

There was a lot of discussions in regards to Angus Hutchins before the first witness was called today. Unfortunately everything that was discussed is covered by an NPO (Non Publication order) so none of it will leave the courtroom.

The first witness for the day has just been called.

Gen Cruz

Began at Dreamworld in September 2014 as a mechanical engineer.

Mr Cruz would approach Peter Gardner (a senior maintenance staff member) to raise any concerns about the ride. Mr Cruz and Mr Gardner were the only two people at the time who had formal tertiary qualifications.

Mr Cruz was asked if there should be recourse management after the event of a critical incident, such as a near miss.

Mr Cruz was not aware of two near miss incidents in 2014 on rides nor was he aware of the 2014 TRR raft collision that happened. He was only made aware of this, days after the incident when he located the risk assessment completed after the raft collision.

Mr Cruz was shown photos from the 2001 raft collision and he agreed with barristers that there should have been changes made but he was not aware of the incident.

Mr Cruz was never shown cctv footage of the 2014 incident as it still exists. Mr Cruz maintains that this is the first time he has heard of a raft collision incident in 2014 but doesn't agree that it would have been helpful if he was made aware of the incident as risk assessments are not a part of his role.

Mr Cruz was asked if there was someone who was made aware or in charge of any incidents when they occur in terms of recourse management. Mr Cruz's response "I don't know".

Mr Cruz then later agreed that it would be helpful for engineering staff to be shown CCTV footage of the 2014 incident, or any critical incidents that occurred.

Mr Cruz states that when there is a near miss, it is a collaborate effort to perform recourse management. Sina (new engineer hired in 2017) was the only other person with formal engineering qualifications outside of Mr Cruz and Mr Gardner.

We were then shown the termination letter of the 2014 staff member. During the 2014 incident, there was a low air alarm and the ride operator shut the ride down without checking where all the rafts were. This resulted in a raft bottoming out on-top of the conveyor, one floating into the reservoir, and another colliding with the raft in the conveyor, pushing it down the conveyor until the conveyor was turned off. The ride operator at the time was only aware of the raft in the reservoir when the photo shop called and informed them.

At this point, the ride op escalated the situation to a code 6 but has not followed the procedure to initiate shut down. Which states that the ride must be shut down in any situation where there is a risk of seriously injury to guests or staff or damage to equipment. The ride op did not raise the rapid ride alarm but instead restarted the conveyor when there was a raft at the bottom that was at a large risk of flipping due to the increased water pressure.

CCTV Footage of the 2014 incident was shown. A raft stopped at the bottom of the conveyor, outside of the unload station, the conveyor kept operating and a another raft came in contact and the rafts were bumping until the conveyor was stopped.

Mr Cruz had never had any discussions with senior team members about previous incidents on the rapids ride.

Mr Cruz has not been trained to complete risk assessments, audits or safety procedures on rides. Until recently, DW mostly engaged outside companies to complete risk assessments as there was a lack of knowledge and expertise within the Dreamworld staff.

Mr Cruz agrees that other DW maintenance staff should be shown the CCTV as it would be useful.

Mr Cruz was asked if there was a culture of secrecy around ride issues prior to 2016. Mr Cruz didn't respond.

Mr Cruz was in contact with an external expert when they were required to visit the park.

Mr Cruz was asked if external organisations should be aware of the CCTV footage of incidents. He responded with "I don't know"

Mr Cruz was asked about Pitt and Sherry and advised that they were onsite in the days before the 2016 incident, completing audits on other rides.

Mr Cruz was instructed to provide documentation to Dreamworld lawyers after the incident. Mr Cruz was asked if those documents were available to any staff members but he doesn't believe so.

Mr Cruz was tasked with developing an auditing tool. As part of this, he went to a WHS conference. He then worked closely with WHS and Dreamworld Management to develop this tool. During the 2016 annual maintenance Mr Cruz can't remember having difficulty finding maintenance documents to provide to the annual maintenance auditor.

Mr Cruz was then shown emails between him and the Auditor of the 2016 maintenance. It was then confirmed that he did have difficulty finding daily and annual inspection schedules and documents for some rides but not others.

Mr Cruz has stated that he received 3 months of training and that includes being shown each ride and their operations. This included the daily inspections and maintenance programs for 90% of the rides. He was only officially trained on about 60% of the rides. Mr Cruz was explained prior to starting that there was an electronic system for determining preventative maintenance. Mr Cruz believes after that 3 months, he had a full understanding of all the rides and daily/weekly maintenance programs at Dreamworld.

Mr Cruz cannot remember viewing any urgent safety alerts from any ride manufacturers in regards to updates or problems with the rides. Mr Cruz will take onboard all of the recommendations from the manufacturer including to shut the ride down if required.

Mr Cruz was asked if part of his qualifications included building risk assessments but he cannot remember.

Since 2016, risk assessments are completed by a number of people. Mr Cruz was not aware of the managers and general managers qualifications.

Mr Cruz was not aware that the general manager was in charge of registering the rides.

