

Annual Diving Incident Report 2025

Recreational diving incidents in the UK and overseas
for the calendar year 2025

Introduction

The incident report for recreational diving occurring in the UK and Overseas, for the calendar year 2025.

The majority of information contained within this report is also shown in graphical form. Please note that all data information is produced from UK data only and does not include overseas incidents unless noted as 'all incidents'.

The contents of this report are split into an overview of the year and then the details of eight incident categories, plus some historical analyses. Within each category, the incidents are listed in the order of occurrence, not necessarily that of Incident Reference. They are laid out in the following form:

MONTH/YEAR OF INCIDENT	INCIDENT REF.
<i>Brief narrative of incident</i>	

Diving incidents often involve multiple contributing factors or outcomes. In such cases, each incident has been categorised according to the most significant cause or effect. For example, if a rapid ascent leads to decompression illness, it will be listed under 'Decompression Incidents'.

We encourage you to read through the details in this report and reflect on the synopses provided. The individuals who shared their experiences have done so with courage and generosity, allowing others to learn from their situations and helping to prevent similar occurrences in the future.

If you ever experience an incident yourself, please consider contributing to the world's most comprehensive recreational diving incident reporting system by submitting a report via the BSAC website or directly through BSAC HQ. Your anonymity is fully protected, and all personal information recorded in the BSAC Incident Report database is handled with the utmost confidentiality.

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October 2026

Acknowledgements

Data for this report are collected from many different sources. We would like to extend our thanks and appreciation to the following for their assistance in its production and in ensuring its completeness:

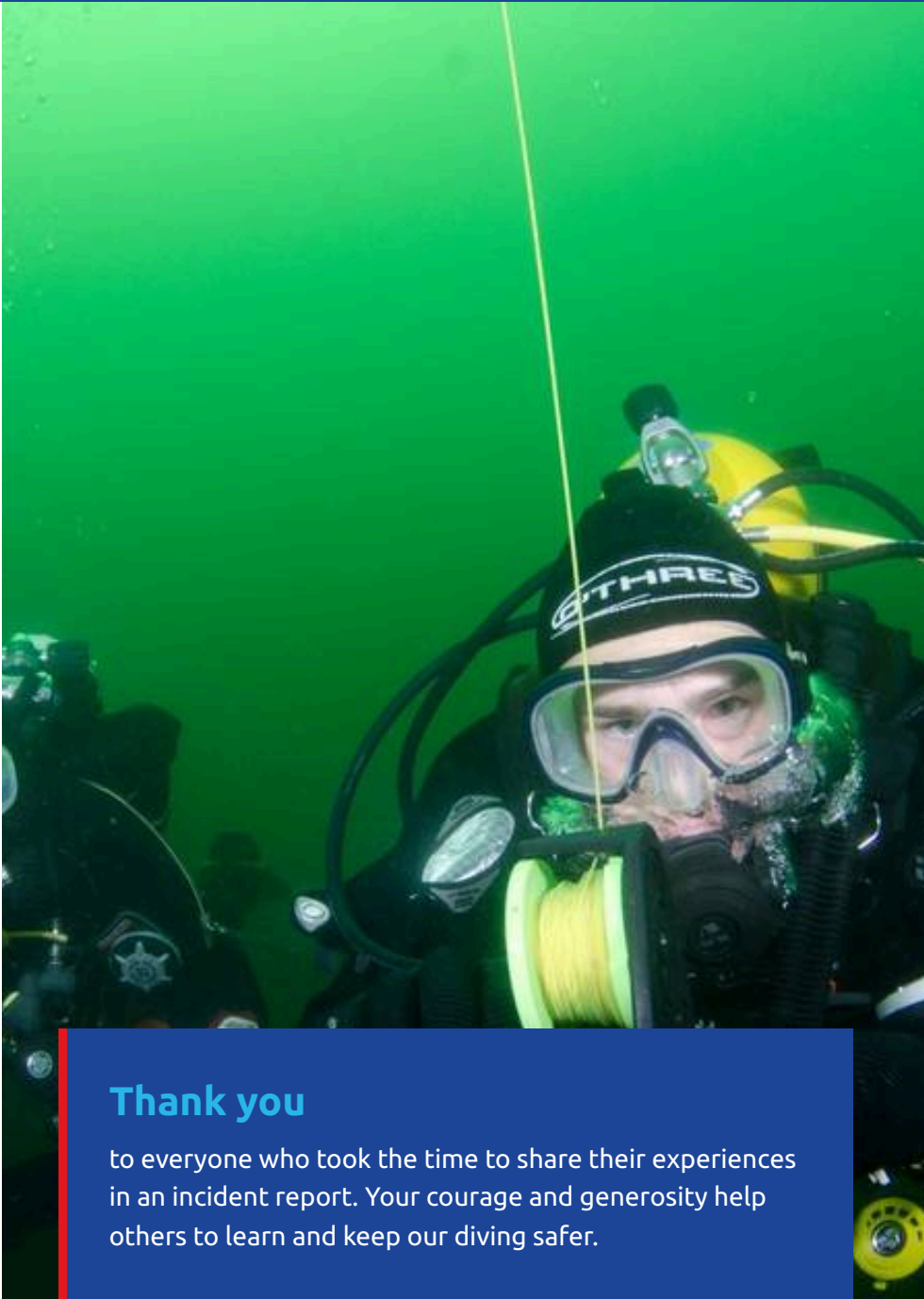
- Maritime & Coastguard Agency
- MOD Joint Service Adventurous Training Diving Officer
- PADI Europe, Middle East and Africa
- Royal National Lifeboat Institution
- Scottish Sub-Aqua Club
- Sub-Aqua Association
- CFT – Comhairle Fo-Thuinn – Irish Underwater Council
- RAID – Rebreather Association of International Divers
- Sophie Heptonstall for proofreading this report
- and, in particular, all of those divers and other sources who have taken the trouble to complete incident reports and share their learning experience with others



Cover photograph by Steve Jones

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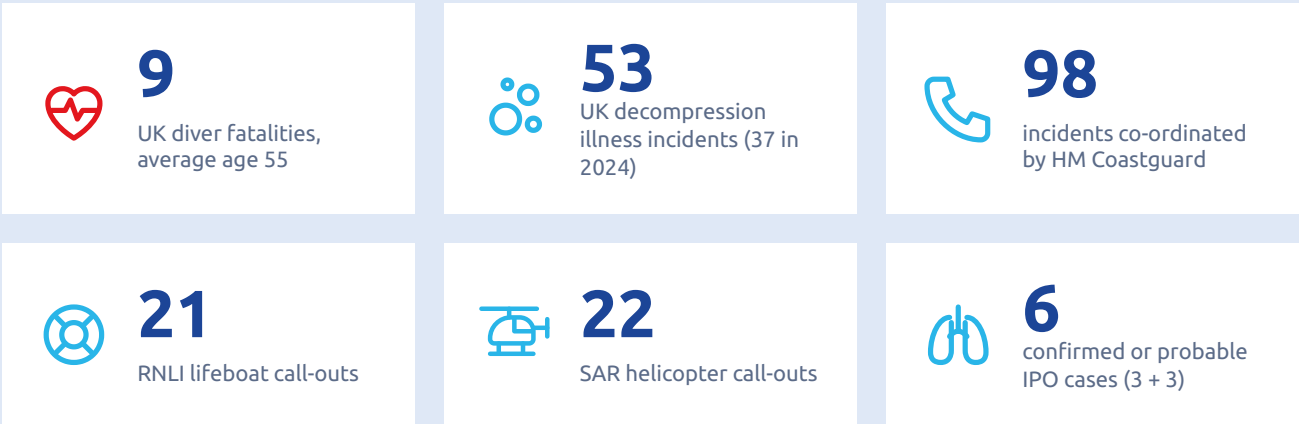


Thank you

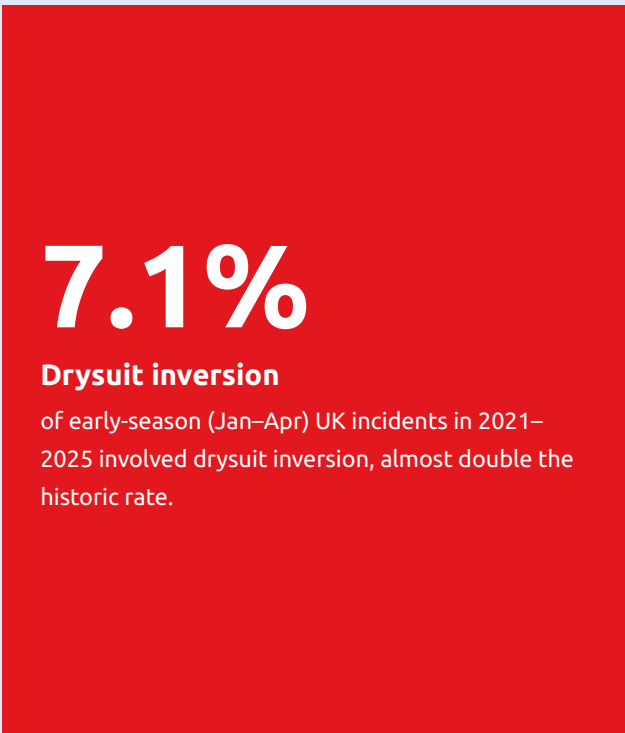
to everyone who took the time to share their experiences in an incident report. Your courage and generosity help others to learn and keep our diving safer.

2025 at a glance

A snapshot of the incidents reported to the BSAC incident database for the 2025 calendar year.



UK incidents by category



Analysis of the incident database

Each year, BSAC produces the Incident Report as part of its role as the National Governing Body for scuba diving and snorkelling in the UK. The report provides valuable information for diving organisations, training agencies, and rescue services, supporting informed decision-making and helping to identify emerging trends and contributing factors in recreational diving incidents.

It also serves as an important resource for divers and instructors by highlighting lessons that can enhance safety and risk management within the sport.

The report covers recreational diving incidents occurring throughout the UK and draws on information from a wide range of sources. Reports are submitted by divers of all affiliations, UK and Irish diving agencies, and the emergency and rescue services involved in diver support and response. Additional data is obtained from annual reports produced by organisations such as the Maritime and Coastguard Agency (MCA), the RNLI, the Ministry of Defence Joint Service Adventurous Training Diving Officer (JSATDO), and PADI Europe, Middle East and Africa. BSAC also utilises a media monitoring service to identify relevant incidents reported through news and online media outlets.

A significant proportion of incidents are reported directly via the incident reporting forms available on the BSAC website. Figure 1 illustrates the range of sources used to compile the report and reflects the total number of contributions received, including occasions where multiple reports relate to a single incident.

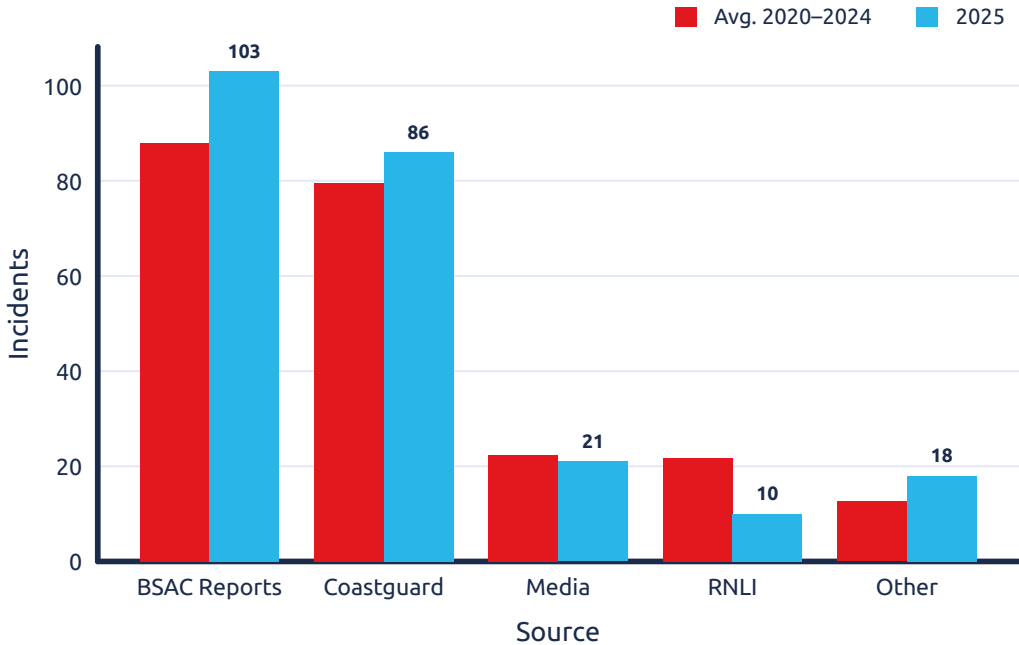


Figure 1
The source of reports contributing to the BSAC incident analysis

103 reports came directly from divers via BSAC reporting — the largest single source, up from an average of 88.

To maintain the accuracy of the dataset and minimise duplication, particularly where the same incident has been reported through multiple channels, BSAC carries out a detailed cross-referencing process. This involves comparing information such as the date, location, and circumstances of each incident to identify duplicate reports. In the vast majority of cases, BSAC is confident that duplicate entries have been removed. However, an increasing number of reports contain insufficient detail to determine with certainty whether they relate to the same event. In such cases, both reports are retained within the dataset.

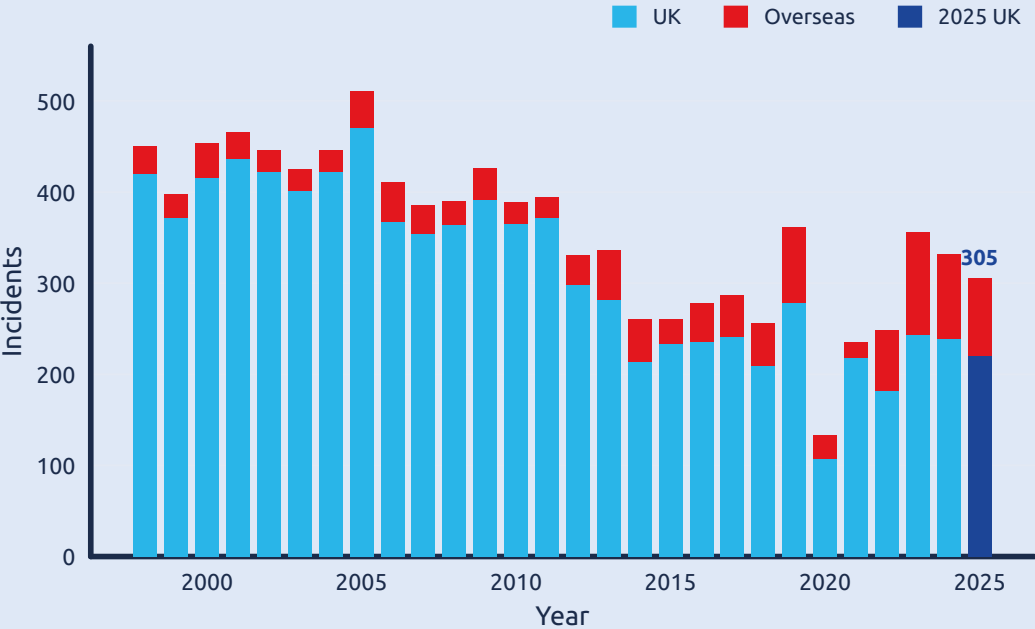


Figure 2
Total number of UK and overseas reported incidents each year, 1998–2025

A stable picture

During the 2025 calendar year, a total of 305 diving incidents were recorded, of which 85 occurred overseas (see Figure 2).

In line with our previous observations the number of UK-based incidents has remained relatively stable since 2014, with the exception of the pandemic year, when restrictions on diving activity led to a noticeable decline in reported cases.

This incident report excludes commercial diving operations, including professional scallop fishing and harbour-based work dives, as responsibility for investigating and regulating such incidents rests with the Health and Safety Executive (HSE). Recreational instructional dives, however, are included regardless of whether they are delivered by commercial instructors, as they have direct relevance to the sport. The collection and analysis of these incidents contribute to the continuous improvement of training standards and the guidance available to both divers and instructors.

220

UK incidents

85

overseas incidents

28%

of all reports were overseas

Incidents by month

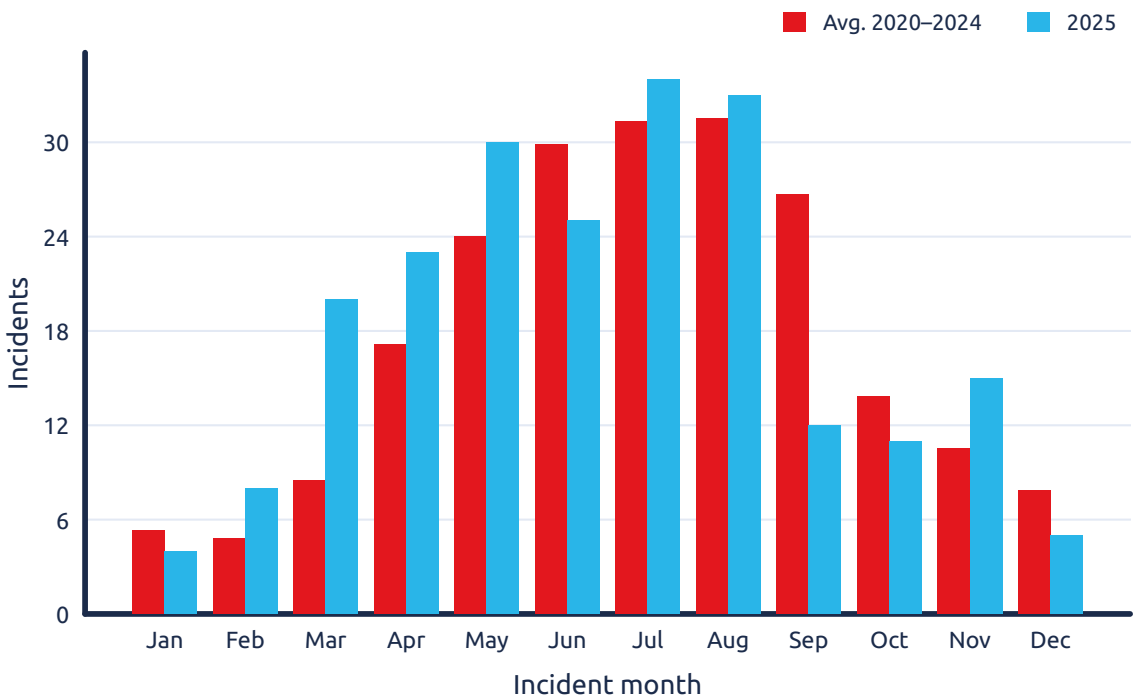


Figure 3
Number of UK incidents occurring in each month of the calendar year

Figure 3 illustrates the number of incidents reported in the UK across each month of the calendar year. As in previous years, the distribution of incidents closely mirrors the periods of peak diving activity: more diving tends to result in more incidents.

A noticeable increase in incidents is recorded in March 2025 compared with previous years, and it is tempting to make the assumption that these incidents are due to lack of preparation for the diving season; however, closer analysis of the incidents in March showed that the incidents were across all the different categories, and that there was insufficient evidence to conclude that lack of preparation or training was involved.

In 2025, the previously observed increase in incidents later in the diving season was not repeated and in September there was a noticeable decrease in incidents compared to the previous five years. We do see a slight increase in incident reports during November. These early and late season incidents are, for the most part, linked to diving at inland sites.

- March** 20 incidents vs 8.5 average
- September** 12 incidents vs 26.7 average
- July** busiest month — 34 incidents

Incidents by category

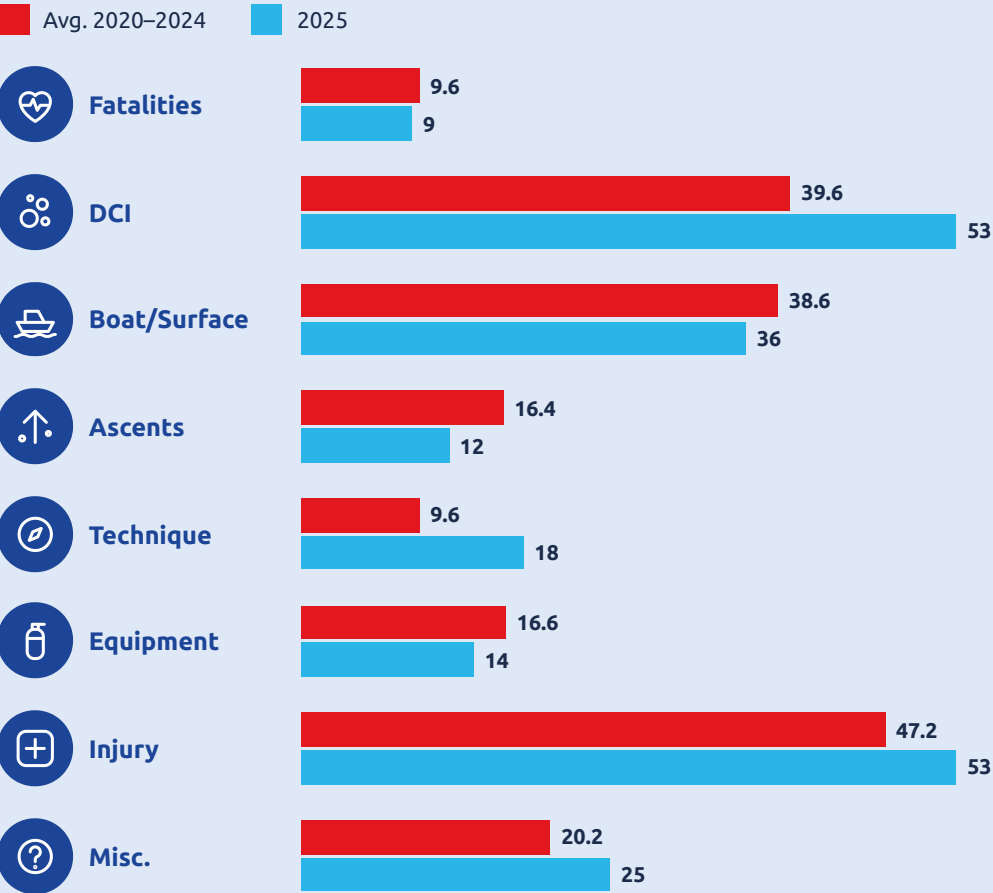


Figure 4
Reported UK incidents by category

Each incident is reviewed and assigned to the category representing its primary contributing factor.

For example, where a rapid ascent results in decompression illness (DCI), the incident is classified as a DCI case. In contrast, a rapid ascent that does not lead to significant harm is recorded as an ascent-related incident. Events that cannot be confidently linked to a single cause are assigned to the miscellaneous category. The ascent category therefore includes cases in which divers made an abnormal ascent but did not develop DCI or sustain other injuries.

In 2025, the distribution of incidents across the various categories remained broadly comparable to previous years. As in recent reports, there was an increase in incidents classified as either miscellaneous or injury. These categories are often used when insufficient information is available to support a more specific classification, which may indicate a rise in reports submitted with limited detail.

As noted in previous reports, we continue to receive a number of notifications relating to false alarms raised in good faith, particularly by the Maritime and Coastguard Agency (MCA). We also received a smaller number of reports involving the provision of accident-prevention advice to divers. We remain extremely grateful for the continued support of the emergency services, whose prompt response and commitment to diver safety are invaluable. Early notification of a potential incident, even when assistance is ultimately not required, is always preferable to a delayed call-out, which could reduce the effectiveness of any subsequent rescue effort.

Regrettably, there were nine diver fatalities in 2025. Further details of these incidents are provided later in this report.

Incident depths

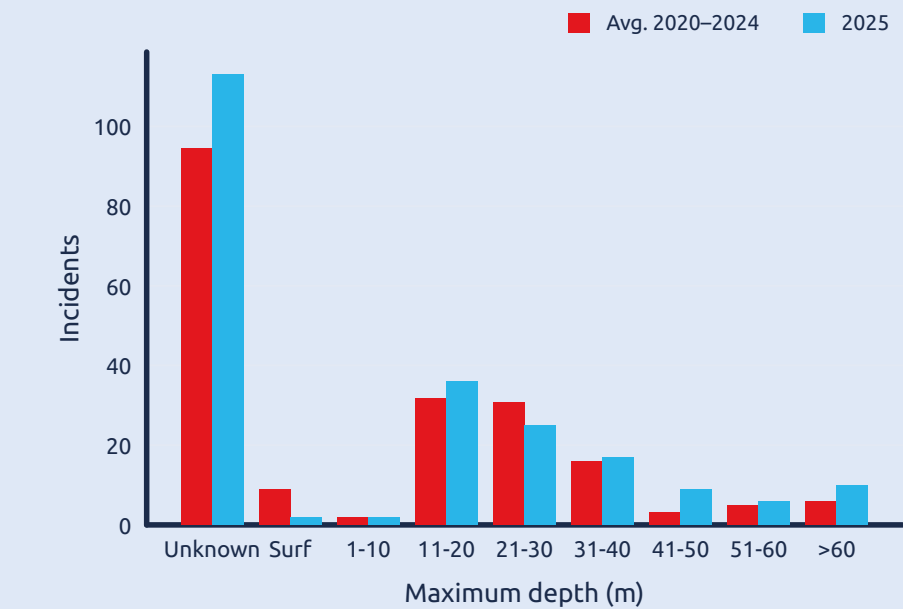


Figure 5
Maximum dive depth (m) in which incident occurred

Figures 5 and 6 present data on dive depths associated with reported incidents. Figure 5 illustrates the maximum depth reached during the dive, grouped into 10-metre intervals, while Figure 6 shows the depth at which the incident began. Due to limited detail provided by some emergency services and media sources, a significant number of incidents are categorised as ‘unknown’ in terms of dive profile. This trend has grown in recent years, reflecting an increase in reports submitted with incomplete depth information.

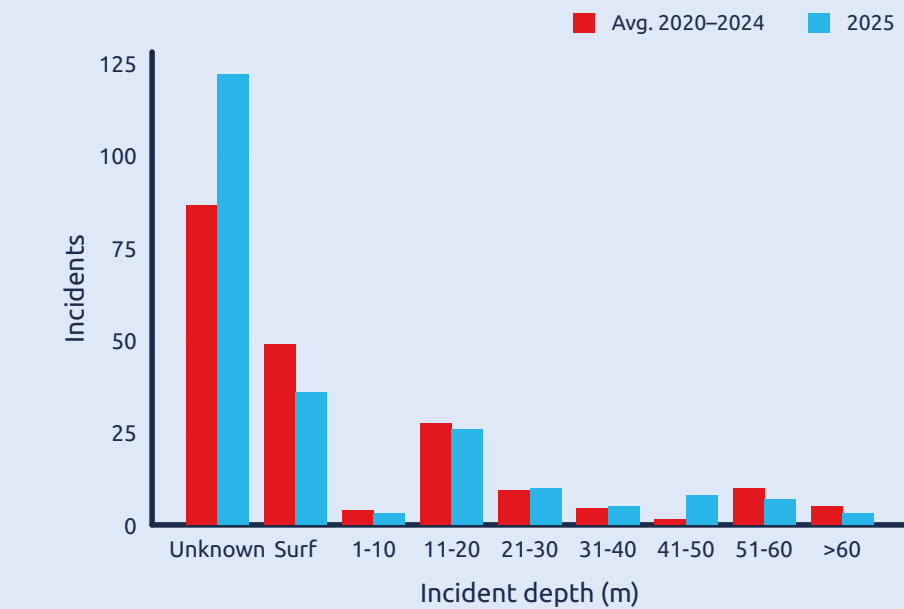


Figure 6
Depth (m) at which incident started

Where depth data is available, the overall distribution remains broadly consistent with previous years. As noted in last year’s report, both figures highlight a continued decline in incidents beginning at the surface, alongside a rise in cases where both the starting and maximum depths are unknown.

Diver qualification

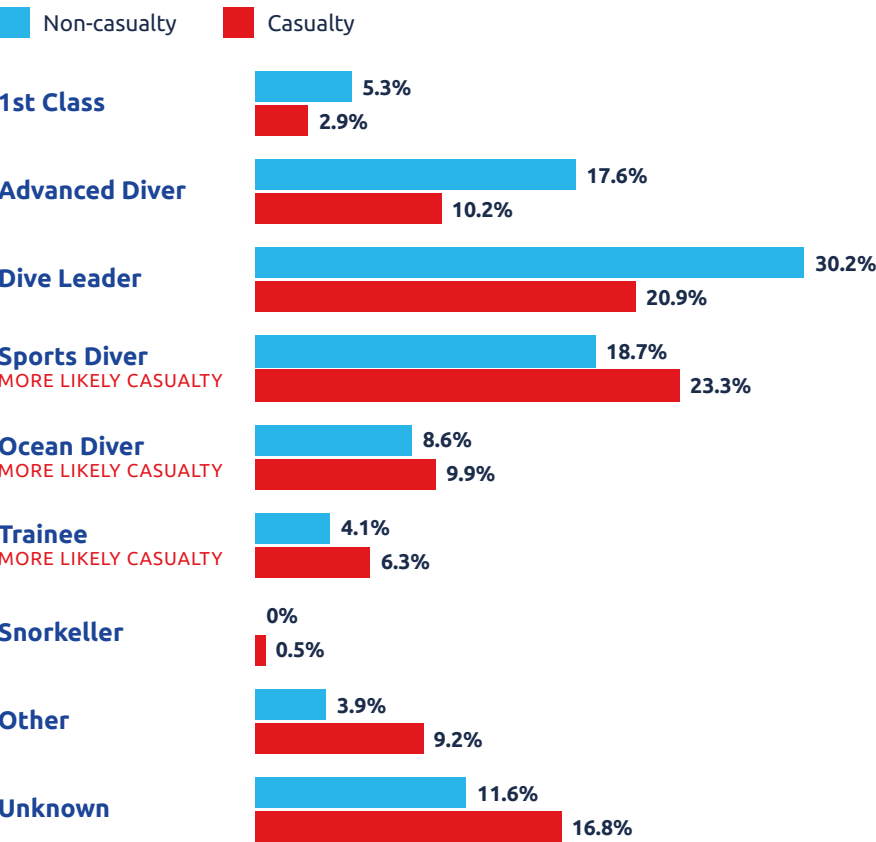


Figure 7
The BSAC qualification of the divers involved in each incident in 2025, separated by casualty or non-casualty (% of divers in each group)

In Figure 7, we show the BSAC diving qualifications of the divers who were casualties in incidents in comparison with the BSAC qualifications of the divers who were involved.

