IN THE CORONERS COURT HELD AT NELSON

IN THE MATTER of the Coroners Act 1988

AND

IN THE MATTER of an inquest into the deaths of NARELLE TANIKO TE PUREI, RICKI GRAEME McDONALD and MICHAEL DAVID WELSH

Before: Mr I R Smith

Dates of Hearings: 20th August 2002, 17th March 2003 and 14th April 2003

Date of finding: 14th April 2003

Appearances: Senior Sergeant S Koefoed and Sergeant C Stringer for the Police

Mr G Barkle for the extended families of Ms Te Purei and Mr McDonald

FINDINGS OF CORONER I R SMITH

Introduction

(1) On the 28th of January 1827 Admiral Dumont d'Urville, Captain of the French Navy corvette "Astrolabe", sailed through "Passe des Francais' (French Pass). Just after 7.60 a.m. that morning, with slack tide. the corvette was underway and a few moments later the wind had *dropped* and suddenly the rushing boiling tide zapped up and swung the corvette leeward. She did not respond to any handling and was completely at the mercy of the tide.

The corvette struck the reef twice. The first shock was slight. The second shock sent a sinister cracking sniver through her. There was a pause - a heavy list to leeward. The crew gave yells of terror. Then the tidal flow washed her over the reef and swept her into Admiralty Bay. The. tide continued to sweep the corvette further into Admiralty Bay.

Men on the corvette said - "It was a most impressive sight to see the "Astrolabe" at one moment lying on her beam ends as if about to be swallowed up by the whirlpools that surrounded her, lift herself by a graceful movement, advance majestically through the midst of the waters from which the fury had departed".

Admiral Dumont d'Urville was then of the opinion that no one should attempt to navigate the French Pass except in extreme emergency.

*"History, legends of French Pass. d'Urville Island, St*ephens Island, situated *at the head of the Northern Marlborough Sounds) Cook Stralt, and their relation to the history to other areas of New Zealand".*

Now

ii. From the story of New Zealand's French Pass and d'Urville Island by Olive Baldwin, Fields Publishing House 1979, pages 65 & 56

(2) This respect for the waters of French Pass has been held by Seafarers over the next 173 years and therefore this backgrounds the location of the student diving course tragedy that occurred on the 10th of March 2000.

(3) Since the 10th of March 2000, there have been successful prosecutions of both the Nelson Dive Centre Limited (Dive Centre) and a Mr Andrew Stuart. A subsequent appeal to the High Court by the Nelson Dive Centre Limited, upheld the findings of the lower Court but ordered the lower Court to review the sentence to be imposed.

As a consequence, Mr Stuart was ordered to pay the sum of $15,000 and the Nelson Dive Centre Limited, the sum of $50,000. (I will return to the issue of those orders later in this Judgment), suffice to say at this point the High Court decision being issued on the 4th of March 2002 and the District Court sentencing being completed on the 10th of April 2002.

(4) The High Court and District Court matters concerned charges brought against the Nelson Dive Centre Limited and Mr Stuart, by the Department For Labour under the Health and Safety in Employment Act 1992.

(5) Both the learned District Court Judge and the Honourable High Court Justice, described the water of French Pass, where this tragedy unfolded, as being "a turbulent and energetic piece of water".

(6) The deceased and the survivors were part of a student group of divers who were participating on a fourteen week Dive Master Course, under the New Zealand Qualifications Authority guidelines (NZQA).

(7) This particular course had begun on the 1st of February 2000 and the divers were into their fifth week of the course when the tragedy occurred.

(8) Evidence was given by a Mr Hallet Smith, the partner of Ms Te Purei and who had also taken part in a previous Dive Centre course. Mr Smith had obtained his Dive Master qualification from completing that course. The night prior to the dive on the 10th March 2000, most of the diving group attended a barbecue at Mr Stuart's place where several of the divers drank beer and that Marijuana was also being smoked by some of the party participants, Mr Smith and Ms Te Purei left the party at about 2.00 a.m. and when they left both Mr McDonald (who also died the next clay) and Emma McLeod (who survived the diving tragedy), were among others remaining at the party.

(9) The next day, being the 10th of March 2000, at about 10.30 a.m., the diving party travelled from Nelson to Okiwi Bay where the group put on their diving suits and boated to French Pass, arriving there at about 1.00 p.m. At that stage the group motored through the area known as "the gap" checking the depth. The goat drifted back through "the gap" when it hit a whirlpool. The boat at this time was idling and was spun around 360° degrees two or three times.

(10) The group then returned to the Okiwi Bay side of "the gap", where they had something to eat before preparing to dive at around 2.00 p.m. There appears to have been confusion over the time of High Tide at the Pass. This was important to know because at High Tide the water through the Pass remains slack for about 20 minutes, then returns to pick up momentum ranging up to a speed of eight knots. Mr Stuart thought High Tide was at 1.30 p.m, but in fact it was 11.53 a.m., however by the time the group entered the water around 2.00 p.m. the tidal ebb was well underway.

