such august personages as Sir John Rawlins, Dr. Val Hemplman and Dr. John Betts.

There have been many day-to-day decisions, such as requests from Branches for guidance on the use of full-face masks. A subject needing far more work has been the compiling and referencing of all rules, recommendations, and regulations relating to diving, which is now in draft form for publication.

A number of new events have been introduced during 1980. More will be said about the Lifesaver Awards during the weekend, but there are three - the Elementary for the Snorkel Diver, the Lifesaver itself for pool assessment and the Advanced for the complete lifesaver, assessed in open water.

The First Aid endorsement courses started during 1980, and the new Diving Officers' Workshops have been well supported.

During 1980 the publication Snorkel Model Lecture Notes have been a great success and the 3rd Class Lecture Notes are published this weekend. The new Diver Training Programme and the Decompression Table Workbook are also published today, and will be described later. There are also a newly-laid out decompression table, a decompression slide rule, Programme of Events, Courses and Examinations, and a booklet of Air Stations, Inland Waters and Charter Boats - all new and all available today.

I have mentioned briefly the decompression problem. We have to grasp this nettle and the discussion that started last year will continue over the weekend.

Future publications will include an up-

DIVING INCIDENTS REPORT

George Skuse -
Chairman, Diving Incidents Panel

"I have to start off by saying that accidents are funny. I have the word of a named BSAC Branch on page 9 of the November edition of Diver magazine. Someone has found it highly amusing and something to laugh about that a member should surface from depth upside down in a variable volume dry suit, and has not reported it to me by word, rumour, or in any way other than publishing a humorous poem in Diver. Why should I make a fuss?

One BSAC member this year has died upside down in a variable volume dry suit. Surely we need these reports. How many more must suffer minor indignities of all sorts, unreported, so that we know nothing of the trends that are happening in diving?

Last night I was sitting in the bar, and a friend told me of another variable volume dry suit accident, which had not been reported. Now, I am not here making a fuss of variable volume dry suits; I am making a fuss of people not reporting. However, now to my report and the accidents that occurred whilst I have been chairing the Panel. (See Appendix 1)

In 1978 there were 89 incidents reported, in 1979 there were 120 and in 1980, 131. Does this mean that divers are having more accidents?

The membership has, in fact, fluctuated. The number of incidents has gone up in 1980 when, in the same period, the membership has gone down.

Let us take the particular misfortune of fatalities. The number of fatalities to BSAC members has fluctuated. It would appear to me that there is no tie-up between the number of incidents reported, the number of fatalities and the membership figures. However, the more reports I get, the more reliance I can place on statistics. It does not mean that more accidents are occurring just because I am getting more reports.
Here is my analysis which I will now identify. Take something of what I have said. 18 cases of decompression sickness occurred during the year. 5 of these were recompressions in a chamber, a procedure that we do not recommend. Of the 18, 12 were BSAC members.

However, I must place little reliance on these figures because last year we received a late report updating the decompression sickness figures by some 12 or more incidents. This present report only represents those which have been reported so far; it is not the whole story.

Let me take the other incidents that have occurred during the year. I am only going to talk about the kind of incidents that occurred 10 or more times. Aborted dive, diver acting as rescuer, helicopter involvement, recompression, decompression sickness, lost divers - a growth area this year, something involving decompression sickness, all happened more than 10 times.

You will be delighted to know that I am considering 10 incidents for awards where good practice was involved. The sorrow is, of course, that for the vast majority of those incidents, something went wrong before a buddy did something that went right. Nevertheless 30 members of the BSAC have been involved directly in saving life in some way or another.

Finally, you will see that there is a fair number of incidents involving ascents of one kind or another.

Now to move on to some particular cases. My report, of which you all have a copy, is written in a peculiar way, which is explained in the text.

July: No. 79 Whilst diving the Aeolian Skv, a diver became unconscious with a possible embolism. Having received the report I analysed it, to record all the various aspects and involvement - hence the hieroglyphics in my report. However, after I closed my report on the 31st October, further information came to me - about this incident in July!

It was a cerebella arterial gas emolisrn, involving 1 recompressions in a chamber and one minor operation. This updated my analysis which I will now identify.

A BSAC member, snorkel diver grade, on a branch dive, a boat dive, occurred at home (not abroad) in the sea (not in fresh water). The depth was 30m, involved an emergency ascent, recompression in a chamber and the use of an ambulance and helicopter. There was good diving practice by the buddy, the person was rescued, unconscious and had an embolism. It makes a complicated report, but that sort of analysis was needed. I would give it for every incident in the report.

Let us take some of the other features. These are well illustrated in the report, but I wish to read a few selected ones.

November No. 9. Death while on holiday abroad due to embolism Narcosis, contributed, at a depth of 51m - by the way, you know of course, that the BSAC/RPNI table finishes at 50m - this 1-month lapsed member was signed up by both Branch Secretary and Diving Officer and had the Branch stamp of approval right up to Second Class. I have a photocopy of his logbook, with the following lectures not signed off at all: 'Rescue and resuscitation', 'Diving Suits and Protective Clothing', 'Burst Lung and Emergency Ascents', 'Decompression Sickness - avoidance', and 'Condition and treatment'. Basic Navigation', 'Basic Seamanship', 'Expeditions - safety and emergency services'. I do not say that he did not have the training, for the Branch Secretary and Diving Officer signed him off as Second Class. He lapsed, and died in Israel.

