ONE PUMP COURT

Barrister

ANGELINA NICOLAOU

Email: an@onepumpcourt.co.uk

Call: 2015

Specialist in

Personal Immigration
Prison Law
Public Law
Civil Law
Civil Actions Against Public Authorities
Inquests & Public Inquiries Team

Experience

Angelina specialises in immigration law, inquests and inquiries, civil actions against public bodies (including the police, prison services and the Home Office), domestic and international human rights law and universal jurisdiction/international criminal law.

She has established experience of representing vulnerable clients with a history of trauma in cases of a particularly sensitive nature.

Inquests/Inquiries

Angelina has been ranked Tier 5 by Legal 500, and 'Up and Coming' by Chambers & Partners in the 2025 Inquests and Public Inquiries category.

Angelina is currently instructed as First Junior representing the Non-Police, Non-State Cooperating Group of the Undercover Policing Inquiry. She is led by Kirsten Heaven.

Previously Angelina was seconded part-time to assist Hickman and Rose Solicitors as part of 'Team 1' representing the bereaved, survivors and residents (BSRs) in both Phase 1 and Phase 2 of the Grenfell Tower Inquiry and the related civil claims.

Angelina also represents families in both Article 2 and non-Article 2 inquests, ranging from deaths following contact with the police, mental health services and social services as well as deaths occurring in custodial settings. She has successfully represented families in associated civil claims for damages arising out of deaths involving a breach of the deceased's Article 2 'right to life'. Angelina also is instructed on public law challenges arising from Coronial decisions.

Immigration

Angelina is ranked Tier 4 in Immigration by Legal 500. She is regularly instructed on a number of immigration matters, in both the First-Tier Tribunal and Upper Tribunal Immigration and Asylum Chambers. She is frequently instructed in asylum (including trafficking claims), deportation and human rights appeals. She regularly represents immigration detainees in bail hearings and has a particular interest in false imprisonment civil claims arising from immigration detention. Angelina has experience using intermediaries in the context of immigration tribunal hearings for clients with communication or processing issues.

Notable cases include:

- AAA & Ors Junior in the 'Rwanda policy' litigation representing one of the 15 linked Claimants in the challenge to an inadmissibility decision pursuant to the Migration and Economic Development Partnership ('MEDP') with Rwanda. Led by Richard Drabble KC and Leonie Hirst in the proceedings heard in the Divisional Court, Court of Appeal and Supreme Court.

- FXJ v SSHD [2023] EWCA Civ 1357 appeal relating to the circumstances giving rise to a duty of care on the part of public authorities (in the context of immigration decision making). Led by David Chirico
- AXB v SSHD (Art 3 health: obligations; suicide) [2019] UKUT 397 (IAC): Represented the Appellant in a reported case providing guidance on the procedural duty under Article 3 ECHR in 'medical' cases. Led by David Chirico

Prison

Angelina is part of the One Pump Court Prison team, and contributed to the drafting of Section 4 of The Prisons Handbook for the 21st, 22nd and 23rd editions of this publication (2019-2021).

International Law

Angelina accepts instructions to advise in cases concerning matters of Universal Jurisdiction for war crimes or crimes against humanity. She has also advised on or prepared individual communications/submissions to the United Nations Human Rights Council (OHCHR) and the United Nations Working Group on Arbitrary Detention (UNWGAD)

Angelina sits on the Executive Committee for the charity Lawyers for Palestinian Human Rights. In this role she has contributed to the submission of various urgent action letters to the UK government, as well as a submission to the UN Commission of Inquiry on the 2018 Gaza Protests, and LPHR's submission to UN Special Rapporteur Michael Lynk on accountability in the oPt.

What the directories say

Legal 500 Tier 4 in Immigration; Tier 5 Inquest and Inquiries:

"Angelina has excellent analytical skills and thinks strategically. She is very reliable and very good with clients"

"Angelina is a strong advocate but also takes a subtle and gentle approach where required"

'Up and Coming' – Chambers & Partners Inquests and Public Inquiries:

"She is really able to uncover all the evidence, and use it to uncover failings and neglect"

"She quickly picks up the key issues and keeps us focused throughout the inquest process"

"Angelina has got great client care, and she is a good advocate"

"She is really into the detail and very hands-on"

"Angelina explains things to the client well"

"Angelina provides thorough advice"

Education

BPTC – BPP Law School (Very Competent)

LL.M – United Nations Interregional Crime & Justice Research Institute (108/110)

