, who was the acting Governor on the day, heard the alarm and went to the security department to view the CCTV. He saw Mr Nykolyn on the floor with a lot of blood around his head and that the other prisoners were kicking him. In line with incident management procedures, he went to the command suite as Silver Commander (the tactical commander) and instructed senior managers to attend.
89. The Deputy Governor told the investigator that Woodhill had a local response team (LRT) of 12 specially trained officers to deal with hostage situations. He said that his initial plan was for the LRT to go onto the exercise yard to force the perpetrators away from Mr Nykolyn, using PAVA spray (an incapacitant spray) and dogs if necessary. However, he was then told that the LRT team were only trained to deal with hostage situations within cells. He said that he asked managers to come up with a plan as soon as possible, and using any means, to rescue Mr Nykolyn. He also instructed the control and restraint (C&R) team to get prepared.
90. At 3.15pm, a Custodial Manager (CM A) arrived at the gate of the exercise yard. He was the Orderly Officer (the operational manager in charge of the prison that day) and took on the role of Bronze Commander in charge of the management at the scene. CM A told the investigator that when he arrived, Prisoner A and B were assaulting Mr Nykolyn and Prisoner C was standing near the gate.
91. CM A said that he instructed officers to put on personal protection equipment (PPE), which included leg and arm guards, stab vest, overalls, helmet and shields. CM A said that in a standard C&R situation he would use three members of staff in PPE per prisoner. However, this day he decided that he needed four members of staff in PPE per prisoner, 12 in total, due to the level of violence. He said that initially, he did not have 12 properly trained staff available to enter the yard with PPE, so he called for staff from across the prison. He also said that a dog handler attended with a dog, but he did not feel that one dog was enough to control the situation. He also said that he had not been trained in the use of dogs and did not know whether he had authority to deploy a dog into the yard. (The dog was never used.)
92. CM A said that two other CM's trying to speak to the perpetrators to de-escalate the situation, while he had several brief radio conversations with the Deputy Governor update him. CM A said that the Deputy Governor instructed him to resolve the incident as best he could and said that he did not need to check his plan with him. CM A told the investigator that he had between six to eight staff with him at that point, but he would not allow them to go onto the yard until they had the right number.

93. Prisoner A walked to the gate and told a CM (CM B) that he wanted to talk to a trained negotiator. CM B radioed for negotiators to attend immediately but told Prisoner A that it was going to take time before negotiators could arrive. She asked Prisoner A why they had attacked Mr Nykolyn, and he said it was because the move to Long Lartin had been cancelled.
94. Another CM (CM C) told the police that she tried to talk to Prisoner A, but he said that if officers came onto the yard, they would be hurt. However, when he heard the instruction for officers to put on PPE, he said they would surrender once all the officers were 'in kit'. CM C went to the command suite to brief other managers.
95. The Deputy Governor told the investigator that he was briefed by CM C and was also told that Prisoner A had asked to speak to a negotiator. He said that he would negotiate if possible, but his intention was for officers to intervene as soon as they were ready. He said that he could see on CCTV that the prisoners were continuing to attack Mr Nykolyn.
96. CCTV shows that at different points, Prisoners A, B and C returned to Mr Nykolyn to continue their assault on him. They punched, stamped and kicked him in the head, and Prisoners A and C cut his neck and back with bladed weapons. At a later point, Prisoner B tied a jumper around Mr Nykolyn's neck and pulled at it forcefully and Mr Nykolyn's head repeatedly hit the floor.
97. CM B remained at the gate and repeatedly asked the prisoners to stop the assault and surrender the weapons, but they refused and Prisoner A asked again about speaking to negotiators. CM B said that the negotiators were on their way.
98. More officers arrived and were asked to put on PPE. One of the officers told the police that it took around 10 minutes to put on the PPE. Another officer said that there had only been six or seven stab vests and a third said that he had come to the scene from the segregation unit and then had to return there to get his PPE.
99. At 3.29pm, Prisoner B walked to the gate and spoke to CM B. Prisoner B said that they had been planning the attack for two weeks. CM B asked Prisoner B about the weapons. Prisoner B said they had three weapons, but then said they had two. Prisoner A then came to the gate and CM B asked him to hand over the weapons. He answered they would not do that until they were certain that Mr Nykolyn was dead.
100. The Deputy Governor told the investigator that he became frustrated with the length of time it was taking for officers to respond and to put on PPE equipment. He said though that he later learned that some of the C&R team members had responded to another incident elsewhere in the prison and this had delayed them.
101. At around 3.37pm, CM B persuaded Prisoner A to surrender the weapons and Prisoner B passed them to the officers. The weapons were two 'shanks' (improvised weapons made from razors attached to handles). CM B asked the prisoners to go to one corner of the yard, kneel on the ground and put their hands behind their heads, which they did.
102. CM A told the police that once he had sufficient officers dressed in PPE, he split them into three teams and told them to enter the yard as quickly as possible, with

