IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1861

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	Eugene Allen Tearanhanga MAHAUARIKI
Delivered on:	24 November 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest dates: 29, 30 & 31 August, 1, 2, 5, 6, 7, 8 & 9 September and 16 November 2022 Oral Submissions: 12 December 2022
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	R. Ellyard instructed by Coroners Court of Victoria
Counsel for Eugene's family:	C. Boyle instructed by Slater and Gordon
Counsel for Wittingslow Amusements and Michael Wittingslow:	S. Russell instructed by Sparke Helmore Lawyers
Counsel for Hamish Munro:	D. Hegarty, HBA Legal
Counsel for WorkSafe:	C. Mandy, KC with D. Chisholm for the Victorian WorkCover Authority
Other Matters	*Amusement ride safety*

The Cha Cha is an example of many rides which are fun because they're a bit dangerous, or at least they feel dangerous. They involve speed and movement and an element of thrill or danger, but parents only let their children go on those rides because although it might feel dangerous, they assume that it's actually safe. They assume that although it might let the children feel like they're on the edge of danger, in fact, they're safe. Although they might feel they're going to fall out, they're not going to fall out.

...anyone who rides such a ride will expect that the machinery will be in good order, that staff will be well trained, and that they'll be taking care to operate the ride in accordance with clear and appropriate procedures. And so, an accident like this, ..., invites consideration not just for Eugene and his family, but for all children who ride such rides.

Was the Cha Cha safe on this day, and by that I mean was it safe in how it was designed, was it safe in how it was being operated both in terms of who was permitted to ride and how whoever was turning the dials was turning them and paying attention or not, on that day, and was it safe in how it was being monitored and maintained both by its owner and by regulators.[1]

[1] Rachel Ellyard, Counsel Assisting at T10 L19-31, T11 L1-14

Family Impact Statement

Our Baby, Our Juju, Our Mister was taken away from us on the 17 April 2017, a day that has changed our lives for ever.

Eugene, 6 years of age, was an outgoing, bubbly, family-orientated child. He was the youngest of our children, but he ran the house. He was adored by all of his siblings, the baby of the family and a real Mummy's boy.

On the 17 April 2017 he didn't want to go the carnival. But when he learnt his cousins and family would be there, he changed his mind.

He loved to dance, enjoyed going to school, playing video games and he loved to visit the beach. He loved his pies, his lollies and his ice-creams.

Eugene was a humble child. Often at school he would take other children under his wings. Whenever he would see other child alone at school he would want to help them and was a real support to them. Although he was the youngest of our children, he was wise, and with that he knew that he could get away with quite a bit. He was sometimes mischievous and when he was angry he would pack his bags and say" I am leaving the house" and "I don't want to be a part of this family"

We are a part of a large community of friends and family and he loved his siblings, his uncles, aunties and his cousins. His favourite place to sit at home was at the front door. Always ready to welcome people into his home. He would love to have friends and family over and was always happy to visit them.

Stacey and I have lost parents and siblings but the grief of losing a child is like nothing else. There is a ripple effect that impacts your whole family and it changed the whole dynamic in our home, forever. They say you know when something happens to your loved ones. When we heard the loud metallic bang, Stacey and I, had a gut feeling that something had happened to our child. We could just feel it. A few days later, at the chapel, we knew in our hearts that our baby wasn't going to make it. We didn't want to let go of our baby, we wanted to hold onto him for as long as we could. That is when we decided to donate his organs.

The next few weeks after his death, they were a blur. The years that followed, they were hell. Stricken by grief, Stacey and I were not able to be the best parents to our children. To

Atalia, Bronson, Tanysha, Hine, Tammy and Zhavanna, Mum and Dad love you and are sorry for not always being there.

There is a piece missing from our family, that we will always feel. Us as a family experience nightmares and constant trauma. My children have been suppressing their feelings for the longest time. We are often tip-toeing around each other and dismissing the elephant in the room. But inside we are all suffering, yearning, crying for Eugene. Our family home that was once, happy, full of life has become silent. We don't talk to each other as much. Instead we have the music on loud and proud, just the way Eugene liked it. This has been a process of healing within our family.

We are always reliving his death and not being able to fully grieve and find closure. His father Stacey, who is not religious, makes a prayer for our son, every night. He prays that Eugene is watching us and protecting us.

Eugene is no longer with us in person, but he will always be around us in spirit. This urn that I have with me, contains his ashes and he comes with us everywhere.

…….

We hope for the Coroner to make findings that will bring about serious changes to the regulation of amusement rides in Victoria along with adequate training and accountability of the owners and operators to follow those guidelines and implement training measures. We don't want another family to go through the tragedy that we have. Eugene, we want you to know that Mum and Dad are doing everything we can to bring you justice.

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INTRODUCTION

1. Eugene Mahauariki[2] was born on 27 November 2010. He was 6 years old at the time of his passing and the youngest of six children to Tammy White and Stacey Mahauariki at that time. His siblings are Tanysha, Bronson, Atalia, Tammy, Hine and Zhavanna with additional children in the family's care at the time being Cherish, Renaia and Richard.

2. Tragically, Eugene passed away at the Royal Children's Hospital (**RCH**) on 21 April 2017 after being ejected from an amusement ride called the Cha Cha on 17 April 2017 at a carnival in Rye. His parents were working at the carnival on the day of the incident.

THE CORONIAL INVESTIGATION

3. Eugene's passing was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) because his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[3]

The coronial role

4. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

5. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

6. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

7. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[4]

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[2] Referred to in my finding as 'Eugene' unless more formality is required.
[3] Deputy State Coroner Caitlin English (as she then was) initially had carriage of this investigation.
[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been*

OTHER INVESTIGATIONS

8. Section 7 of the Act requires a coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

WorkSafe Investigation

9. WorkSafe Victoria (**WorkSafe**) is Victoria's workplace health and safety regulator as well as the workplace injury insurer.

10. Following the incident which led to Eugene's passing, WorkSafe investigated Wittingslow Carnivals Pty Ltd (**Wittingslow**) as the operator of the carnival in Rye.

11. During this time, the coronial investigation was suspended.

12. The WorkSafe After Hours Incident Response team attended the scene of the fatal incident at around 7.40pm on 17 April 2017. WorkSafe issued a 'Non-Disturbance Notice' to Wittingslow, requiring it to ensure that the Cha Cha ride be stopped, not interfered with, not moved and left undisturbed. The notice was enforced for two days for evidence-gathering purposes.

13. On 18 April 2017 WorkSafe personnel including Thinh Tran, Benjamin Wright, Glenn McWilliams, Shane Taylor, Kahn Sheu (Geoff) Ooi, Principal Engineer Les Kriesfield and Mark Clair[5] attended the scene. No specific action was taken as there were no Wittingslow representatives onsite and Wittingslow's lawyer indicated that they were too upset to attend.

14. The Cha Cha was able to operate from the expiration of the Notice, but for a time it was out of action and secondary restraint systems in the form of seat belts were fitted to the ride.[6]

15. On 24 November 2017, WorkSafe issued Wittingslow two Improvement Notices, one of which related to modifications required to the Cha Cha which were later complied with.

16. On 30 November 2018 charges were filed against Wittingslow pursuant to section 23(1) of the *Occupational Health and Safety Act 2004* (**OHS Act**), namely that at Rye between 1 and 17 April 2027, it was guilty of an offence in that, as an employer, it failed to ensure, so far

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proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".

[5] Engaged to take aerial Remotely Pilot Aircraft footage at the Rye Foreshore.

[6] AM-25

as reasonably practicable, that persons other than its employees were not exposed to risks to their health or safety arising from the conduct of its undertaking.

17. On 12, 13 and 27 February 2020, committal proceedings were held at the Melbourne Magistrates' Court before His Honour Magistrate Maxted.[7]

18. The focus of the criminal proceedings were on the patron restraint system fitted to the Cha Cha ride at the time of Eugene's accident, and whether it was reasonably practicable for Wittingslow to have further reduced the risk to riders by not operating the ride unless:

    (a) a secondary rider restraint system, such as a seat belt, had been installed in each car; and

    (b) the length of the U-shaped bars had been increased so as to make it impossible for a rider's leg to slip under the bar.

19. After hearing evidence at the committal hearing on 12 and 13 February 2020, counsel for WorkSafe indicated to the presiding magistrate on 27 February 2020 that the prosecution was to be discontinued, and an application to withdraw the charge was made.[8]

20. The reasons for the withdrawal are not reflected in the transcript, but I note there was evidence given that an improvement notice was not served on Wittingslow by WorkSafe until November of 2017 (approximately seven months after the incident which led to Eugene's passing) and that industry practice in Victoria may not have dictated that secondary restraint systems ought to have been in place as of April 2017.

21. Following completion of the criminal proceedings, the coronial investigation resumed under the Act.

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[7] At pps 453-454, Coronial Brief (**CB**), the particulars of the prosecution were noted as:

a. Your undertaking including operating carnival rides at the Rye Easter Carnival, including the Cha-Cha. The Cha-Cha:

a. has three arms that radiate out from and rotate around a central column; and

b. attached to the ends of each arm are four cars, each with a double seat, which also rotates.

b. If a rider fell or was thrown out of the Cha-Cha they could be seriously injured or killed.

c. In order to reduce this risk, a rider restraint system had been installed in each car in the form of a lap bar that locked in place over the legs of the riders, with tow ushaped downward-pointing horns attached to the bar, designed to go between each rider's legs.

d. It was reasonably practicable for you to further reduce the risk to riders by not operating the ride unless:

a. a secondary rider restraint system, such as a seat belt, had been installed in each car; and

b. the length of the u-shaped bars had been increased so as to make it impossible for a rider's leg to slip under the bar.

e. On 17 April 2017, the risk eventuated when a 6-year-old boy called Eugene Mahauariki fell from the ride and received critical head injuries from which he subsequently died.

[8] The effect of this is that *ne bis in idem* does not attach and criminal proceedings can be re-enlivened.

Discretionary inquest

22. Eugene's family made an application for an inquest to be conducted as part of the investigation[9]. The family's primary concerns were around prevention of death and/or serious injury in the carnival industry. They noted that the subject matter under investigation *touches families across all of Victoria and it is important that all carnivals and ride operators change their practice to keep everyone safe.*

23. I subsequently determined that an inquest would be held as part of the investigation.[10]

Scope of Inquest

24. The inquest scope was determined as follows:

Immediate circumstances

1. The circumstances and immediate cause/s of the incident on 17 April 2017 at Rye foreshore which led to the death of Eugene on 21 April 2017, including but not limited to:

(a) The manner in which patrons were permitted to ride on the Cha Cha during the carnival in April 2017 and on 17 April 2017, including the ride during which Eugene was injured;

(b) The rules applicable to when and how patrons were eligible to ride the Cha Cha and whether they were complied with on 17 April 2017; and

(c) The training provided to operators of the Cha Cha and the extent to which that training was given effect on 17 April 2021.

The Wittingslow Cha Cha ride as at 17 April 2017

2.(a) Was the Cha Cha ride safe for patrons, staff and other members of the public?

(b) Did the Cha Cha comply with the relevant standards?

(c) Was the Cha Cha being appropriately audited and monitored (and where relevant modified) in accordance with applicable safety and audit requirements or otherwise?

3. (a) Was the Cha Cha ride being operated in a safe manner?

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[9] Enclosed in correspondence from their legal representatives dated 11 March 2020.
[10] A directions hearing was convened on 25 February 2021.

(b) Were the rules applicable to when and how patrons were eligible to ride the Cha Cha appropriate to ensure its safety?

(c) Was there appropriate training and supervision of staff?

Regulatory system including roles of owners, engineers/auditors, industry standards and WorkSafe

4. Whose responsibility was it to ensure that the Cha Cha was safe as a matter of design and construction?

5. Whose responsibility was it to ensure that the Cha Cha was operated in a safe manner on 17 April 2017?

6. How were those responsibilities, where identified above, carried out?

7. What was the state of 'Industry Knowledge' about appropriate restraints for rides such as the Cha Cha ride at and leading up to 17 April 2017?

8. Was the regulatory system as at 17 April 2017 adequate in its scope and effect in relation to the safe operation of the Cha Cha?

Sources of evidence

25. As part of the coronial investigation, Coroner's Investigator Detective Acting Sergeant Rodney Eaton (**DS Eaton**) prepared a coronial brief. The brief comprises statements from witnesses including those present at the scene of the incident, the forensic pathologist who examined Eugene, an ambulance paramedic, investigating police officers, as well as other documentation such as photographs and video recordings.[11] The WorkSafe brief of evidence and the transcript of the criminal proceedings also formed part of the evidence before the Court.

Court Expert

26. The Court sought an expert opinion from engineer, Timothy Gibney (**Mr. Gibney**) regarding the most recent assessment of the Cha Cha undertaken by the engineer engaged by Wittingslow. During the course of the inquest, evidence was produced which documented

[11] Following delivery of the CB further evidence was obtained and included such as witness statements and WorkSafe documentation.

that Mr. Gibney had conducted several examinations of the Wittingslow Cha Cha which included: Inspection for Royal Agriculture Show (**RAS**) dated 26 October 2001[12]; Inspection for RAS dated 17 November 2001[13]; Magnetic Particle Inspection on 11 September 2012[14] and a structural check on 19 January 2013[15].

27. In addition, a letter dated 31 March 2015, referred to Mr. Gibney having undertaken a visual, non-destructive inspection of some of the Wittingslow's rides in January 2015 and included a note that *WorkSafe Victoria will be blitzing seaside carnivals next year and given the current regulatory climate due to the Adelaide fatality, Brooks accident and Mule World plant failure, I cannot sign-off your rides in the currently* [sic] *condition. If you would like me to continue to inspection* [sic] *your rides and are serious about improving the condition of your rides, please call me to discuss your concerns.*[16]

28. Further documents produced by Wittingslow referred to Annual Inspections of the Cha Cha which were purported to have been completed by Mr. Gibney on 22 February 2014 and 3 January 2015[17]. No certificates were produced in relation to the logbook entries.

29. Mr. Gibney disputes the latter entry and stated,

I did not and have no recollection in the undertaking of the inspection of the Cha Cha ride at the Rye Carnival dated 03/01/2015 and both the handwriting and signature relating to that inspection is not mine. I do not recognise that handwriting or signature.