'The previous day he had dived 30 minutes to 25m, 43 minutes to 12m and 37 minutes to 12m. No decompression was done as the last two dives were mainly at 10m.'

He had got it wrong anyway, it should have been 9m, but in fact they were dives to 13m. He needed decompression for 110 minutes diving to 25m, which is off the table. He should have used the extended table in the manual, when he would have seen that he missed the following stops - after the second dive 1 and 50 minutes and after the third dive 1 and 120 minutes, a total of 230 minutes stoppages missed, all because of a wrong belief that dives to 10m do not require decompression! Anyway, that was the day before.

On the day in question he dived for 22 minutes to 33m and decompressed for 8 minutes at 10m and 5 minutes at 5m.'

He missed out 10 minutes of stops. He got a cerebral bend, which required extensive treatment. He was Branch Diving Officer at the time.

This is the Branch's own report, supplemented by a couple of letters, a model of perfection:

'On Saturday he dived for 25 minutes to 20m, 22 minutes to 22m followed by seasickness, headache, lager and Paracetamol. On Sunday he had a headache and two Paracetamol, which he kept quiet about, and four cigarettes. He went out for a run, but was violently sick on surfacing, but they attempted re-entry decompression.'
The re-entry decompression that they tried was 5 minutes at 10m and 15 minutes at 5m. In practice only what they had missed. Proper re-entry decompression is a far more rigorous regime; they should have done 5 minutes at 10m, 5 minutes at 15m, 10 minutes at 20m and 30 minutes at 30m. They did 20 minutes decompression instead of 30 minutes.

'On arrival ashore he complained of pain in his back. This eased and on Monday he still said he was OK.' Let's be perfectly honest the person who was suffering disguised his own symptoms - 'but late in the evening complained of pains in the knee and shoulder. He was taken to hospital overnight, was recompressed on the Tuesday by the RAP and on Thursday again by the Royal Navy'.

The Branch's enquiry was a model of perfection, and I would like to quote some of the Branch's own conclusions:-

- Dive planning for the whole weekend was completely inadequate.
- Good basic diving rules and practices were ignored.
- There was a failure to recognize symptoms promptly and act accordingly.
- Logged records show divergence, which cannot be accounted for satisfactorily.

I would just remind you of what happened: 18 minutes to 'at least 31m' - it was in fact 14m - an ascent without stops, a re-entry decompression too short by 65 minutes.

In August - just to repeat the lost diver problem the cox was only 200 yds from the divers but still could not see the surface marker buoy. After half-hour contact was finally made. In response to an enquiry from me, the Inland Waterways Branch told me of what happened.

Inland Waterways Branch had 15 reports since I closed the files for this report on the 31st October and by coincidence 4 of them relate to ear trouble. These 4 late ear drum incidents reinforce the trend of the year, making 10 more altogether.

As I am completing the third of my three years as Chairman of the Diving Incidents Panel and my twelfth year on the Panel, I have prepared an analysis of the last 3 years as a whole. We have had 360 incidents reported - 18 fatalities (1.4% of incidents reported) of which 13 were SAC members, 80 bend cases (23% of incidents), assisted ascents (8% of incidents) and so on. (Appendix 1).

You will note, incidentally, that a significant proportion of the bend cases occur after dives to greater than 30m. This is not to say that such dives are dangerous, rather that they need more careful planning and adherence to the tables than is reflected in the reporting procedure. The simple post dive preliminary incident report cards have worked very well. They give me the very basic information of a name, locality, date and broad outline of the type of incident. I am sure that that applies to other Branches too.

The last report that I wish to quote - the Aeolian Sky again. The leader dived without a depth gauge. They planned a no-stop dive. Two divers were seen a mile downstream, so the boat left the wreck and investigated. They were strangers, however, and about to be picked up by their own boat. The boat returned to the wreck to find their own divers, but there is now some confusion about their bottom time. The subject vomited, blaming it on seasickness due to waiting for the boat to return. By the way they did not have an easy ascent, either.

Next day he had a pain in the arm, not thought to be a bend as it was now 20 hours after the dive. He was ultimately recompressed.

Now it is so easy to confuse divers surfacing elsewhere with your own divers; it happened here, but meanwhile one got bent.

One other item - ear trouble. Burst ear drum during a dive - I do not know the depth. Burst ear drum in dive to 20m - he dived soon after a cold. Burst ear drum during a dive. Reversed ear - he had a VDSS with a face seal which caused the trouble. Burst ear drum during a Test. I have already had 15 reports since I closed the files for this report on the 31st October and by coincidence 4 of them relate to ear trouble. These 4 late ear drum incidents reinforce the trend of the year, making 10 more altogether.

Moving on again to the nasties. October - decompression sickness due to misunderstood tables. In the report the following is the link that appears that in our Club there would appear to be a lack of knowledge of metric decompression tables, especially where older members are concerned. I am sure that that applies to other Branches too.

Finally, some last words about the reporting procedure. The simple post dive preliminary incident report cards have worked very well. They give me the very basic information of a name, locality, date and broad outline of the type of incident. I want from any group of divers involved in an incident - you may, in fact, hold back more details than this basic amount until an enquiry has been held.