Presenting these data in this way enables us to account for the relative engagement of each of these diving qualifications in diving and the likelihood of being the casualty.

This year we see that Trainee divers, Ocean Divers and Sports Divers are relatively more likely to be the casualty in a diving incident than the more qualified and experienced Dive Leaders, Advanced Divers and First Class Divers.



Experience helps — but is no guarantee. Qualified, experienced divers still appear among casualties in every grade.

Divers' use of emergency services



98

incidents co-ordinated by the Coastguard —
73 of them May–September



21

RNLI call-outs — 15 in May–September



22

helicopter call-outs — 16 in May–September

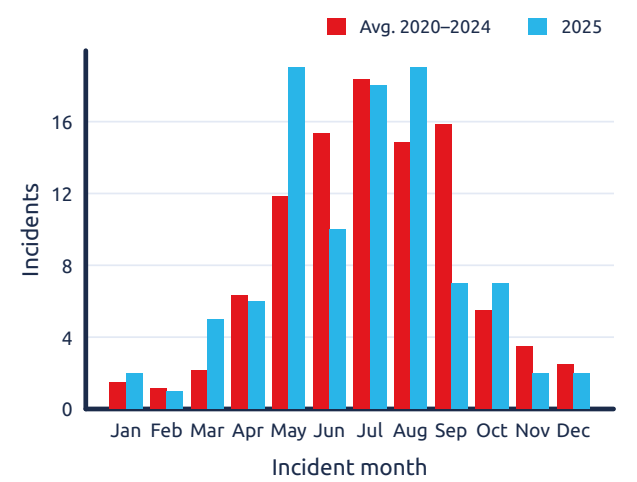


Figure 8
Incidents involving HM Coastguard in each month

The Coastguard co-ordinated the rescue services during 98 of the 220 UK dive incidents reported in 2025, 73 of these incidents occurred in May, June, July, August and September (Figure 8). In 2025, the RNLI was called 21 times to help in the rescue of divers. Fifteen of

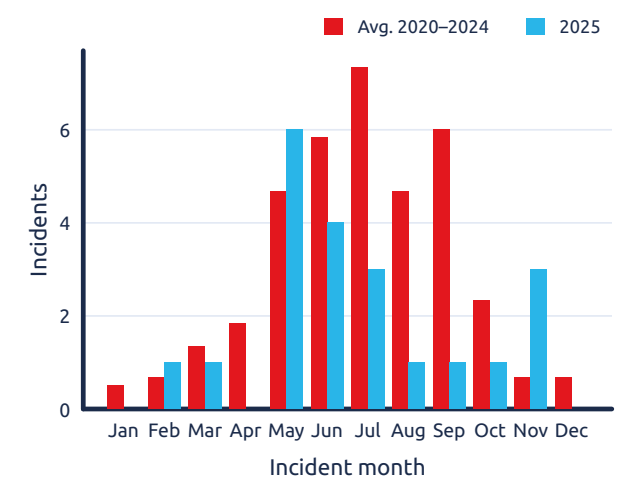


Figure 9
Divers' use of RNLI facilities in each month

these were in May, June, July, August and September (Figure 9). Also, in 2025, helicopters were called out 22 times to help in the rescue of divers. Sixteen of these call-outs were in May, June, July, August and September (Figure 10).

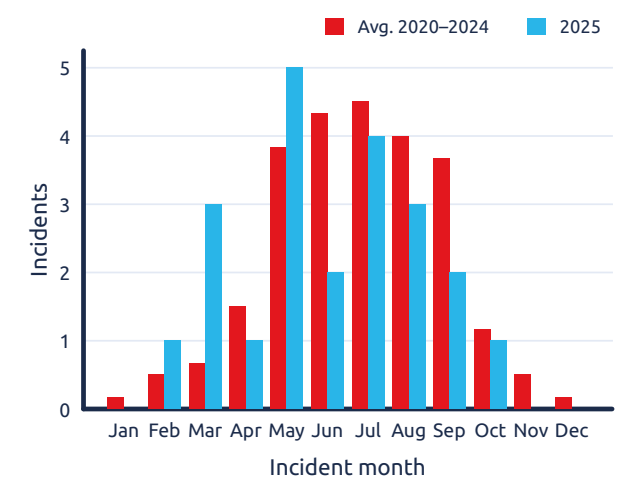


Figure 10
Divers' use of SAR helicopters in each month

Where incidents happen

Locations of UK incidents with a recorded position in the BSAC incident database. Circle size reflects the number of incidents recorded at each location; the concentrations mirror the UK's most popular inland sites and coastal diving areas.

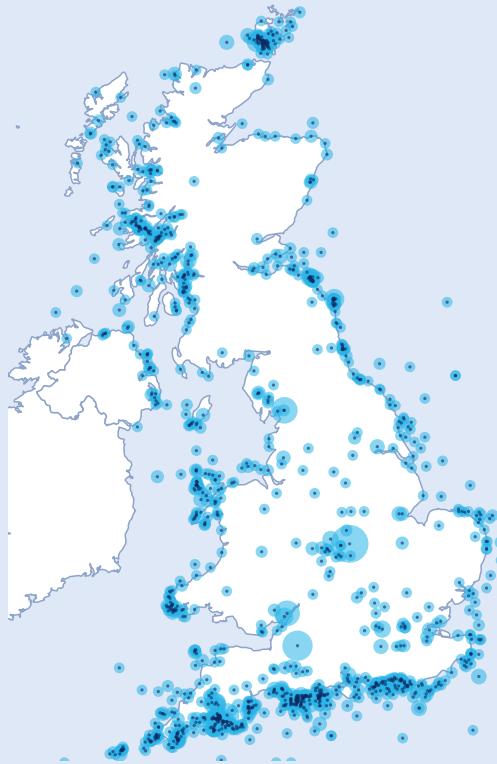


Figure 19a
All incidents

2,864 incidents · 1,174 locations

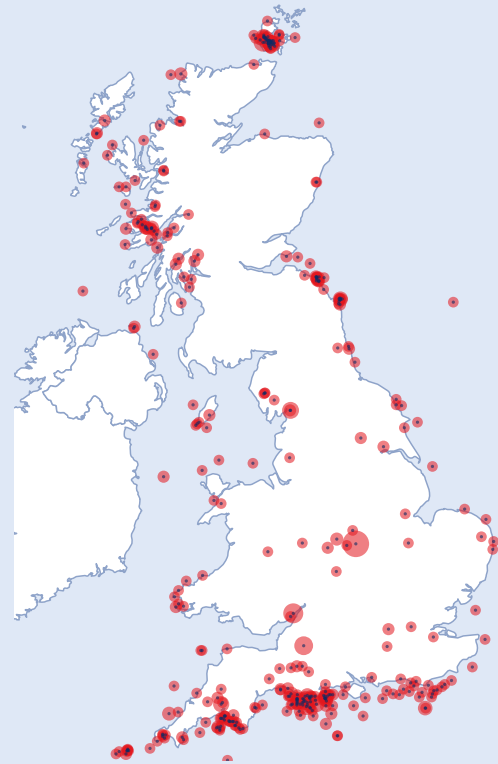


Figure 19b
DCI incidents

667 incidents · 371 locations

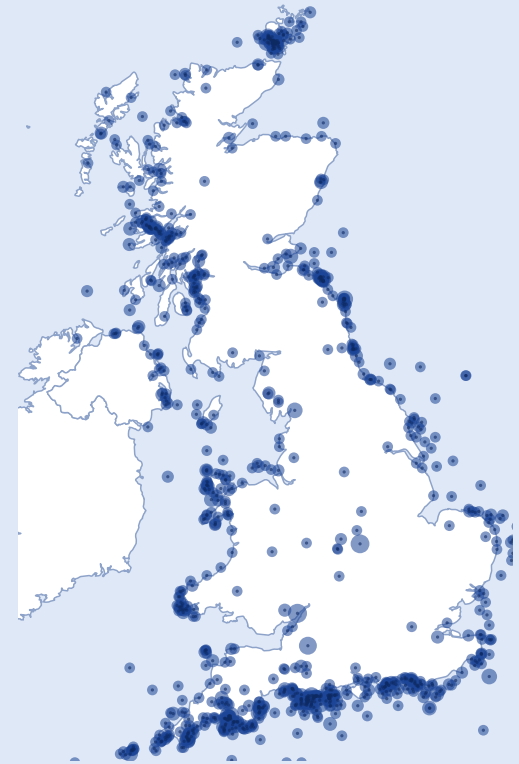


Figure 19c
Emergency services involved

1,463 incidents · 923 locations

Decompression illness trends



Figure 11a
Incidents involving DCI using BSAC membership as a proxy for estimated participation in the sport. Trendline is a 5-year rolling average.

Figures 11a and 11b seek to account for variability in the data arising from the relatively small number of incidents linked to individual factors, as well as fluctuations in overall diving activity. To identify meaningful trends, BSAC membership figures are used as a proxy for the level of diving taking place in the UK, and incident rates are presented using a five-year rolling average. This approach helps highlight factors associated with incidents that may warrant attention from organisations responsible for developing training programmes and issuing safety guidance.

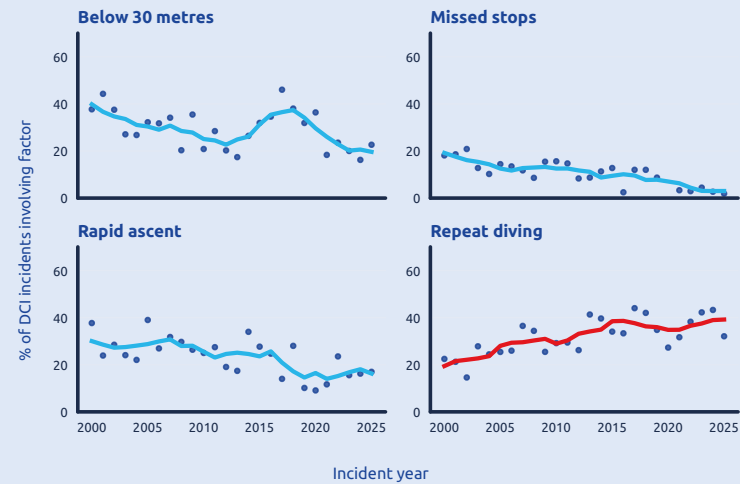


Figure 11b
DCI incident rates by factor involved. Trendlines are a 5-year rolling average.

Figure 11a shows that the decline in recent years of the frequency of reported incidents involving decompression illness (DCI) has started to level out. Where DCI has occurred, Figure 11b provides information on the relative impact of contributing factors, showing a continued reduction in cases linked to dives deeper than 30 metres and missed decompression stops, leaving repeat diving to be a contributing factor relevant in a growing proportion of the instances of DCI.

Ascent-related incidents

It continues to be positive to see fewer DCI cases linked to both missed stops and improved buoyancy control and dive planning minimising the risks associated with deeper dives and ascent-related errors.

As the influence of these three factors diminishes, and with most divers now undertaking multiple dives per day, the relative contribution of repeat diving to DCI incidence will become more prominent as an underlying factor. It remains true that despite our best efforts some cases of DCI are not linked to a known causative factor; some of us are just unlucky and develop DCI despite uneventful dive profiles.



Don't discount DCI. When presented with possible DCI symptoms, do not dismiss them because nothing happened on the dive that might provoke DCI.

In the last three years we have seen a very slight upward trend in the number of incidents categorised as ascent-related (when normalised by BSAC membership numbers). These are incidents that involve an uncontrolled ascent but have not resulted in DCI or a Fatality. When we categorise the cause of these ascent-related incidents we see a clear trend in a positive direction with respect to air supply issues indicating that fewer divers are needing to make fast ascents due to out of air situations. All other factors remain important factors implicated in causing ascent related incidents and some factors seem to be slightly improving in their influence on fast ascents.

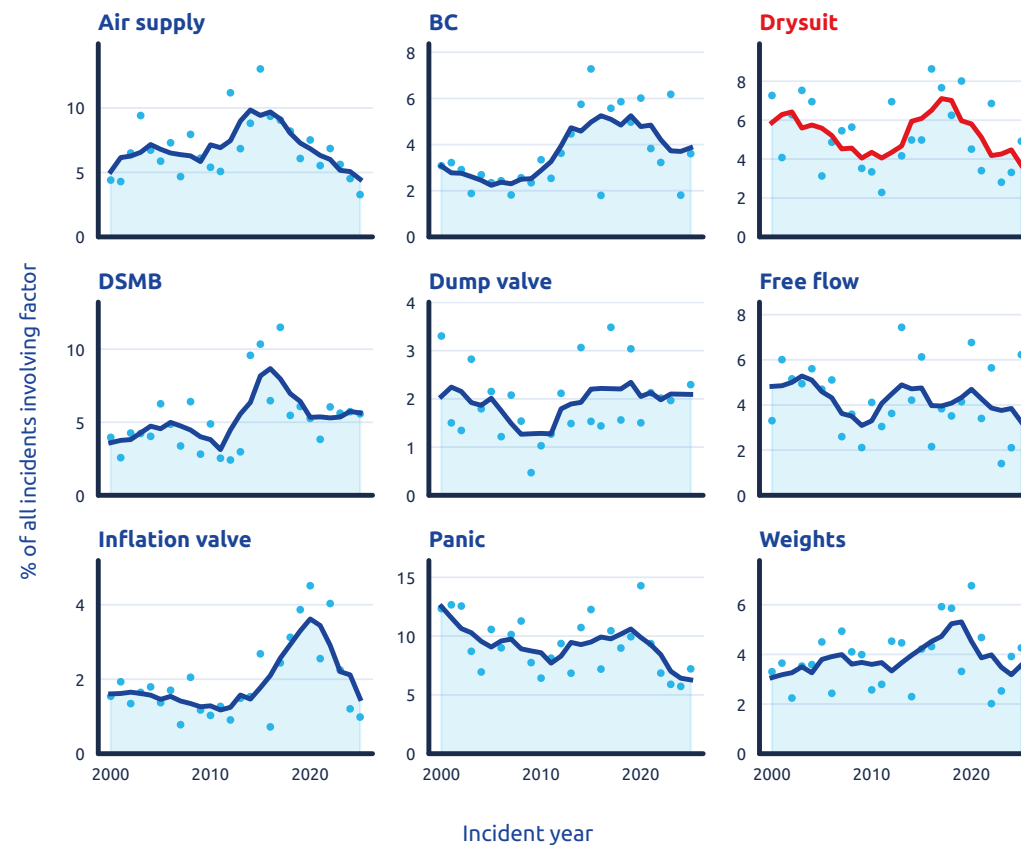


Figure 12

Causes of ascent-related incidents not involving DCI or fatality. Trendlines are a 5-year rolling average.

Immersion Pulmonary Oedema (IPO)

Over recent years, we have refined our methodology for identifying incidents in which Immersion Pulmonary Oedema (IPO) may have been a contributing factor.

Confirmed professional diagnosis or verification is available	Probable three or more diagnostic criteria are present	Possible one or two criteria are identified
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In some cases, subsequent information, such as findings from a coroner’s inquest, provides evidence that allows incidents previously classified as ‘probable’ to be reclassified as ‘confirmed’. When this occurs, both the database and associated analyses are updated accordingly. As a result, Figure 13 may include revised information relating to incidents from previous years, helping to ensure that the data presented remains as accurate, complete, and up to date as possible.

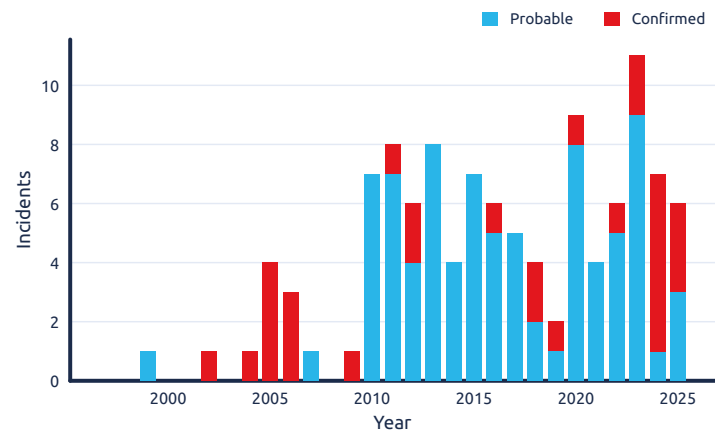


Figure 13
The frequency of confirmed and probable cases of IPO, 1997 to 2025

Indicators of Immersion Pulmonary Oedema

- 1 Diver is underwater with breathing difficulties when not exercising particularly strenuously — rapid, uneven or heavy breathing, or coughing uncontrollably with or without bloody sputum.
- 2 Indication of difficulty of breathing when on the surface.
- 3 Confusion, swimming in the wrong or random directions.
- 4 Inability to carry out normal functions whilst appearing to have to concentrate on breathing.
- 5 Belief that a regulator is not working properly.
- 6 Indication of ‘out of gas’ when their regulator(s) are found to be working correctly and with adequate gas supplies.
- 7 Divers refusing or rejecting an alternate source when ‘out of gas’.



If you have any breathing difficulties underwater:
terminate the dive, ascend safely and exit the water. Once ashore, sit the diver up, give oxygen and get medical assessment.

Through the Incident Report and other communications, the BSAC have worked hard to improve awareness of the impact of Immersion Pulmonary Oedema (IPO) among recreational divers and snorkellers.

The BSAC has embedded information in its training programme to ensure that all new divers are aware of the symptoms and the recommended course of action when symptoms occur. Figure 13 shows that since 2010,

divers reporting incidents are increasingly recognising and reporting symptoms consistent with IPO in incident reports, whereas previously, such diagnoses were primarily made by medical professionals. However, we plan to do some further work in 2026, to ascertain the effectiveness of these communications and learn how prevalent awareness of IPO has become in the diving community.

The advice upon experiencing any symptoms of an IPO remains unchanged and clear: if you have any breathing

difficulties underwater, terminate the dive, ascend safely, and exit the water. If you observe signs of IPO in a buddy, assist them from the water as safely and promptly as possible. Once ashore, the individual should be seated, administered oxygen, and assessed by medical professionals. It is very important to get medical advice to eliminate an IPO before diving again. Early recognition of IPO symptoms is key to preventing escalation and ensuring diver safety.



Fatalities

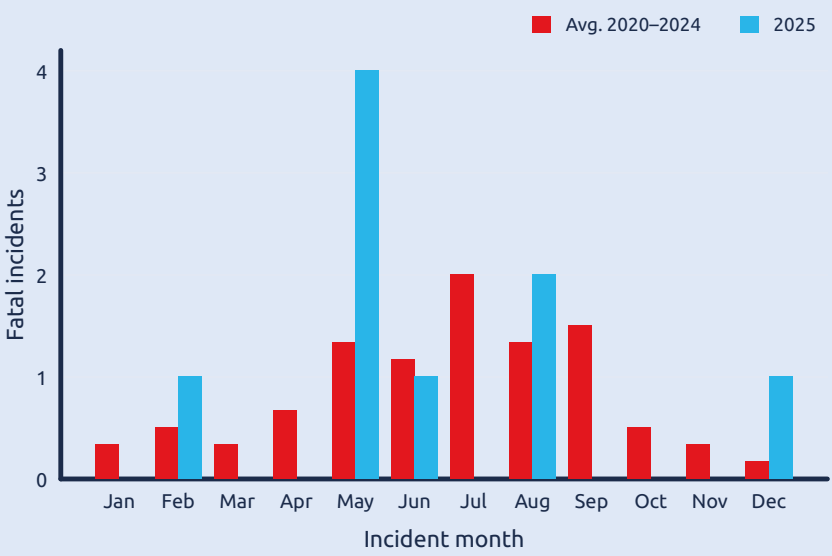


Figure 14
Fatal incidents in 2025 by calendar month compared to the previous five years

9

UK fatal incidents

55

average age

3

dives deeper than 50 m — all on rebreathers

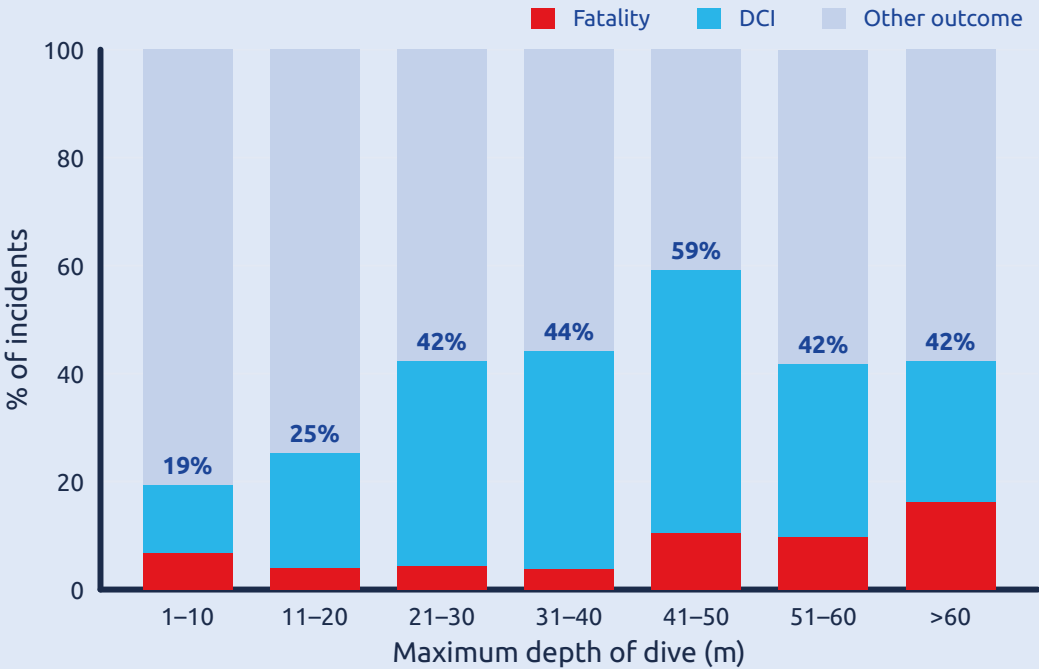
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fatality confirmed as IPO

Sadly, 9 fatal incidents occurred in the UK during the 2025 incident year, involving the death of 9 divers.

Figure 14 shows the fatalities by month compared to the average by month for 2020–2024. Analysis of the fatal incidents showed that the average age of the people who died was 55 years. Three of the nine fatalities involved dives to deeper than 50m and all three of these dives were on rebreathers. Immersion Pulmonary Oedema has been confirmed as the cause of one fatality and there are predisposing medical and/or physiological factors implicated in at least one other fatality.

One diver died before entering the water, but is included in the fatality section as the diver died following a preparation for diving. As is often the case, we simply do not have enough information in over half of the cases to make sound conclusions about the cause of death.



Depth raises the stakes

Figure 15 reminds us that the chances of an incident resulting in DCI or a fatality increase significantly with the depth of the dive.

In dives to less than 20 metres, if you have an incident serious enough to be reported to the BSAC incident reporting system there is less than a 25% chance that it will result in DCI, and less than 5% chance it will result in a fatality. These risks approximately double in dives below 40 m and are exacerbated not only by nitrogen narcosis, but also the impact of gas density and work of breathing as explained more fully in the BSAC Deeper Diving Course.

Figure 15
The proportion of incidents which result in DCI or a fatality, by the maximum depth of the dive



Equipment Risks

Equipment of a format similar to that used by a diver who died, reported in last year’s incident report, continues to be freely available online despite concerns raised in this report and by the British Diving Safety Group as to the risks associated with its use. This concern refers to equipment where small battery-operated compressors are mounted on floats above the diver and deliver air to second stage regulators on 9–12 m long hoses.

Drysuit inversion

A 25-year review of incidents where gas migrated into the legs and boots of a drysuit, causing loss of buoyancy control, inversion and feet-first ascents.

7.1%

of early-season (Jan–Apr) UK incidents in 2021–2025 involved drysuit inversion

up from 3–4% in earlier years

Last year we noted that there seemed to be an increase in inversion incidents presented as a cause of uncontrolled ascents reported to BSAC in the last two years.

This year we have conducted a review of the incident reports contained within the database since 2000 pulling out reports of drysuit divers who experienced migration of gas into the legs or boots of their suit, resulting in loss of buoyancy control, inversion and/or a feet-first ascent to the surface.

In Figure 16 we show that consistently across 25 years of data, around 2–3% of reported incidents contain examples of divers losing control of their buoyancy through their drysuit in mid- (May to August) and late season (September to December) diving. In the years up to 2020, this rate of incidents is higher in early season (January–April), around 3–4%. However, somewhat concerningly, in the last five years, the rate of early season (January–April) instances of drysuit inversion has almost doubled to 7%.

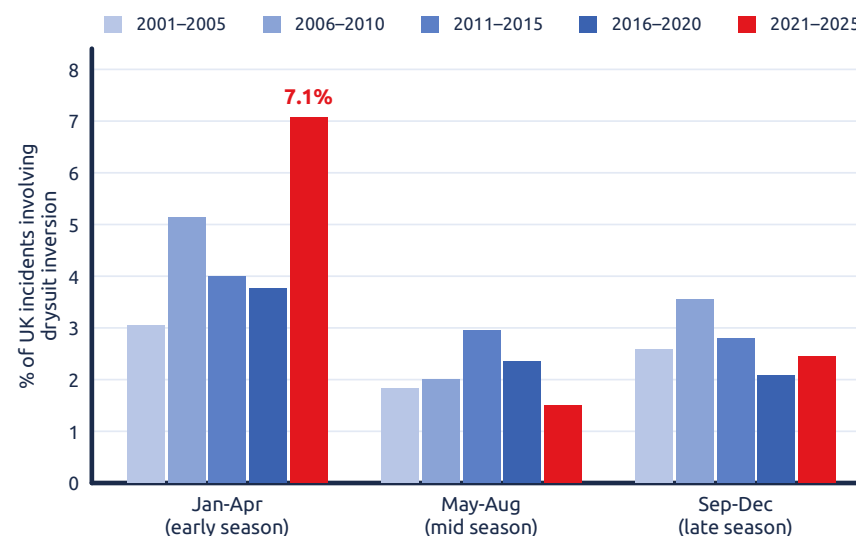


Figure 16

Analysis of incident reports involving drysuit inversion in the BSAC incident database since 2001, by five-year period and season

Anatomy of an inversion

A recurring theme throughout all the reports is the interaction between diver trim, drysuit fit and buoyancy management.

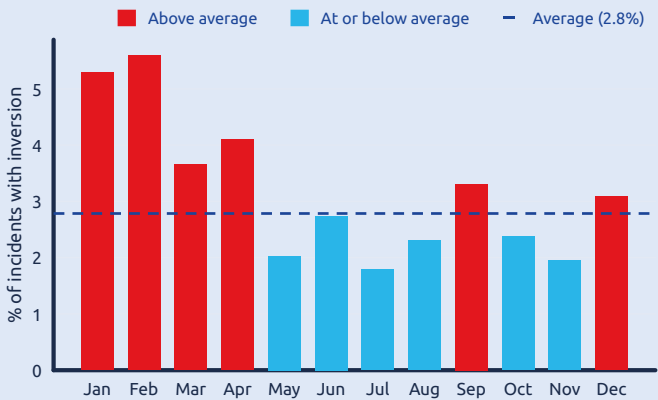


Figure 17
Drysuit inversion as a share of UK incidents by month, all years

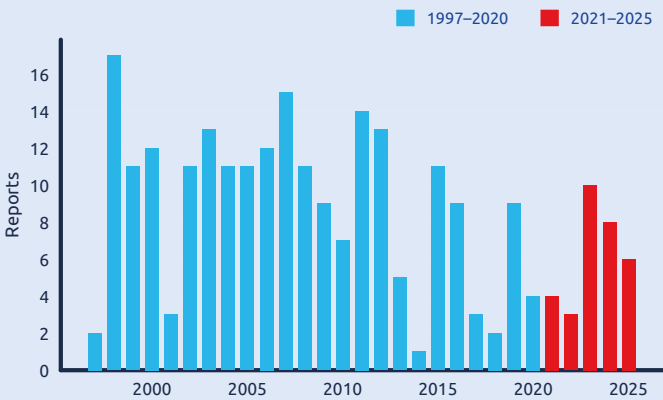


Figure 18
Number of UK incident reports involving drysuit inversion each year, 1997–2025

In many cases divers became slightly head-down or horizontal while carrying out tasks such as DSMB deployment, responding to equipment problems, managing a reel, resolving line entanglements or swimming over sloping terrain. Once air has migrated into the legs of the suit, the diver is often unable to return to an upright position or vent gas effectively, resulting in a rapid inverted ascent.

What the reports tell us



Suit & boot fit

A significant number of incidents involved divers using borrowed, recently modified or new drysuits. Poorly fitting drysuits, oversized boots and new undersuits were frequently identified as contributory factors. Changes between neoprene and membrane drysuits, or unfamiliar undersuits, sometimes resulted in buoyancy characteristics that had not been fully assessed. Several divers' feet slipped from within their boots once inversion occurred, significantly reducing their ability to recover. In several cases divers reported buoyancy difficulties earlier in the dive before the final inversion event.



Weighting

Weighting issues were also common. Divers were variously reported as being under-weighted, diving without normally used ankle weights, losing weightbelts or losing integrated weights during the dive.



Valves & controls

Several incidents included drysuit inflation valves sticking open, dump valves obstructed by undersuits, BCD inflators leaking gas into the jacket and difficulties locating or operating dump controls. Although genuine equipment failures were identified in a minority of cases, many reports suggest that unfamiliarity and lack of practice were more significant than equipment malfunction.



