# NOTICE OF FILING

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## Details of Filing

| | |
|---|---|
| Document Lodged: | Statement of Claim - Form 17 - Rule 8.06(1)(a) |
| File Number: | QUD182/2020 |
| File Title: | COLIN GRAHAM INGRAM AND JUDY GAIL TULLOCH AS TRUSTEES FOR THE INGRAM SUPERANNUATION FUND v ARDENT LEISURE LIMITED (ACN 104 529 106) & ORS |
| Registry: | QUEENSLAND REGISTRY - FEDERAL COURT OF AUSTRALIA |

Dated: 26/09/2022 4:51:50 PM AEST Registrar

## Important Information

As required by the Court's Rules, this Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Court and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

The date and time of lodgment also shown above are the date and time that the document was received by the Court. Under the Court's Rules the date of filing of the document is the day it was lodged (if that is a business day for the Registry which accepts it and the document was received by 4.30 pm local time at that Registry) or otherwise the next working day for that Registry.

Form 17
Rule 8.05(1)(a)

# Further Amended Statement of Claim

No. QUD182 of 2020

Federal Court of Australia
District Registry: Queensland
Division: General

Amended pursuant to the Order of the Court dated 26 September 2022
Piper Alderman, Lawyers for the applicants
Dated: 26 September 2022

**COLIN GRAHAM INGRAM and JUDY GAIL TULLOCH as trustees for the INGRAM SUPERANNUATION FUND**
Applicants

**ARDENT LEISURE LIMITED (ACN 104 529 106)**
First Respondent

**ARDENT LEISURE MANAGEMENT LIMITED (ACN 079 630 676)**
Second Respondent

**ARDENT LEISURE GROUP LIMITED (ACN 628 881 603)**
Third Respondent

**CRAIG MALCOLM DAVIDSON**
Fourth Respondent

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Filed on behalf of (name & role of party): The Applicants, Colin Graham Ingram and Judy Gail Tulloch as trustees for the Ingram Superannuation Fund
Prepared by (name of person/lawyer): Greg Whyte
Law firm (if applicable): Piper Alderman
Tel: +61 7 3220 7777 Fax: +61 7 3220 7700
Email: gwhyte@piperalderman.com.au
**Address for service** (include state and postcode): Level 26, Riparian Plaza, 71 Eagle St, Brisbane QLD 4000, DX105 Brisbane


[Form approved 01/08/2011]

## A. THE APPLICANTS AND THE GROUP

1. This proceeding is commenced as a representative proceeding pursuant to Part IVA of the *Federal Court of Australia Act 1976* (Cth) by the Applicants on their own behalf and on behalf of all persons who:

   (a) acquired an interest in fully paid AAD Stapled Securities (as defined in paragraph 8(c)) in Ardent Leisure Group (ASX:AAD) between 17 June 2014 and 25 October 2016 (**Relevant Period**);

   (b) have suffered loss or damage by reason of the conduct of the Respondents pleaded in this Statement of Claim; and

   (c) were not during any part of the Relevant Period, and are not as at the date of this Statement of Claim, any of the following:

(i) a related party (as defined by section 228 of the *Corporations Act 2001* (Cth) (**Corporations Act**)) of the Respondents;

(ii) a related body corporate (as defined by section 50 of the Corporations Act) of the Respondents;

(iii) an associated entity (as defined by section 50AAA of the Corporations Act) of the Respondents;

(iv) an officer or a close associate (as defined by section 9 of the Corporations Act) of the Respondents; or

(v) a Judge or Chief Justice of the Federal Court of Australia or Justice or Chief Justice of the High Court of Australia,

(**Group Members**).

2. The Applicants are natural persons who acquired an interest in AAD Stapled Securities as trustees for the Ingram Superannuation Fund, on or about 25 July 2016.

**Particulars**

*Details of the particular acquisitions of the AAD Stapled Securities by the Applicants are set out below:*

| Settlement Date | Average AAD Stapled Securities Price (AUD) | Quantity purchased | Total consideration (inc. brokerage and other fees) (AUD) |
|---|---|---|---|
| 25 July 2016 | $2.06 | 7,500 | $15,469.96 |

3. Immediately prior to the commencement of this proceeding, the Group Members, on whose behalf this proceeding is brought, comprised more than 7 persons.

## B. THE RESPONDENTS

4. The first respondent (**ALL**):

(a) is a company capable of being sued in its corporate name and style; and

(b) was, since 28 April 2003 and at all material times during the Relevant Period, the owner and operator of the Dreamworld theme park at Coomera near the Gold Coast in Queensland (**Dreamworld**).

5. The second respondent (**ALML**):

   (a) is a company capable of being sued in its corporate name and style; and

   (b) was, at all material times during the Relevant Period, the responsible entity of the Ardent Leisure Trust (**Trust**) which owned the land upon which Dreamworld is situated.

6. The third respondent (**ALG**) is a company capable of being sued in its corporate name and style.

7. The fourth respondent (**Davidson**) was the Chief Executive Officer of the Theme Parks Division (defined in paragraph 11) from around 2 September 2013 until 3 July 2018.

**B.1 ALL and ALML**

8. At all material times during the Relevant Period:

   (a) ALL and ALML traded in combination as "Ardent Leisure Group" (**AAD**);

   (b) ALL and ALML had identical boards and appointed a single management team;

   (c) units in the Trust and shares in ALL were issued as stapled securities (**AAD Stapled Securities**);

   (d) AAD reported as a consolidated group consisting of the Trust (and its controlled entities) and ALL (and its controlled entities), with the Trust being deemed to be the parent entity of AAD under Australian Accounting Standards;

   (e) ALL and ALML were each:

      (i) persons within the meaning of section 1041H of the Corporations Act;

      (ii) persons within the meaning of section 12DA of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**);

      (iii) persons within the meaning of section 18 of the *Australian Consumer Law* set out in Schedule 2 of the *Competition and Consumer Act 2010* (Cth) as applicable pursuant to that Act and:

         (A) section 7 of the *Fair Trading Act (Australian Consumer Law) Act 1992* (ACT);

(B) section 28 of the *Fair Trading Act 1987* (NSW);

(C) section 12 of the *Australian Consumer Law and Fair Trading Act 2012* (Vic);

(D) section 16 of the *Fair Trading Act 1989* (Qld);

(E) section 6 of the *Australian Consumer Law (Tasmania) Act* 2010 (Tas);

(F) section 19 of the *Fair Trading Act 2010* (WA);

(G) section 14 of the *Fair Trading Act 1987* (SA); and/or

(H) section 27 of the *Consumer Affairs and Fair Trading Act 1990* (NT),

as in force after 1 January 2011 (individually or together, the **ACL**);

(f) AAD was included in the official list of the financial market operated by the Australian Securities Exchange (**ASX**) and the ASX listing rules applied to AAD Stapled Securities issued by AAD;

(g) by reason of the matters in the preceding subparagraph:

(i) AAD Stapled Securities were:

(A) 'ED securities' under section 111AE of the Corporations Act;

(B) 'quoted ED securities' under section 111AM of the Corporations Act; and

(C) able to be acquired and disposed of by investors and potential investors in AAD Stapled Securities (**Affected Market**) on the financial market operated by the ASX;

(ii) each of ALL and ALML was:

(A) a 'disclosing entity' within the meaning of section 111AC of the Corporations Act;

(B) a listed disclosing entity within the meaning of section 111AL(1) of the Corporations Act;

(C) subject to and bound by the listing rules of the ASX (**ASX Listing Rules**);

(D) obliged by sections 111AP(1) and/or 674(1) of the Corporations Act and/or ASX Listing Rule 3.1 to, once it is, or becomes aware of, any information that has, or a reasonable person would expect to have, a material effect on the price of the value of AAD Stapled Securities, tell the ASX that information immediately unless the exceptions in ASX Listing Rule 3.1A apply (**Continuous Disclosure Obligations**); and

(E) obliged by ASX Listing Rules 4.7 and 4.10.3 to give the ASX a copy of its annual report by the earlier of the first day that document is sent to security holders, or the last day for documents to be given to security holders, under s 315 of the Corporations Act, and either incorporate its corporate governance statement in its annual report, or file its corporate governance statement by Appendix 4G, which corporate governance statement must specify the date it is current, and state that it has been approved by the board of the entity.

9. During the Relevant Period, the principal activity of AAD was to invest in and operate leisure and entertainment businesses in Australia, New Zealand and the United States.

10. During the Relevant Period, AAD's business divisions were:

(a) Family Entertainment Centres (later called 'Main Events');

(b) Theme Parks;

(c) Health Clubs (disposed of on 25 October 2016);

(d) Marinas (disposed of on 14 August 2017); and

(e) Bowling Centres (disposed of on 30 April 2018).

11. During the Relevant Period, the Theme Parks division of AAD consisted of the Dreamworld and the WhiteWater World theme parks at Coomera in Queensland, and the Sky Point building climb and observation deck at the Gold Coast in Queensland (**Theme Parks Division**).

12. Dreamworld is, and was at material times, a theme park and zoo with approximately 30 rides and attractions situated on 30 hectares of land at 1 Dreamworld Parkway, Coomera.

13. During the Relevant Period, AAD derived a material proportion of its revenue and profits from the Theme Parks Division, and from Dreamworld.

**Particulars**

*Dreamworld was opened to patrons on 15 December 1981. It is Australia's largest theme park.*

*AAD acquired Dreamworld from the Macquarie Leisure Trust on 3 July 1998 for $100.3 million. ALL was incorporated on 28 April 2003 and took over the ownership, management and responsibility of the Dreamworld assets from that date. AAD later opened WhiteWater World on 8 December 2006 at the cost of $56 million and acquired SkyPoint on 18 December 2009 for $13.3 million.*

*In the financial year ending 30 June 2008, revenue for the Theme Parks Division was reported as follows:*

*(a) $91.4 million contributed by Dreamworld; and*

*(b) $16.6 million contributed by WhiteWater World.*

*In the financial year ending 30 June 2016, attendance numbers for the Theme Parks Division was reported as follows:*

*(a) 2.4 million in total for Dreamworld, WhiteWater World and SkyPoint;*

*(b) of the above, 1.8 million patrons visited Dreamworld (75%).*

*Carrying values for the Theme Park Division property, plant and equipment for the financial year ending 30 June 2013 to the financial year ending 30 June 2016 are tabulated below:*

| | 2013 $'000 | 2014 $'000 | 2015 $'000 | 2016 $'000 |
|---|---|---|---|---|
| Health Clubs | 70,122 | 74,605 | 83,092 | 84,711 |
| Family Entertainment Centres | 46,898 | 78,360 | 157,236 | n/a |
| Dreamworld and WhiteWater World | 216,500 | 227,000 | 227,500 | 235,000 |
| SkyPoint Observation Deck | 19,000 | 22,500 | 26,500 | 34,300 |
| Marinas | 6,574 | 7,806 | 7,777 | n/a |
| Bowling Centres | 103,867 | 99,235 | 106,250 | 105,322 |

*Revenue and earnings before interest, tax, depreciation and amortisation (**EBITDA**) by the business divisions of AAD from the financial year ending 30 June 2013 to the financial year ending 30 June 2016 are tabulated below:*

| | 2013 $'000 | | 2014 $'000 | | 2015 $'000 | | 2016 $'000 | |
|---|---|---|---|---|---|---|---|---|
| | Revenue | EBITDA | Revenue | EBITDA | Revenue | EBITDA | Revenue | EBITDA |
| Health Clubs | $140,689 | $30,329 | $164,070 | $33,990 | $178,388 | $28,152 | $187,555 | $30,114 |
| Family Entertainment Centres | $72,695 | $17,001 | $98,121 | $24,714 | $177,123 | $45,657 | $238,974 | $59,168 |
| Theme Parks | $97,086 | $30,450 | $100,139 | $32,799 | $99,571 | $32,015 | $107,582 | $34,725 |
| Marinas | $23,141 | $10,687 | $23,466 | $10,396 | $22,952 | $10,150 | $23,000 | $10,157 |
| Bowling Centres | $115,230 | $12,773 | $113,889 | $13,765 | $116,510 | $13,989 | $130,494 | $18,224 |
| Total | $448,903 | $101,233 | $499,703 | $115,663 | $594,603 | $130,012 | $687,614 | $152,388 |

## B.2 Safety Committees

14. During the Relevant Period, there was a safety, sustainability and environment committee within AAD which was:

    (a) comprised of members from AAD's board of directors; and

    (b) responsible for monitoring, reviewing and evaluating OH&S, sustainability and environmental matters,

    (**AAD Safety Committee**).

15. During the Relevant Period, there was an Executive Safety Committee within Dreamworld:

    (a) whose members included the Chief Executive Officer of the Theme Park Division, the Group Safety Manager for AAD and the Dreamworld Executive Team (as defined in paragraph 16 below);

    (b) met regularly (on a monthly or quarterly basis); and

    (c) was responsible for reviewing safety issues within Dreamworld, including discussing ride modifications, considering the engagement of safety consultants (such as JAK and DRA, as pleaded further below) and reviewing the executive summaries of the JAK audits,

    (**Dreamworld Safety Committee**).

16. During the Relevant Period, the General Managers of each of the following departments reported to the Chief Executive Officer of the Theme Park Division:

(a) ~~Engineering and Technical~~Technical Services;

(b) ~~Operations~~Park Operations;

(c) Safety;

(d) Life Sciences

(e) ~~Retail~~ Commercial Operations;

(f) ~~Sales and Marketing~~ Chief Financial Officer; and

(g) ~~Food and Beverage~~ People.~~;~~

~~(h) Finance and Administration; and~~

~~(i) Employee Relations,~~

(**Dreamworld Executive Team**).

16A. In addition, during the Relevant Period the Group Safety Manager, Angus Hutchings, reported to both:

(a) the Chief Executive Officer of the Theme Park Division; and

(b) the Group Manager Audit & Compliance of AAD.

**B.3 Officers of AAD**

17. Deborah Thomas (**Thomas**):

(a) was appointed a director of ALL and ALML on 1 December 2013;

(b) was appointed Managing Director and Chief Executive Officer of AAD on 10 March 2015, effective from 7 April 2015, and as such had responsibility for the matters set out at section 3 of the Executive Services Agreement between her and ALL, which matters include:

(i) the day-to-day management of AAD's business;

(ii) ensuring the development and implementation of corporate policies and procedures suitable to a listed public trust and company~~identifying and managing financial, operational and corporate risks for AAD and, where those risks could have a material impact on AAD, formulating strategies for managing and mitigating those risks~~;

(iii) ensuring the development and implementation of corporate governance and risk management systems and reporting practices suitable to a listed public trust and company~~managing AAD's financial and other reporting mechanisms, and control and monitoring systems, to ensure that these mechanisms and systems captured all relevant material information on a timely basis, were functioning effectively and were founded on a sound basis of prudential risk management~~; and

(iv) putting in place and monitoring observance of appropriate compliance with corporate policies and procedures and corporate governance and risk management systems and reporting practices.

