DECISION

IN THE CORONER'S COURT HELD AT RANGIORA

IN THE MATTER of the Coroner's Act 1988 AND IN THE MATTER of an Inquest into the deaths of STEPHEN JOHN SINTES, NEVILLE GORDON BENNETT and STEVEN LESLIE COPE

Before: Coroner D 0 Crerar

Hearing: 13th November 2006

Appearances: Sergeant D Harvey for the Police

In attendance: Family Members and Interested Parties

Expert Witnesses:

Sergeant P Summerfield

Senior Sergeant B Adams - Police National Dive Squad

Dr L Taylor - President NZ Underwater Association

Mr D B Carter - Technical Director NZ Underwater Association

STEVEN JOHN SINTES Witnesses:

Wayne Arthur Smith Joanne Marie Smith Constable D A Riley

NEVILLE GORDON BENNETT Witnesses:

Michael James Galbraith

Graham Ernest Bennett

Sergeant David Robert Edward Harvey

STEVEN LESLIE COPE Witnesses:

Murray Edward Jones

Robin David Jones Constable Lee Stokes

Constable Nicolai Anton Leslie Wenborn

Media Representatives: Christchurch Press Northern Outlook

North Canterbury News Hurunui News

DECISION OF CORONER D 0 CRERAR

DECISION

1. An Inquest is a legal or judicial enquiry to ascertain or decide a matter of fact. The term Inquest is the entire enquiry from the moment that the Coroner decides to open an Inquest after receiving a report of a death from the Police and includes both the preliminary investigations and the formal public hearing.

2. Section 15 of the Coroners Act states that a Coroner holds an Inquest for the purpose of establishing as far as possible that a person has died, the persons identity, when and where the person died, the causes of death and the circumstances of death and make recommendations, or comments, on the avoidance of circumstances similar to those in which the death occurred or on the manner in which any person should act in such circumstances, that in the opinion of the Coroner, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in such circumstances.

3. As Coroner for the North Canterbury / Kaikoura Police District I have, over the last decade, held Inquests into a number of deaths of persons engaged in water activities off the east coast of the South Island, such deaths could be loosely termed "diving deaths".

4. The number of the deaths, and the fact that some, at least, exhibit a number of common factors, has persuaded me to conduct a more comprehensive investigation, in respect of diving practise and the diving industry, than would be the case if I was faced with merely a single death in such circumstances. There have been constraints in respect of logistics, witness availability and time, which have meant that the investigations, and the Inquest hearing, may not be as timely or comprehensive as some may consider appropriate but I am none the less grateful for the contribution made by the those persons and organisations making submissions or giving evidence to the Inquest hearing or otherwise assisting the Police with the presentation of the three particular cases I have considered.

5. I particularly acknowledge the contribution made by Sergeant David Harvey of the Rangiora Police. Sergeant Harvey is an experienced diver. He has been responsible, on behalf of the Rangiora Police, to collate all of the information placed in front of the Inquest hearing and has been responsible for both the summonsing of, and liaison with, the witnesses. The Court is grateful to Sergeant Harvey for his assistance which is above and beyond the role of his normal duties.

6. As part of my investigations into the circumstances of the deaths of STEPHEN JOHN SINTES, NEVILLE GORDON BENNETT and STEVEN LESLIE COPE, I have undertaken research into other "diving" deaths and received from other New Zealand Coroners copies of their Findings in relation to deaths in similar circumstances. My researches were by no means exclusive but included the Finding of Coroner R G McElrea of Christchurch after the Inquest into the death of David John Beecroft; the Finding of Coroner P Radich in respect of the Inquest into the death of Robert Kenney Davidson; the Finding of Coroner T L Savage in respect of the Inquest into the death of Alan Stuart

Tippett and the findings of Coroner C H Ayrton in respect of the Inquests into the deaths of Winifred Hazel Absalom and Diane Rachel Brocklehurst.

7. In some of the cases investigated there were underlying medical conditions which, if declared, would have resulted in the, now deceased, diver being advised not to dive. In other cases the real cause of the diver getting into difficulty appears to have been equipment related.

8. There is a common theme in the comments of Coroners who have presided over all of the Inquests. These comments follow recommendations from experts giving evidence to the Inquests. Divers ought to ensure that they are physically and medically fit for diving, that they are using the appropriate equipment and that they have received appropriate training, including the concept known as "buddy" diving.

9. In two earlier cases, into which I have been required to conduct an Inquest, the bodies of the deceased divers have not been able to be located. A definitive ruling on the medical cause of death is therefore impossible. In two other Inquests I have held, in respect of deceased divers whose bodies have been recovered, the medical cause of death has been pulmonary barotrauma (burst lung) and I or decompression disease with gaseous damage to brain tissue (the bends). The brief circumstances of each of these deaths appear to similarly identify difficulties with equipment, health and experience/training.

10. The paper produced in evidence by Dr Lynn Taylor (Exhibit No. 15) summarises, also in general terms, the causes and circumstances of the deaths of 18 divers who dived in the period 2000 - 2005. Of these, 10 divers suffered some underlying medical condition which could have contributed to their deaths and ought to have been considered by each to have disqualified them from diving. Other causes were attributed to a lack of experience (or a lack of recent experience), inadequate training, diving without a "buddy" and poorly maintained, or poorly selected, dive equipment. The similarities in the statistics are alarming.I will refer to my concerns later under Conclusions and Recommendations.

11. The Inquest hearing held on the 13th November 2006 heard evidence from a number of witnesses. Within this Finding I will treat some of those witnesses in the following list as "generic" and as expert witnesses. By this I mean that each of these witnesses has given evidence as an overview of diving practice both as an industry and as a recreation.

12. I have not overlooked the fact that, in conducting the hearing I was required to focus upon, the purposes of Section (1) of the Coroners Act 1988. The Inquests relate to the deaths of three divers. Out of courtesy and respect I will arrange for the formal Finding for each death to be in two separate parts. The first part will be the generic overview referred to earlier; the second part will be specific to the individual death in respect of which I am required to hold an Inquest. Although witnesses were heard, in the case of the specifically identified individuals, in a specific order, I have

adopted the convention that Inquest hearings normally hear evidence first in respect of deaths which occurred earliest in time.

13. I will ensure that the full Finding is made part of the Inquest record for each of the deceased. Copies of all evidence will be appended to the file for each of the deceased namely NEVILLE GORDON BENNETT, STEVEN LESLIE COPE and STEPHEN JOHN SINTES. The originals of the generic exhibits and evidence will be appended to the file of NEVILLE GORDON BENNET and copies only will be attached to the Findings and files of STEVEN LESLIE COPE and STEPHEN JOHN SINTES. I will brief the Ministry of Justice accordingly when the Findings are lodged with the Coronial Services Administrative Support Officer by me.