Training & experience

A considerable number of incidents involved trainees, recently qualified divers, individuals using drysuits for the first time, or divers returning after periods of inactivity. Several reports described divers struggling to perform inversion recovery techniques under stress, reinforcing the importance of progressive training and gaining experience with drysuits in controlled conditions before undertaking more demanding dives.

Although many inversion incidents resulted in no lasting harm, many divers required oxygen administration, medical assessment or precautionary recompression treatment. Several incidents resulted in confirmed neurological decompression illness following uncontrolled ascents and missed decompression obligations. Some fatal accidents within the dataset involved inversion followed by rapid ascent, pulmonary barotrauma, arterial gas embolism or drowning.

What was clear from the analysis was that inversion incidents are rarely caused by a single factor. Most incidents involve a combination of equipment configuration, buoyancy management, diver position, task loading and factors such as stress or panic. Once an inversion develops, recovery opportunities can reduce rapidly, particularly if the diver is inexperienced, using unfamiliar equipment or engaged in another task.

Has anything changed?

Whilst this report has identified a recent increase in the incidence of drysuit inversion events early in the year, comparison of the 2021–2025 early season inversion incidents with the complete inversion database showed no clear evidence that the fundamental mechanism behind the cause of drysuit inversion has changed.

Air migration into the legs and feet remained the predominant initiating factor in both datasets. There is a suggestion of an increased proportion of incidents involving trainees, students and recently qualified divers. However, the recent dataset contained only 15 cases and the observed differences were not sufficiently large, nor the instances frequent enough to conclude that these changes are statistically significant. The available evidence therefore supports continuity rather than change in the principal factors associated with inversion and loss of buoyancy control.

15	=	?
early-season inversion incidents, 2021–2025	same issue recorded: gas migration to legs and feet	possible, not significant, shift towards trainees and newly qualified divers

Principal lessons

- ✓ Get a correct, close drysuit boot fit to reduce gas migration — especially when hiring, borrowing or buying second-hand.
 - ✓ Make sure boots cannot slip off the foot, which makes recovery from inversion very difficult.
 - ✓ Use appropriate weighting, including ankle weights if you normally use them.
 - ✓ Get familiar with your equipment and its buoyancy characteristics before demanding dives.
 - ✓ Practise inversion recovery drills regularly.
 - ✓ Manage task loading carefully during critical phases of the dive.
- If you are hiring, borrowing or buying a second-hand suit, the fit of the feet is important to ensure that excess gas cannot accumulate there and that the boots cannot slip off the foot.

Conclusions

Key conclusions from the BSAC Incident Report 2025 include:

- 1 The number of reported incidents remains closely linked to overall diving activity, which has now returned to pre-pandemic levels.
- 2 Regrettably, nine diving incidents resulted in nine fatalities during the reporting period.
- 3 Experience and qualifications alone do not eliminate the risk of becoming involved in a diving incident.
- 4 Awareness of Immersion Pulmonary Oedema (IPO) continues to increase among divers. Anyone who experiences symptoms of IPO should seek medical advice and clearance before returning to any water-based activity.
- 5 Before using any equipment configuration that supplies compressed breathing gas underwater, divers should be fully trained in its use and understand the associated risks.
- 6 Many potentially serious incidents are prevented from escalating through the prompt application of rescue skills and the swift response of emergency and rescue services.
- 7 Several incidents may have been avoided if basic safe diving practices had been followed and greater consideration had been given to the conditions at the time. BSAC's guidance provides a comprehensive summary of the key principles of safe diving.
- 8 Divers should ensure they have received appropriate drysuit training and that their drysuit fits correctly, particularly around the feet and legs, to reduce the risk of fin control problems or inversion underwater.
- 9 Instructors leading training dives should pay particular attention to the fit of the boots of drysuits and ensure that they cannot easily become displaced.

Summary

The report highlights the importance of proper training, equipment familiarity, careful assessment of diving conditions, and adherence to established safe diving practices. It also emphasises that, regardless of experience level, all divers remain susceptible to incidents and should maintain a vigilant approach to safety.

SYNOPSIS · UK



Fatalities

9 fatal incidents in the UK in 2025

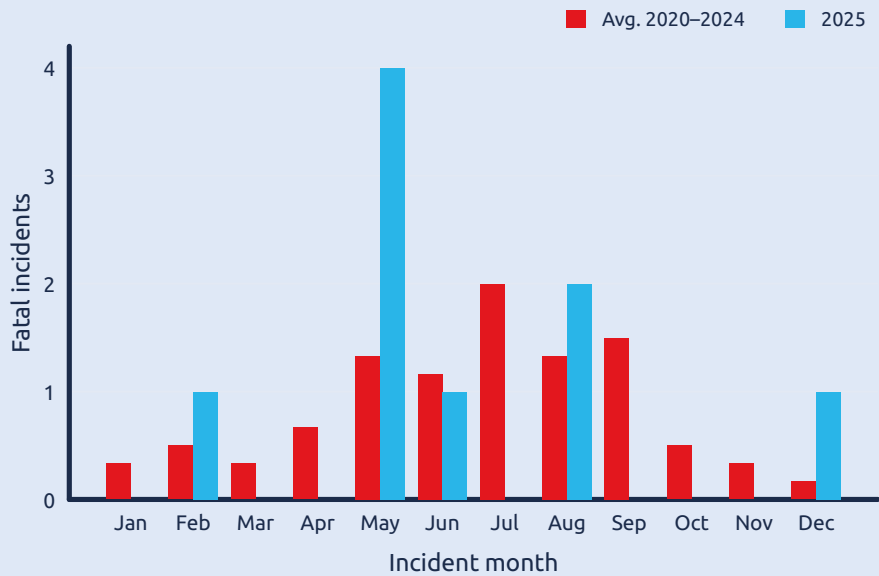


Figure 20
The month of occurrence of fatalities



February 2025**25/006**

An experienced diver conducted a dive with two other divers to a maximum depth of 22m. The group reached their maximum depth and then made their way slowly back up a slope and deployed a DSMB from a depth of 17m, then continued on to an underwater feature. The lead diver checked all in the group were OK and then continued up to a 6m shelf and conducted a safety stop. At the safety stop the lead diver turned but could not see one of the divers, so the pair made an ascent to the surface where they found the missing diver motionless on the surface. Prior to that point two divers, not associated with the group, came across a diver inverted and holding onto an underwater feature and signalling with their torch. As the divers closed in they found the diver holding onto wreckage with one hand whilst signalling with the other, and fully inverted with their drysuit legs full of gas. One of the divers grabbed the diver's right arm and their BCD and tried to pull them down. The diver was conscious and breathing, with their regulator in their mouth and was actively trying to pull themselves down towards the wreck structure. The second diver arrived quickly and both tried to pull the diver down against the excess buoyancy in their legs. Then suddenly, the diver was pulled from the rescuer's grip and made an uncontrolled ascent direct to the surface. The rescuers ascended rapidly and found the diver face down in the water. The first rescuer shouted for help and saw a member of the shore team speaking into their radio. The second rescuer meanwhile turned the casualty face up. The casualty did not have a BCD on, which was hanging below the casualty suspended by the drysuit inflation hose, and their regulator was no longer in their mouth and they had no mask and was unresponsive. One of the rescuers tried to disconnect the drysuit inflation hose but it proved too difficult with the tension. The rescuers then began to recover the diver to the shore with one towing and the other pushing from the side. The site rescue boat arrived but held off. The casualty kept flipping over to a face down position and the rescuers had to struggle to turn them face up again. As they reached the shallows another diver swam up to assist. At the shore a group of divers helped recover the diver from the water. Divers ashore, the site rescue team, and shortly after the emergency services arrived, and administered CPR with oxygen enriched rescue breaths. Subsequently a rescue helicopter arrived with a helimed doctor aboard. The casualty was successfully resuscitated and was

breathing when they were airlifted to hospital. However, they sadly passed away two days later.

May 2025**25/221**

A qualified diver was undergoing further training, along with three other students, and had completed two dives earlier in the day. The diver had consistently been the first to indicate they were low on gas on both preceding dives. The group of students and their instructor, and two safety divers, carried out a third dive. All skills were completed with no problems during the dive. The student was again the first to indicate they were at 70 bar and indicated they wanted to ascend with one of the supervisors. During the ascent, as they approached 5m, the supervisor provided the student with their AS, which they accepted, and the pair continued to the surface. Once on the surface, initially everything seemed OK, but then the student suddenly started to flail around and shouting for help. The supervisor attempted to assist and add gas to the panicked diver's BCD, but was dunked underwater without a regulator. The pair briefly submerged together, and the supervisor managed to bring them both back to the surface. However, as the student continued to panic before they eventually stopped moving altogether and sank again and did not resurface. The site rescue team had been alerted and had initiated their emergency plan and alerted more staff to assist, launching the RHIB and set up emergency equipment to receive the casualty. Rescuers swam to the last known location but poor visibility made it difficult to locate the missing diver. The diver was eventually found at a depth of 14m, face up and unresponsive, and without a regulator in their mouth. The casualty was brought to the surface, within 3 min of when they last sank, and after recovery from the water resuscitation efforts commenced, including the use of an AED. The emergency services arrived, with multiple paramedics and an air ambulance team continued to work on the casualty. The diver was subsequently declared deceased in hospital. An inquest recorded that the diver's equipment was operational and their cylinder had sufficient gas remaining, and found the cause of death to be Immersion Pulmonary Oedema (IPO)

May 2025**25/037**

A diver was diving a wreck from a RHIB, when they experienced problems with their buoyancy at 27m and ascended upside down direct to the surface. The diver was recovered aboard the RHIB and found to be

unconscious and not breathing and CPR was initiated. The diver did not recover.

May 2025**25/039**

A student, together with a fellow student, an instructor and a dive leader were preparing for a training dive and had carried their equipment down to the beach. It was a warm day and during kitting up, the student regulator second stage became trapped inside their BCD and took some time to rectify. The student was out of breath and asked to pause for a moment, and the dive leader advised them to take their time and get their breath back. The dive leader then noted that the diver's drysuit inflation hose was not connected, and when they tried to assist they found the hose was too short to connect easily. The dive leader had a spare longer hose in their toolkit and advised the student to sit down on a ledge in the shade, whilst they went back to their vehicle to get the hose. Meanwhile the other student and the instructor entered the water to cool down whilst they waited. The dive leader returned and quickly switched the suit inflation hose and connected it up, by which time the other pair had left the water to join them. The group then entered the water to waist depth to fit fins. Once the dive leader had fitted their fins they noticed that the student did not have their mask on or regulator in and seemed preoccupied with trying to fix something on their BCD. The dive leader asked if they needed some help to fix it and the student confirmed they did. As the dive leader swam around behind the student, the student leaned forward and placed their face, still without mask and regulator, into the water. The dive leader quickly looked underwater and found the student was not reacting to anything, then lifted them up and turned the student onto their back and alerted the instructor that something was wrong. The instructor shouted to the shore cover to call an ambulance. The student was unconscious but breathing at this stage making a gurgling sound. The dive leader and instructor removed the casualty's equipment and then their own and instructed the other student to collect them whilst they dragged the casualty ashore, but had difficulty getting fully out of the water's edge, so made sure the head was clear of the water. They then commenced Basic Life Support (BLS). The dive leader ran to the vehicles to get the oxygen kit, but on returning couldn't get the oxygen to flow correctly so the instructor took over preparing the oxygen whilst the dive leader continued BLS. Meanwhile two other

divers surfaced and were shouted to come and assist. An AED kit was brought and scissors used to cut the diver's suit away to expose their chest and the AED pads were fitted and a shock was advised. Chest compressions, following the instructions from the AED, were then continued, whilst keeping the oxygen mask on the casualty. The AED had delivered 4 shocks by the time an ambulance had arrived. The ambulance crew advised the divers to continue their CPR efforts whilst they set up their equipment. The lead diver briefed the ambulance crew on the sequence of events before the crew took over resuscitation. Subsequently the police arrived and took statements, an air ambulance landed with a doctor and two further crew assisting with the casualty. After 20 min the doctor declared the diver deceased.

May 2025**25/042**

Three divers, all using rebreathers, entered the water from the shore to carry out a build-up dive prior to a liveaboard trip. One diver had made several trips down a roadway from the car park with their equipment including a heavy camera set up and lights, plus multiple battery packs and three stage cylinders. The group descended to around 85m before the lead diver swam through a tunnel down towards 88m. The second diver followed but indicated that the third diver was no longer with them. The pair retraced their steps back to a shelf at 70m, where they noticed a light and followed it down to 85m where they found the missing diver at 85m, upside down, with all their equipment around their shoulders. The diver was unresponsive and it was clear there was nothing the divers could do to rescue them, having already accumulated 90 min of decompression. They decided to ascend and complete their decompression before surfacing and raising the alarm, with the intent of returning the next day to recover the diver. Once the alarm was raised, two divers from another group on the site, who had completed their own dive earlier in the day, re-entered the water to attempt to locate the missing diver and attempt a rescue/recovery. During the dive the two divers became separated and one surfaced under a DSMB. The other diver was able to locate the missing diver and sent them up to the surface with a yellow DSMB attached to them as had been briefed to the surface recovery team. When the diver surfaced with the yellow DSMB attached to them the surface safety diver swam out, secured the diver on the surface and closed their drysuit dump valve. The local Fire and Rescue service were in

(continued) attendance and had launched a casualty rescue sled, which was taken over and recovered the diver onto it and also towed the surface divers back to shore. The rescue sled was directed to a jetty, where, with the help of others, the casualty was de-kitted and recovered from the water. The casualty had been in the water for 201 min before recovery and so no CPR was attempted. After recovery from the water a check was made of the airways, confirming they were fluid filled, and the decision not to perform CPR was confirmed with paramedics. The diver's suit was then cut to allow electrodes to be attached to perform an ECG, which confirmed no electrical activity and the diver was declared deceased. The diver who had recovered and sent up the casualty had accrued 82 min of decompression requirements and they completed all before surfacing safely.

June 2025

25/050

A diver surfaced from a wreck dive to a maximum depth of 51m. Soon after de-kitting the diver reported shoulder pain and oxygen was administered. Their condition continued to deteriorate and the skipper issued a 'Mayday' request for immediate evacuation. A rescue helicopter airlifted the diver to hospital to be stabilised before transfer to a hyperbaric chamber for recompression for DCI, but the diver failed to recover and was declared deceased. The diver's dive-computer indicated an uneventful profile, with full decompression carried out as normal and a total dive time of 81 min. (Coastguard report).

August 2025

25/305

A diver using a rebreather was on a dive to a maximum depth of 62m, when they started to have difficulty breathing and started cough uncontrollably. The diver surfaced after a total dive time of 34 min and was seen not to be coping well on the surface having dropped their mouthpiece and had to be instructed twice to re-insert their mouthpiece. The diver was recovered aboard their dive boat and CPR was commenced, with copious amounts of water discharged from their mouth. The diver did not recover.

August 2025

25/092

Emergency services were called to a pier to attend to a diver who had got in difficulty whilst diving. The diver was transferred to hospital for treatment but died a short time later.

December 2025

25/297

The Coastguard responded to a diving vessel, which had a diver aboard in need of medical assistance. The diver had been spotted on the surface very low in the water with their fins in the air. The diver was quickly brought alongside the boat by another diver. The recovery diver was told to drop weights and inflate the diver's suit. The recovery diver and the boat crew then struggled to get the diver onto the boat lift, and they eventually they had to jettison the diver's twin-set. On recovery aboard, CPR was commenced but the diver did not survive.

SYNOPSIS · UK



Decompression incidents

53 DCI incidents in the UK in 2025

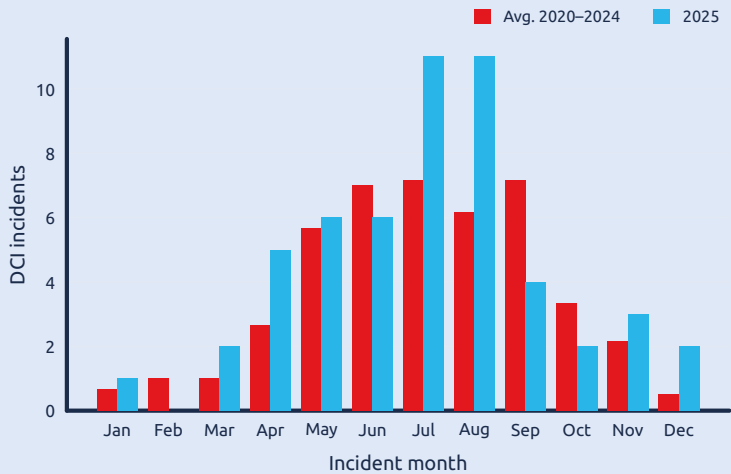
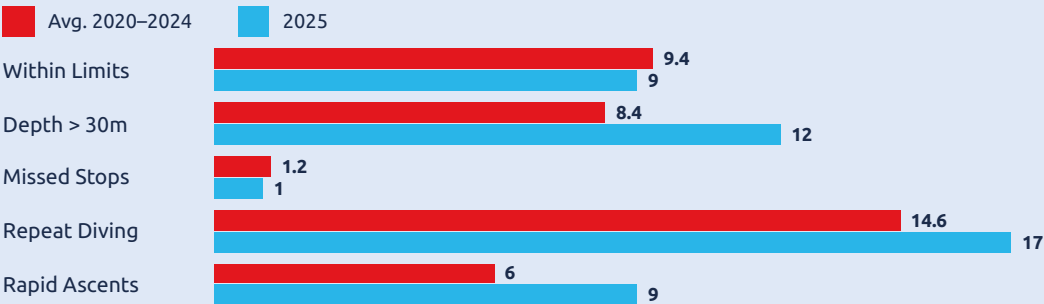


Figure 21
The month of occurrence of DCI incidents

DCI contributing factors



January 2025**25/005**

A diver and their buddy had completed a dive to a maximum depth of 22m for a total duration of 33 min. Some time after surfacing the diver complained of dizziness and that their head was spinning. They were brought to the on-site first aid room suffering from nausea and vertigo and looked pale but when sat down and not moving they felt OK. The diver struggled to stand and walk unaided and oxygen was administered. A member of staff from a local chamber called the chamber doctor for advice and were advised to visit the chamber. The member of chamber staff drove them there in their own vehicle.

March 2025**25/013**

Following a report of a diver experiencing difficulties having had a rapid ascent the Coastguard was contacted and they tasked a lifeboat, rescue helicopter and an ambulance to respond. On arrival on site the diver was transferred aboard the lifeboat, where they were assessed by a medic/winchan from a rescue helicopter who determined they should be airlifted to a recompression chamber. (Coastguard & RNLI reports).

March 2025**25/016**

A diver using sidemounts and their buddy using CCR conducted a first dive of the day to a maximum depth of 36m. Some time into the dive the diver went to make their second gas switch and signalled their buddy to that effect. As they switched regulators they had a problem with the bungee necklace, one of the knots had slipped and had fouled the mouthpieces so that when they put it in their mouth it allowed water in as they breathed from it. The diver was unable to feel anything due to his lips being cold in the 5 deg C water, and their buddy was unable to see the problem. The diver switched back to their primary regulator but again got water, believed to be due to snagging part of the hood with it. The diver then tried their reserve regulator but got the same result. Their buddy then provided the regulator from their bailout cylinder but again they were unable to get a good seal. By now the diver was starting to panic and headed for the surface pulling their buddy up with them. The pair surfaced rapidly and on the surface the buddy shouted for help. The pair were assisted to shore and placed on oxygen. The diver was grey and visibly shaking but had no symptoms of DCI. Paramedics were called and after slowly warming and

on oxygen the diver's colour returned. An on-call hyperbaric doctor was contacted for advice and they advised keeping on oxygen but there was no need to visit the chamber at that time. The next day the diver reported to the on-call doctor that they had some tingling in their shoulder and they were advised to attend a chamber for assessment and they underwent two sessions in a recompression chamber, with complete resolution of symptoms.

April 2025**25/242**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

April 2025**25/038**

On the sixth day of a diving trip on a charter boat, a group of three divers had completed a dive earlier in the day to a maximum depth of 27m with a total duration of 40 min. After a surface interval of 270 min, the trio entered the water from the boat to dive a wreck at a maximum depth of 30m for a total duration of 46 min, including a safety stop at 6m for 3 min. The divers were recovered aboard the dive boat using a diver lift. After recovery aboard and removing their equipment, 15 min later one of the divers began to feel unwell and notified their buddies. The buddies immediately suspected DCI, given a previous DCI, and one escorted the diver to a sheltered area of the boat, whilst the other prepared an oxygen set and informed the skipper. Whilst walking the diver stumbled and began to feel numbness in their foot. Once seated the numbness began to move up their right leg. Oxygen was administered, with the diver sat on the deck and being reassured. The skipper had alerted the Coastguard, who organised evacuation to a recompression chamber. Meanwhile the skipper made way to harbour to rendezvous with the emergency services for evacuation. After around 10 min on oxygen the symptoms in the diver's right leg resolved and, following a casualty assessment being conducted, no neurological symptoms were recorded. The diver was able to stand but they were found to have significant blue/grey mottling and marbling around their midriff, suggestive of a skin DCI. The diver used two and a half 3 litre cylinders of oxygen over 60-90 min after onset of symptoms and being handed into the care of the helicopter crew for transfer to a recompression facility. The diver received recompression treatment and released early the next morning with the advice not to dive pending further

tests. The diver had suffered a previous DCI and had been tested for a PFO, which had been negative.

April 2025**25/243**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

April 2025**25/025**

A diver completed two dives in the day using nitrox 32 for the dive and nitrox 40 for the decompression stops on the first dive. The first dive was to a maximum depth of 36m for a total duration of 54 min including a safety stop of 2 min at 6m and 5 min of required stops at 3m followed by a further 5 min safety stop. After a surface interval of 150 min the diver completed a second dive to a maximum depth of 22m for a total duration of 54 min including a safety stop at 6m for 8 min. After the first dive the diver had felt joint pain in their hand but as they suffer from arthritis thought nothing of it. Following the second dive the diver was feeling 'rubbish' and their buddy noticed and asked if they were OK but were assured that this was how the diver frequently felt after a dive. The following day the diver's hand had swollen and they were unable to use it for much other than operating a computer mouse. Their condition worsened during the course of the day and the diver contacted a recompression chamber and was advised to attend and they received recompression treatment with significant resolution of symptoms.

April 2025**25/032**

The Coastguard was notified of a diving vessel with a diver aboard experiencing symptoms of DCI. The vessel made towards shore and was met by a Coastguard rescue team and an ambulance. The diver was transferred by ambulance for recompression treatment. (Media report).

May 2025**25/031**

A diver completed a dive to a maximum depth of 34m, with a total duration of 38 min including a safety stop at 6m for 3 min and slow ascent to the surface. Approximately 34 min after surfacing the diver developed a rash on their right shoulder and went on to oxygen, whilst images of the rash were sent to a recompression chamber. After 15 min on oxygen the rash cleared. The chamber then called the diver and confirmed they were suffering from DCI and advised the diver to attend. At the chamber the diver was

treated on a RN table 62 and cleared. The diver was advised to seek a test for PFO.

May 2025**25/244**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

May 2025**25/068**

A diver prepared for a deep dive to a maximum depth of 50m on a hot day. Divers made a number of trips with equipment to the water's edge and a gazebo had been sited to provide shade, and undersuits and drysuits were donned shortly before diving. The group entered the water and swam out on the surface before descending to 45m. They made their way to a platform at 40m and then dropped down a ladder to 50m to conduct a narcosis check. The group then ascended back up to the platform and then made their way steadily back to shore. The diver switched to nitrox 50 at 22m and proceeded to make stops at 9m for 4 min, 6m for 17 min and 3m for 5 min and surfaced with a total dive time of 67 min. The diver's decompression had cleared earlier than others in the group due to using nitrox 50 and so they had conducted an additional 8 min deco using nitrox 50. On exiting the water the diver had an urgent need to use the facilities and so removed their drysuit and then visited the toilet on site. The group remained under the shade of the gazebo for 25-60 min before recovering equipment to their vehicles and departing the site to return to their accommodation. On returning to the property, whilst changing the diver noticed mottling and a red rash over their back, shoulders, side and torso, approximately 210 min after surfacing. The diver was placed on oxygen and a local chamber was called, but it was unable to take the diver and so the diver was transported to a chamber further away. The diver continued to breathe oxygen throughout the drive and drank approximately 2 litres of water. The journey to the chamber took 3 hr 50 min and symptoms had disappeared during the trip. On arrival at the chamber the diver was assessed and received recompression treatment on a Table 62. As this was the second time the diver had experienced a skin DCI it was suggested that the diver should have a PFO check, which they did. It was confirmed the diver had a small PFO and the diver was awaiting further tests and resolution.

May 2025 **25/036**

A Coastguard rescue helicopter was tasked to respond to reports of a diver suffering from DCI. Coastguard rescue teams and an ambulance were also tasked to the scene. The helicopter airlifted the diver to a recompression chamber for treatment. (Media report).

May 2025 **25/094**

A diver using a rebreather with air diluent conducted two dives in the day. The first dive was to a maximum depth of 35m for a total duration of 42 min, including a safety stop at 3m for 3 min. After a surface interval of 130 min, the diver conducted a second dive to a maximum depth of 32m for a total duration of 42 min. The ascent was slightly faster than that indicated by their rebreather handset to 6m, and the diver misread their computer, thinking it was indicating they had exceeded their ceiling depth, and they descended back down to 16m, before ascending to 3m and conducted a 1 min safety stop before surfacing, believing they had no decompression requirement. On recovery aboard the RHIB, the diver complained of a tingling in their finger and slight shoulder pain. The diver was given oxygen during the return to shore, with a slight improvement in symptoms. A recompression chamber was contacted for advice, who advised attending the chamber so the diver was driven to the chamber still on oxygen. The diver was given recompression treatment for 6 hours with full resolution of symptoms.

May 2025 **25/245**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

June 2025 **25/045**

A diver and their buddy had completed a first dive to a maximum depth of 34m with a total dive time of 60 min including a decompression stop at 6m for 12 min. After a surface interval of 90 min the pair entered the water and conducted a dive to a maximum depth of 34m for a total duration of 53 min including decompression stops at 6m for 7 min. The water temperature was 12 deg C at the surface and 6 deg C at 30m. Shortly after surfacing the diver complained of a headache but this was attributed to sinus problems. Later the diver complained of being itchy but there was no sign of a rash or any pain and the itch was described as mild. After returning home, 3

hours after surfacing from the second dive, the diver noticed a bruise and sent a message to a recompression chamber. The chamber staff requested photos of the bruise and indicated it was suspicious and agreed to see the diver in the morning. On attending the chamber the next day the diver was confirmed with DCI and received recompression treatment over 4 sessions.

June 2025 **25/246**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

June 2025 **25/247**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

June 2025 **25/056**

A lifeboat was launched in response to a dive vessel reporting a diver had taken ill with suspected symptoms of DCI. Once on site the diver was taken aboard the lifeboat. Where the crew provided medical assistance whilst awaiting for a rescue helicopter. The diver was airlifted from the lifeboat and transferred to hospital for further assessment. (Coastguard & RNLI reports).

June 2025 **25/058**

Two divers had completed a dive earlier in the day to a maximum depth of 23m for a total duration of 33 min including a safety stop of 3 min at 6m. After a surface interval of 240 min the pair entered the water from a dive boat for a wreck dive. They descended the shotline and located the wreck, then followed the side of the wreck looking at sea life. The less experienced diver had agreed to lead the dive and to signal their buddy when they had reached 160 bar remaining to turn back. It was agreed that the buddy would deploy their DSMB for the ascent. As they reached the end of the wreck the leading diver signalled they had 160 bar remaining and signalled to return around the other side of the wreck. The buddy signalled to ascend and the diver thought this was an indication to ascend onto the deck of the wreck and return that way, there were no signs of distress or symptoms. When they reached the deck, the buddy signalled to ascend and was opening and closing their hand which the diver did not understand. The diver asked if the buddy was OK and received a signal indicating that something was wrong. The diver signalled whether they should

deploy their DSMB but the buddy had already prepared their DSMB and deployed it. The pair had started to ascend when the buddy started coughing and passed over the DSMB reel to the diver and then sped up their ascent from 10m ascending directly to the surface omitting a safety stop. The diver followed a little slower with the DSMB but omitted their safety stop as something was clearly wrong with their buddy. On the surface the buddy was coughing up red froth and the diver waved to the boat, but they were in the process of recovering two other divers. The diver tried to reassure their buddy and continued to wave at the boat. The buddy seemed a bit breathless and was saying they "couldn't do this". The diver told the buddy to take some deep breaths and gave them the DSMB to relax on whilst the boat came for them. The buddy was recovered from the water, and they continued to feel unwell and was still bringing up red frothy fluid. (linked to 25/057). The diver felt fine and dived again the next day to a maximum depth of 12m for a total duration of 49 min, including a safety stop at 6m for 3 min. Later that night the diver began to experience shoulder pain, which they attributed to lugging cylinders on the RHIB and sleeping on uncomfortable caravan beds. The condition deteriorated over the next few days and, on the fourth day after the last dive, the diver contacted a recompression chamber and was advised to attend for assessment. The diver was assessed and found to have neck, shoulder and forearm pain, with some left side weakness and balance problems and was recompressed for 5.5 hours followed by three treatments on each of the following two days.

June 2025 **25/060**

A diver suffered a serious DCI following a dive on a wreck at a maximum depth of 106m. (Media report).

July 2025 **25/059**

A diver had dived an offshore reef when they started suffering symptoms of DCI on course back to harbour. The skipper initially had planned to transport the diver to hospital but on arrival in harbour, the diver's condition quickly deteriorated and they collapsed on the pontoon next the lifeboat. Three lifeboat crew immediately responded and provided medical assistance, whilst the Coastguard was alerted and a rescue helicopter tasked. The diver was transported to a local heliport where the helicopter was due to land rather than await an ambulance transfer. On arrival at the heliport the diver was transferred to the

waiting helicopter and airlifted to a recompression facility for treatment. (Media report).

