**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. CHIEF EXECUTIVE SNOWDONIA NATIONAL PARK AUTHORITY** |
| 1 | **CORONER**<br><br>I am Nicola Jones assistant coroner, for the coroner area of North West Wales |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 22 April 2014 I commenced an investigation into the death of Dylan Arwel Rattray aged 21 years. The investigation concluded at the end of the inquest on 30 July 2014. The conclusion of the inquest was that the medical cause of death was 1a Multiple Injuries 1b. Consistent with a fall from a height |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>**The deceased was a fit and healthy young man who walked to the summit of Snowdon along the challenging route of Crib Goch with his friend who was of similar fitness. Neither were particularly experienced mountaineers. Their footwear was unsuitable to areas off the paths. It was their plan to stick to the paths on Snowdon they did not carry maps or guide books and were therefore heavily reliant upon the paths.**<br>**The pair decided to descend from the summit using what appeared to be an established path heading down towards Glaslyn. This covers an area known as Clogwyn Y Garnedd. After walking for 30 minutes the path petered out and the pair found themselves on loose scree. The deceased decided to press on as the pair realised that it was impossible to return the way they had descended due to the terrain. Moments later the deceased fell some 200 metres sustaining fatal injuries.**<br>**The surviving friend was left in a perilous position on the mountain and was rescued thanks to the joint efforts of the RAF search and Rescue Helicopter and Llanberis Mountain Rescue Team whose lives were also at risk due to the terrain. The deceased was recovered by the SAR helicopter but prior to the arrival of the helicopter some nearby walkers ( medical students) left the PYG track to attempt to assist the deceased. Their lives were also endangered by this act. The friend of the deceased gave evidence that the pair would never have taken the descending route had they known that this was not a continuous and established path.**<br>**At Inquest Mr [redacted] the Chairman of Llanberis Mountain Rescue Team gave evidence that there have been multiple casualties and rescues on Snowdon due to walkers using paths which appear to be established and continuous paths down /up the mountain but eventually peter out leaving walkers in life threatening situations. In April 2012 a walker died in similar circumstances to the deceased. He stated that on three occasions the LMRT have written to the Park Authority and** |

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| | **have requested that the Park Authority give serious consideration to breaking up these paths to prevent further serious injury and loss to life, not just to walkers but also to rescuers. He stated that LMRT did not feel sign posting alone would provide the necessary safeguards. [redacted] in particular requested minor changes to the definitive lines near the Summit of Snowdon in particular at The Watkin Path and The Cwellyn , together with work to diminish paths which appear established but peter out. The Snowdonia national Park did not follow the advice but invested in signposting. On the day of the Inquest another walker fell to his death in the same location of the deceased** |
| | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Whilst it is acknowledged that Snowdon is an inherently dangerous terrain which attracts millions of walkers of all abilities every year without incident in most cases, I am concerned that the Snowdonia National Park Authority have chosen not to follow the advice of an organisation such as the Llanberis Mountain Rescue Team which has been given in writing on two occasions detailing how the risk of future deaths and serious injury could be reduced.<br><br>(2) The deceased in this Inquest was a sensible , fit , hardworking young man, not a foolhardy risk- taker. He followed what he thought was an established path that would take him down to Glaslyn. Had the Park taken the previous advice of the Llanberis Mountain Rescue team to break up these misleading paths then this death would not have occurred as the deceased would not have attempted to descend the route which he took, which led to his death<br><br>(3) It is acknowledged that the Park not only has to consider budgetary constraints but also the difficult and dangerous terrain where improvement works would be required. However, unless robust and permanent measures are taken to ensure that walkers cannot access what they believe to be established paths at the Summit of Snowdon ( thereby providing a mistaken sense of security ) when such paths peter out and leave walkers in perilous positions, then I am satisfied that there will be repeated deaths in these circumstances on Snowdon . |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 October 2014. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted] father of deceased. [redacted] witness. [redacted] Chairman Llanberis Mountain Rescue Team. Chief Constable, North Wales Police. Senior Officer , RAF 22 Squadron, Valley, Anglesey. Chief Executive, Cyngor Gwynedd , who may find it useful or of interest. |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | **[DATE] 12/08/14 Nicola Jones** |