14. The first witness to the combined Inquest hearing was SERGEANT PETER GREGORY SUMMERFIELD, (Sergeant Summerfield), the Canterbury District Search and Rescue Coordinator based at Christchurch. At my request the Police provided, through Sergeant Summerfield, details of the location where each of NEVILLE GORDON BENNETT, STEVEN LESLIE COPE and STEPHEN JOHN SINTES went missing. In addition, at my request, Sergeant Summerfield gave evidence in respect of the location of the death of GREGORY JOHN BUCKLAND, another diver in respect of whom I had previous conducted an Inquest, who went missing in 1994.

15. Sergeant Summerfield gave comprehensive evidence, assisted by a Power Point presentation, showing both a general overview of the North Canterbury coastline and then, specifically, locations where each of the deceased went missing. Further evidence was able to be given in respect of the aerial searches conducted for some of the divers. I will record specific search procedures for each of the deceased, separately. I express my confidence in the search procedures and am satisfied, from the evidence given by Sergeant Summerfield that each disappearance was followed by a comprehensive search conducted with an appropriate level of care and expertise.

16. DAVID BRUCE CARTER (David Carter) Technical Programs Manager for the New Zealand Underwater Association (NZUA) also gave evidence. David Carter has been involved in the dive industry since 1979 and has been in this role for the Association since then. His responsibilities within the dive industry include acting as auditor, certifier or tester of cylinder filling stations and he also conducts nation-wide updates and seminars for scuba cylinder testers and air fillers. David Carter is a Maritime New Zealand authorised person to audit safe operational plans for small dive vessels and is authorised by Maritime New Zealand to issue certificates of competency for Masters of small commercial dive boats and for diving activities supervisors.

17. In his role as Technical Programs Manager and principal auditor of the scuba auditing programme (SCAP), one of the duties of David Carter is to complete air purity checks at air filling stations nation-wide. NZUA now require air purity checks to be conducted four times annually. David Carter gave evidence that there are six dive shops in Canterbury registered as air filling stations. He conducted regular audits of each. Particular mention was made of the audit of "Dive HQ Ltd", Moorhouse Avenue, Christchurch and "Kaiapoi Dive Shop", Ohoka Road, Kaiapoi. The

Certificates produced proved that cylinders filled at each of these filling stations comply with the required air purity standard.

18. LYNN TRACEY TAYLOR (Lynn Taylor) has been President of the New Zealand Underwater Association since 2003. She is an experienced diver with a number of academic and professional qualifications and, as dive safety, and education co-ordinator, for the NZUA, she has co-authored articles and given presentations on diving related issues.

19. Lynn Taylor produced to the Inquest detail of training standards set by the professional dive training agencies - PADI and SSI. Also produced to the Inquest by Lynn Taylor was a "Health Status Screening" questionnaire and a "Best Practice Guideline for Recreational Diving", both prepared by NZUA.
Lynn Taylor also produced a copy of the NZUA review of the "Five Years of Coroner Inquest Reports Into Diving Fatalities in New Zealand", referred to earlier, and a paper on "Dive Medicals in New Zealand".

20. Lynn Taylor gave evidence that the NZUA sent a letter to its members on the 3rd April 2006 setting out resources available in relation to diver health reviews and diver medicals.

21. Lynn Taylor, after producing her formal evidence, answered a number of questions from Sergeant Harvey, for the Police, and from myself. I found the evidence of Lynn Taylor of great assistance.
A recreational diver is not required by legislation to have any formal qualification or undergo any training. The training programmes offered by the industry cover theory and practical advice on diving and what to do in difficult conditions and in emergencies. There is an "industry best practice promoted by NZUA, but compliance is voluntary.

22. A specific matter, of interest to the subject matter of the inquests, revolved around the questions of Lynn Taylor by Sergeant Harvey in relation to NZUA recommendations for the safety equipment to be utilised by scuba divers. Lynn Taylor responded that NZUA does not have specific recommendations but follows what is recommended by the training agencies. Devices such as safety sausages, an air horn and a surface signalling torch or mirror as well as dye or gel which can be released on the surface and seen by aerial searchers, were discussed. Lynn Taylor was unaware of the underwater effectiveness of EPIRB.

23. NZUA adopt the recommendation of both PADI and SSI in relation to "buddy diving". Lynn Taylor quoted standards from standard safety diving practices promoted by NZUA.

24. Sergeant Harvey asked Lynn Taylor about dive conditions off the Motunau coast and specifically raised the issue of strong currents and in limited visibility. Lynn Taylor confirmed NZUA practice recommendations to divers in such conditions.

25. SENIOR SERGEANT BRUCE ROBERT ADAMS (Senior Sergeant Adams) is currently Officer in charge of the Police National Dive Squad stationed in Wellington.
Senior Sergeant Adams gave specific evidence in respect of the searches for Neville Gordon Bennett and Steven Leslie Cope. These searches were unsuccessful. Extracts, summarising the evidence of Sergeant Adams in respect of the Police National Dive Squad action during the searches, will be included in the Findings specific to each of these deceased persons.

26. The Police National Dive Squad located the body of Stephen John Sintes on the 20th March 2006. I will refer to the Police Dive Squad evidence in the Finding specific to the death of Steven Sintes.

27. Senior Sergeant Adams gave evidence that the Police National Dive Squad have received, over the past 10 years, 46 sets of equipment for examination and reporting following diver deaths and the recovery of their bodies and equipment.

28. In commenting upon actions which contribute to diver deaths the Police National Dive Squad have identified factors as follows:

1. Using all of the available air supply
2. Exceeding safe ascent rates
3. Exceeding dive times and/or allowing insufficient times between dives
4. Incorrect set up of equipment 5. III fitting equipment
6. Use of equipment that has not been maintained
7. Carrying excessive buoyancy weight
8. Using equipment not specific for diving
9. Diving without a partner
10. Diving after consuming alcohol or drugs
11. Securing catch-bags or other equipment to their person
12. Diving without formal training
13. Exceeding diving capability
14. Diving without having undergone a diving medical examination
15. Diving with medical conditions which are contra-indicated to diving
16. Conducting unsafe diving activities
17. Failing to monitor weather and water conditions

29. Senior Sergeant Adams stated his belief that it is often a combination of a series of factors which cause death to occur. One factor on its own can be dealt with by a diver. A combination of events places the diver under stress, panic ensues and the diver is unable to deal with the successive factors as they arise.

From the research I have been able to undertake, and from the evidence given to me at these Inquests and previously, I concur with the factors identified by Senior Sergeant Adams.