July 2025 **25/248**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

July 2025 **25/181**

A diver had conducted a series of dives during a dive trip on a charter boat for 4 days, using a rebreather. Day 1 - 32m for 49 min & 42m for 73 min; day 2 42m for 59 min & 28m for 107 min; day 3 - 33m for 74 min & 28m for 96 min; day 4 - 45m for 73 min & 33m for 104 min. All dives passed without incident. Following the final dive and having packed equipment for departure, the diver took a nap in their cabin. They were awoken for a group photo and felt drunk and unable to balance, felt they had a migraine and their eyes wouldn't focus. A fellow diver noticed this and raised the alarm. The other divers and skipper arranged oxygen within minutes and called the Coastguard who tasked a helicopter. The diver was airlifted by helicopter 70 min after first experiencing symptoms and, after diverting to refuel, they transferred the diver to a recompression chamber 100 min later. The diver received recompression treatment that evening and again the following day before being discharged the next day, with advice that they might have a PFO. The diver had a PFO check 53 days later, which confirmed a PFO, and the diver is trying to get a closure.

July 2025 **25/249**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

July 2025**25/072**

On the fourth day of a diving holiday a diver had conducted a first dive to a maximum depth of 26m for a total duration of 49 min including a safety stop at 6m for 3 min. Then, after a surface interval of 195 min, a second dive to a maximum depth of 26m for a total duration of 41 min including a safety stop at 6m for 3 min. About an hour after the last dive, whilst back ashore in the accommodation, the diver developed a skin rash on their left shoulder. They were provided oxygen in their holiday flat and contact was made with a recompression chamber for advice. The chamber doctor briefed a local hospital to conduct neurological tests and administered oxygen for six hours. No further symptoms presented and the diver was discharged.

July 2025**25/061**

A Coastguard rescue team was called to a beach to assist a diver suffering from DCI. The diver was transported to hospital for assessment and treatment. (Media report).

July 2025**25/250**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

July 2025**25/109**

A diver conducted a dive to an offshore wreck to a maximum depth of 46m, using a rebreather with two buddies. After a bottom time of 56 min the diver and their buddies ascended to complete 40 min of accumulated decompression requirements. During the ascent, whilst at their 6m stop, the diver experienced a slight leak from their diluent mass addition valve (MAV), that did not stop after disconnecting and reconnecting. The diver monitored the rate of gas loss and determined that it did not represent a significant problem for the 18 min of decompression remaining. The group surfaced after a total dive time of 120 min. Approximately 30 min after recovery aboard the charter vessel the diver felt a pain in their left elbow, which they attributed to muscle ache in their arms and legs they had prior to the dive due to a fitness test involving lifting and carrying weights they had conducted 3 days prior. The diver decided to go below and sleep during the long transit back to shore. The diver slept fitfully and when they awoke fully felt clammy and had a headache and now had a pain in their right elbow. The diver went on

deck for some fresh air but that did not improve their condition and the diver then checked their stomach and chest and noticed severe marbling across their chest and stomach. The diver informed members of their party and was placed on oxygen. After 20 min on oxygen the clamminess and headache had gone and the marbling had significantly reduced. There was a doctor aboard who was managing the incident and had informed the Coastguard who tasked a helicopter to airlift the diver to a recompression chamber for assessment. On arrival at the chamber all symptoms had dissipated and the diver felt well. They were treated in the chamber as a precaution and then kept in hospital overnight and received a second follow up treatment the next day, before being released with no remaining effects.

July 2025**25/251**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

July 2025**25/067**

Two students with their instructor completed three training dives successfully during the day, with minor issues addressed during training. The first dive was to a maximum depth of 9m with a total dive time of 32 min. After a surface interval of 151 min they completed a second dive to a maximum depth of 7m with a total dive time of 18 min. After a further surface interval of 135 min they completed a third dive to a maximum depth of 9m with a total dive time of 22 min. All members of the party reported being fit and well at the end of the day's diving. Later that evening one of the students experienced a headache and noticed a rash on their head but did not report the symptoms at that time. Two days later the student self-referred themselves to a recompression chamber and, following a phone conversation, the duty diving doctor advised them to attend for an immediate assessment. The diver was given a precautionary recompression treatment. The chamber staff did not believe the symptoms were due to DCI but may possibly have been due to a minor gas embolism. No further neurological or systemic symptoms were reported and the diver was discharged.

July 2025**25/177**

A diver had completed a boat dive to a maximum depth of 30m for a total duration of 23 min. After returning to shore for lunch, the diver complained of an itch on their right shoulder. The diver was using a

wetsuit, which they had used for swimming the previous week when swimming in an area with jellyfish, and the diver initially assumed that some of the stings may have been caught inside the wetsuit. The diver decided not to carry out the second planned dive that day. Later in the day the diver was still itching. The following morning the diver's buddy called a recompression chamber who advised the diver should be placed on oxygen and driven to the chamber. The diver was recompressed, with some improvement in symptoms and it was concluded the diver had suffered a spinal DCI. The diver had five further recompression treatments over the course of a week, to minimise and lasting symptoms.

August 2025**25/081**

A diver conducted a dive to a maximum depth of 19m for a total duration of 42 min including a safety stop at 6m for 3 min. On surfacing the diver felt dizzy, uneasy and tired. They were unable to get onto the diver lift and back aboard the dive boat without assistance. Once aboard the diver sat down immediately and informed a crew member that they were not feeling right. The crew member added gas to the diver's suit, removed their BCD, fins, gloves and mask and sat the diver further along the boat to allow other divers to board safely. The crew member notified another crew member and asked them to take over care for the diver. The diver described how they felt shaky and that they wanted to lie down and go to sleep, and the motion of the boat was also making them feel dizzy. The diver was moved to the centre of the boat outside the wheelhouse and asked if they wanted a drink. The diver had a couple of sips of hot chocolate and was placed on oxygen whilst the boat made way back to harbour. An ambulance had been called to meet the boat in harbour, and the crew checked the diver's computer, which was found to have an alert between 9m to 6m and again on surfacing but the diver had not noted it at the time. On the way back to shore the diver started to feel better, but still felt very tired. Once back in harbour the diver was laid down in the recovery position, still on oxygen, and covered with a dry robe as they were cold and shaking. An ambulance arrived and the diver was able to get themselves onto the trolley and was then switched to the ambulance oxygen supply. The diver was taken to hospital and remained on oxygen for a number of hours before being discharged. The diver met with a diving doctor the following day who

was happy with their current state of fitness and cleared them to dive.

August 2025**25/080**

A diver and their buddy entered the water for a shore dive to try out the diver's new drysuit and undersuit. After around 10 min the pair came across an area of poor visibility at a depth of 18m. The diver had no previous experience of low visibility and became anxious, felt their vision was blurred and felt exhausted. The diver believed that they were also over-weighted and added air to their drysuit resulting in an uncontrolled ascent direct to the surface, separating from their buddy. Concerned about their buddy the diver descended back to 18m, unable to control the descent and experienced pain in their left ear drum. During the descent the diver passed their buddy, who was ascending. Near the bottom the diver inflated their BCD in an attempt stop the descent and reach their buddy, which resulted in a further ascent direct to the surface. The diver then descended again to 6m to rejoin their buddy who was conducting a safety stop. Due to still being stressed the diver had difficulty maintaining their stop depth and varied between 2.8 and 8.5m, after which a final uncontrolled ascent occurred with a total dive time of 19 min. Some time later that day the diver felt unwell and drove themselves to A&E where they were assessed and placed on oxygen before transfer to a recompression chamber for treatment for 4 hr 30 min on RN table 62.

August 2025 **25/085**

A diver had conducted a dive the previous day to a maximum depth of 54m using a rebreather with a trimix 11/50 diluent for a total duration of 110 min. After a surface interval of 22 hours, the diver conducted a dive using the same equipment to a maximum depth of 54m and a total duration of 85 min, including decompression stops at 18m, 15m, 12m & 9m. The diver was using a dive computer set to gradient factor 60:80. Once back aboard the boat the diver assisted others as they came aboard, including unclipping stages. Around 20 min later the diver experienced an ache in their shoulder and whilst they ate lunch tried to decide whether it was due to DCI or a strain. The diver discussed with the skipper and then breathed from their rebreather set to a low set-point of 0.9 bar for 20 min, after which the ache eased, although there was a slight shoulder rash, which had completely disappeared by the following morning with no further ill effects.

August 2025 **25/252**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

August 2025 **25/253**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

August 2025 **25/097**

A diver had completed deep dives on the previous two days using CCR with trimix 12/65 diluent. On day one 74m for a total duration of 150 min including stops at 33m for 1 min, 30m for 1 min, 27m for 2 min, 24m for 3 min and all other stops completed. On second day 57m for a total duration of 120 min including stops at 21m for 1 min, 18m for 3 min, 15m for 3 min, 12m for 3 min and all other stops completed. On the third day the diver and their buddy descended to investigate a target at a depth of 84m, which turned out to be a pile of girders and large pipes. The pair swam around for their bottom time of 20 min and then started their ascent. Around 50m during the ascent the diver experienced an indigestion type pain over their left abdomen. The pain increased to the point where the diver considered whether they would be able to complete their decompression stops, however the pain started to fade and then disappeared. The ascent continued with their decompression following a similar progression to the previous days and surfaced

after a total dive time of 104 min. During the stops at 6m the diver suddenly had become aware that their right leg was quite warm, whilst their left was cold. The diver initially thought it was due to a suit leak but then determined that was not the case. Once decompression requirements were clear the diver was less aware of the leg issue and surfaced and got back aboard the boat without any problems. The diver de-kitted and changed out of their suit. They reported the abdominal pain but did not mention the altered sensation in their legs. The boat set off back to harbour, and the diver sat in a rather uncomfortable camping chair in the wheelhouse. After about 40 min a large bait ball was spotted and everyone stood up to look, at which point the diver realised they had 'pins and needles' in their left leg, that did not settle after standing up. The diver alerted the crew who placed the diver on oxygen and called the Coastguard, who tasked a helicopter. The helicopter evacuated the diver to hospital for assessment and they received recompression treatment. The first treatment was for 8 hours after which the diver had difficulty walking but was OK with support, and they had numbness in both legs. The following day they had a further 5 hour treatment followed by 7 further 2 hour daily treatments. Each day there was improvement to both numbness and walking ability. Two weeks after the incident the diver was almost walking normally, sensation had returned in their right leg but there remained some surface numbness on their left leg. Their right leg has diminished temperature sensation but the left was almost normal to temperature changes.

August 2025 **25/254**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

August 2025 **25/103**

A diver and their two buddies completed a first dive to a maximum depth of 35m using air and completed accelerated decompression stops at 9m for 3 min using nitrox 50, and 6m for 7 min using nitrox 50 before a further 5 min at 6m using air, for a total duration of 91 min. After a surface interval of 225 min the group entered the water for a second dive to a maximum depth of 21m with a total duration of 54 min including a stop at 6m for 10 min breathing air. The diver started to experience symptoms of pain in their right shoulder and slight marbling and itchiness in the same area, approximately an hour after the

second dive. A recompression chamber was contacted and the diver advised to attend for assessment. They were recompressed for a 5 hour treatment and then received two follow-up treatment the following 2 days for 110 min each.

August 2025 **25/255**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

August 2025 **25/256**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

August 2025 **25/257**

Coastguard received a report of diver suffering from DCI. (Coastguard report).

September 2025 **25/098**

A diver was diving a wreck from a charter vessel at a maximum depth of 30m. During ascent the diver lost control of their buoyancy at a depth of around 16m, whilst deploying a DSMB, due to being under-weighted, and ascended direct to the surface arriving before the DSMB and shouted an expletive. The diver was recovered aboard the boat and monitored and seemed fine but was advised they would not be doing the subsequent dive as a precaution. After recovering all divers the boat made way to the second site and deployed a shotline and the remaining divers were deployed. 15 min after the divers entered the water the diver noticed 'pins and needles' in their left hand and so was placed on oxygen and a call was made to the Coastguard. Within 10 min the diver reported a pain radiating to their elbow so the skipper requested a helicopter evacuation. A lifeboat was on scene and as the charter vessel had divers in the water the injured diver was transferred to the lifeboat from which they were airlifted by the helicopter and transferred to a recompression chamber for treatment.

September 2025 **25/217**

A qualified diver had joined a training group to gain more experience and was buddied with another diver on a dive to a maximum depth of 5m. On returning home the diver showed signs and symptoms of DCI and sought medical advice. The diver received hospital treatment for DCI.

September 2025 **25/086**

A diver and their two buddies had completed two dives the preceding day, the first to a maximum depth of 21m and a total duration of 20 min including a safety stop of 3 min at 5m, and after a surface interval of 165 min, a second dive to a maximum depth of 20m and a total duration of 20 min including a safety stop of 3 min at 5m. On the second day the group descended to a maximum depth of 19m. After 9 min the diver had their regulator fall from their mouth and when placing it back in it was uncomfortable and not correctly fitted, which caused some water to enter their mask. Whilst the diver started to clear their mask, but by the time they had cleared it they had started to ascend with their drysuit dump closed. They then tried to open the drysuit dump but were now ascending increasingly quickly direct to the surface omitting safety stops. The diver was joined on the surface by their buddies and they swam ashore. The diver was administered oxygen, whilst still in the water and once recovered lay down still on oxygen until the supply was exhausted. The Coastguard was called soon after the oxygen was exhausted, who tasked an ambulance, due to the diver developing a high breathing rate, increased pulse and worsening condition. After speaking to a recompression chamber the diver was transferred and received at 2 hour treatment, before being released home.

September 2025 **25/112**

A diver was on a diving holiday diver from a charter vessel. After two dives on the first day the diver conducted two further dives on wrecks. The first to a maximum depth of 38m for a total duration of 68 min, including decompression stops at 9m for 1 min and 6m for 16 min. After a surface interval the diver conducted a dive to a maximum depth of 37m and a total dive time of 67 min, including decompression stops at 9m for 2 min and 6m for 13 min, and a further 3 min safety stop at 6m. All dives were conducted using nitrox 29 for the dive and nitrox 77 for decompression and monitored by dive computer set to gradient factor 40/80. One hour after surfacing from the final dive the diver developed a skin DCI, with a rash on their belly, which cleared after 20 min breathing nitrox 80. The diver continued to breathe the nitrox 80 whilst transferring to a recompression chamber and then was placed on oxygen during assessment at the chamber. The diver was recompressed on navy table 6.

October 2025 25/258

Coastguard received a report of diver suffering from DCI. (Coastguard report).

October 2025 25/259

Coastguard received a report of diver suffering from DCI. (Coastguard report).

November 2025 25/260

Coastguard received a report of diver suffering from DCI. (Coastguard report).

November 2025 25/185

A diver and their buddy had completed a first dive to a maximum depth of 21m for a total duration of 48 min. After a surface interval the pair descended to a maximum depth of 22m to practise sidemount drills before ascending and completing a safety stop, before surfacing with a total dive duration of 36 min. Once out of the water the diver appeared confused and exhausted. The pair made their way up to the car park but once they were back to their vehicle the diver collapsed. The on-site was alerted and stretchered the diver to the on-site first aid room, where they were placed on oxygen, their drysuit cut off and 999 called. An ambulance was quickly on scene and paramedics found the diver conscious and talking by the time they arrived, although the diver still showed signs of confusion. The diver was transported towards a hospital but was diverted en-route to a recompression chamber, where they received recompression treatment that day with a follow up treatment the next day.

November 2025 25/214

A student completed 4 training dives over two days. Three days after the final dive, the diver reported shoulder pain that had spread to their right arm and sought medical attention at a minor injuries clinic before being referred to hospital. The diver was subsequently transferred to a recompression chamber where they received a 6 hour session followed by a 2 hour session. The day following recompression treatment the diver was still in hospital, experiencing loss of feeling in their legs. The diver was advised by a neurologist that they would be able to walk again with physiotherapy. The diver has since commenced physiotherapy and was awaiting transfer to a rehabilitation centre.

December 2025 25/121

A diver with an instructor and another diver who would be acting as a simulated casualty entered the water and descended to a maximum depth of 20m, with an agreed turnaround at 150 bar. They then made their way back up to 5m where they conducted a safety stop, before descending as planned to a depth of 10m to conduct a simulated rescue, supervised by the instructor. The controlled buoyant lift ascent was too fast, but on surfacing they practised simulated rescue breaths and then towed the simulated casualty to the shore. During the surface interval of 90 min the diver felt no ill effects before they conducted a second shallower dive to a maximum depth of 6m, which was terminated after 45 min due to the diver feeling cold. The diver travelled home and the next day went about their normal activities until around 4 pm when they started to feel some tingling and unpleasantness. Around 3 hours later the diver contacted a recompression chamber for advice and after discussion with a doctor was advised to contact the centre again the next morning. The diver attended the chamber and received recompression treatment, with a further follow-up treatment the next day.

December 2025 25/178

A diver conducted two dives in the day with two buddies. The first dive to a maximum depth of 20m for a total duration of 57 min including a safety stop at 6m for 3 min and, after a surface interval of 100 min, a second dive to a maximum depth of 21m for a total duration of 50 min including a safety stop at 6m for 3 min. After getting changed and going for some refreshments the diver went to collect their cylinder from the on-site compressor shed and loaded it into their car. About 10 min later the diver started to experience a pain in their left upper arm and shoulder joint, but considered they had strained it whilst loading their car. During the drive home the pain increased slightly but the diver still considered it a strain. The diver did not sleep well that night and visited their GP the next morning, believing it was a strain. The GP agreed it appeared to be a strain but as they had been diving decided to seek advice from the BHA Diver Helpline. The diver was referred to the nearest chamber and following assessment was recompressed, although the doctor was 'on the fence' on whether it was DCI or a strain. The diver received a 6 hour treatment with significant improvement in

their condition and was discharged with no need for any follow-up treatment.

SYNOPSIS · UK



Boating and surface incidents

36 boating & surface incidents in 2025

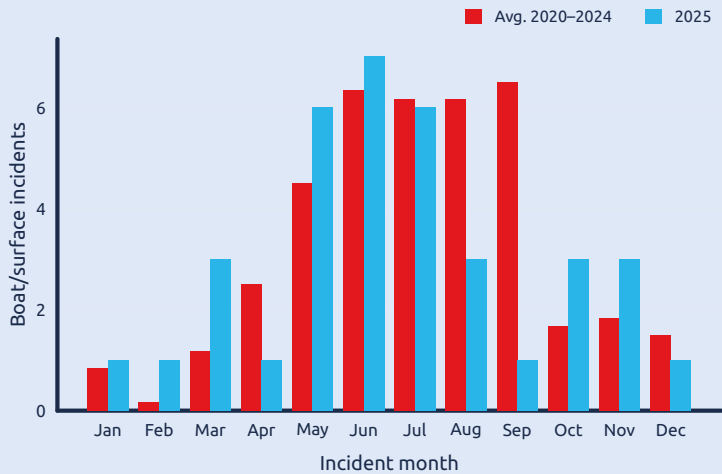
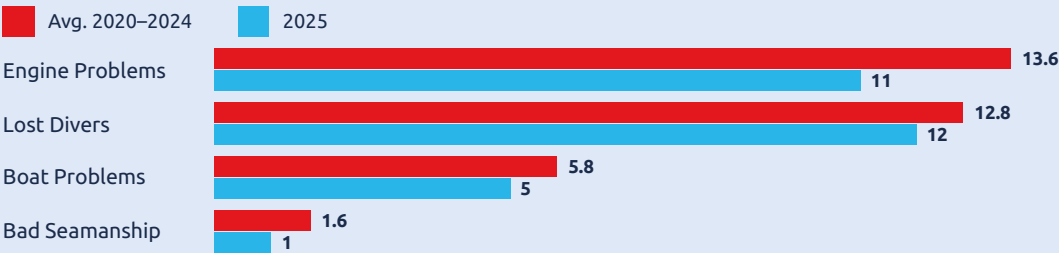


Figure 22
The month of occurrence of boat and surface incidents

Boating factors



January 2025 25/261

Coastguard received a report of diver overdue and missing. (Coastguard report).

February 2025 25/040

A pair of divers had completed a first dive of the day to a maximum depth of 12m. After a surface interval of 152 min the pair entered the water and were joined by two other buddy pairs who were unfamiliar with the site and so followed closely. The group made a slow steady descent past various platforms down to a depth of 10m, and the more experienced diver made regular checks their buddy was OK. The group then swam down further to a rocky outcrop from where they could see a boat wreck at a depth of 18m. On arrival at the boat the lead diver checked again that the buddy was OK and received an OK signal in return. The whole of the boat was clearly visible and the lead diver swam to the deck but turning to check could not see their buddy and indicated to the other two buddy pairs to swim around the boat in opposite directions to see if they could locate the missing buddy. Meanwhile the lead diver swam back to the rocky outcrop and looked up towards the surface, but was unable to locate the missing buddy. (Linked to Incident 25/003) The lead diver then swam back to the boat and the other two pairs and signalled for all to ascend via a shotline attached to the bow. The group ascended to a safety stop at 6m during which, an inexperienced diver lost control of their buoyancy and made an uncontrolled ascent direct to the surface, omitting the remainder of their safety stops. It was subsequently found that the diver had lost control of buoyancy due to failing to dump air from their drysuit during ascent. The remaining four divers completed their safety stops and then ascended to the surface.

March 2025 25/012

During a boat handling course an assistant boathandling instructor, supervised by a boat handling instructor (BHI), had demonstrated a sidestep manoeuvre to their three students and a qualified boat handler. One student then successfully repeated the manoeuvre twice. The second student then repeated the manoeuvre once but then on the second attempt caught a small wave causing a minor jolt. The qualified boat handler, who had been sitting on the tubes and leant over the side to see forwards, was thrown out of the boat by the jolt. Their lifejacket deployed as they hit the water and the boat handler

was able to signal to the boat they were OK. 'Man-overboard' was called by the BHI and the Assistant instructor took control to reduce the speed of the boat and then took over control from the student to recover the ejected boat handler. Once recovered the boat handler was checked for any injuries but reported no pain, loss of consciousness or any other signs of injury. The following morning they reported minor aches and stiffness in their left shoulder.

March 2025 25/262

Coastguard received a report of diver overdue and missing. (Coastguard report).

March 2025 25/289

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

April 2025 25/104

Two pairs of divers entered the water for a shore dive from a cove that faces northeast, with a slight current past the north westerly headland. The first pair entered but their direction was not noted by the shore cover. The second pair entered the water later and headed in a north easterly direction and after a period of time came back into the cove and exited the water to be told by the shore cover the first pair had not returned yet, but it was not unusual for the pair to carry out long dives. As the second pair made their way back to their vehicles to de-kit they spotted the first pair on the surface, at the edge of the headland. One diver was just making it back into the shelter of a small beach but the other was unable to swim back into the safety of the bay. The shore cover was called to the high point as they had a radio and they tried to call a fishing boat in the bay but could not get a response. They then called the Coastguard, which the fishing boat overheard and could see the struggling diver and went over to them. However the boat was only small and didn't have the facility to get the diver out with all their equipment, so they gave the diver a ring float and towed them gently along the headland into the next bay. In the bay there were two paddle boarders who took over from the fishing boat and towed the diver into the bay. Once in standing depth the diver was met the other pair who had waded in to assist the diver to carry their equipment back up to the car park. The diver was given oxygen as a precaution as they were exhausted. The divers had gone too far west and got caught in a current that had pulled them past the headland and they surfaced

outside the bay having dived to a maximum depth of 10m for a total duration of 35 min.

May 2025 25/034

A lifeboat was launched following a report of two divers missing following a dive. Shortly after raising the alarm the cox'n of their support boat reported the divers had surfaced safe and well after drifting further east than anticipated. The lifeboat met the boat to make sure no one required medical assistance and escorted the vessel back to harbour. Following the incident the RNLI issued safety advice to the divers. (Coastguard report).

May 2025 25/282

Coastguard received a request to respond to a diver in the water. (Coastguard report).

May 2025 25/290

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

May 2025 25/044

A group of divers were on day two of a two day trip using a RHIB. The plan was to conduct a drift dive and then dive a second site on slack water. Conditions were good with 2 knot winds and clear skies. On arrival at the first site the RHIB experienced some rough running from the engine which was resolved. Shortly after two pairs of divers entered the water to start their drift dive. Each pair deployed a DSMB on arrival at the seabed. Shortly after the divers entered the water the boat's engine stopped and would not restart. The divers were approximately 220m and 400m from the RHIB. A decision was made to make a 'Mayday' call to the Coastguard, however the Cox'n had some issues with the fixed VHF radio and so the call was made using a mobile phone. The Coastguard tasked two lifeboats to respond. The crew on the RHIB used paddles to make way towards the nearest pair who had now surfaced next to their DSMB and despite slow progress against a slight wind the two of the divers were recovered aboard the RHIB. The second pair had now surfaced and the RHIB started to be paddled towards them. When approximately 100m away an AWLB arrived and recovered the second buddy pair. The dive vessel was then taken under tow back to harbour by the lifeboat. Once ashore the group were met by the Coastguard team and questioned over their safety equipment, which they

were able to show them. A member who was ashore at the time came to the harbour with a spare battery and jump leads and was able to restart the engine without any problems. The battery was then tested using a meter and it was found to be indicating an issue with the charging system.

May 2025 25/281

The Coastguard responded to reports of a diver cut off or stranded. (Coastguard report).

May 2025 25/234

A lifeboat was tasked to respond to a report of a diver in the water. (Coastguard & RNLI reports).

June 2025 25/291

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

June 2025 25/049

Following a dive earlier in the day a group of divers on a RHIB planned to dive a wreck, but deteriorating weather conditions meant a change of plan to conduct an inshore drift dive at a constant depth of 13m towards a well-known series of rocks, with an expected current of 0.5 knots. The RHIB deployed two pairs of divers, each diving under SMBs and the RHIB displaying an 'A' flag. The current was faster than anticipated and the drifting dives soon passed by the rocks when the first pair surfaced. As the divers were being recovered the crew realised their position on the edge of a shipping channel. The crew used their emergency recall procedures of revving the boat engine and pulling on the SMB line to signal the divers to surface as quickly and safely as possible. At that point a large cross-channel ferry was fast approaching and had to take action to stop. The remaining divers surfaced and were recovered safely. The harbourmaster initiated an investigation and subsequently published a report with safety guidance.

June 2025 25/236

A lifeboat was tasked to respond to a report of a diver in the water. (RNLI report).

June 2025 **25/052**

A dive boat suffered engine failure whilst 4 divers were still in the water. A lifeboat was tasked and once on site recovered the four divers, whilst a harbour launch took the dive boat under tow back to harbour. (Media report).

June 2025 **25/292**

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

June 2025 **25/288**

The Coastguard responded to reports of a diving vessel drifting or dragging anchor. (Coastguard report).

June 2025 **25/070**

A cox'n was driving a RHIB for a group of divers on a very hot day with no wind. Divers were deployed in two waves over a 2 hour 30 min period, and the cox'n was, in hindsight, overdressed for the conditions and overheated. As the RHIB set off for the return journey, the cox'n felt they were going to faint, stopped the boat and handed over control to another qualified cox'n and sought a first aider aboard to check them out. Lying on the tube prevented them fainting and within a short time the breeze caused by the boat's movement cooled the cox'n down and they felt fine again.

July 2025 **25/300**

A group of divers were on a day charter boat to carry out a drift dive to collect scallops. The initial brief from the skipper was for them to be dropped in and swim against the current to get onto the scallop bed. The group leader requested they be dropped upstream so they could drift down onto the bed, which was reluctantly agreed to after some discussion. Travelling to the site sea conditions were poor, travelling with the current with a swell to starboard, with all aboard having to hold on tightly. On site conditions were worse and as divers started to kit up, the boat was rocking so badly that two divers fell off the bench seat, with one falling on top of the other. Other divers shouted to alert the skipper's attention as they seemed not to have noticed. The skipper stopped the boat, which proceeded to rock violently, and came out to help the diver's up. They asked the first diver how they wanted helping up but then pulled the diver up, fully kitted. The righted

diver's cylinder was immediately above the other diver's head and the other diver was fending off the cylinder in case the diver fell again. The diver still on the deck de-kitted and the skipper lifted their kit onto the bench, whilst the diver got up, and slotted back into their BCD whilst the skipper held on to it. The pair continued to kit up when the boat rocked again nearly pitching them onto the deck again. When about to enter the water one of the diver's cylinders had been bungeed to the bench, which had contributed to preventing them falling again. linked to incidents 25/099 and 25/301.

July 2025 **25/301**

A group of divers were on a day charter boat to carry out a drift dive to collect scallops. The initial brief from the skipper was for them to be dropped in and swim against the current to get onto the scallop bed. The group leader requested they be dropped upstream so they could drift down onto the bed, which was reluctantly agreed to after some discussion. Travelling to the site sea conditions were poor, travelling with the current with a swell to starboard, with all aboard having to hold on tightly. On site conditions were worse and as divers started to kit up, the boat was rocking badly. A group of three divers, one using a rebreather prepared to dive. One diver had inflated their DSMB on the boat before jumping in. The three descended and a second diver inflated their DSMB and then held onto the rebreather whilst they inflated theirs. Shortly after, the second diver drifted away from the other two and was unable to get back to them, despite trying to swim against the current. The diver had already deployed their scallop bag and so collected about a dozen scallops and then decided to ascend. Initially they had difficulty getting off the bottom due to the current and so sent their goody bag up and they were then able to ascend normally. On surfacing in heavy seas they were unable to see their charter boat, so inflated their BCD and drysuit and held the DSMB taut to ensure it stayed upright. The diver was passed by two other boats but not acknowledged. After some time their charter skipper came near, about 30m away, but was the only one on the boat and was looking in the opposite direction and did not respond to shouts from the diver, before driving off again in the opposite direction. The boat came close a number of times but did not see the diver until there were more people back aboard who spotted the diver waving. The brief had been that the current would drift the

divers back into calmer conditions, but that was not the case. The diver had considerable difficulty getting onto the lift, being washed off a number of times as they had difficulty holding on as no one had taken their DSMB and scallop bag off them. linked to incidents 25/099 and 25/300.