LL.B – The University of Manchester (1st Class (Hons))

Memberships

Lawyers for Palestinian Human Rights

Communities Empowerment Network

INQUEST Lawyers Group

Police Actions Lawyers Group
Refugee Legal Group
Young Legal Aid Lawyers
Immigration Law Practitioners' Association
Bar Human Rights Committee of England and Wales
Constitutional and Administrative Law Association (ALBA)

Awards

RG Lawson Award – The University of Manchester
BPP Entrance Award
Inner Temple Exhibition Award
Inner Temple Duke of Edinburgh Award

CASES

Inquest jury finds that insufficient access to mental health services and lack of information sharing at prison led to prisoner's death at HMP Lewes

Following an inquest held by HMSC King at East Sussex Coroner's Court, a jury concluded that the deceased died by suicide and found that the circumstances that led to the death included "insufficient access to and management of mental health services", and "a lack of information between prison staff in relation to potential risk" at HMP Lewes.
The jury found that (among other factors), the following contributed or led to the deceased's death:

- The deceased's relationship with inmates (including a prison debt)
- Reports to the deceased's mother regarding his safety stating that a bounty of £3000 had been placed on him
- The deceased's request not to be moved to another wing had been decline
- The deceased's request for medication had been refused
- The length of time the deceased was waiting for a mental health review

The inquest heard of widespread changes that have been made to practices within the prison healthcare to improve information sharing, training ensure a trauma informed approach to mental healthcare, and clinical supervision of healthcare staff. Similarly, HMP Lewes has implemented system changes, including the creation of "safety and security" representatives on the wings to ensure improved information sharing, and the requirement for 'handovers' to take place upon every wing move.
Angelina was instructed by Alice Helm at Irwin Mitchell solicitors.

Area of Law:

Inquests & Public Inquiries Team

Related Barristers:

Angelina Nicolaou

INQUEST INTO THE DEATH OF ALAN DAVIES

On 15 March 2024, after a three-week inquest into the death of Alan Davies, a jury returned a conclusion with critical findings, including a neglect rider.

Mr Davies was in HMP Cardiff when he died in September 2021. The jury heard evidence that he had undergone a period of food and fluid refusal prior to his transfer into prison from a previous clinic, and continued to deteriorate whilst in prison. A clinical decision to send Mr Davies to hospital on 10th September 2021 was reversed on the basis of an apparent misunderstanding about the length of time he had been refusing food, which came about during the course of discussions about staffing levels at the prison which would be impacted by the hospital transfer. The nursing and healthcare staff responsible for monitoring Mr Davies over the weekend of 11-12th September were not aware of anything in particular to look out for in respect of his presentation. Despite being on hourly observations, and in a cell with a CCTV camera, Mr Davies was not given emergency medical attention or taken to hospital in the early hours of 12th September 2021, despite laying unclothed on the floor for a number of hours. At times whilst on the floor he was asking for help and trying to get attention by various means including banging things, slapping his body and waving in his cell. Footage shows that during this time Mr Davies was told to cover himself up and put himself back into bed.

The jury found:

- Mr Davies died from an equal combination of misadventure, self-neglect and neglect.
- Mr Davies contributed to his death by deliberately refusing food and fluid, but he did not intend to end his life. It was an unintended consequence of such refusal.
- There were missed opportunities regarding the transfer of Mr Davies to hospital.
- The management, co-ordination and planning, including the handover of information within the prison and healthcare was unsatisfactory.
- The level and adequacy of observations was insufficient in noticing Mr Davies signs of deterioration.
- The events between the 10th and 12th of September were highly unacceptable.

The Coroner indicated at the end of the hearing that he would be issuing a Preventing Future Deaths report to Cardiff & Vale University Health Board, HMP Cardiff and Swansea Bay University Health Board. The PFD report can be found here.

The family of Mr Davies was represented by Angelina Nicolaou, instructed by Craig Court and Kay Evans of Harding Evans.

Related Barristers:

Angelina Nicolaou

Inquest into the death of Eshea Nile Dillon

Nile was just 22 when he died at HMP Stocken in the East Midlands. He had severe asthma and had called for help as he was locked in his cell and struggling to breathe. There was an 8-minute delay in providing an emergency response.