NEVILLE GORDON BENNETT

1. At about 9.40am on 26th December 2003 the Police were called to co-ordinate a search for a missing diver off the Motunau Coast.

2. NEVILLE GORDON BENNETT (Neville Bennett) had been camping with his extended family at the Hurunui River Mouth and travelled, on the morning of the 26th December 2003, to Motunau, to go diving.

3. GRAHAM EARNEST BENNETT (Graham Bennett) of Templeton, near Christchurch a Truck Driver, the brother of Neville Bennett, gave evidence to the Inquest . They travelled to Motunau from the Hurunui River Mouth not by the main roads but by farm roads, which led more directly to Motunau.

4. Graham Bennett asked questions of the expert witnesses during the Inquest as to whether the height gain achieved by travelling over the farm access roads may have contributed to a diver's difficulties in the water. My understanding of the responses is that a relatively modest gain in elevation, an hour or so prior to diving, would not have contributed significantly to any difficulties.

5. Graham Bennett and Neville Bennett reached Motunau at approximately 6.30am where they were joined by Michael James Galbraith (Michael Galbraith). After seeking directions, Michael Galbraith, Graham Bennett and Neville Bennett took their boat out to sea and then anchored. Michael Galbraith and Neville Bennett went diving. Neville Bennett encountered difficulties with his equipment but eventually submerged and followed down the anchor rope. At about 7.35am Michael Galbraith surfaced. Graham Bennett could still see the bubbles from Neville Bennett they were travelling Northeast under the boat to where Michael Galbraith had surfaced. Graham Bennett raised the anchor - this took some time because it was jammed - and moved to where Michael Galbraith was waiting.

6. In his evidence Graham Bennett said "I said to Michael that something was wrong, Neville should have been up by now and I have lost track of his bubbles."
"The bubbles were like the water was boiling, like a submarine coming up." I had never seen anyone dive before and I just thought that was what happens when a diver gets to the surface."

7. Mike Galbraith got into the boat and fixed its location by GPS. They drove around the area searching but saw no further bubbles. They tried to call for assistance but received no reply from their radio. Another boat was located, and

this continued searching whilst Mike Galbraith and Graham Bennett returned back towards the shore calling 111 for assistance at 8.02am.

8. Graham Bennett gave evidence of a helicopter search and of searching by other boats.

9. Graham Bennett also gave evidence that his brother had undertaken dive training courses. He understood they were both "basic" and "advanced" with Dive Headquarters in Moorhouse Avenue, Christchurch. Neville Bennett purchased all his gear from Dive Headquarters and was "very fussy" about his equipment. His tanks were checked in the days before the dive. Graham Bennett knew that Neville Bennett had undertaken at least six dives.

10. The evidence of MICHAEL JAMES GALBRAITH (Michael Galbraith), a Drilling Supervisor of Rangiora, was sworn before me on the 7th January 2004. Michael Galbraith was employed in Peru, South America and it was considered appropriate that his evidence be taken at a time suitable to him and prior to the Inquest hearing.

11. The evidence of Michael Galbraith confirmed the evidence of Graham Bennett. Michael Galbraith reported that the weather on the day was calm and clear and that there was a slight chop on the sea. The conditions were good and no one had any concerns.

12. In referring to the dive, Michael Galbraith said Neville Bennett had a little trouble getting the air out of his BCD. He was a little buoyant. On descending the anchor line Neville Bennett stopped at about 6 metres. Michael Galbraith was at about 14 metres so went back up and met him at about 7 metres.

"Neville was having trouble equalising. He pointed to his ears and shock his head. I indicated that he should wait and calm down. He tried to equalise blocking his nose, his eyes seemed "beady". I spent some time with him at that 7 metres. He was not comfortable. He indicated that he was going up. He pointed to his ears, thumbed towards the surface and then drew his hand across his throat indicating he had had enough and was going up. He started to go up. He was holding on to the rope and starting pulling himself up. He had one hand on the rope and the other on his BCD inflator. There was no panic in the way he went up. "

13. Michael Galbraith descended to the bottom, caught a few crayfish and surfaced about 200 metres to the east of the boat. Michael Galbraith called out to Graham Bennett and asked where Neville was. Graham Bennett said he could still see his bubbles. They were heading in a northerly direction and were close to the boat. A current pushed Michael Galbraith away from the boat. After about 10 minutes, still not having seen Neville Bennett, Michael Galbraith was retrieved by the boat. He recorded, on his regulator, a depth reached of 22 metres.

14. Michael Galbraith continued to describe the search and the call for rescue assistance. Michael Galbraith gave further evidence.

"Neville was an inexperienced diver."
"He had not dived for 12 months."
"It was our first dive together. "

Neville had told me some stories about his diving experience. He told me once about him
"coming up so fast he was almost out of the water. " "He may have mentioned equalising problems previously but I cannot recall."

15. Michael Galbraith gave evidence that the clothing and equipment of Neville Bennett was all very new gear although it had been borrowed by a friend whilst Neville was away and had not been serviced. Michael Galbraith knew that Neville Bennett had completed a dive course and an advanced dive course about two years previously and considered that he had good fitness although Neville Bennett had complained of
"a crook stomach this morning. " "I think it may have been nerves. "

16. SERGEANT DAVID ROBERT EDWARD HARVEY (Sergeant Harvey), a Police Sergeant stationed at Rangiora, gave evidence for the Police in relation to the disappearance and search. Six vessels conducted a sea search in conjunction with the Canterbury Westpac Rescue Helicopter. The following day the search (both sea and aerial) continued.

17. The aerial search continued on the 28th and 29th December 2003 in good or reasonable conditions. On 4th January 2004 the Police National Dive squad carried out an underwater search.

18. Senior Sergeant Adams was asked to hypothesise in relation to the disappearance of Neville Bennett. He had of course been able to listen to the evidence of the witnesses to the events. The most reasonable and probable explanation is, that during the decent described by Michael Galbraith, was that Neville Bennett had trouble "equalising" and, after suffering either pain or panic, lost his regulator, inhaled water and drowned.

SUMMARY
In spite of the comprehensive search and in spite of the Police giving a description of the diving equipment worn by Neville Bennett, to both commercial fisherman and recreational divers operating out of Motunau, no trace of Neville Bennett or his equipment has been found.
I am satisfied, from evidence given to me at this Inquest, that Neville Bennett, for reasons unknown has failed to surface after diving and has drowned.

STEVEN LESLIE COPE

1. Evidence in respect of the disappearance of, and presumed death of, STEVEN LESLIE COPE (Steven Cope) was given to the Inquest by MURRAY EDWARD JONES, (Murray Jones), a self employed plumber who resides at Christchurch. Murray Jones is an experienced diver who has been diving for about 20 years. The majority of his, between 60 - 80, dives per season, have been in the Motunau area.

