Inquiry into Dreamworld Thunder Rapids Ride Tragedy

The incident – 25th October 2016

Sydney-based mother Cindy Low and Canberra visitors Kate Goodchild, her brother Luke Dorsett and his partner Roozi Araghi died on October 25, 2016, after being thrown from a raft that collided with an empty raft and flipped over.

The Ride

The Thunder River Rapids Ride began operating at Dreamworld in the 1980s and had been extensively modified over the years.

The court heard that the ride had a history of faults and errors, and on the day of the tragedy, one of the water pumps on the ride had failed twice already. According to Dreamworld's own operating manuals, it should have been shut down for 24 hours after the second failure, until a supervisor authorised its restart. Instead, it was re-started a third time at 2.03pm. When it failed again, it had tragic consequences.

The findings of the inquiry

On 24 February 2020, Coroner James MacDougall delivered his findings, stating there was 'a systemic failure by Dreamworld in relation to all aspects of safety'.

Coroner MacDougall found that Dreamworld's safety standards meant that 'it was simply a matter of time' and he found 'there is no evidence Dreamworld ever conducted a proper risk assessment in the thirty years of operation of the ride' and that the safety systems in place were 'frighteningly unsophisticated'.

The inquiry looked into various aspects about Dreamworld's safety standards including inspections, operator training, risk assessments, maintenance and record keeping.

How do the Dreamworld findings relate to Scouts NSW?

On a personal level it is very sad to know that four people lost their lives especially when the idea of a theme park is to have fun. The tragedy prompts Scouts NSW to reflect on the standards, practices and behaviours we have in place to prevent serious injury to participants, leaders and bystanders. A small team of employed staff and volunteers helped to prepare the material for the following summary.

The activities at theme parks and operators of amusement rides draw similarities with activity structures used by Scouts NSW:

- **Challenge rope activities**
  - Covered by Challenge Rope Activities SOP
- **Flying Foxes (zip lines)**
  - SOP's currently being reviewed by Flying Fox Review Committee
- **Rock Activities**
  - Covered by Rock Activities SOP
- **Commercially operated activities**
  - Covered by Commercial Activities SOP
- **Permanent activity structures at State Activity centres**
  - Covered by Cataract Scout Camp and Baden Powell Scout Centre SOP's

The following list is not exhaustive however it provides a framework for leaders, activity instructors etc to refresh their awareness and to reinforce safe practices when running these activities.

Seven principles of safe operation of activity structures

1. Inspect structures regularly

All permanent structures must be inspected regularly (eg annually) by a suitably qualified independent person. Any shortfalls identified by the inspector must be addressed in order of risk priority. Inspection reports should be circulated to management.

2. Inspect equipment regularly
Equipment such as helmets, ropes and harnesses must be inspected regularly. There must be a suitable repair and replacement policy.

3. Ensure training and competency
Only suitably qualified Activities Instructors are to be used to run activities. Each instructor to be inducted into each structure before they can run it. Refresher training and information about changes to equipment and procedures is to be provided to leaders as appropriate.

4. Report incidents
Incidents including near misses are to be reported and reviewed so that improvements can be made to prevent someone being injured in the future.

5. Assess risks
The risk assessment is to be reviewed regularly to account for any new information or changes such as equipment modifications and reported incidents. For temporary structures, a site specific risk assessment is essential each time the structure is set up. Leaders are to monitor and respond to changes through the day such as weather, changes in supervision levels and participant behaviour. Have an emergency rescue plan.

6. Keep records
Keep records of all the above. Records show evidence that tasks were performed, prevent confusion and provide a formal communication tool between leaders responsible for monitoring events on the day.

7. Select commercial operators carefully
Outsourcing the activity does not mean outsourcing the risk. Seek basic WHS information prior to booking. The SOP for Commercial Adventurous Activities includes a review procedure to assist event organisers to seek basic WHS information prior to booking. Inform the operator of all incidents.

Overall, Scouts NSW has processes in place to mitigate risks. When our activities leaders follow these processes, implement the requirements and continue to review and respond to any issues in consultation with others, Scouts NSW can effectively manage the risks associated with activity structures.

References used to prepare this report:

The Brisbane Times, Workplace Safety Australia Pty Ltd Safety Alert

Report prepared August 2020 by:

Head of Risk, Scouts NSW – Tracey Perrin