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FAO: [redacted], **HM Assistant Coroner for Surrey**

By email only [redacted]

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TELEPHONE: [redacted]

YOUR REF:

OUR REF [redacted]

DATED: 3 December 2025

URGENT PRE-ACTION PROTOCOL LETTER

RESPONSE REQUIRED BY 14 DAYS OF THE DATE OF THIS LETTER

Dear HM Assistant Coroner for Surrey

Re: R (Willow Longmuir) v HM Assistant Coroner for Surrey

1. We write this letter in accordance with the Pre-Action Protocol for Judicial Review.

2. We are instructed by Willow Longmuir ("**the Claimant**") to challenge the decisions of HM Assistant Coroner for Surrey ("**the Defendant**") arising from the inquest touching on the death of her son, Aiden Longmuir ("**Aiden**").

The Claimant:

3. Willow Longmuir, [redacted]

The Defendant:

4. HM Assistant Coroner for Surrey, [redacted] HM Coroner's Court, Station Approach, Woking, Surrey, GU22 7AP

Reference details:

5. Our reference is at the head of this letter.

The details of the matter being challenged:

6. The Claimant is challenging the Defendant's decisions arising from the Inquest touching on the death of her son, Aiden. The decisions are:

    a. To record Aiden's sex as 'female' for the purposes of the death certificate, as opposed to his lived gender which was 'male'.

    b. To refuse Aiden's family's application to adjourn the Inquest.

    c. To fail to list a Pre-Inquest Review Hearing.

    d. To limit the scope of the Inquest.

    e. To hold a documentary inquest.

Background:

7. Aiden tragically died on 3 May 2025. He was a 20-year-old trans man and struggled with his mental health. Aiden had joined a suicide forum that is being investigated by Ofcom. He died by ingesting [redacted] which he had sourced online.

8. Aiden was diagnosed with gender dysphoria in November 2018 and had been on the waiting list for the Tavistock Gender Identity Clinic since 2021. He had been living as a male since 2017 and his NHS records, bank, and DWP records recorded him as male or 'Mr'.

9. The family received a phone call on 6 May 2025 from Woking Coroner's Court to ask some questions about Aiden. In that call, Aiden's adoptive mother, Amanda Longmuir (his biological grandmother but whom Aiden called his mum) ("**Amanda**"), asked if Aiden's death certificate would be registered as male, as this was the last thing she could do for him. She was told this would be down to the discretion of the Defendant.

10. The Inquest into Aiden's death was opened on 16 May 2025. On this date, Amanda was also sent Aiden's interim death certificate, which recorded his sex as female.

11. Aiden's biological mother (the Claimant) and Amanda ("**the family**") started investigating obtaining legal advice, particularly regarding how Aiden's sex would be recorded on his death certificate, in August 2025. However, after an initial internet search, the family were concerned that it would cost a significant amount of money. They also came across the Chief Coroner's Guidance (set out in detail below) which states that a trans person's sex can be recorded as their lived gender on their death certificate, rather than their sex assigned at birth, without the need for a Gender Recognition Certificate. The family believed that, with the time Aiden had spent living as a male, and with all his family, friends, and organisations knowing Aiden as male, that this would not be a contentious matter and the Defendant would make a finding that his sex was male. Therefore, in light of the potential costs of finding legal representation, and the Guidance for coroners on the issue they were primarily concerned about, they did not believe

that it was necessary for them to make substantive efforts to obtain legal representation at that stage.

12. On 30 September 2025, the Court called the family to explain they had some evidence for the Inquest and would email it to the family.

13. An initial bundle was provided to the family on 2 October 2025 along with two separate documents setting out Aiden's medical history, which were provided by his GP. On 17 October 2025, the family were also provided with a statement from Surrey and Borders Partnership in relation to Aiden's care under CAMHS. The family were informed on 17 October 2025 that a Rule 23 documentary hearing would be held on 24 October 2025.

14. Aiden's family had a number of concerns about the circumstances leading to his death, which they felt strongly should be investigated as part of the Inquest proceedings. These included matters relating to how Aiden sourced the [redacted] poison, the failure to provide him with a proper psychiatric assessment after he turned 18 despite ongoing concerns about his mental health, and the delays he experienced in accessing gender identity services. Each of these reflect issues that have been properly investigated by other Coroners (see, amongst other examples, the inquest touching upon the death of Sophie Williams; HM Assistant Coroner for Inner North London, 20 February 2023).

15. Aiden's family first began to consider the documents provided to them by the Coroner after they received the additional statements on 17 October 2025. It was only then that they realised what limited, if any, evidence had been obtained regarding the issues they felt should be investigated. The family contacted a journalist, [redacted] who reports on coronial inquests into the deaths of learning disabled and autistic people on 18 October 2025, to obtain support. They then tried to seek legal advice on Monday 20 October 2025 (the next working day) but, unfortunately, were unable to find solicitors who had capacity to represent the family in the short period in advance of the listing. The family were also not aware that a PIR hearing is required in more complex investigations, such as where the family had concerns about the scope of the proceedings, and therefore did not know to request this.