each team to secure the first prisoner they encountered. CM A said that as they approached the exercise yard gate, he called the command suite to confirm that they were ready to go in and was then told that the prisoners had surrendered their weapons.

103. At 3.42pm, 28 minutes after the alarm was first raised, fourteen officers in PPE went onto the yard: four took hold of Prisoner A, five took hold of Prisoner B, and five took hold of Prisoner C. The prisoners did not resist.
104. At 3.44pm, several healthcare staff went into the yard with paramedics and examined Mr Nykolyn. The Deputy Head of Healthcare, saw two ligatures that were tight around Mr Nykolyn's neck, which she cut off. She started chest compressions and the paramedics attached a machine to provide compressions automatically.
105. At 4.03pm, the paramedics moved Mr Nykolyn from the yard and at 4.17pm, he was taken to hospital by air ambulance. At 4.23pm, Mr Nykolyn was pronounced dead by the air ambulance doctor.

### **Weapons seized during and after the attack**

106. In addition to the two 'shanks' used to attack Mr Nykolyn, the police found two more weapons in the MCBS unit. Both were sharpened metal spikes, one was found in Prisoner A's cell and the other in Prisoner B's cell.

### **Contact with Mr Nykolyn's family**

107. The prison assigned Supervising Officer (SO) as family liaison officer (FLO). Mr Nykolyn's next-of-kin was his partner. Due to the distance to her home, Woodhill contacted HMP Belmarsh to ask for officers to visit her to break the news. At around 9.00pm, Belmarsh contacted Woodhill to say that the address they visited was a multi-occupancy address with many of the occupants working night shifts and that they had not been able to break the news. At around 3.20am on 6 June, police officers were able to break the news. The FLO telephoned Mr Nykolyn's partner at 9.10am to introduce himself and to offer support.
108. Woodhill contributed to the cost of Mr Nykolyn's funeral in line with national instructions.

### **Support for prisoners and staff**

109. After Mr Nykolyn's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
110. The prison posted notices informing other prisoners of Mr Nykolyn's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nykolyn's death.

## **Post-mortem report**

111. The post-mortem examination found that Mr Nykolyn had suffered multiple blunt force and sharp force injuries. The pathologist noted that despite the dramatic nature of the sharp force injuries, there was no damage to any major bodily structure, and he concluded that these injuries played no major part in Mr Nykolyn's death. However, the blunt force injuries, caused by kicks and stamps, had caused severe traumatic brain injury. The pathologist concluded that the mechanism of Mr Nykolyn's death was a combination of traumatic brain injury, and interference of respiratory effort caused by damage to the integrity of the facial structure together with aspiration of blood and vomit blocking his airways (meaning that the injuries to Mr Nykolyn's nose and mouth, and the blood and vomit he had inhaled, prevented him from breathing).
112. Toxicological tests found a therapeutic level of un-prescribed amitriptyline (an antidepressant) in Mr Nykolyn's system.
113. The police confirmed that none of the perpetrators were under the influence of any illicit substances at the time of the attack.

## **Prosecutions of the perpetrators**

114. Prisoners B and C pleaded guilty to murder. Prisoner A pleaded not guilty but was found guilty at trial. Prisoner A was given a 35 year sentence to run concurrently to his existing sentence. Prisoner B received a 10 year consecutive sentence to be added to his existing sentence of 29 years and eight months. Prisoner C was sentenced to a minimum term of 20 years and nine months.
115. The motive for the attack remains unclear, although Prisoner B told the investigator that Mr Nykolyn was 'rude' and had been 'rubbing people up the wrong way'. He also said that he and the other perpetrators had discussed their plan to attack Mr Nykolyn for a week or two.