The medical cause of Nile's death was unascertained and the jury delivered an open conclusion, finding that:

- Staff had missed the opportunity to call the emergency 'code blue' as soon as it was observed that Nile was struggling to breathe and undoubtedly when he was seen to fall unconscious
- The prison officer in attendance was unaware of their discretion to call a 'code blue' without referring to supervisors. He did not exercise this discretion.
- The prison officer in attendance was unaware of their discretion to enter a cell without fellow officers if, in his opinion, there was an immediate risk to life. He did not exercise this discretion.
- From the commencement of CPR until Nile received treatment from the ambulance crew Nile was not given any oxygen.

During the course of evidence on 'Preventing Future Deaths', the Prison confirmed that new 'spot checks' had been instigated during night patrol states where Supervisors would visit prison officers on duty and remind them of their training in respect of Code Blue and Cell Entry procedures. The prison appeared to accept that it was reasonable that such spot checks should also be undertaken during the 'patrol state' shift (which is the shift which was in place when Nile first called for help).

HMAC Tanyka Rawden indicated that the Prison would have 56 days to confirm whether the practice of spot checks would be expanded in this manner, and if not, to provide 'good reasons' for a decision not to implement that change. A Regulation 28 report may be considered at that juncture depending on the outcome of that correspondence.

Area of Law:

Public Law, Civil Law

Related Barristers:

Angelina Nicolaou

Inquest into the death of Tariq Dalton

Angelina Nicolaou, instructed by Duncan Lewis Solicitors represented the family of Tariq Dalton at the inquest at Surrey Coroner's Court between 15 March – 15 April 2021. The inquest involved 8 interested persons.

Tariq Dalton died of a perforated ulcer whilst remanded at HMP Highdown. The jury were permitted to return a narrative conclusion which set out a number of failures and missed opportunities which contributed to his death

The jury's narrative conclusion stated that Tariq attended a pain clinic and was assessed by the GP. He was prescribed Meloxicam pain relief without a co- prescription of a PPI, alongside other medications. The GP was unaware of two previous occurrences of vomiting blood (haematemesis) which were recorded on Tariq's community GP records. However these records were not obtained. The jury noted that every prescribing clinician agreed that they wouldn't have prescribed Meloxicam

with a known history of haematemesis.

The jury found that Tariq was at a high risk of gastrointestinal irritation despite being assessed as moderate risk. They found that the continued prescription of Meloxicam throughout his time at HMP Highdown made a material contribution to his death.

The jury also referred to Tariq raising concerns about his health with staff which were recorded in his record, and noted that despite a number of requests for him to be seen by a GP, he was not assessed. The jury found that the failures to assess him in person by a GP were missed opportunities which made a material contribution to Tariq's death.
The jury were also permitted to record 'possible' contributions to Tariq's death, and noted that the failure to prescribe a PPI to reduce the GI irritation caused by Meloxicam was a possible contributor, as well as ineffective communications between members of staff responsible for Tariq's care. It was also recorded that Tariq's behaviours and apparent mental health issues may have affected the care he received, and this may have contributed to his death.

INQUEST press release

File on Four – A death sentence? The inmates dying after poor healthcare in prison

INQUEST: Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination (featuring Tariq's case)

Area of Law:

Prison Law, Civil Law

Related Barristers:

Angelina Nicolaou

AXB v SSHD (Art 3 health: obligations; suicide)

Guidance from the Upper Tribunal on the procedural duty under Article 3 ECHR in 'medical' cases:

The burden is on the individual appellant to establish that, if he is removed, there is a real risk of a breach of Article 3 ECHR to the standard and threshold which apply. If the appellant provides evidence which is capable of proving his case to the standard which applies, the Secretary of State will be precluded from removing the appellant unless she is able to provide evidence countering the appellant's evidence or dispelling doubts arising from that evidence. Depending on the particular circumstances of the case, such evidence might include general evidence, specific evidence from the Receiving State following enquiries made or assurances from the Receiving State concerning the treatment of the appellant following return.

Related Barristers:

David Chirico KC

Angelina Nicolaou

Inquest into the death of Rebekah Legg-Mead

Angelina Nicolaou, instructed by Simpson Millar Solicitors represented the family of Rebekah Legg Mead, at the inquest into her death, held at West London Coroner's Court. Rebekah was a 16-year old girl who died after jumping of the Waterloo Bridge.

Metro: Girl, 16, jumped from Waterloo Bridge after 'constant bullying (22 Feb 2019)

Daily Mail: Bullied 16-year-old girl jumped to her death from Waterloo Bridge eight months after a mental health service for young people closed her case, inquest hears

Related Barristers:

Angelina Nicolaou