I have also since gone through my company records and have no record of my or anyone from my company conducting an inspection of the Cha Cha Ride at the Rye Carnival on 03/01/2015.[18]

The Inquest

30. The inquest ran for 11 days and heard evidence from a range of witnesses. They were: Stacey Mahauariki, Tangi Tungaane Goodnight, Krystal McLeod, Benjamin Jones, Benjamin Rawlinson, Chi Ho Ahn, Anne Murray, Nicole Grant, Mr. Gibney, Kahn Sheu

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[12] AM-9-3 Timothy Gibney clarified at inquest that this would not have been an annual inspection.
[13] AM-9-3
[14] AM-6-2
[15] AM-6-1
[16] AM-7
[17] AM-15-8
[18] AM-22-1

(Geoff) Ooi, Glenn McWilliams, Ben Wright, Thinh Tran, Ian Sandlant, Ashley Bracken, Hamish Munro, Michael Wittingslow, William (Billy) Paul and DS Eaton.[19]

31. Following the commencement of the Inquest, Michael Wittingslow filed a statement with the Court. In addition, further statements from other witnesses as well as other material was obtained from different sources.

32. Both Hamish Munro and Michael Wittingslow were compelled to give evidence under section 57(4) of the Act as I determined that it was in the interests of justice that they do so. The evidence they gave as well as the statement provided by Michael Wittingslow are protected by certificates granted under section 57(6) of the Act.

33. A key witness, Lukas Kohler, who operated the ride at the time of Eugene's accident had returned to his home country of Germany shortly after the incident[20] and, despite the Court's best endeavors, he did not make himself available to give evidence. He was however advised in writing of his right to seek a certificate under section 57 of the Act and that an adverse finding in relation to his actions may be open on the available evidence. The Court also arranged for a member of the Victorian Bar (Pro Bono Scheme) to be available to assist him.

34. After the conclusion of the Inquest, I received written submissions from Counsel Assisting and the interested parties. Oral submissions were made on 12 December 2022.

35. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel (including Counsel Assisting), written and oral submissions of counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Eugene's death. I do not purport to summarise all the material and evidence in this finding, but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

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[19] Seonjin Yoo was excused from giving evidence on medical grounds.
[20] Records suggest that he left Australia on 25 June 2017.

BACKGROUND

Wittingslow Carnivals Pty Ltd

36. Wittingslow had a licence granted by the Mornington Peninsula Shire Council to run a carnival on the Rye Foreshore Reserve over the Easter period in 2017. The carnival was an annual event held at the Rye Foreshore at 2416 Point Nepean Road.

37. In 2017, the carnival operated between 1 and 17 April inclusive. The licensed area of the Rye Foreshore Reserve constituted a 'workplace' for the purpose of the licence, as defined in section 5 of the OHS Act, and Wittingslow constituted an 'employer' at the relevant time. Wittingslow Amusements Australia is a related entity for the purposes of the *Corporations Act 2009* (Cth) and was the owner of the amusement rides at the workplace, including the Cha Cha.

Operation of the Cha Cha

38. The Cha Cha is an amusement ride with three arms radiating from a central column. Each arm has four carriages, each with a double seat. Both the arms and the seats turn whilst the ride is in operation. Each car has a bar comprising three horizontal rods. A U-shaped rod is attached to the lowest horizontal rod in front of each seat in the car designed to go between the legs of the patrons.

39. The bar has a spring-loaded lever to lock into the seat. There is also a safety rope which is pulled behind from the bar and secured in a cleat. The operator controls the speed and length of each ride. A ride was typically three to three and a half minutes although this did vary, and the ride would be at its top speed for 30 to 40 seconds of that time, although again this would vary.

40. Rules were imposed by Wittingslow, as conditions of riding the Cha Cha, and consisted of height and health restrictions, as follows:

    - Anyone over 130 centimetres (**cm**) in height could ride unaccompanied.
    - Anyone at least 120 cm in height could ride on the condition of being accompanied by an adult.
    - Patrons who were pregnant, had health conditions or neck or bone injuries were not allowed.

- Smoking and the consumption of food or drinks was banned.

41. All of these restrictions, including height markers, were displayed on a large board near the entrance of the ride.[21] There was also a sign indicating that the ride operator should not be spoken to when the ride was in operation. It was also a matter of practice that the largest person be seated on the outside, as the operation of the ride forces the occupants to the outer side of the carriage.

42. At the time, the Cha Cha was one of the most popular rides at the carnival.

Rye Carnival – Easter 2017

43. On the 14 April 2017 which was three days before the fatal incident, Nicole Grant and her children were at the Rye Carnival and lined up to go on the Cha Cha. She recalled that the ride operator said to her son, '*You're too little to go on your own, buddy*', but he was allowed to get on the ride if she accompanied him. The operator escorted them to a carriage and pulled the lap bar down. She stated that during the ride she gripped her son as he was sliding underneath the bar and she felt he was at risk of falling out.[22] She added the following at inquest after being shown footage of her on the ride,

I remember it vividly and because as it picked up speed, as you can also see, my body, the velocity was sliding, being slammed. You could see, you know, that I was having trouble containing myself. I couldn't sit in the middle anymore. The force of the ride was just growing, ..., and therefore I had to link and put my hand behind my son's back and put my hand under the ride and physically hold him in to try to stop us, stop him from being free in the - the ride, and that myself, I was starting to be thrown around as well.[23]

...

....and it was quite obvious to me how I was not safely placed within the carriage. ..., the movement that was going on but also as it picks up speed, it's – the video doesn't really show it easily, but there were times when my son's legs were – he was becoming horizontal and I was keeping him on the ride by my bare arms and that obviously felt wrong and it wasn't just a feeling of distress or a feeling of the ride, or it feels a bit scary and it feels like the - sometimes people have experiences on rides where the guard, it feels a bit loose and it

[21] Photographs at pp. 212-216, WorkSafe brief (**WSB**)
[22] p. 83, CB. This ride was video recorded by Nicole Grant's husband.
[23] T335 L20-29

adds to a bit of the drama. This wasn't that. This was he was going to fall out, he was going to come out.[24]

44. Eugene's father said that in his experience *little kids* who ride with their parents do have a tendency to slide around.

45. On 17 April 2017, Chi Ho Ahn and his girlfriend Seonjin Yoo (both adults) rode the Cha Cha shortly before the final ride. He said that he and his girlfriend walked onto the ride, chose the carriage, and that he put the safety bar down himself, which was not checked by anybody. He also said that a seat was broken on a carriage but after being picked up and placed back down by the ride operator, it was re-occupied by patrons without further checks.

CIRCUMSTANCES OF DEATH

46. On 17 April 2017, the Cha Cha was being operated by Lukas Kohler[25]. Whilst there was other more experienced operators of the Cha Cha present that day, such as Eugene's father and Ben Rawlinson, they were engaged as relievers (also referred to as supervisors). There was no evidence to suggest that a person was employed as an assistant or second operator, whilst he operated the Cha Cha on that day.

47. By all accounts it was observed to be a quiet day for the carnival.

48. At approximately 5.10 pm, Lukas Kohler called out 'last ride' for the Cha Cha. This resulted in a number of people, including employees of Wittingslow, who were generally wearing red shirts, and members of the public, gathering around the Cha Cha.

49. According to Lukas Kohler, he stood at the entrance of the ride checking heights of kids before loading and securing them into their seats, and then asking if everyone was locked and safe.[26]

50. In contrast, Chi Ho Ahn who was watching the last ride said *these kids just rushed into the ride and got onto the carriages themselves*.[27] His girlfriend Seonjin Yoo who also witnessed

[24] T336 L31 P337 L1-12
[25] His statement is signed using this spelling for his name.
[26] p.1, CB
[27] p.52, CB

the ride said that *people ran past the barrier and onto the ride without stopping at the entrance… I noticed the young children were climbing onto the carriages themselves*.[28]

51. Anne Murray (**Ms Murray**) who also watched the last ride from the outside barrier said that *half* of the ride occupants were in red Wittingslow tops, and were swapping carriages. She stated that one Wittingslow boy jumped out of a carriage and started helping the operator put people in and tie up ropes. He then jumped back into his carriage and lowered himself back into the seat without releasing the safety bar.[29] At inquest, she was not as confident that this individual helped with other patrons and that he may have just changed carriages.[30] Through inquiries made by the Coroner's Investigator, this individual was likely to have been Bronson who advised him,

that he did jump in out and help out, and then jump back in. ..., but he didn't, ..., direct anybody, ..., from the exterior of the actual, ..., ride, ..., to their seats, and take the daughter who didn't want to take the ride, out, ... or anything like that.[31]

52. Benjamin Jones (**Mr Jones**) boarded the ride with his two daughters. His 8-year-old who was 124 cm in height at the time was placed in a carriage by herself. This placement was contrary to the displayed rules for the Cha Cha. Mr Jones and his other daughter who was 122 cm in height rode together in a carriage separately. He said that there were no height checks at the gate and they were escorted straight onto the ride.[32] Mr Jones also said that he and his daughters were assisted to their seats by a person wearing a red shirt, of *Islander appearance* (Māori appearance) – who was not the ride operator. He said that this person also called 'last ride', met the family in front of the control panel outside the ride and allowed them to ride if he was paid $10 cash.

53. Ms Murray also observed a *stocky islander person* wearing a red shirt helping with security latches.[33] She said that he later got on the ride. I was not able to identify this person during the course of my investigation.

54. Eugene was on the last ride and rode with another six-year-old child named Caprice McCormack[34]. They were well known to each other. Eugene was 132 cm in height and

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[28] p. 56, CB
[29] p. 59, CB
[30] T307 L14-17
[31] T595 L9-14
[32] p. 64, CB
[33] T305 L1-19

according to the rules was able to ride by himself. Caprice was approximately 121 cm in height[35] and according to the rules could only ride with an adult. This placement therefore was contrary to the displayed rules for the Cha Cha. Caprice said that Lukas Kohler locked them into place on the ride.

55. Krystal McLeod (**Ms McLeod**) who was a Wittingslow employee (Teacups operator) seated herself on the Cha Cha with her partner, Harry McCormack (**Mr McCormack**). They are Caprice's parents. Mr McCormack was initially on the inside, but Lukas Kohler instructed her to swap places with Mr McCormack so she wouldn't get squashed. He then closed the bar and locked it before securing the rope on the locking system.[36]

56. Lukas Kohler said in his statement that every carriage on the ride was in use with 21 of the possible 24 spaces occupied. He said that before the ride commenced he asked the patrons if they were locked in and safe before starting the ride. He said that the ride is normally about 2 and half minutes in duration but at the end of the day or if it is quiet, he would let it go for 4 minutes.

57. Mr Jones thought that the ride built up to a constant speed and felt it maintained that speed with no slow down before the incident.

58. Mr McCormack said that the *ride started up and everything was going normal. I had been on the ride before and nothing felt different.*[37]

59. Caprice said that after the ride started, she was sliding into Eugene and squashing him, and Eugene was pushing back on her.

60. Lukas Kohler said that he did not notice Eugene to be *stressed but he was on the outside and a little bit squished*, which was normal for the ride. He was unable to say how Eugene fell as it *all happened so fast.*

61. Chi Ho Ahn said he observed a young boy slipping out from underneath the iron bar with his legs hanging from the outside of the carriage. The boy was holding onto the bar trying not to fall off and looking very scared.

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[34] Caprice gave evidence via a VARE statement on 25 May 2017.
[35] Measurement taken by police on 25 May 2017, p. 106, CB
[36] p. 64, CB
[37] p. 499, CB.

62. Soon after the ride commenced, Eugene slipped out from underneath the lap bar, resulting in him falling out of the carriage. Caprice said that she was trying to hold onto his hand to pull him back.

63. Lukas Kohler said he saw Eugene fly across the arm and heard a loud bang, after which he immediately stopped the ride.

64. Some witnesses said they saw the ride operator holding out stuffed toys to patrons during the ride, who would then lean out and try to grab them. Other witnesses did not observe such an activity taking place. I was not able to resolve this factual issue, given the state of the evidence.

65. Eugene was subsequently airlifted to the RCH with critical head injuries. He tragically passed away from his injuries on 21 April 2017. He was surrounded by family at the time of his passing.

66. At the time of the carnival, Manya Wittingslow and Michael Wittingslow (**Mr Wittingslow**) were the Director/Producer of Wittingslow Amusement Australia Pty Ltd.

67. The Safety Officer on 17 April 2017 was Mr Wittingslow[38] whose role it was to,

at all times be the responsible person for ensuring that the standards implemented by the company's OH&S policy are maintained. This person will monitor the site in advance of the event, during set up, during the event itself and throughout the pull-down.

IDENTITY OF THE DECEASED

68. On 21 April 2017, Tammy White identified her son Eugene Allen Tearanhanga Mahauariki born on 27 November 2010.

69. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

70. On 24 April 2017, Dr Victoria Francis, forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and prepared a written report dated 3 May 2017.

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[38] p. 313, CB (as well as Operations Director)

71. Eugene was noted to weigh 29 kilograms and measure approximately 132 cm in height.

72. Dr Francis formulated the cause of death as *1(a) Complications of Head Injury following a fall from a Fairground Ride.*

73. I accept Dr Francis' opinion as to the medical cause of death.

FURTHER INVESTIGATIONS

Pre-incident

The Cha Cha

74. The Cha Cha was built on 11 September 1961 by Nuttall Engineering. Since that time, it has been owned by Tom Wittingslow Amusements, Des Wittingslow Amusements and since at least 1998, by Wittingslow Amusements.

75. Historical documentation noted amongst other things that it was a Class 3 device with its recommended running speed of 11-12.5 RPM and maximum cycle time for the ride operation of 3.5 minutes.[39]

Pre-incident modifications to the Cha Cha

76. Over the course of its life, the Cha Cha had been subject to certain modifications. Mr Wittingslow advised that the following modifications (not exhaustive) were made as a result of recommendations made by either WorkSafe or engineers:[40]

    a. 2005 – secondary locking strap[41];

    b. 2007 – lap bar horn and foot rest; and

    c. Modifications to the structure of the fold arms.

Pre-incident WorkSafe Notices

77. There was no recent evidence of WorkSafe notices made in relation to the Cha Cha prior to April 2017. There was however a notice relating to an entry report on 7 January 2008 which noted in relation to the Cha Cha that Billy Paul had undertaken to fit an additional restraint

[39] AM-14-11
[40] AM-21, dated 7 September 2022.
[41] This is likely to have been in 2008 given the WorkSafe notice noted in the following paragraph.

system as a back up to the present lap bar system so as to prevent patrons releasing the lap bar whilst the ride is in motion. The additional safety feature was to be located in a position that patrons cannot accidentally or intentionally release during the ride operation.[42]

Pre-incident Information and guidance provided by WorkSafe

78. Prior to the incident, WorkSafe advised that they had published *considerable* literature in respect to a duty holder's obligations under relevant legislation (including the OHS Act) and associated regulations; as well as literature and guidance material in respect to the safe operation and maintenance of plant.

