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The Dreamworld deaths: corporate crime and the slumber of the law

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ABSTRACT

On Tuesday 25 October 2016, four people were killed on the popular Thunder River Rapids Ride (TRRR) at Dreamworld, Australia. Ardent Leisure Ltd pleaded guilty to three charges under section 32 of the *Work Health and Safety Act* 2011 (Qld) and was fined $A3.6 million with convictions recorded. This article analyses the charges, penalties and ways in which the responsibility of Ardent Leisure Limited for these deaths has been framed by the criminal jurisdiction – essentially, to minimise and neutralise the criminality. The article contends that the legal framework for governing corporate crime in Australia does not reflect the culpability of corporations or provide sentences of deterrence, as illustrated in the case of *Guilfoyle v Ardent*. The article explores the ways in which the Inquest and sentencing remarks in relation to Ardent demonstrate the failure of the legal system to grapple with the personhood of corporations, specifically in terms of agency and the implications for culpability.

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Introduction

On Tuesday 25 October 2016, four people were killed on the popular Thunder River Rapids Ride (TRRR) at Dreamworld, Australia's largest theme park. The ride simulated white water rafting and held up to six patrons per raft. It was classified as suitable for everyone over the age of two. Rafts floated around a circular water channel propelled by a current that was created by two large pumps. At the end of the channel, rafts went on a conveyor to the highest point of the ride where rafts were loaded and unloaded. On the day in question, one of the pumps failed and this led to the water level of the ride to drop, and a raft to become stranded on support rails at the end of the conveyor near the unloading area. A second raft containing four adults and two children collided with the stranded raft. The second raft was vertically inverted and drawn into the gap between the conveyor and support frame. Kate Goodchild, Cindy Low, Luke Dorsett and Rozzbeh (Roozi) Araghi were caught in the mechanism of the ride and were either trapped in the raft or ejected into the water beneath the conveyor. There was no

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evidence of drowning. They died by being pummelled to death. The two children on the raft escaped without injury.

Ardent Leisure Ltd ('Ardent') is responsible for the operations at Dreamworld since it took over Dreamworld in 2003. It is registered as a public company that has over 100 holdings internationally and is highly profitable. Ardent pleaded guilty to three charges under section 32 of the *Work Health and Safety Act* (2011) ('*WHS Act*') and was fined $A3.6 million with convictions recorded. In pleading guilty, Ardent accepted that it had failed, so far as was reasonably practicable, to ensure the provision and maintenance of safe plant and structures, safe systems at work, and the training, instruction and supervision that was necessary to protect all persons from risks to their health and safety. The penalty was the largest fine in the history of Work Health and Safety ('WHS') prosecutions in Australia. After sentencing, the WHS Prosecutor, Aaron Guilfoyle, determined that 'it was not appropriate to lay any further charges' (OWHSP, 2020).

This article analyses the charges, penalties and ways in which the responsibility of Ardent for these deaths was framed by the criminal jurisdiction (as opposed to the civil procedures[1]) – essentially, to minimise and neutralise the criminality. We undertake a close reading of the coronial findings in relation to the four deaths,[2] then proceed to analyse the sentencing remarks of the Queensland Magistrates Court in *Guilfoyle v Ardent Leisure Ltd* (2020) ('*Guilfoyle v Ardent* 2020'). Coronial inquiries and sentencing hearings have different, but related, purposes. Trabsky and Baron (2016) write that:

> [t]he coroner examines unexpected, unnatural or violent deaths, seeking to determine the identity of the deceased, the immediate and underlying causes of death, and in certain situations the circumstances of death. The death investigation process may proceed to an inquest and it may result in the coroner making comments and/or recommendations to prevent similar deaths from taking place in the future. (p. 583)

The coroner not only aims to discover the cause of death but also memorialises the lives of the deceased. By contrast, sentencing hearings occur after a conviction and consider a range of matters relating to the perpetrator's culpability, including the nature of the offence, the seriousness of the harm and the character of the offender. The court hands down sentencing remarks that provide an explanation to the perpetrator, victim and public on how a sentence has been assessed and how the sentencing purposes, such as punishment, deterrence, rehabilitation, denunciation, and protection (*Penalties and Sentences Act* 1992, s 9(1)), apply to the perpetrator (*Porter v R* 2019, [67]). We argue that despite the evidence in the inquest that Ardent made a series of choices over a number of years that contributed to the homicides, and despite the imposition of fines upon Ardent in the sentencing judgment, both the coronial inquiry and sentencing remarks exhibit a tendency to erase or reduce Ardent's agency and responsibility for the homicides.

