



The Lessons from Two Australian Workplace Tragedies

When a WHS incident occurs in a workplace you can be almost 100% sure that it happened because of a failure to eliminate or minimise risks so far as is reasonably practicable. You can avoid having WHS incidents by having an effective system of risk management in place as required under the WHS Act and WHS Regulation. An effective system of risk management may sound easy enough but somehow it does not always get done completely.

Dreamworld Used to be the Largest Theme Park in Australia

An outstanding and horrifying example of not carrying out effective risk management was revealed last week when the 297 pages of the Coroner's Report into the 4 fatalities that occurred at the Dreamworld Theme Park in Brisbane at the Thunder River Rapids Ride (TRRR) was released on 24/2/20. It is an impinging case study of what must be done to have a safe and healthy workplace.

The Coroner's Report includes the specific issues he identified and considered during the course of the inquest hearings. The four deceased persons died because of *"the combined effect of severe internal and external injuries as a result of multiple compressive impacts"* when the raft they were in collided with another raft and became caught in the mechanism of the ride.

The Coroner sets out the specifics of numerous instances over a period of many years where **key WHS risks were not eliminated or minimised at Dreamworld and their risk management system was disfunctional**. It did not comply with the WHS risk management requirements of the WHS Act or WHS Regulation. A number of those instances are set out at the end of this article for your reference.

Those instances clearly show that the hazards at the Thunder River Rapids Ride were not fully identified and understood. Key risks were not assessed and eliminated or minimised in accordance with the hierarchy of risk controls in the WHS Regulation 36, and the *"must minimise risks, so far as is reasonably practicable"* requirement was not achieved.

In referring to *"how rudimentary and deficient the safety management practices"* were at Dreamworld the Coroner wrote; *"Such a culpable culture can exist only when leadership from the Board down are careless in respect of safety."* – p270

The Sydney to Melbourne XPT Tragedy

On the 20th February 2020 the Sydney to Melbourne XPT train set out for Melbourne. It never reached Melbourne. It was about 45 kilometres north of Melbourne when the locomotive and 5 carriages came off the rails at a place called Wallan.

The NSW driver and the Victorian co-driver were killed. Both men were very experienced, highly respected in their industry and personal life, and well aware of the dangers of the track in this area of Victoria. Eleven passengers were injured.

The train has a “black box” that records the events of the trip that will provide reliable assistance about the facts of the journey. It will probably take 18 months before we see an official report giving the facts on why this tragedy happened.

All we have at this time is the certainty that this tragedy happened because one or more risks were not eliminated or minimised so far as was reasonably practicable.

Future Actions

Courtenell is very keen to be involved in helping clients to eliminate or minimise WHS risks and achieving a safer workplace. Feel free to contact us to discuss your needs. We can deliver training or consulting services to help you achieve your goals.

Quotations from the Coroner’s Report

“These incidents should have prompted a thorough risk and hazard assessment of the ride, including the design, looking beyond the circumstances of the particular incident. In accordance with the hierarchy of controls, plant and engineering measures should have been considered as solutions to identified hazards. A heavy and unreasonable reliance on administrative controls to ensure the safety of patrons on the TRRR was clearly not a reasoned decision following a proper risk assessment.” – p258.

“This reliance by Dreamworld on the operation history of the ride as to whether a risk or hazard was present is clearly unsound and dangerous. The various high and low probability hazards and risks associated with the ride, which have been highlighted by the experts, were present and should have been identified by a suitably qualified risk assessor.” – p258

“It was agreed by the experts, and became obvious during the inquest hearing, that best practice for the TRRR was not followed by Dreamworld, particularly in relation to compliance with introduced Australian Standards designed to ensure the safety of devices.” – p259

“There is no evidence that Dreamworld ever conducted a proper engineering risk assessment of the ride in its 30 years of commission. The risks and hazards, which have now been highlighted by the experts, were never identified and considered by Dreamworld because such an assessment was never undertaken.” – p259

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“... it is unfathomable that this serious and important task fell to staff, who did not have the requisite qualifications or skillset to identify such hazards.” – p260

“The resounding message of the General Managers responsible for the Departments at Dreamworld was that, as such risks and hazards had never been identified to them, they were unaware and therefore unable to take any action.” – p260

“.. it was evidence of an inherent lack of proper training and process in place at Dreamworld to ensure the training provided to new Ride Operators and Instructors was suitable for the roles and responsibilities to be undertaken.” – p266

“Those responsible for managing the ride, whilst following the process and procedure in place, were largely not qualified to perform the work for which they were charged.” – p266

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