(c) attended all four meetings of the AAD Safety Committee held in the financial year ending 30 June 2016; and

(d) attended all seven meetings of the AAD Safety Committee held in the financial year ending 30 June 2017.

18. Roger Davis (**Davis**):

(a) was appointed a director of ~~ALL~~ Macquarie Leisure Operations Limited on 28 May 2008 (which company subsequently became ALL on 1 September 2009, at which time Davis became a director of ALL);

(b) was appointed a director of ALML on 1 September 2009;

(c) was the Chair of the AAD Safety Committee for the financial years ending 30 June 2016 and 30 June 2017;

(d) attended all four meetings of the AAD Safety Committee held in the financial year ending 30 June 2016; and

(e) attended six of the seven meetings of the AAD Safety Committee held in the financial year ending 30 June 2017.

19. David Haslingden (**Haslingden**):

    (a) was appointed a director of ALL and ALML on 6 July 2015;

    (b) attended three of the four meetings of the AAD Safety Committee held in the financial year ending 30 June 2016; and

    (c) attended all seven meetings of the AAD Safety Committee held in the financial year ending 30 June 2017.

20. Don Morris AO (**Morris**):

    (a) was appointed a director of ALL and ALML on 1 January 2012;

    (b) attended all four meetings of the AAD Safety Committee held in the financial year ending 30 June 2016; and

    (c) attended all seven meetings of the AAD Safety Committee held in the financial year ending 30 June 2017.

21. George Venardos (**Venardos**):

    (a) was appointed a director of ALL and ALML on 22 September 2009;

    (b) attended all four meetings of the AAD Safety Committee held in the financial year ending 30 June 2016; and

    (c) attended all seven meetings of the AAD Safety Committee held in the financial year ending 30 June 2017.

22. Davidson:

    (a) was the Chief Executive Officer of the Theme Parks Division from around 2 September 2013 until 3 July 2018;

    (b) served as a member of the Dreamworld Safety Committee from around 2 September 2013 until 3 July 2018;

    (c) at all material times in the Relevant Period:

        (i) held the ultimate decision-making authority for Dreamworld;

(ii) liaised directly with the Board of Directors of AAD, including in relation to matters such as safety and expenditure;

(iii) was responsible for ensuring the Board of Directors of AAD were kept abreast of safety related issues at Dreamworld;

(iv) was responsible for reporting to the Board of Directors of AAD;

(v) was designated by AAD as one of AAD's key management personnel and as such:

(A) had authority and responsibility for planning, directing and controlling the activities of AAD;

(B) was obliged to comply with all AAD corporate policies including AAD's Continuous Disclosure Policy and specifically the policy that directors and employees must ensure that any information which may require disclosure is reported to the Company Secretary or his/her nominee as soon as it is known;

(vi) was the direct report for:

(A) ~~Mr Richard Johnson (the Chief Financial Officer of AAD from around December 2004 until around July 2017);~~

(B) Mr Angus Hutchings (the Group Safety Manager for AAD from around 2010 until July 2018); and

(C) all of the General Managers within the Dreamworld Executive Team including:

(1) Mr Bob Tan (the General Manager of the Engineering and Technical Department from around 2007 until around 2014);

(2) Mr Chris Deaves (the General Manager of the Engineering and Technical Department from around 2014 until around March 2019);

(3) Mr Troy Margetts (the General Manager of the Operations Department from around May 2015 until around 2016, and

to whom Mr Andrew Fyfe (the General Manager of the Attractions Department) reported); and

(4) Mr Mark Thompson (the General Manager of the Safety Department from around 14 March 2016 until around June 2017).; ~~and~~

~~(5) Mr Andrew Fyfe (the General Manager of the Attractions Department (which is a sub-department within the Operations Department) from around 2009 until around March 2018);~~

(vii) had responsibilities including:

(A) assisting the business to develop and implement work health and safety plans and to meet safety objectives;

(B) ensuring that General Managers under his delegation were aware of their work, health and safety responsibilities;

(C) ensuring that relevant personnel perform risk assessments and implement controls in accordance with relevant regulations, Australian Standards and Codes of Practices;

(D) establishing an annual review of the safety management system to ensure it reflects the current legislation and supports the needs of AAD;

(E) regularly assessing (at least every year), via internal auditing, how effectively operations comply with the required health and safety standards; and

(F) participating in and supporting safety inspections;

(viii) held the ultimate decision-making authority with respect to health and safety in all areas under his control; and

(ix) by reason of the matters pleaded in paragraphs 9 to 13, and sub-paragraphs (i) to (viii) above was a person who, during the Relevant Period, made or participated in making decisions that affected a

substantial part of the business of AAD and/or was a person who had the capacity to significantly affect AAD's financial standing.

23. By reason of the matters in paragraphs 17 to 22 above, each of Thomas, Davis, Haslingden, Morris, Venardos and Davidson was an officer of each of ALL and ALML within the meaning of s 9 of the Corporations Act and ASX Listing Rule 19.12 from the respective dates of their appointments to the end of the Relevant Period.

24. By reason of the matters pleaded in paragraphs 14 to 23, any information of which any of:

(a) Thomas;

(b) Davis;

(c) Haslingden;

(d) Morris;

(e) Venardos; or

(f) Davidson,

became aware, or which ought reasonably to have come into their possession in the course of the performance of their respective duties as officers of ALL and ALML, was information of which each of ALL and ALML was aware (as 'aware' is defined in ASX Listing Rule 19.12).

## C. THE THUNDER RIVER RAPIDS RIDE AND ITS SAFETY

### C.1 The Thunder River Rapids Ride

25. The Thunder River Rapids Ride (**TRRR**) was an aquatic based amusement ride situated in the 'Gold Rush Country' (later called 'Town of Gold Rush') area of Dreamworld.

26. The TRRR was a 'Class 2' amusement device under Australian Standard AS 3533 (**AS 3533**).

**Particulars**

*The best particulars the Applicants can presently provide of the TRRR's 'Class 2' categorisation under AS 3533 is taken from the evidence of David Randall given on day 24 of the coronial inquest held into the Incident (defined at paragraph 99) (**Inquest**) at*

*page 24-64 of the transcript; the evidence of Thomas Polley given on day 18 of the Inquest at page 18-51 of the transcript; and from paragraphs [314] and [721] of the Coroner's Findings and Recommendations (**Coroner's Findings**); Workplace Health and Safety Queensland Certificate of Registration of Plant – Rapid Ride dated 1 February 2014 (ARD.001.002.0818); and Rapid Ride 2016 Annual Mechanical and Structural Inspection Certificate/Report 39/16 – Dreamworld dated 17 October 2016 (ARD.001.002.0838). Further particulars will be provided following completion of interlocutory steps.*

27. The TRRR:

(a) conveyed passengers on rafts through a water filled trough which contained obstacles designed to simulate a white-water rafting experience;

(b) was approximately 450 metres long and weaved around the Gold Rush Country section of Dreamworld, and took approximately 4 minutes and 10 seconds to complete;

(c) sourced water for the trough from two pumps known as the north pump and the south pump;

(d) had a conveyor belt near the end of the ride to convey rafts from the trough up an incline and then down a short decline to the passenger offload area (**Conveyor**);

(e) had been operated at Dreamworld since approximately December 1986; and

(f) was one of the most popular attractions at Dreamworld.

**Particulars**

*The best particulars the Applicants can presently provide of the TRRR's ride specifications is taken from the evidence of Steven Cornish and Nicola Brown given on day 1 of the Inquest at pages, 1-11, 1-12, 1-51 and 1-73 of the transcript, and from paragraphs [15], [52], [77], and [99] of the Coroner's Findings; Operations Procedure Manual – Rapid Ride Load operation at section 3.5.7 (ARD.001.002.0049); Thunder River Rapids Annual Shutdown Maintenance 2008 at pages 31 and 32 (ARD.001.002.0744); and Letter from Binnie & Partners, Consulting Engineers to Dreamworld dated 30 January 1987 (ARD.001.002.0509). Further particulars will be provided following completion of interlocutory steps.*

28. The rafts used on the TRRR:

(a) consisted of a fibreglass shell inserted into a large custom-built rubber tube known as a flotation collar; and

(b) could seat six passengers in an upright position in the fibreglass shell, secured by a Velcro lap belt.

**Particulars**

*The best particulars the Applicants can presently provide of the raft specifications is taken from the evidence of Steven Cornish and Nicola Brown given on day 1 of the Inquest at pages 1-29, 1-30 and 1-68 of the transcript, and from paragraphs [15] and [82] of the Coroner's Findings and TRRR photographs dated 18 January 2001 (ARD.001.002.0068). Further particulars will be provided following completion of interlocutory steps.*

## C.2 Operation of the TRRR

29. The TRRR was one of the most complex rides to operate at Dreamworld.

**Particulars**

*The best particulars the Applicants can presently provide is taken from paragraphs [169] and [1025] of the Coroner's Findings. Further particulars will be provided following completion of interlocutory steps.*

30. The main operating control panel at the passenger embarkation area (**Control Panel**) had a number of controls for the operation of the TRRR, including an emergency stop button to deactivate the north pump (**Pump Stop Button**), a button which closed the pneumatic gates ('jacks') to the trough (**Gate Closure Button**) ~~and~~, a button which brought the Conveyor to a stop (**Conveyor Button**) and a lock and key (**Dispatch Isolator Key**) which was required to be removed when an operator was not at the Control Panel.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-29 and 1-31 of the transcript; and the evidence of Steven Cornish given on day 2 of the Inquest at page 2-36 of the transcript; Coronial Report of Steven Cornish dated 25 October 2016 at page 8 (ARD.002.001.0186); JAK Leisure Management Report dated 22 February 2013 at page 18 (ARD.001.002.0263); and Operations Procedure Manual – Rapid Ride Load operation at section 3.2.4 (ARD.001.002.0049). Further particulars will be provided following completion of interlocutory steps.*

31. The Conveyor Button had a slow stop function taking approximately eight seconds before the Conveyor would come to a halt during which period, rafts on the Conveyor would travel approximately four metres.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page1-32 of the transcript. Further particulars will be provided following completion of interlocutory steps. Coronial Report of Steven Cornish dated 25 October 2016 at page 54 and 82 (ARD.002.001.0186).*

32. The emergency shutdown procedure for the TRRR required the Level 3 operator to engage each of ~~the Pump Stop Button,~~ the Gate Closure Button, ~~and~~ the Conveyor Button, the Pump Stop Button and then remove the Dispatch Isolator Key in sequence as well as sound a rapid ride alarm.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-25 and 1-29 of the transcript; the evidence of Peter Nemeth given on day 2 of the Inquest at pages 2-60 to 2-61 of the transcript; the evidence of Sarah Cotter given on day 7 of the Inquest at pages 7-26 to 7-27 of the transcript; and the evidence of Jennie Knight given on day 15 of the Inquest at page 15-52 of the transcript; Operations Procedure Manual – Rapid Ride Operator at sections 3.4.2 and 3.4.3 (ARD.003.001.6747); Operations Procedure Manual – Rapid Ride Load operation at sections 3.4.2 and 3.4.3 (ARD.001.002.0049); Shutdown buttons procedure poster (ARD.010.015.8105); and Email from Jason Johns to John Lossie dated 6 May 2016 (ARD.001.002.0430). Further particulars will be provided following completion of interlocutory steps.*

33. A separate emergency stop button for the Conveyor was located on a post in the passenger offload area where the Level 2 operator was stationed (**Emergency Stop Button**).

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-28 to 1-29 of the transcript; and the evidence of Courtney Williams given on day 3 of the Inquest at page 3-76 of the transcript; Evidence of Steven Cornish given on day 1 of the Inquest at pages 1-84 and 1-87 of the transcript (ING.002.007.0280) and on day 2 of the Inquest at page 2-4 of the transcript (ING.002.007.1482); and Memorandum to Rapid Ride Operators and Load Operators entitled "Unload E-Stop" dated 18 October 2016 (ARD.001.002.0066). Further particulars will be provided following completion of interlocutory steps.*

34. The Emergency Stop Button:

(a) could halt the Conveyor within two seconds during which period, rafts on the Conveyor would travel approximately 0.7 metres;

(b) was not labelled; and

(c) was incapable of initiating a complete shutdown of all of the TRRR's mechanisms.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-32 and 1-40 of the transcript; and the evidence of Mark Thompson given on day 6 of the Inquest at pages 6-66 to 6-68 of the transcript; Evidence of Steven Cornish given on day 1 of the Inquest at page 1-83 and 1-84 of the transcript (ING.002.007.0280); Memorandum to Rapid Ride Operators and Load Operators entitled "Unload E-Stop" dated 18 October 2016 (ARD.001.002.0066); Memorandum entitled "Rapid Ride Operator Control Conversion" from Greg Handley to Bob Tan dated 26 June 1998 (ARD.001.002.0432); Chapter 15 – Rapid Ride at page 2 (ARD.001.001.0124); JAK 2013 Report dated 22 February 2013 at page 17 (ARD.001.002.0263); Email from Jason Johns to John Lossie dated 6 May 2016 (ARD.001.002.0430); and Expert Report of Murray Feddersen dated 16 March 2022 at page 41 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

35. The operation manual for the TRRR directed that a ~~Level 2 operator was not authorised to engage the Emergency Stop Button unless the~~ Level 3 operator was the only operator authorised to initiate an emergency shut down of the TRRR, unless incapacitated or injured ~~or directed the Level 2 operator to engage it~~.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-28 and 1-38 of the transcript; the evidence of Peter Nemeth given on day 2 of the Inquest at pages 2-73 to 2-75 of the transcript; the evidence of Sarah Cotter given on day 7 of the Inquest at page 7-37 of the transcript and from paragraphs [184], [194] and [208] of the Coroner's Findings; Operations Procedure Manual – Rapid Ride Load operation at sections 3.4.3 and 3.6.3 (ARD.001.002.0049); Memorandum to Rapid Ride Operators and Load Operators entitled "Unload E-Stop" dated 18 October 2016 (ARD.001.002.0066). Further particulars will be provided following completion of interlocutory steps.*

36. The design and operation of the TRRR therefore involved a system where:

(a) the Level 2 operator was stationed at a position proximate to the Conveyor and had access to the Emergency Stop Button which had close to immediate effect, but was not authorised to engage the Emergency Stop Button unless the Level 3 operator was incapacitated or directed it to be engaged; and

(b) the Level 3 operator who was authorised to engage the Emergency Stop Button was stationed away from the Conveyor and the Emergency Stop Button, and only had direct access to the Conveyor Button which had slow operational effect;~~.~~

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-32 of the transcript; and the evidence of Peter Nemeth given on day 2 of the Inquest at page 2-75 of the transcript; Operations Procedure Manual – Rapid Ride Load*

*operation at sections ,3.3.1, 3.4.3 and 3.6.3 (ARD.001.002.0049); Memorandum to Rapid Ride Operators and Load Operators entitled "Unload E-Stop" dated 18 October 2016 (ARD.001.002.0066); and Memorandum to all Operators and Load Operators entitled "TRR New buttons" dated 12 February 2016 (ARD.010.015.8107). Further particulars will be provided following completion of interlocutory steps.*

(c) the Level 2 and 3 operators did not have access to electronic communication methods, such as hand-held radios.

