IN THE CORONERS COURT
HELD AT HASTINGS
(In Chambers)

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an inquiry into the death of
William John GRANT

Date of death: 19 December 2009

Date of findings: 15 November 2010

FINDINGS OF CORONER

Introduction

[1] On 19 December 2009 William John Grant and six other persons went to Tatapouri Reef, near Gisborne for the purposes of collecting seafood using SCUBA. Three of the group (Mr Gingles, Mr Ryan and Mr Hughes) went out to the reef in a 12 foot aluminium motorised dingy. The remainder of the group including Mr Grant travelled out on kayaks.

[2] Mr Grant asked Mr Ryan if he could borrow his gear so that he could go for a dive. Mr Grant went for a dive using a dive cylinder and regulator owned by Mr Ryan, a weightbelt owned by Mr Hughes, and the remainder of the equipment which Mr Grant had hired from Adventure Dive in Gisborne. Mr Grant did not wear a wetsuit. Mr Grant dived with Mr Gingles as his diving buddy. Both of them collected kina, with Mr Gingles indicating to Mr Grant kina to collect. According to Mr Gingles, Mr Grant appeared to be a competent diver.

[3] After approximately ten minutes into the dive, Mr Gingles noticed Mr Grant slowly ascending towards the surface, holding onto his catch bag and heading towards the 12 foot dingy. Mr Gingles considered Mr Grant to be swimming normally. On the surface Mr Grant swam over to the dingy and spoke to Mr Ryan and Mr Hughes, indicating that he was having difficulty with his mask. Mr Grant held on to the side of the 12 foot dingy and they slowly made their way towards a small rock at the end of the Tatapouri Reef. Prior to reaching the rock Mr Grant let go of the boat, telling the two occupants that he would swim over. At that stage a very light sea breeze had come up, changing the surface conditions from a flat sea to a 1 to 1.5 foot swell. Mr Hughes observed Mr Grant playing with his mask, then a short time later Mr Grant was observed with his head down in the water, apparently looking at the sea bed.

[4] Mr Gingles surfaced from his dive and returned to the boat and queried where Mr Grant was. The three men in the boat observed Mr Grant still face down on the water but realising something was wrong powered over to him. They managed to pull Mr Grant on to the dingy and called for assistance from a nearby jetskier, who made contact with persons on a 9.2 metre dive boat who came to assist. CPR was commenced both on the dingy and following the transfer of Mr Grant to the dive boat. An ambulance was summoned and CPR continued by ambulance

staff following the return of the dive boat to the ramp. Mr Grant could not be revived.

[5] A post mortem examination was undertaken by Dr Richard Massey in Tauranga. Dr Massey was satisfied that Mr Grant's death was due to drowning. Sections of Mr Grant's lungs showed prominent intra-alveolar oedema. The changes present were consistent with drowning. A toxicology report showed a blood THC level consistent with Mr Grant having smoked the equivalent of a single cannabis cigarette from 0.5 to 6 hours prior to his death. Analysis also showed the presence of methamphetamine at a level consistent with recreational use. Traces of alcohol were detected in the blood and urine but the pathologist acknowledged that the traces may be due to means other than deliberate indigestion.

[6] An examination of the diving equipment used by Mr Grant was conducted by Constable Bevan Sheffield-Cranstoun of the Police National Dive Squad. Constable Sheffield-Cranstoun comments in his report that he believed the dive equipment used by Mr Grant did not contribute to his death, however:

- Mr Grant was heavily weighted/negatively buoyant;
- Mr Grant failed to wear a wetsuit;
- Mr Grant had ill fitting fins due to not wearing wetsuit booties
- Mr Grant failed to release his weightbelt when in difficulty, an indication of inexperience, panic, or being overcome quickly.

[7] There was evidence that Mr Grant suffered from epilepsy, and was prescribed medication for epilepsy, but that Mr Grant failed to take the medication regularly. In Constable Sheffield-Cranstoun's opinion, Mr Grant's medical condition contributed to his death on the basis that:

- Mr Grant had a medical condition- epilepsy, which is a contradiction to safe diving practices;
- Mr Grant appeared to be have been in denial about his medical condition. He failed to attend medical appointments and was not taking his medication for epilepsy;
- Mr Grant enrolled in an Open Water Course and Advanced Open Water

Course, failing on each occasion to complete the medical questionnaire honestly, hiding from Adventure Dive, Gisborne that he had a medical condition – epilepsy.

[8] Constable Sheffield-Cranstoun also commented that from his investigations he obtained evidence that Mr Grant had consumed alcohol the previous evening, and that the consumption of alcohol and use of cannabis and methamphetamine were contradictions to safe diving practices.

[9] Constable Sheffield-Cranstoun made several recommendations for recreational divers, namely:

- Ensure persons are medically fit to dive.
- All diving should be conducted in accordance with methods taught from training agencies.
- Divers need to conduct buoyancy checks to ensure they are neutrally buoyant prior to leaving surface.
- Seek medical advice if diving with prescription drugs, and never dive after taking recreational/illegal drugs.
- Do not dive within 10 hours of consuming alcohol.

Recommendation

[10] The issue was also raised about the obtaining of medical certificate as to fitness for persons undertaking recreational diving courses. As a result of Mr Grant's death, it is the recommendation of Constable Sheffield-Cranstoun to the Department of Labour and Dive training establishments within New Zealand to ensure persons obtain a diving medical with input/comments from their family General Practitioner prior to completing every course (an individual's national history must be checked for contradictions to diving). The only exemption would be for courses completed within one calendar year of the last dive medical so long as no significant change in health has taken place.

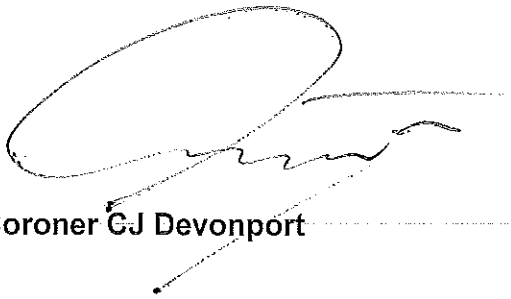
[11] **I endorse the recommendation** made by Constable Sheffield-Cranstoun directed to the Department of Labour and dive training establishments within New Zealand.

[12] I did not hold an Inquest into this death because the death have sufficiently disclosed the identity of the deceased, the date, place, cause of death, and circumstances concerning the death and the particulars needed to register the death under the Births, Deaths, Marriages, and Relationships Registration Act 1995. I did not consider that the holding of an Inquest would elicit any information further to that disclosed by the investigations which have been conducted, nor serve any other useful purpose.

Finding

[13] I am satisfied that William John Grant, aged 17 years, late of 139 Bushmere Road, Gisborne died at Turihaua Beach, Turihaua, Gisborne on 19 December 2009 from drowning. Mr Grant suffered from epilepsy and had consumed alcohol, cannabis and methamphetamine prior to his death.

Signed by the Coroner at Hastings on 15 November 2010



Coroner CJ Devonport