## Findings

116. The PPO's investigation of a homicide is not a criminal investigation. Our role is to examine the circumstances surrounding the death and establish whether anything can be done to help prevent similar tragedies in the future.
117. Homicides involving prisoners are rare and make up a small proportion of the deaths the PPO investigates. Nine prisoners, including Mr Nykolyn, have been the victims of homicides in prison between the beginning of 2018 and the end of June 2021. In the same period, there have been around 1,160 prisoner deaths from other causes. However, while homicides in prison are uncommon, the killing of those in the care of the state is a particularly shocking and serious matter. At the same time, these are some of the hardest deaths to learn lessons from: prisons contain many people who pose a serious risk of harm to others, but very few kill in custody, and learning can be slow to emerge because the PPO's investigation can only take place once the criminal process has been completed.
118. In this case, Mr Nykolyn was killed in June 2018, more than three years ago. The perpetrators have been convicted and the MCBS unit at Woodhill has closed. Our findings are, therefore, no longer of direct relevance to Woodhill, but we hope that they may be of use to those who manage other central MCBS units. We have looked in particular at risk assessment, security and searching, and the emergency response.

### Could Mr Nykolyn's death have been predicted or prevented?

#### *Location and management of Mr Nykolyn and the perpetrators in the MCBS unit*

119. The MCBS was launched in 2008 to manage men who do not reach the threshold for the CSC system, but who nevertheless require central management because their behaviour is dangerous, disruptive or otherwise particularly challenging.
120. Mr Nykolyn, and the perpetrators, were clearly challenging prisoners. All had a history of serious violence and other behavioural problems. We consider that the decisions to locate each of the four prisoners in a central MCBS unit were appropriate.
121. The MCBS unit provided a supportive environment for Mr Nykolyn and staff devised an appropriate care plan for him which included actions to help him move back to standard location. Mental health staff and psychologists were available to assist Mr Nykolyn if he had wanted to engage with their services. Officers also provided meaningful support: Prisoner B told the investigator that he felt the officers in the unit listened and were helpful.
122. However, it seems that neither Mr Nykolyn nor the perpetrators fully engaged with the services provided. This might in part have been due to the long-term plan to relocate them to Long Lartin and the lack of clarity on when the move would take place, which may have made their stay at Woodhill feel temporary. We also note that the regime at Woodhill was more limited than at other MCBS

units, with prisoners having only around three hours out of cell each day. Prisoner B told the investigator that he would have access to more activities at Long Lartin, such as cookery and workshops, and that one of the reasons he attacked Mr Nykolyn was because he had first been told about a move to Long Lartin and then later told that the move had been delayed. It may be that staff and managers underestimated the unsettling effects of the planned move on prisoners in the unit.

### ***Risk assessments of prisoners***

123. In some of our previous homicide investigations we have found that too little consideration was given to factors that might have made the victim vulnerable to attack, such as their offence or age. In this case we are satisfied that there was nothing about Mr Nykolyn that would have indicated that he was particularly vulnerable.
124. Prisoners in the MCBS unit were divided into two association groups, with Mr Nykolyn and Prisoners A, B and C allocated together. Staff reviewed the association groups and the activities they could attend together at the fortnightly DRAMs where they considered intelligence reports, the unit's observation book and NOMIS records before making decisions on security levels and association.
125. The manager of the MCBS at the time, told the investigator that during his interactions with Mr Nykolyn and the perpetrators they behaved well and respectfully. A CM told the police that he worked with all the prisoners at the MCBS unit and had regular one to one contact with them, and that there was no sign that there was an issue between them. He said Mr Nykolyn and the perpetrators had exercised together in the yard many times without problems.
126. There was one potentially relevant intelligence report made on 6 March, which referred to 'tension' involving Mr Nykolyn and Prisoners A and B. However, it was unclear whether this related to tension within the group, or tension from the group towards staff. Other than this, we have seen nothing to suggest any possible animosity towards Mr Nykolyn and certainly nothing to suggest that the perpetrators were planning to seriously assault him.
127. We note that Prisoner B said that one of the reasons he attacked Mr Nykolyn was that he was 'rude' and 'rubbed people up the wrong way', and there are references to Mr Nykolyn acting strangely in April 2018 (which was attributed to his dental pain or a possible deterioration in his mental health). We accept that there was nothing to indicate to staff that Mr Nykolyn had annoyed the perpetrators before he was attacked. However, if Mr Nykolyn's mental health was deteriorating, he may not have responded normally to the other prisoners.
128. Minor grievances can easily become magnified in a small closed community. Staff in MCBS units therefore need to be especially alert to the possibility that an individual's personality or behaviour may irritate others, particularly given that many prisoners in these units have a history of responding to minor triggers with violence. (We should emphasise that we are not suggesting that the attack on Mr Nykolyn was in any way justified or that it was his own fault.)
129. However, we are concerned that Prisoner B had threatened to assault staff on 4 June, the day before the assault on Mr Nykolyn. This was a serious incident and