79. WorkSafe further advised that the primary sources of the information in respect to the risk and the available reasonably practicable measures were the:

a. WorkSafe Victoria – Compliance Code – Plant (1995);

b. WorkSafe Victoria – Compliance Code – Plant (2018); and

c. Australian Standard – Amusement Rides & Devices.

80. WorkSafe advised that the Codes apply to amusement structures and set out the risks posed by such structures; the available control measures; regulatory obligations; and how and when a relevant technical standard applies.

WorkSafe visits relevant and/or proximate to the fatal incident

2015

81. On 16 December 2015 WorkSafe Inspector Glenn McWilliams (**Inspector McWilliams**) entered the Wittingslow-operated carnival site at the Rye Pier Foreshore. A number of defects were identified but none relating to the Cha Cha.

82. At the time of the visit WorkSafe were not able to sight the annual engineer report for the Cha Cha which had been prepared by Hamish Munro (**Mr Munro**), and they intended to view the report on a follow-up visit planned for 23 December 2015.[43]

83. On 23 December 2015 WorkSafe carried out their follow up inspection.[44]

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[42] AM-27
[43] p. 698, WSB

2016

84. On 22 December 2016, Inspector McWilliams and Inspector Michael Devlin (**Inspector Devlin**) attended the Wittingslow-operated Rye Pier Foreshore carnival, as part of the *Victorian Public Events Project*. Mr Wittingslow advised the inspectors that the engineering inspection on the Cha Cha ride had been completed on 20 December 2016 by Mr Munro but the report was not yet available.

85. In the course of inspecting the YoYo Chair-O-Plane, the inspectors identified issues with the patron restraint system, as well as the seats. An Annual Engineer Inspection had been carried out on this ride on 5 December 2016 by Mr Munro and these issues had not been addressed. A Prohibition Notice was issued by WorkSafe in relation to the YoYo Chair-O-Plane. This was subsequently changed on a follow-up inspection on 28 December 2016 to 'immediate risk remedied'.

86. On 23 December 2016, Inspectors McWilliams and Devlin entered the Wittingslow-operated Rosebud Carnival, noting that the operation of a Scrambler (also referred to in the notice as a Cha Cha) had been sub-contracted. Inspector McWilliams formed the belief that there was a risk to health and safety of patrons of the Scrambler whereby they could access and release the rider restraint system during the ride. An Improvement Notice was issued which was to be remedied by 29 January 2017. This was not complied with[45].

87. I note that two days after the fatal incident, being 19 April 2017, Inspector McWilliams met with the sub-contractors regarding the Scrambler, which was not assembled at the time of the visit. He noted that,

> '*…at the time of the visit I provided a copy of the Workplace Health and Safety Queensland document titled, 'Re-design of Rider Restraint Systems On Amusement Devices', dated May 2015. Within this document the action of riders being able to manoeuvre from within the rider restraint to a position where they are more likely to be ejected, is identified as a risk requiring the introduction of further engineering control measures.*[46] [Emphasis added]

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[44] p. 612, WSB
[45] It was intended that the ride was to be put in storage and not used until the necessary upgrades were made.
[46] p. 1171, WSB.

Post-incident

WorkSafe safety issues identified in relation to the Cha Cha following the fatal incident

88. On 3 May 2017, an amusement structure intervention review meeting was convened by WorkSafe personnel,

> *to explore Inspectors concerns relating to latent risks associated with the current structure intervention methodology. The intended objective was to provide state of knowledge to Senior Management of any inherent short comings of the current amusement structure intervention and technical guidance on solution strategies for consideration, so as to initiate a coordinated state-wide regulatory intervention compatible with public expectations with amusement structure safety.*[47]

89. This meeting resulted in a document tilted 'Amusement Structures: Intervention Review' dated 9 May 2017, which contained evidence suggesting that WorkSafe personnel were concerned that older rides such as the Cha Cha, Sizzler and Scrambler may not meet relevant Australian Standards. Inspector McWilliams who prepared the document and also gave evidence at the Inquest, highlighted this in the document as noted below:

> *Many rides deemed Class 3, which are an intermediate level ride are 40+ years old designs and have restraint systems that are non-compliant with Section 2.8.1.1 of AS 3533.1. Whilst some progression has occurred in relation to secondary locking mechanisms, enforcement levels remain aligned with 'Industry Standard". In particular restraint systems of some older Class 3 rides, e.g. Cha Cha, Pirate Ship, etc may still enable riders to place themselves in jeopardy through not remaining in the confines of the designated riding position for the duration of the ride cycle.*[48]

90. He further noted that,

> *Considerable reliance* [is placed] *upon the competence and integrity of consulting engineers undertaking annual inspections of rides for ride owners, as the preeminent defence against ride incident occurrence.*

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[47] pps 124-125, WSB.
[48] 'Amusement Structures: Intervention Review' at p. 1180, WSB.

91. Inspector McWilliams noted in this document that adherence to the relevant Australian Standards is hampered by a lack of national coordination for what constitutes compliance, particularly in relation to rider restraint[49].

Work Health and Safety Queensland published a safety alert 05/2015

92. Inspector McWilliams also highlighted in this document that *Work Health and Safety Queensland* published a safety alert in May 2015 titled *'Re-design of Rider Restraint Systems On Amusement Devices'* (**Queensland Safety Alert**).[50] The safety alert indicated that if design deficiencies are found, engineering control measures should be implemented to improve the effectiveness of the rider restraint system'.[51]

93. The Queensland Safety Alert highlighted,

> *incidents resulting in serious injuries and fatalities have occurred in recent years where rider restraints have failed to work properly. One such restraint system relied on the patrons' ability to hold onto the restraining mechanism (e.g. A lap bar) to avoid being thrown from the carriage during the ride. These incidents have highlighted the need for ride owners to assess the effectiveness of rider restraint systems on their rides in accordance with AS 3533.1 2009 and, where necessary, implement engineering control measures to improve patron's safety.*

94. The Queensland Safety Alert applied to rides which, through their motion, result in an ejecting force on the patron and,

> **One***: Rely on the patron to hold on to parts of the carriage (e.g. The lap bar) to avoid being moved into a position where they could be ejected from the carriage (e.g. Legs can be moved from under lap bar onto the seat)*
>
> **Two***: do not have a secondary lock to prevent the rider restraint system from opening during the cycle of the ride (in the event of failure of primary lock)*
>
> **Three***: the patron can access and disengage the rider restraint system, while the ride is in motion.*

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[49] p. 1184,WSB
[50] p. 1175, WSB.
[51] p. 1176, WSB

95. The Queensland Safety Alert further specified the role of the engineer was to conduct '*a risk assessment of the existing rider restraint system, in accordance with Australian Standard AS3533.1 2009, clauses 2.2, 2.8 and appendix G*' (discussed later). It outlined, *that if the rider restraint system design is found to be deficient, the role of the engineer is to develop engineering control measures to prevent the following situations from occurring to a patron who is allowed to go on the ride (i.e.. not covered by the physical restrictions such as height restriction imposed on patrons)*:

- *the patron being able to manoeuvre into a position (e.g. both legs on to the seat) where the patron is more likely to be ejected.*

- *the patron being able to slip under the rider restraint system and into the footwell of the car from where the patron may be ejected from the ride.*

96. Further, that the *objective of the engineering control measure is to improve the ability of the restraint system to secure the patron in the intended position and prevent them from being ejected from a car. Any improvement to the rider restraint system should remain effective for a patron who is slim and only marginally above the restriction height limit*.

97. Inspector McWilliams commented that the Queensland Safety Alert had not been adopted in Victoria by WorkSafe at the time of Eugene's passing.[52]

Mr Ooi's research regarding the safety of the Cha Cha and similar rides

98. Kahn Sheu (Geoff) Ooi (**Mr Ooi**) provided two statements[53], and gave evidence during the criminal hearing as well at the Inquest. Mr Ooi is an engineer but also an authorised inspector. In his first statement, Mr Ooi indicated that when he first visited the scene of Eugene's accident on 18 May 2017 and inspected the Cha Cha, '[f]*rom the parts of the amusement ride I was able to inspect, I did not identify any item of concern at the time'*.

99. In a supplementary statement dated 21 June 2018, he made the following comment,

'*a primary concern was the number of* '*Cha Cha' or similar amusement rides that posed similar risks to that operated by Wittingslow. It was decided that further research and investigation was required in order to better understand the potential extent of the issue*'.

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[52] p.1184, WSB
[53] One dated on 1 or 5 October 2017 (discrepancy in dates) and one 21 June 2018.

100. He noted amongst other things about the Cha Cha, that there were no seat belts fitted on any of the carriages. Some of the hazards associated with the design of the patron restraint system on the Cha Cha ride he identified included the following:

- Patron sliding out from under the lap bar;
- Lateral sliding of the patron along the seat;
- Patron able to bring their leg up onto the seat, and then stand up in the seat;
- Possible tampering of the restraint system by the patron with components that are accessible.

101. He also identified a number of amusement rides that operated in a similar manner to the Cha Cha, including the Scrambler and Sizzler.

102. Mr Ooi undertook research and, using the website 'rideaccidents.com', compiled details associated with 19 incidents (fatal and non-fatal) that occurred on similar rides (including Scramblers, Sizzlers, Whizzers and Twizzlers) between September 1993 and July 2012 from around the world.[54] From the 19 incidents noted by Mr Ooi, Australian incidents included:

a. 3 December 2000, Adelaide, South Australia. A Sizzler ride collapsed, injuring a 30-year-old woman and an 8-year-old boy; and

b. 10 January 2004 – Broadbeach, Queensland. A 6-year-old girl suffered serious head injuries after being thrown from a Sizzler ride.[55]

103. Two further documents referred to previous incidents in Cha Cha-type rides being:

a. Safety Alert from Big Eli dated 31 January 2006 which referred to a recommendation to have a seatbelt fitted to the Scrambler following the death of a young girl who was ejected from the carriage;[56] and

b. Wisdom Industries noted several incidents in previous years of children coming out of their seats in the Sizzler and issued a service bulletin on 1 August 2007 recommending installation of seat belts on the Sizzler.

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[54] p.105, WSB
[55] pp. 434-438, WSB
[56] p. 474, WSB

104. Mr Ooi also referred to the Queensland Safety Alert, as already discussed.

105. Mr Ooi set about locating currently owned Cha Cha or similar amusement rides in Victoria and identified potentially 10 fitting that category. He intended to investigate patron restraints on those rides with a view to establishing industry standards at the time, as well as whether there were any safety issues.

106. Following this review, he concluded that:

- *There was a number of 'Cha Cha' or similar amusement rides in operation around Victoria other than those operated by Wittingslow.*

- *From those 'Cha Cha' or similar amusement rides inspected and information received, the restraint system configuration observed on the Wittingslow ride was the exception rather than the rule. This is because all the other rides have had some additional or modified restraint system fitted that was above and beyond the lap bar and horn on the Wittingslow ride.*[57]

107. I note however that some of the rides examined had their restraint system modified after Eugene's accident.

WorkSafe change subsequent to the fatal incident

108. WorkSafe developed an information sheet on its website dated November 2018 titled '*Effective Patron Restraint systems for Cha Cha, Scrambler and Sizzler Amusement Rides*'.[58] The information noted that the use of a lap bar patron restraint only, may expose patrons to risks while the rides are in use by allowing patrons to:

a. Slide under the lap bar;

b. Slide laterally, which may result in a collision with another patron;

c. Not remain in the designated riding position (eg. Swing their feet and legs onto the seat; and

d. Stand on the seat.

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[57] p. 111, WSB.
[58] AM-3

109. I note that these were similar to the risks identified in the Queensland Safety Alert.

110. The risk control measures highlighted in the information sheet include: an effective patron restraint system; procedures for screening patrons; and checking patrons are effectively restrained.

111. Effective patron restraint systems were noted to include: lateral restraint system such as seat belt loops, dividers in the car, or appropriately designed and built in seat horns, as well as a tamper resistant locking device, seating design to minimise the lower edge of the lap bar and seat.

112. Specific suggestions of patron restraint systems were provided for the Cha Cha noting,

Duty holders should consider the following combinations of patron restraint systems as a means of ensuring that patron restraint is effective.

113. The information sheet was developed by WorkSafe engineers including Mr Ooi, and appears to recommend engineering control measures to mitigate the risks identified with the Cha Cha (and similar rides), consistent with the objective of the Queensland Safety Alert.

Why was the Queensland Safety Alert not formally adopted, or in the alternative, a similar alert not developed, in Victoria?

114. It was apparent through investigations that the Queensland Safety Alert which identified safety issues with rides such as the Cha Cha in 2015 was known to WorkSafe but a similar alert was not formally adopted, or in the alternative, a similar alert not developed, in Victoria. The Court was made aware of a national network led by Workplace Health and Safety Queensland, which included state regulators, who met to discuss issues relating to amusement ride safety, amongst other matters.

115. Available evidence included an email dated 21 January 2015 sent to a network of stakeholders [including WorkSafe via Ian Sandlant (**Mr Sandlant**)] from Michael Chan (**Mr Chan**), Director and Chief Safety Engineer, Workplace Health and Safety Queensland advising that in view of recent incidents associated with amusement rides he had reviewed

an earlier safety alert which was now being forwarded for comment prior to the Amusement Devices Stakeholder's Forum in Brisbane on 17 February 2015.[59]

116. Further, a string of emails all dated 23 February 2015 showed that a draft of the Queensland Safety Alert was distributed by Mr Chan to a network which included engineers[60] containing the following communications:

- comments were sought on the draft from engineers (including Hamish Munro, Mr Gibney and Brian Bradley);

- followed by a suggestion from engineer Brian Bradley that a time frame could be placed on compliance by ride owners as well as asking if other regulators would follow the Queensland Safety Alert;

- a response from Mr Chan on 23 February 2015 agreeing that a time limit for compliance would be a good idea and, regarding whether other states would follow he commented, *I cannot guarantee if the other states will publish similar alerts. Any comments Chris, David, Ian? In any case, we may have to rely on the 'state of knowledge' to encourage ride owners in other states to implement similar control measures*; and

- an internal WorkSafe email (which included Principal Engineer Les Kriesfeld) from Mr Sandlant dated 23 February 2015 which said, *FYI, Les can we meet and discuss this ...I mentioned that we should prepare a position on this last week as I suspected this might occur.*

117. Mr Sandlant gave evidence at the Inquest and his best recollection was that there was a discussion within WorkSafe about the secondary locking system only. He conceded however that on a fair reading of the document, it also concerned a review of rider restraints. He stated,

and in this I'm talking about a conversation between myself and the principal engineer, Les ..., that there ... seemed no ... reason that we needed to ... react to this document, ...- that at the moment ...- my understanding was ... that the existing ... restraints on the ... types of rides ... that were articulated in there were satisfactory ... I.. assumed to Les' assessment

[59] AM-19
[60] AM-19

but I saw no reason …- to push for change either. We were seeing no incidents … or injuries that were - … indicating that need at that … time that I can recall.[61]

118. He stated further,

I had interpreted that document to be primarily focussed at secondary restraint. Not focussed at the ejection forces, or the primary ability to defeat the primary lock. And in hindsight, … – my view would then being to look at it from both angles. However, looking back at it, and looking at the document, even at the start of this proceedings today, my view was I've always understood this document to be about the secondary locking of it. …, however there's – there's been a lot of conversation, and a lot of question, …, around it, and it's – it's reasonable that you – you need to reflect on other views that are given, and take a look at that, but I must say, I still thought it was about secondary locking, I always did.[62]

119. Inspector McWilliams was asked about the risks identified in the Queensland Safety Alert (particularly noting the three points in paragraph 94) and was confident that the second (secondary lock) and third (patrons' ability to disengage the restraint system) points were already matters considered as part of the Audit Tool prior to 2017. He was less confident about Point 1 (risk of ejection)[63] although he suggested that it was already his practice to consider each of these matters.