16. Finally, the family did not anticipate that Aiden's Inquest would be scheduled with just seven days' notice and that they would not be given more time to attempt to seek legal representation. The Court did not draw this to the family's attention when the initial bundle was provided on 2 October 2025, or indeed in any of the correspondence they had with the family prior to 17 October 2025.

17. Amanda emailed the Coroner's Officer on 21 October 2025, following two emails on 19 October 2025 to which she had not received a response, asking for the hearing to be adjourned to give the family adequate time to prepare. She stated that she did not believe a documentary hearing was appropriate, and that not all the relevant evidence had been obtained. She asked for written confirmation that the documentary hearing would be adjourned.

18. The Coroner's Officer responded on 21 October 2025 stating that she had forwarded Amanda's emails to the Coroner (including an email regarding how Aiden's sex would be recorded on his death certificate) and would revert. Amanda chased a response on 22 October 2025 and received a response from the Coroner's Officer later that day. It stated:

> *"The Coroner advises in relation to the request for inquest adjournment that they believe that the evidence provided in the disclosed bundle shows how Aiden sourced the poison and the websites used. So far as the other issues are concerned, it is their view that these are outside of the scope of the inquest as they go to "why" Aiden may have taken the actions he did, rather than "how". The Coroner understands that the family have concerns but they would need to identify of those, which relate to the "who, when, where and how" questions that are to be addressed at Inquest. Based on the email provided the Coroner is not currently prepared to adjourn the hearing listed for Friday.*
>
> *The Coroner also advised they intended to record all details in the name of Aiden and only reference him as male as per Chapter 19 of the Coroners Bench book, They also propose not to read into evidence the pathologists reference to the 'body of a female' as this is not relevant to the inquest. I am awaiting further guidance from the Coroner in relation to the remainder of the email and Aidens listed sex."*

19. Amanda responded with a detailed email that evening clarifying which aspects of the circumstances leading up to Aiden's death relate to the "who, when, where and how" questions and should therefore be included within the scope of the Inquest. She stated:

> *"I understand the distinction between the "how" and "why" questions that guide an inquest. However, as Aiden's mother, I believe several of the matters I raised are not about "why" he made certain choices, but rather about how the circumstances surrounding him allowed those choices to become possible.*
>
> *For example:*
>
> *How Aiden was able to obtain a restricted substance online.*
>
> *How different services failed to communicate or intervene when his vulnerabilities were clear.*
>
> *How he never received a full psychiatric evaluation after turning 18, despite ongoing concerns about his mental health and wellbeing.*
>
> *How the lack of joined-up care between his GP, mental-health services, and school may have contributed to the events that led to his death.*

How there appeared to be no meaningful support for Aiden in relation to his gender identity, and how inconsistent medical practices meant he was denied access to the same bridging prescriptions that other GPs in different areas provide."

20. Amanda expanded on the above issues in significant detail in her email, and explained how it was her view that these issues were not about a 'motive' but the systemic failures and missed opportunities that contributed to Aiden's death. She repeated her request for an adjournment to allow the family time to properly prepare and to obtain legal representation. She explained that the family had only recently received the documents and felt able to face discussing matters with lawyers.

21. The Claimant is autistic and struggles to process things quickly. She states that her executive functioning is poor and she typically gets additional time in exams as a reasonable adjustment. She considered writing to the Coroner beforehand about this but was afraid that she was placing too much emphasis on herself and her needs when she felt this was about Aiden.

22. On 23 October 2025, Amanda was informed by the Coroner's Officer that the Defendant would deal with her application to adjourn during the hearing the next day at 14:00 and that, if the application was refused, the Coroner would proceed to a full hearing. Amanda responded to provide a list of attendees for the hearing and highlighted that she was still waiting to hear back regarding how Aiden's sex would be recorded on his death certificate.

23. The documentary hearing took place on 24 October 2025. We have recently received a recording of the inquest and are looking into requesting a professional transcription of it. In the meantime, we **enclose** a note from the journalist [redacted] who attended the Inquest (**"the note"**).

24. The Defendant stated that the first issue she wanted to consider was the family's application for an adjournment. She confirmed she had read and considered the emails Amanda had sent her and gave the Claimant permission to make further oral submissions in Court. The Claimant stated the family wished to hear oral evidence from:

    a. Aiden's GP regarding why, during a telephone consultation with Aiden on 18 February 2025, she did not escalate Aiden's request for testosterone and why she did not make a referral for mental health support when Aiden became distressed as documented in his medical records. The statement of [redacted] included in the inquest bundle shows that Aiden started searching about 'suicide' online shortly after this call (from 11 March 2025) and the family considered this was directly related to his interaction with his GP.

    b. The ICB regarding the delays Aiden experienced in accessing gender identity care. This caused Aiden great distress, and the family understood it led to a decline in his mental health. The family hoped that

a Prevention of Future Death ("**PFD**") Report might have been made in relation to this.

c. Surrey and Borders Partnership Trust ("**SABP**") regarding their failure to carry out a full psychiatric assessment of Aiden. SABP services discharged Aiden due to his established diagnosis of ASD and were of the view that his depression and anxiety were part of his ASD. However, the family felt that this was incorrect, and did not reflect the reality of Aiden's mental health issues.

