



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 000648**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Paul Lawrie
Deceased:	Earl Allen Blessing Jr.
Date of birth:	3 September 1967
Date of death:	3 February 2024
Cause of death:	Drowning in the setting of scuba diving
Place of death:	Port Phillip Bay in the vicinity of Rye Pier Rye Victoria 3941
Keywords:	Scuba diving; use of scuba equipment; rebreather equipment; checking and calibration; exhaustion of air supply; reserve buoyancy; “buddy” system

## INTRODUCTION

1. On 3 February 2024, Earl Allen Blessing Jr. was 56 years old when he died while scuba diving in Port Phillip Bay near the Rye Pier. At the time of his death, Mr Blessing lived at Beaumaris, Victoria with his wife, Jeanette Anderson.
2. Ms Anderson described her husband as a very outgoing person with a lot of friends. He was interested in scuba diving and long-exposure photography. She explained that he always thoroughly researched any hobbies and interests and “never did anything by halves”.
3. Mr Blessing’s medical history included two cardiac stents (inserted in 2014) followed by two episodes of pericarditis. He was prescribed multiple medications (antihypertensives, antiplatelets and cholesterol lowering) for his heart conditions. In January 2024, Mr Blessing consulted with his general practitioner for a routine health check. He reported that he was happy with his general health, maintained a healthy diet and was sleeping well. His doctor documented Mr Blessing had lost weight, however his BMI of 28.1 was still in the overweight category, and his blood pressure was elevated.<sup>1</sup>

## BACKGROUND

4. Mr Blessing began scuba diving training in August 2017 through a PADI<sup>2</sup> accredited dive school. He received a Discovery Scuba Diving certification, followed by an Open Water certification on 13 December 2019, Enriched Air Diver certification on 5 March 2020 and Advanced Open Water certification on 3 February 2021.
5. On 30 July 2021, Mr Blessing commenced training under dive instructor, Rubens Monaco, at the Scuba School International (SSI). The purpose of this course was to become certified to use a Mares Horizon Semi Closed Rebreather (SCR). Shortly before beginning this training, Mr Blessing purchased a Mares Horizon XR SCR.
6. The Mares Horizon XR SCR is a recreational diver rebreather with multiple automatic safety systems. It automatically alerts the user’s onboard computer if it detects a problem. Due to its complexity, the device must be checked at frequent intervals, including the pre-dive assembly check, the closed check, the pre-jump check and the post-dive check. Mr Blessing created his

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<sup>1</sup> 140 / 90

<sup>2</sup> Professional Association of Diving Instructors

own electronic checklist. According to Mr Monaco, the pre-dive assembly check should occur no more than seven days prior to the planned dive.

7. On 2 November 2021, Mr Blessing completed his SCR certification which enabled him to dive to a maximum depth of 30 metres, at greater than (or equal to) 30% oxygen and no decompression. On 7 March 2023, Mr Blessing completed his SCR Extended Range certification. This enabled him to dive to a maximum depth of 40 metres, at greater than (or equal to) 30% oxygen with a maximum of 25 minutes decompression.
8. As part of his training at SSI, Mr Blessing was required to complete a medical waiver, which he signed on 30 July 2021. Mr Blessing answered 'no' to questions about having a stent placed, taking medications for heart conditions, heart conditions generally, high cholesterol and high blood pressure, despite having all such conditions/history. If he had answered 'yes' to any of those questions, he would have been required to undergo a medical evaluation.

## **THE CORONIAL INVESTIGATION**

9. Mr Blessing's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
10. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
11. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
12. Senior Constable (SC) Benjamin Hall of the Victoria police Search and Rescue Squad acted as the Coronal Investigator for the investigation of Mr Blessing's death. SC Hall conducted inquiries on my behalf and compiled a coronial brief of evidence. SC Hall is a highly experienced diver with multiple commercial diving certifications. He was able to provide expert analysis of data retrieved from Mr Blessing's dive computer and Apple watch. He was also able to provide expert opinion based upon examination of Mr Blessing's dive records and

equipment. Where further expertise was required, this was sought from the appropriate dive operators and BOC Limited.