### C.3 Training and supervision

37. Training for a Level 2 operator on the TRRR:

(a) was conducted at the ride commencing 30 minutes prior to the ride opening to the public;

(b) was conducted by an instructing operator, who provided the trainee with instructions and assessed the trainee's competence, while the ride was in operation; and

(c) took approximately 90 to 105 minutes,

following which, a trainee would be tasked with operating the TRRR without direct supervision.

38. Training for a Level 3 operator involved the same training as that described in the previous paragraph for a Level 2 operator, except the training:

(a) took longer than 105 minutes; and

(b) included an assessment of competency with start-up and shutdown procedures.

39. Training for operators of the TRRR did not involve:

(a) emergency drills; or

(b) practical training regarding the use of the emergency shutdown procedure.

### C.4 TRRR modifications

40. The TRRR opened on 11 December 1986.

41. At some time between 16 January 1989 and 1990, the TRRR underwent modifications to its design, namely the removal of every second and third full sized slat on the Conveyor (**Slat Removal**).

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-25 of the transcript; Services Maintenance Report dated 7 December 1988 to 19 January 1999 (ARD.001.002.0492); Thunder River Rapids Annual Shutdown Maintenance 2008 at pages 34, 35, 40 and 42 (ARD.001.002.0744); Memorandum from Len Shaw to Garth Bell regarding Rapid Ride Tail Shaft Failure dated 25 January 1987 (ARD.003.002.8173); Memorandum from Len Shaw to Wes Hepburn re TRRR turntable dated 13 August 1987 (ARD.003.002.7860); Memorandum from Len Shaw to Garth Bell regarding Rapid Ride Loading Dock Raft Track dated 25 January 1988 (ARD.003.002.8173); Memorandum from Len Shaw to Garth Bell regarding Rapid Ride dated 16 January 1989 (ARD.003.002.8173); Memorandum from Len Shaw to Gareth Bell regarding Rapid Ride Turntable dated 20 February 1990 (ARD.001.002.0491). Further particulars will be provided following completion of interlocutory steps.*

42. In or around 2015, the TRRR underwent further modifications to its design, namely the installation of support railings near the passenger offload area in respect of which:

(a) the support railings were submerged when the TRRR was operational, but when water was removed from the offload area the railings primarily operated as a dry dock stand for the rafts (**Dry Dock Rails**);

(b) the Dry Dock Rails were installed following the removal of a large timber turntable at the end of the Conveyor which cost $25,000 per year to maintain; and

(c) following the installation of the Dry Dock Rails, a gap was created between the Conveyor and the beginning of the Dry Dock Rails wide enough for a raft to fall through (**Gap**).

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-13 and 1-25 to 1-27 of the transcript; and paragraph [112] of the Coroner's Findings; Coronial Report of Steven Cornish dated 25 October 2016 at pages 12 to 14 and 20 to 22 (ARD.002.001.0186); Memorandum from Len Shaw to Gareth Bell regarding Rapid Ride Turntable dated 20 February 1990 (ARD.001.002.0491); and Expert Report of Murray Feddersen dated 16 March 2022 at pages 23 to 24 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

43. The Slat Removal posed an obvious risk to the health and safety of passengers in that the removal of the slats left a gap between the remaining slats of such size that a

passenger could fall through the gap if rafts collided and inverted or if a passenger fell out of the raft.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-19 of the transcript; the evidence of Steven Cornish given on day 1 of the Inquest at page 1-93 of the transcript; the evidence of Bob Tan given on day 29 of the Inquest at pages 29-25 to 29-26 of the transcript; and paragraphs [763], [764], [853]. [854], [905], [906], [908] and [988] of the Coroner's Findings. Further particulars will be provided following completion of interlocutory steps.*

44. The installation of the Dry Dock Rails posed an obvious risk to the health and safety of passengers in that it:

(a) created the Gap into which a raft could become lodged between the Conveyor and the Dry Dock Rails;

(b) created an obstacle to moving rafts which, if the water level within the watercourse fell, had the potential to stop the progress of a raft and therefore created a risk of a following raft impacting the stopped raft with the potential for the following raft to flip or to become caught in the Gap.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Steven Cornish given on day 1 of the Inquest at page 1-93 of the transcript (ING.002.007.0280); the evidence of Andrew Fyfe given on day 19 of the Inquest at page 19-56 of the transcript; and paragraphs [765], [896] and [988] of the Coroner's Findings.; Expert Report of Murray Feddersen dated 16 March 2022 at pages 23 to 24, 28 and 49 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

45. AAD did not conduct any hazard identification or risk assessment of the TRRR:

(a) having regard to the Slat Removal, at any time after ALL commenced to operate Dreamworld in 2003; and/or

(b) having regard to the installation of the Dry Dock Rails.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-25 and 1-34 of the transcript; the evidence of Scott Ritchie given on day 17 of the Inquest at page 17-79 of the transcript (ING.002.007.1138); the evidence of Andrew Fyfe given on day 19 of the Inquest at page 19-55 of the transcript (ING.002.007.1360); ~~and~~ the evidence of Dr Frank Grigg, Dr Duncan Gilmore*

*and George Rutherford given on day 30 of the Inquest at pages 30-35 and 30-45 of the transcript; Expert Report of Murray Feddersen dated 16 March 2022 at pages 22, 30 to 33 and 35 to 37 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

46. AAD did not implement any engineering solution to respond to:

(a) the risks posed to the health and safety of passengers on the TRRR posed by the Slat Removal, as pleaded in paragraph 43; and/or

(b) the risks posed to the health and safety of passengers posed by the installation of the Dry Dock Rails, as pleaded in paragraph 44.

**Particulars**

*The best particulars the Applicants can presently provide is inferred from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-27 of the transcript; the evidence of Scott Ritchie given on day 17 of the Inquest at page 17-79 of the transcript; the evidence of Andrew Fyfe given on day 19 of the Inquest at pages 19-55 to 19-56 of the transcript; the evidence of Chris Deaves given on day 22 of the Inquest at page 22-75 of the inquest; ~~and~~ the evidence of Bob Tan given on day 29 of the Inquest at pages 29-16, 29-17 and 29-19 of the transcript; Expert Report of Murray Feddersen dated 16 March 2022 at pages 21 to 22, 25, 27 and 33 to 37 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

## C.5 TRRR incidents

47. At all times during the Relevant Period, the TRRR had a history of incidents involving rafts colliding on the Conveyor:

(a) on or about 18 January 2001, two stationary rafts banked up at the offload area, following which an additional three rafts came off the Conveyor and collided with the stationary rafts and one raft inverted (**2001 Incident**);

(b) on or about 7 October 2004, two rafts came into contact in the passenger offload area causing a passenger who was disembarking a raft to fall into the trough;

(c) on or about 28 August 2005, a near collision of rafts occurred on the Conveyor;

(ca) on or about 27 June 2010, a power dip caused the South pump at the ride to shut down, causing two rafts to float into the reservoir and a third raft to become stalled in between the conveyor and the offload area (with guests on the raft unable to be safely offloaded until both pumps could be re-started);

(d) on or about 30 June 2010, two rafts collided in the passenger offload area causing a passenger in one of the rafts to fall into the trough; and

(e) on or about 16 September 2011, two rafts came into contact at the bottom of the Conveyor.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-19 to 1-20 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-66, 21-91 and 21-93 to 21-96 of the transcript; the evidence of Dr Frank Grigg, Dr Duncan Gilmore and George Rutherford given on day 30 of the Inquest at page 30-65 of the transcript; and paragraphs [217] to [271] of the Coroner's Findings; Coronial Report of Steven Cornish dated 25 October 2016 at pages 94 to 96 (ARD.002.001.0186); Incident Report No. HI01-0019 dated 18 January 2001 (ARD.001.002.0070); TRRR photographs dated 18 January 2001 (ARD.003.001.1981); Amusement Ride – Mechanical Audit/Inspection Report by RISKPAC for Bob Tan dated 24 August 2001 (ARD.010.042.6599); Rapid Ride Incident October 7, 2004 Report (ARD.001.002.0073); TRRR Feasible Improvements dated 11 October 2004 (ARD.003.003.1290); Investigation Report dated 25 November 2008 at page 2 (ARD.003.002.2155); Incident logs at pages 229, 265-266, 486 and 529 (ARD.003.003.6005); Incident Investigation Report for incident on 28 August 2005 (ARD.001.002.0082); Human Resources/Environment & Safety/Training Report dated 13 September 2005 (ARD.010.034.7336); Dreamworld Management Committee – Meeting Minutes dated 1 September 2005 (ARD.003.006.0658); Figtree Incident Report AHR00344 dated 1 October 2011 at page 55 (ARD.001.002.0084); Email to Dreamworld Safety dated 16 September 2011 (ARD.001.002.0176); Figtree Incident Report AHR00243 dated 19 September 2011 at page 3 (ARD.001.002.0177); Figtree Incident Report AHR00227 dated 21 September 2011 at page 9 (ARD.010.042.1278); and Expert Report of Murray Feddersen dated 16 March 2022 at pages 26 to 29 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

48. Further, at all material times during the Relevant Period after 6 November 2014, the TRRR had a history of incidents involving rafts colliding on or near the Conveyor, colliding in or near the offload area, or of rafts becoming stranded in or near the offload area, namely:

(a) the incidents pleaded in paragraph 47(a) to (e) above; and

(b) an incident which occurred on or about 6 November 2014, in which one raft (Raft 7) became stranded on the Dry Dock Rails at the offload area due to a water level drop, following which, another raft (Raft 8) containing passengers descended from the conveyor and collided with the stationary raft (**2014 Incident**).

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Stephen Buss given on day 12 of the Inquest at pages 12-94 to 12-102 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-79 of the transcript; and paragraphs [257] to [264] of the Coroner's Findings; Video footage of incident dated 6 November 2014 (ARD.003.002.7551, ARD.003.002.7552, ARD.003.002.7553 and ARD.003.002.7554); Forwarded email from Jarad Drysdale to Dreamworld Operations Ideas regarding Rapid ride, cyclone feed back [sic] dated 17 November 2014 (ARD.001.002.0426); Email from Andrew Fyfe to Troy Margetts regarding response to Jarad dated 18 November 2014 (ARD.010.015.7346); HR/Training/Safety & Environment report to Executive Committee (ARD.010.034.7619); Letter to Stephen Buss dated 14 November 2014 (ARD.001.001.0060); Stephen Buss personnel file and incident documents (ARD.003.002.6431); and Expert Report of Murray Feddersen dated 16 March 2022 at page 29 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

49. By reason of:

(a) the matters pleaded in paragraph 47, at all material times as at and from the 2001 Incident, and by the commencement of the Relevant Period;

(b) the matters pleaded in paragraph 48, at all material times following the 2014 Incident,

the TRRR was subject to a hazard, namely that there was a risk of rafts colliding in the passenger offload area and capsizing.

**Particulars**

*The best particulars the Applicants can presently provide is taken from paragraphs [994] and [995] of the Coroner's Findings and the Expert Report of Murray Feddersen dated 16 March 2022 at pages 28 to 30 and 49 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

50. AAD did not conduct a thorough hazard identification and risk assessment of the TRRR:

(a) following the 2001 Incident (or any of the other incidents pleaded in paragraph 47(b) to (e) above); and/or

(b) following the 2014 Incident.

**Particulars**

*The best particulars the Applicants can presently provide is inferred from the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-84 and 21-95 to 21-96 of the transcript and the Expert Report of Murray Feddersen*

*dated 16 March 2022 at pages 26 to 27 and 30 to 33 (ING.004.001.0001).*
*Further particulars will be provided following completion of interlocutory steps.*

51. AAD did not implement any engineering solution to respond to the risks posed to the health and safety of passengers on the TRRR as pleaded in paragraph 49 above:

(a) in response to the 2001 Incident (or any of the other incidents pleaded in paragraph 47(b) to (e) above); and/or

(b) in response to the 2014 Incident.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-21 of the transcript; and the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-79 to 21-80, 21-84 and 21-95 to 12-96 of the transcript; Expert Report of Murray Feddersen dated 16 March 2022 at page 34 (ING.004.001.0001); and Coronial Report of Steven Cornish dated 25 October 2016 at pages 29 to 31 and 39 (ARD.002.001.0186). Further particulars will be provided following completion of interlocutory steps.*

## C.6 JAK's safety audits

52. During 2003, JAK Leisure Management (**JAK**) conducted a ride safety audit at Dreamworld and recommended that the TRRR be modified to install a single emergency stop button at the Control Panel that would stop all moving components of the TRRR including the Conveyor.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-68 of the transcript; and from paragraph [525(l)] of the Coroner's Findings; Dreamworld Safety Audit – Scope of Works dated 9 January 2003 (ARD.003.006.4180); and JAK 2003 Audit Chapter 15 – TRRR (ARD.003.006.4208). Further particulars will be provided following completion of interlocutory steps.*

53. During 2004, JAK conducted a ride safety audit at Dreamworld and recommended that the TRRR be modified to install a single emergency stop button at the Control Panel that would stop all moving components of the TRRR including the Conveyor.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-69 of the transcript; Letter from JAK enclosing scope of work dated 3 September 2004 (ARD.003.006.4283); JAK General Chapter 2004 (ARD.003.006.4316); JAK Chapter 15 Rapid Ride 2004 (ARD.003.001.2103); Letter from JAK regarding proposed follow-up safety audit dated 6*

*December 2004 (ARD.003.006.9369); and JAK Executive Summary dated 12 November 2004 (ARD.003.006.4345). Further particulars will be provided following completion of interlocutory steps.*

54. During 2006, JAK conducted a ride safety audit at Dreamworld and recommended in relation to the TRRR that:

(a) operator buttons be clearly labelled; and

(b) an additional person be rostered to work with the opening crew to assist with the daily inspections because without additional labour the tendency would be to shortcut the daily checks and requirements.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-24 of the transcript; and the evidence of Angus Hutchings given on days 21 and 22 of the Inquest at pages 21-71 and 22-22 of the transcript; Executive Summary of JAK 2006 Report (ARD.001.002.0864); and JAK 2006 Audit Chapter 15 (ARD.003.006.4371). Further particulars will be provided following completion of interlocutory steps.*

55. During 2009, JAK conducted a ride safety audit at Dreamworld and recommended in relation to the TRRR that:

(a) a simpler, automatic shutdown process be considered for emergencies and that the safety shutdown system be upgraded to a single emergency button which would ensure appropriate timing and sequence;

(b) current staffing levels were such that the mechanical and electrical technicians might feel rushed and not do as thorough an inspection as is necessary and that without additional labour the tendency might be to shortcut the daily requirements or miss critical checks; and

(c) ride operators be rostered to start work earlier to allow them more time to perform pre-operational procedures and checks.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-74 to 21-76 of the transcript; and paragraph [545(IV)] of the Coroner's Findings; JAK Executive Summary 2009 (Dreamworld Audit) at page 4 (ARD.001.002.0933); and JAK Chapter 15 – Thunder River Rapid at page 6 (ARD.001.002.0904). Further particulars will be provided following completion of interlocutory steps.*

56. During 2013, JAK conducted a ride safety audit at Dreamworld and recommended in relation to the TRRR:

(a) the implementation of a simpler, automatic emergency shutdown on the TRRR, including that a single emergency stop button be installed at the Control Panel within six months;

(b) that there be a review of staffing resources to ensure daily inspections are being properly completed; and

(c) that ride operators be rostered to start work earlier to ensure daily procedures could be properly completed.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-24 of the transcript; the evidence of Mark Thompson given on day 6 of the Inquest at pages 6-73 to 6-74 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-76 to 21-77 of the transcript; the evidence of Chris Deaves given on day 23 of the Inquest at pages 23-13 to 23-14 and 23-36 of the transcript; and from paragraphs [548 (XIII)] and [877] of the Coroner's Findings; JAK Executive Summary 2013 (Dreamworld Audit) at page 4 (ARD.001.002.0221); JAK 2013 Report dated 22 February 2013 at page 16 (ARD.001.002.0263); and JAK 2013 Loss Prevention Survey Final Report at page 260 (ARD.003.006.5141). Further particulars will be provided following completion of interlocutory steps.*

56A. JAK's ride safety audits were not conducted in accordance with Australian Standards.