July 2025 **25/099**

A group of divers were on a day charter boat to carry out a drift dive to collect scallops. The initial brief from the skipper was for them to be dropped in and swim against the current to get onto the scallop bed. The group leader requested they be dropped upstream so they could drift down onto the bed, which was reluctantly agreed to after some discussion. Travelling to the site, sea conditions were poor, travelling with the current with a swell to starboard, with all aboard having to hold on tightly. On site conditions were worse and as divers started to kit up, the boat was rocking badly. A group of three divers, one using a rebreather prepared to dive. One diver had inflated their DSMB on the boat before jumping in. The three descended and once on the bottom a second diver inflated their DSMB and then held onto the rebreather diver whilst they inflated theirs. Shortly after, the second diver drifted away from the other two and was unable to get back to them, despite trying to swim against the current. The remaining pair continued their dive and collected some scallops and enjoyed the drift. At the end of their time they had some difficulty in getting off the bottom but were ultimately able to ascend to the surface. Meanwhile the pair were considered missing by the skipper, who instructed all aboard to look out for the missing divers on the starboard side. The skipper tracked back and forth from the area they had deployed the divers, then in the direction of the drift. After a number of tracks the skipper was in the process of alerting the Coastguard when another vessel reported the location of the divers. The vessel then steamed in the direction and recovered the divers. Linked to incidents 25/300 and 25/301.

July 2025 **25/071**

A diving boat lost power and communications, whilst it had 3 divers still in the water. The Coastguard was alerted and tasked two lifeboats. The first lifeboat on scene located and recovered the divers. Meanwhile a nearby yacht had assisted the stricken dive boat and taken it under tow back to harbour. The second

lifeboat was then stood down. (Coastguard & RNLI reports).

July 2025 **25/069**

Two divers entered the water from the shore for an evening dive. The dive was initially uneventful until the pair swam through an underwater gully, looking to go around a large rock and return to the bay. Once on the seaward side of the rock they encountered an unexpectedly strong current given the dive was conducted for high water just off neaps. The lead diver decided that they would be safer on the surface as underwater visibility was around 2m, they conducted their safety stops in the kelp and then surfaced with a total dive time of 41 min. On surfacing they began swimming towards the island but the lead diver then found themselves on submerged rocks with a swell forcing them further onto the rocks. The diver called for help and was spotted by a member of the public who called the emergency services. The diver kept sight of their buddy using torches until they drifted out of sight. The diver moved across some shallow gullies until they could reach higher ground to de-kit. They were able to see their buddy being picked up by a lifeboat and signalled that they were OK. The diver then made their way across a small island and into the bay where they had started the dive. The buddy had experienced some cramp in their leg but after massaging it sufficiently, they managed to swim sideways out of the rip tide. The buddy then ditched their weights and inflated both their suit and BCD to keep themselves above the waves, whilst continuing to breathe from their regulator for safety. On recovery by the lifeboat the buddy was very tired but out of immediate danger. Back on the beach the pair were checked by a Coastguard rescue team and once happy all was OK they stood down the helicopter that had been tasked.

July 2025 **25/090**

A dive boat with 5 people aboard were on a day's diving. The boat had a designated cox'n and dive manager, who planned to hand over to a qualified boathandler to take over when the cox'n took their chance to dive in a group of three. The first dive was on a wreck at a maximum depth of 28m for a total dive time of 26 min. After a surface interval of 156 min, the cox'n handed over to the boathandler and the trio entered the water for a drift dive, just after slack water on a neap tide. The group had an orange DSMB deployed from the start of the dive and on

(continued) reaching the bottom found the current stronger than anticipated. The group continued their planned dive time of 35 min and surfaced having been to a maximum depth of 25m. On surfacing they realised that their boat was about a mile away and searching in the wrong area. The sea was calm and the trio drifted on the surface for 30 min before a passing motor vessel spotted them and recovered them aboard. The skipper of the vessel called the Coastguard using a 'Pan Pan' but this was stood down after the cox'n called their own vessel on the VHF to come and pick them up. It was discovered that the boathandler had been distracted when they had entered the water due to being unfamiliar with the boat and the crew members had succumbed to seasickness. It was also noted that there were two AIS/DSC diver location units aboard, hanging in plain sight, which the trio had forgotten to take with them.

August 2025 25/240

The Coastguard tasked a helicopter to assist divers. (Coastguard report).

August 2025 25/087

The Coastguard tasked a lifeboat to respond to a Personal Location Beacon (PLB), which had been activated. The lifeboat arrived on scene and commenced a search during which a crew member spotted two divers in the water. The pair were checked and confirmed they were OK but had become separated from their dive vessel, having drifted around 1.5 nm from the site. Unable to see their vessel they had activated their PLB. Their dive vessel subsequently arrived on scene and collected their divers allowing the lifeboat to return to station. (Coastguard & RNLI reports).

August 2025 25/298

The Coastguard responded to a diving vessel, which had reported a person overboard. (Coastguard report).

September 2025 25/293

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

October 2025 25/241

The Coastguard tasked a helicopter to assist divers. (Coastguard report).

October 2025 25/107

The Coastguard was alerted to two people shouting and waving for help and tasked lifeboat to attend. The lifeboat arrived on scene within 20 min and recovered the divers. (Coastguard report).

October 2025 25/294

The Coastguard responded to reports of a diving vessel with machinery failure. (Coastguard report).

November 2025 25/115

A group of divers were travelling to a dive site when the engine cut out and would not restart. When trying to call for assistance the VHF radio would not work as a result of a dead battery. They made calls for assistance on a handheld radio and mobile phone, and a lifeboat came and took the vessel under tow back to port.

November 2025 25/238

A lifeboat was tasked to respond to a report of a diver in the water. (RNLI report).

November 2025 25/119

The Coastguard tasked a lifeboat to respond to a report of a dive RHIB that had suffered engine failure whilst two divers were still in the water. The two divers had to swim around a mile to get back to their boat. Once on scene the lifeboat transferred three of the casualties to the lifeboat, where two of them received casualty care. The RHIB was then taken under tow back to harbour. (Coastguard report).

December 2025 25/263

Coastguard received a report of diver overdue and missing. (Coastguard report).

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Ascents

12 ascent-related incidents in 2025

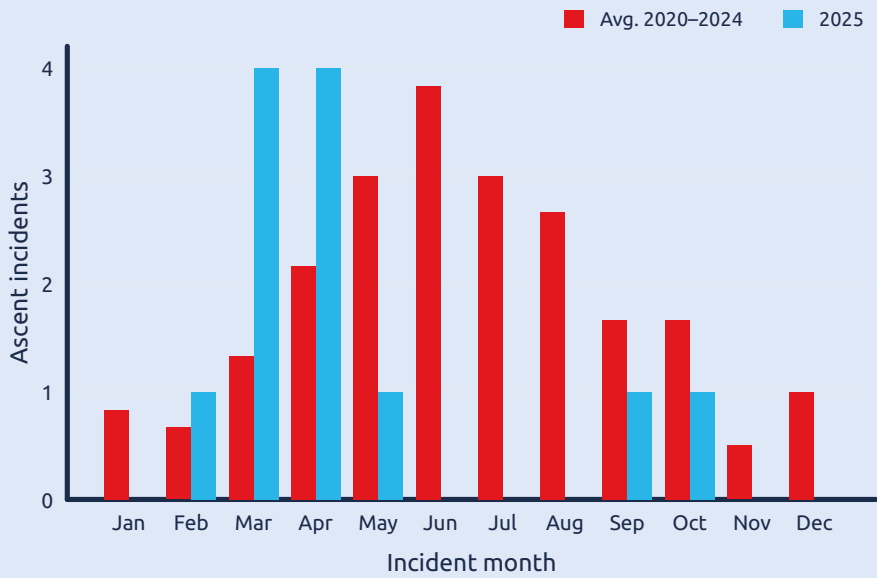


Figure 23
The month of occurrence of ascent-related incidents which did not result in DCI or a fatality



February 2025**25/003**

A pair of divers had completed a first dive of the day to a maximum depth of 12m. After a surface interval of 152 min the pair entered the water and were joined by two other buddy pairs, who were unfamiliar with the site and so followed closely. The group made a slow steady descent, past various platforms down to a depth of 10m, and the more experienced diver made regular checks that their buddy was OK. The group then swam down further to a rocky outcrop from where they could see a boat wreck at a depth of 18m. On arrival at the boat the lead diver checked again that the buddy was OK and received an OK signal in return. The whole of the boat was clearly visible and the lead diver swam to the deck, but turning to check could not see their buddy, and indicated to the other two buddy pairs to swim around the boat in opposite directions to see if they could locate the buddy. The lead diver then swam back to the rocky outcrop and looked up towards the surface, but was unable to locate the missing buddy. The lead diver then swam back to the boat and the other two pairs, and signalled for all to ascend via a shotline attached to the bow. The group ascended to a safety stop at 6m during which an inexperienced diver lost control of their buoyancy and made an uncontrolled ascent direct to the surface. (linked to incident 25/040) The remaining four divers completed their safety stops and then ascended to the surface. Meanwhile the missing diver had surfaced normally and swam back to shore and was being spoken to by the assistant dive manager when the lead diver surfaced. The lead diver then swam to where the missing diver was and found them somewhat panicked and so calmed them down and assisted them to exit from the water. The diver had lost control of their buoyancy due to overinflation of their drysuit and had made an uncontrolled ascent direct to the surface from 13m. The diver was taken to the on-site first aid room where they were checked over and found to have no signs or symptoms of any diving related injuries and did not require oxygen.

March 2025**25/018**

During a buoyancy course a diver made a rapid uncontrolled ascent with their buddy from a maximum depth of 18m with a total dive time of 15 min. On surfacing both divers called for help. On recovery to shore the pair were given oxygen and a duty doctor was called for advice. The doctor advised them to attend a recompression chamber for assessment.

March 2025**25/010**

Two students and their instructor had completed a training dive without incident earlier in the day to a maximum depth of 5m and a total dive time of 40 min. After a surface interval of 120 min the group entered the water for some further training, together with an exploratory dive. The group descended to a maximum depth of 12m and then followed a wall to an underwater feature. The instructor signalled one student to kneel down and then looked round for the other student but could not see them. The pair retraced their route looking for the missing student and reaching the last known position looked around through 360 degrees and then with no sign of the missing student they ascended a shotline. The pair surfaced to find that the student had surfaced in front of an instructor training group, and had been assisted to shore, and was being looked after by the group and their own shore party. With a confirmation that all was under control the pair then decided to complete their dive. The student subsequently confirmed that they had started to become too buoyant and had attempted to dump air from their suit and swimming down, but had been unable to regain control and surfaced. They had been taken to the on-site first aid room to be checked over but no symptoms developed and the student was monitored throughout the day but none developed.

March 2025**25/017**

A diver, wearing a wetsuit, and their buddy conducted a first dive of the day to a maximum depth of 17m. The dive was normal until about 25 min when, at a depth of 12m, the diver started to feel light and attempted to dump air using their normal practice of pulling the mouthpiece on the corrugated hose to operate the dump valve on their left shoulder. The diver presumed that the jacket was empty and that they were not carrying sufficient weight. The diver picked up some rocks and continued the dive until they approached the exit point. As the diver started their safety stop, they discarded the rocks and grabbed hold of some larger boulders but lost their grip and ascended direct to the surface with an uncontrolled fast ascent. Shortly after the diver reunited with their buddy and the pair swam to the exit and left the water. After de-kitting the diver found that their BCD was full of air and the pull dump was not operating. The diver realised they should have tried one of the three alternative ways the BCD had of releasing gas.

March 2025**25/223**

A site rescue team responded to a diver who had made a rapid ascent from a depth of 25m, omitting safety stops.

April 2025**25/021**

A diver was on a dive with a group and achieved a maximum depth of 22m. As they moved shallower and reached a depth of 19m the diver's regulator began to free flow. They changed to their AS and then made a rapid ascent to the surface and called for help. The diver was recovered by the site rescue boat and taken to the first aid room. The diver complained of feeling nauseous and was given oxygen. After 20 min the diver was feeling better and had no further symptoms and so returned to the group.

April 2025**25/055**

Two divers had conducted a dive to a maximum depth of 20m. As they ascended up a wall one diver suffered a slight inversion and panicked resulting in a fast ascent from 18m direct to the surface, omitting safety stops. On reaching the surface, the diver felt tight chested and struggled to breathe. The diver signalled distress and was recovered by the site safety boat and returned to shore and taken to a first aid room and placed on oxygen. A call was made to a recompression chamber for advice, they felt there was no need for treatment unless symptoms arose. The diver had a total dive duration of 13 min to a maximum depth of 20m. The buddy had descended slightly and then ascended, completed their safety stop and surfaced.

April 2025**25/054**

A group of three divers descended to a maximum depth of 31m. They then started a slow ascent up a slope. When they reached a depth of 13m one of the divers lost control of their buoyancy and made a rapid ascent direct to the surface, omitting safety stops. The remaining two divers completed their safety stops and made a steady safe ascent. Meanwhile the diver who had made a fast ascent exited the water and de-kitted then walked to the on-site shop for assistance. They were placed on oxygen as a precaution and advised not to dive again that day.

April 2025**25/029**

A diver on a dive trip had completed two dives the previous day. The first to a maximum depth of 26m for a total duration of 40 min, including a safety stop

at 6m for 3 min, and after a surface interval of 190 min, a second dive to a maximum depth of 24m for a total duration of 39 min. The following day after a surface interval of 16 hr 51 min, the diver descended to a maximum depth of 25m on a wall and then slowly made their way shallower. On reaching 13m the diver lost control of their buoyancy and made a fast ascent direct to the surface omitting safety stops and became separated from their buddy in the process. The diver was recovered aboard the boat and placed on oxygen for 30 min and monitored, but they suffered no ill effects. The diver believes they were under-weighted having changed their dive configuration.

May 2025**25/228**

A diver made a fast ascent from 15m direct to the surface omitting safety stops. On the surface the diver was breathless and panicked. The diver was towed back to shore by another diver and handed into the care of the site rescue team. The diver was placed on oxygen and a recompression chamber was contacted for advice.

September 2025**25/108**

A diver had conducted two dives the preceding day, the first to a maximum depth of 32m for a total duration of 42 min, then, after a surface interval of 178 min a second dive to a maximum depth of 25m for a total duration of 38 min. The diver had felt overweight and so removed 1 kg of weight from their weightbelt. The following day they undertook a wreck dive with two buddies and was using nitrox 24. They entered the water from a charter vessel to dive a wreck at a maximum depth of 37m. The diver felt they were under-weighted during the dive and so considered they had needed the 1 kg weight but in reality, they had forgotten to fit their weightbelt at all and the 1 kg had simply masked the missing weightbelt. Continuing the struggle the diver decided to abort the dive and sent up a DSMB, but lost control of their buoyancy and made an ascent direct to the surface, with a total dive time of 19 min to a maximum depth of 37m. On realising they had not worn their weightbelt they considered that, if realised underwater, they could have returned to the shotline to help slow their ascent.

October 2025**25/229**

A diver suffered a rapid ascent, omitting safety stops.

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Technique-related incidents

18 technique-related incidents in 2025

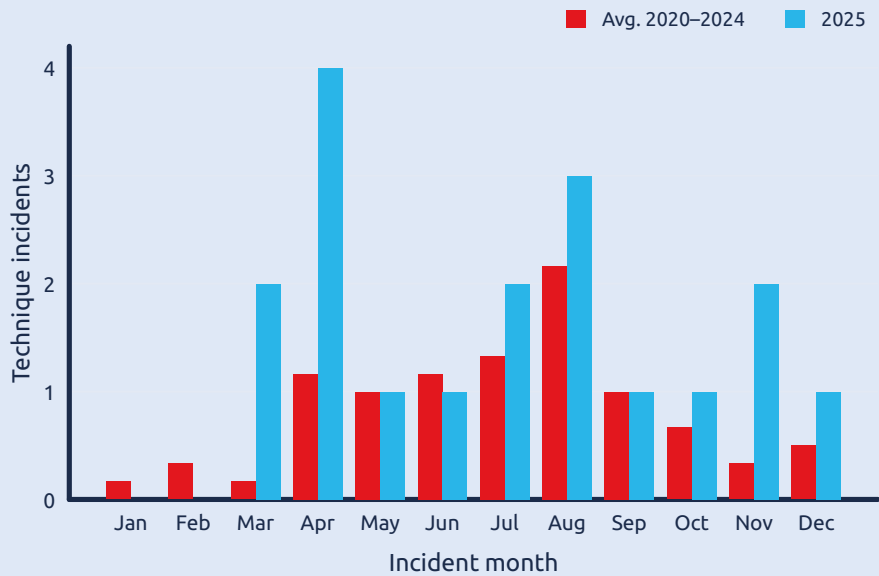


Figure 24
The month of occurrence of technique-related incidents



March 2025 **25/303**

A diver had organised a trip for a group of divers on a liveaboard offering the opportunity to dive wrecks and deep walls. After a first dive on a wreck the group conducted a wall dive off a channel. The diver was pushing for others in the group to accompany them on a deeper dive but they declined as they wanted to dive shallower again to resolve some minor issues with their rebreathers. The diver buddied with another in the group and they agreed to meet each other on the wall, but missed each other, and both continued the dive on their own. At the end of the dive everyone was back aboard the boat except the diver. After looking around their DSMB was spotted behind the boat in the middle of the channel. When the diver was recovered aboard the boat, they were boasting about having reached just short of 50m. The diver appeared unaware they were diving on the biggest tides of the year and could have been swept out of the channel.

March 2025 **25/304**

A diver had organised a trip for a group of divers on a liveaboard offering the opportunity to dive wrecks and deep walls. On the second day of the trip the group dived a wreck sitting on a slope with a maximum depth of 50m. The diver was buddied with a less experienced diver. Another pair in the group had become separated briefly as one had a problem and surfaced and their buddy continued down intending to join another pair. At 35m the separated diver came across the diver and their less experienced buddy. The buddy did not look comfortable and so the separated diver indicated they would take them shallower, whilst the diver joined another pair nearby. The inexperienced diver then seemed to settle down and relaxed and was able to enjoy the marine life. After the dive the inexperienced diver, who was qualified to dive only to 35m, explained they had been taken to 42m, which was what made them uncomfortable, as they had only dived to 35m once before, and that was 7 months previous. Meanwhile the pair the diver had joined surfaced without the diver who subsequently surfaced on their own.

April 2025 **25/134**

During a drysuit training exercise, where they had practised an inversion drill successfully earlier in the dive, a student became inverted at a depth of 6m and made an uncontrolled ascent direct to the surface.

Their buddy maintained physical contact with the diver and made themselves negatively buoyant to help slow the ascent.

April 2025 **25/224**

A site rescue team responded to a report of a missing diver. The diver was located safe and well.

April 2025 **25/225**

A lone diver was spotted popping up to the surface and then descending again.

April 2025 **25/043**

A diver and their buddy had conducted a dive earlier in the day to a maximum depth of 30m and a total dive time of 35 min including a safety stop at 6m for 3 min. After a surface interval of 60 min they prepared to conduct a second dive on a wreck. The diver was using a manifolded twin-set with nitrox 32, and a stage cylinder, whilst the buddy used a single cylinder with nitrox 32 and a pony cylinder. The pair entered the water and descended the shotline. During the descent the diver made a rapid descent unable to add sufficient buoyancy to their drysuit and was followed closely by their buddy. The diver landed heavily on the boilers of the wreck at 30m. After taking stock, the pair agreed to continue with the dive for approximately 15 min and then return to the shotline. The diver's regulator was slightly free flowing and the diver attempted to clear this by taking a deep breath which resulted in a complete free flow. The pair ascended up the shotline to 15m at which point the buddy turned off the cylinder to the free flowing regulator as the diver switched to their stage cylinder. At that point the shotline went slack and the divers were left with a frayed end of rope as the line had parted. The buddy deployed a DSMB and the pair conducted safety stops at 6m for 3 min and 3m for 3 min. During the safety stops the buddy switched to breathe from their pony cylinder to conserve gas for inflation on the surface. The divers surfaced with a total dive time of 32 min to a maximum depth of 30m. The pair were recovered by their dive vessel and the diver was found to have 20 bar of gas remaining, whilst the buddy had 30 bar. Their dive vessel had recovered their shotline whilst the divers were down. The shotline that had parted belonged to a RHIB also on site.

May 2025 **25/227**

A diver surfaced on their own and made their way back to shore. They were met by the site rescue team who confirmed the diver was fit and well.

June 2025 **25/047**

Two divers had conducted a dive earlier in the day to a maximum depth of 31m for a total duration of 43 min. After a surface interval of 150 min the pair entered the water from a boat for a drift dive to search for scallops. By the end of the dive to a maximum depth of 20m the pair had collected a large bag of scallops and commenced a smooth ascent to 12m where the bag was attached to the DSMB reel, which resulted in one diver becoming under-weighted and the other over-weighted. The pair spent some time yo-yoing in depth until they were unable to hold depth and ascended direct to the surface omitting a safety stop and becoming entangled in the excess line. The pair were recovered aboard their boat and after an assessment with no issues they were placed on oxygen as a precaution for 10 min. Neither diver had any ill effects after coming off oxygen.

July 2025 **25/146**

A group of three divers were diving in low visibility towing an SMB. They encountered another group of divers and became disoriented causing a separation. All divers aborted the dive and conducted normal ascents and regrouped at the surface.

July 2025 **25/084**

A trainee, accompanied by an instructor and another qualified diver, had completed a training dive the evening before to a maximum depth of 7m. Following a surface interval of 24 hours the group went for a boat dive on a near-shore reef, as an experience dive for the trainee. The Shot line was supposed to be deployed at 7m on top of the reef but it had drifted off and was at 17m. The group moved off and spent time looking at marine life. The instructor noted that the trainee's buoyancy and trim control was excellent for their stage of training. After 30 min the instructor deployed their DSMB at which point the trainee lost control of their buoyancy, inverted and pulled all three to the surface omitting a safety stop. The instructor tried to reach the diver's shoulder dump and did so just before the group broke the surface. The instructor had been through the inversion procedure with the trainee the day before.

August 2025 **25/082**

Two qualified divers entered the water from the shore for a training dive to refresh skills with an instructor and descended to a platform at 5m. One student was practising an AS drill with the instructor acting as donor, and the second student observing 2m away. As the student took the AS they put it into their mouth upside down, and as a result breathed in a little water, which then resulted in them having trouble breathing. The student then panicked, threw away the instructor's AS and started to wave their hands. The instructor was unable to see the students primary or secondary AS, and so lifted them direct to the surface using a controlled buoyant lift.

August 2025 **25/083**

Two qualified divers entered the water from the shore for a training dive to refresh skills with an instructor and descended to a platform at 5m. The instructor demonstrated a partial mask flood and then clear and invited the first student to mimic. The student was unable to clear the mask and started to panic, waving their arms. The instructor gripped their BCD and the student started to calm down and stopped waving their arms. The instructor then lifted them to the surface using a controlled buoyant lift. The student stated they panicked because they could not clear their mask. Total dive duration was 3 min.

August 2025 **25/093**

A student was being taught DSMB deployment by an instructor, accompanied by another diver. Following a demonstration by the instructor the student deployed their DSMB from a 6m platform to the surface but only managed to get it a quarter full. The instructor pulled the DSMB down and emptied it so the student could try again, which they did successfully. However, once inflated and deployed the student allowed their AS to fall and it began to free flow. The instructor attempted to stop the free flow but was unable to, so donated their AS to the student, who then dropped their regulator, which also began to free flow. The pair ascended in a cloud of bubbles and a fast ascent direct to the surface, taking around 20 secs from 6m. On surfacing the instructor orally inflated the student's BCD and then turned off the cylinder to stop the further release of gas. The student had 170 bar remaining at the start of the second DSMB drill and 50 bar remaining on the surface once isolated. The student and instructor then found that the DSMB

(continued) line was wrapped around them both, however the third diver, who had surfaced after them was able to unentangle them. Water temperature was 18 deg C.

September 2025

25/113

A diver was preparing for a solo dive, but due to time pressure decided not to use their sidemount rebreather, with offboard air and diluent, and off board oxygen stage. Instead they opted to use twin 7 ltr sidemounts, one with air and the other with trimix 17/45, both with 200 bar. When they were kitting up the diver noticed that their air cylinder was empty, presumably the purge button had been depressed. The diver filled the cylinder from an air bank, providing approximately 150 bar. The diver then planned to do a solo dive to a maximum depth of 30m, with a bottom time of 30 min and 15 min decompression stops, guessing that they could complete the dive on the air cylinder without the need to use their expensive diluent cylinder. Towards the end of the dive, with 3 min deco left at 6m, the diver felt their regulator going tight, although their contents gauge indicated 15 bar remaining. The diver then switched to their diluent mix, trimix 17/45, and switched their computer to that mix as well. The computer indicated a much longer decompression profile whilst using the diluent gas and so the diver switched between the two, monitoring their computer until it cleared. The diver surfaced with a total dive time of 55 min, 10 min over what had been briefed to the skipper. The diver exited the water and explained to the skipper why they were overdue, but that they had completed their required decompression.

October 2025

25/230

A group of divers surfaced and the lead diver requested help for a diver struggling with their buoyancy. A site rescue boat responded and after taking the struggling diver's equipment aboard, the diver was then able to swim back to shore.

November 2025

25/117

An instructor and their student conducted a wreck dive from a boat both using nitrox 32. After 15 min exploring the outside of the wreck the instructor noted someone swimming out of an enclosed section of the wreck and assumed it was safe to enter. The instructor checked with their buddy they were happy to enter the wreck and they agreed and so the pair

entered. They found a gap to enter the next room/compartment and the instructor scanned it with their torch and it seemed clear, with room to turn around and so they swam in. On reaching the next compartment the instructor looked around but realised that with both divers in the room there was very little room to turn around. As the pair both attempted to turn at the same time there was a great deal of silt stirred up and visibility was reduced to the extent that the instructors torch could only penetrate 30-50cm. The instructor tried to locate their buddy but could not see them and so stayed where they were and gently spread their arms and legs to reach for them. After about 30 seconds the instructor felt something latch onto their fins and a small kick confirmed the buddy had grabbed hold. The instructor took a moment to control their breathing, but then felt themselves sinking into the silt at the bottom of the compartment. The instructor then swam in the direction they thought the exit was but banged their head, they then changed direction twice, each time banging their head again. Conditions by then were completely black and the instructor could see nothing. Accepting their blindness the instructor began to feel their way through various compartments before realising they had actually gone deeper inside the wreck and so tried to turn around. At that point the instructor's DSMB reel snagged and they were unable to unentangle it and so detached it from their BCD and left it. The instructor then tried to work out what direction to go in and realised there was a large space above them. The instructor ascended and their head poked out over the silt and they were able to get a clearer view of where they were. Their buddy ascended next to them and the instructor checked they were OK. Looking up the instructor saw a small hatch that was barely big enough to get through so the instructor poked their head through and looked around but couldn't see any other divers. Considering their options the instructor decided to try and squeeze through the hatch. As they attempted to squeeze through their cylinder boot became wedged and the instructor was unable to move up or down. They saw some divers in the distance and tried signalling them with their torch, they looked but didn't approach and shouting through the regulator didn't attract them either. The instructor then felt their buddy pushing their cylinder from below, and they managed to push the instructor free after a few seconds. The buddy followed the instructor out, and being slimmer only required a small tug on their

cylinder to free them. The instructor checked both their gas contents and then signalled to ascend, but the buddy ascended too quickly and the instructor had to chase them to control their ascent. The pair arrested their ascent at 10m and the pair ascended at a slightly slower rate direct to the surface. The instructor's dive computer indicated a very fast ascent. The instructor signalled distress to the cover boat and they were recovered from the water and their condition was checked. The remaining divers were recalled and then returned to shore where the two divers were advised to breathe from their nitrox 32 until they were back ashore and able to access the club oxygen set, where they then alternated breathing from the oxygen set for the next hour. Whilst penetrating the wreck they appear to have disturbed some diesel container or pipework and it appeared from symptoms afterwards that the buddy may have ingested some of the contamination as they had symptoms of headache and queasiness. The two divers were observed at the accommodation and had a night to rest.

November 2025

25/231

A diver surfaced alone and a site rescue boat was dispatched to check on them.

December 2025

25/232

A lone diver was spotted on the surface and a site rescue boat was dispatched to check on their welfare. The diver spotted their buddy and descended to rejoin them at 5m.

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Equipment-related incidents

14 equipment-related incidents in 2025

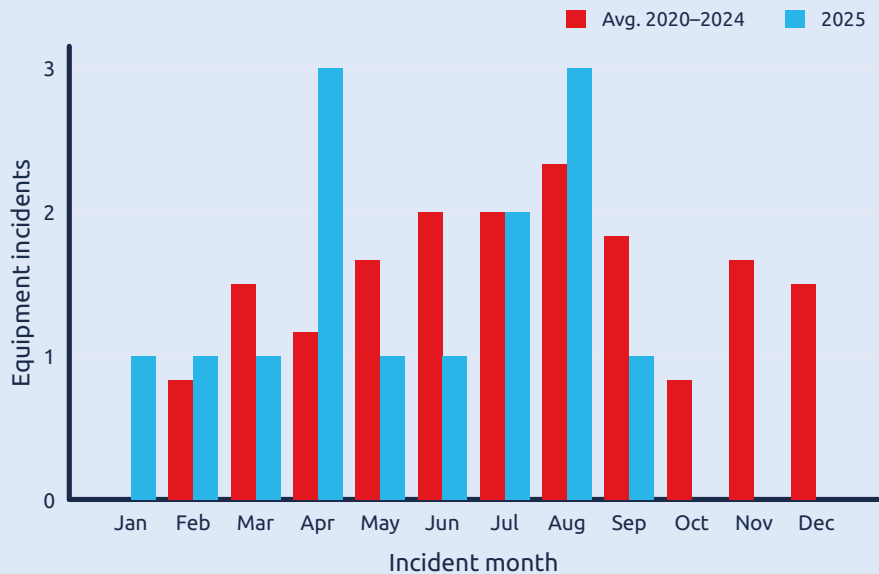


Figure 25
The month of occurrence of equipment-related incidents



January 2025 **25/002**

A diver using a rebreather entered the water for a night dive with their buddy. During the swim out the diver noticed their CCR loop was filling up slightly more than it should. They thought initially that the oxygen solenoid had jammed but on checking their PO2 was stable. The diver then realised that the Automatic Diluent Valve (ADV) was free flowing in the cold 5 deg C water. The diver confirmed this by fluttering the diluent valve to control buoyancy. Once the source of the fault had been confirmed the diver closed the ADV flow stop and manually controlled the dive for the rest of the dive to a maximum depth of 21m, with a total duration of 49 min.

