



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION: **Non-inquest findings into the death of Robert Norvell Brown**

TITLE OF COURT: Coroners Court

JURISDICTION: MACKAY

DATE: 14 September 2026

FILE NO(s): 2023/2151

FINDINGS OF: Wayne Pennell
Mining and Resources Coroner and Northern Coroner

CATCHWORDS: CORONERS: Findings pursuant to section 45(2) of the Coroners Act 2003 (Qld) – recreational scuba diving death – experienced diver – sudden distress underwater – collapse following ascent – cardiorespiratory arrest – prolonged resuscitation – multiorgan failure – cause of death uncertain – consideration of immersion pulmonary oedema – decompression illness – pulmonary barotrauma – cardiovascular disease – hypertension – coronary atherosclerosis – toxicology negative – equipment examination – no significant equipment malfunction identified – Workplace Health and Safety Queensland investigation – Queensland Ambulance Service review – Dive and Snorkelling Death Review Panel – systemic public safety observations – diver recall procedures – emergency communications between vessels – offshore retrieval protocols – no evidence of criminal conduct – no evidence of negligence – no breach of statutory duty – no regulatory non-compliance – no enforcement action warranted – comprehensive multidisciplinary investigation – inquest not required – public interest – State Coroner's Guidelines.

INTRODUCTION

1. The death of Robert Norvell Brown (Mr Brown) on 5 May 2023 was investigated through an extensive and multidisciplinary coronial process. The investigation drew upon the work of the Queensland Police Service (QPS), Workplace Health and Safety Queensland (WHSQ), the Queensland Ambulance Service (QAS), Queensland Health Forensic and Scientific Services (QHFSS), specialist diving equipment examiners and the Dive and Snorkeling Death Review Panel. Collectively, those bodies examined the circumstances of the dive, the conduct of the operator and its personnel, the emergency response, the integrity of the equipment and breathing gas, Mr Brown's medical history, and the pathological, radiological and toxicological evidence.
2. The central questions were how and why an experienced diver, who appeared well when the dive commenced, developed acute distress underwater and thereafter suffered cardiorespiratory arrest; whether equipment failure, environmental conditions, human conduct or a breach of duty contributed; and whether the medical evidence permitted the precipitating event to be identified. The investigation established the sequence of events and excluded a wide range of external causes. It did not, however, identify a single pathological mechanism capable of explaining the initial collapse with certainty.

PERSONAL BACKGROUND, DIVING EXPERIENCE AND MEDICAL HISTORY

3. Mr Brown was 59 years of age and a highly experienced recreational diver. He had completed more than 500 dives and had previously qualified as a PADI Dive Master and diving instructor. Although his diving activity reduced after the COVID-19 pandemic, he had recommenced diving and successfully completed a dive approximately two weeks before his death. Family members and witnesses described him as active, physically capable and enthusiastic about the ocean and scuba diving.
4. Mr Brown received regular medical care. His principal chronic condition was longstanding hypertension, documented from at least 2011. Perindopril was discontinued after he developed angioedema, and atenolol thereafter became his principal antihypertensive medication. His history also included hypercholesterolaemia, fatty liver disease, anxiety and episodic renal calculi. There was no documented history of myocardial infarction, significant arrhythmia, heart failure, stroke or diagnosed coronary artery disease, and no known chronic respiratory illness. Nevertheless, his age, hypertension and hypercholesterolaemia placed him within a recognised cardiovascular risk profile. Those matters later assumed importance in the post-mortem and specialist diving medicine reviews.

CIRCUMSTANCES OF THE DIVE

5. On the morning of 5 May 2023, Mr Brown joined a commercial recreational dive conducted by Scuba World at the ex-HMAS Brisbane wreck site off the Sunshine Coast. Divers received pre-dive briefings addressing ascent rates, buddy responsibilities, emergency procedures and recall signals. Mr Brown was allocated to a dive group with

John Currie and Michael Cole, under the supervision of dive master Christopher Maxwell (Mr Maxell).

6. The dive commenced at about 9:10 am and initially proceeded without apparent difficulty. At a depth of approximately 14 to 15 metres, Mr Brown was observed moving rapidly towards the transit line. He appeared panicked, was breathing heavily and showed clear signs of distress.
7. His air supply was checked and was available. Assistance was arranged for his ascent. Witnesses later reported that he clutched his chest and became increasingly unwell. After reaching the surface, he vomited, lost consciousness and entered cardiorespiratory arrest. Rescue and resuscitation measures commenced immediately.