**Particulars**

*The Applicants will rely upon the minutes of the AAD Safety Committee dated 9 March 2016 that "JAK ... had proven unwilling to audit to Australian standards." (ARD.008.001.2758 at .2759).*

57. Notwithstanding the matters pleaded at paragraphs 52 to 56, AAD did not:

(a) install an automatic safety stop system on the TRRR;

(b) install a single, comprehensive stop system at the Control Panel; or

(c) increase staffing levels for the TRRR,

at any time after 2003, or during the Relevant Period.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-25 of the transcript; the evidence of Steven Cornish given on day 1 of the Inquest at page 1-86 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at pages 21-74 to 21-77 of the transcript and from paragraphs [877], [1015] and [1016] of the Coroner's Findings; Safety Audit 2003: Log of Actions and Status dated 15 July 2003 (ARD.003.006.4177); Safety Audit Review Nov 2004: Log of Actions and Status dated 25 November 2004 (ARD.003.006.4270); JAK 2004 Audit Chapter 15 Implementation (ARD.003.006.4324); JAK Audit Recommendations Register 2006 (ARD.003.005.1947); JAK Audit Recommendations Register 2009 (ARD.003.007.0502); and Minutes of Safety Executive Meeting 12 January 2010 (ARD.003.002.8420). Further particulars will be provided following completion of interlocutory steps.*

## C.7 DRA's safety audits

58. Between 4 February 2013 and 8 February 2013, DRA Safety Specialists (**DRA**) conducted an audit of Dreamworld's safety management systems against the National Audit Tool. The audit produced a result of 41% against a pass standard of 70%.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Mark Thompson given on day 6 of the Inquest at page 6-59 of the transcript; and the evidence of David Randall given on day 24 of the Inquest at pages 24-14 to 24-15, 24-20 and 24-24 to24-25 of the transcript; DRA Safety Management Systems Audit dated 4-8 February 2013 at page 75 (ARD.001.002.0297). Further particulars will be provided following completion of interlocutory steps.*

59. During 2014, DRA conducted an audit of Dreamworld's safety management systems against the National Audit Tool. The audit produced a result of 46% against a pass standard of 70%.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-24 of the transcript; and the evidence of David Randall given on day 24 of the Inquest at page 24-48 of the transcript; DRA Safety Management Systems Audit dated 24-28 February 2014 (ARD.002.001.0960). Further particulars will be provided following completion of interlocutory steps.*

60. On 13 July 2015 and 14 July 2015, DRA conducted an audit of Dreamworld's safety management systems against the National Audit Tool. The audit produced a result of 61% against a pass standard of 70%.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-24 of the transcript; and the evidence of David Randall given on day 24 of the Inquest at page 24-48 of the transcript; DRA Safety Management Systems Audit dated 13-14 July 2015 (ARD.001.001.0062). Further particulars will be provided following completion of interlocutory steps.*

61. Following its 2014 audit, DRA recommended to ALL that an engineer be engaged by Dreamworld because no tertiary qualified engineers were employed in Dreamworld's Engineering Department.

**Particulars**

*The best particulars the Applicants can presently provide is inferred from the evidence of David Randall given on day 24 of the Inquest at pages 24-11 and 24-66 of the transcript; and DRA Safety Management Systems Audit dated 24-28 February 2014 at page 96 (ARD.002.001.0960). Further particulars will be provided following completion of interlocutory steps.*

62. On or around 29 September 2014, Dreamworld employed Mr Generic Cruz, a first year engineer, who was tasked with conducting an internal audit ~~(over a five year period)~~ of the records maintained by Dreamworld in relation to its rides by reference to the Australian Standard. Mr Cruz prioritised newer rides in his review programme and by the end of the Relevant Period had not yet commenced an audit of the TRRR.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Generic Cruz given on day 11 of the Inquest at pages 11-93 to 11-96, 11-110 and 11-112 of the transcript (ING.002.007.0473); the evidence of Mark Thompson given on day 6 of the Inquest at pages 6-54 to 6-57 and 6-62 of the transcript (ING.002.007.3063); ~~and the~~ evidence of Chris Deaves given on day 22 of the Inquest at pages 22-37 and 22-50 of the transcript (ING.002.007.1747); Letter of offer and contract of employment dated 25 September 2014 (ARD.008.001.2768); Graduate role advertisement July 2014 (ARD.008.001.2772); Email from Generic Cruz dated 14 July 2015 (ARD.003.003.7988); Email from Generic Cruz dated 10 March 2016 (ARD.003.003.8032); Email from Chris Deaves to Mark Thompson, Tim Gibney and Generic Cruz dated 18 August 2016 (ARD.010.007.8375); and Expert Report of Murray Feddersen dated 16 March 2022 at page 35 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

## C.8 Staff concerns

63. On 13 November 2014, following the 2014 Incident in which rafts collided, Bob Tan emailed Davidson and the Dreamworld Executive Team referring them to the 2001 Incident when rafts collided and inverted and stating: *"Fortunately there was no injury except for property damage. I shudder when I think if there had been guests on the raft."* (**Bob Tan Email**).

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Bob Tan given on day 29 of the Inquest at page 29-26 of the transcript; and from paragraph [995] of the Coroner's Findings; Email from Bob Tan dated 13 November 2014 (ARD.001.002.0423); and Emails between Bob Tan and Chris Deaves dated 13 November 2014 (ARD.003.002.6260). Further particulars will be provided following completion of interlocutory steps.*

64. On 17 November 2014, following the 2014 Incident, Dreamworld ride operator Mr Jared Dryisdale, emailed the General Managers of the Operations and Attractions Departments at Dreamworld:

(a) raising concerns regarding the number of responsibilities ride operators were required to address while working; and

(b) recommending a single emergency stop button be installed on the TRRR.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Andrew Fyfe given on day 19 of the Inquest at pages 19-67 to 19-70, 19-72 and 19-79 of the transcript; Email from Jarad Drysdale dated 17 November 2014 to +Dreamworld Operations Idea (ARD.001.002.0426); and email response from Andrew Fyfe to Jarad Drysdal dated 20 November 2014 (ARD.003.005.9458). Further particulars will be provided following completion of interlocutory steps.*

65. On 6 May 2016, Mr Jason Johns, Dreamworld Attractions Supervisor, emailed Mr John Lossie in the Engineering Department requesting that a simplified shutdown procedure be installed on the TRRR.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Angus Hutchings given on day 21 of the Inquest and at page 21-84 of the transcript; Email from Jason Johns to John Lossie dated 6 May 2016 (ARD.001.002.0430). Further particulars will be provided following completion of interlocutory steps.*

66. Notwithstanding the matters pleaded in paragraphs 63, 64 and/or 65, AAD did not:

(a) install a single emergency stop button on the TRRR;

(b) increase staffing levels for the TRRR; and/or

(c) take any other steps to improve and simplify the shutdown procedures applicable to the TRRR,

on or after 17 November 2014, or during the balance of the Relevant Period after that date.

### C.9 Hazard identification and risk assessment

67. Further to paragraphs 45 and 50, AAD did not conduct a thorough engineering, design and safety assessment, hazard identification or risk assessment of the TRRR at any time prior to or during the Relevant Period.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at page 1-24 of the transcript; the evidence of Mark Thompson given on day 6 of the Inquest at page 6-21 of the transcript; the evidence of Thomas Polley given on day 19 of the Inquest at page 19-15 of the transcript (ING.002.007.1360); the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-55 of the transcript; the evidence of Chris Deaves given on day 23 of the Inquest at pages 23-9 to 23-10 of the transcript; the evidence of Dr Frank Grigg, Dr Duncan Gilmore and George Rutherford given on day 30 of the Inquest at pages 30-35 and 30-45 of the transcript; and from paragraph [996] of the Coroner's Findings; Risk assessment form regarding railing height around TRRR dated 7 July 2015 (ARD.003.001.7036); Risk assessment form regarding conveyor chain breakage and water depth causing raft to flip dated 9 July 2015 (ARD.010.042.2368); Risk assessment form regarding surveillance of ride area and increased ride breakdowns dated 19 October 2015 (ARD.010.003.0160); Risk assessment form regarding risk of slip/fall dated 4 November 2015 (ARD.003.001.7034); Risk assessment form regarding height of fence around water cannons at TRRR (ARD.003.005.2906); and Expert Report of Murray Feddersen dated 16 March 2022 at pages 22 and 31 to 33 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

### C.10 No engineering response to risks

68. Further to paragraphs 46, 51 and 57, AAD did not, at any time prior to or during the Relevant Period, implement any engineering solution to:

(a) ensure the operation of the TRRR was stopped when water levels in the trough of the TRRR fell below the level necessary to ensure rafts did not become grounded on the Dry Dock Rails or elsewhere; rather, ride operators were required to judge the water level in the trough by eye against a scum line that had developed along the sides of the trough; and/or

(b) ensure the operation of the TRRR was stopped when a raft came within an unsafe proximity to another raft.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-29 and 1-33 of the transcript; the evidence of Steven Cornish given on day 1 of the Inquest at pages 1-68, 1-74, 1-84 and 1-92 of the transcript (ING.002.007.0280); Coronial Report of Steven Cornish dated 25 October 2018 at page 99 (ARD.002.001.0186); the evidence of Quentin Dennis given on day 10 of the Inquest at pages 10-22 to 10-23 of the transcript; the evidence of Matthew Sullivan given on day 16 of the Inquest at pages 16-27 to 16-28 of the transcript; and the evidence of Angus Hutchings given on day 22 of the Inquest at pages 22-19 to 22-20 of the transcript; Rapid Ride Operator Draft Procedure dated 16 May 2016 at sections 3.2.10 and 3.5.4 (ARD.013.001.0076) attached to email from Jason Johns to Andrew Fyfe [ARD.013.001.0049]; Rapid Ride Operator Training at sections 3.4.1 and 3.7.1 (ARD.003.001.2260); Thunder River Rapids Conveyor Chain Break and Raft Slip Monitoring dated August 2015 (ARD.003.001.2481); and Expert Report of Murray Feddersen dated 16 March 2022 at page 40 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

## C.11 Record keeping deficiencies

69. A comprehensive permanent log, recording in a single location, a history of the TRRR's tests, inspections, maintenance, commissioning and alterations, and stored with the TRRR, was not maintained in relation to the TRRR.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-25, 1-27 and 1-34 of the transcript; the evidence of Quentin Dennis given on day 10 of the Inquest at pages 10-22 and 10-72 of the transcript; the evidence of Generic Cruz given on day 11 of the Inquest at pages 11-104 to 11-106 and 11-112 of the transcript; the evidence of Thomas Polley given on day 18 of the Inquest at page 18-94 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-97 of the transcript; the evidence of Bob Tan given on day 29 of the Inquest at pages 29-22, 29-24, and 29-67 of the transcript; the evidence of Chris Deaves given on day 23 of the Inquest at pages 23-42 to 23-43 of the transcript; and the evidence of Ian Baker given on day 28 of the Inquest at pages 28-55 to 28-56 of the transcript and Expert Report of Murray Feddersen dated 16 March 2022 at pages 35 to 37 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

## C.12 Regulatory Contraventions

70. At all times material to these proceedings ALL:

(a) was a *"person conducting a business or undertaking"* within the meaning of s 19(2) of the *Work Health & Safety Act 2011* (Qld) (**WHSA**); and

(b) was required by:

(i) s 19(3)(b) of the WHSA to ensure, so far as is reasonably practicable, the provision and maintenance of safe plant and structures;

(ii) s 19(3)(c) of the WHSA to ensure, so far as is reasonably practicable, the provision and maintenance of safe systems of work; and

(iii) s 19(3)(f) of the WHSA to ensure, so far as is reasonably practicable, the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking.

71. ALL failed to comply with its obligations under s 19(3)(b) of the WHSA by failing to:

(a) ensure that adequate risk assessments, at sufficient intervals, including following any modifications, were conducted of the TRRR to ensure compliance with Australian Standard AS 3533 Amusement Rides and Devices;

(b) implement adequate and appropriate engineering controls on the TRRR, including:

(i) reducing the distance between the top of the Conveyor and the adjacent raft support frame, including by extending the raft support frame; and/or

(ii) reducing the distance between cross-members on the raft support frame at the top of the Conveyor; and/or

(iii) reducing the risk of positive engagement between the slats and the bottom of the rafts, including by installing additional slats on the Conveyor; and/or

(iv) a water level sensor, engineered to automatically shut down the Conveyor in the event of a drop in water level; and/or

(v) an interlock device that would have automatically shut down the Conveyor in the event of a pump failure; and/or

(vi) a stationary raft sensor between the top of the Conveyor and the unload area that would have automatically shut down the Conveyor in the event that a raft became stuck at that juncture; and/or

(vii) an emergency stop button at the main control panel, that would have allowed for a near instantaneous, single button, shutdown of the Conveyor; and/or

(viii) an alarm to alert ride operators in the event of a pump failure; and/or

(ix) an alarm to alert ride operators in the event of a drop in water level.

72. ALL failed to comply with its obligations under s 19(3)(c) of the WHSA by failing to:

(a) implement a procedure for the TRRR which provided clear and adequate instruction to workers in relation to:

(i) the process to be followed in the event of a pump failure;

(ii) the process to be followed when a raft became stranded on the support frame at the top of the Conveyor due to a pump failure;

(iii) the use of the emergency stop button at the unload area; and/or

(b) ensure that the emergency stop button at the unload area was clearly and prominently labelled to indicate its function; and/or

(c) ensure lines of communication were clear between operators at the load and unload areas at all times, including through the provision of electronic communication methods such as handheld radios.

