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HM Assistant Coroner Mr J. Stevens
St Pancras Coroner's Court
Camley Street
London N1C 4PP

First by email & 1st Class Post

Law and Governance
Islington Council
222 Upper Street
London N1 1XR

[redacted]

Date: 13 May 2024 sent on 6 June 2024

Dear Sirs,

Letter before claim for Judicial Review concerning procedural irregularity around the Prevention of Future Death Report in the Rose Hollingworth Inquest

This is a Letter Before Claim in accordance with the Pre Action Protocol for Judicial Review. Part 54 CPR and Part 54(a) of the Practice Direction are relevant.

1 Proposed claim for judicial review

To: HM Assistant Coroner Mr J. Stevens
St Pancras Coroner's Court
Camley Street
London N1C 4PP

2 The claimant

Islington Council
Law and Governance
Islington Council
222 Upper Street
London N1 1XR

3 The defendant's reference details

Inquest into the death of Rose Hollingworth heard by HMAC Mr Stevens on 25 & 26 July 2023 and the Prevention of Future Death Report dated 8 March 2024 received by the Claimant on 22 March 2024.

4 The details of the claimants' legal advisers dealing with this claim

[redacted]
Senior Legal Services Officer
Law and Governance
Islington Council
222 Upper Street
London N1 1XR
DX 122230 Upper Islington

5 The details of the matter being challenged:

1. The matter under challenge is the Court's failure to facilitate receiving submissions by the Claimant, pursuant to its own directions, and the consequent prevention of Future Death Report to the Claimant.

2. The Grounds for challenge are procedural irregularity.

3. On 26 July 2023, HM Coroner completed the inquest of Rose Hollingworth concluding that the cause of death was by natural causes and made the following directions.
    i. The family to file their written submissions by 23.8.23 if they sought a PFD.
    ii. LBI and Care agency to file their response by 20.9.23.

4. The Claimant, mindful of the importance of being heard, sent several emails to the Court to check if submissions from the family had been received by the Court and requested the court to send the famiy's submissions. The Claimant sent emails on the following dates **04.09.23 – 12.09.23 – 02.10.23 -12.01.24 – 17.01.24 & letter 25.03.24** to which no response was received from the court office. The Claimant communicated to try to ensure that the directions were complied with, that it was able to make submissions and

that these would be considered before the Court determined whether its duty to issue a PFD report was engaged.

5. The family submissions were dated 21.8.23. The Court had an obligation to serve those submissions on the other Interested Persons. There was no order for cross service of the same and that it not standard in the Coroners Court's, as disclosure to and from the Court is via the court office. It is clear from the family submissions that they are critical of the Claimant and the care agency and would generate a written submission in response.

6. The Court failed to send the family submissions to either Interested Person (the care agency) to enable them to reply. Quite clearly from the family's position and that which HM Coroner was therefore considering, it is reasonable for him to expect receipt of submissions from the Claimant in accordance with his directions. The absence of the same should have alerted him to the fact that his directions had not been met by 2 Interested Persons, who can reasonably be expected to have made such submissions. The same should have caused him to check, that the IP's had something to respond to, and that the court office had sent out the family submissions to the IPs.

7. The PFD Report was made a considerable time after the hearing, approximately 8 months. The Chief Coroner's Guidance 5, paragraph 38 states a report should be sent out within 10 working days of the inquest. Even on the timetable of the directions, any PFDR should have been issued within the first week in October 2023, not March 2024.

8. Additionally, the PFDR was made on 8 March 2024 but not sent to the Claimant until 22 March 2024, amounting to further inexplicable delay. The significance of this is that there is a statutory period of 56 days in which to respond from the date of issue, and so the clock was run down by the Court issuing the Report 14 days after it was dated.

9. The procedural irregularity should not be confused with a matter of fact in a report which is disputed by an IP. The latter requires disputed facts to be responded to within the

formal PFD reply. However, the procedural irregularity is the matter of greatest concern. The Court failed to send the family submissions to the IP's, respond to repeated requests to see whether the same had been received, recognise that it was making a decision which excluded the IP's from that process when they had a legitimate expectation to be heard, and went on to make a PFDR which, had the Court been in receipt of the latest position from the Claimant, would likely not have made a PFDR.

10. The Claimant wrote to the Court on 25 March 2024 to express its concerns about receiving a PFDR out of the blue and was told,

Your letter of 25th March 2024 has been referred to the coroner. The coroner officer that dealt with this matter has left the coronial service and the coroner confirms that he was unaware that the family's submissions had not been provided to the Council nor that they had written to the court requesting a copy. It was, of course, open to the council to also request a copy of the family's submissions directly from the family, however, a copy is now attached. It is regrettable that the Council did not receive a copy of the family's PFD submissions, but the Council can still, of course, respond in full to the matters raised in the PFD in their response to that. The PFD issued arises out of evidence heard at the inquest.

11. The response is perfunctory. It is not for the Claimant to go directly to the Family when it communicates with the Court and can expect a reply to comply with directions. The Coroner should have been made aware of whether the IP's had received the submissions as a matter of court administration. The remedy is not to simply respond to the concerns as the Court cannot be confident that it has made the decision to issue a PFDR based on the current and best information nor that it has acted fairly in allowing the Claimant to be heard. Had it done so it is likely that the PFDR would have issued only against the care agency, about whom HM Coroner was critical in the inquest but he was not critical of the Claimant.

12. It was important that HM Coroner had submissions in response. As a matter of transparency, IPs and the public must be confident that court processes and decision

making are fair, that the Court facilities its own directions to enable compliance with them and that the court administration and resources support the role of the judges who make decisions, by communicating with IP's responding to their correspondence.

6 The details of any Interested Parties

The other Interested Parties are:

1. The Family
2. Home dot care

We confirm that they have been sent a copy of this letter.

7. The details of the action that the defendant is expected to take

Whilst the Court has no power to withdraw a PFDR, it is asked to consent to an application to the High Court for the decision to issue a PFDR against the Claimant to be quashed. For clarity, this would remove PFDR paragraph 5(4) which states there was *a failure to monitor, review, manage and check the performance of the care agency* and would remove the Claimant as a recipient. There would be no application for costs.

9 ADR proposals

We would welcome ADR or a meeting to try and resolve the matter via a Consent Order, if that is not readily forthcoming.

10 Proposed reply date

Please respond with 14 days of the date of this letter and by 26 June 2024.

Yours faithfully

[redacted]

[redacted]
Senior Legal Services Officer
Mental Health First Aider - (Trained in Mental Health First Aid)
Law & Governance