(11) The divers were to carry out a "drift-dive" by being attached to a rope that was approximately 30 metres long with loops tied in it at various intervals. The divers were to put their hands through the loops while they drifted along and down. One end of the rope had a buoy and ski biscuit attached.

(12) When all of the divers had entered the water, the ski biscuit was seen to take off with the current. After a while the buoy appeared to jump in the water and then disappear with the ski biscuit remaining on the surface going around in circles. When Mr Smith (who remained in the boat) inspected the biscuit he realised that only the inflatable inner part of the biscuit remained and was deflated and unattached to the rope and that the outer shell had gone down with the rope.

13 It was clear by that time something had gone significantly wrong and from then on Mr Smith and other boats which had arrived, assisted in retrieving the divers who re-surfaced. It is now apparent that the divers were caught up in a whirlpool which dragged them down to a hole in the sea floor, known as 'Jacobs Hole'. The force was so great it tore the innertube out of the outer shell of the ski biscuit. The depth of this descent was in excess of 60 metres with the result, it appeared, that several of the divers lost consciousness resulting in their mouthpieces falling out. The group appear to have been spun, to the bottom of the hole and then spun back up to the surface again.

(14) Unfortunately, both Ms Te Purei and Mr McDonald were deceased and the body of Mr Welsh has never been recovered. The other divers were lucky to survive.

The Nelson Dive Centre

(15) There is no evidence before this Court as to when the Nelson Dive Centre began to operate, but what is clear is that as at the 3rd of January 1999, the Dive Centre was operating as a Sole Trader by a Mr Edwin Torr, who had been granted a licence to operate by the Adventure Sports Institute of New Zealand (ASINZ) as a Private Training Establishment (PTE).

(16) The New Zealand Qualifications Authority (NZQA) had assigned and accredited ASINZ to become a PTE but in this instance it is now revealed that NZQA did not know that the NDC had become a licensed delivery site until October 1999 NZQA did not effectively know that the NDC was a training, facility under its schemes.

(17) What we do know about the NDC, is that shortly after receiving the accreditation; ceased to be a sole trader and became a Limited Company. That Company had two directors being Mr Torr and Mr Eric Walker, The date of registration of the company being the 30th of March 1999. There were only two shares in the Company, with Mr Torr having ore share and Mr Walker the other.

This was effectively a new organisation which did not have licence to operate under ASINZ nor the NZQA. No one apparently told ASINZ, nor did ASINZ pick this up in any of its audits, therefore at the time of the tragedy, the operation was being carried out by an unlicensed company.

(17) Subsequent to the tragedy of the 10th of March 2000 and shortly after the District Court handed down its decision on the 9th of May 2001, Mr Walker sold his share to Mr Torr and resigned as a Director of the Company. The sale price of the shares of $47,000.00 being made up of $22,000,00 Cash, $4,000.00 Goodwill and the transfer of an Alloy Boat for $21,000.00.

(19) The last set of accounts rendered by the NDC was as at the 31st of March 2002 (which still recorded Mr Walker as both being a Shareholder and Director). The accounts showed that the sum of $324,304-00 had been achieved in the year ending 31st March 2001 but had reduced to only $33,238.00 by the 31st of March 2002.

(20) The accounts show that as at the 31st of March 2002 the business was running at a loss. Mr Torr himself was declared Bankrupt on the 23rd of October 2002 and, while the Company still exists in theory, it is not operating, is devoid of any Directors and would appear to have no assets and substantial liabilities.

New Zealand Qualifications Authority (NZQA)

(21) NZQA sets requirements for the registration of PTE's through a set of standards known as the Quality Assurance Standard.

In this regard, ASINZ has been a registered and accredited PTE since mid (1997) and the NZQA relied on ASINZ to meet its standards. NZQA has advised that although the licence between ASINZ and the NDC was signed on the 3rd of January 1999, NZQA was not aware that the NDC was a licensed delivery site until October of 1999.

NZQA now advise that as of May 2000, PTE's have primary responsibility for implementing and maintaining valid and current licence agreements with all site providers (such as the NDC) and that the NZQA specifically sights and reviews all such agreements as part of its regular quality audits.

(22) The initial accreditation of ASINZ to deliver Diver Training Courses was based on the recommendations of the Dive Industry Training Organisation which listed what accreditation was required for recreational diving. The qualified instructors to operate the courses were to have qualifications from among others, the Professional Association of Diving Instructors (PADI), but did not have to meet Regulation 48 of the Health and Safety in Employment Regulation (1995) which requires that Dive Professionals have a valid Occupational Safety and Health Certificate of Competency, however I am now advised that since September 2001 a compliance with Regulation 48 is now a requirement.

Adventure Sports Institute of New Zealand Limited

(23) As previously stated, this was the PTE registered under the NZQA.

It was this organisation that granted the NDC its licence and was charged with the audit of the NDC during the term of its licence. Clarification has been received that the

ASINZ was in fact owned by PADI New Zealand until both PADI New Zealand and PADI Australia was merged into PADI Asia Pacific in May of 1999.