120. As noted above, following Eugene's accident WorkSafe developed an Information Sheet which recommended engineering control measures to mitigate the risks identified with the Cha Cha (and similar rides), consistent with the objective of the Queensland Safety Alert. The risks highlighted in the WorkSafe Information Sheet appear to relate to that of a patron being ejected from the ride.

121. It is apparent that the restraint system on the Cha Cha at the time of Eugene's accident would no longer be considered to meet industry standard in Victoria. I do however note the comment of Mr Chan which suggests that in his mind, a *'state of knowledge'* might have been established in 2015 around these issues. This appears to be consistent with the evidence Mr Gibney gave at the Inquest, at least from the perspective of inspecting engineers, which is discussed later in my finding.

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[61] T843 L14-24
[62] T921 L27-31 to T922 L1-10
[63] T716 L3-21

122. The risks presented by a ride such as the Cha Cha are obviously the same regardless of its geographic location, although a regulator's response to managing such risks could clearly vary.

123. Relevant to this investigation, Mr Wittingslow as the owner/business operator of the Cha Cha had an obligation to inform himself of information relevant to the industry he was undertaking, which would have included the Queensland Safety Alert (and other relevant information identified by Mr Ooi). Hamish Munro was aware of its existence, having been consulted on its development.

124. WorkSafe submitted that a duty holder, such as Mr Wittingslow is expected to be proactive in identifying and responding to risks in its workplace, particularly in *inherently dangerous* workplaces such as amusement carnivals.[64] It was apparent from Mr Wittingslow's evidence that despite this responsibility, he did not appear to be well informed about the available literature and appeared to rely on the annual WorkSafe inspection and the engineer's certification to ensure the Cha Cha's safe operation.

125. WorkSafe submitted that the Queensland Safety Alert re-enforced duties to ensure safety:

> *To make sure that riders can't escape their primary restraints; that is, get free so that the forces on the person permits their ejection from the ride*. And that the duty *is so obvious and fundamental to amusement rides that its communication has to be regarded as meaningfully unnecessary*.[65]

126. I hold a different view about the value of the Queensland Safety Alert which required an owner to have their rider restraint system assessed after the Queensland regulator formed a view that such action was necessary in view of incidents resulting in *serious injuries and fatalities* where rider restraints have failed to work properly.

127. It is my view that the implications of the 2015 Queensland Safety Alert could have been further explored in the Victorian context prior to Eugene's accident, and this appears to be a missed opportunity to re-enforce rider safety for Cha Cha type rides. An example being the Information Sheet later prepared by WorkSafe in 2018. I do not suggest that any such action would necessarily have altered the outcome in this case.

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[64] WorkSafe closing submissions at para 14(c).
[65] WorkSafe closing submissions at para 82(a).

Safety and Regulatory System

128. WorkSafe is the statutory body which regulates health and safety in Victoria. I invited WorkSafe to detail the safety and regulatory system in Victoria relevant to my investigation. Submissions dated 22 March 2021 were made and are set out in part below.

129. At the time of the incident, WorkSafe administered legislation (and associated regulations) including the OHS Act which impose a number of duties and obligations on employers, employees and other persons in respect to workplace health and safety.

130. The objects of the OHS Act include: to secure the health, safety and welfare of employees and other persons at work; to eliminate, at the source, risks to the health, safety or welfare of employees and other persons at work; and to ensure the health and safety of members of the public is not placed at risk by the conduct of undertakings by employers and self-employed persons.

Role of WorkSafe

124. WorkSafe's general functions under the Act include:

a. to monitor and enforce compliance with the OHS Act (and associated regulations);

b. to disseminate information about the duties, obligations and rights of persons under the Act or the regulations and to formulate standards, specifications or other forms of guidance for the purpose of assisting persons to comply with their duties and obligations;

c. to promote public awareness and discussion of occupational health, safety and welfare issues and an understanding and acceptance of the principles of health and safety protection;

d. to monitor the operation of measures taken and arrangements put in place to ensure occupational health, safety and welfare; and

e. to do all things necessary or convenient to be done for or in connection with the performance of its function;[66] including the power to obtain information; make guidelines, accept undertakings and give advice on compliance.

125. In order to fulfil its functions, WorkSafe is empowered to: obtain information from employers and other persons; make guidelines in respect to the provisions of the OHS Act and associated regulations; accept undertakings from a person in respect to a contravention, and give advice on compliance.

126. In addition, WorkSafe's powers include the power to enter workplaces and require the production of documents; issue a non-disturbance notices; issue an improvement notices; and issue a prohibition notices.

Operational Safety

127. The OHS Act imposes a number of duties on employers, self-employed persons, employees and other persons which in broad terms are to ensure a working environment which is safe and without risk to health or safety, so far as is reasonably practicable.

128. WorkSafe advised that a duty holder is to eliminate risks to health and safety, so far as is reasonably practicable; and if it is not possible to eliminate the risks, to reduce them so far as is reasonably practicable.

129. WorkSafe advised that in determining what is reasonably practicable, a criminal court is required to have regard to: the likelihood of the hazard or risk concerned eventuating; the degree of harm that would result if the hazard or risk eventuated; what the person concerned knows, or ought reasonably to know, about the hazard or risk and any ways of eliminating or reducing the hazard or risk; the availability and suitability of ways to eliminate or reduce the hazard or risk; and the cost of eliminating or reducing the hazard or risk.

130. It was noted that these matters are not assessed subjectively according to the knowledge and particular circumstances of the employer but are determined objectively, including against industry standards.

131. Duty holders relevant to this investigation include Mr Wittingslow (Wittingslow Amusements Australia) as the owner of the Cha Cha and operator of the Rye Carnival,

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[66] Sections 9-11 OHS Act

Hamish Munro as the engineer who inspected the Cha Cha most proximate to the fatal ride and Lukas Kohler was the operator of the Cha Cha at the time of the fatal ride.

132. As already noted, it appears that the question of whether industry standards dictated further restraint for the Cha Cha at the time of the fatal incident was considered during the criminal prosecution against Wittingslow, and the prosecution was subsequently withdrawn. There was no information to suggest that charges under the OHS Act were laid against Hamish Munro or Lukas Kohler.

Inspection and maintenance of equipment

133. The Occupational Health and Safety Regulations 2017, and its predecessor and the Equipment (Public Safety) Regulations 2017 (**EPS Regulations 2017**), and its predecessor contain provisions relevant to the Cha Cha.

134. Firstly, there are a number of provisions directed at the maintenance and inspection of *plant*.

135. Plant is defined to include amusement structures:

amusement structure means powered equipment operated for hire or reward that provides entertainment or amusement through movement of the equipment, or part of the equipment, or when passengers travel on, around or along the equipment.

136. The Cha-Cha meets the definition of an amusement structure.

137. The regulations provide that an employer is required to inspect its plant and also require an employer to keep records of the inspection and maintenance of the plant.

138. Secondly, a regulatory regime is prescribed for the inspection and maintenance of *prescribed equipment*. The Cha-Cha is also considered to be prescribed equipment.

139. Prescribed equipment is required to be inspected and maintained to ensure that the risk arising from the use of the prescribed equipment is eliminated or if not practical to eliminate the risk, is reduced so far as is practicable. In addition regulations require that a person who is in charge of prescribed equipment[67] must take reasonable care for his or her own health and safety and for the health and safety of any other person who may be affected by his or her acts or omissions in relation to the equipment.

[67] Duties are also imposed on proprietors of prescribed equipment; manufacturers, designers, importers, suppliers and people who erect or install prescribed equipment.

140. Information available to the Court suggests that Wittingslow had written procedures in place for the inspection and maintenance of rides (Wittingslow Amusements Australia Pty Ltd – 'Occupational Health and Safety Policy Manual). There was also evidence available that a record was kept in relation to these activities.

Registration of design

141. The OHS Regulations 2017 (and its predecessor) and EPS Regulations 2017 (and its predecessor) require the design of plant to be registered.

142. The purpose of design registration is to ensure that the design has been reviewed by an independent and suitably qualified person prior to use. The registration of design process does not involve or require WorkSafe to come to its own conclusion as to the safety of the design. Rather, it is the designer's obligation to ensure they have engaged the relevant independent person to perform the safety review.

143. Where a plant design is to be registered, the provision of a design verification statement by a suitably qualified design verifier who was not involved in the design and has checked the plant accords with the relevant technical standards is required.

144. Plant design is however not required to be registered if:

a. the amusement structure design was started before 1 July 1995, or

b. the amusement structure is referred to as a Class 1 structure in accordance with the relevant Australian Standard.

145. The Cha-Cha was designed and manufactured before 1 July 1995 and so there was no obligation for its design to be registered. As already noted, the Cha Cha was designed and manufactured on 11 September 1961 by Nuttall Engineering.

146. It is apparent therefore that in the absence of design registration the only other means by which the adequacy of the design of an old ride against any up to date measures might be able to be measured is the annual inspection by an engineer or a WorkSafe inspection.

Registration of plant

148. The OHS Regulations 2017 (and its predecessor) and EPS Regulations 2017 (and its predecessor) require *plant* be registered.

149. The purpose of plant registration is to enable WorkSafe to maintain a record of the locations (workplaces) at which plant is being used in Victoria. Such information enables WorkSafe to conduct state-wide inspections of specific plant when, and if, issues arise with respect to the safety of that piece of plant.

150. At the time of the fatal incident, the OHS Regulations 2007 applied and the employer had an obligation to register the item of plant, as opposed to the plant design. However, on 1 July 2014, the regulations were amended to no longer require the registration of plant.

151. In those circumstances, the Cha Cha had been registered on 19 November 2013, when registration of plant was still required[68], with registration lasting for a period of 5 years.

152 Mr Gibney said that as a consequence of the change in regulations, no Victorian ride owners or operators have plant items registered in Victoria. He said that New South Wales and Queensland allow Victorian travelling showmen to plant item register their rides in their states to provide certificates of currency for when they are working interstate.

153. Mr Gibney considered that high risk plants such as amusement rides, cranes, concrete pumps and boom type elevated platforms should be plant item registered and that plant item registration would allow WorkSafe to know what plant exists in Victoria, that may not be design registered, and to apply a more strict inspection regime to those devices.

155. Plant registration would also mean that the number of plant would be apparent and could quickly and easily be tracked and inspected annually by WorkSafe. It was noted that Mr Ooi struggled to locate all the Cha Cha rides in Victoria during his research as they were not registered.

156. Plant registration could also ensure that operators are abiding by the requirements of applicable regulations, and in particular the requirement regarding inspections and maintenance.

Certification/Audit Processes

157. Annual audits by WorkSafe of items of plant, as were carried out at the Rye Foreshore at the end of 2015 and 2016, are said to be a general means of fulfilling WorkSafe's obligations

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[68] p.2884, WSB

under the OHS Act. The audits involve a careful visual inspection for signs of obvious defects but are not an engineering inspection.

158. It was noted during evidence that unlike other workplace inspections of plant, the rides at a carnival are not always in operation. In addition, they are not static and once the carnival leaves a location they can be anywhere including interstate.

159. Victoria has not adopted the national model work health and safety laws including Regulation 241 of the of the *Work Health and Safety Regulations 2011* (Cth) (*Annual inspection of amusement devices and passenger ropeways*).[69] It is however WorkSafe's practice to use the 'Work Health and Safety – OHS Regulators' National Audit Tool for Amusement Devices (**Audit Tool**) to audit the safety of amusement rides,[70] which is said to reflect the requirement under Regulation 241 to conduct an annual inspection and certification of plant by an engineer. It was noted during the criminal proceedings that, whilst the national regulation does not apply in Victoria and there is no statutory requirement in Victoria for annual inspections to take place, it is a matter of practice that WorkSafe conducts the inspections.[71]

160. The Audit Tool was however noted by Inspector McWilliams to be a '*cumbersome document within which actual safety pertinent enforceable prompts are lost amongst procedural non-enforceable distraction*'.[72] Two other inspectors who gave evidence at the Inquest agreed with this view including Mr Ooi who described going through the Audit Tool as *very close to* a *meaningless ritual* as it doesn't *marry off … a safety payoff.*

161. Inspector McWilliams noted the following in the alternative,

> *…. It's not consistent, in my opinion, with how we would normally do workplace intervention. …. Most of our guidance document is tailored – and I'm talking across industries – is tailored around a specific item of plant; what's the hazard, and what are the controls.*

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[69] In 2011, Safe Work Australia developed the model work health and safety (**WHS**) laws to be implemented across Australia. To become legally binding the Commonwealth, states and territories must separately implement them as their own laws. Safe Work Australia is responsible for maintaining the model WHS laws, but do not regulate or enforce them.

[70] Statement of Glenn McWilliams at p. 116, WSB. p. 595, WSB.

[71] Mr Gibney commented that the Australian Standard AS3533.1 2009 is called up in the Model Work Health and Safety Regulations 2011 adopted by NSW, NT, Queensland, SA and Tasmania. Victoria and WA have not signed up to the Model Regulations but follow very closely to Model Regulations 2011.

[72] p.1181, WSB

...it identifies a status – ... , a state of knowledge, if you like, which is then usually done in consultation with, ..., stakeholder bodies, ... With reference to standards and best practice, whether it's within Australia, nationally or internationally. And then we produce a document that provides that – that particular – that's what compliance looks like.

