Neutral Citation Number: [2022] EWHC 3186 (KB) (Admin)

Case No: CO/246/2022

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 December 2022

Before:

LADY JUSTICE SIMLER
MRS JUSTICE FARBEY
HIS HONOUR JUDGE TEAGUE KC
CHIEF CORONER OF ENGLAND AND WALES

- -

Between:
R
On the application of

DIARRA DILLON	**Claimant**
- and -	
HM ASSISTANT CORONER FOR RUTLAND AND NORTH LEICESTERSHIRE	**Defendant**
-and-	
(1) THE MINISTRY OF JUSTICE	
(2) PRACTICE PLUS GROUP	
Interested Parties	

- -
- -

Angelina Nicolaou (instructed by **Simpson Millar LLP**) for the **Claimant**
Jonathan Landau (instructed by **Leicestershire County Council**) for the **Defendant**

Hearing dates: 1 November 2022

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 14 December 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

Lady Justice Simler, Mrs Justice Farbey, HHJ Teague KC:

Introduction

1. This is the judgment of the court to which all its members have contributed.

2. The claimant applies for judicial review of the decision of the defendant ("the Coroner") refusing to make a report for the prevention of future deaths ("PFD report") under para 7 of Schedule 5 to the Coroners and Justice Act 2009 ("the Act"). The Coroner's decision was made on 20 October 2021 during an inquest touching on the death of Eshea Nile Dillon, who was known as Nile. The claimant is Nile's brother. We wish to express our condolences to the claimant and to his family.

Factual background

3. Nile was a prisoner at HMP Stocken in Rutland, a Category C prison. He suffered from asthma and serious allergies. On 24 March 2018 at 5:32 pm, he called for assistance by pressing his cell bell. At 5:33 pm, Prison Officer John Frain attended.

4. When Nile pressed his bell, the prison was in "patrol state", meaning that all prisoners were locked in their cells in the prison's six wings and that only one prison officer was on duty on each wing. The officers on duty would undertake regular patrols of their wing in order to check on prisoners at risk of self-harm or suicide. Patrol state extended from 5:30 pm to 8:45 pm on Fridays, Saturdays and Sundays. Nile's cell was in M Wing where Officer Frain was the officer on patrol. He was responsible during patrol state for all 206 prisoners on M wing.

5. On arrival at Nile's cell, Officer Frain noticed that Nile was experiencing breathing difficulties and struggling to find his inhaler. Officer Frain spoke to Nile through the cell observation panel and gave him some advice. He did not enter the cell because he thought that three prison officers needed to be present before he could do so. He was unaware that he had a discretion to enter a cell without other officers if, in his opinion, there was an immediate risk to life.

6. Officer Frain radioed Custodial Manager ("CM") Vincent Brame and said that Nile was struggling to breathe. He asked if he could enter Nile's cell but was told not to do so as other officers were on their way. Approximately 8 minutes later, CM Brame arrived with other officers who entered the cell. At 5:40 pm, a "Code Blue" was called to all other prison officers by radio which signalled a medical emergency, and triggered an ambulance being called. Further officers responded. CPR was commenced.

7. Of the officers who initially entered the cell, only Custodial Manager Brame had first aid training and it appears that Nile was not placed in the correct position for CPR. Officer Jade Mitchell attended at the same time as Custodial Manager Brame and had first aid training but she was tasked not with administering the CPR itself but with keeping a CPR log.

8. At 5:44 pm, the incident was logged by East Midlands Ambulance Service. At 6:00 pm, an ambulance arrived at the prison. At 6:04 pm, a second ambulance arrived. At

6:15 pm, a doctor entered the prison and was taken to Nile. Tragically, just under an hour later, Nile was pronounced dead.

9. In September 2018, the Acting Prison and Probation Ombudsman Elizabeth Moody ("the PPO") published a report of her independent investigation into Nile's death. In relation to his clinical care, she observed:

> "The clinical reviewer concluded that the care that Mr Dillon received at Stocken was equivalent to that which he could have expected to receive in the community. He noted that although Mr Dillon did not use his prescribed dipropionate inhaler, did not attend all his asthma reviews and had a poor inhaler technique, the healthcare that he received for asthma and eczema appear to have been delivered well and in line with national guidelines."