25. The Claimant explained to the Defendant that it was not until they saw the bundle that the family realised how little evidence there was. She felt it raised even more questions regarding the lack of a psychiatric evaluation, the waiting list for gender affirming care, and the lack of support from Aiden's GP and local mental health services about his gender identity. The family consider these failures are even more stark given Aiden's previous suicide attempt at 18 years old. The Claimant also raised various factual inaccuracies and inconsistencies in the evidence that had been provided to the family which were relevant to the chronology. For example, the Claimant noted that Aiden's suicide note said that he would be found in his bedroom, but the post-mortem report stated Aiden was found at the bottom of the stairs.

26. The Claimant stated at the start of her submissions for an adjournment that she was autistic and asked for that to be taken into account. She stated that the time frame provided – less than five working days – was not adequate, particularly given the complexity of the case and her neurodivergent processing needs. The Defendant asked if there was anything else the Claimant wanted to say on this and how it would impact upon her at the hearing. The Claimant was confused by the question and felt put on the spot. She believed the Defendant was asking what adjustments she would need if the hearing went ahead on that day. She thought that, as she had stated that she was autistic and needed an adjournment, the Defendant would know that she would need additional processing time. As she had already asked for an adjournment, she simply stated that going through the events in chronological order would be helpful.

27. The Defendant adjourned to consider the Claimant's oral submissions but ultimately refused their application for an adjournment of the Inquest and for oral evidence. She stated that the issues raised by the family were speculative and that there was no evidence that they made more than a minimal contribution to Aiden's death. The Defendant also stated that, despite the hearing only been listed a week ago, because the Claimant had said she had been looking for representation since August, she was not persuaded that it was necessary to adjourn. Finally, the Defendant stated that she would be giving consideration to how Aiden had sourced the [redacted], and whether to issue a PFD report.

28. The Defendant then went on to consider the issue of Aiden's sex for his death certificate. The note states:

I am required however to make certain findings of fact for the purpose of registration. The interim and final death certificate will require us to make findings of fact on sex, I note sex is used and not gender. I take that to mean biological sex.

Take recent Scottish case... on use of that term...

Very carefully considered your submissions and the Chief Coroner's guidance. Everyone is entitled to respect to their gender identity... Aiden was waiting to be seen as we know at the Gender Identity Clinic and therefore did not have a GIC certificate

Had he done so legally sex becomes issues of male for these purposes. That had not happened. Therefore, I am required to make a finding of fact on the evidence before us, biologically the body was that of a female.

I won't read into evidence but will take into account when making my findings at the end.

29. After reading the statements and reports into evidence, the Defendant made a number of findings of fact relating to Aiden's death, including that he died by suicide by intentionally consuming a chemical substance, and concluded the Inquest. She asked the family whether they had any questions.

30. The Claimant asked why Aiden's letter, where he stated he wanted to be a "*Proper biological boy. With a flat chest, and a penis, and testosterone. Fuck, I hate this body. I'm miserable*", was not read into evidence. The Defendant stated this was because she didn't believe the reasons for suicide were within the scope of the Inquest. The Claimant also asked about how Aiden's sex would be recorded on his death certificate. The note states:

C: My understanding, I think the law is very complex in this area, my interpretation on the issue of sex when completing death certification will be based on factual evidence I have today, I haven't read that out into inquest... dealt with today as Aiden and using preferred pronouns

W: A trans person's death should be being registered in their experience or acquired gender... the coroner should record sex as their experience.... paragraphs 37-38 of the Chief Coroner's Bench Book June 2025 Chapter 19 Trans people and the coroner's court, quite clearly states you do not need a GRC to be registered in their experienced or acquired gender... should record sex based on their experienced or acquired gender.

...

C: I have read the Chief Coroner's Guidance, that's what it is, guidance to coroners. It is at odds with how I interpret the law. I have no choice but to

address as biological sex, but to all other intents and purposes I will refer to Aiden in his preferred or acquired gender and name

Amanda: Aiden fought so hard to be a boy and to be called a boy (she is trying to fight back tears as she addresses the coroner). To me registering him not under male is disrespecting him

C: I understand that

Willow: It also recorded... unnecessary questions when you go to close accounts, he's under male on his national insurance, on his bank, at his doctors. So when mum went to close Aiden's bank account there were questions over what was written on death certificate and why it didn't match what was on his bank

C: It's an area outside the law. I'm able to deal with this today. Had parliament wished coroners to record gender I feel the form would say gender, but it says sex.

I take on board recent case law has outlined the difference between sex and gender, and I take it to mean biological sex in this case.