The full report later may come in any form that you like. It does make my
filing work easier if it comes in on a standard form, but it is not essential. And as it takes me one whole week of my holidays to compile this report, the standard form helps.

I must offer a huge vote of thanks to the Coaching Scheme, particularly for the way that they have sent in the Preliminary Incident Report Cards, also to HM Coastguard. They send me a copy of all their reports involving the Coastguard and divers, BSAC or not. Yesterday's post for instance brought from the reports of 1 more incidents in September and October that had not been reported by any other source. It is an extremely valuable service that they provide me with.

There are also one or two individuals who are a great help, mainly in sending me cuttings from newspapers. The best cuttings are from local papers, which give much fuller details than the national newspapers can ever find room for. Unfortunately, these often turn out to be the first and only reports I receive.

There you are, then. The success of the person who does the job next year will depend very largely on the support that you give him. I cannot help being sorry that in my twelve years' association with the Panel, and three years as Chairman I have failed to influence diving safety in any way; it is a major disappointment. You see before you a frustrated man.

QUESTIONS

Philippe Dumortier (Lensbur and London): George might not be so disappointed as most divers now are more ambitious, and the dives that they do are more difficult than 3 years ago. The increase in the number of incidents, then that itself is a result.

I would like to talk about EAR and life-saving techniques, as they are currently in training, and I think that this is a good thing. In the last year I was very surprised to see in your report national newspapers and television reporting of EAR techniques being used in incidents in a positive way. Can you comment?

George Skuse: We have, from memory, this year two proven cases of EAR in the water, saving life. We have a number of other cases with EAR on the land. Lifesaving and its training is being used.

Nigel Bailey (Chester): I would like to try to balance the situation, to point out that a situation is not always the branch's fault. After last year's presentation on decompression problems, we had numerous reports of Branches who failed their 2nd Class Examination principally by omitting decompression stops completely on repeat dive requiring two stops - a potential accident peninsula.

He was advised to study the Tables and Table Card for another 6 months and take the examination again. He complained to the Diving Officer, not the examiner, and threatened to leave the Branch if he was not re-examined. The DO did not contact the examiner out the National Coaching Committee and re-examining of the candidate would leave the Branch. Do we want potential incidents contained within the BSAC in order to improve examination statistics?

George Skuse: This is a perennial problem - should you keep or sack the sinner. My personal opinion, and not necessarily anyone else's, is sack the sinner.

Brian Judd (Oxford): I am interested that you do not recommend re-immersion procedures for missed decompression stops. It would seem that a lot of people look on this as a normal tool of diving, in that they actually plan to come up, go to the boat, and then re-immersion to hang on a line from the boat rather than do the stops in mid-water on the way up. I feel that any re-immersion that happens, for whatever reason, is a reportable incident.

George Skuse: I underplayed the part of re-entry decompression because the matter is going to be dealt with at length later. I can assure you that a result of this and the previous year's incidents, the procedure of re-entry decompression is to be discontinued within the BSAC. In every one of the reported cases, the bend was made worse by re-entry, apart from the fact that the procedure was wrong in every case.

So, you will be strongly dissuaded from using this technique which was developed for hard-hat divers standing on a stage and for divers who were to be put straight into a recompression chamber on surfacing. It was not developed for re-entry into the water. It appears to be grossly misunderstood and potentially dangerous procedure and, although currently in the Diving Manual, you will be asked to forget it. If someone misses stops, you are to take them ashore, inform the authorities and chamber that you have such a case without symptoms and they will then advise you. We believe that your chances of avoiding serious decompression illnesses are greater by not putting him back in the water, but by keeping him under observation.

Keith Rose (Birmingham): Have you had any reports of people trying EAR in the water and not able to do it. My region's Coach told me he had one of two cases where the people could not make themselves give the victim EAR. They could not bring themselves to make a seal over the victim's nose. How often does this happen?

George Skuse: To my knowledge, not at all. I do not recall seeing these statements in any reports, and such comments would have stuck in my mind in my recent readings of the file. Maybe I have not been informed. The BSAC would be delighted to have firm reports in writing.
Mike Collins (Bexley): At last year’s Conference there was quite a large appeal from members that we should ‘name names’ as a stick to use of people who do not send in reports. Have the Panel had any further thoughts on this?

George Skuse: This year no one who has been approached has failed to report. The real problem remains of finding an address to approach in the first place.

I am currently under a directive from the National Diving Officer to report to him any incident where it is felt that a member has been naughty. The NDO will communicate directly, but not publicly, with these people who have broken the various rules, regulations and recommendations of the BSAC. To that extent, sinners will be acquainted with their sins.

If you have any information about any incident not listed in this report, additional information about any incident that is listed in this report, or wish to correct any report, or my interpretation of any report PLEASE PUT IT IN WRITING, quote the reference number if applicable, and send it to:

George Skuse, Chairman, Diving Incidents Panel, Yeer-Tiz, Springfield Road, Uplands, STRoud, GL5 lTF

The minimum information that is of use consists of:

- DATE of incident
- NAME of victim(s)
- VICINITY of incident
- NATURE of incident

All of which may be briefly stated on a Preliminary Incident Report Card.

