M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

09 January 2024 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **North Somerset Council (via their instructed solicitors, Clyde & Co)** **Boatfolk Marinas Ltd**
1	**CORONER** I am Myfanwy Buckeridge, Assistant Coroner for the Area of Avon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24th February 2023 an investigation was commenced into the death of Andrew James Rees. The investigation concluded at the end of the inquest on 9th January 2024. The conclusion of the inquest was: **Accident** The Cause of death was recorded as: 1a) Immersion in water
4	**CIRCUMSTANCES OF THE DEATH** Mr REES consumed very high levels of alcohol on a night out with friends on 3rd February 2023 which impaired his motor control when walking home severely intoxicated. His route home was alongside an unguarded part of Portishead Marina from which his body was later retrieved. He died at Portishead Marina Portishead North Somerset due to immersion in water
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) Boatfolk Marinas Ltd only In evidence it was identified that, in the vicinity of where the deceased was retrieved from the water, the rescue chain on the wall of the marina was broken and that the system of visual inspection in place by Boatfolk Marinas Ltd had not identified this. Whilst a monthly, documented visual inspection has been introduced it is a concern that visual inspection alone may be insufficient to identify the risk of a deteriorating chain. (2) **North Somerset Council only** During the course of evidence one of the triggers to generate a review of the Port Marine, Portishead Risk Assessment by North Somerset Council was stated to be a significant change of use but no formal assessment or measure of whether a change of use (e.g. increase in amount or type of footfall/increased cyclists etc.) had taken place was apparent.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Boatfolk Marinas Ltd and North Somerset Council, 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 11th March 2024. 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 persons: The Rees family 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	9th January 2024 Myfanwy Buckeridge Assistant Coroner