I understand the distress to you... I feel only options available to me in that interpretation, is finding of fact and facts according to biology are clear from the evidence

Amanda: I think that's one I find extremely hard to accept

C: I do understand that

Amanda: I know how hard he fought to be accepted and what he had to go through and to me that's like spitting in his face

C: I'm very sorry that issue causes you that, those are my findings and the reasons for my findings. Could be an area Parliament could revisit to be clear how to proceed in these issues... not in my scope today to redefine the language in those documents

31. The record of inquest in Aiden's case therefore records Aiden's sex as "female".

The law:

Sex

32. Section 10(1)(b) Coroners and Justice Act 2009 (**"the 2009 Act**") requires the coroner (or jury) to "*make a finding*" as to the particulars required for the registration of the person's death:

"10 Determinations and findings to be made

> *(1) After [considering the evidence given to]1 an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must—*
>
> *...*
>
> *(b) if particulars are required by the [Births and Deaths Registration Act 1953] to be registered concerning the death, make a finding as to those particulars."*

33. Section 15 Births and Deaths Registration Act 1953 requires that the death of every person in England and Wales be registered by the local registrar.

34. Regulation 39 Registration of Births and Deaths Regulations 1987 ("**the 1987 Regulations**") states:

> *"The particulars concerning a death required to be registered pursuant to section 15 of the [Births and Deaths Registration Act 1953] shall, subject to the provisions of this Part of these Regulations, be those required in spaces [1 to 7 and 9] in form 13 and that form shall be the prescribed form for registration of deaths for the purpose of section 20 of the Act (which provides for registration of deaths free of charge)."*

35. The particulars required on Form 13 to register a person's death include their name, sex, age and occupation, the cause of death, and the date and place of death. There is no definition of "sex" in either the 2009 Act, the Births and Deaths Registration Act 1953, or the 1987 Regulations. Nor is the word "sex" used in that statutory scheme in any way as to suggest it was intended to be different to "gender".

The For Women Scotland judgment

36. The Defendant cited the Supreme Court's decision in *For Women Scotland v Scottish Ministers* [2025] 2 WLR 879 ("***FWS***") in her reasons for making a finding of fact that Aiden's sex was female.

37. The issue for the Supreme Court in *FWS* was the statutory definition of "sex" in the Equality Act 2010 ("**the EA 2010**") for a person with a Gender Recognition Certificate ("**GRC**") in light of s.9 Gender Recognition Act 2009 ("**GRA 2009**") which states that:

> *(1) Where a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman).*
> *(2) ...*
> *(3) Subsection (1) is subject to provision made by this Act or any other enactment or any subordinate legislation.*

38. The Supreme Court held that the terms "man", "woman" and "sex" in the EA 2010 refer to biological sex, not the sex on a GRC. This was an exercise in statutory construction, which depended on the way in which those words were used in the wider statutory scheme. The Supreme Court's judgment is confined to the interpretation of "sex" within the EA 2010, undertaken for the purpose of establishing a coherent and practicable framework within the EA 2010 for the protection of people with protected characteristics. The Supreme Court did not suggest, still less find, that its findings extended beyond this context, and certainly not to the statutory framework surrounding the registration of deaths.

The Chief Coroner's Guidance

39. The Chief Coroner has published Guidance to assist Coroners during inquest proceedings. The Courts and Tribunals Judiciary website states:[1]

> "*The Chief Coroner provides detailed Guidance to coroners on various matters relating to the Coroners and Justice Act 2009, and also occasionally on the law, following an important case. These are written to assist coroners with the law and their legal duties, and to provide commentary and advice on policy and practice.*"

40. Chapter 19 of the Guidance concerns trans people and deals specifically with the question of the sex that should be recorded on the record of inquest. It was updated following *FWS* and states (with footnotes and some references removed):

> ***Recording the sex of a deceased trans person***
>
> *34. Where the deceased has a full GRC then, regardless of their sex on their original birth certificate, the deceased should for all purposes (unless s9(3) of the GRA 2004 applies) be regarded as the gender (and sex) shown on the GRC. However, having a GRC is not a pre-requisite to living as a gender that is different from one's sex as recorded at birth. A person recorded at birth as male can have lived for many years as female, changed their name to a female one, have key documents recording their new name and sex (such as a passport, driver's licence, credit cards and bank statements) and even be collecting a woman's or widow's pension in that name. Without a GRC that woman cannot obtain a birth certificate in her new gender, nor will she have all the legal rights that flow from the possession of a GRC, but to all intents and purposes she is otherwise regarding herself, and no doubt would wish to be regarded by others, as female. So what sex should appear on a trans person's death certificate, and does the answer depend on whether the person had a GRC?*
>
> *35. When a person dies and their death is registered, regulation 39 of the Registration of Births and Deaths Regulations … 1987 requires the 'particulars of death' as set out on parts 1-7 and 9 of Form 13 to be*

recorded. This includes the person's name and surname, and sex. However, there is no definition of 'sex' in the legislation. Where an inquest is held, s.10(1)(b) Coroners and Justice Act 2009 requires the coroner (or jury) to 'make a finding' as to the particulars required for registration. Such registration particulars as are found will then be certified by the coroner and sent to a Registrar. The Registrar is bound by law to record in the register of deaths the particulars that the coroner records, without alteration.

36. As has already been noted, the Supreme Court decision in For Women Scotland Ltd does not determine the interpretation of the term 'sex' in any other legislation. There is no case law on what 'sex' means in the death registration context, so it is open to interpretation.