Much more use is the greater detail that can be set out on an Incident/Accident Report Form, and one is sent out to all those who send in a Preliminary Incident Report Card.

APPENDIX 1

ACCIDENTS AND INCIDENTS OVER A THREE YEAR PEIOD

<table>
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<th>ITEM</th>
<th>1978</th>
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<tr>
<td>Incidents analysed</td>
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<td>British incidents</td>
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<tr>
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<td>National Snorkellers Club</td>
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ITEM | 1978 | 1979 | 1980 |
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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Total fatalities</td>
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<td>13</td>
<td>13</td>
</tr>
<tr>
<td>BSAC fatalities</td>
<td>8</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>BSAC Branch diving</td>
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<td>2</td>
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<tr>
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<tr>
<td>on the surface three or more in party</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
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Decompression sickness | 29   | 33   | 18   |
| Recompressed | 23   | 22   | 16   |
| Depth reported | 19   | 12   | 16   |
| 30m or deeper | 12   | 5    | 14   |
| Repetitive diving | 4    | 2    | 6    |
| Attempted recompression underwater | 5    | 6    | 4    |
| Commercial chamber | 5    | 7    | 7    |
| Service chamber | 27   | 7    | 7    |
| BSAC Members | 13   | 12   | 4    |
| Definitely NOT BSAC | 4    | 4    | 4    |

Ascents | 22   | 25   | 36   |
| Emergency ascents | 13   | 12   | 16   |
| Aborted dives | 12   | 20   | 11   |
| Assisted ascents | 12   | 9    | 8    |
| Buoyant ascents | 6    | 7    | 5    |

Coastguard alerted | 17   | 34   | 24   |
| Ambulance | 8    | 4    | 4    |
| Police | 5    | 7    | 7    |
| Lifeboat | 21   | 11   | 11   |
| Helicopter | 12   | 22   | 12   |
| Reported by HM Coastguard | 35   | 19   | 19   |

Boat incidents: reported by Branch | 9    | 17   | 11   |
| NOT reported by Branch | 7    | 6    | 4    |
| Club/Branch unknown | 13   | 13   | 13   |
| Independent club | 3    | 1    | 1    |

Divers in the water | 83   | 128  | 128  |
| 30m or deeper | 19   | 30   | 30   |
| 50m or deeper | 12   | 42   | 42   |
| 1m to 30m | 23   | 21   | 21   |
| On the surface | 5    | 17   | 17   |
| Involving boats | 10   | 3    | 3    |
| On land | 6    | 4    | 4    |
| Unknown | 8    | 3    | 3    |

Swimming pool | 6    | 3    | 3    |

Bad seamanship | 6    | 3    | 3    |
| Injury caused | 14   | 8    | 6    |
| Weight/bouyancy involved | 10   | 3    | 6    |
| Solo diving | 9    | 5    | 12   |
| Separation | 9    | 12   | 6    |
| Resuscitation | 4    | 11   | 8    |
| Narcosis reported | 3    | 2    | 6    |
| Ears | 2    | 4    | 5    |
| Good practice involved | 1     | 2    | 2    |

MONTHLY ALL

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<td>Resuscitation</td>
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BENDS

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<td>March</td>
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All the above reports are based on information received between 1st November 1979 and 31st October 1980.

Each of the following reports is set out in a standard way: month, serial number, precis, membership, qualification, organisation of dive, type of dive, where - country/water, depth in metres, and a set of numbers which indicate an analysis of the major factors in accordance with the key set out below:

Membership: B = BSAC, I = Independent, o = no organisation

Qualification: O = none, S = Snorkel, 3 = Third Class, 2 = Second Class, 1 = First Class, Inst = Instructor.

Organisation of dive: C = Club/Branch, P = private, Comm = commercial, H = holiday.

Type of dive: B = boat, Sh = shore, Sn = snorkel, D = drift, Tr = training drill, Q = none.


Depth: indicated s = on the surface, l = on land in metres.

In all the above, X = unknown by the Diving Incidents Panel.

The numbers in brackets indicate the incidents reported in 1980.

CODE

ITEM

1 Aborted dive (11)
2 Assisted ascent (8)
3 Buoyant ascent (5)
4 Emergency ascent (8)
5 Other ascent (6)
6 Aural barotrauma (5)
7 Pulmonary barotrauma (5)
8 Boat trouble (18)
9 Decompression sickness - not recompressed (3)
10 Recompressed in water (6)
11 Recompressed in chamber (13)
12 Ambulance (4)
13 Coastguard (25)
14 Helicopter (12)
15 Lifeboat (14)
16 Police (2)
17 Fatality (13)