2. Murray Jones gave evidence that the dive party on Saturday the 17th December 2005 included his brother Robin Jones, who has been diving for about 17 years, Bruce Rattray with whom Murray Jones had been diving for about 7 years and Paul McFarlane whom he has known for three years and with whom he had been diving for about 18 months.

3. Steven Cope was the Physiotherapist for Murray Jones and mentioned to him that he would like to get back into diving having completed an advanced divers certificate previously. Murray Jones and others had dived off Motunau on the weekend of the 10th - 11th December 2005. Murray Jones expressed no concerns about the competency of Steven Cope or his equipment.

4. On the 17th December 2005 the group, Murray Jones, Paul McFarlane, Robin Jones, Bruce Rattray and Steven Cope met in Christchurch and travelled to Motunau. They embarked in their boat and arrived at their dive location at about 7.45am on that date. Murray Jones told Steven Cope that they would dive together. Murray Jones assisted Steven Cope with his mouth piece and regulator and followed him into the water. They talked on the surface. Murray Jones checked the gear of Steven Cope again. Steven Cope was told they were diving to a rock at 22 metres. Steven Cope agreed to follow the bubbles of Murray Jones to where Murray Jones would be waiting.

5. Visibility at the bottom was about 2 - 2.5 metres but visibility was not as good going down. Once at the bottom Murray Jones checked his gear and waited for Steven Cope moving first down current and then back again to the marker buoy. Murray Jones said:
"I never saw him again. / though he may have had gear trouble and gone back to the boat. I pretty much confined my dive to the search / did for him and / did not want to go too far in case he turned up. "At about 22 minutes, I saw my air was getting low so I made my ascent back. I was first out of the water. Robin had remained on the boat and he pretty much saw me straight away when I popped up."

6. As soon as he got back to the boat, Murray Jones assumed Steve Cope would also be surfacing at about that time. Although he did not use his air as quickly as Murray Jones thought he might, the party became anxious about Steve and his air supply and commenced searching.

7. ROBIN DAVID JONES (Robin Jones), the brother of Murray Jones, a self-employed drainage contractor of Christchurch, gave evidence to the Inquest. He is an experienced diver, having completed about forty dives per year for the last twenty years; the majority of these dives have been in the Motunau area.

8. Because of ear problems, Robin James had not dived for several years. He gave evidence of the preparations. He was boatman and was helping Murray Jones, Bruce Rattray, Paul MacFarlane, and Steve Cope. They set out from Motunau at about 7:30 am and went straight to the reef upon which they wished to dive, the divers reaching it about 7:45 am. They put out a buoy.

9. The party checked their gear before they entered the water. Murray Jones and Steve Cope descended a few minutes prior to Bruce Rattray and Paul MacFarlane. Each had discussed the depth of the dive they were to undertake. Those less experienced were to dive to around eighteen to twenty meters. Murray Jones intended to dive to twenty-two meters.

10. The weather conditions included a southerly tide pulling North, with the swell it was about one meter, which was quite messy with chop. There was a slight Southwest wind. It was overcast. The surface visibility was good. From the chop on the surface, observers couldn't tell where the divers were from their air bubbles.

11. Robin Jones idled around the South of the buoy looking North, to give better visibility with the light. He did this because the drift was North and he could see divers when they surfaced. Robin Jones waited for divers to surface. He picked up his brother Murray Jones after about thirty minutes, approximately thirty meters north of the marker and then moved back to the marker. He then picked up Paul MacFarlane and Bruce Rattray, thirty meters Northwest of the marker and Northeast of the marker, respectively.

12. They did not see Steve Cope and assumed he had surfaced and drifted North. They zigzagged about looking for him, but after fifteen minutes, it was decided that the longer Steve Cope was left, the further he would drift. They called for help.

13. The Westpac helicopter was tasked and, once in the air, asked for GPS location. Bruce Rattray, was by then at the helm of the boat and it returned to the buoy to obtain co-ordinates. They remained at this site, dropped anchor and waited, not returning to Motunau until 9:00 pm.

14. The observation of Robin Jones about Steve, was that he was *"really fit", "keen to get in the water" "no hesitation", "happy about it" and "appearing to enjoy himself*'.

15. ROBERT BRYAN STOKES (Robert Stokes), a Police Officer of Christchurch, gave evidence that he had known Steve Cope for approximately twenty-five years. At the time of the disappearance of Steve Cope, Robert Stokes was

employed as Advanced Paramedic Crewman on the Westpac'rescue helicopter. As a sideline, Robert Stokes purchased and sold dive equipment.

16. Steve Cope discussed his starting diving again with Robert Stokes and requested advice, After the dive the week before Steve Cope disappeared, he spoke to Robert Stokes. Robert Stokes thought, from the symptoms explained, that Steve Cope came up too fast from that dive. Robert Stokes assisted Steve Cope with his choice of equipment and arranged for this to be serviced. Robert Stokes counselled Steve Cope over dive procedures and safety.

17. By coincidence, Robert Stokes was Crewman of the Westpac helicopter when it was tasked to look for Steve Cope. Robert Stokes gave evidence of there being four persons on the helicopter looking for a person and considered that if a person had been on the surface, they would have been located.

18. STEPHEN JOHN LEE (Steve Lee), a team manager residing at Christchurch, gave evidence of his background in diving and specifically, on work in dive shops to service equipment. He knows Robert Stokes well. Robert Stokes specifically recalled the equipment of Steve Cope and its repair and testing. He believed this was appropriate in all respects.

19. NICOLAI ANTON LESLIE WENBORN (Constable Wenborn), a Police Constable stationed at Kaiapoi, gave evidence for the Police. As Relieving Constable at Cheviot, Constable Wenborn was directed to Motunau at about 9:30 am on 17th December 2005. Constable Wenborn gave evidence of the search, which included the Westpac rescue helicopter, three Motunau based charter vessels and the North Canterbury Dive Club vessel. Later they were joined by the Canterbury Coast Guard vessel and a fourth commercial boat from Littleton. A comprehensive search was undertaken of all locations to which Steve Cope may have drifted. Constable Wenborn interviewed the witnesses, Murray Edward Jones and Robert David Jones and spoke to the other divers Paul Hone MacFarlane and Bruce Rattray.

20. At 4:10 pm, the Police National Dive Squad arrived in Motunau. They were taken to the marker buoy established by Robin Jones and undertook two dives in the vicinity but did not locate anything.

