Record of Investigation into Death (without inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Stephen Raymond Carey, Coroner, having investigated the death of Jason Scott STEPHENSON

Find that:

a) The identity of the deceased is Jason Scott STEPHENSON ("Mr Stephenson");
b) Mr Stephenson died in the circumstances set out further in these findings;
c) Mr Stephenson was born in Bendigo, Victoria, on 28 January 1973 and was aged 40 years at the time of his death;
d) Mr Stephenson was a single man who was employed as a security guard;
e) Mr Stephenson died on 13 January 2014 at Picnic Beach, Eddystone Point, Tasmania;
f) Mr Stephenson died as a result of drowning whilst engaged in scuba diving, and
g) No other person contributed to the cause of Mr Stephenson's death.

Circumstances surround the death:

Mr Stephenson’s parents, May Cox and Laurie Stephenson separated when he was a child. He lived with his mother until he was approximately 15 years old at which time he attempted to live with his father. He then spent a period of time living on the streets in Sydney before then returning to live with his mother. He continued to live with his mother until 2012 when she relocated to Tasmania.

Prior to his death, Mr Stephenson had been in full-time employment as a security guard for approximately 5 years. He was an avid traveller, and was said to have travelled overseas on holidays at least twice a year. He also enjoyed scuba diving; in 2011 he gained his PADI level 2 open water dive qualification in Cambodia. Since that time he had completed multiple open water dives, the majority of which were recorded in his dive log book. A high proportion of those recorded occurred in South East Asia, in particular Cambodia.

Mr Stephenson moved to a share house following his mother’s relocation to Tasmania. He did not have a partner or children and was described by his family as a person who worked in order to be able to travel. His family also reported that he was suffering from high blood pressure for which he
took medication, he was overweight and was on medication in an endeavour to address this and also had expressed the intention to obtain a gym membership to work on his fitness level.

Also living in Tasmania was his sister, Tracey McLaughlin along with his half-brother, Andrew Cox. Mr Stephenson advised his family that he would be visiting them in Tasmania which he did so in January 2014. He requested that his sister, Tracey McLaughlin, contact her ex-husband, Marc McLaughlin in order to arrange a scuba diving trip.

Mr Stephenson flew to Tasmania on Friday, 10 January 2014 and met up with family members. On Saturday, 11 January 2014 his sister Tracey, attended Go Dive in Launceston and hired two wet suits for him of different sizes. On Sunday, 12 January 2014 the family group spent time together including a trip swimming at the St Leonard’s picnic grounds. Also on this day Mr Stephenson tried on the wet suits that had been obtained and decided that he would use the larger size, and he commented that it was tight but was adequate for his purpose. Also on Sunday, 12 January 2014 Marc McLaughlin went scuba diving with his friend, Justin Brown. At the end of the dive, Justin left his dive equipment with Mr McLaughlin as it was arranged that Mr Stephenson would use that equipment on the following day. That night Mr McLaughlin refilled the scuba tanks using his personal air compressor as was his usual practice.

On Monday, 13 January 2014 Mr Stephenson travelled to Scottsdale with his sister Tracey and nephew Callum McLaughlin. When they arrived at Scottsdale, Tracey McLaughlin was dropped off at work and Mr Stephenson and Callum continued on to Branxholm where they met Marc McLaughlin at his residence. After this they also picked up Mr Wayne McLaughlin, Marc McLaughlin’s father, who had been requested by Mr Marc McLaughlin to accompany them so there would be someone on the beach observing the dive. As a result of discussions about diving experience whilst they were travelling, Mr Marc McLaughlin determined that they would dive from the Picnic Corner Beach at Eddystone Point as Mr Marc McLaughlin had dived in this area on numerous occasions and rated it as being a safe location.

They arrived at the location between 11:00am and 11:30am, parked the vehicle and then had to walk a distance from the vehicle to the beach area. Mr Stephenson put on his wet suit but his diving equipment was transported to the beach by Mr Wayne McLaughlin pulling a trolley containing the equipment. It was noted that when they reached the beach after a walk of approximately 400m, Mr Stephenson was noted to be out of breath. Mr Stephenson was observed to fit the scuba equipment appropriately and demonstrated that he was familiar with the various components. After donning the equipment, Mr Stephenson and Mr Marc McLaughlin waded into the water. Once they were in deep enough water to float, Mr Marc McLaughlin checked Mr Stephenson’s buoyancy. He believed he was slightly over-buoyant but Mr Stephenson was content to continue the dive not believing that he would have any difficulties submerging. The two then swam a distance of approximately 20m to an island of rocks where they stopped to reassess the situation. Whilst standing on the rocks, Mr Marc McLaughlin observed that Mr Stephenson was breathing heavily. Mr Stephenson removed his wetsuit hood stating that it was restrictive. Mr Stephenson appeared apprehensive and it was suggested that they return to shore however Mr Stephenson was determined to continue on with the dive. They continued swimming for around 10 minutes during which time Mr Marc McLaughlin looked back to check on Mr Stephenson on two occasions. On both occasions Mr Stephenson indicated that he was comfortable by using the appropriate hand signal. On the third occasion Mr
Marc McLaughlin checked he observed that Mr Stephenson had sunk, his regulator mouth piece was floating in front of his face and he appeared to be fitting. Mr Marc McLaughlin attempted to put the regulator back in his mouth however he did not appear able to hold the regulator in his mouth. Mr Marc McLaughlin then unclipped Mr Stephenson’s weight belt and floated him to the surface. Mr Marc McLaughlin inflated his own buoyancy vest and turned Mr Stephenson on to his back and commenced to pull him towards the shore which was approximately 40m away. During this time he observed that Mr Stephenson was gurgling water from his mouth. When approximately halfway back to shore, Mr Marc McLaughlin inflated Mr Stephenson’s buoyancy vest to provide further buoyancy for the swim back to shore. When they reached shallow water, Mr Marc McLaughlin removed both his and Mr Stephenson’s dive tanks and he and Mr Wayne McLaughlin dragged Mr Stephenson to shore. Mr Marc McLaughlin attempted to administer CPR; however he was unsure of the process. He continued this process for approximately 15 minutes also attempting to use air from Mr Stephenson’s regulator. Whilst Mr Marc McLaughlin was attempting CPR, Mr Wayne McLaughlin left the beach with Callum McLaughlin and drove to the lighthouse which was approximately 5 minutes away, where they gained mobile phone coverage and contacted emergency services. By the time Tasmania Ambulance Service personnel arrived at approximately 1:30pm, Mr Stephenson showed no signs of life and no medical intervention was provided.