CODE

ITEM

19 Good practice involved (10)
20 Illness (4)
21 Injury (6)
22 Lost diver(s) (23)
23 Rescuer (11)
24 Rescued (24)
25 Resuscitation (2)
26 Unconsciousness (9)
27 Embolism (2)
28 Pressure accident (3)
29 ABLI (10)
30 Breathlessness (2)
31 Buoyancy/weight (6)
32 Carelessness (9)
33 DV performance (9)
34 Equipment - faulty (11)
35 Equipment - fitting (3)
36 Equipment - use (3)
37 Equipment - wear (1)
38 Equipment - inadequate (5)
39 Fires/explosion (2)
40 Poul air (5)
41 Fuel (1)
42 Hypothermia (1)
43 Illness beforehand (10)
44 Ignorance (4)
45 Malice (1)
46 Motor (8)
47 Narcosis (6)
48 Out of air (10)
49 Prec-dive check (3)
50 Repetitive diving (4)
51 Ropes (0)
52 Rough water (14)
53 Bad seamanship (1)
54 Good seamanship (0)
55 Separation (8)
56 SMB absent (9)
57 SMB inadequate (5)
58 Solo dive (12)
59 Three diving together (4)
60 Training drill (4)
61 Training inadequate (4)
62 Sharing (1)
63 Deep dive (6)
64 Low vis. underwater (1)
65 Disregard of rules (9)
66 False alarm (5)
67 Cold (5)
68 VD's (4)

Membership: B (108) I (15) O (16) C (2) N (3) X (15)

Qualification: O (13) S (6) 3 (41) 2 (16) 1 (1) Inst (7) X (62)

Organisation of dive: C (80) P (18) O (2) Comm (5) H (11) X (35)

Locality: H (125) A (9) F (20) S (121) L (4) P (8) X (6)

Appendix II

Each of the following reports is set out in a standard way: month, serial number, precis, membership, qualification, organisation of dive, type of dive, where - country/water, depth in metres, and a set of numbers which indicate an analysis of the major factors in accordance with the key set out below:

Membership: B = BSAC, I = Independent, o = no organisation

Qualification: O = none, S = Snorkel, 3 = Third Class, 2 = Second Class, 1 = First Class, Inst = Instructor.

Organisation of dive: C = Club/Branch, P = private, Comm = commercial, H = holiday.

Type of dive: B = boat, Sh = shore, Sn = snorkel, D = drift, Tr = training drill, Q = none.


Depth: indicated s = on the surface, l = on land in metres.

In all the above, X = unknown by the Diving Incidents Panel.

The numbers in brackets indicate the incidents reported in 1980.
SUMMARY REPORTS

November 9/80: Trapped nerve due to a road accident in the past gave symptoms of a bend. (It had happened before once.) B.3.C.H/S. 30. 20.45.68.

November 9/80: Death while on holiday abroad due to embolism, narcosis contributing as film. N.B. This 7 months-lapsed member was signed off by by both the Branch Secretary and Diving Officer and given the Branch Stamp of approval signs up to Second Class Diver, yet was without the following lectures signed off: Snorkel Diver: Rescue and resuscitation. Diving suits and protective clothing. Third Class Diver: Burst lung and emergency ascents.

He was signed off Second Class the same month his membership lapsed. His logbook was validated the month before he lapsed. B.3.H.X.A/S. 51. 7.13.36.49.65.

November 19/80: Strange diver could not prove his qualifications but was allowed to travel. He was found unconscious at 6m. He was rescued and resuscitated. B.3.C/P.Sn.A/S. 6. 19.23.26.46.


November 21/80: He confused his buddy when he vented his ABLJ, so the buddy thinking it was an emergency rescued him. B.3.P.Sn.H/T. 12. 5.69.


November 90/80: BSAC member walking along the edge rescues attempted suicide from city docks. B.1/Inst.B.O.H/F. 1. 19.23.23.


February 39/80: Compressor hoses ruptured injuring club member. Hoses had not been hydraulically tested and should have been. B.2.C.G.H/L. 1. 21.27.28.40.

February 41/80: Full face mask 'fell to bits'. X.X.X.X.H/F. X. 2.19.36.


February 59/80: Holiday in Israel. 50m. Out of air, refused to share, 'rushed to surface'. Given oxygen and taken to hospital. He had in any case disregarded prior instructions not to go below 20m. B.3.H.Sh.A/S. 60. 4.19.49.50.65.


March 37/80: Shared ascent training - water in mouth, panic, buoyant ascent. B.3.C.T/H/F. 7. 3.18.62.64.


April 13/80: Member of one branch signalled distress, and in distress rescued by members of a more observant branch. B.3.C.G.H. 3. 19.24.

April 42/80: He thought the dive had started. He went down on his own, had a look, surfaced, drifted off and was lost for a time while the anchor was raised. Faulty assembly of ABLJ did not help. B.3.C.H/S. 23. 22.11.37.59.60.


April 60/80: Independent-club member gashed by propeller as he entered the water. I.X.C.B/H/S. s. 21.55.


May 51/80: Member died in Israel while snorkelling back after a dive. Heart attack suspected. B.3.H.Sh.A/S. 11. 19.45.
May 51/80: BSAC members rescue a member of a Sea Scout branch. X.X.X.X.H/S. X. 12.

May 51/80: Correct no-stop dive, but diver tired and short of air on ascent (too quick?) B.Inst.C.B.H/S. 30. 11.45.

May 52/80: Independent divers in 5m swoll by boat and 37 minutes to 12m. "No decompression was done as the last two dives were mainly at 10m" However as the dives were over 9m deep they all counted and was done as the last two dives were.

May 52/80: Mother died while snorkelling with son in Scotland.