WITNESS VERSIONS

8. The witness accounts were substantially consistent and complementary. Each witness observed the incident from a different position, but the accounts collectively established that Mr Brown appeared well before and during the early part of the dive, developed acute distress underwater, was assisted towards the surface, deteriorated rapidly and then became unresponsive. No material inconsistency emerged that undermined the reliability of this chronology.
9. Particular weight was attached to the contemporaneous handwritten notes of Mr Maxwell. Mr Maxwell recorded that, shortly after entering the water, he was near the forward gun barrel area when he saw Mr Brown swimming rapidly towards the transit line at about 14 metres. Mr Maxwell intercepted him at about 12 metres and observed rapid breathing, a wide-eyed appearance and apparent panic. He attempted to reassure Mr Brown and checked his equipment. Air remained in the cylinder, and the alternate air source regulator functioned. At that stage, Mr Brown was conscious, responsive and cooperative. When other members of the dive group arrived, Mr Maxwell directed them to escort Mr Brown to the surface and vessel.
10. The evidence of those aboard the vessel established a rapid deterioration after Mr Brown was recovered. Emergency procedures were activated, oxygen and cardiopulmonary resuscitation were provided, assistance was summoned and an automated external defibrillator was applied. The device repeatedly advised that no shock was required. The crew was simultaneously required to account for divers who remained underwater. Four divers did not initially respond to the recall signal, and Mr Maxwell assisted in locating and alerting them. Once all divers were recovered, the vessel departed for shore while resuscitation continued without interruption.

QUEENSLAND POLICE SERVICE INVESTIGATION

11. The QPS conducted the primary coronial investigation. It adopted a systematic, hypothesis-testing approach rather than proceeding from a predetermined cause. Police reconstructed the dive, obtained and compared witness statements, reviewed medical and emergency response material, coordinated forensic inquiries, secured the diving

equipment and arranged specialist examination of the equipment, breathing gas and dive computer. Potential criminal conduct, negligence, operational failure, environmental factors, equipment malfunction and a medical event were each considered.

12. The QPS Dive Unit examined the buoyancy control device, first and second-stage regulators, hoses, cylinder and dive computer. Testing coordinated with the Safety in Mines Testing and Research Station established that the breathing gas complied with the applicable Australian standard and contained no contaminant capable of causing illness or impairment. The only equipment abnormality was a slightly increased inspiratory effort in the primary second-stage regulator. Although that feature may have made breathing somewhat more laborious, the regulator remained functional and the abnormality was not capable, of itself, of preventing respiration or causing the fatal collapse.
13. The dive computer recorded a maximum depth of approximately 19.5 metres and a 'SLOW' warning consistent with an ascent rate exceeding 10 metres per minute. The device did not permit the exact ascent profile to be reconstructed. The warning provided useful context for consideration of decompression illness and barotrauma but did not establish why Mr Brown first became distressed.
14. Police also reviewed the emergency response and found that procedures were activated promptly, CPR commenced without delay, oxygen and an automated external defibrillator were used, and advanced care followed when QAS gained access to Mr Brown. The offshore location and the need to recover remaining divers created operational difficulty, but there was no evidence that any deficiency in the response caused or materially contributed to the outcome.
15. The police investigation excluded suspicious circumstances, deliberate self-harm, criminal conduct, significant equipment failure and an identifiable external cause. Its inability to identify the exact physiological trigger did not reflect an investigative omission. Rather, after all reasonably available avenues were pursued, the residual uncertainty was medical.

WORKPLACE HEALTH AND SAFETY QUEENSLAND INVESTIGATION

16. The Office of Industrial Relations (OIR), through WHSQ, conducted a separate regulatory investigation under the *Work Health and Safety Act 2011 (Qld)* and the *Safety in Recreational Water Activities Act 2011 (Qld)*. Its focus was whether any duty holder's act, omission, equipment, supervision, risk management system or emergency arrangement breached a statutory obligation or contributed to the death.
17. Investigators considered witness evidence, police material, operational and emergency records, dive waivers, participant screening, briefing documents, manifests, staff qualifications, hazard assessments, risk controls and equipment reports. The operator had buddy arrangements, pre-dive briefings, emergency communications, oxygen resuscitation equipment, an automated external defibrillator and qualified supervisory personnel. The evidence of Mr Maxwell and Kevin Lowndes demonstrated that

emergency procedures were promptly activated and that both responded within their qualifications and experience.

18. The regulatory review did not identify inadequate supervision, deficient training, defective equipment, a failure of emergency preparedness, reckless conduct or another breach of duty. It found that the operator's safety framework was appropriate and functioning. No contravention of the relevant legislation was established, and no prosecution or other enforcement action was warranted. The investigation supported the conclusion that the collapse was most consistent with an acute medical event rather than an operational or regulatory failure.

