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[redacted]
Prif Gwnstabl | Chief Constable

Friday, 16 October 2026

HM Assistant Coroner Sarah Riley
Coroner's Office
Shirehall Street
Caernarfon
Gwynedd
LL55 1SH

Dear Ms Riley,

Response to Report to Prevent Future Deaths (Regulation 28) concerning the deaths of Jayden Jackson Long and Eddie Joseph Hill

Thank you for your Report to Prevent Future Deaths dated 10 September 2026, issued following the inquest into the deaths of Jayden Jackson Long and Eddie Joseph Hill. North Wales Police has carefully considered the matters of concern identified within your report and welcomes the opportunity to outline the actions that have been taken and the arrangements now in place to address those concerns.

At the outset, I wish to acknowledge the tragic circumstances surrounding the deaths of both young men and the concerns identified during the course of the inquest. North Wales Police has reviewed the learning arising from this incident and has taken steps to strengthen policy, guidance, learning dissemination and quality assurance processes within the Force Communications Centre.

Matter of Concern 1

"Evidence identified that not all service failures had been recognised or recorded as areas requiring improvement e.g. there is no organisational policy or procedure in place to guide call handlers, call centre supervisors or others within the Force when responding to calls from remote, mountainous locations and no training is provided. A lack of guidance, training and documented process raises a potential for risks in the future."

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Following review of the incident and the organisational learning identified through the Death or Serious Injury investigation, North Wales Police has amended its Force Communications Centre Policy.

Version 4.1 of the policy, introduced on 16 September 2026, includes new guidance relating specifically to silent or discontinued 999 calls originating from remote or mountainous locations. The policy now states:

> *"In the event of a silent or discontinued 999 call being received from a remote/mountainous location, if the location is confirmed via EISEC (BT confirmed auto data) or other means of confirmation of location (e.g. GoodSAM Location Services) then consideration should be given to making the Mountain Rescue Team (MRT) aware for consideration of deployment if appropriate and relevant. Given the geography of North Wales, this action is proportionate as silent 999 calls from these locations, where the locations are confirmed, would be out of the ordinary."*

In addition, organisational learning arising from the investigation was communicated to all Force Communications Centre staff during July 2026. This learning highlighted the circumstances of the incident and reinforced the requirement for staff to notify a supervisor or Force Incident Manager where concerns exist regarding abandoned 999 calls from mountainous areas. The learning also reinforced the requirement to consider Mountain Rescue involvement where appropriate.

Training and guidance for new Communications Operators already includes instruction on the process for contacting Mountain Rescue Teams through the SARCALL system. This is supported by a dedicated Mountain Rescue Team Calls Crib Sheet, which is available to staff and forms part of the training and mentoring process. This material has now been supplemented by the additional guidance introduced through the revised policy. The guidance documentation is also available to Force Communications Centre staff through internal systems for ready reference.

Matter of Concern 2

"The systems in place for sharing identified learning were inadequate. Evidence identified that learning arising from this incident was shared primarily through discussions with individual members of staff. This may lead to inconsistent messaging and a difference in understanding."

The Death or Serious Injury investigation identified both individual and organisational learning.

Where individual learning has been identified, this is delivered through structured one-to-one discussions between the member of staff and their line manager. This approach ensures that the learning is understood, allows any concerns to be raised, and enables discussion regarding any development needs arising from the investigation.

Organisational learning arising from this incident was disseminated through a written communication issued to all Operational Support Services personnel. This communication detailed the circumstances of the incident, highlighted the learning identified and provided clear expectations regarding future practice. Supervisors subsequently reinforced this learning through local discussions with staff to ensure understanding and application.

North Wales Police considers that the combination of formal written communication and supervisory reinforcement provides a more consistent and auditable method for the dissemination of organisational learning.

Matter of Concern 3

"No evidence was available as to whether identified learning had been formally recorded or disseminated more widely across the Force."

North Wales Police can confirm that learning identified through Death or Serious Injury investigations is formally recorded by the Professional Standards Department.

Learning is entered onto a centrally maintained register, and its implementation is monitored through established governance arrangements. Recording learning in this manner enables progress to be tracked and provides organisational oversight through the Strategic Performance and Organisational Learning Board.

The learning identified from this investigation was formally recorded through these arrangements and subject to the relevant governance processes.

Matter of Concern 4

"Whether calls received by North Wales Police are routinely audited was not known. This raises a concern that service failures are not routinely identified and addressed."

North Wales Police can confirm that call handling activity within the Force Communications Centre is routinely audited.

Each Communications Operator is subject to review of three calls per month by their line manager. The completion and quality of these reviews are monitored through monthly governance arrangements. Where required standards are not met, management action is taken to address non-compliance.

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In addition, there is ongoing supervisory oversight of incidents within the Force Communications Centre. Greater scrutiny is now applied by Supervisors and Force Incident Managers to ensure that incidents are appropriately managed and that the correct actions are taken. Supervisory updates are required to be recorded on incidents and compliance with these processes is subject to review by Force Communications Centre managers.

Furthermore, closure of incidents recorded on the ICAD system is overseen by on-duty supervisors to ensure that all necessary actions have been completed and that incidents have been managed appropriately prior to closure.

Conclusion

North Wales Police has carefully considered the matters raised within your report. The Force has implemented amendments to policy, reinforced training and guidance relating to mountain rescue incidents and silent 999 calls from remote locations, ensured organisational learning has been formally communicated and recorded, and can confirm the existence of established call auditing and supervisory governance processes within the Force Communications Centre.

I trust this response provides reassurance that the concerns identified have been addressed and that lessons arising from this tragic incident have been recognised and acted upon.

Yours sincerely,

[redacted]

Prif Gwnstabl | Chief Constable

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