73. ALL failed to comply with its obligations under s 19(3)(f) of the WHSA by failing to:

(a) provide appropriate training ad instruction to workers, specifically ride operators, in relation to the procedure for shutting down the TRRR in the event of an emergency, including by means of emergency drills and practical emergency shut down training; and/or

(b) provide appropriate supervision to less experienced workers while operating the TRRR.

74. On 21 July 2020, Mr Aaron John Guilfoyle, Work Health and Safety Prosecutor, charged ALL with three offences under s 32 of the WHSA arising from a failure to comply with its obligations under ss 19(3)(b), 19(3)(c) and 19(3)(f) of the WHSA.

75. On 29 July 2020, ALL entered guilty pleas in relation to each of the charges referred to in the preceding paragraph.

76. On 28 September 2020, ALL was convicted of the three charges under s 32 of the WHSA referred to above, and was fined $3,600,000.

77. Further, because ALL was a *"person with management or control of the plant at a workplace"*, ALL was required to:

    (a) ensure that any emergency stop control was prominent, clearly and durably marked and immediately accessible to each operator of the plant, pursuant to r 211(2)(a) of the *Work Health & Safety Regulation 2011* (Qld) (**WHSR**);

    (b) keep a record of all tests, inspections, maintenance, commissioning, decommissioning, dismantling and alterations of the TRRR pursuant to s 237(2) of the WHSR; and

    (c) keep a logbook ~~which complied with s 242A of the WHSR,~~ pursuant to s 242 of the WHSR.

78. Contrary to its obligations in the preceding paragraph, ALL:

    (a) failed to ensure that the emergency stops for the TRRR were prominent, clearly and durably marked and immediately accessible to each operator of the plant, pursuant to s 211(2)(a) of the WHSR;

    (b) failed to keep the records required by s 237(2) of the WHSR; and

    (c) failed to keep a logbook which complied with s 242A of the WHSR.

79. In the premises of paragraphs 70 to 78 above, during the Relevant Period, the TRRR was operated in contravention of relevant workplace health and safety legislation, namely, the WHSA and WHSR.

### C.13 Australian Standard Contraventions

80. Section 5.1 of Part 2 of AS 3533 provides:

> *"Following major maintenance and repair, and at random intervals on other occasions, a hazard identification and risk assessment procedure should be completed to ensure*

*new hazards are not present and residual risks identified by the designer or manufacturer are not increased."*

81. No mechanical hazard identification or risk assessment was ever undertaken of the TRRR, including when the Conveyor was modified to remove every second and third slat (as pleaded in paragraph 41), and when the Dry Dock Rails were installed.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Nicola Brown given on day 1 of the Inquest at pages 1-25, 1-27 and 1-34 of the transcript; the evidence of Andrew Fyfe given on day 19 of the Inquest at pages 19-55 to 19-56 of the transcript; and paragraph [991] of the Coroner's Findings; Risk assessment form regarding railing height around TRRR dated 7 July 2015 (ARD.003.001.7036); Risk assessment form regarding conveyor chain breakage and water depth causing raft to flip dated 9 July 2015 (ARD.010.042.2368); Risk assessment form regarding surveillance of ride area and increased ride breakdowns dated 19 October 2015 (ARD.010.003.0160); Risk assessment form regarding risk of slip/fall dated 4 November 2015 (ARD.003.001.7034); Risk assessment form regarding height of fence around water cannons at TRRR (ARD.003.005.2906); and Expert Report of Murray Feddersen dated 16 March 2022 at pages 22, 30 to 33 and 35 to 37 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

82. Section 5.5 of Part 2 of AS 3533 provides:

*"A permanent record of an amusement ride or device containing sufficient details to form a comprehensive history of the amusement ride or device shall be kept as a log. The log shall be a record that provides a history of ownership, inspection and operation for the ride or device. The log shall be available for inspection by regulatory authorities in accordance with Appendix L."*

83. No log was kept for the TRRR in accordance with s 5.5 of Part 2 of AS 3533.

**Particulars**

*The best particulars the Applicants can presently provide is taken from paragraph [901] of the Coroner's Findings and Expert Report of Murray Feddersen dated 16 March 2022 at page 37 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

84. Point 2.13.2 of AS/NZS 4024.3610:2015 Safety of Machinery Part 3610: Conveyors - General Requirements (**AS 4024**) provides:

*"All accessible shear and nip points which create a risk to health or safety shall be safeguarded in accordance with this Standard or the AS 4.24.1 series, except for belt conveyor applications in accordance with AS/NZS 4.24.3611."*

85. The nip point created between the end of the Conveyor and the Dry Dock Rails was not safeguarded as required by AS 4024 and was maintained in a manner which permitted a raft to become trapped in the Gap between the end of the Conveyor and the Dry Dock Rails.

**Particulars**

*Expert Report of Murray Feddersen dated 16 March 2022 at page 37 (ING.004.001.0001).*

86. In the premises of paragraphs 80 to 85 above, the TRRR was operated in contravention of AS 3533 and AS 4024 during the Relevant Period.

### C.14 International Standard contraventions

87. The International Standard *"ISO17842-1 Safety of Amusement Rides and Amusement Devices"* commenced on 1 July 2015 (**ISO Standard**).

88. Section 5.1.2.2 of the ISO Standard requires the 'controller and operator' of an amusement ride to produce an Operation and Use Risk Assessment (**OURA**).

89. No operation and use risk assessment was conducted of the TRRR and no OURA was prepared in relation to the TRRR.

90. In the premises of paragraphs 87 to 89 above, on and from 1 July 2015, the TRRR was operated in contravention of the ISO Standard.

**Particulars**

*Expert Report of Murray Feddersen dated 16 March 2022 at page 38 (ING.004.001.0001).*

### C.15 Registration

91. The TRRR, as a class 2 amusement device, required registration under part 5 of the WHSR.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Thomas Polley given on day 18 of the Inquest at pages 18-50 to 18-51 of the transcript and Workplace Health and Safety Certificate of Registration of Plant – Rapid Ride dated 1 February 2015 (ARD.001.002.0067). Further particulars will be provided following completion of interlocutory steps.*

92. The registration of all rides at Dreamworld with the Queensland Department of Workplace Health and Safety (**WH&S**) was due for renewal on 31 January 2016.

**Particulars**

*The best particulars the applicant can presently provide is taken from the evidence of Mark Thompson given on day 6 of the Inquest at page 6-30 of the transcript; the evidence of Angus Hutchings given on day 21 of the Inquest at page 21-40 of the transcript; and the evidence of Bob Tan given on day 29 of the Inquest at page 29-86 of the transcript; Workplace Health and Safety Certificate of Registration of Plant – Rapid Ride dated 1 February 2015 (ARD.001.002.0067). Further particulars will be provided following completion of interlocutory steps.*

93. As of 17 August 2016, the registration of rides at Dreamworld had not been renewed and WH&S emailed Mr Mark Thompson advising that an extension of Dreamworld's ride registrations would expire on 30 September 2016.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Mark Thompson given on day 6 of the Inquest at pages 6-30 to 6-31 of the transcript; Emails between Workplace Health and Safety Queensland, Mark Thompson and Michael Chan dated 16 August 2016 to 29 September 2016 (ARD.001.002.0823); Emails between Mark Thompson, Workplace Health and Safety Queensland, Chris Deaves, Angus Hutchings, Craig Davidson and Michael Dodd regarding renewal of plant registration – owner 739075 (reference L2) dated 16 August 2016 to 29 September 2016 (ARD.010.007.2624); and Email from Workplace Health and Safety Queensland to Mark Thompson dated 5 October 2016 (ARD.003.005.6381). Further particulars will be provided following completion of interlocutory steps.*

94. In September 2016, ALL engaged Mr Thomas Polley, engineering consultant, to urgently inspect all the rides at Dreamworld and certify them before 30 September 2016.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Thomas Polley given on day 18 of the Inquest at pages 18-51 to 18-52 and 18-58 of the transcript; Rapid Ride 2016 Annual Mechanical and Structural Inspection Certificate/Report 39/16 – Dreamworld dated 17 October 2016 (ARD.001.002.0838); Email from Chris Deaves to Thomas Polley regarding inspections dated 25 August 2016 (ARD.003.006.0415); Email chain between Chris Deaves and Thomas Polley regarding engagement dated 25 August 2016 to 6 September 2016 (ARD.003.006.0421); and Email from Chris Deaves to Thomas Polley regarding inspections dated 15 September 2016 (ARD.010.003.4386). Further particulars will be provided following completion of interlocutory steps.*

95. On 29 September 2016, Mr Thompson, on behalf of ALL, emailed WH&S stating that ~~Dreamworld had complied with its statutory obligations in relation to~~ the inspection of the TRRR had been completed.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Mark Thompson given on day 6 of the Inquest and at pages 6-29 to 6-31 and 6-45 to 6-46 of the transcript; Emails between Mark Thompson, Workplace Health and Safety Queensland, Chris Deaves, Angus Hutchings, Craig Davidson and Michael Dodd regarding renewal of plant registration – owner 739075 (reference L2) dated 16 August 2016 to 29 September 2016 (ARD.001.002.0823); and Contract of Employment for Mark Thompson dated 22 February 2016 (ARD.008.001.8248). Further particulars will be provided following completion of interlocutory steps.*

96. On 17 October 2016, Mr Polley purported to certify the TRRR as required for WH&S registration purposes.

**Particulars**

*The best particulars the Applicants can presently provide is taken from the evidence of Thomas Polley given on day 18 of the Inquest at page 18-56 of the transcript; Rapid Ride 2016 Annual Mechanical and Structural Inspection Certificate/Report 39/16 – Dreamworld dated 17 October 2016 (ARD.001.002.0838); and Email from Thomas Polley to Chris Deaves and Generic Cruz regarding 2016 Certificates/Reports A1 to A7 dated 24 October 2016 (ARD.003.006.0499). Further particulars will be provided following completion of interlocutory steps.*

97. The certification of the TRRR was not in accordance with the WHSR because:

(a) section 240(1) of the WHSR required an inspection of an amusement device to be carried out by a 'competent person';

(b) section 240(2) of the WHSR provided that a person is not a competent person to carry out a detailed inspection of an amusement device that includes an electrical installation unless the person is qualified, or is assisted by a person who is qualified, to inspect electrical installations;

(c) the TRRR includes an electrical installation;

(d) Mr Polley was a mechanical engineer, had no electrical qualifications and was not assisted by anyone with electrical qualifications during his inspection of the TRRR; and

(e) Mr Polley was accordingly not a 'competent person' within the meaning of section 240 of the WHSR for the purpose of registering the TRRR with WH&S.

98. Further, contrary to the requirements of section 241(2) of the WHSR, Mr Polley failed to:

(a) check information concerning the operational history of the TRRR since its last inspection;

(b) check the logbook for the TRRR;

(c) check that maintenance and inspections had been undertaken under section 240 WHSR;

(d) check that any required tests had been carried out and that appropriate records had been maintained; or

(e) complete a detailed inspection to ensure compliance with WHSA and WHSR, including a specific inspection of critical components.

**Particulars**

*Mr Polley had never viewed the TRRR in operation, had no electrical qualifications, and his inspection of the TRRR took no more than a few hours. The best particulars the Applicants can presently provide is taken from the evidence of Thomas Polley given on day 18 of the Inquest at pages 18-56, 18-67, 18-70, 18-74 to 18-75, and 18-86 of the transcript; Memorandum of Thomas Polley regarding inspection of Class 2 Amusement Devices dated 24 October 2016 (ARD.003.001.2175); Rapid Ride 2016 Annual Mechanical and Structural Inspection Certificate/Report 39/16 – Dreamworld dated 17 October 2016 (ARD.001.002.0838); and Expert Report of Murray Feddersen dated 16 March 2022 at page 38 to 40 (ING.004.001.0001). Further particulars will be provided following completion of interlocutory steps.*

## D. THE DREAMWORLD TRAGEDY

### D.1 The Incident

99. On 25 October 2016:

(a) at approximately 2:03:50PM, the south pump on the TRRR failed, causing water levels in the trough to fall below the level required to float rafts above the Dry Dock Rails and Raft 6 to become grounded on the Dry Dock Rails;

(b) at approximately 2:04:50PM, Raft 5 (carrying adult passengers Kate Goodchild, Luke Dorsett, Cindy Low and Roozbeh Araghi and infant passengers Ebony ~~Goodchild~~ Turner and Kieran Low) was carried by the Conveyor up into the offload area where Raft 6 was grounded on the Dry Dock Rails;

(c) at approximately 2:05:03PM, Raft 5 collided with Raft 6, each of Raft 5 and Raft 6 were driven up into a vertical position with the bottom of each raft facing the other, Raft 5 shook violently as the Conveyor continued to rotate and became inverted, with the result that Kate Goodchild and Luke Dorsett were shaken from Raft 5 into the moving Conveyor and Cindy Low and Roozbeh Araghi became trapped between Raft 5 and the moving Conveyor and were fatally injured; and

(d) at approximately 2:05:22PM, the Conveyor ceased movement allowing Ebony Goodchild and Kieran Low to climb out of Raft 5 onto a platform,

(**Incident**).

## D.2 Events following the Incident

100. Dreamworld issued press statements about the Incident at approximately 4:45pm and 9.12pm on 25 October 2016. AAD issued an announcement to the ASX about the Incident at approximately 6.03pm.

**Particulars**

*AAD ASX Announcement titled 'Dreamworld Ride Incident' dated 25 October 2016.*

101. AAD released a further announcement to the ASX on 26 October 2016 which stated:

> *"Park safety is our priority. Dreamworld would like to assure the public and our guests that at the time of the incident the park was fully compliant with all required safety certifications. The Thunder River Rapids Ride had completed its annual mechanical and structural safety engineering inspection on 29 September 2016.*
>
> ...
>
> *Our safety procedures have been endorsed by Mr David Randall, Managing Director of DRA Safety Specialists. Mr Randall said, 'In my capacity as a safety professional, I have been involved with Ardent Leisure conducting safety audits against the National Audit Tool over a period of the last six years.*
>
> *Dreamworld under the leadership of Craig Davidson, the CEO, has demonstrated a commitment to developing and maintaining a strong safety culture across all*

*departments. Annual audits have resulted in continuous improvement in the management of safety.*

*A number of consultancy visits to assist in the implementation have been undertaken and include regular training programmes with the Senior Leadership Team which have kept* then [sic] *abreast of legislative requirements and changes.' Mr Randall said."*

**Particulars**

*AAD ASX Announcement titled 'Dreamworld Ride Incident Update' dated 26 October 2016.*

102. Following the Incident:

(a) the price of AAD Stapled Securities declined materially;

(b) Dreamworld was closed for 45 days and re-opened on 10 December 2016; and

(c) AAD recognized a statutory loss of $49.4m for the half year ending 31 December 2016, which included incurrence of write downs, impairments and costs associated with the Incident totalling $95.2m, and the price for AAD Stapled Securities declined materially.