QUEENSLAND AMBULANCE SERVICE RESPONSE AND SUBSEQUENT INVESTIGATION

19. The QAS response was unusually complex because Mr Brown was in cardiac arrest aboard a vessel that remained offshore. At approximately 9:40am, QAS received a Triple Zero report that a diver was unconscious, not breathing and undergoing CPR. The incident was categorised as a Priority 1A cardiac arrest, resources were dispatched, and coordination commenced between communications staff, frontline crews, critical care clinicians, police and hospital services.
20. The vessel could not immediately return because divers remained underwater and first had to be recalled and safely recovered. That circumstance delayed direct access by QAS but did not arise from any failure by ambulance personnel. CPR continued aboard the vessel while QAS maintained situational awareness and positioned resources to provide advanced life support upon arrival ashore.
21. At the boat ramp, Mr Brown was unresponsive, centrally cyanosed, without spontaneous respiration and in asystolic cardiac arrest. QAS clinicians provided sustained advanced life support, including airway management and intubation, intravenous fluids, repeated adrenaline, cardiac monitoring and bilateral thoracostomies. They continued resuscitation in light of the diving context and potentially reversible causes. Return of spontaneous circulation was achieved after prolonged treatment, following which Mr Brown was stabilised and transported to Sunshine Coast University Hospital.
22. Following concerns raised by Mrs Brown, Professor Stephen Rashford (Professor Rashford), Medical Director of QAS, reviewed the Triple Zero audio, dispatch and operations records, patient care documentation, clinical records and coronial material. He assessed call handling, categorisation, dispatch, resource allocation, communications, treatment priorities, clinical interventions and the operational effect of the vessel remaining offshore. Professor Rashford concluded that QAS correctly recognised the urgency, deployed appropriate resources and provided care consistent with contemporary emergency medical practice. He identified no deficiency in clinical judgment, treatment or operational management and no alternative QAS action that would have altered the outcome.

PATHOLOGICAL AND TOXICOLOGICAL INVESTIGATION

23. The forensic investigation was undertaken by Dr Isaac Han and reviewed by Dr Beng Ong and Dr Andrzej Kedziora. It comprised a full autopsy, post-mortem computed tomography, histological examination, radiological review, toxicological testing, consideration of the clinical records and integration of the equipment findings. Its task was to identify both the terminal mechanism and, if possible, the event that precipitated Mr Brown's distress and cardiorespiratory arrest.
24. External examination disclosed a well-developed adult male. Most external findings reflected resuscitative and hospital procedures, including intubation, vascular access, nasogastric tube placement and thoracostomies. Minor abrasions, bruising and a superficial scalp laceration were not causative and were consistent with rescue or resuscitation.
25. Mr Brown's heart weighed approximately 520 grams, consistent with cardiomegaly and chronic hypertensive strain. His coronary arteries showed atherosclerosis, and histology demonstrated mild to moderate coronary artery disease, small vessel change, myocyte hypertrophy and mild fibrosis. These findings established chronic cardiovascular disease. They did not, however, reveal acute plaque rupture, thrombosis, myocardial infarction, myocarditis, dissection or an abnormality of the conduction system capable of definitively explaining the sudden collapse.
26. Examination of his lungs identified pulmonary haemorrhage, a superficial left lower lobe laceration, a small amount of blood in the left pleural cavity and a left pneumothorax. Its timing and significance could not be resolved. It may have resulted from pulmonary barotrauma during ascent, may have arisen before ascent, or may have been associated with the bilateral thoracostomies. Mild to moderate emphysematous change, anthracosis and focal bronchopneumonia were regarded as background findings. There was no pathological evidence of aspiration.
27. Antemortem imaging demonstrated widespread intravascular gas in several vascular beds. The radiological opinion was that its degree and distribution supported decompression illness, consistently with the dive computer's rapid-ascent warning. No cerebral arterial or pulmonary arterial gas embolism was identified. Decompression illness therefore remained plausible but could not be established as the cause of the initial collapse.
28. Mr Brown's brain showed cerebral oedema, loss of normal grey-white differentiation and histological hypoxic-ischaemic encephalopathy. Those changes resulted from prolonged oxygen deprivation after the cardiac arrest and explained the subsequent neurological deterioration and multiorgan failure. They did not explain what initiated the underwater emergency.
29. QHFSS toxicological testing on Mr Brown's antemortem blood detected atenolol at a therapeutic concentration. No alcohol, illicit drugs, sedatives, stimulants, narcotics or other impairing substances were identified, and carbon monoxide saturation was not

clinically significant. Intoxication, substance misuse and medication toxicity were thereby excluded.