13. This finding draws on the totality of the coronial investigation into the death of Earl Allen Blessing Jr. including the evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>3</sup>

## **MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE**

### **Circumstances in which the death occurred**

14. Mr Blessing had two cylinders filled by the Scuba Repair dive shop in Moorabbin on 12 January 2024. The two cylinders had a label attached with the fill date and the oxygen percentage (32% at 300 bar<sup>4</sup> of pressure).
15. On 2 February 2024, Ms Anderson observed her husband organising and preparing for a dive on the weekend of 3 to 4 February 2024. Mr Blessing had last calibrated his oxygen sensors 10 days earlier on 23 January 2024. He did not calibrate them on 2 February 2024.
16. On the morning of 3 February 2024, Ms Anderson woke shortly after 7.00am and saw that her husband was already awake. He told her that he was going to go for a dive and left the house between 7.30am and 7.45am.
17. Mr Blessing drove to the Rye Pier car park. After parking, he transported his scuba equipment on a trolley to the lower landing of the pier. Another scuba diver, Peter Barns, saw Mr Blessing sitting on the lower landing, blocking the steps he wished to use to enter the water.
18. Mr Barns observed Mr Blessing putting on a rebreather unit with two cylinders. Mr Barns noticed that Mr Blessing also had an underwater propulsion system. He spoke briefly to Mr Blessing as he stepped past him. Mr Blessing then entered the water and began his dive at 9.21am. As Mr Barns adjusted his gear, he saw Mr Blessing enter the water but did not see

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<sup>3</sup> Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

<sup>4</sup> 1 bar = 100 kPa; 14.5 psi; 0.987 atmospheres

him perform any pre-dive checks. Mr Barns began his dive approximately one minute after Mr Blessing had descended.

19. Approximately 25 to 30 minutes into Mr Barns' dive, he observed Mr Blessing using his propulsion system, travelling back towards the pier. He was about half a metre to a metre above the sea floor and did not appear to be in distress.
20. Data from Mr Blessing's dive computer, Apple watch and other equipment revealed the following key features of the dive –
  - (a) At 9:21am Mr Blessing commenced his dive.
  - (b) Over the first 7:30<sup>5</sup> he slowly descended to 8 metres.
  - (c) Mr Blessing recorded a total of 6 videos between 8.2 and 10.1 metres.
  - (d) At 24:30 he recorded a 33 second video at a depth of 8.8 metres. There is nothing out of the ordinary at this time to suggest that he was in any kind of distress or difficulty.
  - (e) From approximately 29:00, he began ascending from 8 meters.
  - (f) At 32:29 he reached 4 metres.
  - (g) At 34:29 he ascended to the surface.
  - (h) At 35:44 he was at the surface.
  - (i) At 36:45 he descended back down to 3 meters.
  - (j) At 37:14 he was at 3 meters. (9:58am)
21. Another group of divers arrived at the pier at approximately 9.30am. In this group was a dive instructor, David Taylor. Within a few minutes of Mr Taylor starting his dive, he saw Mr Blessing upside down on the bottom. A light on Mr Blessing's equipment had caught Mr Taylor's attention. The light was pointing towards one of the pier pylons and Mr Blessing's head was facing the same direction. Mr Taylor first thought Mr Blessing was looking at a seahorse (noting they sometimes gathered around the pylons), however he quickly realised Mr Blessing was not moving.

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<sup>5</sup> Elapsed time during the dive.

22. Mr Taylor and one of his group swam over to Mr Blessing and brought him up to the surface. The dive data reveals that this was a rapid ascent which began at 39:15. I am satisfied that Mr Blessing's descent at 36:45, after being at the surface for approximately one minute, is likely the point at which he became incapacitated or unconscious. Accordingly, he was submerged for 02:30, and on the bottom for 02:01, before Mr Taylor began bringing him to the surface.
23. Mr Taylor attempted to inflate Mr Blessing's buoyancy control device (**BCD**) but nothing happened. He fully inflated his own BCD but still he was struggling to keep Mr Blessing above the water. Mr Taylor was not familiar with rebreather units and was unsure how to remove the weights.
24. Mr Taylor removed his own weights and BCD while one of his group members removed Mr Blessing's gear. The divers swam to the pier with Mr Blessing and pulled him from the water, onto the lower platform.
25. Mr Taylor began cardiopulmonary resuscitation and other witnesses removed Mr Blessing's Apple Watch and dive computer watch and cut away his drysuit and undergarments.
26. Paramedics and firefighters soon arrived at the scene and continued the resuscitation efforts for approximately 45 minutes, but they were unable to revive Mr Blessing. He was declared deceased at 11.06am.

