**CERTIFICATE OF FINDINGS**

**Section 94, Coroners Act 2006**

IN THE MATTER of **Tyron Mitch NORTH**

**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: | Tyron Mitch NORTH |
| Late of: | 23 Park Estate<br>Rosehill<br>Papakura |
| Occupation: | Unknown |
| Sex: | Male |
| Date of Birth: | 17 November 1973 |
| Place of Death: | Lake Pupuke<br>Takapuna<br>Auckland<br>New Zealand |
| Date of Death: | 15 July 2011 |
| Cause(s) of Death | |
| (a). Direct cause: | Drowning |
| (b). Antecedent cause (if known): | |
| (c). Underlying condition (if known): | |
| (d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known): | |

Circumstances of death (if known): Tyron Mitch North and Daniel Waata Stoneham drowned in Lake Pupuke on the 15th July 2011. Daniel and Tyron were undertaking a deep dive to 39m as part of the diving course they were completing with Helix Training Ltd. The group consisted of 8 members including one instructor, two trainee instructors and 5 student divers. The dive was to be the last of 25 qualification dives, to a depth of at least 30 metres. The dive was a deep dive using a descent or shot line. After gearing up and a briefing on shore, the group swam out to a position on Lake Pupuke where the descent line was positioned. No member of the group was carrying a knife or cutting implement or a torch. Tyron North and Daniel Stoneham were over weighted for a fresh water dive. A further briefing followed and the group was instructed to be positioned around the descent line and were then to descend at a rate no faster than the instructor. Once the group reached their target depth, they were then to return to the surface. The target depth was 39m. As the group descended, the men maintained the rate set by the instructor for the first 5m but then quickly fell out of formation, descending at a much quicker rate than the instructor. At a depth of between 25m - 30m, visibility suddenly decreased to blackout conditions. The divers lost sight of each other. Daniel and Tyron became disoriented, affected by nitrogen narcosis and vertigo, as the men continued to descend, dropping to the lakebed at a depth of 54m. Daniel and Tyron became stressed and panicked. Neither

Daniel nor Tyron inflated their BCD nor dropped their weight belt. Tyron became entangled in the descent line. I find that the decision made by Tyron and Daniel to descend at a rate faster than the instructor has contributed to their deaths. I also find that the failure to inflate BCD's and / or drop weight belts has contributed to the deaths. Although the decisions and actions were decisions and actions of Tyron and Daniel, there is no suggestion that such decisions or actions were made with the intention of causing death. The deaths of Tyron North and Daniel Stoneham are therefore found to be accidental.

I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that, in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

Pursuant to section 57(3) Coroners Act 2006 I recommend as follows:

1. All diving instruction courses using Lake Pupuke as a dive site should set datums on dive profiles so that the target depth of a dive cannot be exceeded.

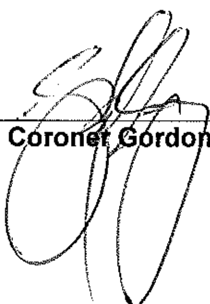
2. All diving courses should emphasise to their students the need to carry appropriate equipment on all dives including:

   a. A dive knife or other form of cutting implement that is easily reachable in an emergency;
   b. A source of light in restricted visibility;
   c. A watch or timing device on all dives so that time as well as depth can be monitored;
   d. An arrest line rather than a descent line be used when performing deep dives during training.

I direct that a copy of these Findings be distributed to all instructional diving courses in New Zealand with the request that the circumstances of this death be discussed with trainee divers. This will reduce the chance of other deaths in similar circumstances in the future by highlighting the need to follow the instructions of the instructor, carry appropriate gear, the importance of pre-dive checks, considering the possibility of the loss of or restricted visibility during the dive and encourage better planning of training dives.

Those findings, and my reasons for making them, are also set out in my written findings dated: 24th July 2013.

Signed at Hamilton on 29th day of July 2013.



**Coroner Gordon Matenga**