10. In considering the prison's emergency response, she concluded:

> "When the officer answered Mr Dillon's cell bell and saw that he had breathing difficulties, he radioed for assistance and called the custodial manager but should also have called a medical emergency code blue. Not using a medical emergency code meant that an ambulance was not called immediately and staff were not sufficiently aware of the serious nature of the incident to enable them to respond appropriately…
>
> The Governor should ensure that staff are given clear guidance and understand the circumstances in which they should go into a cell during patrol state and radio a medical emergency code."

11. An inquest before the Coroner and a jury took place from 18 October to 20 October 2021. It proceeded on the basis that article 2 of the European Convention on Human Rights was engaged. Ms Angelina Nicolaou appeared for Nile's family as she appears for the claimant before us. She was able to examine the witnesses and make submissions to the Coroner.

12. The jury returned a narrative conclusion which we need not set out in full. The jury noted that propranolol was found in Nile's blood at the lower end of the therapeutic level. Propranolol is contra-indicated in asthma sufferers. However, reflecting the pathologist's evidence in the case, the medical cause of death was unascertained and the jury found that any delay by prison officers in the commencement of CPR "did not affect the outcome for Nile."

13. On the final day of the inquest, in the absence of the jury, the Coroner heard detailed oral evidence on matters relating to whether she should make a PFD report. She heard evidence from Ms Louise Binns (Head of Safer Prisons and Equalities within the Prison Service) who had also given evidence to the jury. She heard from Ms Jenny Poole who worked for the Practice Plus Group ("PPG"), the company that provided healthcare services at HMP Stocken. The Coroner had already heard from other witnesses - who had given evidence to the jury over more than two days - about the circumstances of Nile's death and the prison regime.

14. As we have observed, the jury did not conclude that anything done (or not done) by prison officers contributed to Nile's death, but there was no legal bar to the Coroner making a PFD report if satisfied that the relevant circumstances justified it. The following aspects of the evidence before the Coroner are material to her decision not to do so.

Staff understanding of emergency procedures

15. It is common ground that any prison officer at HMP Stocken had a discretion to enter a cell on his or her own if, in the officer's opinion, there was an immediate risk to life. As we have mentioned, the Coroner heard evidence that Officer Frain did not appreciate that he had any discretion to enter Nile's cell. He did not send out an immediate Code Blue, preferring to contact a superior officer (CM Brame) when he saw that Nile was struggling to breathe. At the time of Nile's death, there was no system of spot checks on prison officers undertaking patrol state duty in order to check their understanding of emergency procedures. By contrast, spot checks were carried out during night duty.

Healthcare provision

16. The Coroner heard evidence that the prison healthcare department would close at 5:00 pm on Fridays, Saturdays and Sundays and would therefore be closed during the hours of patrol state on those days. Ms Poole gave evidence that contractual arrangements with NHS England for healthcare at HMP Stocken did not provide for 24 hour cover. Those arrangements could not be changed because NHS England was responsible for contractual arrangements at a national level.

First aid training for prison officers

17. The officers assigned to patrol state duty in each wing would not necessarily be trained in first aid. If an emergency arose, an officer would call for response staff from other wings, some of whom would be first aid trained. A CM, trained in first aid, would also respond.

18. During night hours (8:45 pm to 7:00 am), a different system was in place. A single officer would be on duty in each wing at Operational Support Grade ("OSG") who would be trained in first aid. The rationale for providing an OSG officer at night was that the prison healthcare department was not available to provide medical care during night hours.

19. First aid training was part of the entry level training requirements for new prison officers but longstanding officers on patrol duty would not have been trained. There was discussion before us about whether officers trained in first aid received refresher training or re-training after a fixed period of time. Some of the evidence before the Coroner on this, as on other topics, was imprecise. The court was asked to spend considerable time during the hearing perusing the records of oral evidence given to the Coroner in order for the parties to impress upon us its meaning and effect from their contrasting perspectives. We do not regard judicial review proceedings as a forum for dissecting witness evidence. The assessment of evidence was the task of the Coroner.