staff should have considered its implications on Prisoner B's risk to associate freely and participate normally in the regime the following day. The next DRAM was scheduled for 12 June, but we consider that an assessment of Prisoner B's risk should have taken place immediately.

130. In addition, the DRAMs did not evidence how staff decided on the make-up of the association groups. The risk assessments about exercise were unclear and staff rationale for the decisions they made were not clearly documented. Nor did the DRAMs appear to consistently take account of relevant information about risk, for example Prisoners Bs' threatening behaviour on 1 May was not discussed at the following DRAM.
131. Although we do not consider that staff could have anticipated the events of 5 June, the MCBS unit was made up of prisoners who were difficult to manage and had a history of serious violence, including violence in custody. The MCBS unit did not have the same level of control and separation as a CSC unit, which meant that there was a particular need for more effective and proactive care in the management of the men. There is a constant need in such circumstances to guard against complacency by staff.
132. We recommend:

**Governors should ensure that managers and staff in MCBS units:**

- **are aware that certain personality traits and behaviours may make individual prisoners more vulnerable to assault;**
- **are aware of potential conflicts between individuals; and**
- **record, monitor and manage such issues proactively.**

***Risk assessment of the environment***

133. The association groups exercised together at the Woodhill MCBS unit, although communal exercise did not take place at any other of the central MCBS units. We understand from an internal report that the risk assessment for the exercise yard at Woodhill may have said that no more than two prisoners should be allowed to exercise together at one time. We requested a copy of the exercise yard risk assessment, but Woodhill was unable to locate the document.
134. It is unfortunate that we have not been able to examine Woodhill's risk assessment for ourselves. Even so we are very concerned that Woodhill allowed communal exercise when this was clearly recognised as a danger at other sites. In addition, the risk of prisoner-to-prisoner assault on the exercise yard was compounded by the fact that there was no contingency plan to enable a sufficiently large and properly equipped group of staff to enter the yard quickly if they needed to intervene.
135. We recommend:

**Governors should ensure that association and exercise groups in MCBS units are regularly risk assessed.**

### ***The management of razors***

136. Razors obviously present a risk in prisons, both in terms of self-harm and of assault on others. Prisons therefore need to have measures in place to manage these risks and this is particularly important in the MCBS unit given the proven dangerousness of the prisoners held there.
137. As with all prisons, prisoners at Woodhill purchased razors from the prison shop (known as 'canteen'). We were told that, at the time of Mr Nykolyn's death, staff in the MCBS unit checked prisoners' orders before they were collected and removed the razors from the order. The razors were then kept in the office and officers would issue up to two new razors in exchange for used razors. Officers would check the used razors to ensure the blades were intact before placing them in a sharps bin.
138. Prisoner B told the investigator that around a week before Mr Nykolyn was attacked, staff had given out prison shop orders without removing the razors. He said that, as a result, he received six razors, some of which were used to make the 'shanks' used to attack Mr Nykolyn. Although we cannot be sure if what Prisoner B said was accurate, we make the following recommendation:

**Governors should ensure that safe and appropriate practices are always followed in the supply of razors to prisoners in MCBS units.**