Our analysis of the Dreamworld/Ardent cases contributes to critical research which identifies the limits of the criminal justice system in relation to corporations, including the futility of low-level fines, relative to corporate scale, in curbing corporate crimes. For example, critical criminologists, Tombs and Whyte (2015), claim that corporate

[1]The family of one victim, Cindy Lowe, was awarded $2.1 million by the Queensland Supreme Court. Ultimately the civil shareholder class action was settled for $26 million, see https://www.abc.net.au/news/2023-08-24/ardent-leisure-announces-26-million-class-action-settlement/102770516.

[2]Goodchild, Kate; Dorsett, Luke; Low, Cindy & Araghi, Roozbeh (2016/4486, 2016/4485, 2016/4480, 2016/4482) [2020] QldCorC 4 (24 February 2020).

regulatory models enable profiteering from crimes. We similarly contend that the legal framework for governing corporate crime in Australia does not reflect the culpability of corporations or provide sentences of deterrence, as illustrated in the case of *Guilfoyle v Ardent* (2020). We explore the ways in which the inquest and sentencing remarks in relation to Ardent demonstrate the dereliction of the legal system to grapple with the personhood of corporations, specifically in terms of agency and the implications for culpability. In turn, the legal processes fail to come to terms with the harms generated by corporations. Throughout the coronial and sentencing courts ('the courts') findings, there is a tendency to downplay and neutralise Ardent's culpability and criminality. This is epitomised in the proclivity of the courts to accept the erasure of Ardent's choices and actions across time, framing the deaths as tragedy or accident. Rather than attribute responsibility to the decisions of Ardent contributing to the deaths, the courts characterise the deaths as occurring randomly and without control. We contend that Ardent's choices *not* to heed the advice of the Australian Workers' Union to put in systems to protect safety, and not to appropriately respond to machine malfunctions leading up to the fatal incident, were calculated decisions on the part of a highly profitable and sophisticated organisation. Unless courts recognise the wrongfulness of corporations' actions and omissions and impose condign sentences, the courts are perpetuating corporate harms and their lack of accountability.

We start by contextualising the charges laid against Ardent in comparison with other health and safety and criminal offences with which Ardent could potentially have been charged. In the next two sections, we highlight a dominant conceptualisation of corporations as seemingly lacking in agency or choice. We go on to argue that this is expressed by the legal system through representations of the harms as resulting due to inadvertent failure, rather than from long-term deliberate actions and choices by Ardent. We then demonstrate that this lack of agency is articulated through the language of tragedy or accident – as though there is no culpable legal agent to which responsibility can be ascribed. We go on to consider the ways in which health and safety concerns are considered by courts as policy or systems-wide issues to trump any ascription of criminal responsibility. We conclude by analysing these themes in the sentencing remarks in *Guilfoyle v Ardent* (2020) – and the consequent fines. We consider the gross inadequacies of the fines, which can be written off as costs of doing business, rather than disrupt corporate activities to an extent that it provides substantial deterrence.

Charges against Ardent and the limits of corporate culpability

Ardent was charged with and pled guilty to three offences under section 32 the *WHS Act*. Each charge concerned a breach by Ardent of its primary safety duty under section 19(2) of the *WHS Act* to ensure that the health and safety of members of the public were not put at risk. The maximum penalty available for these breaches of the *WHS Act* was $A4.5 million, with each charge carrying a maximum penalty of $1.5 million. Ardent was ultimately fined $A3.6 million for the three breaches, which resulted in four deaths.

The *WHS Act* commenced operation on 1 January 2012 as part of a uniform scheme adopted in six states and territories. It provides a framework to protect the health, safety and welfare of all workers at work, and the health and safety of people who may be affected by that work. There is a great deal of academic and policy debate about the

legal response to work fatalities – and whether the WHS framework grapples sufficiently with the culpability and criminality of corporate homicides – or whether the framework has effectively decriminalised corporate homicides (see, e.g., Almond, 2013; Johnstone, 2013; Matthews, 2019).