The findings on post-mortem autopsy are described as:

“Autopsy reveals pulmonary oedema and over expansion of the lungs consistent with drowning….The heart does show a 40% stenosis of the left anterior descending coronary artery, however this degree of stenosis would not normally cause sudden death even during exercise and does not appear to be enough to precipitate the death. There is focal fatty infiltration of the free wall of the left ventricle without significant fibrosis. Mr Stephenson was reported to be unfit, overweight and breathing heavily during the swim out and it is possible that an arrhythmic event could have precipitated the drowning.”

**Comments and recommendations:**

Although there is no suggestion that the condition of the equipment used by Mr Stephenson caused or contributed to his death, inspection of the equipment did determine that it was in an overall poor condition. Scuba diving can be a safe and enjoyable past time but risks are accentuated when equipment is not in a good, serviceable condition. The report upon the inspection of the equipment by Mr Carl Price, Hyperbaric Technician, Diving and Hyperbaric Medicine Unit, Royal Hobart Hospital, concluded:

- The diving equipment appears to be working albeit not in a condition suitable for safe diving at the time of testing.
- The cylinder is 5 years out of test date and had light corrosion on the inside with loose particles of rust which likely had been caused by the high water content in the air used in the cylinder.
- The buoyancy compensator was in a poor condition, it was missing the rear dump toggle/knob and the power inflator was faulty resulting in very poor performance to inflate the bladder.
- An inspection of the compressor used to fill the tank found that the primary filter was covered in vegetation debris, insects and soil.
• No maintenance documentation or log book was presented with the equipment.
• The combination of 30lb (13.6kg) weight belt used by Mr Stephenson and total weight of equipment of 26.6kg resulted in 40.2kg total weight which appears excessive. 

This is a timely warning to all those engaged in scuba diving to ensure that their equipment is properly serviced and is at all times in a safe condition for the use for which it was designed.

Mr Stephenson was obese and apparently unfit, showing signs of overexertion on the walk to the beach and in the initial stage of the dive. I note that there is no obligation on recreational divers to undergo periodic medical testing after their initial entry medical assessment. However, divers must ensure that they discuss any new medical conditions with their doctor and also that it be recognised that aging and weight gain are matters to be considered in the risk factors for someone to engage in scuba diving.

I recommend that guidance provided by the South Pacific Underwater Medicine Society be applied both by divers and their medical advisors. In relation to age and fitness, the following recommendations are pertinent:

• There is no upper age limit provided to undertake scuba diving however appropriate medical fitness standards should always be met. It is recommended that from the age of 45 years, all candidates should have regular assessments at no longer than 5 yearly intervals, with emphasis on evaluation of cardiovascular fitness and pulmonary reserves. Emergency situations may demand a high degree of fitness.
• Consideration must be given to a diver having adequate reserves of physical fitness to cope with unexpected demands due to adverse weather or sea conditions, surfacing away from a boat, having to aid a distressed buddy or other emergencies. Whilst all divers should undergo appropriate functional assessment during dive training, if the medical risk assessment reveals a probable lack of adequate physical fitness, this should be indicated in medical advice given.
• Obesity may imply a lack of physical fitness and also represents a possible hazard to divers by increasing the risk of decompression illness. The general medical risks of obesity should be discussed with the diver.

This was an unfortunate accident most likely contributed to by the poor level of physical fitness of Mr Stephenson and perhaps his apparently undetected cardiac condition. No fault lays with Mr Marc McLaughlin and no criticism is made of him in relation to this event. He clearly made an appropriate assessment in identifying a safe diving area and he satisfied himself, observing the preparation for the dive and use of the equipment, that Mr Stephenson was competent; this was confirmed by his documented history of having undertaken several previous dives.

I have decided not to hold a public inquest hearing into this death because my investigations have sufficiently disclosed the identity of Mr Stephenson, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the Births, Deaths and Marriages Registration Act 1999. I do not consider that the holding of a public inquest hearing would elicit any significant information further to that disclosed by the investigations conducted by me.

Before I conclude this matter, I wish to convey my sincere condolences to the family of Jason Scott Stephenson.

This matter is now concluded.
Dated: 30th of June 2015 at Hobart in the state of Tasmania.

Stephen Raymond Carey
CORONER