21. A further search was undertaken by aeroplane on Tuesday the 20th December 2005, but neither Steve Cope nor any equipment was located. On the 12th February 2006, the Police posted signage requesting information and describing his equipment and the location in which he was diving. Constable Wenborn made further enquiries but established that the equipment of Steve Cope was appropriate and had been professionally serviced.

SUMMARY

In spite of the extensive searches, no trace of Steve Cope or his equipment has been found. I am satisfied from the evidence given to me at this Inquest that Steve Cope, for reasons unknown, has failed to surface after diving and has drowned.

STEPHEN JOHN SINTES

1. Evidence in respect of the death of Stephen John Sintes (Steve Sintes) was given to the Inquest by WAYNE ARTHUR SMITH (Wayne Smith), a company manager who resides at Clarkeville. Steve Sintes worked for Wayne Smith, and the brother of Wayne Smith, Nigel Smith, and managed their workshop. They had a good relationship as employer and employee and this developed into a friendship.

2. Wayne Smith had been diving for about 12 years. Wayne Smith said that he did not know what training Steve Sintes may have received, but did know that there had been a gap of between 7 or 8 eight years since Steve Sintes had last dived. Steve Sintes and Wayne Smith went on a couple of fishing trips together. Steve Sintes asked to go diving with Wayne Smith. Wayne Smith had reservations in relation to the diving equipment of Steve Sintes, thinking that it was outdated but said that when they were diving, Steve Sintes was surprisingly confident and exhibited no bad habits. They dived regularly together. Steve Sintes had his gear checked at the Kaiapoi Dive Shop and he was stated to be "fussy" with his gear. Steve Sintes became more fit each time he dived and his air consumption improved the more he went diving. Steve Sintes had been updating his equipment in the year prior to his death.

3. Steve Sintes and Wayne Smith agree to basic safety rules - they always descended using the anchor rope and didn't dive if visibility was low, they discussed what to do if they ran out of air and acknowledged the phenomenon "crayfish fever", which results in divers not looking at their air gauge and continuing to search for crayfish when they ought to have been ascending.

4. The collecting bag for crayfish used by Steve Sintes, was of an older style and was equipped with a "posi-catch" where the opening works only one way. Steve Sintes had the bag hooked to his weight belt by a hose clip. Wayne Smith recalled no problems with use of the catch bag. Wayne Smith invited Steve Sintes to go diving with him and his father. Steve Sintes was stated as being excited about going diving. No concern was expressed about the health or alcohol consumption of Steve Sintes and there appears no medical reason for any diving problems he encountered.

5. Mark, an instructor for the Kaiapoi Dive Shop, had also been diving with Steve and gave advice and assistance with checking and filling tanks and weight belt.

6. Steve Sintes arrived at Motunau Beach early on Sunday the 19th March 2006. He and Wayne Smith checked sea conditions and agreed to go out in the boat for the purposes of diving. Steve Sintes was seen checking and laying out his gear and it was loaded into the boat carefully and stowed neatly. Wayne Smith drove the boat out to Kirsten's Reef,

approximately 2.5 miles east of the Motunau Beach bar and slightly south of Motunau Island. Both Wayne Smith and Steve Sintes were familiar with the area; they did not consider it to be a risky dive site.

7. Steve Sintes and Wayne Smith agreed to dive one at a time to leave "two skilled sets of eyes on board the boat". Wayne Smith saw Steve Sintes prepare for the dive and considered the preparation to be normal. He stated that the visibility in the water was about 3 to 4 meters and that the swell of the sea was about one meter, which made matters more uncomfortable for those in the boat than divers in the water. The current did not appear to be a problem. Before Steve Sintes went into the water, both Wayne Smith and his wife Joanne Smith, checked his gear and made sure that everything was appropriate. Steve Sintes went into the water, swam to the anchor rope and went down. He was expected to resurface between 20 and 25 minutes later.

8. His bubbles were spotted a couple of times but, because of the choppy nature of the sea, they could not be seen all of the time. This was not a matter of concern.

9. Regular checks were made, but after 25 minutes, Wayne Smith expressed concern and knew that Steve Sintes was in trouble. They checked, downwind and down current, to see if Steve had resurfaced further away and then requested assistance from another boat to search for their missing diver. Wayne Smith called for help on the VHF radio.

10. JOANNE MARIE SMITH (Joanne Smith) of Clarkville, near Rangiora, gave her occupation as `housemother'. Her evidence was that she knew Stephen Sintes "really well for the past two years", he being employed as a mechanic by her husband, Wayne Smith. Joanne Smith was always manning the boat when her husband and Steve Sintes went out diving. She described him as, from not having dived for some years, to maturing into a confident diver whose fitness had improved rapidly. The evidence of Joanne Smith was that Steve Sintes upgraded his dive gear during the time he was diving with them.

11. Joanna Smith recalled the Sunday morning, which was the day Steve died. He arrived at their property in Motunau Beach and carefully checked and loaded his equipment. *"There was nothing different that he did that day than he does every time".*

12. Sea and weather conditions after the boat was launched do not appear to have been ideal with what appears to be a Southerly wind and the water described as "really murky" between the land and Motunau Island but out further "getting clearer". Joanne Smith assisted Steve Sintes with his equipment and checked his gauges. She observed Steve Sintes in the water and did not consider there was a current because he was able to swim freely to the anchor rope. Joanne Smith, and others on the boat, watched for bubbles of Steve Sintes in the water from time to time. Wayne Smith expressed concern when he was told by Joanne Smith that Steve Sintes had been in the water for 20 minutes and said that Steve had been "too long". All in the boat looked around to see if Steve Sintes had popped up further away. The boat left its anchor at 8:06 am and sought assistance from another boat further out. That boat assisted in the search. Wayne Smith

returned to the Kirsten's Reef anchorage and called for help on the VHF Marine radio, stating that "we had a diver missing".

13. Constable David Allen Riley (Constable Riley), a Police Constable stationed at Cheviot Police Station, stated that about 9:00 am on Sunday the 19th March 2007, he was directed to Motunau Beach by Police Communications to investigate a missing diver. Constable Riley established a temporary base and participated in a search for the diver, which was being co-ordinated by the Coast Guard. Three private boats, two local commercial fishing boats and the Westpac rescue helicopter were involved in the search. Local sources ascertained that a surface diver would have been taken by the northerly tidal drift from the point where Steve Sintes disappeared in a northerly direction. The surface search did not locate Steve Sintes, though the wind had dropped and the sea became calmer later in the day and the search was assisted by a fixed wing aircraft.

14. On Monday the 20th March 2006 the Police National Dive Squad was tasked for searching the area Steve Sintes was last seen. The aerial search continued by the fixed wing aircraft. At about 3:20pm Police divers located the body now known to be that of Steve Sintes. Constable Riley produced evidence of identification for Steve Sintes in the form of fingerprint records. The fact of death was adequately established.