### ***Searches of prisoners***

139. The MCBS unit security policy stated that every time a prisoner left their cell, they should have a rub down search and be searched with a metal detector. We are concerned however that CCTV shows that searches were not always sufficiently thorough.
140. For example, on 5 June, Prisoner B left his cell with a laundry bag, which staff did not check properly, and he later left his cell with a jumper, which again was not properly searched. Prisoner B said that officers did not check laundry bags and that in the days leading up to the attack, the weapons were moved around the unit inside laundry bags. Prisoner B also said that on several occasions he had metallic weapons on his person when leaving his cell which had not been detected.
141. CCTV also clearly shows that just hours before Mr Nykolyn was attacked, Prisoner B removed a package concealed inside his shoe which he handed to Prisoner C in the TV room, although we cannot say whether this was a weapon.
142. In addition, although they were not used in the attack on Mr Nykolyn, sharpened metal spikes were found in the cells of Prisoners A and B after the attack. Prisoner B told the investigator that these were made from shelf dividers taken from the prison library.
143. We are extremely concerned that, despite comprehensive security requirements, Prisoner B and the other perpetrators were able to transport metal objects and razors into and around the unit and onto the exercise yard and to use them in their assault on Mr Nykolyn.

144. We are also very concerned that it appears that other areas of the prison to which MCBS unit prisoners had access, such as the library, had not been risk assessed, and that prisoners were able to bring dangerous items into the unit without being detected.

### ***Cell searches***

145. Prisoner B told the investigator that his cell was not searched while he was at Woodhill. However, Woodhill told us that cells in the MCBS unit were searched once every three months. They told us that Prisoner B's cell was searched twice during 2018: first on 25 January and again on 31 May. This was clearly not compliant with the required frequency of checks.

146. We recommend:

#### **Governors should ensure that:**

- **there is an effective security and searching strategy in place in MCBS units, which reflects the specific risks of the prisoners housed there;**
- **prisoners and cells are searched thoroughly and in line with the local policy; and**
- **measures are in place to guard against staff becoming complacent about security and staff are able to discuss these issues in a safe, non-judgmental and supportive environment.**

### ***Incident management and emergency response***

147. Given the characteristics of the prisoners held in MCBS units, there will always be the possibility of a serious or violent incident occurring, even if all procedures are followed to the letter. When a serious incident does occur, Prison Service Instruction (PSI) 09/2014, *Incident Management*, requires that prisons should have contingency plans in place to ensure incidents are resolved with the minimum of harm to staff, prisoners and the public.
148. The PSI says that the principles that underpin contingency planning include preservation of life and prevention of injury. Incidents such as the attack on Mr Nykolyn must be reported to the Prison Service National Operations Unit and a Gold Commander will be appointed to take strategic control of the incident, while tactical management of the incident is the responsibility of the Silver Commander, the local officer in charge (in this case, the Deputy Governor). The Silver Commander is responsible for developing the tactics necessary to resolve the incident - in other words, to decide what should be done. The Bronze Commander (CM A in this case) is responsible for implementing the tactics set by the Silver Commander.
149. The attack on Mr Nykolyn was rapid and brutal. This was an exceptional situation which required a rapid, robust, coordinated and decisive response from the Silver Commander and from the staff at the exercise yard.

150. We are very concerned that around 32 minutes elapsed between the initial assault on Mr Nykolyn and prison staff entering the exercise yard to help him. During this time the perpetrators continued to kick and stamp on Mr Nykolyn's head. It is possible that Mr Nykolyn suffered unsurvivable injuries during the first few minutes of the attack, and we cannot, therefore say whether the outcome might have been different if staff had entered the yard more quickly. However, it is also possible that Mr Nykolyn's injuries might not have been as severe if staff had intervened sooner.
151. It is unacceptable that the Silver Commander's incident log has been lost. We have been able to establish the broad sequence of events from the interviews conducted by the police and the PPO investigator, but there is no record of the minute by minute events, the decisions taken and the rationale for taking them, or when the Silver Commander finally spoke to the Gold Commander. There is also no record of the contact and discussions between the Deputy Governor and CM A.
152. The Deputy Governor's initial instruction to staff was for the LRT to enter the yard using force, including PAVA, if necessary. However, the LRT were only trained to deal with hostage situations in cells, and of Woodhill's 12 trained LRT members, only three were at Woodhill at the time and two of them were already helping CM A. The local C&R team were asked to attend and put on PPE, but as that was going on, the Deputy Governor explored further options and appears to have left the responsibility for dealing with the incident to CM A without offering him adequate support or guidance. For example, the Deputy Governor asked a dog handler to attend the yard but did not provide any further instructions or guidance to CM A as to how and when to deploy the dog. CM A told the investigator that he had not been trained to use dogs and said that he did not know whether he had any authority to deploy them and so did not do so.
153. PSI 09/2014, lists resources available for use in serious incidents, including PAVA, pyrotechnics and direct use of water. However, the Deputy Governor only contacted the Gold Commander at around the time officers were ready to enter the yard. HE told the investigator that he did not immediately contact the Gold Commander as that would have delayed matters further. However, the Gold Commander's role is to support and assist the Silver Commander to resolve serious incidents. If he had contacted the Gold Commander sooner, they could have discussed the use of PAVA, pyrotechnics and water, as well as the possibility of using dogs.
154. We also consider that the Deputy Governor should have been more proactive in preparing for the use of negotiators at the same time as preparing an intervention by force. Two other CMs found themselves in the position of unofficial negotiators, but without having been trained to act in that capacity. The early use of trained negotiators might have led the perpetrators to surrender earlier.
155. PSI 09/2014 says that the numbers and size of the intervention teams will depend on the circumstances of each incident, but as a general guide three teams of three officers to each prisoner should be enough to control an incident. CM A believed that he needed 12 officers in PPE to intervene (four officers per prisoner). While we understand CM A's concern, it took far too long to get sufficient numbers of C&R trained staff ready and dressed in PPE. The PSI says that during hostage situations or similar, if there is a serious attack on a hostage,