February 2025 **25/073**

During a shore dive to a maximum depth of 12m a diver suffered a regulator free flow and was unable to locate their buddy in the low visibility. The diver panicked and surfaced rapidly and was recovered by a safety boat. The buddy had become entangled in a fixed datum line and also suffered a free flow whilst unentangling themselves, but was able to switch to their pony cylinder and surfaced normally and was also recovered by the safety boat. Total dive time was 10 min and water temperature was 4 deg C.

March 2025 **25/302**

A diver had organised a trip for a group of divers on a liveaboard offering the opportunity to dive wrecks and deep walls. On the first day, the diver conducted a checkout dive on a wreck at a maximum depth of 25m. During the dive the diver's torch battery canister flooded.

April 2025 **25/026**

A diver and their buddy, both using rebreathers, had completed two dives the previous day. The first to a maximum depth of 27m and a total duration of 35 min and the second to a maximum depth of 23m for a total duration of 41 min. The following day the pair entered the water for a dive to a maximum depth of 51m. The diver used trimix 16/36 diluent and the buddy used trimix 21/37 diluent in their rebreathers. After completing the dive to their planned maximum depth the pair were completing their decompression stops at 6m when the diver's Open Circuit Bail-out (OCB) mouthpiece became detached. The buddy noticed this and handed the diver their AS until the diver could access their own Bail-out supply of a 7 ltr

cylinder of air. The diver had completed their own decompression stops but the buddy still had 5 min of stops remaining and so the pair agreed to remain together until the buddy had cleared their stops. On inspection after the dive it was found that the mouthpiece securing tie-wrap had been lost.

April 2025 **25/027**

An instructor, accompanied by another instructor and a qualified diver who was training for the next grade had completed a first diver of the day to a maximum depth of 14m for a total duration of 40 min. After a surface interval the group entered the water for further training and descended to a maximum depth of 15m. After approximately 18 min the instructor's regulator began to free flow. The instructor switched to their pony regulator and attempted to stop the free flow by inverting the valve but this did not stop the free flow. The instructor also tried shaking the regulator and then tapping it gently on the handrail of an underwater feature but neither worked and the entire cylinder contents were lost. The group aborted the dive, ascended safely, surfaced with a total dive time of 20 min and exited the water. Water temperature was 9 deg C.

April 2025 **25/030**

An instructor was supervising a depth progression dive for a student to 40m. The instructor had a 12 ltr cylinder and a pony cylinder and the student had a single 15 ltr. After attaining their maximum depth of 40m the pair slowly began their ascent, but on reaching 33m the instructor's regulator began to free flow. They attracted the student's attention and signalled to ascend. The student readied their own AS and presented it to the instructor but they refused as they had a redundant source. The instructor tested their pony regulator and was happy that it was functional but decided to continue to breathe from their free flowing regulator until it ran out, to conserve the gas in their pony cylinder. The gas ran out on their main cylinder between 20 and 15m and the instructor then switched to their pony regulator. The student had remained close by the instructor during the ascent ready to help if necessary. The final stages of the ascent were slightly faster than normal but not excessive or concerning. On surfacing the instructor orally inflated their BCD and then signalled to shore cover that all was OK. Water temperature was 6 deg C.

May 2025 **25/226**

A diver suffered a free flowing regulator and the dive was aborted.

June 2025 **25/051**

A pair of divers entered the water from a boat for a drift dive. It was the first dive of the season for the experienced divers. As the last pair down the shotline the current was starting to pick up and they had to fin hard down the line to reach the lifting bag for recovery. The divers paused to inflate the lifting bag so that it was easy for the boat crew to recover to the surface. The pair then swam away from the shotline to a reef wall at a depth of 11m, where they deployed a DSMB, and then drifted along the wall with the current. The current was strong and occasionally lifted the divers over the lip of the wall, but they were able to relocate the reef and continue until lifted again and then repeated. After a short time the pair became aware of two other divers, one intent on taking photographs, whilst their buddy was holding on to the lip of the reef and held their DSMB. The divers drifted past between them as they had no opportunity to change course to avoid them. As the divers continued to repeat the sequence along the reef the diver holding their DSMB began to feel some friction on the line and realised their line must have tangled with that of the pair they had passed. They continued for a short time before deciding to ascend. The pair had spent the majority of the dive between 8-9m and as they ascended, they could see their DSMB above them with the line extending away and then back again to the reel. The pair realised they would be unable to conduct a safety stop and would be unable to swim against the current to unentangle their line. They considered cutting the line but decided to release the reel expecting that the buoy would keep it afloat and it could be recovered from the surface. On recovery aboard the boat the diver asked the cox'n if they could drive over and recover their DSMB but they declined, concerned that in doing so it might pull the other divers to the surface. When the other pair of divers surfaced, they had a problem with a loose cylinder where the cam band had released and the crew had to help them aboard. Once completed the boat moved quickly to go over and recover the DSMB, which had slowly been deflating, but it was no longer visible. The pair had completed a dive to a maximum depth of 11m with a total duration of 25 min, omitting a safety stop.

July 2025 **25/089**

Prior to a dive trip a diver replaced the drysuit inflation and heating bulkhead on their drysuit and pressure tested the suit at home, which appeared to hold pressure and no leaks were detected. On the first dive of the trip the diver noticed a minor leak in the suit, which the diver thought was due to the bulkhead seal. They skipped the planned second dive, dismantled the bulkhead and replaced all 'o' rings before reassembling, ready for diving the next day. The next day the diver and their buddy, both using CCR with trimix 21/32 diluent, entered the water to dive a wreck at a maximum depth of 45m. Approximately 45 min into the dive the diver suffered a catastrophic flooding of their drysuit. The dive was aborted immediately, but as the pair had 30 min of mandatory deco to complete, they decided to complete as much decompression as the diver could endure. The diver also switched on their heated vest to try and compensate for the loss of body heat. All decompressions stops were cleared and the dive concluded without further incident, with a total dive time of 78 min. The group aboard the boat decided to cancel a second dive and return to harbour where the diver removed their drysuit. Due to the speed of the boat returning to harbour the diver decided it was preferable to remain in their suit with the heated vest switched on, rather than experience additional wind chill. Back in harbour the drysuit was inspected and it was found the locking ring on the quick release neck seal had unseated causing the seal to become partially detached and flood the suit. The diver seemed fine for 3 hours after the flooding, however during the drive home they showed signs of suffering from hypothermia. Two days after the incident the diver developed a fever and a cough and contacted their GP and subsequently made a full recovery. Water temperature on the day was 16 deg C.

July 2025 **25/074**

A student was being led by their instructor on a second open water training dive at a depth of 6m. Whilst practising regulator retrieval the student had a small free flow from their demand valve whilst breathing from their own AS to practise the skill. The slight free flow was able to be controlled by holding the mouthpiece facing down, and so the instructor continued with training. The instructor demonstrated the full recovery sequence. The student was a little nervous about removing their regulator fully and so the instructor had their AS ready for donation should

(continued) it be necessary. As the student removed their regulator it started to free flow. The instructor provided their AS and then attempted to stop the free flow but was unable to do so. The instructor started to try and reach for the cylinder valve to close it, but the student was looking confused and anxious and so the pair made a controlled ascent direct to the surface from 6m. On surfacing the student's BCD was inflated before turning off the cylinder, at which point the contents gauge was reading zero. The pair were around 30m from the shore and so they both swam on their backs to the nearest exit ramp, with the student continuing to breathe from the instructor's AS. On inspecting the equipment there was no obvious reason for the free flow. The regulator and cylinder were isolated for further inspection and servicing as necessary.

August 2025 25/078

A diver was accompanied by a buddy on a wreck dive from a RHIB to expand the diver's experience. They descended the shotline to a depth of 20m and explored the wreck. After approximately 8 min they signalled their buddy that they had difficulty breathing. The buddy noted the diver was starting to show signs of panic and took hold of them to reassure them. The diver then started to ascend and the buddy followed, the ascent was faster than usual but not rapid, and the pair surfaced with a total dive time of 10 min. On surfacing the diver explained they were struggling to get a full breath and had panicked. Both divers were recovered aboard the boat. On inspection of the diver's equipment, it appeared that the chest strap was far too tight, preventing the full movement of the chest rise and consequently full lung capacity. The diver stated they had tightened it underwater as the BCD compressed. The strap was loosened and a subsequent dive to 15m was conducted without incident.

August 2025 25/079

A diver and two buddies started a dive to wreck in 25m from a RHIB. As they descended, at about 5m, the diver's BCD inflator stuck open when pressed to inflate. The diver disconnected the hose and signalled the other two divers, and all surfaced where the diver was recovered to the RHIB before the other two continued with the dive. On inspection on the boat the BCD inflator was found to not be screwed all the way. The fault was fixed and the diver conducted a second dive without incident. The equipment was

subsequently checked again and no remaining issues were found.

August 2025 25/088

Two divers were diving a wreck at a maximum depth of 15m when one diver noted that their BCD was not holding gas. The diver, with assistance from their buddy, made a controlled ascent to the surface where they were recovered aboard the dive RHIB. On inspection, the inflator valve had developed a crack in it.

September 2025 25/102

Following a drift dive to a maximum depth of 9m a diver deployed a DSMB using their AS to inflate. After deployment the diver's AS started to free flow and attempts by both divers failed to stop it. The pair started their ascent immediately but the diver was unable to slow their ascent for a safety stop and ascended direct to the surface, arriving with little or no gas remaining. The buddy had stopped and completed their safety stop observing the diver at the surface.

SYNOPSIS · UK



Illness or injury-related incidents

53 injury or illness incidents in 2025

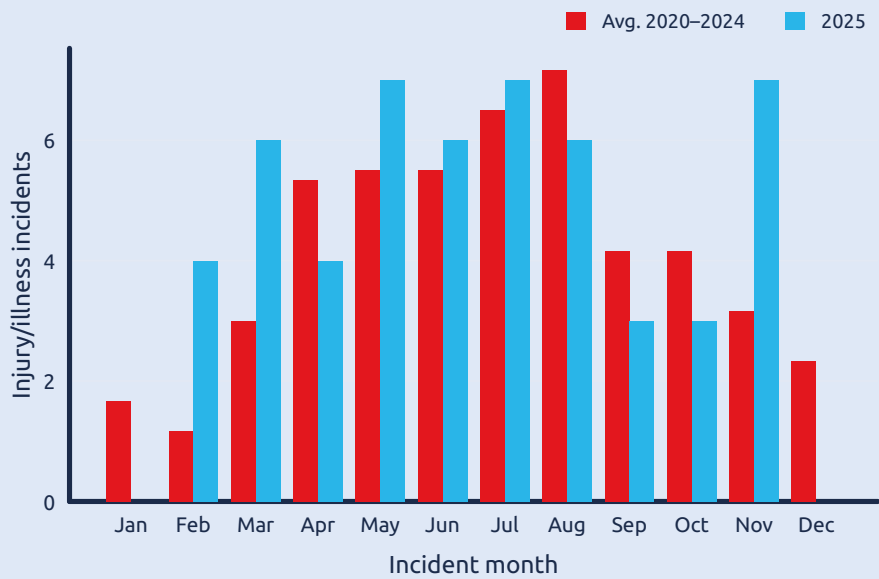


Figure 26
The month of occurrence of injury or illness-related incidents



February 2025**25/004**

A student and an instructor had completed a dive earlier in the day to a maximum depth of 30m for a total dive time of 28 min. After a surface interval of 186 min the pair commenced a second dive to a maximum depth of 25m for a total duration of 22 min. The student had been conducting a dive leading exercise, leading an experienced diver, with the instructor simulating the role of the experienced diver. The dive was uneventful until reaching a safety stop where the student experienced slightly floaty feet. The student held onto a rock and carried out two inversion drills and other than slight exertion experienced no ill effects or ascent at all. The pair surfaced and exited the water and, after approximately 10 min, the student began to feel sick and slightly nauseous and then vomited several times. The student explained that they had been suffering from indigestion and had not eaten or drunk much all day. The student was placed on oxygen as a precaution and given water to drink along with biscuits and bread. A duty doctor at a hyperbaric chamber was contacted for advice, and they were advised to stop oxygen but continue with food and drink.

February 2025**25/222**

A site rescue team responded to a diver in the water who was cold and in difficulty.

February 2025**25/007**

During an instructor training course in a swimming pool, following a demonstration of a simulated exit into a boat by an instructor, one of the students mimicked but as they placed their hands on the side of the pool and pushed up one of their hands slipped on the wet tiles and they landed on the side of the pool injuring their side and ribs. The student was winded and felt their side was tender but there was no sign of bruising or marks and the student was able to continue with the pool session. The student was checked again at the end of the day and again two days later to find they had contacted 111 the following day as the injury was painful but they were advised not to go to hospital but to take ibuprofen and paracetamol for the pain.

February 2025**25/014**

Two people, who were qualified divers with CPR training, were cycling in a city and as they approached

a junction they saw a pedestrian fall to the pavement. Other pedestrians were just standing around and so the pair called an ambulance and placed the person in the recovery position. The casualty started fitting so they monitored them and when the fitting ceased checked for a pulse but did not find one and so started CPR until an ambulance arrived. The pair passed on details to the ambulance crew who applied a defibrillator and then transported the casualty away in the ambulance. Two weeks later an ambulance dispatcher contacted the pair to inform them that the casualty had survived and had called to thank them.

March 2025**25/008**

Two divers completed a dive to a maximum depth of 6m for a total duration of 50 min without incident. 20 min after surfacing one diver felt faint and then fainted and as they fell hit their head, suffering a small cut to their forehead but recovered consciousness immediately. The diver attended the on-site first aid room and the diver had a dressing applied and was given oxygen for 8 min before being released, with advice to visit A&E due to the head injury. The individual was found not to have eaten or drunk anything that day and had smoked a cigarette after the dive.

March 2025**25/009**

Prior to the start of an instructor training event in open water a student notified the lead instructor of their prior medical conditions and confirmed they had a medical fitness to dive certificate obtained subsequent to the conditions. Following two training dives, the first to 2m for 13 min and, after a surface interval of 48 min a second to a maximum depth of 5m for a total duration of 17 min. The course then broke for lunch. After ten min the student's group instructor informed the lead instructor the student was not feeling well. The lead instructor asked the student how they felt and they reported they were feeling faint and nauseous and looked pale. They were laid down and someone was sent to the site office to inform staff and ask for an ambulance to be called. The student's symptoms deteriorated to include blurred vision, dizziness, and a pulse of 119 despite lying down, their cheeks were very flushed and their skin pale. The student was placed on oxygen and monitored whilst awaiting an ambulance. The ambulance arrived and following a handover the student was transported to hospital where they were

assessed, including a CT scan, and discharged the same day but referred to a specialist.

March 2025**25/011**

A snorkel diver had been swimming in a pool during a club pool session, but after a couple of lengths they got out and went into the changing rooms. Shortly after a club member who also worked as a lifeguard notified the pool supervisor that someone had collapsed in the changing room. The pool supervisor and two other members of the group, one of whom was a doctor and the other a nurse, entered the changing room to find the snorkel diver unconscious and not breathing on the tiled floor. The doctor took control and commenced BLS, whilst the nurse started chest compressions and the pool supervisor went to get an oxygen set and AED unit. The oxygen sets were found to be away for servicing but the AED unit was brought, only to find the pool staff had brought their AED. The casualty had received 4 rounds of CPR and the AED pads had been placed. The AED advised a shockable rhythm and two shocks were delivered before CPR was continued. The casualty's pulse returned and they slowly started gasping for breath so resuscitation efforts were stopped. Shortly after the casualty began to vomit and so was rolled into the recovery position as they were breathing but still unconscious. An ambulance and paramedic doctor arrived and stabilised the casualty then transported them to hospital.

March 2025**25/015**

Following a shore dive on a wreck to a maximum depth of 8m for a total duration of 10 min a diver was exiting the water when they twisted their leg causing severe pain. They were assisted from the water by the shore party who had quickly rushed to assist. The diver later attended A&E where they were confirmed to have a torn meniscus on their left leg.

March 2025**25/028**

A trainee diver was kitting up prior to a training dive when they felt dizzy and decided not to dive.

March 2025**25/019**

A diver had organised a trip for a group of divers on a liveaboard offering the opportunity to dive wrecks and deep walls. The diver claimed to have a MOD2 qualification for their rebreather and regularly spoke during the trip to two experienced rebreather divers

about wanting to complete some deep dives during the trip. The two experienced divers made clear they were not interested in joining in such activities, in part because they did not have the correct diluent mixes available. On the second day of the trip the group had completed a wreck dive earlier in the day. The group then prepared to dive a wall and the diver said they would join two of the group to dive, then bounce down and then rejoin the pair on the wall at about 30m. The pair surfaced in due course but the diver was not with them. The group and skipper started to look for signs of the missing diver, who was using a rebreather, and whilst searching another dive vessel called to ask if one of their divers were missing. The diver's DSMB was down tide and over 1 nm away from the dive site, drifting in the channel. The dive boat travelled to the location and monitored the DSMB and after just over an hour dive time, noted bubbles coming up, assumed to be a sign of a rebreather diver ascending. The bubbles continued and at 80 mins, the two experienced rebreather divers agreed that the bubbles should not be continuing and the diver should have surfaced by then. One of the divers kitted up again and entered the water as a support diver, and swam over to the DSMB line, and noted the DSMB was not fully inflated. The support diver then descended the line and on reaching the diver asked if they were OK. They looked confused and not 'with it'. The support diver then asked how much deco they still had to complete and were showed the diver's computer, which indicated 37 min of required decompression stops, and the rebreather was running at a PO2 of 1.0 bar. The support diver signalled to push the PO2 to 1.6 bar to allow them to clear sooner, but was then shown the contents gauge for the O2 cylinder that was almost at zero. The support diver asked if the diver wanted additional O2 getting and they indicated 'yes'. The support diver surfaced and requested an additional cylinder of O2. The support diver got onto the dive lift and requested their own spare O2 cylinder they used for deeper dives, but when this was turned on by the skipper the valve did not seem to operate properly. Another cylinder was found to be empty, but eventually another was found and clipped onto the support diver's harness. The support diver entered the water again and descended to find the diver at 6m, where they were turning their nitrox 50 cylinder on and off. The regulator first stage was leaking from both the body and the plug inserts, indicating it had failed. The diver's oxygen cylinder had run out about that time but the diver kept trying

(continued) to inject oxygen from the empty cylinder. The support diver then plugged in the additional cylinder of O₂ they had brought, then indicated to the diver to push their PO₂ to 1.6 bar, but again the diver just looked confused. The support diver then manually injected oxygen whilst monitoring the O₂ pressure on the rebreather handset, but it would not rise above 1.2 bar. The support diver thought this indicated either a flooded loop or the oxygen cells had water on the membrane. Whilst this was happening underwater, a second support diver had kitted up, and was given a 2m long DSMB by the skipper. The second support diver entered the water intending to the inflate the long DSMB and then attach it to the diver's now limp DSMB. As the second support diver jumped into the water the diver's DSMB disappeared from the surface. The diver had fallen unconscious and was negatively buoyant and started to sink. The first support diver tried to keep hold of the diver, but their rebreather was sounding an alarm and their head up display was showing two flashing red lights. The support diver tried to hold on whilst inflating their wing but the pair were dropping rapidly. The support diver was aware that they were in a channel approximately 100m deep and at a depth of 20m they were unable to retain their grip, due to mask and suit squeeze, and pain in their ears, and let the diver go, then noticed the diver's DSMB pass in front of them. The support diver surfaced and was recovered from the water, where they reported that the diver had gone. A minute or two passed, when the diver suddenly surfaced right next to the boat. The diver was coughing up water but managed to get onto the dive lift and was recovered aboard. The diver was de-kitted and then sat down and placed on oxygen. One of the other divers was a doctor and took over management of the oxygen and care for the diver. The diver was then helped out of their drysuit and their skin checked for signs of a rash, and also provided them with water to drink, whilst the boat made best speed to harbour. The diver's computer was checked and it showed the diver had gone to 101m and had missed between 15 and 30 min of stops, using a very conservative gradient factor. The dive profile showed that the diver had made an initial continuous descent over 10 min, direct to 100m, then a slow ascent to 90m over two min, before a rapid ascent to 70m, followed by a rapid descent back down to 92m. Shortly after the diver made a further rapid ascent to 30m before making a slower controlled ascent, eventually reaching 6m stop depth about 65 min into

the dive. The diver stayed around the 6m level until 1 hr 50 min into the dive where the profile shows them making a steady descent to around 30m, where they stayed for around 2 min before making a fast ascent to about 6m and then a further fast ascent direct to the surface around 2 min later. The diver's rebreather was checked and the breathing loop was found to be full of water and, after stripping it further, the scrubber canister was also full of water. Once ashore the diver was handed over to paramedics, who transferred the diver to hospital, where they were assessed and kept in for observation, but told if their condition deteriorated, they would be transferred to a recompression chamber. The diver could not remember anything about the latter stages of their decompression before they found themselves on the seabed at a depth of around 30m, at which point they panicked and made a buoyant ascent to the surface.

April 2025

25/022

A RHIB had arrived on site for a dive, and the first pair of diver began to kit up. One of the divers had a knife in a neoprene stitched to the leg of their semi-dry suit. As the diver pulled on the spring fin strap their hand jerked upwards and pushed against the sheath causing the point of the knife to pierce the neoprene sheath and make a deep puncture wound in the diver's hand, which then bled profusely. The wound was dressed and the diver sat down on the deck of the RHIB in a stable position and with their arm raised. The planned dive was aborted and the RHIB returned to harbour to allow the casualty to be taken to hospital for treatment. The diver was treated at the hospital and the wound closed with three steri-strips and then released home.

April 2025

25/023

On a first dive of the first day of a dive trip, a diver was under-weighted and struggled to leave the surface. The boat crew passed an additional 2 kg but they were still unable to sink and so an additional 2 kg was provided. During the dive the diver continued to struggle with their buoyancy and the dive was aborted having been to a maximum depth of 14m for a total duration of 14 min. After a surface interval of 196 min the diver dived again and completed a dive to a maximum of 12m for a total duration of 45 min including a safety stop at 6m for 3 min. After returning to their hotel and showering the diver noticed the start of some bruising and bloodshot eyes below their lower eyelids, consistent with mask

squeeze barotrauma. The diver's vision was unaffected and there was no discomfort. The diver did not dive again during the trip and was advised to have their eyes checked by a GP or an optician on their return home.

April 2025

25/024

Two divers descended to a maximum depth of 33m. Towards the end of the dive the pair became separated due to the poor visibility caused by disturbed silt. Each separately carried out a brief search for the other and then ascended at a normal rate to a safety stop at 6m. One diver cut short their safety stop to surface and look for signs of their buddy, whilst the buddy completed their stops and then surfaced. The diver recorded a total dive time of 30 min, whilst the buddy recorded 35 min. As a precaution the diver, who had skipped some of their safety stop, was placed on oxygen and the group had a 120 min surface interval before driving to altitude on the way home. The following morning the diver had an ache in one of their elbows and so was advised to call a hyperbaric centre for advice. The duty doctor advised there was no need for recompression at that time and would call the diver the following day. On calling the next day the diver reported that the ache had resolved and there were no new symptoms.

April 2025

25/135

A diver had descended to a maximum depth of 15m. Towards the end of the dive at a depth of 5m, the diver's regulator was knocked from their mouth causing damage to a tooth. The dive was completed to a maximum depth of 15m with a total duration of 47 min. The diver subsequently made a dental appointment.

May 2025

25/033

An inshore lifeboat was launched to attend to a diver in difficulty just off the shore. The lifeboat crew recovered the diver and returned the casualty to station where they were met by Coastguard rescue teams, a rescue helicopter paramedic, an enhanced care paramedic and two ambulance crews. The diver was stabilised and transferred by ambulance to an airport, where the rescue helicopter was waiting to transfer the casualty to hospital. (RNLI report).

May 2025**25/041**

Two divers commenced a dive by swimming out on the surface from the shore. One of the divers appeared to be tiring and struggled to maintain both direction control and speed. The pair rested at a stanchion to allow the diver to get their breath back. The diver seemed anxious and their buddy checked if they wanted to proceed and received an OK. The pair attempted to descend to a depth of 2m but the diver struggled to maintain depth and surfaced. The diver had difficulty with their mask leaking and the buddy noticed that the mask seal was partially over the diver's hood and corrected it. The pair tried descending again but then resurfaced as the diver was getting water in their mouth. The buddy identified that the diver was not fully forming a seal around their mouthpiece. The pair then descended again and conducted a dive to a maximum depth of 8m. After 14 min the buddy checked gas contents and found the diver had 120 bar remaining and so the buddy signalled they should turn around and head back towards the shore. At around 20 min and at a depth of 7m the buddy turned to see the diver suddenly make an uncontrolled ascent direct to the surface. The buddy ascended at a slower rate, but still triggered an alarm on their computer, and omitted safety stops. On surfacing the buddy swam over to the diver and supported them whilst fully inflating their BCD and tried to calm them down. The diver was waving their arms and struggling to remove their hood from around their neck. The buddy instructed the diver to remove their regulator to enable them to breathe easier and tried to calm them down and slow their breathing. The diver's breathing rate slowed slightly but they were still agitated. The pair were drifting offshore and so the buddy advised the diver to lie on their back so that they could tow them back to shore, a distance of 150-200m against a building current. After around 12 min of towing the pair were able to grab hold of a stanchion and the buddy signalled to the shore cover by waving their DSMB and blowing a whistle, and the shore party responded by alerting the emergency services. A Lifeboat was tasked from a nearby lifeboat station and was on scene within 10 min and recovered the diver from the water and returned to the lifeboat station where the diver was handed to the care of the emergency services. The diver was taken by ambulance to an airport where a helicopter transported the diver to hospital and subsequently, they were referred to a hyperbaric chamber where they received a precautionary

treatment. The diver remained in hospital for eight days.

May 2025**25/035**

A diver, using a rebreather, was diving a wreck at a maximum depth of 31m. Towards the end of the dive the diver started to feel uncomfortable breathing. The diver signalled their buddy to ascend and deployed a DSMB, whilst breathing heavily and coughing. The diver felt a gurgling in their chest and had to stop several times to cough, including closing the loop and coughing whilst off the loop. A slow ascent had cleared the limited amount of decompression they had incurred and they surfaced. Once alongside the boat the diver had difficulty detaching their equipment, and once aboard they continued to cough, with a gurgling chest. The diver went back onto their rebreather and manually added oxygen to maintain a high concentration of oxygen to breathe whilst waiting for diving to finish and all divers to be recovered before returning to shore. Once ashore the diver called a diver helpline for advice and a doctor called back and diagnosed immersion pulmonary oedema (IPO) and advised the diver to get checked out that evening. The diver saw a doctor who confirmed the diagnosis of IPO.

May 2025**25/295**

The Coastguard responded to a diving vessel, which had a diver aboard in need of medical assistance. (Coastguard report).

May 2025**25/091**

A diver used their full open water equipment during a regular club training session. At some point during the training session their knife, which was strapped to their BCD, was dislodged. The following morning the pool manager contacted the club to advise that a knife had been found by pool staff.

May 2025**25/233**

A lifeboat was tasked to attend to a dive vessel that had an unwell diver aboard. (Coastguard and RNLI reports).

May 2025**25/220**

A diver was exiting the water following a training dive, when they slipped and fell, hitting their head against a rock. The diver was immediately attended to by an instructor, standby diver and an off-duty paramedic,

who stabilised the diver's head and removed their equipment. A student was sent to the site-office and the site-rescue team dressed a wound to the diver's forehead with sterile bandages and pressure. The diver remained conscious, with no dizziness, throughout the afternoon before being driven home. The diver was advised to visit A&E, which they did and had steri-strips applied to the cut and discharged.

June 2025**25/046**

A diver and their buddy carried out a wreck dive from a RHIB, both were experienced UK wreck divers and both were using independent twin-sets, but neither had any experience of diving from a RHIB. Sea conditions were described as 'bumpy' and the diver had found their kit very heavy on the boat, which was made more difficult due to the tubes being slightly deflated. As a result the diver was over-exerted on entry to the water. The buddy indicated that they should stop at 6m on the way down to allow the diver to recover, but once underwater this was omitted and the descent was normal and the pair proceeded with the dive. The buddy noted that the diver's trim was off and their feet were down indicating potentially being over-weighted. The buddy then changed the intended plan to ascend under a DSMB, choosing to return to the shotline instead. The pair started to ascend after 25 min and took 3 min to ascend to 9m, where they conducted a decompression stop for 2 min before ascending to their second decompression stop at 6m for 9 min until their computers cleared and they added an additional safety stop for 3 min. The pair surfaced with a total dive time of 42 min to a maximum depth of 33m. Back aboard the RHIB the diver complained of a headache, which had started during the safety stop and persisted on the boat. This had been a recurring problem since they had purchased a new drysuit and so the buddy helped the diver remove the suit and others aboard offered them a stage cylinder of nitrox 80 to breathe. The drysuit was donned again for the return journey and the headache slowly dissipated. Later in the afternoon the diver took a short nap due to poor sleep the night before and the early start. On waking the headache had returned more intense than previously and they were provided painkillers and advised to visit a recompression chamber. They were provided oxygen to breathe during the 90 min car journey to the chamber, where they were examined and found to have no evidence of DCI and it was suggested that the combination of tight neck seal, overexertion and poor

sleep contributed to a CO2 build up during the dive, which may have resulted in the headache. The diver was discharged the same day and has experienced no recurrence of symptoms since.

June 2025**25/139**

During descent a diver suffered sinus pain at a depth of 4m and aborted the dive.