The courts' procedure in response to the homicides minimised the criminality of Ardent in three significant ways. First, the corporate crimes causing deaths were classed as summary matters and heard in a lower court. The classification of Ardent's crimes as minor matters, heard by a magistrate rather than a higher court judge, diminishes its seriousness and fails to provide a sense of justice to the families of the deceased. By contrast, all other homicide matters are heard in the Queensland Supreme Court. Although Part 2A of the *WHS Act* enshrines the offence of industrial manslaughter due to negligence, Ardent could not be charged with this offence because it requires the death of a worker. Second, Ardent was charged with three breaches of health and safety duty offences under section 32, rather than separate homicide offences. This is consistent with the findings of the Australian Law Reform Commission ('ALRC') (2020) that breach of duty offences are the most common type of prosecution under the WHS framework in Australia. Breach of duty offences are '"inchoate" offences, which focus on the creation of unacceptable risk at work rather than on the outcome' (Matthews, 2019, p. 639). Ardent was prosecuted with failure to meet a legal duty, requiring only a failure to comply with a health and safety duty that exposes an individual to a risk of death or serious injury or illness (*WHS Act*, s 32). Finally, by conflating the four deaths into three breaches of duty, the individual lives lost were not reflected in the process. Ordinarily in homicide prosecutions, there are separate charges for each death. Moreover, as the Queensland Magistrate noted in *Guilfoyle v Ardent* (2020, p. 2), the deaths were not an element of the offences:

> The failures of the defendant resulted in a risk of both serious injury and death. Whilst the result of actual injury or death is not an element of the offences the defendant is to be sentenced for; however, that four unsuspecting members of the public lost their lives is highly relevant and compelling.

Given that Ardent was charged for breach of duty, rather than for causing four deaths, the gravity of the offences, the lost lives and the impact on families and loved ones is depreciated (Matthews, 2019).

Strict liability offences

Rather than requiring the prosecution to prove negligence, Ardent was prosecuted with strict liability offences. These lack the requirement of any *mens rea* (specific mental state) – intention or otherwise. While this s 32 provision of the *WHS Act* renders corporate prosecutions more likely to succeed by displacing the *mens rea* requirement,[3] it can nonetheless dilute recognition of deliberate acts and proactive choices (frequently over long periods of time) that undergird harmful consequences (including death/s). In accordance

[3]The ALRC found that prosecutions of corporations are relatively frequent under WHS legislation in comparison with enforcement action under legislation regulated by ASIC or the ACCC. Corporate Criminal Responsibility (ALRC Report 136) 2022.

with the tenor of the *WHS Act* strict liability provisions, the prosecution focused on inadvertent failure which had the effect of downplaying Ardent's culpability.

Strict liability corporate offences are a pragmatic response by the legislature to difficulties of establishing the *mens rea* of the corporation. At common law, the identification doctrine requires the prosecution to identify the 'directing mind' of the corporation and then to prove that the directing mind had the necessary *mens rea* at the time of the conduct causing the prohibited outcome (*Tesco Supermarkets v Natrass* 1971). This doctrine has been recognised as a serious obstacle for prosecutions of corporate crime, particularly for large organisations (Campbell, 2018; Lim, 2013; Wells, 2010). It is one of the reasons why it has been very rare to successfully prosecute large organisations for criminal offences that require *mens rea* or even for common law involuntary manslaughter offences that do not require *mens rea*. For example, in 1990, P&O Ferries was prosecuted for manslaughter by criminal negligence as a result of the capsize of the *Herald of Free Enterprise* cruise ship, which caused the deaths of 193 people in Belgium. This occurred because the ship set sail with its bow doors open, which flooded the ship within minutes of its departure. Justice Sheen in a public court of inquiry in 1987 identified a 'disease of sloppiness' and negligence at every level of the corporation's hierarchy (Sheen, 1987, p. 14). Despite this, and errors of omission on the part of senior staff and the board of directors, the charge of corporate manslaughter was dismissed by Turner J of the Central Criminal Court, who affirmed that it was not possible to identify a single individual as the controlling mind of the company, and who had been grossly negligent (*R v P&O Ferries (Dover) Ltd* 1990, pp. 84–85). Likewise, Ardent could conceivably have been prosecuted for manslaughter under section 303 of the *Criminal Code Act* (1899). However, given the similarities in the UK and Australian common law pertaining to manslaughter, this would likely have met the same kind of difficulties of proof as confronted by the prosecution in the P&O Ferries case. As we argue, Ardent could, generously, be regarded as afflicted with a 'disease of sloppiness', but there was no specific senior executive to whom negligence could be attributed. The failures causing the deaths reflected an entrenched culture of conducting business for Ardent, such as the employment of young, cheap staff and a lack of safety checks and training. The *WHS Act* is a relatively successful attempt to circumvent the requirements of the identification doctrine for corporate crime by focusing on breach of legal duty rather than upon the subjective fault of the corporation. However, this comes at the cost of appropriately reflecting the corporation's criminal liability.