..., there isn't an exhaustive number of rides out there. ...., there's all different names for similar classes of rides – ... I think there's better ways than a generic audit tool, ..., to effect an outcome ... – than that particular document.[73]

162. Inspector McWilliams suggested the possibility of a more targeted tool for different kinds of rides, that would focus more on the particular risks that the rides pose. He said that there was probably only a handful of things that should be kept from the Audit Tool. The examples provided included the critical components list, evidence that there has been non-destructive testing, and at what frequency, a log book or history of maintenance associated with it, and the annual engineer inspection.

163. Mr Sandlant who also gave evidence at the Inquest, noted that the Audit Tool had been developed nationally and disagreed with the views of the inspectors about its value.

164. I note in addition that the annual *certification* by an engineer is considered a task undertaken by pre-1 July 1995 plant owners in order to meet the WorkSafe audit requirements. In the absence of a certificate from an engineer however a ride can still operate.

165. As already noted, the annual certification of the Cha Cha was completed in December 2015 and 2016 by engineer, Hamish Munro. The requirements of the certification are discussed below.

The Australian Standard – Amusement rides and devices

166. The applicable standards for an amusement ride such as the Cha Cha are the Australian Standard – Amusement rides and devices[74] (**AS 3533.1 2009**).

167. AS 3533.1 2009 provides regulators, designers and manufacturers with requirements for the design and construction of amusement rides and devices to promote uniformity with regards to design principles, manufacture and registration of these devices. Australian Standards do not however have the force of legislation.

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[73] T656 L17-31 – T657 L1-3
[74] pp. 633-1125, WSB

168. AS 3533.1 2009 also sets out what is required during the service and inspection of an amusement ride or device so that a set of competencies can be established in respect to the inspection and use of that equipment.

169. As AS 3533.1 2009 applies to the Cha-Cha, WorkSafe said that it may form part of the industry literature available and applicable to the plant and as such, it informs a duty holder's obligation under the OHS Act.

Annual in-service inspection under AS 3533.1 2009

170. The annual inspection is normally undertaken by a professional engineer who has access to all records about the ride. The annual inspection requires the ride to be fully assembled and operational for the final part of the inspection. AS 3533.1 2009 requires the ride to be examined in detail visually. The inspector forms an opinion as to the safety operation of the ride.

171. According to Mr Gibney, the annual inspection considers the condition of patron seating; the condition and effectiveness of the restraint devices; condition and integrity of the primary structural elements supporting the seats as well as the condition and integrity of mechanical components supporting and driving the cars or carriages; a check of all the structural and mechanical elements involved in the load paths from rider restraint to ground level; a check of the ride main frames, chassis, including jacking points, outriggers and anchorage systems; a check of the drive system including the motors, hydraulic system and pneumatic systems that affect acceleration, ride speed and braking; and the proper operation of the ride controls, including interlocks, stopping and emergency stopping. In addition, a check of all fences, barriers and access and egress to the ride by patrons.

172. Mr Gibney said that particular attention should be given to the patrons' restraints to ensure they effectively restrain the smallest patron allowed to ride on the ride. This may involve testing the restraints with the smallest sized patron whilst the ride is stationary and asking the child to try and get out of the restraints, if the restraints have not been checked previously. Every individual restraint should be checked to ensure the primary lock and secondary lock work independently of each other where required and cannot be defeated by a patron.

173. Mr Gibney said that the inspecting engineer should enquire that all of the safety tests set out by the manufacturer have been undertaken in the course of the past 12 months. The engineer should check the ride logbook, servicing and the maintenance records for the past

12 months, including any repairs affecting the ride safety and any safety upgrades. The owner should be queried about any notices issued by a Workcover authority over the past 12 months and check that the critical components have been Non Destructive Testing (**NDT**) tested and that an electrical sign-off has been carried out on the ride. Finally, the owner should be queried on any accidents or incidents that have occurred in the past 12 months. Once these items have been satisfied the inspecting engineer can provide a certificate stating that the ride is safe to work at the time of the inspection. The engineer should sign the logbook after the inspection is complete.

Restraint Assessment under AS 3533.1 2009

174. According to AS 3533.1 2009 – *Provision of restraints to counter the effects of acceleration and seat inclination that restraint devices* – restraints will be fitted in circumstances where it is reasonably foreseeable that patrons could be lifted or ejected from their seats or riding positions by the acceleration of the amusement ride or device, or by seat inclination, during the ride or device cycle and other reasonably foreseeable situations.[75]

175. The patron restraint properties are determined in accordance with clause 2.8 *Containment and Restraints* and Appendix G *Guidance on Risk Assessments Concerning Provision of Patron Containment and Restraint Systems* of AS 3533.1 2009.

176. The device classification (or class) is not reflected in the determination of the patron restraints.

177. The restraint type is determined primarily from the measured ejection forces on the patron riding in the carriage seats of the amusement device. The more severe the ejection forces the higher level of safety that is required for the restraints.

178. AS 3533.1 2009 notes,[76]

The coordinate system shown in Figure 2. 1 shall be used as the standard reference for acceleration directions, including the application of the different means of restraint in accordance with the criteria of the acceleration diagram shown in Figure 2.2.

The acceleration diagram in Figure 2.2 shall be used as part of the risk assessment for determining if a restraint is required and, if required, what type.

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[75] p.654, WSB
[76] p.654 -655, WSB

Figure 2.2 identifies and graphically illustrates five distinct areas of theoretical acceleration. Each of the five distinct areas may require a different type of restraint, as indicated in Clause 2.8.2. Figure 2 .2 applies for sustained acceleration levels only. It is not applicable to impact accelerations.

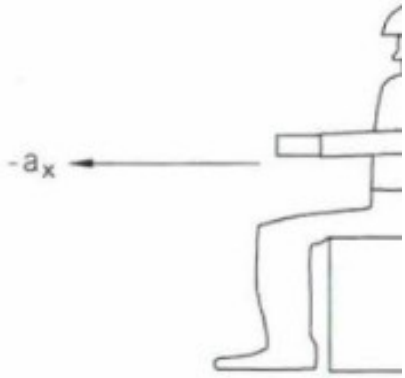

FIGURE 2.1 COORDINATE AXES REFE

179. The calculations of the restraint type undertaken in accordance with AS 3533.1 2009 of the Cha Cha by engineer Hamish Munro are discussed below.

Owner/business operator – Wittingslow

180. Mr Wittingslow made a statement following the commencement of the Inquest and also gave evidence under compulsion. He was the owner/operator of the carnival at the time of Eugene's passing. He stated that he had been involved in the amusement and carnival business all his life and was the third generation in his family to operate amusements and carnival rides.

181. Mr Wittingslow said that he accepted that as part of the business of amusement rides and running carnivals, that Wittingslow must ensure, as far as reasonably practicable, that all of the rides are safe for the people on the rides and the following actions were undertaken to ensure this occurred;

    a. having the rides inspected by a qualified engineer to confirm that the rides are safe in accordance with the Australian Standards;

    b. having the rides inspected annually by WorkSafe;

    c. the completion of daily checklists prior to the ride operations;

    d. maintenance of the rides;

    e. training of the ride operators in accordance with the engineers requirements and Wittingslow's training procedures; and

    f. the attendance of supervisors at all times to ensure the rides are conducted safely.

182. Wittingslow documents formed part of evidence before the Court including the Wittingslow Amusements Australia Pty Ltd – 'Occupational Health and Safety Policy Manual', which included:

    a. Ride Maintenance Program – *A schedule of ongoing maintenance has been developed to ensure all rides are inspected and kept in good working condition. This program continues on an annual basis and encompasses remedial and preventative maintenance. All rides are disassembled and inspected in accordance with Australian Standard AS 3533.2, all stress points are checked via a magnetic particle or ultrasonic testing*

according to the ride manufacturers specifications and the requirements of the consulting engineer.

b. Pre Show Maintenance – *Each ride will be inspected prior to opening. The Ride Assembly Checklist (pre show) must be completed and certified by Wittingslow Amusements Australia Site/Operations Manager before the ride is considered safe.*

c. Daily Maintenance –

1. Prior to opening any ride the daily maintenance check is to be performed. This check is a visual and mechanical inspection of all ride parts as per the Ride Maintenance Inspection Sheet.

2. The ride must not be opened to the public until the above inspections and daily maintenance sheets have been completed and certified by the operator.

d. Seasonal Maintenance –

1. Weekly, bi-weekly and monthly preventative maintenance is performed on each ride, as specified……

3. A Consulting Engineer performs vigorous inspections and specifies the ride components that require Non Destructive Testing (NDT) annually.

183. As previously noted, Mr Wittingslow was the Safety Officer on the day of the fatal incident. He said that he made some inquiries about how the accident had occurred, but was unable to give an explanation as a result of those inquiries,

I know it happened, …, of course, that someone let the person in to the car when they shouldn't have let them in, that's all I know.[77]

184. And then later in his evidence at inquest commented,

a last ride and we had a lot of …, young kids that …, show kids and …, …., I think it might've been a mistake on the, maybe on the, on the sake of the operator that he's …, done

[77] T1145 L24-26

that but …, the kids are familiar with the ride and he might've assumed that …, they were all the right size they might've rushed in through the gate, I'm, I'm not too sure.[78]

KEY FOCUS OF INVESTIGATION

185. During the course of the investigation two primary areas of concern emerged in the context of the operation of the carnival and in particular the Cha Cha at the time of the fatal incident.

186. They included the following,

a. Whether the restraint system fitted to the Cha Cha at the time of the fatal incident was compliant with AS 3533.1 2009.

b. Whether Lukas Kohler was appropriately trained to operate the Cha Cha at the time of the fatal incident.

Was the restraint system fitted to the Cha Cha at the time of the fatal incident compliant with AS 3533.1 2009?

187. Mr Wittingslow stated that various engineers had provided advice that the restraints system on the Cha Cha was compliant with Australian Standards with the most recent being engineer Hamish Munro. He said that he had never received advice that seat belts should be fitted on the Cha Cha and if he had, he would have done so.

188. As already noted, in accordance with AS 3533.1 2009 the inspecting engineer is required to conduct a risk assessment of the existing rider restraint system to ensure it is compliant with those standards.

189. In relation to the Cha Cha, engineer Hamish Munro checked the ride restraint assessment on 20 December 2016[79] and certified the restraint system to be satisfactory and fit for purpose. His report refers to Appendix G of AS 3533.1 2009, and that the Cha Cha restraints were certified as compliant on the basis of his assessment. He also completed an annual inspection of the Cha Cha on 18 December 2015.[80]

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[78] T1150 L19-25
[79] p.496, CB
[80] An annual inspection was noted to have been completed by Hamish Munro on 18 December 2015 (Rye, 15-732) and 20 December 2016 (Rye Carnival, 16-719).[80]

190. In his statement to the Court dated 29 January 2021, Hamish Munro said, amongst other things, that his usual practice when undertaking an inspection of an amusement ride was to inspect the logbook for the ride and to *inspect the aspects of the ride according to the fields on my Report of Annual Inspection of Amusement Device.* He would only make a note if an issue was identified and he would observe the ride in operation.

191. An Amusement Ride/Device Logbook for the Cha Cha (registration PL65596520) was provided in evidence noting the inspecting engineer as Hamish Munro.[81]

192. The Logbook included the following introductory remarks,

> *This logbook has been compiled to complement the National Audit Tool that has been developed by the National Regulators Amusement Device Committee and which is currently being used to audit amusement ride operators in most Australian States. ... If this logbook is accurately and comprehensively completed, an audit should only involve "turning the pages' to satisfy the Regulator that the ride operator has complied with all the statutory requirements.*

193. For the assessment of the Cha Cha on 20 December 2016, Hamish Munro noted that it was a Class 3 device and it was exempt from design registration in Victoria (as it was built in 1961).

194. The Hazard Risk Analysis was noted to include, *Patrons ejected from ride*. The *Action to Eliminate or Minimise* was stated as,

> *All safety restraints are secure and checked prior to the ride starting. Operators to visually check each patron while the device is in operation at a minimum of one visual check per cycle. Stop the ride immediately if patrons display distress.*[82]

195. The Logbook included a training procedure for Operators and Attendants and other training records but these were not completed (that is, they were blank).[83]

196. The Rider Restraint Assessment completed on 20 December 2016 by Hamish Munro noted that it was assessed to AS 3533.1 2009 Appendix G, with the following documented:

    a. F=2, P=1, H=2, V=3, Sum R = 8;

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[81] p.406, CB.
[82] p. 414, CB.
[83] p. 418, CB.

b. 7-10 was underlined which indicated Type 3;

c. a positive indication ('Yes') that there was compliance; and

d. a notation that – *It is my opinion, as indicated from the details of inspection recorded above, that the restraint system on this device is satisfactory and fit for purpose.*[84]

197. According to AS 3533.1 2009, the patron restraint factor, R, is the parameter for determining the characteristics of the required patron restraint system. The value of R is the arithmetic sum of the ride's ejection force factor (**F**), panic factor (**P**), height factor (**H**) and velocity factor (**V**), i.e., Patron restraint factor, **R = F + P + H + V**. It further notes that if R=1 Type 1 restraints are indicated; more than or equal to 5 and less than or equal to 6 indicates Type 2 restraints; more than or equal to 7 and less than or equal to 10 indicates Type 3 restraints; more than or equal to 11 and less than or equal to 13 indicates Type 4 restraints and; more than or equal to 14 and less than or equal to 15 indicates Type 5 restraints.[85]

198. Hamish Munro's calculation documented that it was his assessment that the Cha Cha required Type 3 restraint. In accordance with AS 3533.1 2009, a Type 3 restraint is generally defined as a locking restraint device for an individual patron or a locking collective restraint device for more than one patron and the following is relevant to the restraint required[86],

A Type 3 restraint shall have at least the following characteristics:

(a) Number of patrons per restraint device The restraint device may be for an individual patron or it may be a collective device for more than one patron.

(b) Final locking position relative to the patron The final locking position shall be variable in relation to the patron, e.g. a bar or rail with multiple locking positions.

(c) Locking The patron or operator may manually lock the restraint or it may lock automatically. The manufacturer shall provide instructions requiring the operator verify that the restraint device is locked.

(d) Unlocking The operator manually or automatically unlocks the restraint.

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[84] p 424, CB.
[85] pps736-737, WSB
[86] p656, WSB

(e) Confirmation of status The design shall allow the operator to perform a visual or manual check of the restraint each ride cycle.

(f) Means of activation The restraint may be manually or automatically (e.g. motorized) opened or closed.