**Particulars**

*As to sub-paragraph (a):*

*(i) the price for AAD Stapled Securities on the ASX at the opening of trading on 25 October 2016 was $2.55. At the close of trading on 25 October 2016 it was $2.35 and at the close of trading on 26 October 2016 it was $2.00.*

*(ii) Over the course of 25 October 2016 and 26 October 2016, 24,570,695 AAD Stapled Securities were traded on the ASX.*

*As to sub-paragraph (b), AAD ASX Announcement titled 'HY Impacted by One-off Events, US Growth Strategy Continues' dated 23 February 2017.*

*As to sub-paragraph (c), the Applicants refer to the AAD Half Year Results Presentation dated 23 February 2017. The price of AAD Stapled Securities at the opening of trading on 23 February 2017 was $2.17, and at the close of trading on 23 February 2017 it was $1.625.*

103. Following the Incident, AAD publicly announced it had:

(a) commissioned a park wide operational and safety review;

**Particulars**

*AAD 2017 Annual Report.*

(b) appointed Pitt and Sherry Engineers to conduct a review of the safety of the Dreamworld rides and systems, to be overseen by Leisure Technical Consultants Ltd, an engineering company with expertise in the safety of amusement rides and theme parks;

**Particulars**

*AAD ASX Announcement titled 'Dreamworld Update' dated 9 November 2016.*

(c) appointed a new acting CEO of Dreamworld, and later a new permanent CEO of Dreamworld, a new director of safety and an independent external safety consultant;

**Particulars**

*AAD ASX Announcements titled: 'Executive Leadership Changes at Dreamworld' dated 2 July 2018; 'Ardent Leisure Reports Full Year Results' dated 22 August 2018; and 'Appointment of Theme Parks CEO' dated 23 October 2018.*

(d) committed to spend approximately $4 million improving safety management systems and applications to improve guest experience through digital platforms and modernising staff communications and efficiencies using best practice solutions;

**Particulars**

*AAD Full Year Results Presentation dated 22 August 2018.*

(e) engaged a range of additional staff to work in operational, safety and engineering roles; and

**Particulars**

~~*AAD Full Year Results Presentation dated 22 August 2018.*~~*AAD Preliminary FY17 Operating Performance Strategic Update and Priorities dated 11 August 2017.*

(f) increased its expenditure on safety, repairs, maintenance and other operational costs at Dreamworld.

**Particulars**

*In the 2019 annual report of the third respondent, the directors of the third respondent reported that EBITDA for the theme park division was $2.4 million below the prior year due to high costs across safety repairs, maintenance and other costs. The Applicants will provide further particulars upon completion of interlocutory steps.*

## E. CONTRAVENTIONS

### E.1 Misleading or Deceptive Conduct

104. Continually from at least 12 April 2013 and throughout the Relevant Period, AAD maintained a publicly accessible website on which AAD published or allowed to be published a statement that:

> *"At Dreamworld, guest safety is our number 1 priority. We adhere to manufacturers' guidelines, industry best practice and Australian standards to ensure that all of our much loved rides and attractions are safe and ready for guests to enjoy. As such, our dedicated and experienced team of engineering* [sic] *conduct daily inspections and testing on all the rides before they are opened to the public. In addition, each year our rides undergo a rigorous maintenance programme which requires their closure for short periods of time during off-peak seasons. During this time manufacturer recommended maintenance, safety and reliability improvements are implemented. With more than 40 rides and attractions on offer, when a ride is closed for maintenance guests are still ensured of an action packed and safe day out at Dreamworld."*

(**Website Safety Statement**).

105. Continually from at least 24 September 2013 and throughout the Relevant Period, AAD published annual reports, which contained the following statement (**Annual Report Safety Statement**):

> *"Principle 7 – Recognise and Manage Risk*
>
> ***Safety, Sustainability and Environment Committee***
>
> *…the Board has established a Safety, Sustainability and Environment Committee (SSE Committee)….The SSE Committee was established by the Board of Directors to monitor, review, evaluate and make recommendations to the Board in relation to the following matters:*

***Safety***

- *The effectiveness of OH&S policies and the safety related aspects of the operational risk management framework necessary to maintain a safe environment for both guests and employees across the Group including drafting, implementing and recommending improvements;*

- *Setting appropriate goals to maintain the Group's lost time injury frequency rate (LTIFR) below industry benchmarks;*

- *Monitoring the adequacy of existing OH&S resources as well as their ongoing training and supervision;*

- *The scope and results of periodic internal and external reviews of OH&S and operational risks including the process of identifying and assessing OH&S risks and the adequacy of existing OH&S risk management systems; and*

- *The compliance of the Company with regard to existing and possible future OH&S regulations and determining what if any changes need to be made to existing work practices in order to ensure compliance."*

**Particulars**

*The Annual Report Safety Statement was contained in the Annual Report published by AAD for the financial year ended 30 June 2013 (**FY13 Annual Report**). The Annual Report Safety Statements were repeated in substantially the same form in the Annual Reports published by AAD for the financial years ended 30 June 2014 on 17 September 2014 (**FY14 Annual Report**), the financial year ended 30 June 2015 on 17 September 2015 (**FY15 Annual Report**) and the financial year ended 30 June 2016 on 28 September 2016 (**FY16 Annual Report**).*

106. By the Website Safety Statement and the Annual Report Safety Statement (considered separately or individually), AAD represented to the Affected Market throughout the Relevant Period that:

(a) AAD adhered to industry best practices and Australian Standards to ensure all rides at Dreamworld were safe for guests; and/or

(b) AAD had systems and procedures in place which maintained a safe environment for guests at all its facilities, including Dreamworld,

(**Safety Representations**).

107. AAD did not at any time before 25 October 2016 withdraw or qualify the Safety Representations.

108. The conduct pleaded in paragraphs 104 to 107 was conduct engaged in by AAD:

(a) in relation to financial products (being the AAD Stapled Securities) within the meaning of sub-sections 1041H(1) and 1041H(2)(b) of the Corporations Act;

(b) in trade or commence, in relation to financial services within the meaning of section 12DA(1) of the ASIC Act; and/or

(c) in trade or commerce, within the meaning of section 2 of the ACL.

109. During the Relevant Period, by reason of:

(a) from the commencement of the Relevant Period:

(i) paragraphs 29 to 36;

(ii) paragraphs 37 to 39;

(iii) paragraphs 40 and 43;

(iv) paragraph 45(a);

(v) paragraph 46(a);

(vi) paragraphs 47 and 49(a);

(vii) paragraph 50(a);

(viii) paragraph 51(a);

(ix) paragraphs 52 to 57;

(ixa) paragraphs 58 to 59 and 61;

(x) paragraph 67;

(xi) paragraph 68;

(xii) paragraph 69;

(xiii) paragraphs 70 to 79;

(xiv) paragraphs 80 to 86;

(b) from on or about 6, or 17, November 2014:

(i) paragraphs 48 and 49(b);

(ii) paragraph 50(b);

(iii) paragraph 51(b);

(iv) paragraphs 63, 64 and 66

(c) from the date in 2015 pleaded in paragraph 42:

(i) paragraph 42;

(ii) paragraph 44;

(iii) paragraph 45(b);

(iv) paragraph 46(b);

(ca) from 14 July 2015, paragraph 60;

(d) from 6 May 2016, paragraphs 65 and 66;

(e) from 1 July 2015, paragraphs 87 to 90; and/or

(f) from 31 January 2016, paragraphs 91 to 98,

it was not the case that AAD adhered to industry best practices and Australian Standards to ensure all rides at Dreamworld were safe for guests.

110. Further or alternatively, during the Relevant Period, by reason of:

(a) from the commencement of the Relevant Period:

(i) paragraphs 29 to 36;

(ii) paragraphs 37 to 39;

(iii) paragraphs 40 and 43;

(iv) paragraph 45(a);

(v) paragraph 46(a);

(vi) paragraphs 47 and 49(a);

(vii) paragraph 50(a);

(viii) paragraph 51(a);

(ix) paragraphs 52 to 57;

(ixa) paragraphs 58 to 59 and 61;

(x) paragraph 67;

(xi) paragraph 68;

(xii) paragraph 69;

(xiii) paragraphs 70 to 79;

(xiv) paragraphs 80 to 86;

(b) from on or about 6, or 17, November 2014:

(i) paragraphs 48 and 49(b);

(ii) paragraph 50(b);

(iii) paragraph 51(b);

(iv) paragraphs 63, 64 and 66

(c) from the date in 2015 pleaded in paragraph 42:

(i) paragraph 42;

(ii) paragraph 44;

(iii) paragraph 45(b);

(iv) paragraph 46(b);

(ca) from 14 July 2015, paragraph 60;

(d) from 6 May 2016, paragraphs 65 and 66;

(e) from 1 July 2015, paragraphs 87 to 90; and/or

(f) from 31 January 2016, paragraphs 91 to 98,

AAD did not have reasonable grounds for considering that it adhered to industry best practices and Australian Standards to ensure all rides at Dreamworld were safe for guests.

111. During the Relevant Period, by reason of:

(a) from the commencement of the Relevant Period:

(i) paragraphs 29 to 36;

(ii) paragraphs 37 to 39;

(iii) paragraphs 40 and 43;

(iv) paragraph 45(a);

(v) paragraph 46(a);

(vi) paragraphs 47 and 49(a);

(vii) paragraph 50(a);

(viii) paragraph 51(a);

(ix) paragraphs 52 to 57

(ixa) paragraphs 58 to 59 and 61;

(x) paragraph 67;

(xi) paragraph 68;

(xii) paragraph 69;

(xiii) paragraphs 70 to 79;

(xiv) paragraphs 80 to 86;

(b) from on or about 6, or 17, November 2014:

(i) paragraphs 48 and 49(b);

(ii) paragraph 50(b);

(iii) paragraph 51(b);

(iv) paragraphs 63, 64 and 66

(c) from the date in 2015 pleaded in paragraph 42:

(i) paragraph 42;

(ii) paragraph 44;

(iii) paragraph 45(b);

(iv) paragraph 46(b);

(ca) from 14 July 2015, paragraph 60;

(d) from 6 May 2016, paragraphs 65 and 66;

(e) from 1 July 2015, paragraphs 87 to 90; and/or

(f) from 31 January 2016, paragraphs 91 to 98,

AAD did not have systems and procedures in place which maintained a safe environment for guests at Dreamworld.

112. Further or alternatively, during the Relevant Period, by reason of:

(a) from the commencement of the Relevant Period:

(i) paragraphs 29 to 36;

(ii) paragraphs 37 to 39;

(iii) paragraphs 40 and 43;

(iv) paragraph 45(a);

(v) paragraph 46(a);

(vi) paragraphs 47 and 49(a);

(vii) paragraph 50(a);

(viii) paragraph 51(a);

(ix) paragraphs 52 to 57;

(ixa) paragraphs 58 to 59 and 61;

(x) paragraph 67;

(xi) paragraph 68;

(xii) paragraph 69;

(xiii) paragraphs 70 to 79; and/or

(xiv) paragraphs 80 to 86;

(b) from on or about 6, or 17, November 2014:

(i) paragraphs 48 and 49(b);

(ii) paragraph 50(b);

(iii) paragraph 51(b); and/or

(iv) paragraphs 63, 64 and 66

(c) from the date in 2015 pleaded in paragraph 42:

(i) paragraph 42;

(ii) paragraph 44;

(iii) paragraph 45(b); and/or

(iv) paragraph 46(b);

(ca) from 14 July 2015, paragraph 60;

(d) from 6 May 2016, paragraphs 65 and 66;

(e) from 1 July 2015, paragraphs 87 to 90; and/or

(f) from 31 January 2016, paragraphs 91 to 98,

there were no reasonable grounds for considering that AAD had systems and procedures in place which maintained a safe environment for guests at Dreamworld.

113. In the premises of paragraphs 104 to 112, above, AAD engaged in misleading or deceptive conduct, in contravention of s 1041H of the Corporations Act, s 12DA of the ASIC Act and/or s 18 of the ACL (each being a **Misleading Conduct Contravention**).

## E.2 Continuous Disclosure Contravention

114. At all material times in the Relevant Period, the following information existed:

(a) there was a material risk or likelihood that an incident would occur on the TRRR or another major ride at Dreamworld which would cause serious injury or death to one or more patrons; ~~and~~

**(Incident Information)**

(b) there was a material risk or likelihood that if an incident occurred on the TRRR or another major ride at Dreamworld which caused serious injury or death to one or more patrons, then:

(i) patronage of Dreamworld would substantially decrease for a period of time and AAD would suffer a loss in revenue;

(ii) AAD would incur additional costs associated with demonstrating to the public and/or regulatory agencies that rides at Dreamworld were safe; and

(iii) by reason of (i) and (ii) above, there would be an adverse impact on AAD's profits in current and future financial periods~~;~~,

**(Incident Impact Information)**.

(c) AAD did not adhere to industry best practices and Australian Standards to ensure all rides at Dreamworld were safe for guests; and

**(Best Practice Information)**

(d) AAD did not have systems and procedures in place which maintained a safe environment for guests at Dreamworld,

**(Safe Environment Information)**

115. The Incident Information was information of which AAD was aware within the meaning of ASX Listing Rule 3.1 (having regard to the definitions in ASX Listing Rule 19.12) throughout the Relevant Period.