Culpability and strict liability offences

One difficulty with these strict liability offences is that they conflict with the currently dominant model of wickedness that is concomitant with *mens rea*: positive wrongdoing, that is, intentional wrongdoing (Midgley, 2001). This is likewise reflected in the criminal legal system's emphasis upon subjective blameworthiness and the *WHS Act* pyramid of blameworthiness based on state of mind rather than harm caused (Crofts, 2013; Fletcher, 1978; Wells, 1982). In the *WHS Act*, crimes that require *mens rea*, such as reckless conduct, attract a maximum five-year prison sentence (*WHS Act*, s 31). By contrast, strict liability offences in the *WHS Act* suggest that corporate homicides are less serious than intentional individual homicides, not only because the homicide is erased

from the charges, but because they lack subjective fault. Philosopher Midgley (2001) aptly points out that culpability can equally be imputed to absence, lack or failure as much as deliberate acts. On this basis, inadvertent failure can be culpable. In the absence of more realistic legal models of corporate intention, which identify the impugned corporate culture and profit motive as culpable, failure and strict liability have become the default mechanisms for conceptualising and attributing corporate fault (Campbell, 2018; Crofts, 2020). Failure to meet legal duties can be constructed as strict liability offences – with no need for the prosecution to prove *mens rea*. However, we argue below that this narrative of inadvertent failure and omission does not adequately capture the agency and culpable choices made by Ardent across time that caused the deaths, and thus fails to sufficiently articulate and attribute culpability to Ardent.

In charging Ardent with Category Two occupational health and safety offences under the *WHS Act* s 32,[4] prosecutors foreclosed the possibility of Ardent's responsibility under the more serious Category One offence of reckless conduct (s 31[5]). Section 31 is more serious in the hierarchy because the *mens rea* is recklessness, rather than 'failure to compuly with health and safety duty' (s 32). The implication of the prosecution under s 32 (which was informed by the limited framing of evidence from coroner) is that Ardent is not criminally culpable because it did not have the requisite state of mind of awareness of a risk of serious injury or death. Yet the Australian Workers' Union had raised concerns with safety at the theme park over the previous 18 months – putting Ardent on notice about the risk (Morgan, 2016).

The Coroner found that the Dreamworld General Managers denied any knowledge of the risks in relation to the TRRR, reflecting, at best, a lack of safety check systems (McDougall, 2020, p. 260):

> The resounding message of the General Managers responsible for the Departments at Dreamworld was that, as such risks and hazards had never been identified to them, they were unaware and therefore unable to take any action. Given no steps were ever taken to properly identify these risks by qualified people, it is unsurprising that such issues were not raised with management.

There is a circularity in the assertion of ignorance – the management did not know because they did not ask and did not have adequate systems in place – even though it was a core duty of management to ensure health and safety. As Box (1983) pointed out, by failing to have processes to enforce safety standards, corporations are able to hide behind their ignorance in denying culpability. More recently, Whyte (2016) has applied Sykes and Matza's (1957) idea of neutralization that they originally developed in relation to young people to corporations, arguing that claims of ignorance are a

[4]Section 32 Failure to comply with health and safety duty – category 2
A person commits a *category 2 offence* if –
(a) the person has a health and safety duty; and
(b) the person fails to comply with that duty; and
(c) the failure exposes an individual to a risk of death or serious injury or illness.

[5]Section 31: Reckless conduct – category 1
(1) A person commits a category 1 offence if –
(a) the person has a health and safety duty; and
(b) the person, without reasonable excuse, engages in conduct that exposes an individual to whom that duty is owed to a risk of death or serious injury or illness; and
(c) the person is reckless as to the risk to an individual of death or serious injury or illness.

'neutralization' technique that corporations use to downplay 'criminal behaviour'. Accordingly, this is a long-term and effective strategy by which corporations minimise responsibility for harms that they have caused. These claims of ignorance and inadvertent failure are commonly imputed by courts to corporate harms and are consistent with the classic negative model of culpability (Simester, 2021).