15. A Post Mortem examination of the body of Steve Sintes was conducted at the Christchurch Hospital mortuary on the 21st March 2006 by Dr. K.R. Anderson. The body had been severely predated by marine animals. From other evidence given at the Inquest, it accepted the major predation had been by Spiny Dogfish. There was also extensive infestation by sea lice. Because of the severely compromised nature of the body, no accurate cause of death could be established.

Dr. Anderson noted *"in the absence of internal organs, particularly the lungs, it not possible in telling whether the death was due to drowning or other cause. Coronary heart disease and cerebral haemorrhage or infarct can be excluded with the exception of cerebellar pontine haemorrhage. There are no injuries to suggest trauma causing death"*.

In the opinion of Dr. Anderson, death was due to "indeterminate causes". I am satisfied however that, from the totality of the evidence I have received, the death of Steve Sintes was most likely drowning. I will refer to this later.

16. The report of the recovery of both the body and the diving equipment of Steve Sintes was produced to the Court by SENIOR SERGEANT BRUCE ADAMS (Senior Sergeant Adams) of the Police National Dive Squad.

The evidence of Senior Sergeant Adams is summarised as follows:

(i) On Monday the 20th March 2006, Constable Cockerell was part of the Police team that located Steve Sintes on the seabed off Matanau Beach at a depth of approximately 24.6 meters. He was not tangled or caught in any obstacles although his catchbag was connected to his weight belt. His equipment was "intact and appeared assembled correctly". Constable Cockerell removed the diving equipment for purposes of examination and completed a schedule of same. He noted, in particular, that the dive equipment, the BCD, regulators, gauges and cylinders were correctly assembled. The cylinder valve was turned on correctly, but this was closed by him to preserve any air content for analysis.
(ii) Other dive equipment, specifically clothing, was left on the body and was later removed at the mortuary.

(iii) The Police National Dive Squad testing was comprehensive. In summary, it does not appear as if there were any faults or defects or any operational shortcomings in the air cylinder or the cylinder valve or the regulator gauges or the buoyancy compensator device (BCD).

(iv) In the "Comment", Constable Cockerell noted:
"I do not believe that the cylinder or its contents were a contributing factor in this death. I believe that the empty cylinder and water contained indicate the circumstances/events of this death, that the deceased has consumed all of his available air supply and attempted to reach the surface but failed and descended to the seabed."

(v) The first stage regulator was not believed to be a contributing factor to the death. The primary regulator second-stage/demand valve was also tested. The comment of Constable Cockerell was:
"had this valve inverted prior to the dive commencing, the diver would have experience water entering his mouth immediately when first entering the water. Air would not be delivered from the cylinder on demand, hence given the pre-dive checks observed by the deceased's associates and duration of the dive observed, I do not believe that the exhaust valve was inverted prior to the dive, but is an indication of the events that had occurred as discussed with the finding in the cylinder section".

(vi) Constable Cockerell did not believe that the regulator was contributing factor to the death but noted the inverted exhaust valve as an indicator of the final events leading to the death and showing that the deceased had *"breathed his cylinder dry"*.

(vii) It was noted that the equipment used by Steven Sintes did not possess a secondary regulator stage second-stage demand valve, which is designed largely as a redundant backup to be used should the primary/medium second-stage, fail.

(viii) It is noted that it was common for experienced divers not to have a secondary air supply and in this case Constable Cockerell did not believe that the absence of one was a contributing factor to the death. The gauges in the equipment show no damage and, when tested, provided accurate readings. It was not considered that the gauges were a contributing factor to the death.

(ix) The BCD, when tested, appeared undamaged and all controls were stated as functioning correctly. It was not believed that the BCD was a contributing factor to the death.

(x) The wetsuit of Steve Sintes was subject to examination by both Senior Sergeant Adams and Professor Malcolm Francis, Principal Scientist for Inshore and Pelagic Fisheries of NIWA. Professor Francis found that the bite marks to the wet suit (top and trousers) were inflicted by one or more small sharks. These were probably those of a Spiny Dogfish, a species which is abundant in the location and which were seen by Constable Cockerell when Steve Sintes' body was located and recovered. It was not considered that Spiny Dogfish are dangerous to humans and it is thought unlikely that they would attack a living diver. In the opinion of Professor Francis, the Dogfish bites were inflicted after death.

(xi) The weight belt of Steve Sintes was checked by Constable Cockerell and an explanation was given in the evidence as to the need for a weight belt. The 10 kilograms of weight carried on the belt was not considered an excessive amount. A diver will normally "ditch" his weight belt in an emergency if he is having a problem ascending. Constable Cockerel) stated:
"The weight belt was not ditched by the deceased".
"It is not uncommon for divers in a stressful situation (such as running out of air supply and attempting to get to the surface) to do, or omit to do, actions that would assist their survival (such as ditching a weight belt). This is due to panic and focussing on an end result (reaching the surface) and not on action that would assist (ditching the weight belt). This omission is not uncommon, even in experienced divers, once panic sets in".

(xii) Attached to the weight belt of Steve Sintes by a lanyard rope was a catch bag containing 25 crayfish. I heard conflicting evidence as to the legal limit for crayfish in the Motunau area. It is between 6 and 10 crayfish per day. The amount of crayfish in the catch bag would have made Steve Sintes more negatively buoyant. The catch bag was attached to the weight belt, which could have been abandoned by simply opening the quick-release buckle. This would have released both the weight belt and the catch bag, making the diver more buoyant and easier to reach the surface, The catch bag itself was not easily detached.

(xiii) The opinion of Constable Cockerell was:
"I do not believe that the weight belt itself was a contributing factor to the death, but the full catch bag attached to it would have made the deceased negatively buoyant".

(xiv) The mask and fins of Steve Sintes were in good condition and did not appear to be a contributing factor to the death.

(xv) Constable Cockerell commented upon the training and medicals of Steve Sintes. He considered Steve Sintes "not an experienced diver". There is an industry standard for recreational divers to undergo a "Diver's Medical" when undertaking their first training course. No further medical examinations are required for recreational divers thereafter. The dive industry has examined the issue of recreational divers and their medical examinations. Safety guidelines have been adopted, which include a recreational diver's health status screening questionnaire, a requirement to undergo a medical review of their suitability to diving on entry into the sport and divers are advised to seek medical review if there is a significant change in their health that would affect their diving. The NZUA recommends that more close consideration to medical issues by recreational divers be given.

(xvi) I append the "Comment" and the "Summary" of Constable Robert Cockerell, noting that this is endorsed by Senior Sergeant Adams.