### **Identity of the deceased**

27. On 7 February 2024, Earl Allen Blessing Jr., born 3 September 1967, was visually identified by his wife, Jeanette Anderson.
28. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

29. Forensic Pathologist, Adjunct Associate Professor Sarah Parsons from the Victorian Institute of Forensic Medicine conducted an autopsy on 7 February 2024 and provided a written report of her findings dated 29 May 2024.
30. The post-mortem examination revealed no natural or toxicological cause of death.

31. Adj A/Prof Parsons explained that death due to drowning is difficult to diagnose as autopsy findings are non-specific and may include foamy fluid in the airways, water in the lungs and hyperinflated lungs. These findings were all identified in the deceased.
32. Adj A/Prof Parsons noted the opinion of investigating police who opined that Mr Blessing ran out of oxygen during his dive and was unable to inflate his BCD or drop his weights.
33. Toxicological analysis of post-mortem samples identified the presence of metoprolol<sup>6</sup> and ticagrelor.<sup>7</sup> Ethanol and carboxyhaemoglobin were not detected.
34. Adj A/Prof Parsons provided an opinion that the medical cause of death was *1(a) Drowning in the setting of scuba diving*.
35. I accept Adj A/Prof Parsons' opinion.

## **FURTHER INVESTIGATIONS**

36. Following Mr Blessing's death, Victoria Police members attended the scene and examined his equipment and spoke to witnesses as part of their wider investigation.
37. SC Hall noted that Mr Blessing's dive computer documented a rapid ascent from 3 metres at 39:15. I am satisfied this is the time when Mr Blessing most likely began experiencing difficulties.
38. SC Hall explained that the SCR was supplied by a 5 litre main cylinder. The SCR itself has a maximum flow rate of 30 litres per minute to maintain a set fraction of oxygen in the rebreather loop. From these parameters I deduce that, if the cylinder was pressurised to 300 bar<sup>8</sup>, this would provide a theoretical maximum<sup>9</sup> of 50 minutes of supply at the maximum rate. If the cylinder was pressurised to 250 bar, this would provide a theoretical maximum of 42 minutes at the maximum rate. I also note SC Hall's opinion that given the depth of the dive and the apparent low work rate (Mr Blessing was using an electric propulsion unit), the flow rate from the cylinder to the SCR would have been well below the maximum thereby increasing the endurance of the main supply.

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<sup>6</sup> An anti-hypertensive drug.

<sup>7</sup> An inhibitor of platelet aggregation indicated for acute coronary syndrome in conjunction with aspirin.

<sup>8</sup> Oxygen at 32%, nitrogen at 68%.

<sup>9</sup> This is not to be confused with a practical maximum duration after allowances are made for appropriate safety margins.

39. The fact that Mr Blessing appears to have encountered difficulties after only 34 minutes is indicative of the main cylinder supply not being what he thought it was from the outset, or a problem occurring during the dive which led to a loss of supply air.
40. One of the other divers who witnessed the incident checked Mr Blessing's gas cylinders. The reserve cylinder had between 280 and 290 bar of pressure. The diver tried to open the main cylinder and thought that there was no connection between the handle and the valve. When SC Hall later checked this cylinder, he found the valve operated properly but the cylinder and hose were empty.
41. SC Hall also examined the dive computer connected to Mr Blessing's SCR. He observed several warnings on the display, the most notable being that the oxygen analyser read 16% immediately before it was flooded with water. SC Hall explained that the SCR would have been flooded with water when the regulator was first removed from Mr Blessing's mouth by those assisting him.
42. On 9 February 2024, police conveyed Mr Blessing's first and second stage regulators, pressure gauges and pressure hoses to Snorkel and Dive Safari for examination. The examiner found that the equipment functioned as expected. The only finding of note was that the pressure gauge attached to Mr Blessing's main cylinder read slightly higher than the actual pressure, by approximately 3 to 5 bar.<sup>10</sup>
43. Also on 9 February 2024, police conveyed the Mares XR SCR to All About Scuba for inspection. The unit had been flooded with sea water during the events of 3 February, and it required emptying, cleaning and drying. Once this had been done, the examiner confirmed the unit performed as expected.
44. On 12 March 2024, Mr Blessing's two cylinders were tested by BOC Limited. The tests revealed that the gases were within safe limits and the oxygen percentage was correct as per the labels on each cylinder.
45. SC Hall concluded that Mr Blessing ran out of supply air during the dive. This view is based on the data from Mr Blessing's dive computer and Apple watch which revealed that he reached the surface for a brief period before descending to the sea floor at a depth of three metres.