20. In relation to refresher training, the Coroner was able to consider the PPO's report. As set out in that report, there was clear evidence before the PPO that refresher training was offered. We are not persuaded that any of the evidence that the Coroner heard was inconsistent with the evidence before the PPO.

21. CM Brame told the Coroner that he received a "first-aid certificate refresher every couple of years." He added: "that doesn't make me a doctor or a nurse." Ms Poole said that prison officers trained in first aid could not be mandated to apply CPR or other first aid techniques because they were not qualified health professionals and so were in the same position as a member of the public in the community.

Reaching prisoners in emergencies

22. The Coroner heard evidence about the size of the prison. CM Brame said:

> "Stocken is very, very spread out. From the front gate to the furthest-away wing now, I would say it's probably about three quarters of a mile through some corridors, etc."

23. CM Brame said that, in response to Officer Frain's call, he had run to M Wing with another officer from the "Centre" which had taken about 5 minutes. The Centre was an administrative centre that was not physically located at the centre of the prison. Time spent unlocking gates into and within M Wing had further slowed down their arrival at Nile's cell.

24. According to other officers on duty at the time, it took 1.5 minutes to go from H Wing to M Wing and no more than a minute to go from F Wing to M Wing.

The Coroner's decision

25. Having heard all the evidence, the Coroner considered the lack of spot checks during patrol state. She discussed the situation with Counsel who appeared for the Ministry of Justice (Mr Andrew Wright) and with Ms Nicolaou. She observed that "it would not take an awful lot" to expand spot checks from night state to patrol state. Such checks would provide an opportunity to address staff understanding of emergency procedures and the circumstances in which a cell could be entered. She said that she did not sense any resistance from Ms Binns on that, and was not minded to write a PFD report but that the prison should write to her within 56 days to let her "know the outcome of the situation." She said that if no good reason were offered within that timeframe for not introducing spot checks, she would be minded to issue a report.

26. The Coroner went on to consider whether to make a PFD report in relation to first aid training. She observed:

> "in terms of other changes made, it is clear to me that changes have been made and that work is ongoing. The first aid issue is very difficult. I have been mulling over as everyone has been talking. I don't have power to enforce first aid training because it is a national issue. If Stocken were telling me they won't train their staff then I could revisit that. I am reassured that the new prison officers are being first aid trained. It will be a

> matter of time before every prison officer is first aid trained. I have listened to Ms Binns saying she would like every officer to be first aid trained and I will leave that with her to send that message back."

27. In relation to 24 hour healthcare, she observed:

> "…with 24 hour healthcare it's not within my gift to say to NHS they must allow 24 hour prisons. I am encouraged that most people seem to be of the view that it is helpful and feeding it back. If it would help in anyway at all, I am content for my comments to be taken back as well. But I can't do anything to enforce that. Happy for my comments to be taken to those groups if that would help."

28. Having made those observations, she heard submissions from Ms Nicolaou and then proceeded to give a short, ex tempore decision:

> "the risk I see is that there are staff carrying out patrols and have responsibility in patrol state and who may not understand codes and understand when it is right to enter cell. That can be dealt with quickly and easily to resolve. I think we're talking ideal world scenarios having everyone first aid trained and 24 hour healthcare. I don't think it meets the PFD threshold. There are first aid trained people in prison and so if code blue is called promptly then first aid will be available. I am content that I can quite safely and properly ask for spot checks to be done in patrol state so they can understand when they need to go into the cells and call for help."

29. The jury then returned and the inquest came to an end with the conclusion that we have indicated.

Post-inquest developments

30. On 21 October 2021, the claimant's solicitors sent written representations to the Coroner on the need for a PFD report in relation to the lack of healthcare after 5:00 pm and the lack of first aid training for officers on duty during patrol state. On 25 October 2021, the Coroner responded to the effect that she had no jurisdiction to reconsider the matter as the inquest had ended.