37. It is the Chief Coroner's view that the law does not prevent a trans person's death being registered in the deceased's experienced or acquired gender (whether the person has or has not got a GRC). There is no stipulated requirement for the sex recorded at death to be the same as the deceased's birth sex, and a person's entry on the register of deaths is not formally matched up to any entry on the register of births. Where a trans person's family are responsible for registering the death, they are not required to provide a birth certificate; presenting a passport as proof of the deceased's identity will suffice. They are therefore able to choose to provide registration details that include the sex relevant to the person's acquired or experienced gender. It would be consistent for the coroner (or jury, if there is one) to determine on the evidence available to them the person's sex based on their acquired or experienced gender.

38. It is therefore suggested that if, after full inquiries, a coroner concludes from the available evidence that, on the balance of probabilities, a deceased person had chosen to present permanently as female, the coroner is entitled to regard the deceased as female and may choose to record this as their sex. Similarly, if after making inquiries a coroner concludes a person has chosen to present as male then the coroner can regard them as male and may choose to record the same.

Scope

41. Section 5 of the 2009 Act provides that the purpose of an inquest is to ascertain who the deceased was and how, when, and where they came by their death. This requires the court to "*seek out and record as many of the facts concerning the death as [the] public interest requires*" (*R v South London Coroner, ex p Thompson* (1982) 126 SJ 625) and ensure that the relevant facts are "*fully, fairly and fearlessly investigated*" (*R v HM Coroner for North Humberside, ex p Jamieson* [1995] QB 1, 26).

42. The Coroner has a statutory duty to carry out an investigation to discover the truth about how Aiden came to die. The touchstone for the exercise of the

satisfy the statutory duty of investigating how the deceased came by their death. Matters should only be excluded from scope if they are "so *remote from the cause of death that they could not even arguably be said to have contributed*": R *(Allen) v HM Coroner for Inner North* London [2009] EWCA Civ 623, §40; R *(Speck) v York Coroner* [2016] 4 WLR 15, at §28. As the Court of Appeal held in *Dove v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289, at §72, and reflected in the Chief Coroner's Bench Book, Chapter 7, §6, where the actions of a public body are said to have contributed to a deterioration in the deceased's mental health, examining the "*extent to which acts or omissions contributed to the deceased's mental health deterioration, which in turn led them to take their own life*" is part of determining the substantial truth of how the deceased died.

43. The proper scope of a *Jamieson* inquest is, therefore, not especially narrow – the question of how the deceased came by their death is clearly wider than merely finding the medical cause of death and may include acts and omissions that are directly responsible for the death (*R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin), §49). Indeed, in *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool* [2022] 4 WLR 15, §73, the High Court emphasised a decision on the engagement of Article 2 "w*ill have little if any effect on the scope of enquiry or conduct of the hearing…because any properly conducted inquest will consider the circumstances surrounding and leading to the death*".

Pre-Inquest Review Hearings

44. A coroner may hold a Pre-Inquest Review Hearing ("**PIRH**") at any time during the course of their investigation before the inquest hearing commences: Rule 6, Coroners (Inquests) Rules 2013 ("**the 2013 Rules**"). The courts have recognised that a PIRH is an "*important stage towards the final hearing*" and bereaved families, in particular, should be given sufficient notice and disclosure to be able to address matters such as the proposed list of witnesses, which witnesses may be called and whose statements may be read, the issues to be considered at the inquest, and the scope of the evidence on an informed basis: *Brown v HM Coroner for Norfolk* [2014] EWHC 187 (Admin), §§39-41.

45. The Chief Coroner's Guidance No 22 provides, at §2, that a PIRH "***should** be held in more complex investigations where there is a need for issues to be aired prior to the inquest and which cannot easily be dealt with by email*" (emphasis added).

Adjournment

46. Rule 8 of the 2013 Rules states that: "*A coroner must complete an inquest within six months of the date on which the coroner is made aware of the death, or **as soon as is reasonably practicable after that date***." [emphasis added]

47. Rule 25(1) of the Inquests Rules go onto provide that: "*A coroner may adjourn an inquest if the coroner is of the view that it is reasonable to do so*." The explanatory memorandum to those Rules states that the policy purpose behind the 2009 Act

and, consequently, the 2013 Rules, was to "*put the needs of bereaved people at the heart of the coroner system*."

48. The discretion as to whether an adjournment is ordered must be exercised both rationally and fairly. Thus, whether or not a refusal of an adjournment complies with the common law obligation of procedural propriety is a matter for the court to determine and it is not sufficient for a Defendant simply to show that the decision was not irrational: *R v Takeover Panel ex parte Guinness PLC* [1990] 1 QB 146, as cited in the context of the refusal to adjourn an inquest in *Wiggins v Her Majesty's Assistance Coroner for Nottinghamshire* [2015] EWHC 1658 (Admin), §24.

Right to private and family life

49. Section 6 of the Human Rights Act 1998 makes it unlawful for a public authority, which includes a court or tribunal, to act in a way which is incompatible with the rights set out in Schedule 1 of the Human Rights Act 1998. The rights in Schedule 1 include the right to private and family life protected by Article 8 ECHR.