COMMENT
"The deceased has breached at least three safe diving drill practises during his fatal dive;
Not monitoring his gauges; Diving without a partner; and
Securing additional weight that cannot be abandoned quickly.
The deceased has failed to monitor his gauges and has run out of air. Had he monitored his air consumption he should have left the bottom with 50bar enabling him to complete his ascent to the surface at a safe rate, and to overcome any events that may occur.
Diving in pairs is a recognised safe diving practice as it endeavours to ensure that if problems occur the partner is able to respond to the predicament and offer assistance to the diver in distress.
In this case a dive partner could have offered to share his air supply by either a secondary air source, "octi" or buddy breathing allowing them to ascend to the surface at a safe rate, or assist in overcoming any possible predicament encountered.

Securing fully laden catch bags or other weight equipment that cannot be abandoned quickly hampers the diver's movements and makes it harder for the diver to ascend to the surface. The diver should carry catch bags and simply let it go, should they encounter difficulty.
Securing catch bags to weight belts, which can be abandoned quickly by ditching the weight belt as one unit, places the diver at risk of becoming extremely positively buoyant in an instant and having a rapid, uncontrolled ascent and suffering a diving illness such as decompression sickness (the bends) leading to an arterial gas embolism or pneumothorax."

SUMMARY
"My examination of the equipment used by Mr. SINTES during his fatal dive found that his equipment was in reasonable condition and sufficient for the dive.

The manner in which his catch bag, that contained 25 crayfish and was attached to him, did not allow quick release in an emergency.

In an emergency situation attempts to release this could promote panic, poor judgement ultimately leading to exhaustion in an anxious diver.

This may have been a contributing factor in this death.

The regulators and buoyancy device were both in reasonable condition and functional.

The cylinder contents slightly exceeded standards for carbon dioxide but this would not adversely affect the function of the equipment or prevent air supply to the diver. It is probable that this raised level is due to material within the water in the cylinder decaying (post death).

It is probable that the deceased has descended to the sea floor and conducted his dive without monitoring his contents gauge.

I believe that the deceased has either run out of air, panicked when he has finally looked at his gauge and realised he is out of air, or very low on air, and attempted to reach the surface but failed, and drowned.

Failing to monitor cylinder contents during a dive and consuming all air supply is a diver error. Correct monitoring of gauges could have prevented this incident from occurring.

It appears that even though the deceased has been a trained diver for some time, he has had a substantial break. Only in the past few years had the deceased got back into diving.

Police have established that deceased had dived the location previously but how many times is not known.

Had the deceased been accompanied by another diver it is possible that this situation could have been prevented.

I believe the equipment was functional and not a contributing factor in this incident, but did indicate the circumstances leading up to the death."

Robert Cockerel) Constable RCJ594
Police National Dive Squad

SUMMARY

17. In summary, there is little more for me to add to the statements by Constable Cockerell of the Police National Dive Squad. The equipment used by Steve Sintes was in reasonable condition and appropriate for the dive he was undertaking. It was functional and was not considered to be a contributing factor. Steve Sintes had descended to the sea floor and collected crayfish without adequately monitoring a gauge showing his available air content. Steve Sintes either ran out of air, panicked when he looked at his gauge and realised he was out of air, or being very low on air, attempted to reach the surface. The result is that Steve Sintes drowned. The training and experience of Steve Sintes is accepted as being appropriate for the dive he was undertaking. A significant contributor to the death was the manner in which the catch bag of Steve Sintes was attached to him. It did not allow quick release in an emergency and contained 25 crayfish which was significantly over the allowed limit for crayfish collection in the area with this being confirmation of "crayfish fever" mentioned early in this Finding.

CONCLUSIONS

1. As I stated, at the commencement of the Inquest hearing and, as recorded in the preliminary paragraphs of this Finding, I had hoped to be able to complete a comprehensive review of New Zealand dive deaths in recent years with a view to making comprehensive Recommendations.

2. (a) The most compelling evidence I heard was that of Senior Sergeant Adams. Deaths investigated by the Police National Dive Squad and by Coroners and by NZUA, normally result from a combination of factors. This is, in fact, common with other deaths investigated by a Coroner. Often one single adverse event is insufficient to create a difficulty. It is when one event is followed by another and then perhaps another, in close proximity that deaths result. These are termed "an event cascade".

(b) Sergeant Adams stated:

"I believe that often it is not one specific event that causes the death to occur, it can be a combination of a series of incidents or factors, which normally, when they occur on their own, can be dealt with by a diver."

"But when the diver is faced with a combination of events at one time, this places the diver under enormous stress and panic ensues. This situation is not under the control of the diver and they may not be able to deal with it successfully."

3. (a) The contributing factors identified by Sergeant Adams (and listed in generic paragraph 28 of this Finding) identify the problems for those with diving as a chosen recreation.

Factors 1 to 13 inclusive and factors 16 and 17 can loosely be grouped under the heading of Training, and factors 14 and 15 grouped as Medical.

(b) In her Report, produced as Exhibit 15, Dr. Taylor also noted that there are common themes within dive deaths among them inexperience, diving in conditions which are outside their training or their level of experience, diving after

inactivity for long periods of time, equipment not being well maintained and either diving alone or becoming separated from buddies.

(c) I am satisfied, from the evidence presented, and whilst I am unable to comment on the quality of the training programs given by the major agencies, these programs appear to be accepted by the New Zealand Underwater Association as being appropriate. There is an obvious difficulty in that the completion of a PADI or SSI course is not compulsory and/or any individual can embark upon diving as a recreation without undergoing any training at all. There are obvious difficulties too, with the quality and length of the training programs and, because the programs are voluntary, there does not appear to be any need to "pass" a course. Even if training were compulsory, it appears as if there is no requirement or obligation for re-training or ongoing experience. I heard evidence from witnesses, advising me that a lack of recent dive experience or fitness is something which is taken into account when considering the difficulty of a dive.

(d) The New Zealand Underwater Association, in exhibits 13, 14, 15 and 16 which were produced to the Inquest, clearly understands and promotes to its members, the need for a medical examination before either embarking upon diving training or before diving.

4. (a) It is significant to note that Senior Sergeant Adams, upon being questioned about the need for a companion to be in close proximity to, or, within viewing distance from, a diver at all times, said:
"that's probably one of the most fundamental rules in regards to safe diving practice, having a dive buddy with you and that's not going diving with someone, doing your own activities, but remain with each other throughout that dive".