(g) Redundancy of locking device Redundancy is not required.

199. Applying the requirements of AS 3533.1 2009 noted above, at the time of Eugene's accident, the restraint system did not appear to comply with Type 3 restraints, as there was no variable locking mechanism for each patron.

200. An expert opinion was obtained from Mr Gibney who gave evidence at the Inquest and also provided a supplementary report[87], as well as a further supplementary report prior to final submissions being made.

201. Mr Gibney was of the opinion that the restraint system installed on the Cha Cha at the time of the fatal incident did not meet the requirements of a Type 3 restraint. He noted that the restraint was not variable in relation to patron and that the installation of a seat belt would have provided a restraint variable in relation to the patron. He considered that the restraints on the Wittingslow Cha Cha were not appropriate to contain smaller patrons from getting out of the restraints. If the lap bar had locked down appropriately on the smaller patron's legs, they would not have been able to get out of the seat. He did however agree that Type 3 restraints were required in accordance with AS 3533.1 2009 as determined by Hamish Munro.

202. During evidence Mr Gibney referred to a requirement in 2015, introduced by the Queensland Safety Alert, that all restraints were assessed and it required an engineer to do that assessment based the AS 3533.1 2009. In his view, there was a need for engineering inspectors to *come with fresh eyes on the question of restraints.* He said that from 2015 onwards this represented best practice for engineers conducting inspections *we started doing more thorough restraint assessments as a result.*[88] He further indicated that,

[87] Dated 2 May 2022
[88] T399 L28-29

...in 2015 I changed my checklist to include restraints after Queensland, ..., suggested that we had to do these restraint assessments. ..., and my new form reflects the more thorough inspections that were required after the, ..., alert from Queensland.[89]

203. He agreed that fundamentally the need for a restraint on the Cha Cha was the risk of being ejected from the designated riding position by the inherent motion of the device, noting the ride's *whipping action.*

Hamish Munro's evidence at inquest

204. At inquest Hamish Munro gave evidence that departed from the documentation in the Logbook which recorded his assessment in December 2016 and gave evidence that as part of his inspection of the Cha Cha, he lessened the value of R and thus found that the Cha Cha only required Type 2 (not Type 3) restraint. He said that while he had no memory of lessening R, and while he recorded the value of R as being 8, he must have reduced R in his mind (and not documented this reduction). He gave evidence that this was permitted by AS 3533.1 2009, on the basis that there were no vertical forces applied to patrons. He acknowledged that he should have made a note of that, but did not. He did however agree that the restraints fitted to the Cha Cha at the time of the incident were not consistent with Type 3.

205. During his examination by Counsel Assisting, I note the following exchange,

Counsel Assisting: *So I just want to make sure it's absolutely clear ... - so you don't remember reducing R on this day, is that right*?

Hamish Munro: *No, not per se, no. I don't remember the action of doing it*.

Counsel Assisting: *But having looked at the assessment and looked at the photographs of the ride what you're suggesting is that in order for you to say that the ride complies you must have reduced R, is that what you're saying*?

Hamish Munro: *Yes*.

Counsel Assisting: *Because unless you reduced R this document would be wrong*?

Hamish Munro: *Yes*.

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[89] T452 L25-30

Counsel Assisting: *Because the Cha Cha didn't have type 3 restraints*?

Hamish Munro: *That's correct*.

Counsel Assisting: *It had type 2 restraints*?

Hamish Munro: *Yes*.

Counsel Assisting: *So it's an explanation that you now offer for why this document is as it is, is that right*?

Hamish Munro: Yes.[90]

206. Hamish Munro did however say that if he was looking at the restraints today,

I'd probably need to consider the sizing and that sort of thing but I think that in this day and age you'd be looking to … restrain them into it a bit better and seatbelts are probably a good answer.[91]

207. As a result of Hamish Munro's evidence at inquest, I sought further expert advice from Mr Gibney, noting that the evidence Hamish Munro gave could not have been predicted from the evidence available to the Court at the time (including the Logbook and Hamish Munro's statement).[92] I further note that no questions were put to Mr Gibney at the Inquest on behalf of Hamish Munro about the appropriateness or otherwise of lessening the value of R. In addition, submissions on behalf of Hamish Munro noted that,

No other competent person, as defined by clause 1.3.8 of AS3533.1-2009 was asked or provided evidence as to whether it was appropriate to lessen the value of R.

Mr Munro's evidence as to why he lessened the value of R, whilst challenged from the bar table, was unchallenged by any competent person as defined by AS3533.1-2009.[93]

208. Mr Gibney was asked three questions arising from Hamish Munro's evidence which are outlined below (including the answers which I have determined should be included in full).

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[90] T1053 L6-20
[91] T1052 L16-20
[92] Dated 9 December 2022. AM-28
[93] Submissions at paragraphs 3.6 and 3.7.

209. Question 1: What does Australian Standard AS 3533.1 2009 require of engineers when deciding whether to, or considering 'lessening the value of R'?

210. The answer was given as follows:

Normally the restraint type is arrived at by using section AS3533.1 2009 2.8 Containment and Restraints. Section 2.8.1.2 requires a risk assessment to be performed. Whilst 2.8.1.3 states " The acceleration diagram in Figure 2.2 shall be used as part of the risk assessment for determining if a restraint is required and, if required, what type. Figure 2.2 identifies and graphically illustrates five distinct areas of theoretical acceleration. Each of the five distinct areas may require a different type of restraint, as indicated in Clause 2.8.2. Figure 2.2 applies for sustained acceleration levels only. It is not applicable to impact accelerations". The figure 2.2 used to determine the Area Type (Restraint type), only addresses fore and aft accelerations (G Forces) and vertical accelerations. This is particularly important when patrons are inverted upside down requiring a Type 5 restraint. The Flat rides, i.e. the Cha Cha has significant accelerations laterally that are not considered in figure 2.1. 2.8.3 Other containment and restraint considerations states the application of figure 2.2 is intended as a design guide. The patron containment and restraint risk assessment in Clause 2.8.1.2 or other factors or requirements in this Standard may indicate the need to consider another level of restraint (either higher or lower) or a form of containment. Any special situation shall be taken into consideration in designing the containment and restraint system. These may include – (d) velocity of the ride or device; and (h) lateral accelerations (side loadings).

NOTE: Appendix G provides guidance for conducting a risk assessment process to take into consideration some of these factors in addition to acceleration. Hence Appendix G is required to be assess the restraint type for a ride like the Cha. The restraint assessment used in AS3533.1 2009 is unique to Australia and considers the patrons fear factor, as well as the velocity of the ride and hence the patron velocity on the ride. The risk assessment method set out in appendix G is more relevant for Flat rides, as they have significant lateral accelerations on the patron not addressed in section 2.8.

To reduce the R value determined from appendix G, the engineer must determine the following factors. "F" ejection force factor, "P" panic factor, "H" Height factor and "V" velocity factor. To change the patron restraint factor "R", the competent person (Engineer) needs to determine each of the factors mentioned previously.

Mr Munro undertook such an assessment on 20 December 2016 and this was documented in page 2523 in the WorkSafe brief and determined "R" to be 8, a Type 3 restraint system.

211. Question 2. If an engineer decides to lessen the value of R, under clause G3.5 of Australian Standard AS 3533.1 2009, how should that decision be reflected in the engineer's report or assessment, or otherwise documented?

212. The answer was given as follows,

If the inspecting engineer decides to reduce the "R" value, it would need to be documented and recorded in the log book and if the restraint type was identified in the original Design registration documentation. The relevant state WorkSafe authority would need to be notified and a variation to the design registration made.

213. Question3. Under clause G3.5 of Australian Standard AS 3533.1 2009, it is noted that 'a competent person may consider lessening the value of R if the accelerations are in a direction that maintains the patrons riding position'. In your expert opinion, in relation to the Cha Cha, are the accelerations are in a direction that maintains the patrons riding position? Why or why not? Do you agree with Mr Munro's conclusion to lessen the value of R? Why or why not?

214. The answer was given as follows,

From my original report, there is a resultant ejection force of 2.9g laterally into the side of the side of the seat. From appendix C of my original report there is a forward ejection force of 1.5g, hence the lap bar is required to prevent the patron from being ejected forward. If the patron is sitting on the outside of the seat the patron would be forced against the side of the seat and there would be a sensation of being forced against the side of the seat and floating forward at the same time.

Mr Munro would need to have reassessed the ejection force, and velocity of the ride to amend the restraint factor "R". I do not agree with Mr Munro's reassessment, as the only change to the product "R", is the velocity factor "V" and ejection force factor "F". For the "R" factor can only be reduced by reducing "F" from area 2, to area 1. The G force plot in appendix C suggests that it is not possible to be in Area 1. The velocity factor "V" has to be 3, the panic factor "P" cannot be 1, as this is reserved for Carousel's and kids rides, Height factor remains at 2, whilst the velocity factor "V" also remains at 3 as the calculated velocity exceeds 4 m/s. Hence the restraint factor "R" is 8, as originally assessed by

Mr Munro and printed in the Cha Cha log book. If there are more than one small child in the seat, they cannot both be sitting against the side of the seat, hence there is the chance of one of the children being ejected under the lap bar.

I do not agree that Mr Munro had sufficient information to change the restraint factor "R" based on the available data.

215. I concluded from all the available evidence that the restraint system fitted to the Cha Cha at the time of the fatal incident was not compliant with AS 3533.1 2009 as a proper calculation required that Type 3 restraints be fitted and the restraint system was not consistent with this type of restraint.

216. Consequently, I consider that the assessment made by Hamish Munro in December 2016 that the restraints fitted on the Cha Cha were compliant with AS 3533.1 2009, was not accurate.

Consequence of restraints fitted to the Cha Cha at the time of the fatal incident

217. Mr Gibney considered that the original design of the Wittingslow Cha Cha would not have been able to be design registered as the patron restraints were not compliant with AS 3533.1 2009 for a type 3 restraint. He noted that the final latching/locking position in relation to the patron has to be variable and that the hinged lap bar is not variable in locking position and the existing restraints would require a seat belt to provide an adjustable restraint.

218. He also commented that to undertake a design registration of the Wittingslow Cha Cha, the applicant would need to provide an assembly drawing of the ride setting out the structural, hydraulic and mechanical components of the ride with supporting design calculations conforming to AS3533.1 2009. There would also need to be an electrical circuit diagram and a statement from an electrical contractor or engineer stating the electrical circuit and wiring complies with AS3533.1 2009 as well as AS300, the Wiring rules. This would allow the design verifier to check the design and drawings and provide a design verification certificate for lodgement with WorkSafe to issue a design registration certificate.

Was Lukas Kohler appropriately trained to operate the Cha Cha at the time of the fatal incident?

Operation of the Cha Cha in practice

219. In addition the rules already noted to be applicable to the operation of the Cha Cha, I heard evidence that once the height restrictions had been considered at the gate, the operator would take the patron to the allocated seat or point to one which was available. The operator would then individually go around to each carriage to firstly ensure that the largest person was seated on the outside. Once the patrons were seated correctly within the carriage, the operator would close the gate on the seat and the bar would lock. The operator would then pull the safety rope and secure it tightly to the back lock of the seat.

220. The operator would keep their eye on the patrons to see if they were comfortable with the speed, and if a patron was distressed or asked for the ride to be stopped, the operator would do so. Through the whole of the ride the operator would be keeping an eye on the occupants to ensure they were safe and comfortable.

221. As the operator was in control of the speed and length of the ride, the Cha Cha could operate in a variety of settings making it able to be operated safely for a wide number of patrons of different ages. For example, very young children could be accommodated on the ride at low speed.

222. There was also evidence that in interpreting the rules, an adult could be interpreted as a teenager.[94]

One or more operators on the Cha Cha

223. I heard varied evidence concerning how many people should operate the Cha Cha at any one time.

224. Billy Paul who has been in the amusement business for 44 years including Wittingslow since 1979 stated that during busy times, the Cha Cha should be operated with an operator and two assistants, and when not busy, the ride should be operated by one operator and one assistant.

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[94] T.92, L1

225. An assistant was also referred to as a *ride attendant* or *second* as distinct from a *ride operator.*

226. Billy Paul said that one person should never operate the Cha Cha alone and on his *watch it has never occurred.*[95] He said, *A second set of eyes is also required as it is impossible for the operator to watch the entire 360 degrees of the ride due to there being blind spots to the ride by one person being in one position.*

227. At inquest however, Billy Paul clarified that the number of operators depended on their experience and how busy the ride was.

228. Tangi Goodnight said it was her experience that the Cha Ca was *never to ride without two people.*[96]

229. Eugene's father Stacey said that usually there was a second for the operation of the Cha Cha – *It's better to have two eyes.* He did however say there was not always two operators and this depended on the conditions at the time, including the experience of the operator. As a very experienced operator, he would operate the Cha Cha without a second.

230. Similarly, Ben Rawlinson who had worked for Wittingslow since he was 16 years old said that it was safer to have an operator and a second, but he was confident that he could operate the ride on his own and had done so,

> *Cause I've been around the ride so long, I've pulled the ride apart, I've rebuilt it myself, I've painted it, I literally know how every single part of that ride works, I was just - I was totally confident in running that ride myself whenever I could.*[97]

231. Mr Wittingslow said that the Cha Cha could be operated without an assistant as long as the ride operator was trained and experienced. He said that if they were busy there would be two operators and if not, there would be one.

232. It was apparent from all the evidence, noting that the Cha Cha could be operated in a number of different settings, that whilst it was better to have a second set of eyes for safety, a second was not always required, particularly where the operator was very experienced. It

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[95] AM-25-3, dated 16 October 2022.
[96] T119 L6-7
[97] T223 L1-5

was apparent however that a single operator would need to be sufficiently trained to operate the Cha Cha alone, even in quiet times.

Training on the Cha Cha

233. There are several documents relevant to training that indicate a 'buddy' system that does not appear to require documentation or sign-off from superiors. Although there was also documentation available to suggest the completion of training for specific rides.

234. The use of the 'buddy system', as opposed to more formal documented training system, is also consistent with the witness statements of Cha Cha operators in this case.

235. Eugene's father said,

'*In relation to my training…., I was trained by the old supervisor, who was a person named Darren. I would stand there with Darren for about a year I reckon and he would operate the ride and I was the assistant. As the assistant I would go around and make sure everyone was secure in their seats and locked in correctly. It was a long time before Darren allowed me to operate the ride. Before Darren even let me operate the control for the ride, he would take me through what he was doing and what to do when operating the ride. ...He did this for a good year as I have said. I was then allowed to operate the ride under the supervision of Darren. I would say I operated the ride at four or five school fares with Darren supervising. Darren liked me to operate these rides because there were more safety things involved and he felt if I was able to run the ride at a school fare where there were more kids then I would have no trouble at operating the ride at other events. ... the training I have received has solely been the passing on of information from experienced workers*'[98]

236. Eugene's father said that he hadn't been provided with any certificate or accreditation in relation to the Cha Cha. He also stated that he wasn't aware of any manual, but there was a Safety Sheet for each ride.