31. On 29 November 2021, the solicitors wrote to the Coroner requesting detailed reasons for her decision not to issue a PFD report. By letter dated 2 December 2021, the Coroner refused to give further reasons and restated that she had no power to change her decision not to make a PFD report because the inquest had concluded.

32. On 2 December 2021, the Ministry of Justice sent a written submission to the Coroner on behalf of HMP Stocken confirming that spot checks on patrol state were to commence in January 2022. Random checks would cover officers' understanding of emergency codes and their understanding about entering cells during an emergency following completion of a dynamic risk assessment.

33. The Ministry of Justice submission went on to explain that HMP Stocken had introduced a "Compact" called "Medical Emergency Response: Guidance for Staff 2021." The Compact provided guidance on the use of emergency codes, such as Code Blue, and on entering cells during an emergency. All staff to whom it was relevant would have to sign and date the Compact on an annual basis to record having received and understood its terms.

34. The Compact emphasised the need for an immediate response to emergencies. It set out - in clear and simple terms - that staff may enter a cell on their own, subject to risk assessment:

> "Under normal circumstances, staff should not enter an occupied cell on their own. However, the preservation of life is paramount, and in situations in which life is endangered (e.g. a prisoner appears to be hanging or in danger), staff can open and enter cells on their own, but only where they have made a dynamic risk assessment and believe that it is safe to do so, and after informing the control room.
>
> If it is assessed as safe to enter the cell, then staff must do so immediately. If it is assessed as not safe to do so, then the member of staff must summon for assistance immediately. If appropriate to do so, then a code red or blue should be called which will call for immediate local healthcare response and inform the emergency services."

The claim for judicial review

35. The present claim was launched on 19 January 2022. The Coroner sought to provide further explanations and reasons for her decision in pre-claim correspondence and in her witness statements. She has however accepted before us that the court should not take these post-decision reasons into account but should judge her decision on the reasons that she gave at the time. She has also now accepted that there is no hard line at which a Coroner may no longer issue a PFD report and that she was in error by asserting that she could not do so after the inquest had ended.

36. The claimant advanced two grounds for judicial review. Under Ground 1, Ms Nicolaou submitted that the Coroner was irrational to conclude that the threshold for making a PFD report had not been met. Under Ground 2, she submitted that the Coroner erred in her approach by fettering her discretion and misapplying the law.

Legal framework

37. Para 7 of Schedule 5 to the Act provides:

> "(1) Where—"
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will

> occur, or will continue to exist, in the future, and
>
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action."

38. On the plain wording of para 7, a Coroner is under a duty to issue a PFD report ("must report") if the statutory criteria are met. There are two important criteria. First, there must be a concern (arising from the investigation) that circumstances creating a risk of other deaths will occur or continue in the future. Secondly, and significantly for present purposes, the Coroner should have formed the opinion that "action should be taken" to prevent the occurrence or continuation of the circumstances creating a risk of death, or to reduce future deaths created by those circumstances. In relation to the second criterion, there is a significant subjective element. The coroner must act rationally in coming to the opinion held, but different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case.

39. Para 7 goes on to provide:

> "(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
>
> (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

40. Regulation 28 of the Coroners (Investigations) Regulations 2013 makes procedural provisions for PFD reports:

> "(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation."
>
> (4) The coroner—
>
> (a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
>
> (b) must send a copy of the report to the appropriate Local Safeguarding Children Board or as the case may be the appropriate Safeguarding Children Board…where the coroner believes the deceased was under the age of 18; and
>
> (c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.

> (5) On receipt of a report the Chief Coroner may—
>
> (a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
>
> (b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest."

41. Guidance to Coroners in relation to PFD reports has been issued by the Chief Coroner (Revised Guidance No 5; last revised on 4 December 2020). It makes plain (at para 7) that:

> "In considering whether they are under a duty to make a PFD report, coroners should focus on the current position. This will normally be the position at the end of the inquest unless, unusually, consideration is being given to making a PFD report before the resumed inquest. Coroners should consider evidence and information about relevant changes made since the death or plans to implement such changes."