50. While the exercise of Article 8 rights concerning family and private life pertains predominantly to relationships between living people, dealing appropriately with the deceased out of respect for the feelings of the deceased's relatives falls within the scope of Article 8 (see *ML v Slovakia (*App. No 34159/17, 14 October 2021), §23). The European Court of Human Rights has also recognised that the "*very essence of the Convention being respect for human dignity and human freedom, protection is given to the right of trans [persons] to personal development and to physical and moral security*" (*Van Kück v Germany* (2003) 37 EHRR 51, §18.

51. Any interference with Article 8 must be justified as a necessary and proportionate means of achieving a legitimate aim (see Article 8(2) ECHR). In assessing whether an interference is justified, the Court will have regard to the impact of a "*discordance between the social reality and the law*": *Hämäläinen v Finland* (2014) 37 BHRC 55 at §66.

Duty to make reasonable adjustments

52. The Defendant is under a duty to make reasonable adjustments to the coronial process for disabled persons. This duty arises pursuant to Article 6 of the European Convention on Human Rights and at common law (see, by analogy and in the context of an employment tribunal: *Rackham v NHS Professionals Limited* [2015] UKEAT/0110/15/LA, at §§31-36).

53. As the Equality and Human Rights Commission's Statutory Code of Practice on Services and Public Functions makes clear in relation to the analogous duty to make reasonable adjustments under s.20 and Schedule 2 EA 2010 at §7.26, once a body party to the duty becomes aware of the requirements of a particular disabled person*, "it might then be reasonable for the service provider to take a particular step to meet these requirements"* which is *"especially so where a*

disabled person has pointed out the difficulty that they face in accessing services, or has suggested a reasonable solution to that difficulty."

Grounds of challenge:

Ground 1: misdirection of law in respect of the requirement to register deceased's sex

47. In refusing to register Aiden's sex as male on his death certificate, the Defendant misdirected herself in law as to the nature of her duty to register Aiden's sex under the 1987 Regulations.

48. The Defendant misdirected herself by determining that "sex" on Form 14 could only mean biological sex, in circumstances where it is not defined as such in the 2009 Act, the Births and Deaths Registration Act 1953, or the 1987 Regulations. She erred in concluding that she had "no choice" but to register Aiden's sex of female on his death certificate – there is no authority for the proposition that the Coroner does not have the power to make findings on the evidence as regards the nature of a deceased's sex (as is the approach provided for in Chapter 19 of the Chief Coroner's Guidance) or that she is required to record the deceased's biological sex.

49. The Defendant also erred in concluding that she was bound by the *FWS* decision, when that decision expressly determines the meaning of sex for the purpose of the EA 2010 alone and says nothing about the meaning of sex in the death registration context. The Supreme Court was clear that its findings related only to the meaning of sex in the EA 2010 (see, for example, *FWS*, §§2 and 8). It reached its conclusion based on detailed consideration of the particular background to, aims of, and structure of the EA 2010. The Supreme Court was clear that its task involved *"a close analysis of the EA 2010"* (§161) and it was strongly influenced, in particular, by the use of the words "woman" and "sex" in the provisions relating to pregnancy (see, for example, §§175-178).

50. That reasoning is of no application here – this is not a provision in legislation which establishes "sex-based rights and protections to be regulated on a practical day-to-day basis" (*FWS,* §173). Rather, the Defendant was tasked with applying a provision which regulates the registration of an official record of a death once a coroner has considered the evidence in relation to an individual's identity. There is no reason of principle why an individual's death should not be registered in a manner which respects and reflects their gender identity.

51. Thus, the Defendant misdirected herself as to the nature and scope of her power to register Aiden's details by refusing to identify him as male on his death certificate.

Ground 2: failure to follow the Chief Coroner's Guidance on registering sex

52. As set out above, the Chief Coroner has issued guidance to coroners to assist them with matters which may arise during their investigations involving trans people. Chapter 19 of the Guidance expressly provides that the law does not *"prevent a trans person's death being registered in the deceased's...acquired*

gender" and that a coroner is entitled to regard the deceased's sex as their acquired gender if "*after full inquiries*" they conclude from the available evidence that, on the balance of probabilities, the deceased chose to present permanently as that gender.

53. While the Guidance is not legally binding, it is well-established that a public authority must follow its published policy absent good reason not to: *Mandalia v The Secretary of State for the Home Department* [2015] 1 WLR 4546, §29.

54. The Defendant failed to follow the Guidance, in particular by: (a) failing to make any inquiries as to, or hear evidence on, the gender Aiden chose to present as; (b) failing to have regard to the family's wishes or their evidence as regard the fact that Aiden was recorded as male on his DWP records, bank accounts and on his medical records; and (c) determining she had no discretion as to register Aiden's sex as male to reflect the gender he permanently presented in.

Ground 3: breach of Article 8 ECHR

55. The refusal to register Aiden's sex as male on his death certificate constitutes a breach of Article 8 ECHR and s.6 Human Rights Act 1998.