May 52/80: 30 minutes to 15m, 43 minutes to 12m and 37 minutes to 12m. "No decompression was done as the last two dives were mainly at 10m}. However as the dives were over 9m deep they all count and require decompression for 110 minutes to 25m. This is off the table and the extended stops are: Dive 1... none Dive 2... 5 minutes at 15m and 80 minutes at 5m Dive 3... 5 minutes at 15m 20 minutes at 10m, and 120 minutes at 5m.

He missed a total of 230 minutes stoppages. He decided on the day in question to dive for 22 minutes to 15m and to decompress for 5 minutes at 10m and 5 minutes at 5m. He missed out the 15m stop, and in any case should have stopped for 5 minutes at 10m and 10 minutes at 5m.

He got a cerebral bend requiring extended treatment. He was Branch D.O. at the time.

B.2.C.X.H/S. 33. 11.46.62.67.


May 60/80: Motor stalled, boat hit by waves and capsized during launch. B.C.C.O.H/S. a. 8.13.46.54.

May 60/80: Club dinghy helped rescue boy who had fallen down cliff. B.C.C.O.H/S. a. 19.23.

May 60/80: Angler fish swallowed flash-gun. Sun recovered but flooded. B.2.C.B.H/S. 1. 34.


May 83/80: Dry suit with neck and face seals caused reversal ear during dive with varying depths. He did feel pain. It died overnight. B.2.C.B.D/T.H/S. 32. 9.70.

May 84/80: Assistant NSC Instructor in charge alone, when 12 year-old went unconscious in shallow water. N.C.H/P. X. 19.24.25.36.87.


June 51/80: DV (recently serviced) alleged to have packed up. It worked again on the surface. Assisted ascent, and then re-entry decompression which was mis-interpreted and incorrect. They went in for 5 minutes at 10m and 15 minutes at 5m which in fact was just the decompression they had missed due to the ascent. They should have done 5 minutes at 20m, 5 minutes at 15m and 30 minutes at 5m! B.3.P.B.H/S. 45. 2.20.19.32.35. 36.46.66.

June 54/80: Changing depth while wearing a VFD be forgot to vent the suit. He started to ascent inverted! By the time he had righted himself he was on the surface. B.3.C.B.H/S. 20. 5.34.70.

June 55/80: Breathing after a dive revealed his eardrum had burst during the dive. B.X.X.X.H/S. X. 6.

June 57/80: Solo scuba diver drowned on holiday. His body was recovered two miles away. O.X.X.X.B.H/S. X. 19.60.

June 70/80: Diver ill on entry. Taken to hospital. Later admitted panicking, and his DV was later found to be in urgent need of extensive servicing. B.3.C.B.H/S. 1. 24.35.45.

June 71/80: On Saturday dived for 25 minutes to 20m and 23 minutes to 22m, followed by seasickness, headache, lager and paracetamol. Sunday - headache and paracetamol which he kept quiet about, and four cigarettes.

They dived for 28 minutes to 'at least 13m' (one gauge, later found to be the accurate one, said 34m. It was not one worn by the dive leader!) He was violently sick on surfacing, but they attempted re-entry decompression for:

5 minutes at 10m 15 minutes at 5m

This would have been correct, for 13m, if they had carried it out during the original ascent. BUT (Manual p.149) the correct re-entry schedule, if there were no symptoms, would have been:

5 minutes at 20m (10m below first planned stop)
5 minutes at 15m
10 minutes at 10m
60 minutes at 5m

On arrival ashore he complained of pain in his back. The pain eased.

On Monday morning and evening he still said he was O.K., but late evening he complained of pains in his shoulder. He was taken to hospital overnight. Tuesday he was recompressed by the R.A.F. Thursday he was recompressed by the R.N.
June 78/80: Boat lost sight of 5MB.


June 79/80: Diving the Aeolian Sky a


they had ditched their weightbelts.

Passing boat picked the divers up after


June 77/80: Motor broke down. Divers

blood the next day. Vertigo due to

meal and four pints of "Old Peculiar"

June 88/80: Non-BSAC member separated

extremely prompt attendance at the

He always dives alone. "He does not

Bent shoulder~ N.B. This was his THIRD

June 85/80: Failure to check contents

--July

July 46/80: Young diver made to dive
deeper, darker and in worse conditions
than ever before. Frightened (quite

July 76/80: Diver working alone and
unmarked, with others similar, working
on wreck. Vomited underNater and died.

July 87/80: On holiday. Ran out of air
after deep dive. Attempted re-entry
decompression. Bent. X.X.X.X.H/S. 42. 10.11.60.

July 89/80: "Clan diver" got bent.


July 92/80: Instructor with dangerous

gear (weights tied on with string over the
quick release. No. lifejacket). Died in shallow rough water.

July 93/80: No-stop dives to 30m followed after an interval by a 12m dive without stops. Mild spinal bend requiring 4½ hours recompression.

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of its conclusions:

"Dive planning for the whole week-end
was completely inadequate."

"Good basic diving practices and rules
were ignored."

"There was a failure to recognise
symptoms promptly and to act accordingly."

"Logged account/records show a divergence
which cannot be satisfactorily accounted for."

B.3.C.H.H/S. 14. 10.11.64.67.