However, despite the exculpatory discourses on behalf of Ardent's board and management, evidence before the Inquest demonstrated sufficient recklessness to ground a prosecution under section 31 of the *WHS Act*. This would meet the Queensland test for use of prosecutorial discretion: sufficient evidence and in the public interest to proceed.[6] The warnings (including repeatedly by the Australian Workers' Union over 18 months) and prior incidents provide an alternative narrative: that the managers did know about the risks. In other words, Ardent was reckless by choosing to proceed with corporate activities in defiance of the dangers for which they had been put on notice (legally and practically) over a prolonged period of time. This case demonstrates the failure of prosecutors to conceptualise and recognise corporate culpability where corporations have intentionally and knowingly created a situation that causes death (Ashworth, 2013). In part this arises from the prosecution of the crimes under the *WHS Act* (as opposed to the *Criminal Code Act* 1899 (Qld)), and in part from the neutralisation of corporate blameworthiness by the sentencing court.

Corporate failure rather than choice and action

Instead of subjective fault, courts centralise *failure* when conceptualising corporate responsibility: failure to meet legal duty, and failure to keep a safe workplace, as demonstrated in the remarks of the criminal and coronial courts. This imputes a lack of knowledge and the absence of deliberate actions on the part of the corporations, resulting in a conflation of *actus reus* and *mens rea*. That is, the focus by the courts on failure assumes and combines omission (that is, failure to act which is part of the *actus reus*) with inadvertence or ignorance (that is, failure to recognise or know risks, which are issues of *mens rea*). It also obfuscates the ways in which corporations, especially large corporations, generate profit from investing in sophisticated systems of policy and strategy that are based on deliberate decision-making (Bant & Paterson, 2021). Decision-making is core to corporate business. Systems and processes are set up for corporations to maximise profits and, where risks are indicated, to shield against responsibility by attributing it to system or process failure. Criminal justice responses reinforce this idea that the corporations that cause harm are inadvertently failing in their responsibilities, rather than recklessly carrying out business with the full knowledge of the attendant risks. For instance, the language in the sentencing remarks in relation to Ardent emphasised failure across time (*Guilfoyle v Ardent* 2020, p. 2):

> The failures of the defendant were not momentary. Nor were they confined to a discrete safety obligation. They encompassed failures in each of the following: the provision of maintenance of safe plant and structures. The provision of maintenance of safe systems of work. The provision of information, training and instruction to staff.

[6]Director of Public Prosecutions guidelines (publications.qld.gov.au), 2–3.

Similarly, the inquest identified a 'total failure' by 'everybody at Dreamworld to identify the safety issues in respect of the TRRR' (McDougall, 2020, p. 260). Despite multiple breakdowns of the TRRR occurring prior to the deaths, the coroner referred to the failure to aver to risks (which would be negligence), rather than contemplating or knowing risks and acting irrespective of them (which would be recklessness). Coroner McDougall (2020, p. 261) notes problems that were known to Ardent through 'arbitrar[y] or accidental' identification. Yet Ardent was 'reactionary' rather than 'proactive' in taking a 'systematic approach', including an independent 'assessment of the ride' (McDougall, 2020, p. 261).

Alternatively, it could be construed that Ardent was inadvertently reckless (not contemplating risks) in choosing not to independently undertake any risk assessments. This is illustrated in the coronial finding below (McDougall, 2020, p. 259; emphasis added):

> [I]t is expected, and is indeed reasonable to do so, that all action has been taken by the owner to eliminate the risks posed. That was not the case with respect to the TRRR. There is *no evidence that Dreamworld ever conducted a proper engineering risk assessment of the ride in its 30 years of commission*. The risks and hazards, which have now been highlighted by the experts, were never identified and considered by Dreamworld because such an assessment was never undertaken.