56. The decision constitutes a serious interference with the Claimant's Article 8 rights, given it undermines an important aspect of Aiden's personal identity on the official record of his death and an important way in which the family wished to honour his life. The registration of Aiden as female on his death certificate, as reflected on the record of inquest, causes the family significant distress. This interference was not "prescribed by law" for the purposes of article 8(2), for the reasons set out above under Ground 2. In any event, a rule or practice of recording an individual as "male" or "female" in accordance with their biological sex alone, rather than the gender they lived in, is neither proportionate nor does it serve any compelling countervailing interest (see, for example, paragraph 37 of the Guidance set out above). The decision to refuse to document Aiden's acquired gender on his death certificate, and instead recording his biological sex, constitutes a disproportionate inference with the Claimant's right to private and family life.

Ground 4: failure to hold a PIRH was an unlawful departure from policy and/or unfair and/or irrational

47. As set out above, the Chief Coroner's Guidance provides that a PIRH is required in complex cases. This is so that Interested Parties, and in particular bereaved families, can make submissions on matters such as witnesses and scope.

48. This was not a straightforward case: It was a case where a suicide conclusion was likely but in which the family had raised specific concerns about matters they considered were causative of Aiden's death. Some of those matters related to Aiden's treatment by public authorities, and a number of them – for example

the impact of delays in the provision of gender affirming care on trans people,[2] and the availability and regulation of poisonous substances such as [redacted] – are matters which previous inquests have considered with great care and have been the subject of PFD reports. Thus, this was plainly a case where a PIRH should have been held.

49. The Defendant erred by failing to follow the Chief Coroner's guidance and hold (or even consider holding) a PIRH in this case without good reason.

50. Further or alternatively, it was unfair and/or irrational not to direct a PIRH be held in circumstances where the family had raised concerns about the scope of the inquest, and the limited witness list and disclosure that was provided to them.

Ground 5: refusal to adjourn the inquest was unfair and/or irrational

47. The Defendant's refusal to adjourn the inquest was unfair and/or irrational in the circumstances of this case.

48. The family were informed that the inquest would take place just seven days before the final inquest hearing. They were unable to find legal representation in that short period of time. Given the family were unrepresented at the final inquest and had real concerns about the scope of the inquest, the nature and extent of the evidence that had been gathered, and the manner in which the Defendant was exercising her duty to register Aiden's death, it was unfair and/or irrational to refuse to adjourn the inquest – even for a short period – so that the family could find legal representation, properly consider the disclosure they had been provided with, and make informed representations. The Defendant's suggestion that there was no purpose to an adjournment, because the Claimant had been unable to find legal representation in the short time between the notification of the listing of the documentary hearing and the hearing itself, was a *non sequitur*.

Ground 6: failure to adjourn the inquest as a reasonable adjustment

47. The Defendant was on notice that the Claimant is autistic at the start of the hearing, and in the Claimant's submissions requesting an adjournment. The Claimant requires additional time to process information in order to understand and respond to it fully. The Defendant was under a duty under Article 6 and at common law to make reasonable adjustments to the coronial process for the Claimant to ensure she could have a fair hearing. That included ensuring the Claimant had sufficient time to process the material disclosed to her and make informed representations.

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[2] See, for example the PFD report produced by [redacted] Assistant Coroner for the Brighton and Hove and West Sussex https://www.judiciary.uk/wp-content/uploads/2023/12/Alice-Litman-Prevention-of-future-deaths-report-2023-0503_Published.pdf

[3] See, for example, the PFD report produced by HM Assistant Coroner [redacted] following a six-day hearing at Surrey Coroner's Court: https://www.leighday.co.uk/news/news/2024-news/coroner-calls-for-government-departments-to-take-ownership-of-suicide-risk-from-poisonous-substance-after-inquest-into-the-death-of-22-

48. The Claimant notified the Defendant that she had difficulty engaging properly in the hearing, given the limited time she had with the material prior to the hearing and her lack of legal representation. The seven days' notice of the inquest was insufficient for the Claimant to fully grasp the material. In addition, it was not clear from the Defendant's question about the Claimant's autism whether the adjournment could have been a reasonable adjustment in itself, or if the Defendant was asking something else. Being asked this question on the day of the inquest made it incredibly hard for the Claimant to advocate for herself and her needs. The Claimant made it clear in her submissions for an adjournment that the timeframe was insufficient, given her neurodivergent processing needs.

49. In refusing to adjourn the inquest, even for a short period of time, the Defendant put the Claimant at a material disadvantage and failed to make the necessary adjustments she was obliged to make.

Ground 7: determination limiting scope of inquest was unlawful and/or irrational

49. The Defendant's decision to limit the scope of the inquest to exclude the concerns raised by the family about Aiden's treatment, or lack thereof, by the ICB, GP and SABP was unlawful and/or irrational for the following reasons.

50. **First**, the Defendant failed to make reasonable enquires in respect of a number of points raised by the Claimant.[4] The Defendant failed to ask Aiden's GP questions regarding her decision-making in the consultation she had with Aiden on 18 February 2025, and what impact his decision-making had on Aiden's well-being and mental health. The decision was also reached prior to making any enquiries of, or receiving evidence from, the ICB or SABP. The premature decision was thus made without the decision-maker being acquainted with the information necessary to answer the question of whether the matters raised by the family were relevant to the exercise of her duty to investigate how Aiden came by his death (or speculative as she suggested).