42. Para 7 of the Guidance goes on to say that if a potential PFD recipient has already implemented appropriate action to address the risk of future fatalities, the coroner may not need to make a report. Whether a coroner needs to do so or not is a judicial decision for the coroner to make on a case by case basis taking into consideration all the circumstances. However, a report to a relevant national organisation to highlight the issues more widely may still be appropriate provided the evidence suggests that the risk of future fatalities may arise nationally.

43. It is well-established that PFD reports are ancillary to a coronial investigation, the primary purpose of which is to consider the death of a particular person and to ascertain who the deceased was and how, when and where the deceased came by his or her death. PFD reports do not concern the rights of any person appearing at an inquest and no person has a right to be heard or to call any evidence that relates only to whether a report should be made. As reflected in the Chief Coroner's Guidance, para 16, coroners may hear and give weight to representations by interested persons at the inquest "as they see fit" (see, to this effect, *R (Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1593, Garnham J at [94] to [96]).

44. As specialist decision-makers, coroners can be expected to be familiar with the Chief Coroner's Guidance. The failure to refer to the Guidance or give a reasoned decision by reference to it will not in itself constitute a reviewable error of law.

45. Rule 20 of the Prison Rules 1999 (made under section 47 of the Prisons Act 1952) provides:

> "1) The governor must work in partnership with local health care providers to secure the provision to prisoners of access to the same quality and range of services as the general public receives from the National Health Service."

46. The effect of this Rule is that prisoners must be provided with healthcare that is equivalent to NHS healthcare services in the community.

Ground 1: irrationality

The claimant's submissions

47. Ms Nicolaou submitted that the Coroner's refusal to make a PFD report was irrational. Officers on patrol state duty had sole responsibility for over 200 prisoners without the resources of the healthcare department to call upon in an emergency. The evidence before the Coroner had been that, while new officers received first aid training, some longstanding officers on patrol state duty were either not trained or had received no refresher training. It followed that there was a gap in the provision of emergency healthcare for prisoners because the primary and immediate source of emergency cover during patrol state might be an officer with no first aid training.

48. Ms Nicolaou submitted that the Coroner had considered the evolving or future position in which all new staff received first aid training whereas she ought to have considered the position that was current at the time of the inquest in accordance with para 7 of the Chief Coroner's Guidance (cited above). She had failed to take into consideration that some longstanding officers continued to work as patrol officers without first aid training and that there was no refresher training for those longstanding officers who had been trained.

49. The same rationale should apply to the deployment of patrol officers as applied to officers on night duty: in the absence of other on-site healthcare provision during patrol hours, officers on duty should all be trained in first aid. The absence of training for all staff on patrol state duty plainly gave rise to a risk to life in a fast-paced emergency situation and met the criteria for a PFD report.

50. The Coroner's attempts to bolster her decision with ex post facto reasons demonstrated that she had had regard to irrelevant considerations, failed to have regard to materially relevant considerations and needed to paper over the cracks in the inadequate reasons that she had given when refusing to make a report.

The Coroner's submissions

51. On behalf of the Coroner, Mr Jonathan Landau submitted that the Coroner's refusal to make a PFD could not be impeached on public law grounds. She had taken appropriate action in relation to officers' understanding of emergency procedures which the Ministry of Justice and the prison had heeded. She heard and considered evidence on the availability of first aiders and had reached conclusions on the evidence that were reasonable. On the question of 24 hour healthcare, she was aware of the PPO's observation that Nile had received care in the prison that was equivalent to that which he could have expected to receive in the community. There was no duty on the prison to provide superior healthcare to that provided by the NHS in the community (Rule 20(1) of the Prison Rules, above).

52. Even if there was a residual risk of future deaths, the question as to whether remedial action should be taken to reduce or eliminate the risk was expressly entrusted by Parliament to the opinion of the Coroner. She had been entitled to take into

consideration resource constraints and not to make a report on purely ideal world scenarios.

