REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Professional Association of Diving Instructors, Pavilion 1, The Pavilions, Bridgewater Road, Bristol BS 13 8 AE.

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of North and West Cumbria

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.

INVESTIGATION and INQUEST

On 4th February 2013 I commenced an investigation into the death of Carl Andrew Morris, aged 39. The investigation concluded at the end of the Inquest before a Jury on 27th February 2014. The conclusion of the inquest was:

The Cause of death was:

1.a. Coronary Artery Occlusion
1.b. Coronary Artery Atheroma

The Conclusion of the jury was:

Died from a heart attack with an already compromised heart on 27th January 2013 whilst diving at Wastwater, Wasdale, Cumbria.

CIRCUMSTANCES OF THE DEATH

Mr Morris was a PADI member and was undertaking a TEC 50 diving course under the supervision of [redacted] another PADI member. The course was conducted under the PADI rules and regulations, which included a requirement for the diver to have a current medical certificate of fitness to dive. He had previously passed a Tec 40 and Tec 45 course.

On the 27th January 2013 Mr Morris together with another diver went to Wastwater in Cumbria to dive to 50metres as the third dive on the TEC 50 course. The instructor for the dive was [redacted]. During the dive, and when at around 50 metres, Mr Morris was seen to be breathing rapidly and indicated that he wanted to ascend. Mr Morris and [redacted] were ascending together, both having one hand on each other's harness. The ascent was rapid without compression stops, and at about 12 metres Mr Morris released his grip on [redacted] harness, and [redacted] lost his grip on Mr Morris's harness. [redacted] tried to grab the halo on Mr Morris's twin set of tanks, but missed it. He continued to the surface and there raised the alarm with the surface cover diver. He again went underwater to attempt to locate Mr Morris but had to resurface because he was suffering from difficulty with his sight. He subsequently recovered sufficiently to dive again to the bottom of the lake for a period of 26 minutes to carry out a grid search for Mr Morris, unfortunately without success. Mr Morris' body was recovered 2 days later.

[redacted], of the HSE gave evidence that having interrogated the dive computers it was clear that Mr Morris was breathing shallowly at the 12 metre mark, and then as he

sank directly to the bottom of the lake he stopped breathing.

The evidence of [redacted] Consultant Home Office Pathologist was that Mr Morris was suffering from degenerative narrowing of the coronary arteries (which supply the heart). This had caused an enlargement of the heart muscle. There was an occlusion (or blockage) of one of the arteries which would have compromised the blood supply to the heart muscle and precipitated a fatal heart attack from which he died.

It was clear from the evidence that Mr Morris had obtained an HSE medical certificate, in accordance with PADI rules when he had started the TEC 40 course in 2011. The medical certificate was dated 11 November 2011, and was limited to 6 months due to the doctors concerns about Mr Morris's BMI. No further medical certificate was obtained by Mr Morris to cover the TEC 45 and TEC 50 courses that he took part in. [redacted] said in evidence that because Mr Morris was himself an instructor he assumed that Mr Morris had an up to date medical certificate but confirmed that he did not ask to see a copy. Evidence was given that Mr Morris was suffering from high blood pressure.

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) Diving is both a method of work and a recreational sport. There is an inherent danger in diving, particularly when diving to a depth that requires decompression stops and the use of different gases. Because of the depth of the dives the risk of death or serious harm is significant.
(2) The inherent danger in Technical diving is recognised by PADI in that there is a requirement for members undertaking Technical diving courses to have a medical certificate confirming their fitness to dive.
(3) In Mr Morris's case he must have been aware of the need for a medical certificate, but omitted or neglected to ensure that his certificates were up to date for each course. No check was made to ensure that he was compliant for the Tec 50 course.
(4) Where recreational divers are undertaking Technical diving courses, particularly with Instructors who know them well, there is a danger that those requirements are overlooked, and there is no system for policing compliance.
(5) As PADI have recognised the need to ensure that divers, before starting a course, are compliant with the PADI rules, there should be a method devised to police the adherence to those rules.

ACTION SHOULD BE TAKEN

The Professional Association of Diving Instructors is in the position of devising the courses, supervising the level of training of Instructors, and providing certificates of competence. In my opinion action should be taken to prevent future deaths and I believe that the Professional Association of Diving Instructors has the power to develop a system for policing adherence to the requirements for its technical courses.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th April 2014. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

and his solicitors
Academy Divers
of the Health and Safety Executive.
of Salutaris Legal, the solicitors to PADI

I have also sent it to the following who may find it useful or of interest:
The Cumbria Constabulary

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.

3rd March 2014	SIGNED: David C Roberts

HM Senior Coroner
on behalf of Robert Chapman.