51. **Second**, the Defendant erred, on the material before her, in considering that there was "*no evidence*" that the matters raised by the family more than minimally contributed to Aiden's death. All that the family needed to show was that the matters they raised were not "*so remote*" that they could not have even arguably contributed to Aiden's death. As to the delays Aiden experienced in receiving gender affirming care having been on the waiting list for the Tavistock Clinic for more than four years with no bridging support, the letter Aiden wrote prior to taking his own life made express reference to the fact that he was "*miserable*" because he hated his body and wanted to be a "*Proper biological boy*" with a "*flat chest, and a penis and testosterone*". Relatedly, as to Aiden's GP declining to prescribe him testosterone prior to his death, Aiden's medical records evidence that Aiden became very distressed following his GP's decision not to prescribe

[4] When making a public law decision, the decision-maker must: (a) "*ask himself the right question*" and (b) "*take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly*": *Secretary of State for Education and Science v Tameside MBC* [1977] AC 1014 at p.1065 (see, in respect of the specific requirements of the duty of enquiry, *Balajigari v Secretary of State for the Home Department* [2019] EWCA Civ 673

him testosterone and the family pointed to a documented change in his behaviour (i.e. researching suicide online) which took place soon after the GP consultation. Finally, it is difficult to see how SABP's decision to discharge Aiden without a full psychiatric assessment and the failure to provide care requested by the family did not at least arguably more than minimally contribute to his death, in circumstances where the family witnessed Aiden's mental health decline when his support stopped.

52. **Third**, the Defendant failed to consider whether the family themselves had evidence to give in respect of the impact of the length of time Aiden was waiting to receive gender affirming care had on his mental health, or the deterioration in his mental health in the period following the GP consultation in February 2025 or the withdrawal of care by SABP.

Ground 8: determination to hold a documentary inquest was unfair and/or irrational

53. The Defendant's decision to hold a documentary inquest under Rule 23 of the 2013 Rules was unfair and/or irrational.

54. That is so considering: (a) the Claimant raised concerns about how Aiden had sourced the [redacted], which the Defendant accepted was within scope and might be the subject of a PFD report, which was promoted to Aiden via his access to a suicide forum that was being investigated by OFCOM. That was a matter which required further evidence to be obtained and called; (b) it was not fair/rational to read the evidence provided by Aiden's GP and the SABP in circumstances where the Claimant noted she had specific questions for them. The Claimant should have been given the opportunity to challenge that evidence at an oral hearing; and (c) the Claimant had raised various factual errors and inconsistencies in the evidence that had been provided to her which were relevant to the question of how Aiden came by his death. Fairness required that those factual matters be resolved at an oral hearing.

Details of the action that the defendant is expected to take:

55. The Defendant is expected to quash the Inquest, commence fresh inquest proceedings and register Aiden as male on his death certificate.

Details of the legal advisers, if any, dealing with this claim:

56. See above.

Details of any interested parties:

57. The Chief Coroner.

Details of any information and document sought:

58. As you will be aware, the Claimant is entitled at this stage to relevant documents which are necessary for her to understand and properly identify the issues in dispute.

59. You will also be aware of your duty of candour, which requires you to "*assist the court will full and accurate explanations of all of the facts relevant to the issue the court must decide*" and to disclose materials "*which are reasonably required for the court to arrive at an accurate decision*": see *R (Quark Fishing) v Secretary of State for Foreign and Commonwealth Affairs* [2002] EWCA Civ 1409 at §50.

60. You must give "*full and fair disclosure of all relevant material*" and the duty of candour applies prior to the Court's consideration of whether to grant permission (*R (Police Superintendents' Association v Police Remuneration Body & ors* [2023] EWHC 1838 (Admin) at §15(3) and (9)). Furthermore, "*if documents matter, they should be provided. If they matter prior to or at the permission stage, that is when they should be provided. Not gists. Nor summaries. Not descriptions of contents or features of the document. Not selected quotations. Instead, the documents themselves. This is proper candid disclosure*" (*Police Superintendents' Association*, §18).

61. The duty of candour does not only arise once permission for judicial review has been granted. It arises before then, at the permission stage. Furthermore, "*similar considerations can be relevant in the parties' dealings with each other at the pre-action stage, as a matter of good practice*" as recognised in the Pre-Action Protocol for Judicial Review at §13 (*National Bank of Anguilla v Chief Minister of Anguilla* [2025] UKPC 14 at §91).

62. Against that background, and without limiting or qualifying the generality of the point just made, please provide the following information (and any documents evidencing the answers to the same):

    a. Any further internal guidance, policies, notes etc relating to how Coroners should record a trans person's sex.

    b. Any of the Defendant's notes, correspondence, memos, regarding the grounds of challenge.

Address for reply and service of court documents:

63. Please see above. We will accept service of documents by email to [redacted]

64. We would be grateful if you could please confirm whether service is accepted by email, and if so, confirm the correct email address for service.

Proposed reply date:

65. We look forward to receiving your response within 14 days, namely by 4.00pm on 17 December 2025.

66. Finally, please note we have made an application for legal aid funding for our client.

Yours faithfully

Leigh Day