GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executives of:** **Bannau Brycheiniog National Park;** **Natural Resources Wales;** **Neath Port Talbot County Borough Council;** **Rhondda Cynon Taf County Borough Council; and** **Powys County Council**
1	**CORONER** I am Rachel Knight H M Coroner, for the coroner area of South Wales Central.
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 22nd January 2026 I held a hearing where three inquests were conjoined as they all raised the same issue. The inquests related to the deaths of Helen Patching, Rachael Patching and Corey Longdon. I attach the Records of Inquest for each of the deceased. All three died accidental deaths within the area known as Waterfall Country within Bannau Brycheiniog National Park (Brecon Beacons).
4	**CIRCUMSTANCES OF THE DEATH** The hearing focused upon:- a. The safety measures in place in Waterfall Country .
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. (1) There is a high rate of accidents, including some fatal accidents, from trips and slips in the area known as Waterfall Country; (2) A previous Prevention of Future Death report has led to the erection of signage concerning the risk of drowning in the water itself. However, the current signage provision does not adequately address the significant additional risk of accidental falling. Many walkers fail to understand the official routes, closed and open paths and the significant risks they face; (3) Serious and fatal accidents will continue to occur unless these risks are addressed; and (4) Mobile telephone signal is poor to non-existent in certain more remote areas, which creates delay in alerting emergency services when accidents do occur.
6	**ACTION SHOULD BE TAKEN**

	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** You are under a duty to respond to this report within 120 days of the date of this report, namely by 9th June 2026. I, 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 of Helen Patching, Rachael Patching, Corey Longdon and to [redacted] who gave evidence during the inquest, who may find it useful or of interest. 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. She may send a copy of this report to any person who she 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	9 February 2026 **SIGNED:** [redacted] Rachel Knight H M Coroner for South Wales Central Coroner Area