June 2025**25/076**

Two divers were on a dive to a maximum depth of 22m. Around 30 min into the dive the pair practised DSMB skills, when an unknown event occurred leading to one diver lifting the other using a controlled buoyant lift. During the ascent the rescuer inadvertently closed the casualties auto dump on their suit resulting in an uncontrolled ascent direct to the surface. On surfacing the alarm was raised and the casualty was recovered by the site rescue boat. Once ashore the casualty reported tingling in their finger and was placed on oxygen and monitored. When the tingling returned a recompression chamber was called and the diver was advised to attend to be checked over.

June 2025**25/075**

A diver and their buddy had descended to a maximum depth of 35m without difficulty. They slowly ascended back to 22m, when the diver became disoriented and signalled that they wanted to ascend. The diver had accrued 2 min of decompression stops but these cleared during the ascent. On surfacing the diver called for help and on recovery to a rescue boat complained of tightness in the chest. Once ashore the diver was escorted to a first aid room and placed on oxygen, where they started to feel better but was still complaining of tightness in the chest. The diver explained they had suffered a similar event in 2022, which was found to be due to a heart problem, but this had not been previously disclosed. An ambulance was called and the diver taken to hospital for further investigation.

June 2025**25/219**

A diver had difficulty clearing their ears whilst descending to dive a wreck from a boat. The diver ascended until their ears cleared and they were then able to descend and complete the dive to a maximum depth of 24m. After surfacing a small amount of blood was noticed in the diver's ear, and by mutual

(continued) agreement the diver sat out the second dive. The diver went to a doctor for a check and was confirmed to have perforated their eardrum.

June 2025

25/057

Two divers had completed a dive earlier in the day to a maximum depth of 23m for a total duration of 33 min including a safety stop of 3 min at 6m. After a surface interval of 240 min the pair entered the water from a dive boat for a wreck dive. They descended the shotline and located the wreck, then followed the side of the wreck looking at sea life. The less experienced diver had agreed to lead the dive and to signal their buddy when they had reached 160 bar remaining to turn back. It was agreed that the buddy would deploy their DSMB for the ascent. As they reached the end of the wreck the lead diver signalled they had 160 bar remaining and signalled to return around the other side of the wreck. The buddy signalled to ascend and the diver thought this was an indication to ascend onto the deck of the wreck and return that way, there were no signs of distress or symptoms. When they reached the deck, the buddy signalled to ascend and was opening and closing their hand which the diver did not understand. The diver asked if the buddy was OK and received a signal indicating that something was wrong. The diver signalled whether they should deploy their DSMB but the buddy had already prepared their DSMB and deployed it. The pair had started to ascend when the buddy started coughing and passed over the DSMB reel to the diver and then sped up their ascent from 10m ascending directly to the surface omitting a safety stop. The diver followed a little slower with the DSMB but omitted their safety stop as something was clearly wrong with their buddy. On the surface the buddy was coughing up red froth and the diver waved to the boat, but they were in the process of recovering two other divers. The diver tried to reassure their buddy and continued to wave at the boat. The buddy seemed a bit breathless and was saying they "couldn't do this". The diver told the buddy to take some deep breaths and gave them the DSMB to relax on whilst the boat came for them. The buddy was recovered from the water, and they continued to feel unwell and was still bringing up red frothy fluid. The buddy was offered oxygen to breathe but as they were continuing to struggle to breathe and coughing up fluid they declined. Once ashore they continued to cough up light brown/red frothy liquid and on returning to their lodgings they were advised to contact a recompression chamber for advice but

they declined and said they would keep an eye on their condition and if there was no improvement, they would seek assistance. The next day they agreed not to dive as they were nervous and their cough, though reduced and no longer productive, was still present, and so they crewed on the boat instead. The buddy was subsequently advised they had suffered from Immersion Pulmonary Oedema (IPO). (linked to 25/058).

July 2025

25/143

A diver suffered sinus pain at a depth of 1m on descent and aborted the dive.

July 2025

25/062

Following a snorkel training dive, a snorkel instructor returned in a boat to the slipway they had launched from. The snorkel instructor had walked along a dry area of the slipway, then walked below the waterline to recover some equipment and slipped on the seaweed covered surface then fell, fracturing their right wrist and caused a slight bump to the head. The Coastguard was contacted and tasked an ambulance to transfer the casualty to hospital for treatment.

July 2025

25/218

At the end of a day's diving a diver reported ear problem. The diver was recommended to consult a doctor.

July 2025

25/063

A student had attended a previous training day and felt dizzy whilst kitting up and so chose not to dive (linked to 25/028). On a subsequent training day the weather conditions were very hot. The diver had donned their drysuit but had difficulty kitting up, complaining of being hot and tired, requiring frequent pauses to recover. Before fitting their scuba set, they reported feeling dizzy and wanted to go into the water in their drysuit to cool down. Accompanied by their instructor the student lay down in shallow water, with the instructor holding onto their drysuit. A short while later the student reported feeling better and was helped to stand up by the instructor. As soon as the student was upright, they fainted, falling over into shallow water at the edge of a slipway. The student regained consciousness almost immediately and was helped by the instructor up the slipway as others came to assist. The student was sat on a wall and their pulse was checked by a retired nurse and found to be

very weak. After a short rest the student was assisted to walk through the car park, but could not do this without stopping for breath. The on-site staff were alerted and the student taken to the first aid room. The student decided not to dive that day.

July 2025

25/183

A student had completed a training dive for twin-set diving earlier in the day and demonstrated competence using a manifolded twin-set configuration. The instructor agreed with the student that for the subsequent dive, following completing further drills, they would use rest of the dive to progress the student's experience of diving at depth. The dive commenced conducting training dives at a depth of 15m and these were completed with ease by the student. The student then agreed to conduct the depth progression and the pair descended to a maximum depth of 35m, exchanging signals every few metres. As they began to make a slow ascent up the slope, at a depth of 32m the student suddenly gave a frantic signal, which the instructor did not understand. As the instructor approached the student went limp and rolled onto their back, and as they approached closer the instructor realised the student was unconscious. The instructor was alarmed and grabbed the student and started to fin upwards raising them both, with the student still unconscious but breathing. At around 20m the student opened their eyes but it was not until they reached a depth of 5m that they regained full awareness. Once at the surface the instructor towed the student to the shore. During a debrief, the student explained they had a poor night's sleep the night before and they had in childhood suffered from blackouts and fainting spells, but had not experienced these in many years. The student was advised to see a diving doctor to discuss the blackouts.

July 2025

25/106

Three divers completed a first dive on a wreck from a charter vessel to a maximum depth of 14m for a total duration of 42 min, including a safety stop at 6m for 4 min. After a surface interval of 185 min the three undertook a second dive on a different wreck and descended to a maximum depth of 20m. After around 20 min at a depth of 19m one diver indicated that something wasn't right to the lead diver. The lead diver stopped and looked at the diver's face and saw it appeared that the diver was about to release or spit out their regulator. The diver seemed 'out of it' and

the lead diver took hold of them and gently held the regulator in their mouth. The third diver then noticed there was a problem and the lead diver indicated for them to deploy a DSMB. The diver meanwhile once again seemed to be losing the regulator from their mouth and so the lead diver once again gently replaced it, whilst the third diver successfully deployed their DSMB. The group then started to ascend quickly to 7m before descending to 10m again to regain control. By this time the diver seemed to be more responsive and was controlling their own buoyancy. They then ascended to 6m and conducted a safety stop for 4 min before ascending to the surface and waited for the boat to collect them. The diver was monitored on the boat and it was suggested that someone else drive them home. The diver told the lead diver that they had a sense of anxiety on the dive and felt like they could not get enough gas and they felt they needed to spit the regulator out. The diver subsequently explained they previously suffered from anxiety attacks but had not experienced an episode for around three years. The diver has since consulted a diving doctor.

July 2025

25/182

A diver and their more experienced buddy, who was using a rebreather prepared to dive but the diver jumped into the water before doing a buddy check or a proper briefing. The diver suffered a regulator free flow, which reduced their cylinder contents to 170 bar in a 12 ltr cylinder. The planned dive was going to be shallow so the pair decided to proceed. The more experienced buddy monitored the diver's gas consumption, and was surprised at how quickly it was being depleted and so decided to turn the dive early and head towards the exit point after a few min. However, whilst some distance from the exit point the cylinder contents had decreased further to 50 bar so a signal to surface was given. The diver then made a faster than normal ascent direct to the surface, omitting a safety stop. The buddy could see the diver on the surface starting to swim off and so surfaced at a safe rate to the surface. On surfacing the buddy could not initially see the diver but then heard them calling after a few min. The diver seemed OK but was swimming towards the shore to an area where the exit would be very difficult as it had high rocks with waves breaking. The buddy shouted not to attempt landing there and to swim back out to sea, but there was no response from the diver as they had started to climb the rock face and was being pounded by the

(continued) waves. The buddy did not want to get too close to the rocks for fear of being pushed onto the rocks by the breaking waves, but eventually the buddy swam within 3-4m of the shore and convinced the diver to enter the water again and swim out. The pair then made their way back to the correct exit point on the surface. At the exit point the buddy had to assist the diver by removing their fins and then their BCD with cylinder. The diver's equipment was undamaged but they suffered some bruising whilst trying to climb the rock face in the breaking waves.

August 2025 25/095

Three divers entered the water for a shore dive in good weather conditions and no surface swell. Underwater they experience 4m visibility and no sign of any current. The group followed a compass bearing for an agreed time of 20 min, then followed a new bearing to return to the planned exit point. After a further 20 min following the new bearing, it was evident that the water depth was not reducing and the lead diver signalled to ascend and the group ascended, completing safety stops at 6m for 3 min and surfaced with a total dive time of 51 min and a maximum depth of 17m. On surfacing it became evident that there was a tidal current and they were approximately 200m from their intended exit point. There was also a strong breeze that had developed making the surface water conditions choppy. The group had also drifted to an area that was out of view of the shore cover. The lead diver signalled the group to swim to the exit point but one diver swam inshore and was caught by the waves forcing them closer to the shore. The diver tried to exit the water onto rocks but there was no viable exit point. Wave action then forced the diver onto the rocks and they struck the back of their head on the rocks whilst struggling to get out of the water. The other two divers went to try and assist but were unable to due to the wave action. The injured diver then de-kitted and climbed approximately 25m up a cliff and called for help. Help arrived quickly and helped the remaining two divers to exit the water safely with assistance and without injury. Medical advice for the injured diver was sought by calling 111, who advised seeking further medical help. The diver declined but agreed to self-monitor and advise if they felt unwell. The following day the diver reported no issues and no further medical intervention was necessary.

August 2025 25/077

A diver had completed a dive to a maximum depth of 30m for a total duration of 40 min. The diver was recovered aboard a RHIB with their buddy and returned to harbour. Whilst divers were unloading their kit in the car park, the diver leaned against the RHIB head first and then passed out. The diver was lowered to the ground with a backpack under their head and their wetsuit was loosened. The diver recovered consciousness within a minute and their awareness to time and place were checked, all OK as was their vision and strength. The diver wanted to stand immediately but they were kept prone for 10 min. Once standing the diver had no issues but was helped to load their car and was driven home by another member. The diver attributed the incident to dehydration, an early start, no breakfast, no fluids whilst aboard the boat and possibly a tight wetsuit. The diver was advised to refer to both their GP and a diving doctor before diving again.

August 2025 25/283

The Coastguard responded to reports of a diver in need of medical assistance. (Coastguard report).

August 2025 25/180

A student on a training course was at a depth of 14m when they started to panic. The group were moved to the bottom of a wall, at which point the student took their buddy's AS. The student felt they were getting water whilst breathing from the AS and as the pair made their way up the wall, at a depth of 10m, the student made a rapid ascent direct to the surface. On surfacing the student shouted for help and they were recovered from the water by the site rescue team. The diver was administered oxygen and was monitored by their dive school.

August 2025 25/179

A diver had descended to a depth of 20m, when they felt uneasy. The diver made a slow ascent with their buddy up to 9m, where the diver felt their regulator was giving them water. The diver's unease escalated to panic at that point and they bolted for the surface. The diver's buddy slowed their ascent up to 6m but the diver then made an uncontrolled ascent to the surface, followed at a slower rate by their buddy. The pair were joined shortly after by the rest of their group. On exiting the water the diver reported feeling shaky but said they knew it was due to adrenaline. The

diver was taken to a first aid room where they were administered oxygen before being released into the care of their club.

August 2025 25/096

Following a first dive from a charter vessel, a diver became unwell. The group had confirmed with the charter boat skipper that oxygen was available and so the group decided to leave their oxygen equipment ashore. When the diver became ill however, it was found that there was no oxygen aboard. A call was made to the Coastguard who arranged a helicopter to evacuate the diver to a recompression facility for assessment. When the helicopter arrived, the winchman was able to provide oxygen to the casualty, whose condition then improved. The diver was airlifted to hospital and was assessed by dive medics, who determined no immediate action was necessary and the diver was discharged the next day after making a full recovery.

September 2025 25/161

During a sheltered water training session a student was unable to clear their ears. The dive was aborted and the student was unable to complete the course.

September 2025 25/100

A diver and their buddy surfaced after an uneventful dive to a maximum depth of 17m and a total duration of 43 min, including a safety stop at 6m for 3 min. The diver reported feeling dizzy and having a fast heart rate. Further symptoms of 'pins and needles' and tingling in both hands and arms developed over the next 10 min. The diver was administered oxygen in three sets of 5 min on 5 min off, after which the symptoms abated. The Coastguard was contacted as a precaution and they advised the diver should be evacuated from site. A helicopter was unable to assist due to weather conditions and so the diver was transported by ambulance to hospital. Examination identified no diving related illness but found some abnormal blood readings and the diver was kept in under observation that night then discharged the following day.

September 2025 25/105

A diver was attending an instructor examination and had briefed all present that they had had both hips replaced, which meant they couldn't move their legs too far to the side and needed to be pulled in a

straight line to be hauled aboard a RHIB. They also advised that they had hearing aids, which needed to be removed whilst diving and meant that they were almost deaf without them and so needed to be directly facing the person speaking. Before departing the marina there was some confusion over who was on each boat, which entailed shuffling equipment around on the pontoon. The diver experienced difficulty hearing instructions and tripped over someone's kit. The boats then travelled to the first dive site and two waves of divers were deployed. Weather conditions were steadily deteriorating, but the diver and four others completed a dive to a maximum depth of 10m for a total duration of 31 min. On recovery to the RHIB the crew member did not pay attention to the instruction not to pull sideways on the diver's leg and started to do so, but the diver was able to stop them. The boats then started to travel to the second dive site, but took a route outside the breakwater in increasingly worsening sea conditions. During the passage hitting one wave caused the diver to bounce off the tubes and land in a position that forced their right leg outwards pulling on their artificial hip causing severe pain on the right side of their body. The diver did not know the extent of the injury and so took no further part in the exam.

October 2025 25/184

A diver had not dived for 10 months due to a lack of confidence following suffering from DCI some time previously. The diver joined a trip, intending to teach the dry components of the course, whilst others taught in water. At the end of the course a fellow diver offered to accompany the diver on a carefree shallow dive to 6m. After some initial hesitation the diver agreed, although whilst getting into their suit noticed it seemed to be a tight fit. The dive went without incident, although the diver noted that their left arm felt constrained even after adjusting for suit squeeze. After the dive the diver experienced some soreness in their upper right arm. During the night the diver was woken twice by loud snoring and after the second waking did not sleep for the rest of the night. The diver chose not to dive the next day but after some persuasion from their buddy from the previous day, agreed to conduct a dive to a maximum depth of 9m, which again passed without incident, although the right upper arm pain persisted. The diver travelled home the following day. Before leaving the diver told their host that they felt soreness in both arms and one wrist, and that these were the same

(continued) symptoms they had experienced when they were treated for DCI previously. However, considering the depths they felt it was more likely to be muscle strain associated with ill-fitting equipment. The following day the diver phoned the recompression chamber they had been treated at previously, but the duty doctor was not available and the chamber staff insisted that any abnormalities after a dive should be assessed at a chamber. The diver argued that an unnecessary treatment would not be beneficial for their mental health, but they reluctantly agreed to travel to the nearest facility. The diver was assessed and was recompressed for approximately 5 hours and a further 2 hour treatment the following day, with no resolution of symptoms. The diver was advised to refrain from diving and flying for six weeks and seek a new approval from a medical referee. When the diver argued that the non-resolution of symptoms did not support suffering from DCI and therefore did not justify such a lay-off or re-assessment of fitness to dive the manager refused to alter their advice, and stated the advice included not diving in a swimming pool. At that point the diver broke down, having recently offered to help several clubs in the area. The chamber attendant had also suggested the diver consider having a PFO investigation, causing the further distress, anxiety and loss of confidence.

October 2025 25/296

The Coastguard responded to a diving vessel, which had a diver aboard in need of medical assistance. (Coastguard report).

October 2025 25/216

A student had previously experienced difficulty in clearing their ears during descent. On subsequent dives, after being advised to descend slowly and equalise carefully, the student noticed clearing was improving. The student subsequently reported severe ear pain, which they had not disclosed earlier, and displayed signs of possible eardrum damage. The student was advised to seek medical attention, and to consider a referral for their final dive.

November 2025 25/167

During a sheltered water training session a student was unable to clear their ears. The dive was aborted and the student was unable to complete the course.

November 2025 25/168

During a sheltered water training session a student was unable to clear their ears. The dive was aborted and the student was unable to complete the course.

November 2025 25/171

A diver was descending when, at 3m, they experienced a sharp pain behind their right eye. The dive was aborted and the diver surfaced with a total dive time of 5 min. The diver sought medical advice and was advised it was likely a sinus problem and the diver was suspended from diving.

November 2025 25/116

Following a training session, a diver exited a pool by the steps at the deep end. The area was congested with a group of the leisure centre lifeguard team, who were engaged in a training activity. As the diver made their way across the pool side they slipped and fell whilst carrying their kit and trying to negotiate the group of lifeguards. The diver banged their knee, which began to bleed. A club member who had been acting as the dive manager and lifeguard for the pool session attended to the diver, whilst another member who had witnessed the incident from the viewing gallery also rushed to assist. The second assistant moved the kit out of the way into the corridor, whilst the first attended to the casualty, assisting them to the corridor and requesting a first aid kit. Once the first aid kit was brought the diver was sat down and the injury dressed to stop the bleeding. Meanwhile the group were approached by a senior member of the leisure centre to query who was lifeguarding the continuing pool session and so the second assistant took over whilst the first continued to care for the casualty. The diver was assisted to the changing rooms and subsequently escorted to their car, where they insisted they were OK to drive themselves home. The diver was called the next day to ensure they were OK.

November 2025 25/215

An instructor and their students had completed two training dives earlier in the day. As they prepared to enter the water for a third dive, the instructor stopped to warn the group about the slippery surface as they were about to enter, then fell. The instructor managed to remove their equipment and help themselves, whilst another instructor took over the conduct of the dive. After resting overnight the

instructor went to hospital and was found to have a fracture to their fibula.

November 2025 25/175

During a sheltered water training session a student was unable to clear their ears. The dive was aborted and the student was unable to complete the course.

November 2025 25/120

Prior to a dive a diver, who was part of a group of 6, informed an instructor they might have difficulty descending. Once in the water the student had difficulty submerging and the instructor moved to assist guiding them to the shotline. The student was given the option to abort the dive at that stage but they signalled to continue. The pair descended slowly to a depth of 12m, taking 8 min to reach that depth. At depth the student signalled OK and the pair began to swim to an underwater feature, intending then to follow a line to join up with the rest of the group. Whilst following the line the diver signalled they were experiencing issues with their ears. They began to ascend, which quickly developed into a fast ascent. The instructor's computer indicated an ascent rate violation and they signalled the diver to slow down, but they did not see the signal. The diver regained control of their buoyancy at 4.5m and then descended back down to 13m without further issue. The instructor then led the diver back to the first feature and then on to the shotline to begin their final ascent. Due to the previous fast ascent the instructor's computer indicated a mandatory decompression stop at 5m for three min, which was completed. Shortly after exiting the water and de-kitting, the diver reported having a headache. They were given water by the instructor and their condition was monitored. About 10 min later the diver felt nauseous, the instructor sent someone to notify the site emergency team, whilst placing the diver on oxygen, before contacting a diver helpline for advice. The doctor spoke directly with the diver and they concluded the minor ear barotrauma was caused by a tight fitting hood and recompression treatment was not necessary. No further medical intervention was necessary.

SYNOPSIS · UK



Miscellaneous

25 miscellaneous incidents in 2025

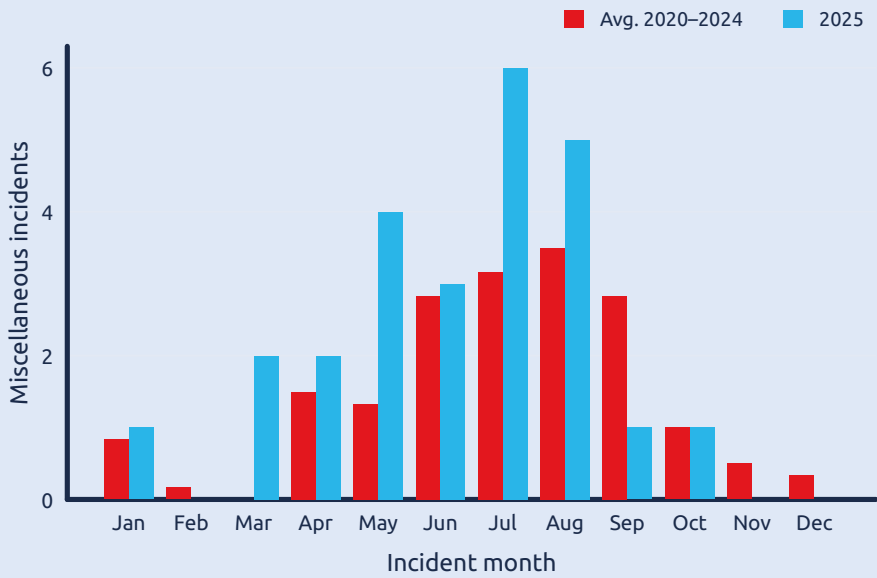


Figure 27
The month of occurrence of incidents for which there is not enough information to attribute to another category, or which were false alarms with good intent



January 2025 **25/264**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

March 2025 **25/239**

The Coastguard tasked a helicopter to assist divers. (Coastguard report).

March 2025 **25/265**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

April 2025 **25/020**

A group of four divers had completed a dive to a maximum depth of 15m. They planned to remove cylinders in shallow water at the exit point. The area was busy with 20-30 divers going in and out of the water. Two children, aged around 4-5 years old, were playing and splashing water at the edge. As they played, they started to move directly behind the de-kitting divers and were advised to be careful and step back away from the heavy cylinders being removed at their head level.

April 2025 **25/266**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

May 2025 **25/267**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

May 2025 **25/268**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

May 2025 **25/269**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

May 2025 **25/284**

The Coastguard gave accident prevention advice to divers. (Coastguard report).

June 2025 **25/270**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

June 2025 **25/271**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

June 2025 **25/272**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

July 2025 **25/273**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

July 2025 **25/274**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

July 2025 **25/285**

The Coastguard gave accident prevention advice to divers. (Coastguard report).

July 2025 **25/065**

A group of work colleagues had booked a try-dive. On the day only three turned up and following a presentation and briefing were paired up with experienced divers. One of the try-divers then claimed to be a qualified diver and said they wanted to take photographs of their friends. This was declined on the basis that no evidence of qualifications had been provided and photo release forms had not been signed. The individual was advised by the Diving Officer that a refresher dive would be more useful for them. The Diving Officer then went to attend to some equipment repairs, whilst the try-dive session proceeded. Once repairs had been completed the Diving Officer entered the pool to help support an instructor with their trainee, but then became aware that one senior diver was at one end of the pool, whilst the try-dive/refresher student they were supervising was at the other end, 25m away. The senior diver then surfaced and was advised to return

to their charge. After the session it was found that despite being told they should not, the try-diver/refresher had been taking photographs of their friends underwater.

July 2025 **25/275**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

July 2025 **25/286**

The Coastguard gave accident prevention advice to divers. (Coastguard report).

August 2025 **25/276**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

August 2025 **25/277**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

August 2025 **25/278**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

August 2025 **25/279**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

August 2025 **25/299**

The Coastguard responded to a diving vessel, which had reported an undesignated Distress signal. (Coastguard report).

September 2025 **25/280**

The Coastguard responded to a call which turned out to be a False Alert with Good Intent - FAGI. (Coastguard Report).

October 2025 **25/287**

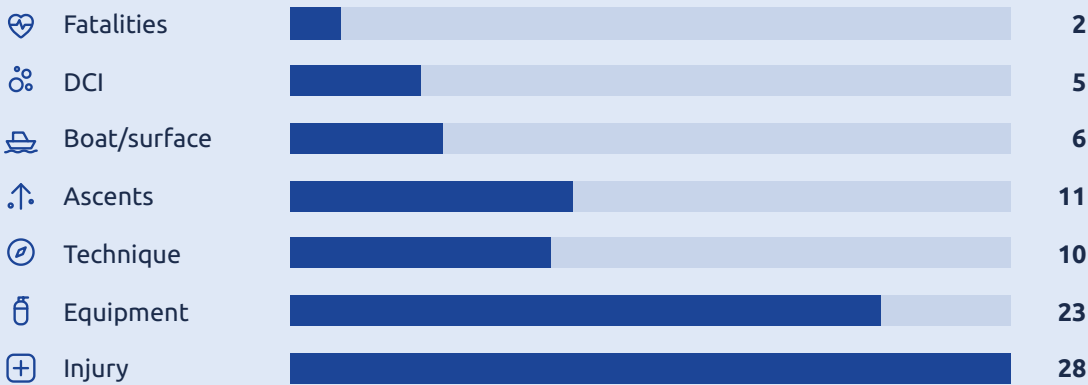
The Coastguard gave accident prevention advice to divers. (Coastguard report).

SYNOPSIS · OVERSEAS



Overseas incidents

85 incidents involving UK divers overseas in 2025



Overseas incidents are not included in the UK analysis unless noted as 'all incidents'. Within each category, incidents are listed in order of occurrence.



Fatality

June 2025 25/201

A diver was found floating on their back unconscious on the surface by their dive boat. The diver was recovered aboard the boat and CPR was commenced, whilst the boat returned to harbour. Once alongside in the harbour the casualty was removed from the boat and CPR continued, including the use of oxygen and an AED. The diver was airlifted to hospital but did not survive. (Eire).

June 2025 25/053

A diver was recovered from the water after being reported to be in difficulty. The diver was taken to hospital but died 2 days later.

DCI

July 2025 25/204

Three days after a previous dive, a diver attended a subsequent dive, and reported they had a skin rash since the previous dive. The diver was advised to seek medical attention and not to dive until cleared by a medical professional. (Eire).

September 2025 25/101

A diver had conducted a dive the preceding day to a maximum depth of 31m with a total duration of 52 min including a safety stop at 6m for 3 min. The next day, after a surface interval of 22 hours the diver conducted a wreck dive to a maximum depth of 38m with a total duration of 25 min including a safety stop at 6m for 3 min. After a further surface interval of 85 min the diver dived another wreck at a maximum depth of 39m for a total duration of 27 min including a safety stop at 6m for 4 min. Some time after the last dive the diver suffered multiple symptoms of DCI and received recompression treatment.

September 2025 25/164

After completing multiple days of diving before flying home to the UK, a diver reported to a doctor 5 days after the last dive, complaining of feeling general fatigue, including muscle fatigue. The diver was diagnosed with mild DCI.

October 2025 25/110

On the first day of a diving holiday a diver conducted a late afternoon dive and then a night dive. The following day the diver had conducted a first dive of the day from a boat, with two buddies, to a maximum depth of 28m for a total duration of 53 min including a safety stop at 5-6m for 5 min. After a surface interval of 90 min the group entered the water and conducted a dive to a maximum depth of 18m, with a total duration of 44 min including a safety stop at 5-6m for 5 min. The boat returned to shore and the diver felt OK whilst storing kit and set up for the next day. The diver then went to a local café for food and drink. After drinking a glass of cola the diver felt dizzy and lightheaded. The diver tried to visit the toilet but was unable to focus and get their balance. The diver's partner contacted the dive centre owner who came to the café to help the diver. The diver drank at least a litre of water and began to feel better. They stayed at the café for 45 min before getting a taxi back to their accommodation. On getting back to their room the diver again felt dizzy. The diver was assessed by a colleague, who was a hyperbaric nurse, and was advised to contact a doctor and inform them they had DCI. A diving doctor called the diver back and advised them to go onto oxygen and so they returned to the dive boat and was administered oxygen for 25 min, during which they felt much better. The diving doctor then called back and advised going to be assessed by a doctor they had arranged a consultation with, a 60 min taxi drive away. On arrival at a hospital emergency department the diver again felt dizzy and was placed on oxygen again and placed on a drip. The diver was then transferred to a recompression chamber 90 min away, where they received recompression treatment for 6 hours. After the treatment the diver felt very tired but well and was advised not to dive for a month and not to fly for 72 hours. The diver flew home 87 hours later arriving home at 0400 and went to bed. The diver woke at 0830 feeling sore and painful in their abdomen and contacted a chamber for advice. The doctor taking the call advised that the flight may have unbalanced the diver again and advised to rest and they would call the following day to check. The doctor called the next day and as the pain was still present the diver was advised to attend for assessment. The diver was assessed and received three 2 hour treatments over the next three days.

November 2025 25/174

A diver had completed a dive to a maximum depth of 30m with a total duration of 38 min, including an extended safety stop. The diver subsequently experienced abnormalities in muscle strength and function in their right arm and leg. The diver was given oxygen, with symptoms improving after 10 min. The diver was then transported to a recompression chamber where they received recompression treatments.

Boat/Surface

May 2025 25/138

A dive boat with divers in the water experienced engine failure. A diver recall signal was initiated and all divers returned to the surface and were recovered aboard the boat.

June 2025 25/200

Shortly after departing a pier, a boat's engine cut out and could not be restarted. The boat was towed back to the pier and subsequently recovered. On inspection the wiring to the battery had broken away from the terminal. (Eire).