Mr Cruz has access to external companies in regards to engineering expertise. Members of external organisations had been working in the park prior to 2016.

Mr Cruz tried to attend every weekly management meetings but was unable to make it to some. Safety was the first point on the agenda of those meetings and if a safety issue was raised, it would be addressed.

We were then shown the annual mechanical and structural report for 2016 which was completed September 29, 2016

The only recommendation is to include the conveyor rollbacks as part of the daily check as the rollback gate at the top of the conveyor wasn't working.

Mr Cruz was asked if there were any documents that were required for this annual inspection that he couldn't locate. His answer was "no". Pitt and Sherry were onsite days prior to the 2016 incident, inspecting the "big 9" but not TRR. Pitt and Sherry are still performing audits, recommendations and development of rides at Dreamworld. After the closure of Dreamworld in 2016, Pitt and Sherry reviewed all the rides which were then re-reviewed by another company (LTC) before they could re-open to the public.

Mr Cruz only accessed TRR documents stored on DW hard drives after the incident in 2016. Prior to this, those documents couldn't be located.

Mr Cruz has just finished giving evidence

Nigel Irwin

Senior Security Control Room Operator/Duty Manager

Was a part time junior manager during the time of the incident.

Mr Irwin is in charge of the security and communications control room. When a ride operator calls for assistance, it goes to the control room to be triaged out to the correct person. Mr Irwin also views the CCTV monitors.

Mr Irwin is the staff member who contacted emergency services when the incident occurred.

Mr Irwin received a call from the ride operators that a pump had shut down and he looked at the CCTV and confirmed that the south pump had failed.

Mr Irwin recalled radio chatter between maintenance guys about a fault with the pump.

The issue was then rectified and the ride was reopened.

Mr Irwin states that it was a quiet day until the incident.

Mr Irwin received a call at 2:06pm to call a code 222 blue which is a medical emergency.

Mr Irwin asked for more details but the operator only stated that "I've got a raft on the conveyor"

Mr Irwin wasn't sure of the nature of the incident so he checked the CCTV and saw a raft on its side in the air and upgraded the call to a code 222 grey which is a medical emergency involving machinery.

At the time, Mr Irwin observed that there was a raft at the end of the conveyor but no guests inside. The conveyor and pumps were stopped and the rapids alarm wasn't sounding.

Mr Irwin states that when first aid arrived onsite, they requested he call Queensland Ambulance.

Mr Irwin then went over the radio to upgrade the call to a code 222 emergency which is the highest response level.

During Mr Irwin's call to Queensland ambulance, he states "we've had a mechanical failure on our rover rapids, we have somebody trapped in the machinery and after being told an ambulance is on its way, his response was "we may need more"

Queensland Police came to view the footage in the control room and Mr Irwin had to view the CCTV footage over and over so many times as he needed to show ever new officer that arrived. Mr Irwin states that this was greatly distressing.

Mr Irwin was asked if there were any improvements that he could think of to this process. "I think there should be an alarm for every ride and every issue so people know exactly what the issue is. The park also doesn't have a PA system which would be helpful" Mr Irwin replied.

Mr Irwin was asked if there was any difficulty or impairment in emergency personnel accessing the site, to which he replied "no".

Senior management has their own radio channel to discuss situations like that.

Mr Irwin filled in as the duty manager from time to time and they would report to the Operations manager. His role was primarily security duty manager. Mr Irwin would often work split shifts where he is in the control room half the day and a duty manager for the other half. This is due to the duty manager being at an advantage if he can view the CCTV monitors.

Mr Irwin was asked about his training which was primarily done through shadowing with an experienced staff member. Mr Irwin also had additional training from the person who has the role before him. The Control room operator is generally hired from the pool of security staff that are excelling in their role and not hired without security experience.

Mr Irwin claims responsibility for almost entirely eliminating bag theft within White Water World.

Mr Irwin was also in charge of the control room on the day of the log ride incident. Where he said he learned a lot about how to react in an emergency situation.

Mr Irwin states that the log ride and TRR emergencies both went smoothly, but unfortunately there was nothing that could be done for the victims when staff arrived.

Mr Irwin states that he doesn't recall a debrief for staff in the days/weeks after the event. He did have RDO's during this period but was still not aware of any briefs that happened with staff.

Mr Irwin is currently not working at Dreamworld as he is suffering from PTSD and has been since May 2017.

Mr Irwin was not aware of any previous incidents on TRR or that there was any potential for rafts to flip. There are 2 main park wide alarms, the rapids alarm and the animal escape alarm. Mr Irwin was under the impression that the river rapids alarm was due to it being such a large unmonitored ride, not because there was such catastrophic potential.

Emergency training has been implemented for staff post incident.

Mr Irwin has mentioned that he would often receive calls that were not urgent as junior staff weren't sure how to react in an emergency situation and he just needed to calm them down and inform them of the correct procedure.

Mr Irwin states that the only emergency drill that he has ever undertaken in the park, was a bomb threat drill. Not a ride evacuation or any other emergency situation.

Mr Irwin doesn't believe there was any delay between contact from the ride op and contact of emergency services, he states that it would have been "3-4 seconds".

