Kate Robertson
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Project Manager, Environment Department, Cyngor Gwynedd Council Landowner, Clough Williams-Ellis Trust
1	CORONER I am Kate Robertson, HM Senior Coroner for North West Wales
2	**CORONER'S LEGAL POWERS** 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** On 27 November 2023 I commenced an investigation into the deaths of Wilfred John Fitchett, Jevon Alexander Hirst, Hugo Oliver Morris and Harvey Graham Owen. The investigations concluded at the end of the inquests on 16 October 2024. A Road Traffic Collision conclusion was recorded with deaths for all four young men resulting from drowning.
4	CIRCUMSTANCES OF THE DEATH The circumstances of the death are as follows :- Hugo Morris was aged 18 at the time of his death. On 19 November 2023 he was driving a motor vehicle and carrying three passengers who were aged 17 (Wilfred), 16 (Jevon) and 17 (Harvey), along the A4085 Garreg, Llanfrothen having been on a camping trip when the motor vehicle in question veered onto the nearside grass verge and entered into a water-filled drainage ditch which led to the deaths of all four young men, where the existing signage would not have given adequate warning of the upcoming bend. The motor vehicle with the four young men was not found until 21 November 2023.
5	**CORONER'S CONCERNS** 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.

	The MATTERS OF CONCERN are as follows – a. The specific road area in question along the A4085 Garreg, Llanfrothen had a ditch downwards from the road at the nearside of the carriageway. This fills with water during heavy periods of rainfall. b. A stock fence had been erected (likely by the private landowner) cornering the lane of the road in question. It is understood that Cyngor Gwynedd had no responsibility for this given that it was on private land. The stock fence had been damaged and had not been replaced prior to the collision on 19 November 2023. c. Whilst the evidence could not determine whether or not the fence, had it been repaired and in situ at the time of the collision, would have altered the outcome the risk to road users who leave the road accidentally is that they may land in the ditch below the road level. d. Cyngor Gwynedd has installed a chevron board at the bend but there is no barrier or fence or otherwise to prevent motor vehicles leaving the road into the ditch at this bend in the event of leaving the carriageway accidentally.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 19 December 2024. I, Kate Robertson, the Coroner, may extend the period. 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 I have sent a copy of my report to the Families, Interested Persons, and to the Chief Coroner. I am also under a duty to send the Chief Coroner a copy of your response. 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	Dated 24 October 2024  Signature Kate Robertson HM Senior Coroner for North West Wales