**Particulars**

*A. Introduction*

*The Incident Information was information which:*

*(a) Davidson:*

*(i) actually came into possession of prior to the commencement of the Relevant Period, and (in any event) by no later than 13 November 2014 (when he received the Bob Tan Email); and/or alternatively*

*(ii) ought reasonably to have come into possession of in the course of the performance of his duties as Chief Executive Officer of the Theme Park Division from the beginning of the Relevant Period, and at all times during the Relevant Period;*

*(b) Thomas ought reasonably to have come into possession in the course of the performance of her duties as an officer of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period; and*

*(c) Davis, Haslingden, Morris and Venardos (or any of them) ought reasonably to have come into possession of in the course of the performance of their duties as officers of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period (save for Haslingden, who ought to have come into possession of it a short time after his appointment on 6 July 2015).*

*B. Davidson*

*It may be inferred that Davidson came into actual possession of the Incident Information in the course of the performance of his duties as Chief Executive Officer of the Theme Park Division from the following matters:*

*(a) his position and responsibilities as Chief Executive Officer of the Theme Park Division, as pleaded in paragraph 22 above;*

*(b) his membership of the Dreamworld Safety Committee, which involved or ought reasonably to have involved consideration of:*

*(i) the status of implementation of additional safety measures on the TRRR following the incidents pleaded in paragraphs 47 and/or 48 (the absence of which is pleaded at paragraphs 50 and 51);*

*(ii) the fact that on and from 2013, Dreamworld had failed safety management systems audits conducted by DRA, as pleaded at paragraphs 58 to 60; and*

*(iii) the fact that on and from 2016, the Safety Department at Dreamworld was under-resourced; and*

(c) *the fact that the following individuals, who directly or indirectly reported to Davidson, were aware of the Incident Information:*

*(i) Bob Tan, who was aware of the Incident Information prior to the commencement of the Relevant Period by reason of (A) to (E) below, and during the Relevant Period by reason of (A) to (F) below:*

*(A) he acquired knowledge of the risk of raft collisions through his investigations into the 2001 incident, while he held the position of Technical and Services Director;*

*(B) he acquired knowledge of the 2004 incident from discussions he had with Ian Baker and Angus Hutchings regarding the implementation of engineering controls following the incident;*

*(C) from 2004, he discussed the JAK audits in the Dreamworld Executive Safety meetings;*

*(D) from 2009, he was aware of the JAK recommendation to implement a single emergency shut down procedure for the TRRR; and*

*(E) decisions as to the implementation of external auditor recommendations were made by Mr Hutchings, Mr Deaves and Mr Tan; and*

*(F) on 13 November 2014, he authored an email regarding the 2001 incident and the risk of rafts flipping (described herein as the Bob Tan Email).*

*(ii) Angus Hutchings, who was aware of the Incident Information prior to the commencement of the Relevant Period by reason of (A) to (F) below, and during the Relevant Period by reason of (A) to (J) below:*

*(A) he acquired knowledge of the risk of raft collisions through his investigations into the 2004 and 2005 incidents;*

*(B) decisions as to the implementation of external auditor recommendations were made by Mr Hutchings, Mr Deaves and Mr Tan;*

*(C) from 2009, he was aware of the JAK recommendation to implement a single emergency shut down procedure for the TRRR;*

*(D) from 2004, he was aware of the JAK recommendation to increase the staffing levels for the TRRR;*

*(E) on a date unknown but prior to 2014, he discussed the risk associated with raft collisions with JAK;*

(F) *on a date unknown but prior to 2014, he discussed the JAK recommendations with the engineering department in 'implementation meetings';*

(G) *in 2013, 2014 and 2015, he advised Craig Davidson that Dreamworld had failed its safety management systems audit;*

(H) *he received the Bob Tan Email;*

(I) *in or around 9 March 2016 he advised Craig Davidson of deficiencies in the reporting structure of the Dreamworld Departments; and*

(J) *in or about early 2016, he advised the AAD board of directors of the need to undertake an audit of the kind being performed by JAK against the applicable Australian Standards.*

(iii) *Troy Margetts, who was aware of the Incident Information prior to the commencement of the Relevant Period by reason of (A) to (B) below, and during the Relevant Period by reason of (A) to (C) below:*

(A) *from 2004, he discussed the JAK audits in the Dreamworld Executive Safety meetings;*

(B) *from 2013, he assessed it was ~~risk~~ acceptable not to implement the JAK recommendation for a single emergency shut down procedure for the TRRR; and*

(C) *he received an email from Jared Dryisdale dated 17 November 2014 regarding the 2014 incident.*

(iv) *Chris Deaves, who was aware of the Incident Information during the Relevant Period after 2014 by reason of (A) to (C) below:*

(A) *decisions as to the implementation of external auditor recommendations were made by Mr Hutchings, Mr Deaves and Mr Tan;*

(B) *he received the Bob Tan Email;*

(C) *in the performance of his duties, he became aware:*

(1) *that AAD did not carry out a hazard or risk assessment when it took over Dreamworld in 1998;*

(2) *that a holistic risk assessment was never performed on Dreamworld's rides;*

(3) *that there was no dedicated person at Dreamworld tasked with undertaking risk assessments; and*

(4) *of the matters in paragraphs 46, 56, 62, 67 and 69 above.*

(v) *Mark Thompson, who was aware of the Incident Information during the Relevant Period after 14 March 2016 because in the performance of his duties, he became aware:*

(A) *that AAD did not carry out a hazard or risk assessment when it took over Dreamworld in 1998;*

(B) *that a holistic risk assessment was never performed on Dreamworld's rides;*

(C) *that there was no dedicated person at Dreamworld tasked with undertaking risk assessments;*

(D) *the Safety Department at Dreamworld was not structured to operate effectively and comprised primarily of first aid officers, rather than experienced safety officers; and*

(E) *of the matters in paragraphs 34, 56, 62, 67 and 69 above.*

*Further or alternatively, the fact that Davidson ought reasonably to have come into possession of the Incident Information in the course of his performance of his duties as the Chief Executive Officer of the Theme Park Division may be inferred from the matters referred to in (a) to (c) above.*

*C. Thomas*

*Thomas ought reasonably to have come into possession of the Incident Information in the course of her performance of her duties as the Chief Executive Officer and Managing Director of ALL and ALML (as pleaded in paragraph 17 above) by reason of either, or both of:*

(a) *her day to day communication with Davidson, which ought to have encompassed consideration of the matters referred to in Section B(b)-(c) above; ~~and~~*

(b) *her participation in the AAD Safety Committee meetings from 1 July 2015, which ought to have encompassed consideration of the matters referred to in Section B(b)-(c) above.*

*D. Davis, Haslingden, Morris and Venardos*

*Davis, Haslingden, Morris and Venardos ought reasonably to have come into possession of the Incident Information in the course of performing their duties as directors of ALL and ALML from the beginning of the Relevant Period (save for Haslingden, who ought to have come into possession of it a short time after his appointment on 6 July 2015); further or alternatively by reason of their participation in AAD Safety Committee meetings in the financial year commencing 1 July 2015, and afterwards, which ought to have encompassed consideration of the matters referred to in Section B(b)-(c) above.*

116. The Incident Impact Information was information of which AAD was aware within the meaning of ASX Listing Rule 3.1 (having regard to the definitions in ASX Listing Rule 19.12) throughout the Relevant Period.

**Particulars**

*A. Davidson*

*The fact that Davidson had come into actual possession of the Incident Impact Information in the course of his performance of his duties as an officer of ALL and ALML may be inferred from:*

(a) *his position and responsibilities as Chief Executive Officer of the Theme Park Division, as pleaded in paragraph 22 above;*

*(b) the fact that, as Chief Executive Officer of the Theme Park Division, Davidson knew that:*

*(i) Dreamworld owed statutory duties to ensure the health and safety of members of the public visiting Dreamworld and utilising high risk plants such as the TRRR, and held itself out as*

*(A) adhering to industry best practices and Australian Standards to ensure all rides at Dreamworld were safe for guests; and*

*(B) having systems in place which maintained a safe environment for guests;*

*(ii) Dreamworld derived its revenue from patronage;*

*(iii) patronage at Dreamworld would substantially decrease for a period of time if an incident occurred on the TRRR which caused serious injury or death to one or more patrons (either because patrons would not attend, or because Dreamworld would need to close for a period by reason of such an incident);*

*(iv) after such an incident, AAD would incur additional costs associated with demonstrating to the public or regulatory agencies that rides at Dreamworld were safe; and*

*(v) by reason of the above, there would be an adverse impact on AAD's profits in current and future financial periods in the event there was an incident on the TRRR.*

*Further or alternatively, the fact that Davidson ought reasonably to have come into possession of the Incident Impact Information in the course of his performance of his duties as an officer of ALL and ALML may be inferred from his position and responsibilities as Chief Executive Officer of the Theme Park Division, as pleaded in paragraph 22 above and ought to have known the matters set out in (b)(i) to (v) above.*

*B. Thomas, Davis, Haslingden, Morris, Venardos*

*The Incident Impact Information is information which it may be inferred Thomas, Davis, Haslingden, Morris, and Venardos (or any of them) had, or ought reasonably to have, come into possession of in the course of the performance of their duties as officers of ALL and ALML (as pleaded in paragraphs 17 to 21 above), by reason that as officers they knew or ought to have known the matters set out in A(b)(i) to (v) above.*

116A. The Best Practice Information was information of which AAD was aware within the meaning of ASX Listing Rule 3.1 (having regard to the definitions in ASX Listing Rule 19.12) throughout the Relevant Period.

**Particulars**

*The Best Practice Information was information which:*

*(a) Davidson ought reasonably to have come into possession of in the course of the performance of his duties as Chief Executive Officer of the Theme Park Division from the beginning of the Relevant Period, and at all times during the Relevant Period;*

*(b) Thomas ought reasonably to have come into possession in the course of the performance of her duties as an officer of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period; and*

*(c) Davis, Haslingden, Morris and Venardos (or any of them) ought reasonably to have come into possession of in the course of the performance of their duties as officers of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period (save for Haslingden, who ought to have come into possession of it a short time after his appointment on 6 July 2015).*

*Further, the Best Practice Information was information which actually came into the possession of Davis, Venardos and Angus Hutchings by no later than 12 March 2014 when the AAD Safety Committee was informed that the DRA Safety Audit scores for Dreamworld "remained low" (Minutes ARD.008.001.1937 at .1942).*

*Further or alternatively, the Best Practice Information was information which actually came into the possession of Davis, Morris, Venardos and Angus Hutchings by no later than 2 December 2014 when the AAD Safety Committee was informed that the DRA Safety Audit had scored the Theme Parks Division as "46%" (ARD.008.001.2743 at .2744).*

*Further or alternatively, the Best Practice Information was information which actually came into the possession of Davis, Haslingden, Morris, Thomas, Venardos and Hutchings by no later than 9 March 2016 when the AAD Safety Committee was informed that "JAK ... had proven unwilling to audit to Australian standards." (ARD.008.001.2758 at .2759).*

*The Applicants otherwise repeat and rely upon the particulars in paragraphs B to D of paragraph 115 above as though the references to "Incident Information" were to "Best Practice Information".*

116B. The Safe Environment Information was information of which AAD was aware within the meaning of ASX Listing Rule 3.1 (having regard to the definitions in ASX Listing Rule 19.12) throughout the Relevant Period.

**Particulars**

*The Safe Environment Information was information which:*

*(a) Davidson ought reasonably to have come into possession of in the course of the performance of his duties as Chief Executive Officer of the Theme Park Division from the beginning of the Relevant Period, and at all times during the Relevant Period;*

*(b) Thomas ought reasonably to have come into possession in the course of the performance of her duties as an officer of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period; and*

*(c) Davis, Haslingden, Morris and Venardos (or any of them) ought reasonably to have come into possession of in the course of the performance of their duties as officers of AAD from the beginning of the Relevant Period, and at all times during the Relevant Period (save for Haslingden, who ought to have come into possession of it a short time after his appointment on 6 July 2015).*

*The Applicants otherwise repeat and rely upon the particulars in paragraphs B to D of paragraph 115 above as though the references to "Incident Information" were to "Safe Environment Information".*

117. As at, and from, the commencement of the Relevant Period, the Incident Information ~~and the~~, Incident Impact Information, Best Practice Information, and Safe Environment Information was not generally available within the meaning of section 676 of the Corporations Act.

118. As at, and from, the commencement of the Relevant Period, the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information (separately or together) was information that a reasonable person would expect to have a material effect on the price and/or value of AAD Stapled Securities within the meaning of ASX Listing Rule 3.1 and section 674(2)(c)(ii) of the Corporations Act.

119. As at, and from, the commencement of the Relevant Period, the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information was information to which none of the situations listed in Listing Rule 3.1A.1 applied, and was information that a reasonable person would expect to be disclosed.

120. By reason of AAD's Continuous Disclosure Obligations and the matters pleaded in paragraphs 114 to 119, on, and from, the commencement of the Relevant Period, AAD was obliged immediately to tell the ASX any or all of the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information.

121. During the Relevant Period, AAD did not inform the ASX of the Incident Information, ~~or the~~ Incident Impact Information, Best Practice Information or Safe Environment Information immediately, or at all.

122. By reason of the matters pleaded in paragraph 120 to 121, AAD contravened ASX Listing Rule 3.1 and section 674(2) of the Corporations Act at all times in the Relevant Period (**Continuous Disclosure Contraventions**).

### E.3 Continuing Nature of the Contraventions

123. Each of the Misleading Conduct Contraventions and Continuous Disclosure Contraventions was a continuing contravention, which of its nature continued from and

after the commencement of the Relevant Period during and throughout the Relevant Period.

## F. CONTRAVENING CONDUCT OF DAVIDSON

124. Davidson knew:

(a) at all material times in the Relevant Period, that AAD maintained a publicly accessible website containing the Website Safety Statement;

(b) at all material times in the Relevant Period that on and from 24 September 2013, AAD had submitted an Annual Report for the financial year ending 30 June 2013 to the ASX and that it contained the Annual Report Safety Statement;

(c) on and from 17 September 2014, that AAD had submitted the FY14 Annual Report to the ASX and that it contained the Annual Report Safety Statement;

(d) on and from 17 September 2015, that AAD had submitted the FY15 Annual Report to the ASX and that it contained the Annual Report Safety Statement;

(e) on and from 17 September 2016, that AAD had submitted the FY16 Annual Report to the ASX and that it contained the Annual Report Safety Statement; and

(f) at all material times in the Relevant Period until the Incident, that AAD had not notified the ASX of the Incident Information, ~~or the~~ Incident Impact Information, Best Practice Information or Safe Environment Information.

**Particulars**

*Davidson's knowledge is to be inferred from:*

*(a) his position and responsibilities as the Chief Executive Officer of the Theme Park Division (as pleaded in paragraph 22 above), in which capacity he was the ultimate decision making authority for Dreamworld and was the direct report for all of the General Managers within the Dreamworld Executive Team, the Chief Financial Offer and the Group Safety Manager, ~~which included the Sales and Marketing department described in paragraph 16(f) above~~; and*

*(b) his identification, from 2 September 2013, as a member of AAD's 'Key Management Personnel' for the purposes of Australian Accounting Standard AASB 124 'Related Party Disclosures'.*

125. Further, Davidson knew:

(a) at all material times in the Relevant Period, alternatively at all material times following the 2014 Incident, the matter pleaded in paragraphs 51(a) and/or 68; and

(b) at all material times in the Relevant Period on and from about 6, or 17, November 2014 the matter pleaded in paragraph 51(b).

**Particulars**

*Davidson's knowledge is to be inferred from:*

*(a) his position and responsibilities as the Chief Executive Officer of the Theme Park Division (as pleaded in paragraph 22 above), in which capacity he was the ultimate decision making authority for Dreamworld and was the direct report for all of the General Managers within the Dreamworld Executive Team, which included the Engineering & Technical and Safety departments described in paragraph 16(a) and (c) above; and*

*(b) his membership of the Dreamworld Safety Committee, as pleaded in paragraph 15 above.*

126. Further, Davidson knew by no later than 13 November 2014:

(a) the Incident Information, ~~and~~ Incident Impact Information, Best Practice Information and Safe Environment Information;

**Particulars**

*The Applicants repeat and rely upon the particulars to paragraphs 115 ~~and~~ to 116B, above, to the extent that allegation particularises actual knowledge against Davidson.*

(b) that the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information (separately or together) was not generally available or public information; and

**Particulars**

*Davidson's knowledge of the fact that the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information (separately or together) was not generally available is to be inferred from the fact that the Incident Information, and the information upon which it is based (including the history of incidents on the TRRR, as pleaded at paragraph 47 above, the information contained in the Bob Tan Email, as pleaded at paragraph 63 above, the information contained in the DRA audits, as pleaded at paragraphs 58 to 60 above, and the knowledge of individuals who reported to Mr Davidson, as particularised at paragraph 115 above):*

*(a) was not public;*

*(b) did not consist of readily observable matter; and*

*(c) was not made known in a manner likely to bring it to the attention of those who commonly invest in securities.*

(c) the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information (separately or together) was information that a reasonable person would expect to have a material effect on the price and/or value of AAD Stapled Securities.

