REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF JAMES FRANCIS PARSONS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, Cornwall Council** **2. [redacted], Director, Porthleven Harbour & Dock Company**
1	**CORONER** I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & The Isles Of Scilly.
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 10 May 2022, I commenced an investigation into the death of James Francis PARSONS. The investigation concluded at the end of the inquest on 6 February 2023. The conclusion of the inquest was as follows. **Accidental Death**

	The four statutory questions - who, when, where and how – were answered as follows **James Francis PARSONS died at Porthleven Harbour on 23 April 2022 from drowning after falling off the harbour wall and into the harbour waters.** The medical cause of death was established on the evidence as **1a) – disease or condition directly leading to death** **Drowning** **1b) – any other disease or condition leading to immediate Cause of Death** **Alcohol intoxication**
4	**CIRCUMSTANCES OF THE DEATH** On 24 April 2022 Mr Parsons was reported to police as a missing person by his wife, [redacted]. Mr Parsons had spent the evening of Friday 22 April 2022 at the Porthleven Food Festival. He had been due to meet up with his wife at a rented holiday cottage in Porthleven on the morning of Saturday 23 April 2022. He failed to meet her as planned and was uncontactable. The police search revealed that Mr Parsons was last seen just before midnight on 22 April 2022 by a witness in the in the big tent at the harbour. The witness stated that Mr Parsons did not seem to be drunk at the time that they were speaking. On 4 May 2022 the fully clothed body of Mr Parsons was recovered from the sea, approximately 4 miles off the coast of the Isles of Scilly after being spotted by a fisherman. The post-mortem revealed no injuries and gave the cause of death identified above. Toxicology shows raised urine ethanol (alcohol) at 291 mg / 100 ML. For comparison, the legal driving limit alcohol in urine is 107 mg / 100 ML urine. The Inquest findings were as follows • Mr Parsons died after midnight, on 23 April 2023 after falling into the harbour waters and drowning. • Due to Mr Parsons body being located fully clothed, he fell into the water by accident and not through choice. • That if Mr Parsons was still conscious and was able to shout for help, he is unlikely to have been heard by anyone due to the noise of the ongoing

	events. • The alcohol consumed by Mr Parsons made it more likely that when entering the water this would increase the risk of drowning due to impairment of cognition and motor skills. • Police evidence revealed that the sea off Porthleven features a notorious current that means it is not safe to swim in the harbour. • The pier and harbour walls raised safety issues discussed below under matters of concern. The police evidence was that these safety issues amounted to a failing to ensure the safety of members of the public. • Responsibility for public safety rests with the Porthleven Harbour & Dock Company as the owners of the harbour, and with Cornwall Council as the licensing authority for the Food Festival.
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. There were safety issues revealed at Porthleven Harbour, particularly in the evening when festival goers will have been drinking alcohol. Sections of the harbour wall feature sheer drops into water with no railings and trip hazards. The pier presents a particular risk due the absence of railings on one side with a sheer drop into water, and being poorly lit. For anyone falling from the pier, swimming to safety will be difficult due to current and the absence of access ladders or refuge area. The pier is sometimes closed to access by the public but was not closed at the time of the festival.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 by 20 April 2023. 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 Chief Coroner and to the following Interested Person, [redacted] 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	**22 February 2023** **Guy Davies**