30. After integrating the circumstances, pathology, histology, imaging and toxicology, the pathologists considered decompression illness, pulmonary barotrauma, immersion pulmonary oedema, the interaction of chronic cardiovascular disease with the physiological stresses of diving, and an unidentified event. None could be established to the exclusion of the others. The certified cause of Mr Brown's death was multiorgan failure due to cardiorespiratory arrest of unknown aetiology (SCUBA diving), with hypertension and coronary atherosclerosis recorded as significant contributing conditions.

DIVE AND SNORKELLING DEATH REVIEW PANEL

31. In 2025, the Dive and Snorkelling Death Review Panel independently reviewed the complete coronial brief. Its specialist role was not to determine legal liability or replace the formal forensic certification, but to apply expertise in diving medicine, physiology, operations and safety to the unresolved disabling event and to identify potential preventative lessons.
32. The Panel considered the witness evidence, dive data, equipment testing, clinical records, pathology and toxicology, emergency response information and the conclusions of the preceding investigations. It attached significance to the acute respiratory distress, longstanding hypertension, coronary atherosclerosis, exertion and atenolol therapy. Drawing upon the association between cardiovascular risk, beta-blocker use and immersion pulmonary oedema, the Panel considered immersion pulmonary oedema to be the most likely disabling condition preceding Mr Brown's collapse. It did not suggest that this mechanism had been proven. It also considered the mild to moderate emphysematous changes to be incidental and non-contributory.
33. The Panel did not identify negligence, misconduct, equipment failure, inadequate supervision or unsafe operational practice. It did, however, identify prospective safety issues: the safe and timely recall of divers when a medical emergency occurs; whether a dive supervisor should accompany a distressed diver to the surface; the value of a standardised assistance call between vessels operating at popular sites; and site-specific retrieval or recovery arrangements for major dive locations. These observations were directed at possible system improvement, not to a causative failure in this incident.

Comparison with the Forensic Pathologists' Conclusions

34. The Panel's opinion and the forensic conclusions are properly understood as complementary. Both accepted that Mr Brown suffered a sudden medical event during the dive, followed by cardiorespiratory arrest, severe hypoxic-ischaemic brain injury, multiorgan failure and death. Both recognised hypertension and coronary atherosclerosis as relevant, and neither identified intoxication, equipment failure or an acute traumatic cause.

35. The difference concerns the level of confidence assigned to immersion pulmonary oedema. The forensic pathologists, applying a conservative pathological standard, regarded it as one of several plausible mechanisms and retained the formulation of cardiorespiratory arrest of unknown aetiology. The Panel, applying specialist diving-medicine expertise to the totality of the circumstances, regarded immersion pulmonary oedema as the most likely disabling condition. The Panel did not contradict the certified cause of death, because it also acknowledged that the initiating event could not be conclusively established.

WHY AN INQUEST IS NOT NECESSARY

36. Section 45(2) of the *Coroners Act 2003 (Qld)* requires a coroner investigating a death, if possible, to find who the deceased was, how, when and where the person died, and what caused the death. This applies whether or not an inquest is held. The *State Coroner's Guidelines* require consideration of whether those findings can be made without an inquest, whether chambers findings are sufficient, whether material uncertainty or conflict warrants the judicial forensic process, and whether a hearing is likely to advance prevention, accountability or public confidence.
37. This is not a case in which a public hearing is required to complete an incomplete investigation. The QPS reconstructed the dive and excluded suspicious or external causes. WHSQ examined the safety and regulatory framework and found no breach. Specialist testing excluded a significant equipment defect, or contamination. QAS and Professor Rashford examined the emergency response and found no deficiency. QHFSS undertook comprehensive pathological, radiological and toxicological inquiry. The Dive and Snorkelling Death Review Panel then independently considered the complete brief from the perspective of diving medicine and safety.
38. There is no significant conflict in the evidence about the material sequence of events. There is no identified witness who has not been interviewed, test that has not been undertaken, document that remains unavailable or expert discipline that has not been engaged. The remaining uncertainty concerns the precise physiological trigger. Because the experts have already considered the plausible mechanisms and the available evidence cannot discriminate conclusively between them, oral examination at an inquest is unlikely to create evidence capable of resolving that medical uncertainty.
39. The public safety issues identified by the Dive and Snorkelling Death Review Panel do not compel a different conclusion. They are important, but they are prospective policy questions rather than findings that an identified deficiency caused or contributed to Mr Brown's death. They do not depend upon resolution of disputed facts or allegations of wrongdoing. The issues can be recorded in the findings and drawn to the attention of WHSQ, QAS and relevant diving industry bodies for consideration through regulatory, operational and industry processes. In those circumstances, a public hearing is unlikely to add materially to the Panel's specialist analysis or produce a better evidentiary foundation for preventative action.