**Particulars**

*The Applicants repeat and rely upon the particulars to paragraphs 115 to 116B (to the extent that allegation particularises actual knowledge against Davidson) and 124(f) above.*

127. Prior to and during the Relevant Period, Davidson:

(a) took no steps to remove, or qualify the Website Safety Statement;

(b) took no steps to cause AAD (or its directors) to correct or qualify the Annual Report Safety Statement, as published in each of the FY13 Annual Report, FY14 Annual Report, FY15 Annual Report or FY16 Annual Report; and/or

(c) took no steps to cause AAD (or its directors) to publicly disclose the Incident Information, ~~and the~~ Incident Impact Information, Best Practice Information and Safe Environment Information (including by publication of that information to the ASX).

128. In the premises of paragraphs 124, 125 and 127 above, Davidson was involved (within the meaning of section 79 of the Corporations Act, s 5 of the ASIC Act and s 2 of the ACL), in the Misleading Conduct Contraventions by AAD alleged in paragraph 113 above, in that he was knowingly concerned in, or party to, those contraventions.

129. In the premises of paragraphs 124 and 126 to 127 above:

(a) Davidson was involved, within the meaning of section 79 of the Corporations Act, in the Continuous Disclosure Contraventions by AAD alleged in paragraph 122 above, in that he was knowingly concerned in, or party to, those contraventions; and

(b) by reason of subparagraph (a) above, Davidson contravened section 674(2A) of the Corporations Act on each day that AAD contravened section 674(2) of the Corporations Act on and from no later than 13 November 2014.

## G. CONTRAVENING CONDUCT CAUSED LOSS

### G.1 Market based causation

130. The Applicants and some Group Members acquired an interest in AAD Stapled Securities in a market of investors or potential investors in AAD Stapled Securities:

(a) operated by the ASX;

(b) regulated by, inter alia, section 674(2) of the Corporations Act and ASX Listing Rule 3.1;

(c) where the price and value of AAD Stapled Securities would reasonably be expected to have been informed or affected by information disclosed in accordance with sections 674(2) of the Corporations Act and ASX Listing Rule 3.1;

(d) where material information had not been disclosed, which a reasonable person would expect, had it been disclosed, would have had a material adverse effect on the price or value of AAD Stapled Securities (namely the Incident Information ~~and/or the~~ Incident Impact Information, Best Practice Information and/or the Safe Environment Information (together, the **Contravening Omissions**);

(e) where representations had been made, namely the Safety Representations, (together **Contravening Representations**), (the making and maintenance of which amounted to misleading or deceptive conduct) that a reasonable person would expect to have a material effect on the price or value of AAD Stapled Securities, and that if they had not been made (and maintained), no persons comprising the Affected Market would have been in a position to read or rely upon them; and

(f) in which during the Relevant Period each or a combination of:

(i) the Continuous Disclosure Contraventions; and

(ii) the Misleading Conduct Contraventions,

(each being a **Market Contravention**) caused or materially contributed to the market price of AAD Stapled Securities to be substantially greater than their true value and/or the market price that would have prevailed but for the Market Contraventions, from the respective dates that those Market Contraventions commenced, as pleaded above.

**Particulars**

*The extent to which the Market Contraventions caused the market price for AAD Stapled Securities to be substantially greater than their true value and/or the market price that would otherwise have prevailed (that is inflated) during the Relevant Period as follows:*

*(a) where AAD's earnings before interest, taxes, depreciation and amortization (**EBITDA**) decreased by $54.4 million, the market price for AAD Stapled Securities was inflated by $0.45 or 17.74%;*

*(b) where AAD's EBITDA decreased by $39.81 million, the market price for AAD Stapled Securities was inflated by $0.33 or 12.99%;*

*(c) where AAD's EBITDA decreased by $25.22 million, the market price for AAD Stapled Securities was inflated by $0.21 or 8.23%;*

*(d) where AAD's EBITDA decreased by $18.92 million, the market price for AAD Stapled Securities was inflated by $0.16 or 6.17%; or*

*(e) where AAD's EBITDA decreased by $12.6 million, the market price for AAD Stapled Securities was inflated by $0.10 or 4.11%.*

~~*is a matter for evidence, particulars of which will be served immediately following the Applicants filing opinion evidence in this proceeding.*~~

131. The decline in the price of AAD Stapled Securities pleaded in paragraph 102 above:

(a) was caused or materially contributed to by:

(i) the market's reaction to the Incident, in the context of what had been communicated to the Affected Market prior to the Incident; and

(ii) the Market Contraventions,

(b) would, to the extent it removed inflation from the price of AAD Stapled Securities, have occurred or substantially occurred, earlier if:

(i) AAD had disclosed to the Affected Market the information that was the subject of the Contravening Omissions; and/or

(ii) AAD had not made (and maintained) the Contravening Representations to the Affected Market.

**Particulars**

*The extent to which inflation ~~was~~ would have been removed from the price of AAD Stapled Securities on 17 June 2014 is as per the Expert Report of Stephen Prowse dated 27 May 2022 at page 27 (ING.004.001.0115): ~~, and would have been removed at earlier points in time during the Relevant Period is a matter for evidence, particulars of which will be served immediately following the Applicants filing expert evidence.~~*

| *Inflation Calculation* | *Full* | *Scenario 1* | *Scenario 2* | *Scenario 3* | *Scenario 4* |
|---|---|---|---|---|---|
| *Instructed EBITDA Impact [A]* | | *($39.8)* | *($25.2)* | *($18.9)* | *($12.6)* |
| *EBITDA Impact Associated with Counterfactual Disclosure [B]* | | *($54.4)* | *($54.4)* | *($54.4)* | *($54.4)* |
| *Counterfactual to Actual Financial Impact Ratio ([C] = [A]/[B])* | | *0.73* | *0.46* | *0.35* | *0.23* |
| *Excess Dollar Return From Event Study [D]* | | *$0.45* | *$0.45* | *$0.45* | *$0.45* |
| *Excess Percentage Return from Event Study [E]* | | *17.74%* | *17.74%* | *17.74%* | *17.74%* |
| *Constant Dollar Inflation ([F] = [C] x [D])* | *$0.45* | *$0.33* | *$0.21* | *$0.16* | *$0.10* |
| *Constant Percentage Inflation ([G] = [C] x [E])* | *17.74%* | *12.99%* | *8.23%* | *6.17%* | *4.11%* |

## G.2 Reliance

132. Further and in the alternative to paragraph 131, in the decision to acquire an interest in AAD Stapled Securities:

(a) the Applicants and some Group Members would not have acquired interests in AAD Stapled Securities if they had known the Incident Information, ~~and/or the~~

Incident Impact Information, Best Practice Information and/or the Safe Environment Information the subject of the Contravening Omissions; and/or

(b) the Applicants and some Group Members relied directly on some or all of the Contravening Representations.

**Particulars**

*(i) The Applicants would not have acquired an interest in AAD Stapled Securities had they known the Incident Information, ~~and/or the~~ Incident Impact Information, Best Practice Information and/or the Safe Environment Information the subject of the Contravening Omissions and, they relied upon each of the Contravening Representations (namely the Safety Representations).*

*(ii) The identities of all those Group Members which or who would not have acquired an interest in AAD Stapled Securities had they known of any or all of the Incident Information, ~~and/or the~~ Incident Impact Information, Best Practice Information and/or the Safe Environment Information that was the subject of the Contravening Omissions and/or which or who relied directly on any or all of the Contravening Representations (namely the Safety Representations) are not known within the current state of the Applicants' knowledge and cannot be ascertained unless and until those advising the Applicants take detailed instructions from all Group Members on individual issues relevant to the determination of those individual Group Member's claims; those instructions will be obtained (and particulars of the identity of those Group Members will be provided) following opt out, the determination of the Applicants' claim and identified common issues at an initial trial and if and when it is necessary for determination to be made of the individual claims of those Group Members.*

## G.3 Loss or Damage suffered by the Applicants and Group Members

133. By reason of the matters pleaded in paragraphs 130 and 131 and/or 132, the Applicants and Group Members have suffered loss or damage by and resulting from the Market Contraventions (or any one or combination of them).

**Particulars**

*(a) The loss suffered by the Applicants will be calculated by reference to:*

*(i) the difference between the price at which AAD Stapled Securities were acquired by the Applicants during the Relevant Period and the true value of that interest; or*

*(ii) the difference between the price at which the Applicants acquired an interest in AAD Stapled Securities and the market price it would have prevailed had the Market Contraventions not occurred; or*

*(iii) alternatively the days during the Relevant Period where the traded price of AAD Stapled Securities fell as a result of the disclosure of information which had not previously been disclosed because of the Market Contraventions, and the quantum of that fall; or*

*(iv) alternatively the days after the Relevant Period when the traded price of AAD Stapled Securities fell as a result of the disclosure of information which had not*

*previously been disclosed because of the Market Contraventions, and the quantum of that fall.*

(b) *The Applicants' losses based on the share price on 21 July 2016 of $2.06 at which the Applicants purchased 7,500 AAD Stapled Securities and the inflation per the Expert Report of Stephen Prowse dated 27 May 2022 at page 27 (ING.004.001.0115) is as follows:*

| ***AAD EBITDA decrease ($ million)*** | ***Inflation ($)*** | ***True value of shares ($)*** | ***True value of Applicant's shares ($)*** | ***Loss ($)*** |
|---|---|---|---|---|
| *54.4* | *0.45* | *1.61* | *12,075* | *3,394.95* |
| *39.8* | *0.33* | *1.73* | *12,975* | *2,494.95* |
| *25.2* | *0.21* | *1.85* | *13,875* | *1,594.95* |
| *18.9* | *0.16* | *1.90* | *14,250* | *1,219.95* |

~~*Further particulars in relation to the Applicants' losses will be provided after the service of evidence in chief.*~~

(c) *Particulars of the losses of Group Members are not known within the current state of the Applicants' knowledge and cannot be ascertained unless and until those advising the Applicants take detailed instructions from all Group Members on individual issues relevant to the determination of those individual Group Member's claims; those instructions will be obtained (and particulars of the losses of those Group Members will be provided) following opt out, the determination of the Applicants' claim and identified common issues at an initial trial and if and when it is necessary for determination to be made of the individual claims of those Group Members.*

## H. LIABILITY OF ALG

134. In 2018, AAD underwent a corporatisation process, pursuant to which:

(a) ALG was incorporated in order to facilitate the replacement of the stapled structure of ALL and ALML as pleaded at paragraph 8 above;

(b) ALG issued shares to holders of the AAD Stapled Securities on a one for one basis pursuant to a scheme of arrangement approved by holders of AAD Stapled Securities on 20 November 2018 and by the Supreme Court of New South Wales on 28 November 2018 (**Scheme**).

135. By a Deed of Cross Guarantee dated 3 October 2019, each of ALL, ALML, Ardent Leisure Entertainment Pty Ltd and Main Event Entertainment Pty Ltd (Group Entities) covenanted with ALG, for the benefit of each 'Creditor', payment in full of any 'Debt' in accordance with the Deed of Cross Guarantee, where:

(a) 'Creditor' means a person (whether now ascertained or ascertainable or not) who is not a Group Entity and to whom now or at any future time a Debt (whether now existing or not) is or may at any future time be or become payable; and

(b) 'Debt' means any debt or claim which is now or at any future time admissible to proof in the winding up of a Group Entity and no other claim.

**Particulars**

*Deeds of Cross Guarantee between Ardent Leisure Group Limited, Ardent Leisure Limited, Ardent Leisure Management Limited, Ardent Leisure Entertainment Pty Ltd and Main Event Entertainment Pty Ltd dated 3 October 2019. Further particulars will be provided following completion of interlocutory steps.*

136. Pursuant to clause 6 of the Deed of Cross-Guarantee, each of ALL, ALML and ALG gave a deed poll so as to give effect to the Deed of Cross Guarantee and for the benefit of Creditors as defined in the Deed of Cross Guarantee

137. In the premises, to the extent that either or both of ALL and ALML are liable to the Applicants and Group Members as pleaded herein, and that liability is not satisfied with the consequence that ALL or ALML is wound up, each of ALL, ALML and ALG is liable to the Applicants and the Group Members for their loss and damage pleaded in paragraph 133.

138. Further, on 5 October 2018 ALL and ALG entered into an agreement (**Corporate Guarantee**), which:

(a) by clause 2.1, provides that ALG "irrevocably and unconditionally" undertakes to perform the "Guaranteed Obligations", including payment of the "Guaranteed Obligations";

(b) by clause 1.1, defines:

(i) "Guaranteed Obligations" as meaning "all pecuniary penalties, fines, judgments, damages, losses, settlement monies, debts, costs, expenses, interest and monetary liabilities of ALL that become payable to any Third Party after the date of Completion and which arise as a result of, or in connection with, any action, administrative process or proceeding by such Third Party in connection with the incident that occurred at the

Dreamworld theme park on 25 October 2016 that resulted in four fatalities." and

(ii) "Third Party" as meaning "any Government Agency, person, firm, company, corporation, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing and any reference to a particular Third Party includes a reference to that Third Party's executors, administrators, successors, substitutes (including by novation) and assigns."

(c) by clause 3, is binding upon ALL and ALG upon "Completion" (as defined in clause 1.1 of the Corporate Guarantee), which has occurred.

**Particulars**

*The Applicants will rely upon the terms of the Corporate Guarantee for their full meaning and effect.*

139. In the premises, to the extent that ALL is liable to the Applicants and the Group Members as pleaded herein, ALG is liable to the Applicants and the Group Members pursuant to the Corporate Guarantee.

Signed by Gregory John Whyte, Partner
Lawyer for the Applicants

~~This~~ The amended pleading was prepared by Greg Whyte, lawyer and the amended pleading and further amended pleading ~~was~~were settled by W. A. D. Edwards and J. R. Green, of counsel.

**Certificate of lawyer**

I Gregory John Whyte certify to the Court that, in relation to the statement of claim filed on behalf of the Applicants, the factual and legal material available to me at present provides a proper basis for each allegation in the pleading.

Date: 26 September 2022

Signed by Greg Whyte
Lawyer for the Applicants

## SCHEDULE OF DEFINED TERMS