Discussion

53. In our judgment, the Coroner was entitled to conclude that there was no need for action to be taken to prevent future deaths and that the threshold for a PFD report was not met.

54. In relation to first aid training of patrol staff, the Coroner heard evidence that the turnover rate of prison officers at HMP Stocken is high, and accordingly most officers within the prison were relatively new. It follows that, by the time of the inquest, most officers would have been trained in first aid and that the proportion of untrained officers on patrol duty would continue to decrease as other new staff joined. Although the Coroner described first aid training for all staff as being an "ideal scenario", her decision did not hinge on that description.

55. The evidence before the Coroner was that a Code Blue would be heard by all prison staff so that response staff would know that they should attend an emergency. Every wing dispatched one responder who would have been trained in first aid. We accept Mr Landau's submission that it was therefore likely that sufficient trained staff from across the six wings would attend, as well as a trained CM. The Coroner's conclusion was that, if a Code Blue were called promptly, first aid would be available. On the evidence before her, she was entitled to reach that conclusion.

56. Ms Nicolaou emphasised that the response in Nile's case had taken at least 8 minutes (from 5:32 pm when Officer Frain attended until 5:40 pm when the Code Blue was called). During that time, there was no trained officer with him. However, the Coroner heard evidence that, although CM Brame ran to M Wing from the Centre, which took 5 minutes, the response officers from the other wings were nearer and could get there more quickly. As we have set out above, the evidence was that it took 1.5 minutes to go from H Wing to M Wing and no more than a minute to go from F Wing to M Wing. Ms Poole confirmed that by the time that staff entered a cell in an emergency, there would be someone there with first aid training.

57. The Coroner was entitled to take the view that, in considering the question of whether action should be taken to eliminate or reduce the risk of death, first aid training need not and should not be considered in isolation. Although her reasons are brief and do not expressly set out the statutory threshold, her decision demonstrates that she had the correct threshold in mind. She was entitled to conclude that the key issue was not whether every patrol officer had first aid training but whether the prison's emergency response as a whole was adequate.

58. In considering the adequacy of emergency procedures as a whole, the Coroner was in our judgment entitled to regard the proper understanding of when to call a Code Blue as critical. Calling a Code Blue is a call for urgent help and should lead to an immediate response from prison staff and to urgent contact with the Ambulance Service. We accept Mr Landau's submission that, if the Code Blue had been called earlier, first aid trained staff would (on the evidence before the Coroner) have arrived at Nile's cell within 1 or 2 minutes rather than 8 minutes.

59. We are not persuaded that that timeframe would lead to delay in emergency treatment that would be materially longer than in the community or that the test of equivalence in Rule 20 of the Prison Rules would not be met. We agree too with Mr Landau that a rapid response time of 1 or 2 minutes means that the difference between the night regime and the patrol state regime within the prison becomes immaterial.

60. The Coroner also expressed her concern about staff understanding of their discretion to enter a cell without other officers being present. She took action by seeking a response from the prison both in relation to Code Blue and in relation to entering cells. She recommended spot checks. In our judgment, it was open to the Coroner to take such a course.

61. The Coroner knew that the Prison Service would support spot checks because Ms Binns had said so on its behalf in her evidence. The Prison Service's "commitment to take action" was a factor that the Coroner was entitled to weigh in deciding that the formality of a PFD report was not needed (see para 7 of the Chief Coroner's Guidance, above).

62. The Ministry of Justice's response demonstrated that steps had been taken to address the risk of future deaths by the introduction of spot checks and a new Compact. The Chief Coroner's Guidance makes clear that if a potential PFD recipient has already implemented appropriate action, the Coroner may not need to make a report. In our judgment, the Coroner was entitled to regard the spot checks and the Compact as an appropriate response obviating the need for a PFD report.

