

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Sarah Riley, Assistant Coroner, for the coroner area of North West Wales.
2.	DATE OF REPORT 10th September 2026
3.	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.	THIS REPORT IS BEING SENT TO 1. North Wales Police You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th November 2026. I, the coroner, may extend the period if an appropriate application is made.

4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN 1. Not identifying all service failures 2. Inadequate systems for sharing identified learning 3. Learning not disseminated Force-wide 4. No routine auditing of calls
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On the 27th February 2026 , I commenced an investigation into the death of Jayden Jackson Long and Eddie Joseph Hill aged 19 and 20 years. The two individuals were discovered deceased at 11.04am on the 19th February 2026, having fallen down steep, mountainous terrain, in adverse weather with the ground covered in ice and snow. The investigation concluded at the end of the inquest on the 10th September 2026. The conclusion of the inquest was "accident". The cause of death recorded in respect of both individuals was "1a Multiple Traumatic Injuries"

8.	CIRCUMSTANCES OF DEATH JJL and EJH had travelled from their homes in Norwich to North Wales with the intention of climbing Snowdon. They parked in the Pen y Pass car park at 12.50pm on the 18th February 2026 and began their ascent. The route they intended to take is not known. Likewise, the route they did take is not known. At 16.22hrs, EJH sent his girlfriend a message noting that due to the weather they were going back down the ridge. We do not know what ridge they were on at the time. On the basis of this evidence, I found that they had not reached the summit and had begun their descent on or around 16.22hrs. At 16.27pm on the 18th February, North Wales Police were presented with a discontinued call from JJL's mobile. On playback, Jayden was heard to say "hello" followed by "can you hear me?" before contact was lost. North Wales Police made attempts to contact the mobile number from which the discontinued call was made but were unsuccessful. Attempts by North Wales Police to establish who the mobile number belonged to were limited and they did not contact Mountain Rescue until 19.38hrs. At that point, the following actions were agreed between North Wales Police and Mountain Rescue: 1. Can the Police ascertain the name associated with this phone? 2. What do North Wales Police know about the person who made the call? 3. What is the address associated with the mobile number. Once the address is known, can officers visit and discover whether a person from that address is believed or known to be in the North Wales area and planning to climb a mountain, particularly Yr Wyddfa/Snowdon? 4. Is there a vehicle associated with this person? 5. If there is a vehicle, is there any ANPR data for this vehicle? 6. Is the person believed to be alone or with others? The above intelligence enquiries had not been actioned in advance of contact with Mountain Rescue. There is no organisational policy or procedure available to guide staff in respect of the intelligence enquiries that should be considered in circumstances such as those with which NWP were presented in this case.

9.

CORONER'S CONCERNS

During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could 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. 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.
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.
3. No evidence was available as to whether identified learning had been formally recorded or disseminated more widely across the Force.
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.

10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> 1. North Wales Police 2. Family of Jayden Jackson Long 3. Family of Eddie Joseph Hill I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE Sarah Riley