237. Similarly, Ben Rawlinson who had worked for Wittingslow since he was 16 years old said the following of his training on the Cha Cha,

When I first started being schooled in the operation of the Cha Cha ride, Billy Paul would supervise me and remain at the operating area to ensure I was operating the ride correctly.

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[98] pp. 75-76, CB

....[it] would have been about six months until Billy Paul told me he was satisfied that I would be able to operate the Cha Cha machine unsupervised.[99]

238. Tangi Goodnight said she had been trained on the Cha Cha by Morgan Wittingslow (Mr Wittingslow's son) and was trained for about a year before she operated it on her own.[100]

239. Information provided to WorkSafe on behalf of Wittingslow said the following in relation to training,

Ride Operators are required to work as a Ride Attendant under the supervision of an experienced Ride Operator supervisor prior to being deemed competent to operate the ride un-supervised. This supervision lasts for at least 10 ride cycles, but will continue until the Ride Operator is deemed competent.[101]

240. Further, Wittingslow documents which formed part of evidence before the Court including the Wittingslow Amusements Australia Pty Ltd – 'Occupational Health and Safety Policy Manual, stated:

- *Operational Procedures* provides amongst other things that the Ride Operator is responsible for the safety of the customer. Basic keys to being a safe operator includes making sure that all cars are loaded properly.

- Section 11 sets out Staff Training. Staff Training program note that all staff (including those that are operating rides) would undergo an initial safety training session prior to all major events; staff involved in rides are taught by Supervisory staff using a modified form of the 'buddy system'.

- The definition of Competent Ride Operator is documented as[102]:

  Proficient in the operation, assembly, dismantling and maintenance of a ride -

  - *100 Hours Recorded operation;*

  - *10 supervised assembly procedures;*

  - *10 supervised disassembly procedures; and*

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[99] AM-2-2
[100] T122 L15-16
[101] p. 2623, WSB.
[102] p. 289, CB

- *3 unsupervised assembly and disassembly procedures.*

Acceptable levels of maintenance knowledge and documentation for each ride.

241. At inquest, Billy Paul stated that in order to be properly trained, a competent operator should supervise an operator in training at all times for 10 cycles, where a cycle is considered a day or a job at a particular venue.

242. Upon further interrogation however, what actually constituted a cycle was more difficult to determined. Billy Paul noted that the 100 hours referenced in the policy documents was likely drafted when big shows such as Luna Park were undertaken and more recently he had seen examples in states where training hours had been factored down to more manageable levels, noting also that the industry relies on casual employment.[103]

243. Billy Paul said in those circumstances that sufficient training depends on the individual and the technical difficulty of the ride, and whether the trainer is satisfied on the basis of a person's individual performance.[104]

244. This evidence suggests that the current procedures in place at Wittingslow were out of date and apparently no longer used, which is obviously not satisfactory. Training procedures and accreditation should be readily discernible on a piece of plant in a workplace and in particular an amusement ride.

245. In addition, I consider that documentary proof of the training on a piece of plant, such as the Cha Cha, should be available to establish whether an individual is sufficiently trained.

246. At inquest it was suggested that there be some type of standard training methods for ride attendants and operators. It was noted that a licence was required to drive a car, boat, jet ski and motorbike, yet to put people on a ride that carries 32 to 36 people, 52 or 56 people (referring to larger rides) at a time, you don't need a licence, and this was a breakdown is the system. In this context, the Court was advised that the federal government was being lobbied for change.

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[103] T1262 L4-17
[104] T1340 L9-14

Lukas Kohler – employment and training records

247. Lukas Kohler's job application recorded his address as '*backpacker – tent on foreshore*'[105]. He stated that he had worked for about 3 months for Wittingslow as a ride operator and had been performing similar work *on and off* for the previous 8 years.

248. The earliest available documentation provided by Mr Wittingslow in relation to his employment was dated 22 February 2017.[106] The earliest timesheets were for 14 March 2017. The earliest record of him operating rides were on 3 March 2017 (Teacups and D/Slide).[107] The earliest record of him operating the Cha Cha, according to the ride operators log, were 14 and 17 April 2017 which was at the Rye Carnival.[108]

249. Billy Paul later provided a spreadsheet which suggested that Lukas Kohler may have been employed as early as 17 October 2016 (painting Ferris Wheel[109]) and that he may have operated the Cha Cha with Ben Rawlinson supervising on 27 November 2016, although this is unclear.[110]

250. The training records of Lukas Kohler[111] comprise two 'Wittingslow Ride Attendant Training Program' records including for the bungee ride which is dated 22 February 2017 indicating that he successfully completed a training course to competently be an attendant on the bungee[112]. No training records were provided for the Cha Cha. The only formal records of training on the Cha Cha (all signed off by Billy Paul) were for Dale Stephens, Jay Hopcraft and Jimmy Withers (all dated 11 November 2014).[113]

251. There were however other training records of persons who had successfully achieved their training requirements for different rides in 2017.

Lukas Kohler's training on the Cha Cha and views on his ability to operate the Cha Cha

252. Lukas Kohler said,

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[105] p. 2262, WSB
[106] p. 2262. WSB.
[107] AM-15-1
[108] p. 2268, WSB.
[109] AM-26
[110] AM-26 There was no record of Ben Rawlinson working with the Cha Cha on 26 November 2016.
[111] It appears that some documentation refers to the name 'Lukas Koldin' which I have taken to refer to Lukas Kohler.
[112] p. 2279, WSB
[113] AM-15.

I was trained in the safe operation of the 'Cha Cha' ride… in our training we are shown controls including safety shutdown, safe loading based on weights and height, slowing the ride down if children seem distressed and reading their faces… although I am trained to operate solo, I always have supervisors nearby or with me.[114]

253. To clarify, at the 2017 Rye carnival, the evidence is that both Eugene's father and Ben Rawlinson were employed as relievers (also referred to as supervisors), who would take over rides when the assigned operator was on a break, amongst other duties. A reliever's role is different from a second or an assistant and it is clear from the available evidence that Lukas Kohler was the sole operator of the Cha Cha on the day of 17 April 2017 and there is no evidence that he was being supervised at the time of the fatal ride.

254. Eugene's father said that he showed Lukas Kohler how to operate the Cha Cha. He stated,

He went through the same kind of training as me. He stood and watched and I showed him how the ride was operated along with all the height requirements and safety required. ….Before this carnival Lukas ran the ride at two schools.[115]

255. He further stated that Lukas Kohler had worked as his second during the 2017 Rye Carnival but to his knowledge he had not operated the Cha Cha by himself. He said that he did not think that Lukas Kohler had enough training to be operating the Cha Cha on his own.

256. Ben Rawlinson said that over a 2 month period prior to the incident he had shown Lukas Kohler how to operate the Cha Cha and supervised him in the operation of the ride. He stated,

Through this time he was going really well and I had no issue with the way he operated the ride under my supervision.[116]

257. He further stated however, that *Lukas should not have not been operating the ride unsupervised*[117] as he did not think that he had enough training to be operating the Cha Cha on his own as *he wasn't around for that long* and, *Because he hadn't had enough experience in doing the job, and he – I just didn't see it being safe.*[118]

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[114] p.21, CB
[115] pp. 76-77, CB, T57 L 19-23
[116] AM- 2-3
[117] AM-2-5
[118] T218 L13-15

258. Tangi Goodnight who also operated the Cha Cha ride said of Lukas Kohler,

My recollection is that I never saw Lukas ever operate the ride prior to that day. I recall Lukas had previously told me on several occasions at that and other previous carnivals that he was never confident in operating the Cha Cha ride and never wanted to operate it. He just wanted to be the second which was his normal role.[119]

259. Mr Wittingslow stated that the rules that patrons between the heights of 120 cm and 130 cm must ride with an adult, had been in place for approximately 20 years and is part of operator training and that, Lukas Kohler's statement made it clear that he was aware of this requirement. Mr Wittingslow also stated however that he relied on Billy Paul who had responsibility for day to day operational decisions including hiring competent staff and, *had confidence that he only employed qualified and competent people and ensured they were properly trained for their role.*

260. Mr Wittingslow did acknowledge that a record of the hours of operation of a ride for an employee was not kept and agreed there was no record of Lukas Kohler having been trained. He further agreed that there should be a record and the documents in the Logbook regarding training should have been filled out.

261. At time of the fatal incident it is apparent that Mr Wittingslow did not know whether Lukas Kohler was trained in the operation of the Cha Cha, and there wasn't a system in place to readily identify this matter.

262. Having noted that Mr Wittingslow relied on Billy Paul to establish that Lukas Kohler was suitably trained in the operation of the Cha Cha at the time of the fatal incident, I obtained a statement from Billy Paul after the commencement of the Inquest.

263. Billy Paul was not working at the Rye carnival in 2017 but appeared to have worked with Wittingslow in February of that year. He initially said that he had not trained Lukas Kohler but after reviewing records thought he supervised him on a couple of occasions, including whilst he operated the Cha Cha ride in February 2017 (one cycle at Penola School) but did not consider this sufficient to be *considered as being a trained operator.*

264. In addition, that if he was sufficiently trained on the Cha Cha ride, any records in relation to the training should be with Wittingslow.

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[119] p. 504, CB.

265. Billy Paul considered that Lukas Kohler lacked a bit of awareness and at inquest in response to whether he would have felt comfortable, based on his knowledge, for him to operate the Cha Cha safely at the time of Eugene's incident,

> *..., I don't think I can, I don't think I can answer that because, ..., ... – I don't believe that the number of cycles had been completed.*[120] And *not on his own*.[121]

266. There was evidence that Lukas Kohler received training regarding the rules and safety protocols of the Cha Cha, including the height restrictions, and I agree in those circumstances that he acted contrary to the training he received. In the absence of further evidence from him, I can only speculate as to the reasons he did so, whether they be inadvertent or otherwise. Having reached that conclusion however, I was not able to find any evidence, even that of a single witness which included Mr Wittingslow, to suggest that Lukas Kohler was trained to a satisfactory level to allow him to operate the Cha Cha ride without supervision.

CONCLUSION

267. Six year old Eugene tragically passed away on 21 April 2017 after being ejected from a Cha Cha ride on 17 April 2017 whilst at a carnival in Rye. He was the much loved youngest member of a large family. The Cha Cha was his favourite ride.

268. Wittingslow Carnivals Pty Ltd (**Wittingslow**) and Michael Wittingslow were the owner and operator of the Cha Cha at the Rye carnival and Mr Wittingslow's family had owned the Cha Cha since it was built in 1961. Members of Eugene's family including his mother Tammy and father Stacey were employed by Wittingslow and were working at the carnival on the day of the accident.

269. Lukas Kohler was also employed by Wittingslow and was the operator of the Cha Cha at the time of the fatal ride. He was a German national, who said that he had been employed by Wittingslow for about 3 months.

270. Although there were two relievers working at the Rye carnival on 17 April, it is clear from the available evidence that Lukas Kohler was the sole operator of the Cha Cha throughout the day. There is no evidence that he was being supervised at the time of the fatal ride or,

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[120] T1265 L24-27
[121] T1268 L23

that he had an assistant. There was evidence that the Cha Cha could be operated with a single operator, but ideally only when the operator was considered experienced and competent.

271. At the time, the restraint system on the Cha Cha included a bar comprising three horizontal rods with a U-shaped rod designed to go between the legs of the patrons. The bar had a spring-loaded lever to lock into the seat and there was a safety rope which was pulled behind from the bar and secured in a cleat. There were no seat belts of any kind fitted to the carriages.

272. There were rules and a loading plan relevant to the Cha Cha, which included that a patron who was 120 cm or over could only ride on the condition that they be accompanied by an adult. If they were 130 cm they could however ride unaccompanied. Eugene was 132 cm and therefore could ride the Cha Cha by himself. He was an experienced rider on the Cha Cha and knew how to brace himself with his arms and legs and he was tall enough to do so. He had also ridden alone, with another taller child and with adults, and had done so without incident.

273. Although there were some different accounts about how many 'last ride' calls were made for the Cha Cha on that day, I am satisfied that Lukas Kohler called 'last ride' at around 5.10pm. Soon after there was a rush of patrons into the ride area to enjoy this last opportunity, including many Wittingslow employees and members of their families. Eugene was one of those riders. By all accounts, there was an atmosphere of excitement at the time with a lot of noise and laughter. I agree with Counsel Assisting that there was an air of informality and, that the process of placing patrons in carriages was not orderly as some people moved and shifted carriages.

274. It is clear that Eugene was permitted to ride on the Cha Cha with another six year old who was only 121cm in height. They were therefore permitted to ride in a configuration which was contrary to the rules. As both children were small, the U-shaped rod was not effective to go between their legs or otherwise hold them in place.

275. Another child who was 8 years old and only 124 cm was permitted to ride in a carriage by herself, which was also contrary to the rules. There is a suggestion that a male, who I have been unable to identify, may have taken cash from this child's father to allow the family to ride the Cha Cha, and that he also directed them to their carriages.

276. Shortly after the ride commenced, Eugene was forced to the outer side of the carriage and was crushed by the other young rider, as a result of the forces of the ride operation. This was not unusual and the patron loading plan which was in place at the time, was that a larger rider be placed on the outside of the carriage, to account for these forces.

277. Despite Eugene's best efforts to hold on in any way he could, and the efforts of his companion rider, he slipped out from underneath the lap bar, resulting in him being ejected from the carriage and into the central column of the ride, which ultimately led to his fatal injuries which he succumbed to four days later. The loss to his family has been immeasurable and devastating.

278. When turning to the causes and circumstances of Eugene's passing, the varying responsibilities of those involved was examined throughout the investigation and are detailed in my finding.

279. As noted in the criminal proceedings, a person who is running their own business, is fundamentally the expert in carrying out that undertaking and in this case, it was the operation of a carnival. Ultimately therefore, the owner and operator of the Cha Cha is responsible for ensuring it was safe as a matter of design and construction. In addition, they are responsible to ensure that it was operated in a safe manner.