(b) Dr. Taylor confirmed that it was the recommendation of the two major training agencies, PADI and SSI, that a diver should adhere to buddy systems throughout every dive. Both agencies accept that, with additional training, experience and appropriate equipment, solo diving is permitted. This requires a diver to have a lot of experience and carry extra safety equipment to be totally self-sufficient. By the latter I understood, Dr. Taylor to mean, was to include back up air supply and regulator.

Clearly, none of the divers whose deaths I have been called upon to investigate would qualify as being experienced and certainly none were experienced enough to be considered capable of solo diving. None carry a backup air supply and regulator.

5. (a) The area of Motunau, although appropriate for recreational diving, does have a number of recognised hazards, specifically poor visibility, strong currents and significant surface drift.

(b) Dr. Taylor referred to specific requirements in training for diving in difficult conditions and added that: *"diving in strong currents requires special training and experience"*. The PADI Manual recommends that if diving with poor

visibility *"is more difficult to stay with your buddy in limited visibility, so you must stay close to your buddy. If visibility is poor, consider cancelling the dive"*.

6. Another aspect of interest to me, taken from the evidence of Senior Sergeant Adams and Dr. Taylor, involved the ability of a diver who gets into difficulties underwater, being able to signal these difficulties. The Inquest was told of the existence of devices which signal low air availability to a diver and also of air sausages and poppers which could be used by a diver in difficulty to signal his or her need for help to those on the surface. Dr. Taylor advised of the existence of signalling devices for divers on the surface (a torch, mirror, etc., air horn whistle, dive or gel and a divers surface EPIRB).

7. (a) The evidence in respect of the disappearance of Neville Gordon Bennett also created, for me, an item of interest. On this occasion, there were two divers in the water and the boatman did not have a "spotter" to look for the divers with him and advised that he had no previous experience in being a boatman for divers.

(b) This is directly opposite to the precautions taken by the companions of Steve Sintes, who considered it preferable to dive with only one diver in the water at any given time to leave *"two skilled sets of eyes on board the boat"*. There is an obvious diversity in philosophy and practise. As well as an insistence upon "buddy" diving, there should be a standard practise of having a minimum number of trained spotters available during a dive expedition.

8. Dr. Taylor agreed that a person with no diving experience could purchase equipment, have a tank filled and go diving with absolutely no training. There does appear to be some "policing" in that, dive shops probably would refuse to fill a dive tank for a person without a dive qualification or without a "diving certification card".

9. I thank David Carter for his contribution to the Inquest hearing. His expert opinion clarified a number of matters for me. Because the equipment of two of the three divers in respect of whom Inquests are being held, were not able to be located and tested, are unable to draw any conclusions as to equipment failure or shortcomings in the filling processes, etc. David Carter did also give evidence recommending a dive boat master course. I do not intend this comment to be an adverse comment or critical of any individual who appeared at the Inquest and, in fact, the actions or inactions of the boat crew contributed in no way to the disappearance and death of any of the three divers. I do note however the existence of training courses and will refer to this further in my Recommendations.

10. The overall impression with which I am left is that NZUA, the dive equipment retailing industry, and the training agencies (PADI and SSI), understand the absolute need for training and medical clearance and have done their best to promote this to recreational divers, but that the lessons are not being learned.

11. One matter which I had considered, when considering holding the Inquests, and during the hearing itself, was to suggest that the appropriate agencies consider legislative change and, perhaps, the imposition of a statutory licensing

regime. I accept now that the industry and the recreational organisation are fully aware of the hazards and are doing their best to promote training and publicise the need for divers to be medically fit.

12. I specifically withdraw, therefore, from my intended course of calling for such investigation into legislative change, but do put the dive industry, the recreational organisations and the training agencies on notice that further deaths of recreational divers, with all such deaths having a common theme of a lack of training and experience or unsuitable medical conditions or inadequate equipment, then other Coroners may in future call for investigation into possible future law reform.

13. In response to my question as to what I as a Coroner could do to help the diving sport to become safer, Dr. Taylor advised that (and I do not use her words) more publicity and more education would be appropriate. Water Safety New Zealand is the umbrella organisation for the NZUA and I will ensure a copy of this Finding is distributed to that organisation.

RECOMMENDATIONS

I recommend that NZUA, which I accept is a voluntary agency, makes extra effort to ensure that all those who engage in diving as a pastime become members of NZUA in order that all divers benefit from its training and educative roles.

I recommend that Water Safety New Zealand seek more funding for the education role of NZUA. This Finding may assist each organisation, when approaching agencies for funding, to emphasise the potential benefits of such education and training.

I recommend that NZUA and the dive industry investigate further the availability of devices which could be used by a diver, whilst underwater and in distress, to call for assistance, and promote the use of such devices to divers.

I recommend that Water Safety New Zealand and NZUA co-operate with the retailers of diving equipment and services for them to take a leading and stronger role with the supervision of divers (perhaps during the tank filling procedure). More emphasis should be placed on the requirement for a diver when having his/her tank filled to satisfy the operators of the filling station that the diver is embarking upon a dive for which they are fit and qualified.

I recommend that the role of those in charge of boats, from which diving activities are based, take more training, specifically in the form of a Dive Boatmaster course. It is clear that the person in charge of a boat has responsibilities broader than those of merely taking the boat to and from the site for a dive.

I recommend that more emphasis be given by the training agencies (PADI and SSI), during diver training to the concept of "buddy" diving. In the three deaths currently being investigated by me, there appears to be little doubt that,

if a buddy had been in close proximity to each of the divers when they encountered difficulties, immediate aid from the buddy may have resulted in a different outcome.

I FIND THAT:
NEVILLE GORDON BENNETT of 14 Raphael Close, Rolleston, Christchurch died on the 26th December 2003 near Kirstens Reef, just south of Motunau Island near Motunau, North Canterbury. Neville Gordon Bennett disappeared whilst diving and his body has never been recovered. The cause of his death was drowning

I FIND THAT:
STEVEN LESLIE COPE of Christchurch, a Physiotherapist, died on the 17th December 2005 at North Reef north of Motunau Island near Motunau, North Canterbury. Steven Leslie Cope disappeared whilst diving and his body has never been recovered. The cause of his death was drowning

I FIND THAT:
STEPHEN JOHN SINTES of 206 Kaianga Road, Christchurch a Mechanic died at Kirstens Reef, just south of Moutunau Island near Motunau, North Canterbury on the 19th March 2006, whilst diving. The cause of his death was drowning. For reasons unexplained Stephen John Sintes failed to surface after a dive, during which he was collecting crayfish, and he has run out of air.

Dated at Dunedin this 27th day of August 2007
D 0 Crerar, Coroner

NOTE: This form together with the depositions, the prohibitions on publication and, where applicable, a certificate of registration of death, must be forwarded to the Secretary for Justice by the Coroner completing
the inquest.