63. Ms Nicolaou drew our attention to a number of other passages in the evidence which in her submission demonstrated that the Coroner was irrational not to make a PFD report. She drew attention to the risk of error brought about by untrained officers administering CPR either because no trained officers were available to respond to a Code Blue or because there would not be time in an emergency for the officers to work out to any degree of coherence who was best placed among the responders to provide emergency first aid. The risk of an incoherent approach was exemplified by the fact that in Nile's case the officer with the most recent training was tasked with making a log.

64. In our judgment, these criticisms are variants of the same theme, namely that it was critical for all prison officers to be trained in first aid to eliminate a risk of death as at the time of the inquest. For the reasons set out above, we are not persuaded that the question of first aid training should be assessed in isolation from emergency procedures as a whole.

65. In our judgment, the views expressed in the Coroner's witness statements and other documentation post-dating her decision amount effectively to fuller (and better phrased) reasons but are not inconsistent with the reasons that she expressed when delivering her decision. We do not regard them as capable of casting doubt on the reasons expressed at the hearing or as suggesting that the decision is flawed on public law grounds.

66. For these reasons, Ground 1 fails.

Ground 2: errors of approach

The claimant's submissions

67. Ms Nicolaou submitted that the Coroner had misunderstood the nature of her statutory powers and had erred in her approach to their exercise. She had taken into consideration that it was not in her gift to enforce 24 hour healthcare when it was irrelevant that she had no powers of enforcement. She had given weight to the resource implications of 24 hour healthcare which were not for the Coroner to assess. She had erroneously concluded that she could not make a report relating to a national rather than local issue.

The Coroner's submissions

68. Mr Landau submitted that the Coroner's decision did not rest or depend on any of the matters raised by Ms Nicolaou under this ground of challenge. There was a clear distinction between the Coroner's discussions with Counsel – when these matters were raised – and her decision. Although the Coroner's decision was brief, it did not reveal any error of approach. It was open to the Coroner to consider whether action should be taken by reference to actual resource constraints rather than by reference to ideal scenarios. There was little to no evidence of the national picture so that a report dealing with national issues was not justified.

Discussion

69. With the benefit of the hindsight that this court has, we regard the Coroner's remarks about her lack of enforcement powers as infelicitous as they were liable to confuse. However, they were made in the context of a fast moving hearing. They concerned an ancillary issue on which the Coroner was not bound to adopt any particular procedure or to hear any evidence or submissions at all.

70. Although Ms Nicolaou tried to persuade us otherwise, the remarks about enforcement were part of the Coroner's discussions with Counsel and did not form part of her decision. We do not think that the remarks should be implied or imported into her decision or that they undermine the reasoning in her decision. We agree with Mr Landau that the Coroner's decision did not depend on any of the matters raised by Ms Nicolaou under this ground of challenge. Her decision is entirely explicable by reference to the remedial measures either implemented or to be implemented which together reduced the risk of future deaths.

71. We are not persuaded that the Coroner's reluctance to engage with what she regarded as "ideal world scenarios" was wrong or that resourcing issues were irrelevant in any event. The Coroner must by statute form an opinion as to whether "action should be taken" to prevent future deaths. In our judgment, these statutory words are sufficiently broad to entitle a coroner to consider what can practically be achieved – otherwise there is no real or actual action that could or should be taken. The PFD procedure would be thwarted if coroners, who are entrusted by Parliament to take sensitive and difficult decisions, did not regard the procedure as being a realistic one.

72. We would endorse the Chief Coroner's Guidance, para 4, which states that PFD reports should (among other things) be meaningful and, wherever possible, designed to have practical effect. On this basis, it is open to a coroner to take into consideration whether there is any realistic prospect, including on resource grounds,

that a PFD report will be acted upon by its recipient. In any event, resource considerations were not in this case central to the Coroner's decision.

73. We are in no doubt that the Coroner was not under a duty to make a PFD report about national provision of healthcare in prisons because there was a paucity of evidence before her about risks at the national level.

74. We do not think that Ground 2 adds anything of substance to the claim. We dismiss it.

Conclusion

75. Accordingly, while we are grateful to Ms Nicolaou for her well-argued and helpful submissions, this claim is dismissed. The Coroner's decision was a lawful one.