(24) It was a term of the licence, as issued, that the licence to NDC (Mr Torr), was effective for a one year term expiring in January of 2000 and that the licence was not renewed. There was no licence as between ASINZ and the new Company.

(25) In March of 1999, two other local operators wrote to PADI New Zealand, voicing their concerns of the operation of the NDC and that PADI New Zealand knew of various complaints prior to that date. In response to this, ASINZ acknowledge that PADI received two letters of complaint and that the authors were in a business relationship and the letters carried the same allegations and that PADI responded by following it's prescribed quality management procedures and sent course evaluation surveys to all divers certified by NDC and that in June of 1999 PADI NZ and ASINZ conducted a face to face counselling with the two Instructors and it was recommended that no further action be taken.

(26) It is clear that during 1999 and 2000 the NDC conducted several Dive

Training sessions within the French Pass area but there is no evidence to show that the ASINZ either knew or approved of this area of activity and it must be said that the auditing process was significantly flawed. I am advised that since this tragedy occurred the auditing of delivery sites has evolved to a more formal and comprehensive level.

Minister of Social Development (Work and Income)

(27) In response to a series of enquiries made of the above service delivery arm of the Ministry of Social Development, Work and Income provide financial assistance to beneficiaries undertaking training by way of a Training Investment Allowance (TIA) and further, Work and Income administrates the Student Loan Scheme which is designed to assist Tertiary Students to overcome financial barriers to undertake Tertiary Study. In respect of those who lost their lives in this matter, one received the TIA and all three had approved Student Loans. The average Student Loan advance for fees at ASINZ for the year ending 31st March 2001, was $6312,03.

[28] Evidence was given at the Inquest by a Mr Geoffrey Leonard Cooper, a Health and Safety Inspector with the Occupational Safety and Health Service. Among his duties, is to assess

whether applications for Certificates of Competence can be issued to divers under the Health and Safety in Employment Regulations. Certificates of Competence may be issued in the following categories:

1. Construction

2. Scientific and Research

3. Instructor/Tutor
4. Television/Media/Tourism

Mr Cooper's evidence confirmed that as at the 3rd of April 2001, a total of 66 Certificates of Competence had been issued in the Instructor/Tutor category and that neither of the principals at the relevant time being Mr Torr nor Mr Walker, nor Mr Stuart, held such certification.

(29) At the conclusion of both the District Court and High Court trials, as mentioned previously, fines were imposed on the Company ($50,000.00) and the employee Mr Stuart ($15,000.00), of which three quarters were to be paid to the victim's next of kin. I am advised that in the case of Mr Stuart the sum so ordered has been paid, but with respect of the amount imposed on the Company, despite the efforts of the Department for Courts Collection Staff, it is unlikely that this amount will be forthcoming.

(30) It would appear that nothing can be done to eliminate this situation occurring again but it is unfortunate that the families of the deceased will not be able to recover part of the Courts award.

Recommendations

Under Section 15(1)b of the Coroners Act, a Coroner may make any recommendations or comments on the avoidance of circumstances similar to those in which a death has occurred, or on the manner in which any persons 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.

In this instance we have seen three people, while during the course of diving instruction, lose their lives. I have traversed the background as to how the various entities played roles that (rendezvoused) to the point where this tragedy occurred to see whereby a review may eliminate any future deaths occurring. Both the NZQA and ASINZ have advised of new procedures and better auditing has been put in place.

With this background I make the following recommendations:

a) That the appropriate authorities place a warning sign within the French Pass area that denotes that diving in the area should be avoided at all times,

b) Secondly, there is the wider issue of the whole funding and qualification process for Students under the NZQA in respect of Adventure Sport. It would seem that a great deal of funding is provided for Students completing Adventure Sports Courses, with little chance of the outcome providing a real employment opportunity and that the risk factor to Students suffering from injury or death on these courses, is high. Certainly it must be acknowledged that the diving sector of these courses has had a review after this tragedy occurred, but perhaps a wider review is required to ensure that adequate qualified personnel act as trainers for the Students.

Formal Finding:

(1) Ricki Graerne McDonald, late of, 108 Dodsons Valley, Nelson, Student, died at the French Pass on the 10th of March 2000. The cause of death being as result of accidentally suffering a Massive Air Embolism and therefore drowning while taking part in a Dive Training Course.

(2) Narelle Janiko Te Purei, late of Westbrook Terrace, Nelson, Student, died at the French Pass on the 10th of March 2000. The cause of death being as a result of accidentally suffering a Massive Air Embolism and therefore drowning while taking part in a Dive Training Course.

(3) David Michael Welsh, late of 98B Vincent Street, Nelson, Student, died at the French Pass on the 10th of March 2000. The cause of death being as a result of accidentally drowning while taking part in a Dive Training Course. His body was unable to be recovered.

I R SMITH

NELSON DISTRICT
CORONER