the C&R teams must be prepared for an immediate response. It took around 32 minutes for staff to end the incident and attempt to save Mr Nykolyn's life. We consider that this was an unacceptably long delay. It is clear that Woodhill was not prepared to respond to a major incident in line with national policy. This lack of preparedness makes it all the more concerning that four MCBS unit prisoners were allowed to exercise together. The prison was simply not equipped to deal promptly and robustly with an incident involving so many prisoners in the unit's exercise yard.

156. In the absence of the incident log, we do not know to what extent the Deputy Governor and the CM discussed the various options, including the size of the intervention team and the use of resources, including PAVA, or whether the CM was left to make these critical decisions on his own without support and advice.
157. We acknowledge that the events of 5 June were extremely unusual. However, we consider that the possibility of a serious incident in the exercise yard could have been anticipated and planned for, and that the incident could and should have been handled better. We make the following recommendation:

**Governors should ensure that:**

- **contingency plans are in place for a range of possible incidents in MCBS units;**
- **staff who may be called upon to act as Silver Commanders have received the appropriate training, including refresher training and have a clear understanding of their role.**
- **contingency planning exercises are carried out, in accordance with national and local requirements.**

**The Governor of Woodhill should share this report with the Deputy Governor and CM A and discuss the Ombudsman's findings with them.**

## **Clinical Care**

158. The clinical reviewer reviewed the clinical care provided to all four prisoners to determine if their care was equivalent to that they would have received in the community.
159. She did not have any serious concerns about the physical and mental healthcare provided to the three perpetrators., although she noted that there was no evidence of integrated working or sharing of a single health record between primary and mental health care services.
160. The clinical reviewer was satisfied that there was no evidence that clinicians could have foreseen or prevented the attack on Mr Nykolyn.

## **Mr Nykolyn's clinical care**

161. The clinical reviewer was satisfied that the mental health care provided to Mr Nykolyn at Woodhill was appropriate, but, again, she found no evidence of

integrated working or sharing of a single health record between primary and mental health care services.

162. The clinical reviewer noted that from January 2018 onwards Mr Nykolyn suffered a prolonged period of pain from a dental problem. On 14 March, a hospital dentist diagnosed a dental cyst that required urgent attention. However, there was a considerable delay before Mr Nykolyn received the external dental care he needed as a result of a number of prison management problems, including cancelled appointments due to a lack of escort officers, and on one occasion hospital treatment was not able to go ahead because the escort chain was not long enough. Mr Nykolyn was prescribed strong painkillers and his medical records noted on 18 April that he was in pain and acting bizarrely. Mr Nykolyn's dental problem was finally resolved when he had surgery on 4 May. The clinical reviewer questioned whether Mr Nykolyn's dental pain might have contributed to his bizarre behaviour.

163. We recommend:

**The Governor and Head of Healthcare at Woodhill must ensure that urgent healthcare appointments are not delayed.**

## **Inquest**

164. An inquest into Mr Nykolyn's death held from 20 to 29 September 2021 concluded that he had been unlawfully killed.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100