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<sup>10</sup> This represents approximately only one minute of supply air to the SCR

46. SC Hall further opined that a contributing factor was the extensive amount of equipment that Mr Blessing was carrying, which caused him to become negatively buoyant when there was limited or no air for his BCD or dry suit. Without air in his cylinder, he was unable to inflate his BCD or dry suit to become positively buoyant and remain at the surface. Furthermore, Mr Blessing's rebreather unit did not have any quick release weights.
47. Mr Blessing's reserve cylinder<sup>11</sup> was filled with a mix of 50% oxygen and 50% nitrogen<sup>12</sup> at 250 bar. SC Hall explained that if Mr Blessing turned this cylinder on, it would have given him the gas to both breathe and inflate his BCD, which would permit him to become positively buoyant.
48. SC Hall spoke to Mr Monaco, who had trained Mr Blessing in the use of the rebreather. Mr Monaco advised that students are not taught to turn on the decompression / reserve cylinder if they encounter difficulties underwater. The main reason for this advice is that the diver is at danger of high partial pressures of oxygen and oxygen toxicity if inhaling this gas at certain depths. However, even with a 50% oxygen mix, Mr Blessing would have been safe to use this supply down to a depth of 22 metres.
49. SC Hall explained that Mr Blessing was undertaking a relatively shallow dive. As such, a 300 bar, five litre cylinder through a SCR at a maximum depth of 10 metres should have lasted longer than 35 minutes and 44 seconds (which is when Mr Blessing descended, after one minute at the surface). SC Hall opined that at some point during the dive, an error or leak has occurred, and Mr Blessing either did not notice the issue or did not properly monitor or evaluate his pressure levels. SC Hall was unable to determine when this error or leak occurred. It may have occurred in the time between the last calibration (23 January 2024) and the day of the dive. Alternatively, a leak could have occurred during the transport of the equipment or during initial set up.
50. When Mr Barns saw Mr Blessing during the dive he did not see anything that indicated his equipment was leaking or not functioning correctly.
51. SC Hall opined that Mr Blessing either entered the water with less tank pressure than required for his planned dive or a significant leak occurred during the dive, which Mr Blessing was unable to rectify. In either event, SC Hall concluded that Mr Blessing did not appropriately monitor his tank pressure using the gauge on the bottom of the cylinder, or he has monitored

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<sup>11</sup> Often referred to as the decompression or 'Deco' cylinder.

<sup>12</sup> Atmospheric air contains 21% oxygen, 78% nitrogen, 1% argon and trace gases.

it but relied on the slightly higher indicated pressure and continued the dive with an unsafe margin. I accept SC Hall's opinion.

## **FINDINGS AND CONCLUSION**

52. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Earl Allen Blessing Jr., born 3 September 1967;
  - b) the death occurred on 3 February 2024 in Port Phillip Bay, in the vicinity of Rye Pier, Rye Victoria, from drowning in the setting of scuba diving; and
  - c) the death occurred in the circumstances described above.
53. Having considered all of the circumstances I am satisfied that Mr Blessing death was a consequence of him beginning the dive with less pressure than required for what he had planned, or a significant gas leak occurred during the dive. In either event, it appears that Mr Blessing did not adequately monitor his tank pressure levels (or did so using a slightly higher reading), thus causing him to run out of air while underwater.

## **COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

54. The Professional Association of Diving Instructors (PADI) emphasises the importance of Scuba divers diving with a 'buddy'. Indeed, they describe it as a fundamental or golden rule of diving.
55. The additional layers of safety that come with a diving buddy are clear. The advantages include a fresh set of eyes to check equipment and ensure that checklists are followed. The diving buddy is also likely to be well placed to detect and assist with equipment problems, including problems with air supply. In the event of physical difficulties, which may include anything from cramp through to complete incapacitation due to a medical event, the buddy represents the most immediate means of assistance or rescue.
56. Sadly, it is likely this tragic outcome may have been avoided if Mr Blessing had dived with another certified diver as a buddy.

## ACKNOWLEDGEMENTS

I convey my sincere condolences to Mr Blessing's family and friends for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

## ORDERS & DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Jeanette Anderson, Senior Next of Kin

Australian Underwater Federation

Diving Industry of Victoria Association Inc

SCUBA Divers Federation of Victoria

Senior Constable Benjamin Hall, Coronial Investigator

Signature:



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**CORONER PAUL LAWRIE**

Date: 01 July 2026



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NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

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