Whether the Coronial Court refers to the lack of action on the part of Ardent to respond to known risks or to conduct risk assessments, the pervasive narrative is one of 'failure' rather than active choices. By placing a narrative of failure at the centre of Ardent's culpability the coronial inquiry reduces and mitigates Ardent's subjective fault and the active choices that it made across time. This is a theme that permeates legal responses to corporate homicides in Australia and internationally. Clough (2005, p. 117) states, 'workplace deaths are often due to systemic failures within the corporation itself rather than, or in addition to, individual fault' (see also Crofts, 2020, 2017). There is no doubt that failure can and should be regarded as culpable where there is a duty to act. Indeed, murder can be committed by omission, as can manslaughter. However, for corporate harms, often prosecutors and courts centralise failure where subjective fault would be otherwise available. Certainly, the inquest did not frame the Ardent failures that caused the deaths as blameworthy in and of themselves. As further demonstrated below, the coronial and sentencing courts in the Ardent cases fell short of recognising the corporation's choices and actions that contribute to corporate homicides, including choices not to identify risks. In the case of Ardent, the courts' designation of 'failure' mischaracterises the decades of defiance of standard operating practices, which are disclosed in evidence of the standards applied by and practices of its competitor Village, health and safety standards and community expectations (*Guilfoyle v Ardent* 2020; McDougall, 2020, p. 261). We suggest that the framing of Ardent's 'failure' or 'omission' around health and safety does not adequately capture and reflect its blameworthiness. It implies a lack of agency, choice, and knowledge, rather than deliberately or recklessly avoiding measures to protect public worker safety (including those identified by the Australian Workers' Union) in the pursuit of profit.

Discourse of 'accident' and 'tragedy' to conceal 'crime'

Tombs and Whyte (2009, p. 157) identify that public and legal discourses frame corporate actors 'in the dock' in ways that 'do not fit our stereotypical images of "criminals"':

> Corporate criminals do not appear to threaten our interests in the same way that individual thieves and murderers do. The existing order of regulatory politics helps perpetuate the idea that corporations and their officers are not 'real' criminals and that, in any case, their crimes are not 'real' crimes.

The reticence to conceptualise corporations as 'real criminals' is a barrier to understanding and accounting for the level of harm that corporations inflict. Corporations, along with other institutional actors, can create harm beyond the capacity of individuals. Large corporations have a proven record of generated unprecedented global harm, even though the larger the corporation and the greater the harm they cause, the less likely it is that they will be held criminally responsible (Crofts, 2022; Veitch, 2007). This is due to the inability of the legal framework – embedded in a classic theorisation of the mind of the individual – to account for the sprawling operations of corporations that avoid attributing blame to the corporate mind. It has not come to terms with the 'profit motive' as the relevant mindset that contributes to intentional, reckless, and negligent decisions to cause harm. While the criminal law on insider trading has inferred *mens rea* by asking whether the insider's actions sought to gain from unpublished information in possession (see *Securities Exchange Board of India v Abhijit Ranjan* 2022) this is limited to the law of individual fraud. No equivalent is asked of corporations: whether their measures to cut costs over long periods were an endeavour to maximise profits (see Bernat & Whyte, 2017; Hillyard & Tombs, 2021).

The perennial references to 'tragedy' and 'failure' in the Ardent legal proceedings unfolded against a backdrop of mainstream media that amplified its 'tragic' nature (9News Gold Coast, 2016). We engage a linguistic analysis to consider the language in the court proceedings and its role in framing culpability (see Machin & Mayr, 2023, pp. 32–35, who discuss the ideologies of lexical choices). The discourse of 'tragedy' was coupled with pictures of Louise Goodchild, Luke Dorsett, Cindy Low and Roozi Araghi that emphasised the 'unfortunate' nature of the deaths. This narrative undermined the agency and culpability of Ardent.

Despite downplaying the potential criminality of Ardent through the repeated use of 'tragedy' and 'tragic incident' (118 times in the findings), Coroner McDougall (2020, [1060], p. 274) 'reasonably suspected that Ardent Leisure may have committed an offence under workplace law'. Consequently, the coroner recommended a referral to the Office of Industrial Relations to consider prosecutions. The industrial nature of the offences and the investigating body (as opposed to criminal nature) may explain how the coroner can refrain from a language of criminality and yet tout the possibility of offences. On the one hand, this demonstrates that the *WHS Act* provides a scheme of lesser industrial offences, arguably to induce prosecutions of corporations and bypass difficulties in applying classic notions of criminality (set down in the *Criminal Code Act* 1899) to corporations. On the other hand, such reforms fall short of changing legal cultures to reflect the criminal culpability of corporations through standard criminal procedures, offence categories and punishments.

