

When experienced divers don't come home: looking at the system, not just the people

When five people die in a diving accident, and another dies in the recovery effort, the diving community reacts in a way that feels natural and even fair. We look for the decision that went wrong, the person who made it, and the rule that was broken. We reach a verdict quickly, and once we have it, we stop looking. This article is an invitation to slow that process down, engaging the slow, logical part of our brain, moving beyond the emotional reaction. The reason we need to do this is because the questions we ask after an event like this influence whether anything changes and whether the focus is on the right thing. There is a difference between lessons identified and lessons learned – learning means change happens.

This article is not an analysis of what happened inside that cave; the investigation is ongoing. Four families waited a long time for closure, and a great deal of what circulated online in the days afterwards was speculation – normal but not helpful to anyone. I have no privileged access to the facts, and neither does anyone commenting from a keyboard. What I will offer is a way of thinking that applies long before this event occurred and will still apply long after it. The goal is to create the conditions where you think differently about adverse events. Indeed, one of those involved in this operation trained with me five years ago and reflected afterwards: *“this has been a very intense and demanding week, but I often found myself reflecting on what I learned during the course. It genuinely helped me look at such situations from a perspective still quite different from that of the wider community, and for that I am truly grateful.”*

The first story is always the same

After almost every fatality, the same story arrives before the details do.

“They shouldn’t have gone in.”,

“They were only recreational divers.”,

“Someone should have known better.”

It is a comforting story, because it ends with a reassuring thought: I would not have done that, so this could not happen to me.

The problem is that this story doesn’t change anything in material terms. It locates the entire event inside the people who died, and the rest of us are quietly let off the hook. The effect is so common, psychologists have a name for it. When something goes wrong for someone else, we explain it by who they are: careless, arrogant, under-trained. When something goes wrong for us, we explain it by the situation we were in: busy, distracted, unlucky. We apply one standard to others and a far more generous one to ourselves, and the diving community does this with painful reliability after every serious event.



The structure was normal. The scale was not.

The individual behaviours and conditions that contribute to an accident like this are not rare. Divers exceed depth limits and log the dive at the permitted depth. Single-cylinder divers enter short overhead passages on tropical reefs because it is brief, the water is clear, and it has always been fine before. Scientific divers cross into environments their training never prepared them for, because the data is there and the window is short. Each of these things happens somewhere in the world most weeks, and almost none of them produce any reaction at all, because almost all of them end with everyone back on the boat.

What made this event different was not the structure of the behaviour – it was the scale of the outcome. The (social) media and personal responses we are seeing are a response to the scale, not to the structure, and the structure is what produced the conditions in the first place. It is important that we recognise and acknowledge that difference because the same structure is in place this week, on other boats, in other locations, on dives already being planned.

Why “they broke the rules” is rarely the whole story

When we say a rule was broken, we usually picture a careless individual taking a shortcut. But most rule-breaking in diving is nothing of the kind. It is a worn path that the wider system quietly depends on, because the formal route does not quite fit the reality of getting people safely into the water on a busy day. The thirty-metre limit may sit in regulation while the operational norm sits somewhere else entirely, and everyone in that part of the industry knows it.

This is why rules are less about controlling behaviour than about deciding who has to do the explaining

when something goes wrong. Follow the standard and have a bad day, and the system carries the explanation for you. Deviate in a way that everyone around you also deviates, and have a bad day, and suddenly a shared practice becomes the act of one named person. The deviation was collective. The accountability gets personalised, and the outcome is what triggers the switch. This applies at the organisational level too, not just the individual one. If lots of organisations and dive centres are doing it, then it must be okay.



Peer pressure and the silence that looks like agreement

One thread is worth pulling because of its wide-spread applicability. When a group plans something, the quietest members are often reading everyone else's silence as confidence and agreement. Each person privately has a doubt, assumes they are the only one, and says nothing rather than be the person who pulls at the team's image of itself as a competent crew. From the outside it looks like consensus. From the inside it can feel like consensus. But in reality, no single person may have agreed with the plan at all.

The diver who speaks up pays a social cost immediately, in front of the group, before anything has gone wrong. The diver who stays silent pays nothing, unless the dive turns bad. That imbalance is structural, and it is why "just speak up" is advice that is far harder to follow than it sounds. Building teams where the quiet doubt gets voiced is one of the most practical things any operator, instructor, or buddy pair can work on. This is the core belief behind the concept of psychological safety.

What is the accountability that people want?

None of the above means that nobody is responsible. Finding someone to blame is fast and satisfying, but it very rarely prevents the next accident because events emerge from conditions, not by decisions made by 'bad apples'. Finding the conditions is slow and uncomfortable, and it is the only thing with any real chance of working. This means a shift is needed – before we ask who is at fault, ask three questions:

- What made this seem reasonable to the people involved at the time?
- What conditions made it more likely?
- Which of those conditions are still present now?

The reflection I hope you take away

When you plan your next dive, look at its depth, its gas, the environment, your kit, your group, and the schedule. Which of these are comfortably inside the formal standards, and which sit on a worn path that the community quietly tolerates? If that dive ended badly, which of those would suddenly look obvious to everyone? And if it ends fine, as it almost certainly will, who would have noticed any of it at all?

That reflection is the measure of how much we (you) have actually learned from this tragic event.