Mr Irwin was never provided with any reason as to why a code 6 breakdown folder was kept.

Mr Irwin believes this folder was copied by Queensland police when they were gathering evidence. Each folder covers a full calendar year and then gets archived after the year is complete.

Mr Irwin doesn't believe the process of getting in contact with the control room could have been done any quicker.

The only notification Mr Irwin got was the ride operator calling and saying "code 222 blue, I've got a raft on the conveyor" and then hung up. Mr Irwin then Checked the cctv monitors and upgrades the call when he say the raft sideways.

Mr Irwin has just finished giving evidence.

Stephen Buss

Began at Dreamworld in 2006 as a ride operator, was terminated in 2014 after an incident where he stopped the thunder river rapids ride which caused two rafts to collide.

Mr Buss states that he was trained as a level 3 operator for every ride and was trained in every position on thunder river rapids.

Mr Buss was fully trained on all roles on TRR in March 2008.

Mr Buss states that training for the log ride and TRR was over 2 days where all other rides had a 1 day training. The trainer would shadow the trainee for the entire time they are training. Mr Buss confirmed that trainers wouldn't leave until they were confident that the trainee knew what they were doing. Mr Buss states that the level 3 operator is often quite busy due to a lot of multitasking that was required. Mr Buss was asked if it was a lot to deal with and if it was difficult, he stated that it got easier with more experience. The level 3 operator is in charge of monitoring every aspect of the ride from load and dispatch, queues, water levels, stuck rafts and even removing rubbish from recently emptied rafts. During training for the level 3 role, it's generally not taught to be watching the conveyor and the spacing of the rafts as it's already learned in the level 1 and 2 roles.

Mr Buss was advised that during his time there, he was advised about maintaining the spacing between the rafts as that was one of the major things that needed to be monitored as he had heard stories before of a raft flipping but can't remember where he heard this. Mr Buss states that Dreamworld management would drill into trainees that the spacing of the rafts is the most important thing to monitor on TRR.

Mr Buss states that during his time there, staff would constantly be quizzed by management and trainers on safety procedures and other aspects of the rides they would look after.

Mr Buss states that if there is an operational change to the ride, all staff must be signed off to say they have been trained in the new process. If a staff member got questions wrong during the quizzes, they would be taken off the ride and retrained. Mr Buss mentioned that the quizzes would occur a few times a year.

Mr Buss was asked about alarms from the ride. The only alarm was the low pressure alarm which means a pump has stopped. The alarm is in place because the first raft in line needs to be tethered to the station so that it can't float away as it is past the raft jacks in the station.

Mr Buss states that the saying was "when in doubt, just stop the ride. When clarifying this, Mr Buss stated that when that happened, you would shut off the conveyor as the e-stop only turns off the pumps and that would be no help.

Mr Buss can never recall a time that he or another staff member have ever pressed the e-stop button on the unload platform. That button shuts off the conveyor and a pump.

In the event of a low air alarm, all the jacks would automatically lower to allow all the rafts to come home.

Mr Buss states there was a low air alarm, so he anchored the first raft in the station so it doesn't float away. He didn't realise there were 3 other rafts still in the course when he turned off the conveyor.

For a bit of clarification, there were 2 alarms, a low air alarm and a pump failure alarm. During this incident, it was a low air pressure alarm. Which is a different process to a pump failure.

During a pump failure, the process is to shut off the conveyor. During a low air alarm, the process is to anchor the first raft and then let all other rafts return home.

Mr Buss states that he got confused as the low air alarm had fixed itself and forgot there were 3 rafts still on the course when he accidentally shut off the pump which caused a raft to bottom out at the end of the conveyor. Mr Buss didn't notice that one had bottomed out at the start of the conveyor when he restarted the conveyor which caused the second raft to collide with the first one when it came over the conveyor.

Mr Buss continued to operate the ride for the rest of the day and wasn't even aware there would be an investigation into it until 1-2 weeks after.

The CCTV from the 2014 incident was shown again and this is the first time Mr Buss has ever seen it. A raft stops at the end of the conveyor, the conveyor is still moving and another raft comes down and bumps into it 4-5 times before the conveyor is stopped. Mr Buss cannot remember turning off the conveyor but states that if rafts were touching, he would have shut off the conveyor to prevent any issues. A few weeks after the incident, Mr Buss was interviewed and suspended without pay before being terminated.

Mr Buss recalls the low air alarm being an audible alarm and a flashing light on the control panel.

Mr Buss states that there is definitely a flashing light on the control panel for a pump failure alarm but cannot recall if there is an audible alarm.

At the time of the incident, Mr Buss was one of the most senior ride operators at Dreamworld

Mr Buss was shown a picture of the control panel and asked if it is the same as when he was operating the ride. Mr Buss states the only two new things added are a lockout device and a conveyor reset button.

Mr Buss states that there are 2 conveyor stop buttons. A soft stop and an instant stop. The soft stop is generally issued for issues where the whole ride doesn't need to be shut down.

We have just been adjourned for today.