Our analysis of a sample of contemporaneous media reports on Dreamworld in 2016 reveals a language that diminished the criminal aspects of the incident causing the four

deaths. The horrors of the Thunder River Rapids Ride were described by news outlets in the immediate aftermath as an 'accident' (McKirdy et al., 2016) or 'tragic accident' (Chung & Burke, 2016) – reflecting and reinforcing the public and legal failure to imagine the possibilities of recklessness or gross negligence on the part of Ardent. Another trope was that the crime and its harms were an exception – with media describing it as 'the deadliest' theme park 'accident' in Australia (Toh, 2016). This had the effect of downplaying the pattern of corporations in enabling deaths at theme parks internationally. One gratuitous aspect of media headlines related to celebrating the child survivors, which had the effect of overshadowing the four horrific deaths (McKirdy et al., 2016). By contrast, moral panics about non-corporate fatal crimes (such as mass murders committed by individuals) focus exclusively on the victims in order to direct public opinion towards penalty and retribution (Greer, 2007, p. 21).

Similarly, the language choices of the Coroner and sentencing Magistrate reinforce the sentiment that the corporation was acting in a way that was accidental and unintentional (see also Hebert et al., 2019; Slapper, 2017). They do not emphasise violence, danger, or the homicidal nature of the act. The catchwords in the inquest findings, for instance, are a list of banal health and safety issues (McDougall, 2020, p. i):

> Dreamworld, amusement device, Theme Park, safety management systems, ride maintenance, training, amusement device regulation, amusement device designer, amusement device modification, external safety audits.

Throughout the 279-page coronial inquiry, there is no mention of corporate homicide or manslaughter or even blameworthy conduct. In contrast, Coroner McDougall (2020, [3]) noted, 'the in-depth nature of this inquiry was intended to ensure that such a *tragic event* does not happen again' (emphasis added). This reliance on the language of 'tragedy' was also reinforced in Magistrate Dowse's sentencing remarks (*Guilfoyle v Ardent* 2020, p. 5):

> Ardent has accepted the failings particularised in the complaints. Ardent has now demonstrated a thorough approach it has taken to learn from the past, which gave rise to this terrible tragedy.

This framing of the good will of the corporation in response to a tragedy conceals the corporation's responsibility for the deaths. As Hebert et al. (2019, p. 559) note, the language of tragedy is consistent with 'denying or obscuring corporate violence, effectively drawing attention away from corporate responsibility for killing'. It perpetuates the idea that corporations are not 'real criminals', intent on committing harm through minimising safety costs. Instead, the language reflects deterministic ideas of fate and misfortune, rather than agency and culpability (Rader, 2009). It implies intractable forces beyond human agency (Honig, 2013), or – in this case – the unfortunate inexorability of deaths based on system failures. This reflects and reinforces the deflection of responsibility and criminality of Ardent.

The judicial gaze: health and safety trumps corporate violence and homicide

In the coronial inquest, the language in evidence had greater resonance with a discourse of violence: they were 'pummelled' to death, dealt by a 'crushing blow' (McDougall, 2020, p. 3); 'severe internal and external injuries as a result of multiple compressive impacts'

(McDougall, 2020, p. 256). However, the Coronial Court, like the Sentencing Court, framed the breaches as a shopping list of technical issues, rather than a catalogue of responsibility for violence. There is an erasure of choices and actions made by Ardent across time. Rather than confronting Ardent's motivation (of profit), the coronial inquiry constrained a focus on intention and directed its findings to the steps that could have prevented the deaths. It set up a paradox that the deaths were entirely preventable *and* explained away as accident/tragedy (Hebert et al., 2019, p. 559).

In the public imagination, there is a compelling narrative about the potential dangers of amusement parks that emphasises harm but also locates it in a historical era to create a false sense of confidence in contemporary health and safety standards. This is evidenced by the proliferation of documentaries and YouTube channels on the topic. Part of the enjoyment of amusement parks are rides that give a sense of danger, like roller coasters, but that are within safe boundaries. The documentary, 'Class Action Park', which uncovers the world's most dangerous amusement park, was released on HBO in 2020. It is about New Jersey's Action Park, a water park which operated during the 1980s and 1990s that earned a reputation 'as the most insane – and possibly the most dangerous – amusement park that ever existed'.[7] This documentary suggests that this was an amusement park operating in the wild west of the unsafe and unregulated 1980s. The documentary notes that the New Jersey Action Park 'was a lawless land, ruled by drunk teenage employees … The rides were experimental and illogical, and seemed to ignore even the most basic notions of physics or common sense – not to mention safety'. Hauntingly, one voice during the opening montage says, '[i]t was a place where death was tolerated'.[8]