June 74/80: Club members clear rope from

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B.3.C.H.H/S. 14. 10.11.64.67.
July 123/80: Two divers (BSAC) missing, rescue services alerted, but found by their own boat. Only report of this event so far stated a newspaper in a case where the branch has not bothered. (I.O.M.)

B.X.X.B.H/S. s. 14.15.22.58.24.16.11.

July 124/80: When he surfaced he panicked and had to be rescued. O.X.X.X.B.H/S. s. 14.11.50.54.

July 125/80: Notice on first dive was so delayed he made an emergency ascent. He later developed other symptoms typical of air embolism. Panic rather than D V failure seems probable. B.X.C.X.X.X. X. 4.7.35.

July 126/80: Diver suffering from suspected decompression sickness taken to hospital. Released and allowed home. X.X.X.X.B.H/S. X. 12.11.15.70.


August 27/80: Repetitive diving over a period of days using USN repeat tables (NOT recommended either by the BSAC or the Navy) leads to a bend. The victim himself says "I am confirmed in the opinion that many divers must hide their symptoms, sometimes dangerously, due to the same attached to calling outside help." (The DIP says that using non-recommended tables was a major factor.) B.Z.C.X.X.X. s. 10.11.67?

August 10/80: Solo start to 56m, then joined by two more for final duration of 56 minutes. Decompressed according to SOS Decompression Meter. Bent. Needed two sessions of therapeutic recompression. B.Z.F.B.H/S. s. 11.40.60.61.

August 104/80: BSAC Branch picked up three other BSAC divers diving unmarked and lost by their boat. B.S.C.T/B.H/S. s. 19.22.24.54.58.61.

August 107/80: Diver lost for two hours found over a mile off shore, far from the start, cold and frightened. They were without "dayglo" hoods or SMB. They had ditched their weightbelts and lost their masks. The hired hardboat was also poorly equipped for a dive in these areas. B.X.X.X.B.H/S. s. 12.14.22.59.

August 108/80: Divers found by another boat over a mile from their boat near a race. They used a fixed length of line on their tennis-ball sized SMB, which of course they pulled under. B.X.X.B.H/S. s. 19.22.24.54.

August 109/80: One branch boat sank, rescued by two other branches. The victim branch did not help in the rescue despite having a spare boat. They have also not reported the incident. B.X.X.X.H/S. s. 8.24.54.

August 110/80: Boat belonging to unknown Midland divers adrift from shore. B.X.X.X.H/S. s. 8.

August 111/80: One of three divers ran out of air at 36m returning from a 40m dive. Sharing failed and he died. The other two were experienced Second Class divers, and all three had dived to 36m or more within the last three weeks.

It does seem however that the divers underestimated the effects of depth on (i) buoyancy, (ii) reaction to a stress situation, and (iii) the time taken for an incident to turn into an accident. This accident was further complicated by the very close relationship between the deceased and the dive leader. B.J.C.X.H/S. s. 10.11.34.49.50.57.61.

August 111/80: Returning from a dive on a chartered 52' boat. It was noticed that the water level was around the level of the oil sumps of the engines and was rising rapidly. The boat sank under them. B.J.C.X.H/S. 10. 8.24.

August 114/80: aeolian sky again! Divers separated. One without a watch stayed 40 minutes. No stops on ascent. Got pain so re-entered despite the TOTAL BAN on such procedures to decompress. Subsequently recompressed by the Navy. B.J.C.X.H/S. 10. 10.11.11.51.67.

August 118/80: Young woman failed to surface. Found four miles away, safe, but lost. X.X.X.B.H/S. X. 13.11.22.57.


August 121/80: Solo dive. B.X.X.X.X. X. 60.

August 122/80: Assisted ascent after second dive as one ran out of air when stops carried out. Decompressed after the ascent. B.Z.P.B.H/S. s. 10. 2.10.

August 123/80: After one dive the boat skipper went down (alone) to free the anchor. Bent. X.X.P.B.H/S. s. 10.11.13.14.

August 124/80: "The Cox was only 100 yds from the divers but still could not see the SMB. After half an hour contact was finally made." A slightly deflated inflatable buoy was used, and the flag had collapsed. B.Z.B.B.H/S. s. 1.22.24.54.

August 125/80: ABLJ valve spindle sheared during pre-dive check. B.X.X.X.X.H/S. 1. 31.34.

August 126/80: Inflatable rammed by fishing boat alleging diver on pots. Considerable damage to inflatable, not to say danger to occupants. B.X.X.X.X.H/S. s. 8.24.54.49.


August 129/80: Chartered boat and skipper put ten members at risk for...
several days. Very serious incident, but sub judice.

August 15/80: Having completed E and F tests and eight dives he dived to 35m. He ran out of air quickly, necessitating an assisted ascent.


September 6/80: Netchy five hours after a dive he reported to the pot with pain and other symptoms. He had tried to recompress at 30m, but the pains re-appeared on surfacing. Embolism was diagnosed and he was not recompressed. The embolism was attributed to a bout of coughing at depth followed by incorrect ascent procedure.

September 10/80: False alarm re missing divers leading to much wasted time. Really due to "careless talk".

September 11/80: Panic at 3m led to buoyant ascent. Buddy tried to hold him down but was kicked off.

September 12/80: False alarm as shore party saw cox rowing... he was following the divers and decided to row for a change.