280. Relevant to these responsibilities was the annual audit conducted by WorkSafe at least in the preceding 2 years. Most proximate to the fatal event was a WorkSafe inspection carried out in December 2016. As part of this inspection WorkSafe applied as a matter of practice the Work Health and Safety – OHS Regulators' National Audit Tool for Amusement Devices, developed nationally to audit the safety of amusement rides. The Audit Tool, consistent with the requirement of Regulation 241 of the of the *Work Health and Safety Regulations 2011* (Cth), is to conduct an annual inspection and for the certification of plant, being the amusement ride, by an engineer.

281. The inspection by WorkSafe involves an examination of a logbook compiled by the owner which includes evidence of an engineer's certification of the ride, as well as a physical inspection of the ride for obvious safety issues. On this occasion the engineer's certification was undertaken by Hamish Munro in December 2016. He was engaged by Mr Wittingslow to undertake this task. The WorkSafe audit is not intended to be an engineer's inspection and does not examine the accuracy of the work undertaken by an engineer who has certified the ride.

282. WorkSafe submitted that the role of an inspector is confined to enforcing compliance when a breach is observed[122] and that its role should not be expanded beyond the current regime, noting its resource limitations.

283. It is apparent from the evidence that WorkSafe undertook the inspection in December 2016 in accordance with their usual practice.

284. The engineer's inspection undertaken by Hamish Munro certified that the Cha Cha had been assessed in accordance with the Australian Standard (AS 3533.1 2009), that it had been correctly maintained, the required testing was satisfactorily completed and it was free from visible defects that could adversely affect the safety of the ride.

285. With respect to the restraints, Hamish Munro documented in the Logbook that the Cha Cha required Type 3 restraints, and that the restraint system fitted to the Cha Cha at the time of the fatal incident was consistent with this restraint type.

286. An expert engaged by the Court, engineer Timothy Gibney agreed that Type 3 restraints were required on the Cha Cha, but the restraint system at the time of the accident did not meet the requirements of this restraint type. He noted that the restraint in place was not variable in relation to a patron. He considered that the restraints on the Cha Cha were not appropriate to contain smaller patrons from getting out of the restraints. He noted that if the lap bar had locked down appropriately on the smaller patron's legs, they would not have been able to get out of the carriage.

287. At inquest, Hamish Munro gave evidence which departed from the certification he prepared in the Wittingslow Logbook. He stated that as part of his inspection of the Cha Cha, he lessened the value of a variable in the applicable equation, and found that the Cha Cha only required Type 2 restraints and that is how he concluded that the restraints complied with the Australian Standards. He said that while he had no memory of lessening the variable, and while he recorded the value in a different way, he must have reduced it in his mind and not documented the reduction. He acknowledged that he should have made a note, but did not. He did however agree that the restraints fitted to the Cha Cha at the time of the fatal incident were not consistent with Type 3 restraints.

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[122] WorkSafe closing submissions, para 26.

288. Further evidence was sought from the Court's expert in relation the explanation of Hamish Munro given at inquest which was not otherwise known before this time. Mr Gibney was of the opinion that there was not sufficient information for Hamish Munro to have changed the variable as suggested, based on the available data.

289. I accept the expert advice of Mr Gibney on these matters and have concluded that the restraint system fitted to the Cha Cha at the time of the fatal incident was not compliant with Australian Standards as a proper calculation required that Type 3 restraints be fitted and the restraint system was not consistent with this requirement.

290. Consequently, I consider that the assessment made by Hamish Munro in December 2016 that the restraints fitted on the Cha Cha were compliant with Australian Standards was not accurate.

291. The other critical question arising from the evidence of Eugene being permitted to ride on the Cha Cha in a configuration which was contrary to the rules centred around the ride operator and his training.

292. The operator of an amusement ride is responsible for enforcing the applicable rules to ensure the safety of the patrons, and as such Lukas Kohler had a responsibility to operate the ride safely. In addition, Wittingslow had a responsibility to ensure that he was sufficiently trained and in the circumstances of this case, able to operate the ride without supervision.

293. The evidence suggests that there was a 'buddy system' in place where competent riders trained others in the operation of a ride. There is evidence that competent riders such as Eugene's father and Ben Rawlinson had trained Lukas Kohler in the operation of the Cha Cha, but neither were able to say that they were confident he could operate the ride unsupervised.

294. A review of the documentation available to the Court, did not include a certificate of competency for the Cha Cha in the name of Lukas Kohler (which existed for some other rides) or that he had operated the Cha Cha on many occasions.

295. Wittingslow procedures around achieving ride competency did not help clarify the extent of Lukas Kohler's training and the evidence suggests the hours considered appropriate for competency were out of date and apparently no longer used. In any event, the hours of operation for a ride operator on an individual ride was not recorded.

296. Training procedures and accreditation should be readily discernible on a piece of plant in a workplace and in particular an amusement ride.

297. In addition documentary proof of the training on a piece of plant, such as the Cha Cha, should be available to establish that an individual is sufficiently trained. I note that this part of the Annual Audit in 2016 was blank.

298. At the time of the fatal incident Mr Wittingslow did not know whether Lukas Kohler was trained in the operation of the Cha Cha.

299. It is apparent in these circumstances that there wasn't a system in place to readily identify this matter.

300. Mr Wittingslow relied on Billy Paul to establish Lukas Kohler's operator capability and this was first raised during the course of the Inquest. Billy Paul's evidence however was consistent with other witnesses, as he also said that Lukas Kohler was not trained to a satisfactory level to allow him to operate the Cha Cha without supervision.

301. There is sufficient evidence to suggest that Lukas Kohler had received training regarding the rules and safety protocols of the Cha Cha, including the height restrictions, and I agree that in those circumstances he acted contrary to the training he received during the fatal ride. In the absence of further evidence from him, I can only speculate as to the reasons he did so, whether they were inadvertent or otherwise. Having reached that conclusion however, I was not able to find sufficient evidence, including of a single witness, to support a finding that Lukas Kohler was trained to a satisfactory level to allow him to operate the Cha Cha ride without supervision.

302. I agree with Counsel Assisting that the absence of Lukas Kohler as a witness meant the loss of an opportunity to receive his perspective on the training he received and his decision-making before and during the fatal ride.

303. Having considered the central questions in my investigation, it is clear that Eugene's death was preventable. In reaching this distressing conclusion, I note the following. Firstly, at the time of the fatal ride, the restraints fitted to the Cha Cha were not compliant with the applicable Australian Standards. Secondly, I was unable to establish that the ride operator was competent to operate the Cha Cha without supervision at the time of the fatal ride. Finally, the rules for riding the Cha Cha were not enforced by the ride operator. Alteration to any one of these factors, is likely to have altered the tragic outcome.

304. It is important to acknowledge however, that risk control measures which remove the possibility of human error, such as engineering controls, are considered the most effective for the purpose risk control.

305. I note that the risk of a patron being able to slip under the restraint system and ultimately ejected from a ride such as the Cha Cha was a known risk. In my view therefore, known risks were realised in this case.

306. I highlight in particular the 2015 Queensland Safety Alert titled '*Redesign of rider restraint systems on amusements structures*' which recommended that owners of certain rides (including the Cha Cha) should have their rider restraint systems assessed. Amongst the risks recognised was that of a patron being able to slip under the restraint system and into the footwell of a carriage from where the patron could be ejected from the ride.

307. WorkSafe were part of a national network who were consulted about the 2015 Queensland Safety Alert during its development but did not take the same action as Queensland, who are considered the lead in amusement industry safety.

308. Following Eugene's passing however, WorkSafe developed an Information Sheet in 2018 which recommended engineering control measures to mitigate the risks identified with the Cha Cha (and similar rides), consistent with the objective of the 2015 Queensland Safety Alert. Amongst the risks highlighted in the Information Sheet were the risk of a patron being ejected from the ride.

309. It is clear that industry standards have now changed in Victoria and that the restraint system on the Cha Cha at the time of Eugene's accident would no longer be considered to meet industry standard. The Court's expert however considered, at least from his perspective as an inspecting engineer, that in 2015 the requirements around rider restraints became more stringent from that time. I note that Hamish Munro was one of three engineers who were consulted with on the Queensland Safety Alert in early 2015.

310. WorkSafe submitted that a duty holder, such as Mr Wittingslow is expected to be proactive in identifying and responding to risks in its workplace, particularly in *inherently dangerous* workplaces such as amusement carnivals.[123] It was apparent from Mr Wittingslow's evidence that despite this responsibility, he did not appear to be well informed about the

[123] WorkSafe closing submissions at para 14(c).

available literature and appeared to rely on the annual WorkSafe inspection and the engineer's certification to ensure the Cha Cha's safe operation.

311. WorkSafe submitted that the Queensland Safety Alert re-enforced duties to ensure safety:

To make sure that riders can't escape their primary restraints; that is, get free so that the forces on the person permits their ejection from the ride. And that the duty *is so obvious and fundamental to amusement rides that its communication has to be regarded as meaningfully unnecessary*.[124]

312. I hold a different view about the value of the Queensland Safety Alert which required an owner to have their rider restraint system assessed after the Queensland regulator formed a view that such action was necessary in view of incidents resulting in *serious injuries and fatalities* where rider restraints have failed to work properly.

313. It is my view that the implications of the 2015 Queensland Safety Alert could have been further explored in the Victorian context prior to Eugene's accident, and this appears to be a missed opportunity to have re-enforced rider safety for Cha Cha type rides. An example being the Information Sheet later prepared by WorkSafe in 2018. I do not suggest that any such action would have necessarily altered the outcome in this case.

314. Without doubt, members of the public would hold an expectation or reasonable assumption that there is a system in place to ensure the safety of amusement rides in Victoria.

315. Yet this investigation revealed that the Cha Cha was able to operate without restraints which were complaint with Australian standards over many years, despite an engineering certificate and WorkSafe inspections (however limited they may be) and, with a ride operator who was not sufficiently competent to operate the ride unsupervised.

316. Further, the investigation revealed that the older an amusement ride was, the less stringent the regulatory regime.

317. As the Cha Cha was built in 1961 (that is, prior to 1995), it was not required to be design registered, which would have included a certification by an engineer as to its design safety. This means that such amusement rides fall outside the requirement that they meet applicable design and construction standards.

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[124] WorkSafe closing submissions at para 82(a).

318. Mr Gibney said that in the absence of design registration the only other means by which the adequacy of the design of an old ride against any up to date measures can be assessed is the annual inspection by an engineer or a WorkSafe inspection.

319. Also in the context of regulatory change around design registration, WorkSafe made further suggestions which, whilst not directly preventative in this case, would strengthen the design registration process and its oversight. This included: that applicants (and design verifiers) be located in Australia; there be a power to refuse registration in certain circumstances including where the design poses a risk; there be a power to cancel plant and/or design registration, where the design of the item of plant or the item of plant is unsafe; and the operator of an amusement structure to be required to carry the plant's manual and logbook with the item of plant at all times.[125]

320. The Court also heard that from 1 July 2014, regulations were amended so that plant which included an amusement ride, was no longer required to be registered in Victoria. It was universally agreed that the requirement that items of plant be registered should be reintroduced and apply to all amusement structures operating in Victoria.

321. At inquest it was also suggested that there be some type of training standard methods for ride attendants and operators, as well as a requirement that details of training and certification of the operator are recorded and maintained.

322. There were three experienced WorkSafe inspectors who gave evidence that the national Audit Tool did not promote safety and was not consistent with ordinary workplace interventions. Mr Sandlant also from WorkSafe expressed an alternative view. Given that the views expressed around this issue by the inspectors was consistent and profound, it would be a shame that their voices were not explored further. I note that the Audit Tool was developed nationally and consultation may be prudent at this level. I also note that WorkSafe submitted that annual inspections or the requirements of an annual inspection for amusement structures, should be 'beefed-up' – more than simply ticking boxes.

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[125] With respect to rides, where the manual doesn't exist, such as the Cha Cha because it was built in 1961, Mr Ooi suggested that the owner or operator should engage a suitable competent person to develop another ride manual in order to replace the missing or damaged one. He indicated that this would be required for a number of different things, including from assembly and disassembly through to operation and emergency processes as well as training. He said that having the manuals on hand gives whoever is that inspecting the ride, whether it is a regulatory body or an inspecting engineer, the ability to reference that information directly from the manufacturer or designer of that ride.

323. All the suggestions made were valuable and I have determined to make corresponding recommendations for change, which I hope Eugene's family take some comfort from, noting that the investigation, findings and recommendations might be a small part of his legacy and may mean that another young life will not be cut short in future.

FINDINGS

324. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Eugene Mahauariki born on 27 November 2010;

(b) Eugene Mahauariki died on 21 April 2017 at Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from *1(a) Complications of Head Injury following a fall from a Fairground Ride*; and

(c) the death occurred in the circumstances described above.

325. I again convey my sincere condolences to Eugene's family for their loss and acknowledge the heartbreaking circumstances in which his passing occurred.

RECOMMENDATIONS

326. Accordingly, pursuant to section 72(2) of the Act, I make the following recommendations connected with the death:

With the aim of strengthening the safety of amusement operations which constitute workplaces in Victoria, that the Minister for WorkSafe and TAC give consideration to the following:

a. All amusement structures, which are considered *plant* under relevant regulations, be design registered;

b. There be a requirement that the applicant for a design registration of an amusement structure and the design verifier in relation to that application be located within Australia;

c. WorkSafe be empowered to refuse an application for design registration of an amusement structure where an applicant fails to provide the necessary information or WorkSafe forms the view the design poses a risk;

d. WorkSafe be empowered to cancel plant and/or design registration, where the design of the item of plant or the item of plant is unsafe, a power that they currently do not have.

e. The operator of an amusement ride be required to carry the plant's manual and logbook with the item of plant at all times;

f. The requirement that items of plant be registered should be reintroduced and apply to all amusement structures operating in Victoria;

g. The operator of an amusement ride be required to record and maintain details of training and certification of the operator of an amusement ride;

h. A review be undertaken to improve training standards and accreditation of ride operators and attendants, including whether there should be a minimum standard for the training of amusement ride operators; and

i. Consideration be given to enhancing the National Audit Tool used by WorkSafe Inspectors during annual inspections of amusement rides to address WorkSafe inspectors concerns' that it has limited value for the delivery of safety outcomes.

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

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

Tammy White and Stacey Mahauariki, Senior Next of Kin

Slater and Gordon on behalf of Eugene's family

Sparke Helmore Lawyers on behalf of Wittingslow Amusements and Michael Wittingslow

HBA Legal on behalf of Hamish Munro

WorkSafe Victoria

Minister for WorkSafe and the TAC

Detective Acting Sergeant Rodney Eaton, Coroner's Investigator, Victoria Police

Signature:

SARAH GEBERT

Date: 24 November 2023

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