June 2025 25/235

A lifeboat was tasked to respond to a report of a dive vessel with machinery failure. (Eire). (RNLI report).

July 2025 25/203

A dive boat ran out of fuel. An anchor was deployed and a member of the crew swam ashore to retrieve additional fuel. (Eire).

July 2025 25/237

A lifeboat was tasked to respond to a report of a diver in the water. (Eire) (RNLI report).

November 2025 25/170

A dive boat engine failed with divers on the surface. The anchor was deployed and the divers swam to the boat and were recovered aboard. A second boat stood by to assist, but after 5 min the engine was restarted and safe passage was made back to harbour.

Ascents

January 2025 25/001

A student and their instructor had conducted a dive earlier in the day to a maximum depth of 7m with a total duration of 70 min. After a surface interval of 160 min the pair entered the water to conduct SMB training whilst on a wreck. The pair reached a maximum depth of 22m. Approximately 3/4 of the way through their planned dive time the student panicked and started an uncontrolled ascent to the surface without dumping gas from their BCD. The instructor attempted to dump gas from the BCD to control the ascent but the pair were dragged up from 16m to the surface. The student's computer logged an ascent rate of 50m/min. The pair were recovered from the water and placed on oxygen and driven to hospital for assessment. Both divers were assessed on arrival at hospital but displayed no signs of DCI and so were discharged home.

January 2025 25/123

A diver conducted a dive to a maximum depth of 22m. During the ascent the diver's BCD dump hose became entangled and the diver was unable to reach it. They made an uncontrolled ascent direct to the surface, with a total dive time of 36 min. A diving doctor was contacted for advice, which was that the diver should be monitored for any abnormalities but none appeared. The diver reconfigured their equipment before diving again.

April 2025 25/132

A student was on a depth progression dive to a maximum depth of 30m. During the dive the student experienced a flooding mask and this led to a panic attack and a rapid ascent from 12m direct to the surface, during which the student lost their mask and regulator. The diver was placed on oxygen and restricted from diving for 24 hours.

May 2025 25/186

A diver had descended to a maximum depth of 20m and during their ascent they lost control of their buoyancy at a depth of 10m and made an ascent direct to the surface omitting safety stops. The diver was placed on oxygen as a precaution. (Eire).

May 2025 25/192

A diver was on a dive to a maximum depth of 20m when they lost control of their buoyancy during ascent at a depth of 10m and made an ascent direct to the surface, omitting safety stops. The diver was given oxygen as a precaution. (Eire).

May 2025 25/193

Following a dive to around 30m a diver lost control of their buoyancy at 10m. They ascended direct to the surface omitting a safety stop. The diver was recovered aboard the boat and placed on oxygen as a precaution but no symptoms presented. (Eire).

May 2025 25/198

Whilst deploying a DSMB a diver's AS became tangled in the excess line from the reel. The line then got tangled with the diver's snorkel and the diver was pulled up approximately 9m before control was regained. After surfacing the diver was placed on oxygen as a precaution. (Eire).

June 2025 25/196

During a dive to a maximum depth of 20m, after a run time of 21 min and at a depth of 7m a diver's SMB became loose. Whilst the diver was attending to the SMB, they became inverted, which trapped gas in their drysuit boots and resulted in an uncontrolled ascent direct to the surface, omitting safety stops. Their buddy ascended at the correct rate but also omitted safety stops. The diver was administered oxygen on demand for 40 min but no symptoms of DCI presented. (Eire).

July 2025 25/151

A diver had descended to a maximum depth of 20m and towards the end of the dive deployed a DSMB from a depth of 15m. They then made an uncontrolled, but not rapid, ascent direct to the surface omitting safety stops.

September 2025 25/211

During a dive, a diver noticed that their weightbelt was twisted and was unable to be tightened underwater. During ascent, whilst dumping gas from their BCD, the weightbelt slipped off and the diver made a rapid ascent direct to the surface, omitting safety stops. The diver was placed on oxygen and transported to hospital where they were admitted. (Eire).

October 2025 25/212

A diver lost a weight pouch and became positively buoyant and flooded their drysuit to try and slow their ascent. The diver was placed on oxygen as a precaution. (Eire).

 Technique**March 2025** 25/127

A diver entered the water with their drysuit zip not fully closed. The dive was aborted and the diver exited the water to allow the zip to be fully closed.

March 2025 25/131

During a dive to a maximum depth of 23m, two pairs of divers, each using SMBs, had their SMB lines entangle each other, even though they had given each other a wide berth on a reef wall. The four divers ascended together whilst trying to untangle the lines. One pair required to ascend and so they took both tangled SMBs with them, whilst the second pair moved away before deploying a DSMB to continue the dive.

April 2025 25/189

A diver was deploying a DSMB when they became entangled in the line and was unable to maintain a safety stop and ascended direct to the surface, omitting safety stops. (Eire).

May 2025 25/136

Whilst preparing to dive from a boat, a diver picked up and fitted the wrong weightbelt and as a result was unable to descend. The diver returned to the boat, got aboard and then located the correct weightbelt and, after fitting it, entered the water to carry out the planned dive.

June 2025 25/197

Towards the end of a dive a diver deployed a DSMB using and spool and clip from a depth of 7-8m. The clip blocked the spool and the diver kept hold of the spool and ascended direct to the surface. The diver then descended back to 6m to complete their safety stop. The diver was given oxygen as a precaution. (Eire).

July 2025 25/202

The start point for a dive was a shotline to a reef. During descent one diver in a buddy pair lost contact with the shotline. On realising their buddy was missing the second diver surfaced. A short time later the missing diver surfaced on the shotline. (Eire).

August 2025 25/206

A diver lost control of their buoyancy during their safety stop and ascended to the surface. The diver was placed on oxygen as a precaution. (Eire).

August 2025 25/208

A diver lost control of their buoyancy whilst deploying a DSMB and ascended direct to the surface omitting safety stops. The diver was placed on oxygen as a precaution. (Eire).

August 2025 25/160

Following a dive to a maximum depth of 6m for a total duration of 30 min, a training group of divers surfaced further away from shore than they expected. The group had to conduct a long surface swim to return to their exit point.

September 2025 25/209

A diver lost control of their buoyancy during a safety stop and ascended to the surface. (Eire).

 Equipment**January 2025** 25/122

A diver had commenced a dive when their BCD dump cord broke during descent. The diver aborted the dive and the BCD was repaired.

March 2025 25/124

Two divers, at a depth of 25m, had their DSMB entangled with that of another pair of divers, higher on a reef. The divers were unable to disentangle their line and so cut their line and deployed a second DSMB. The pair completed a dive to a maximum depth of 25m and a total duration of 45 min, without further incident.

March 2025 25/125

During a training dive to conduct controlled buoyant lift practice from 20m to 6m, a diver became

entangled in a DSMB line. The line was wrapped around the divers and so it was cut free and then the reel and the DSMB were recovered. The dive had been to a maximum depth of 20m with a total duration of 29 min.

March 2025 25/128

During DSMB deployment at the end of a dive at a depth of 25m the DSMB reel jammed and the diver released the reel. A second DSMB was then released successfully and the divers surfaced after a dive to a maximum depth of 25m for a total duration of 29 min.

March 2025 25/129

During a DSMB deployment at 16m, with the reel tethered to the bottom, the line broke during deployment. A second DSMB was then released successfully and the divers surfaced after a dive to a maximum depth of 22m for a total duration of 45 min.

March 2025 25/130

A diver commenced a dive, but at 6m during the descent, a leak from the diver's first stage was noted during a bubble check. The dive was aborted and the equipment was isolated for repair. The divers then conducted the planned dive with replacement equipment.

April 2025 25/187

Following a giant stride entry a trainee diver experienced a regulator free flow and was unable to stop it, and the dive was abandoned. (Eire)

April 2025 25/188

A diver carried out a dive with a new drysuit. The diver was under-weighted and during the ascent at around 20m, they were unable to control their buoyancy and so flooded their suit to stop a rapid ascent. (Eire).

May 2025 25/191

A diver conducted a dive using a full face mask, which continually fogged during the dive and so the dive was aborted. (Eire).

June 2025 25/195

Towards the end of a dive to 25m, a diver indicated to their buddy, at a depth of 11m, that they had 70 bar of gas remaining. Their buddy indicated that they should rise to 6m to complete a safety stop. The diver seemed to struggle to ascend from 11m and when the

(continued) buddy went to investigate, they found that the diver's BCD inflator had failed. The buddy provided buoyancy and raised the diver up to 6m, where they completed a safety stop. The buddy then lifted the diver towards the surface when, at 1m below the surface, the diver took their buddy's AS, as their own regulator had stopped giving gas. However, the diver placed the regulator in their mouth upside down and received a mouthful of water, panicked and surfaced. On surfacing the buddy tried to manually inflate the BCD but that would not work either, indicating the inflation unit had failed completely. The buddy, along with another diver, then gently towed the diver to an exit point and help the diver out of their equipment. (Eire).

June 2025 25/199

A diver used their AS to inflate their DSMB, causing the AS to free flow. The diver immediately ascended but was completely out of gas on surfacing. (Eire).

July 2025 25/149

During a dive to a maximum depth of 20m, the cam band on the diver's BCD came loose. The diver's buddy rectified the problem and the pair continued with the dive and surfaced with a total dive time of 26 min. The BCD was inspected and swapped for a replacement.

July 2025 25/150

During a dive to a maximum depth of 20m a diver lost a weight pouch from their integrated weights.

August 2025 25/207

A diver noticed their gas tasted bad during a buddy check. The dive was aborted. (Eire).

August 2025 25/154

Prior to entering the water a diver's regulator went into free flow and blew grit into the diver's mouth. The regulator was taken out of service for inspection.

August 2025 25/155

A diver had descended to a maximum depth of 6m. After a few min, the diver's regulator developed a slight free flow and the dive was aborted. The diver surfaced after a total dive time of 10 min to a maximum depth of 6m. The regulator was exchanged and put aside for servicing.

August 2025 25/156

During a training dive for Alternate Source skills, an AS was breathed from and found to be delivering a wet breathe. The dive was aborted and the divers surfaced with a total dive time of 10 min to a maximum depth of 6m. The regulator was exchanged and put aside for servicing.

August 2025 25/157

During a buddy check an AS was found to free flow when breathed from. The regulator was exchanged prior to diving and put aside for servicing.

August 2025 25/158

During a buddy check the primary regulator was found to free flow when breathed from. The regulator was exchanged prior to diving and put aside for servicing.

August 2025 25/159

A diver lost an integrated weight pouch, believed to have been during a backward roll entry. The diver continued the dive, to a maximum depth of 35m, without incident and completed a normal ascent, including a safety stop.

September 2025 25/210

An Octopus got caught in a diver's octopus causing the AS to free flow and resulted in an out of gas situation. (Eire).

September 2025 25/165

A student on a training course had dived to a maximum depth of 20m and carried out a DSMB deployment. The reel jammed and the diver released the reel as they had been taught and then the group made a normal ascent to the surface, including completing a safety stop, with a total dive time of 23 min. On exiting the water it was found that the DSMB and reel had drifted offshore and was too far to be recovered safely. The shore team had not realised the DSMB was loose until it was too late for them to recover.

October 2025 25/111

A diver was in a group of six divers diving a wreck from the shore. After arriving on the deck of the wreck the diver pulled the dump valve to deflate their BCD but the corrugated hose became detached from

the BCD. As the diver was wearing a wetsuit, they then had no source of adjusting their buoyancy and they became negatively buoyant and knelt on the wreck. The diver attracted the attention of another diver in the group, who realised what was happening. The diver then began to remove their weightbelt, which the other diver prevented them from doing so, and signalled the diver to deploy their DSMB, as the wreck was slightly offshore. After deploying the DSMB successfully, the diver was assisted to the surface by the other diver performing a controlled buoyant lift. During the ascent however the diver had not reeled in their DSMB line quickly enough so the other diver signalled them to reel in faster to avoid entanglement. The pair surfaced safely without further incident. On the surface the rescuer provided the diver with an additional inflated DSMB for support on the surface and offered to escort the diver back to shore but the diver declined, so the safety diver descended back down to the wreck to join the rest of the group. The diver began to swim back to shore on the surface with their regulator in their mouth, but due to a slight swell the regulator was knocked from their mouth and could not be recovered. The diver blew a whistle and waved their arms to attract the attention of people on the shore who got a boat to go and tow the diver back to shore, where they were assisted from the water by other divers. No medical attention was required and the diver was monitored for 24-48 hours with no signs or symptoms identified.

Injury

March 2025 25/126

During a training drill for controlled buoyant lift from 15m, following a first lift, a diver experienced sinus pain at 6m during a second descent and the dive was aborted. The diver was able to resume diving 24 hours later.

April 2025 25/133

Following a dive to a maximum depth of 24m for a total duration of 29 min, a diver was found to have a burst blood vessel in their eye, believed to be due to failure to equalise during descent.

April 2025 25/190

A diver slipped whilst stepping onto a pontoon from a boat resulting in a fractured bone in their foot. (Eire)

May 2025 25/194

Towards the end of a dive at a depth of 17m, a buddy noticed a diver attempting to maintain depth by finning downwards. The diver then switched to try an inversion manoeuvre in order to dump gas, but during the manoeuvre they ascended to 2m. The buddy caught up and the pair descended to 6m, where they completed a safety stop. On surfacing the diver was found to have blood coming from their nose and they were placed on oxygen as a precaution. (Eire).

May 2025 25/137

Following completing training exercises at 6m a diver began an exploratory dive. During descent, between 6-8m, the diver was unable to clear their ears, and the dive was aborted. The total dive time was 30 min.

June 2025 25/140

A diver had been diving from a boat for the previous 8 days. Following a dive to a maximum depth of 18m for a total duration of 16 min, the diver injured their wrist on recovery aboard the boat. The diver sought medical assistance and was found to have a soft tissue injury and was treated with rest and ice. They ceased diving for 48 hours.

June 2025 25/064

A pair of divers had completed a first dive of the day to a maximum depth of 11m for a total dive time of 27 min. After a surface interval of 125 min the pair entered the water for a second dive. The dive commenced with a shore entry into a natural pool and required a swim through an underwater rock arch approximately 2m long. Following a dive to a maximum depth of 12m, the pair ascended and completed their safety stop outside the rock arch. Visibility was deteriorating due to other divers and there was a current flowing out through the arch which required the divers to swim against it. The least experienced diver entered the arch first at a depth of 4-5m. Whilst under the arch the diver later reported that their regulator stopped delivering gas. They tried to find to their own AS but began to panic and lost their primary second stage from their mouth, lost control of their buoyancy and lost both fins and their mask. The buddy realised something was wrong when the diver turned to face them and realised there was no regulator in the diver's mouth. The buddy offered their AS but it was not taken and they then donated their primary source and pulled the diver out from

(continued) under the arch and finned for the surface. On surfacing the buddy signalled distress to the shore cover and both divers were assisted from the water and helped to de-kit. On surfacing the diver had been alert and responsive but was estimated to have been without a gas supply for more than a minute, so was given oxygen. The emergency services had been called when the distress signal had been given on surfacing and the Coastguard had tasked a rescue helicopter. The shore cover were in contact with a specialist doctor to ensure recompression treatment was unnecessary. On arrival a helicopter winchman was lowered to assess the diver and they were then, 44 min after surfacing, airlifted to hospital where they were treated for water inhalation and kept under observation for 6 hours before being discharged. The diver's cylinder was found to contain 50 bar of gas. The regulator was sent to a service agent to be investigated. Total dive time had been 41 min to a maximum depth of 12m, including safety stops at 6m. (Eire).

June 2025 25/048

Two students were taken on a try-dive in open water by an instructor supported by a qualified diver. The group entered the water from the shore and after conducting some basic skills they moved off to explore. There were no issues until around 10 min into the dive when, at a depth of 4m, one of the students indicated they could not clear their left ear. After a few further attempts to clear the student ascended with the safety diver and swam on the surface back to shore about 50m away. The instructor continued the dive with the second student and surfaced after a total dive time of 28 min. On leaving the water they found the first student and the safety diver de-kitted and all divers reported being well. The first student was asked about their ear and they reported it was fine and no further issues were reported before the group left the site around 15 min later. 135 min later the instructor received a message from a colleague that the first student was unwell and an ambulance had been called. The student had subsequently explained to the safety diver that during the surface swim they had, for several seconds, felt lightheaded, dazed and confused, in addition to the pain in their ear, but had not reported it at the time to either the safety diver or the instructor. The student was advised that they should be treated with oxygen, not to accept Entonox and get a full check up from medical staff. On consulting medical staff the student was

advised that the incident was not diving related and the symptoms most likely due to work stress and anxiety. They were advised to rest and report to their doctor.

June 2025 25/141

A diver on a training course, slipped on an uneven surface when exiting the water and cut their hand. The diver received first aid treatment and was able to continue with the course.

July 2025 25/142

A diver was lifting equipment into a dive boat at a height of 1.3m, when they injured their shoulder.

July 2025 25/144

A diver had completed a dive the previous day to a maximum depth of 20m for a total dive time of 28 min. The following morning at the dive briefing for the day, the diver reported they were suffering from ear pain. They were sent to the medical centre for review and were found to have a perforated eardrum.

July 2025 25/145

A student on a course descended to a depth of 1m but was unable to clear their ears and aborted the dive.

July 2025 25/066

A group of 8 divers in 4 buddy pairs were diving from a charter boat. The group entered the water in calm conditions for a planned no stop dive in 20-25m, with maximum duration planned for 40-45 min. On surfacing there was a short windy squall, which had created a short chop of waves. Three of the buddy pairs had been recovered when the final pair surfaced, after a dive to a maximum depth of 26m and a total duration of 38 min. The first diver was recovered before the final diver approached the boat and got onto the rear diver lift. Just as the lift began to raise the diver slipped backwards off the lift. The diver's BCD and suit were still inflated, and the slip resulted in their legs coming up underneath the stern of the boat, with the fins between the rudder and propeller. The skipper confirmed that the boat was not under power. The diver shouted, "my legs are stuck" and the lift was stopped and then lowered slightly. The diver then screamed in pain and said, "I can't use my legs", before their legs came free. The diver had lost their regulator from their mouth and was breathing in water. Another diver entered the water and then

stood on the diver lift to keep the diver's head clear of the water, and then recovered the diver's regulator for them, but the diver was unable to keep it in their mouth and was breathing in water. The rescuer managed to lift the casualty from under the boat and sit them on the side of the platform, allowing them to be lifted to deck level. As the diver's legs became visible it was noted that both fins were missing and there was a significant bleed from the casualty's right leg. At deck level the diver's BCD and weightbelt were removed, allowing the casualty to lie down on the deck and was covered with a coat as a blanket and another as a pillow beneath the diver's head. The diver was conscious but confused. The diver had a significant bleed from the lower right leg, and severe fracture protruded through their torn drysuit, with the foot partially amputated. The skipper had called a 'Mayday' to the Coastguard and then made best speed to harbour, 15 min away. Due to the location of the diver's legs still on the lift platform it was not possible to apply dressings to the significant bleed and so the rescuer improvised a tourniquet and then went and brought an oxygen set to provide to the casualty as they were arriving in harbour. The boat was quickly tied up alongside, assisted by the waiting lifeboat crew. As they tied up, an ambulance crew arrived, shortly followed by the island doctor and other medics in cars. A few min later a rescue helicopter landed around two miles away and the winchman was transported to the boat by the RNLI crew, whilst the helicopter left to refuel, which returned whilst the casualty was still being treated on the boat. The casualty was given pain relief; IV fluids and the injury was dressed and the break reduced. The temporary improvised tourniquet was then replaced with a medical tourniquet. The diver was stabilised and then airlifted to hospital. They were found to have multiple fractures and dislocations in both ankles requiring extensive surgeries, two blood transfusions, and suffered cardiac issues due to blood loss. The diver spent two days post-surgery in an induced coma on a respirator and received additional treatment for complications due to infection. Unfortunately, the diver subsequently had their right leg amputated below the knee. Otherwise they were recovering well.

July 2025 25/147

Following a dive to a maximum depth of 15m for a total duration of 17 min, a diver reported having sinus pain and had a small quantity of blood in their mask. The diver went for medical examination and was

diagnosed with mild sinus barotrauma. The diver was given painkillers and advised to take a day off from diving.

July 2025 25/148

A diver had conducted a dive to a maximum depth of 15m, where they suffered ear pain and aborted the dive and surfaced with a total dive time of 17 min. The diver was sent to the medical centre for review and were found to be suffering from ear barotrauma.

July 2025 25/205

A diver was walking down a slipway, carrying equipment to the boat, when they tripped. The diver suffered an impact injury to their shin and knee and twisted their back. (Eire).

July 2025 25/152

A diver had conducted a dive to a maximum depth of 20m for a total duration of 12 min. Five days after the dive the diver reported to a medical centre with ear pain.

August 2025 25/153

After a dive, a diver reported they had difficulty clearing their ears at 10m before they felt a pop accompanied by pain and loss of hearing. They had completed a dive to a maximum depth of 35m for a total duration of 10 min.

September 2025 25/162

A diver was returning to the water to collect a weightbelt that had been removed in the shallows, when they slipped on rocks and cut their hand. The diver received first aid treatment.

September 2025 25/163

A diver had conducted two dives during the day. The first to a maximum depth of 40m with a total duration of 33 min, followed by a second to a maximum depth of 20m for a total duration of 40 min. The diver went to bed that evening but woke 13 hours after the last dive with tingling and numbness in both arms. The diver was transferred to a recompression facility and was treated with oxygen but was not recompressed.

October 2025 25/166

Diver had difficulty clearing their ears on descent, to the extent where the pain became excruciating. The diver aborted the dive and made a slow ascent to the

(continued) surface. On surfacing the diver felt a painful pulsating in their ear. Diver sought medical advice and was diagnosed with a minor ear barotrauma. The dive was to a maximum depth of 15m for a total duration of 15 min.

October 2025 25/213

A diver was filling a cylinder when a component of the compressor exploded. The diver suffered burns and was hospitalised. (Eire.)

November 2025 25/169

A diver, on their second dive of the day, experienced difficulty in clearing their ears at a depth of 5m on descent. The diver aborted the dive and surfaced with a total dive time of 5 min. The diver went to a local pharmacy and obtained some ear drops and refrained from further diving. On a return flight to the UK the diver felt pain and a pop sensation and their hearing has been muffled since their return.

November 2025 25/114

A group of mixed ability and experienced divers were on a commercial dive boat trip to explore an offshore island rarely dived. Following a first dive without incident the vessel relocated to a more sheltered area. The divers then entered the water in buddy pairs, rather than the previous larger groups, and was entry was staggered to allow space for kitting up. The first pair surfaced before the final two pairs entered and reported they had found caves in the reef. The last two pairs entered loosely as a group of four but remaining in their discrete buddy pairs. Locating a series of caves the most experience pair located one of the largest caves and the senior diver assessed that the entrance was too small to go through without risking entrapment or damage to equipment. As the current was starting to build up, the senior diver left the reef to collect a less experienced member of the group who was at risk of getting swept away from the reef in the tide. On return to the lee of the reef they found another member of the group had attempted to enter the cave and had become stuck. The others helped to extract the trapped diver, who sustained minor abrasions on their head from being pulled out by their fins but was otherwise OK. The group had been to a maximum depth of 11m for a total duration of 59 min.

November 2025 25/118

Two divers had conducted a dive to a maximum depth of 14m and as they ascended, they were at 9m when one of the divers stopped to retrieve a fishing lure. The line got stuck and whilst pulling on it, the hook became deeply embedded in their thumb. The pair continued to 6m and completed their safety stop and surfaced with a total dive time of 82 min. The wound was cleaned with disinfectant solution and then betadine. One of the shore crew drove to a nearby Coastguard station but they lacked any medical expertise, so the diver was taken by car to a hospital where the hook was removed and the diver was given two stitches and a tetanus injection.

November 2025 25/172

After a dive to a maximum depth of 10m for a total of 24 min, a diver noticed blood in their ear. They sought medical advice and were advised they had suffered ear barotrauma and were suspended from further diving.

November 2025 25/173

Diver had difficulty clearing ears on descent at a depth of 6m. Dive was aborted and the diver surfaced with a total dive time of 5 min. The diver sought medical advice, but no injury was identified and no treatment required.

December 2025 25/176

A diver reported they had a sticky ear prior to diving and they refrained from diving for 24 hours before returning the diving.

History of previous UK diving fatalities

Year	Membership	BSAC	Non-BSAC	Year	Membership	BSAC	Non-BSAC
1965	6,813	3	-	1998	46,712	5	14
1966	7,979	1	4	1999	46,682	9	8
1967	8,350	1	6	2000	41,692	7	10
1968	9,241	2	1	2001	41,272	10	14
1969	11,299	2	8	2002	39,960	3	7
1970	13,721	4	4	2003	38,340	6	9
1971	14,898	0	4	2004	37,153	4	18
1972	17,041	10	31	2005	37,185	5	11
1973	19,332	9	20	2006	35,422	4	11
1974	22,150	3	11	2007	34,857	8	5
1975	23,204	2	-	2008	34,325	6	5
1976	25,310	4	-	2009	32,790	8	9
1977	25,342	3	-	2010	32,229	7	7
1978	27,510	8	4	2011	30,909	5	7
1979	30,579	5	8	2012	29,632	9	7
1980	24,900	6	7	2013	28,728	5	9
1981	27,834	5	7	2014	28,375	5	11
1982	29,590	6	3	2015	27,803	3	5
1983	32,177	7	2	2016	27,346	5	7
1984	32,950	8	5	2017	26,774	2	13
1985	34,861	8	6	2018	26,717	8	9
1986	34,210	6	9	2019	27,000	10	3
1987	34,500	6	2	2020	21,594	2	4
1988	32,960	10	6	2021	22,047	8	8
1989	34,422	4	8	2022	22,540	0	6
1990	36,434	3	6	2023	23,447	4	5
1991	43,475	8	9	2024	22,153	3	9
1992	45,626	9	8	2025	20,048	4	5
1993	50,722	3	6				
1994	50,505	6	6				
1995	52,364	9	9				
1996	48,920	7	9				
1997	48,412	4	12				

*1999 figure corrected from 9 to 8 due to a double count discovered in 2010.
1998 figures onwards are calendar year figures; 1965 to 1998 are October 1st to September 30th figures.

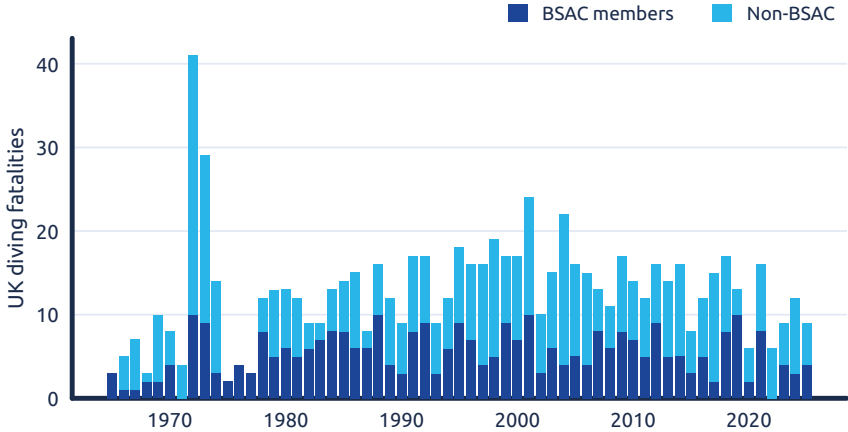


Figure 28
UK diving fatalities each year since 1965, BSAC members and non-members

2025: 9 UK diving fatalities — 4 BSAC members and 5 non-BSAC divers.

Abbreviations used in this and previous incident reports

AIS	Automatic identification system (location beacon)	EPIRB	Emergency position indicating radio beacon	MV	Motor vessel
AS	Alternative source (gas or air)	FAWGI	False alarm with good intent	NCI	National Coastwatch Institute
A&E	Accident and emergency department	FRS	Fire and rescue service	PFO	Patent foramen ovale
AED	Automated external defibrillator	GP	General Practitioner (doctor)	PLB	Personal locator beacon
ARCC(K)	Aeronautical rescue coordination centre (Kinloss)	GPS	Global positioning system	POB	Persons on board
ARI	Aberdeen Royal Infirmary (Scotland, UK)	Helio	Helicopter	QAH	Queen Alexandra Hospital (Portsmouth, UK)
AWLB	All weather lifeboat	HEMS	Helicopter emergency medical service	QAB	Queen Anne Battery (Plymouth, UK)
BCD	Buoyancy compensation device	HLS	Helicopter landing site	RAF	Royal Air Force
BOV	Bailout valve	HSE	Health and Safety Executive	RHIB	Rigid hull inflatable boat
CAGE	Cerebral arterial gas embolism	HUD	Head up display	RMB	Royal Marines base
CG	Coastguard	ILB	Inshore lifeboat	RN	Royal Navy
CCR	Closed circuit rebreather	INM	Institute of Naval Medicine	RNLI	Royal National Lifeboat Institution
CNS	Central nervous system	IPO	Immersion pulmonary oedema	ROV	Remotely operated vehicle
CPR	Cardiopulmonary resuscitation	IV	Intravenous	SAR	Search and rescue
CRT	Coastguard rescue team	kg	Kilogramme	SARIS/SARSYS	Search and rescue information system
DCI	Decompression illness	LB	Lifeboat	SMB	Surface marker buoy
DDMO	Duty diving medical officer	MCA	Maritime & Coastguard Agency	SRR	Search and rescue region
DDRC	Diving Diseases Research Centre (Plymouth, UK)	m	Metre	SRU	Search and rescue unit
DSC	Digital selective calling (emergency radio signal)	min	Minute(s)	UK SDMC	UK Sports Diving Medical Committee
DSMB	Delayed surface marker buoy	MOD	Maximum operating depth	UTC	Coordinated universal time
DPV	Diver propulsion vehicle	MOP	Member of the public	VLB	Volunteer life brigade
ECG	Electrocardiogram	MRCC	Maritime rescue coordination centre	999	UK emergency phone number
ENT	Ear, nose and throat	MRSC	Maritime rescue sub centre		



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