September 139/80: The day before the dive he woke at 0500, worked from 0600 till 1400. Drove to fetch boat and load it. 1600 he left the Midlands arriving at Plymouth at 2230.

September 135/80: Perforated ear drum during 'A' test. B.C.T.H/P. 46. 41.67


September 140/80: At 6m his mask collapsed on to his face. Surfaced checked mask and dived again. 35 minutes later while surfacing it happened again. Overnight his eyes became very bloodshot and they took three weeks to get better. He could not explain the mask collapse.

B.X.X.X.H/S. X. 3.

September 141/80: Boat dragged anchor so boatman decided to re-anchor, and meanwhile lost sight of the SMB of one pair, and the bubbles of the other. 10 minutes later one lost pair asked a passing yacht to radio for help. The yacht left them! 15 minutes later they were picked up by a fishing boat which had already picked up the first pair (after 10 minutes lost).


September 142/80: Boat drugged anchor so boatman decided to re-anchor, and meanwhile lost sight of the SMB of one pair, and the bubbles of the other. 10 minutes later one lost pair asked a passing yacht to radio for help. The yacht left them! 15 minutes later they were picked up by a fishing boat which had already picked up the first pair (after 10 minutes lost).


September 12/80: Towed back by passing boat. Only report from newspaper cutting.

September 121/80: Branch boat capsized. Towed back by passing boat. Only report from newspaper cutting.

September 125/80: Impatient youngster tried out newly-purchased snorkel gear alone in shallow and (despite mother's ban) The mask was described as an 'inadequate toy'. He died.

B.X.X.X.H/S. X. 18.25.40.60.

September 127/80: Cheese-shaped rock from wreck caught fire (it was phosphorus) and set light to M.V. British Diver. A.X.X.X.H/S. 46. 41.67.

September 128/80: Blow-off valve cover broke away whilst under test.

B.X.X.X.H/S. X. 3.

September 129/80: Buoyant ascent.

B.X.X.X.H/S. s. 22.24.48.58.


B.X.X.X.H/S. s. 8.15.24.

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B.X.X.X.H/S. s. 22.21.58.64.


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B.X.X.X.H/S. X. 3.

September 129/80: Buoyant ascent.

B.X.X.X.H/S. s. 22.24.48.58.


B.X.X.X.H/S. s. 8.15.24.
No stops. Missed 5 minutes at 15m, 10 minutes at 10m and 80 minutes at 5m. Bent. Recompressed. Learned from this same diver as 10/80.

C.X.X.Comm.B.H/S. 33. 11.52.60.65.67.

October 14/80: Faulty ABW (dump valve leaking) led to aborted dive.

B.Z.X.X.H/F. 20. 1.31.36.61.

October 15/80: Aeolian Sky again. Leader dived without depth gauge.

B.2.C.B.H/S. 30. 11.22.40.58.

As is inevitable late reports on last year's incidents came to hand after the annual report was presented. The summary of last year's incidents given in this report are therefore corrected and more up to date than those that were published at DOC '79.

This also has led to some alteration and addition to the history of diving fatalities which is therefore given again.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MEMBERSHIP</th>
<th>DEATHS</th>
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</tr>
<tr>
<td>1980</td>
<td>34,700</td>
<td>5 (7)</td>
</tr>
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</table>

The numbers in brackets indicate the number of other, non-BSAC sports divers who died that year as well.

DECOMPRESSION FORUM

Alan Watkinson introduced the next session:

"During my Diving Officer's Report I mentioned the problem of decompression accidents. George Skuse highlighted the problem during his presentation. The next session is to give you some indication of what NDC has done to grasp this particular nettle.

We had hoped that, in addition to our own speakers, we would have a representative from RNFL to give you the Royal Navy view. Unfortunately, Commander Ramsey Pearson, who would have been here, has had to leave for the USA. However, I think it appropriate that I read to you one of the letters I received from Commander Pearson during 1980.

'I am afraid that contrary to expectations, 1980 looks like being a bad year for sport diving accidents. However, detailed analysis can come later. My offer to discuss some of these cases with you remains open.

My main reason for writing you this letter is that we have had four recent cases of sports divers intentionally going into bottom times requiring stops knowing they had insufficient air left to do the story. In these cases I suspect they were trying to carry out something akin to surfaced decompression. I can only point out that such practice displays complete ignorance of the adverse nature that any intervening excursion to the surface has as normal safe decompression.

I would be grateful if you will announce this practice in your Club magazine as soon as possible.

Finally, I have just received details of yet another decompression meter failing to cope with a 200 ft. dive for 20 minutes. Although we do not have full details of the meter it was described as Italian and the diver was bent before he surfaced. Even so, he ignored his symptoms for 12 hours before going to HMS Drake. Unfortunately, this problem of ignoring signs and symptoms seems to be getting worse rather than better.'

This gives you some indication of why I personally, and NDC have thought it necessary to promote this review of education on the use of decompression tables.

The re-entry system was never intended to replace normal decompression procedures. Even so, when you analyse the system - and a considerable amount of work has been done on this by Kevin Murphet of MIDFED - there is no doubt that to do re-entry decompression is not a suitable way of coping with somebody who has missed stops. I get the impression that people have misunderstood what George Skuse said.

If any diver, after completing a dive