

4. PROJECT "STICKYBEAK" - AUSTRALIA AQUATICUS
by Douglas Walker

An on-going investigation of accidents associated with underwater activities in Australian waters.

The object of this research is to indicate the incidence of both fatal and non-fatal accidents occurring in non-military underwater activities. From an investigation of all the discoverable factors involved, it is hoped to indicate 'avoidable factors' in the sequence of events. Planning the prevention or treatment of accidents or hazards requires valid information about their incidence and relative frequency.¹ Such is almost completely lacking, except for strictly military diving. Intelligent planning of public health actions and of regulations controlling or qualifying the act of diving by amateur or professional divers depends on identifying weaknesses in present practices. Such information can only be obtained from conscientious continuous and correlated reporting of such accidents. There is at present both a rapid increase in underwater activities by amateur and professional divers (of very varying skills) and an increasing relatively unresearched problem. All parties should benefit from discussion based firmly on facts relating to the Australian context. Concerted effort and informed action by the divers, their employers, local Health authorities, etc. to all concerned, particularly to the divers themselves. Commercial diving costs could be reduced if accidents could be prevented or if, when they occur unavoidably, proper treatment were available. Many persons could be alive today if this were so, just as many who have been irrevocably crippled as a result of diving accidents² and hazards could be leading normal, healthy, productive lives if both prevention and proper treatment were available.

There are two phases in any such investigation. First, the cases must be identified. Secondly, the facts must be sought. Only the interest and assistance of those approached can ensure success to the investigation.

Identification of cases will be from several sources, it is hoped. The mainstay will be newspaper reports, and these will be added to by direct reporting by clubs, diving organisations, divers and others who hear of incidents and are interested in assisting. The project will be heavily in debt, especially to coroners and their staffs, for copies of inquest proceedings into fatalities, and their interest and assistance is earnestly requested.

The medical cum diving qualifications of those involved in the survey, and the fact that they are members of SPUMS, is the guarantee that all reports will be regarded as medically confidential and not to be identifiably revealed or made available in any circumstances for legal proceedings. The legal view of 'responsibility' for an accident is entirely different from this attempt to plot the 'natural history' of each accident.

Most published reports have concentrated on single factors and all have been aware of the incompleteness of their coverage. The appendix gives brief notes of previous surveys and their sources of information. By far the best report is that recently published by the University of Rhode Island. If their findings should be confirmed here, or other equally important findings be made, the effort of all concerned will certainly lead to the savings of lives.

This article has been written to enlist support and interest. Any incident, not only fatal ones, could indicate a dangerous practice not yet widely so regarded. All offers of assistance, advice, and information, will be welcome. The life saved could be yours.

All correspondence, please, to:

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1. Gillen (Chairman, Committee on Man's Underwater Activities of the Marine Technology Society) *Arch. Environ. Health*. 1967; 14, April.

2. Lanphier. Personal communication.

APPENDIX

<u>AUTHOR</u>	<u>SOURCE OF INFORMATION</u>	<u>DATA</u>
Bayliss	Forensic Pathologists, Depts. of Health in capital cities. Coroners, Commonwealth Statisticians.	1957-67
71 deaths		
Berghage	US Navy NAVMED 816 Accident Reports.	1956-65
Av. 78 accidents		yearly. Average 1.6 deaths yearly.
BS-AC	Voluntary reporting -	1965-70 36 deaths
Denny & ...	Death Certificates with co-operation of Vital Statistics Bureau, Michigan Department of Health. Coroners	1959-65 21 deaths
Desautels	State Board of Health (Florida) Bureau of Vital Statistics. An on-going project, started	1960-69 (10
years)	1 January 1960	150 deaths
Hassel	South California area - Apparently Los Angeles Fire Dept(?)	1953-60 41 deaths
Miles	Cases notified to RN Medical College over 5 years except for 'hard hat'	1959-64? 120 non fatal 45 (deaths)
NZ	Notifiable accidents - professional divers	
Naguchi	Author is Chief Medical Examiner - Coroner, county of Los Angeles. Organised investigation scheme	1961 onwards 46 deaths
Press, Walker, Crawford	12 months check of all drownings in five American states, based on Illinois Dept of Health. Wrote to coroners.	1965-66 3 skin, 16 scuba deaths Total 1201 drownings
Smith FR	Seattle-King Country Safety Council supported by Police Harbour Patrol, Sheriff Patrol, Coast Guard, Coroner.	1959-65 10 deaths 1959-63 181 other drownings
Taylor, Williams,	Florida coded deaths certificates. Skin and Scuba diving from 1960.	32 months 37 deaths

Chappell	Search of Death Certificates, newspaper reports, then questionnaire to coroner/physician certifying cause of death.	(24 deaths in springs)
<u>AUTHOR</u>	<u>SOURCE OF INFORMATION</u>	<u>DATA</u>
UK	Notification of Decompression Sickness in workers	
URI	Newspapers, complimented by other proforma sent to coroner or medical practitioner certifying cause of death	21 skin divers, 101 scuba divers
Webster	Newspapers - author was Chief of Division of Accident Prevention, Bureau of State Services, Public Health Service.	1965 26 skin divers 60 scuba divers
Naguchi 6 points	<ol style="list-style-type: none"> 1. 'At scene' - investigation and recovery by experienced personnel 2. Post-mortem examination by trained forensic pathologist 3. Lab procedures for gas, toxicological and biological analyses 4. Examination of diving gear by expert 5. Co-ordination and presentation of findings to an Underwater Safety Committee 6. Establish Registry of Diving Fatalities 	

Progress Report on "Stickybeak"

The Attorney General's Departments of the states have given their support to the supply of information revealed at Coronial Inquests on fatal diving accidents. This assistance will be invaluable, but to obtain this information it is necessary to supply them with details to identify the victim. For this reason the notification of all known accidents is essential even if few details are known. Name, date and state will identify. Using this source of information will enable the collection of information from past accidents, so please do not hesitate to 'cry stale fish'. To this date, the following fatal cases are known, so please send me any additional deaths known to you.

Mount Gambier	6 April 1960
Adelaide	7 February 1970
North Molle	24 March 1971
Port Hacking	10 October 1971
Jervis Bay	19 December 1971
Piccaninny Ponds	29 January 1972
South West Rocks	31 January 1972
Toowoan Bay	3 January 1972
Mallacoota	3-4 March 1972
Avalon	19 March 1972

The project has been publicised in this Newsletter and also by direct application to several members and to both the Australian Underwater Federation (AUF and FoAUI) and the Scuba Divers Association of Australia (SDAA). To date only one reply has resulted. Please give this investigation every assistance.

Any information about non-fatal accidents is doubly important and can only be obtained by the co-operation of all divers and others with an interest in underwater safety. Additional information concerning the above fatal accidents will be of assistance, as not everyone with knowledge of an accident is called upon to give evidence at the inquest.

All information supplied will be treated as confidential and the names of victims will, naturally, not appear in the final or any other report.

DG Walker
April 1972