CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Blair Anthony KIDDLE**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Blair Anthony KIDDLE
Late of:	14 Sefton Street Ohauiti Tauranga
Occupation:	Lawyer
Sex:	Male
Date of Birth:	05 September 1971
Place of Death:	Waters off Motiti Island Bay of Plenty New Zealand
Date of Death:	01 January 2014
Cause(s) of Death	
(a). Direct cause:	Ischaemic heart disease and associated
(b). Antecedent cause (if known):	Atherosclerotic coronary vascular disease
(c). Underlying condition (if known):	
(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known):	

I have, under section 74 of the Coroners Act 2006, prohibited the making public of the following:

i) The photographs forming part of the evidence
ii) The addresses, telephone numbers, e-mail addresses (where applicable) of persons who have provided signed statements in evidence.

Those findings, and my reasons for making them, are also set out in my written findings dated 25th February 2015.

Signed at Rotorua on 25th day of March 2015.

Coroner Wallace Bain

THE OFFICE OF THE CORONER
AT ROTORUA
(In Chambers)

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquiry into the death of **BLAIR ANTHONY KIDDLE**

Before: Coroner Wallace Bain

Date of Findings: 25th February 2015

FINDINGS OF CORONER WALLACE BAIN (IN CHAMBERS)

I record I opened an inquiry. I decided pursuant to section 80(b) of the Coroners Act 2006 not to hold an inquest for the purposes of my inquiry because the death was not one in official custody and care, and I have also complied with the requirements of section 77 of the Coroners Act 2006 and have received no notification from any person of an intention to give evidence in person.

I, Wallace Bain, Coroner at Rotorua, HEREBY CERTIFY pursuant to section 94 of the Coroners Act 2006 and having considered all the information available for the purposes of the inquiry into the death of the said deceased and for the purposes of section 57 of the said Act I find:

Blair Anthony Kiddle, Lawyer, who died in the waters off Motiti Island on the 1st January 2014 the cause of death ischaemic heart disease and associated atherosclerotic coronary vascular disease.

(1) I have considered all available evidence including:

- Police reports to the Coroner
- ESR Toxicology Report from Matthew Hosking (Forensic Toxicologist)
- Post-mortem report from Dr Simon Stables (Forensic Pathologist)
- Dive Squad report
- Witness Statements

(2) I am satisfied that all the elements of the "first purpose" of an inquiry set out in section 57 (2) Coroners Act 2006 have been established.

(3) I am satisfied that the requirements of section 77 (hearings on papers and chambers findings) have been satisfied without holding an inquest. In particular I am satisfied that persons from whom evidence is generally to be heard for the purposes of an inquiry do not wish to give evidence in person for the purposes of the inquiry. I am also satisfied that notice has been given of my proposal to make a hearing on the papers and make chambers findings to member of the immediate family of the deceased, who concur in the inquiry being concluded on the papers by way of chambers findings.

BRIEF FACTS

(4) Mr Kiddle apparently had no medical problems and had recently had a medical check and was clear. He got those checks because he wanted to be a certified scuba driver. He had completed a diving course in Bali. On the day of his death he was scuba diving with two other friends near Motiti Island. They were diving in about 15 metres of water and on return to the surface Mr Kiddle was seen to be falling backwards with a glazed look on his face. His friends managed to get him to the surface and began CPR but unfortunately he died. It is important to record that the pathologist found significant ischaemic heart disease which gave him an abnormal heart rhythm and resulted in his death. The Police dive squad review states that the equipment used did not contribute to his death but some other failure in the dive practices were identified but due to his inexperience it is stated that a rapid ascent was a contradiction to safe diving practices and combined with his ischaemic heart disease of which he was unaware it has resulted in his death.

(5) Pursuant to section 74 of the Coroners Act 2006, I prohibit the making public of the following:

(i) The photographs forming part of the evidence.

(ii) The addresses, telephone numbers, e-mail addresses (where applicable) of persons who have provided signed statements in evidence.

Signed by the Coroner at Rotorua this 25th day of February 2015.

Coroner Wallace Bain

Regional Coroner - Bay of Plenty