40. Mrs Brown's expressed wish that an inquest not be held is also relevant, though not determinative. Family wishes cannot displace a compelling public interest in a hearing. Here, however, they align with the objective assessment that the investigation is complete and that an inquest would be unlikely to resolve the medical uncertainty, establish additional accountability or materially enhance safety. Subjecting the family to the additional burden of a public hearing without a corresponding forensic or preventative benefit would not serve the coronial purpose.
41. I am therefore satisfied that the statutory purposes of the investigation have been achieved; the findings required by section 45(2) of the *Coroners Act 2003 (Qld)* can be made; all reasonably available avenues of inquiry have been exhausted; and no unresolved issue of fact, accountability or public safety requires determination by public hearing. An inquest is neither necessary nor desirable in the public interest.

FINDINGS REQUIRED BY SECTION 45(2) OF THE CORONERS ACT 2003 (QLD)

42. Having reviewed and considered all police, regulatory, emergency service, medical, forensic, technical and specialist review material, I make the following findings pursuant to section 45(2) of the *Coroners Act 2003 (Qld)*.

- (a) **Identity of the deceased:** Robert Norvell Brown.
- (b) **How he died:** Mr Brown died after suffering a sudden cardiorespiratory arrest whilst participating in a recreational scuba dive at the ex-HMAS Brisbane wreck site. Despite immediate rescue and prolonged advanced medical treatment, he sustained severe hypoxic-ischaemic brain injury and multi-organ failure. Comprehensive investigations excluded equipment failure, intoxication, criminal conduct and breaches of statutory safety obligations. Although several possible medical explanations for the collapse were identified, including immersion pulmonary oedema, decompression illness, pulmonary barotrauma and the effects of chronic cardiovascular disease, the precise precipitating cause could not be determined.
- (c) **When he died:** 5 May 2023.
- (d) **Where he died:** Sunshine Coast University Hospital, Queensland.
- (e) **What caused his death:** Multiorgan failure due to cardiorespiratory arrest of unknown aetiology (SCUBA diving) with hypertension and coronary atherosclerosis recorded as contributing conditions.

CLOSING OBSERVATIONS

43. The investigation has established the circumstances of Mr Brown's death to the fullest extent permitted by the evidence. He was an experienced diver who unexpectedly developed severe distress during an otherwise routine dive. The prompt efforts of those present, the prolonged emergency response and the subsequent hospital treatment were unable to reverse the consequences of the cardiorespiratory arrest. No person, organisation or identifiable equipment defect was shown to have caused or materially

contributed to the death. The inability to identify the precise physiological trigger is a limit of the medical evidence, not a deficiency in the investigation.

CONDOLENCES AND ACKNOWLEDGEMENTS

44. Mr Brown and his wife, Dianne, shared almost 33 years together and 27 years of marriage. He is remembered as a generous and devoted husband and a loving father to Lucas, Benjamin and Sam. His family was central to his life. He loved scuba diving and the ocean and particularly valued sharing time by the sea with those closest to him. I extend my sincere condolences to Mrs Brown, Lucas, Benjamin and Sam, to Mr Brown's extended family and friends, and to all who knew and loved him. I hope these findings provide some measure of understanding of the circumstances of his death.
45. I acknowledge the fellow divers, crew members and Scuba World personnel who responded when Mr Brown became distressed, recovered him, administered oxygen and maintained CPR in difficult offshore conditions. I also recognise the frontline and critical care personnel of QAS, the Flight Critical Care Paramedic, the LifeFlight Emergency Doctor and the hospital clinicians who provided sustained and sophisticated care.
46. Finally, I express appreciation to the investigators and specialists of the QPS, the QPS Dive Unit, the OIR and WHSQ, QAS, QHFSS, the Safety in Mines Testing and Research Station, the Dive and Snorkelling Death Review Panel, and the civilian witnesses whose cooperation enabled the evidence to be assembled and independently assessed. Their professionalism and diligence have ensured that the circumstances of Mr Brown's death were examined comprehensively.
47. I now close the investigation.



Wayne Pennell
Mining and Resources Coroner and Northern Coroner
14 September 2026