Despite the appearance that the documentary is about somewhere 'other than Australia' where regulations are lax and safety standards are flouted, there are notable parallels with Dreamworld. At Dreamworld, the design of the TRRR was approved by the Chief Inspector of Machinery in 1987. However, there had been multiple significant modifications made to the ride since that time – including removing pieces of the ride that had become waterlogged without replacing the parts. Very poor records were kept about the modifications, and they were done without any input from a 'designer'. Despite significant modifications, no one was ever 'formally charged with conducting a holistic engineering risk and hazard assessment of the ride' (McDougall, 2020, p. 262). The litany of preventable actions that Ardent should have taken related to 'multiple … hazards' and breaches of health and safety, including failures to contact the regulator following substantial design modifications (McDougall, 2020, p. 262). These made the ride 'completely unsafe at the time that the tragic incident occurred' (McDougall, 2020, p. 260). Dreamworld's approach is similar to Class Action Park – modifications were made at random in response to specific issues, and no account was taken of how this might affect the safety of the TRRR ride.

[7]Class Action Park (2020) Directed by Seth Porges and Chris Charles Scott III, Production Companies Pinball Party Productions, Strategery Films and Warner Max. Action Park Documentary | https://www.classactionpark.com/

[8]The documentary shows that Action Park had poorly engineered rides that were not well-monitored or supervised. The Park flouted rules and regulations at every turn. Unlike Dreamworld, the owner of the park, Gene Mulvihill, fought every lawsuit and leveraged his relationships with local officials to his benefit. Rather than insuring the Park, Mulvihill created a fake insurance company in the Cayman Islands through which he 'purchased' the park's policy. Multiple children died when the park was open on dangerous rides – including drowning in the wave pool and a child flying off the Alpine Slide and hitting his head.

In the inquest findings, there is also an appreciation that *now*, since the 'tragedy', many failures pertaining to the wider amusement park have been fixed. The courts in both matters commended the good initiative and public citizenship of Ardent. Yet the subsequent risk mitigation strategies should have signalled to the courts that Ardent was in serious derogation of its duty in not initiating similar measures, which were easily implemented, to prevent the four deaths in the question. Other notable failures pertain to a mundane set of failures that can be attributed to basic record keeping (McDougall, 2020, p. 261; emphasis added):

> Departments operating in silos, an absence of risk management and informal and ad hoc record keeping. The manner in which the documentation was provided during the course of the coronial inquiry and inquest further demonstrates the *frighteningly unsophisticated 'systems' in place at Dreamworld intended to ensure the safety of patrons and staff.* (Italics added)

In this quote, the Coroner minimised the dangers arising from Ardent's poor record keeping and a lack of systems (which compromised the public's safety) by simultaneously seeking to highlight the good intentions of Dreamworld. Further, the failure to have adequate record keeping and information sharing to ensure the Dreamworld rides were safe was not described as reckless or negligent. Rather, it was described in neutral terms as 'shoddy record keeping' and 'immature' safety systems (McDougall, 2020, p. 260, 262) to diffuse responsibility and blame (see also Crofts, 2017). The Coroner noted that Ardent started to rectify document management, including version control, and compliance recording (McDougall, 2020, p. 261). Again, the capacity to fix the problem should signal that the company was negligent or reckless in sitting back and waiting for a disaster to prompt change.

A particularly stark example of Ardent's recklessness was the lack of a single emergency stop on the ride to initiate a complete shutdown (McDougall, 2020, p. 263). Although this risk could have been easily mitigated, at the time of the deaths, there was a four-button sequence to shut down the ride. It had been recommended since 2001 that the emergency stop process needed to be fixed (McDougall, 2020, p. 264). Quite simply, the process was very complicated and lacked automation. The failure to address this issue reflects a tendency to prioritise profitability over safety. There were complicated requirements as to how to stop the ride – and 'staff were not given clear direction as to the use of the E-Stop' (*Guilfoyle v Ardent* 2020, p. 4). Two staff members were allocated to the ride at any one time, and (it was believed by staff that) only the most senior staff member was permitted to use the E-Stop button. One staff member was required to monitor water levels whilst also loading and unloading passengers. There was no automated warning in the event of a pump failure or monitoring water level, nor an automatic shutdown in response to dangerous water levels (McDougall, 2020, pp. 263–264). In relation to the critical failure of the pump, the coronial findings noted that there was no 'audible alarm to advise one of the pumps had ceased to operate' (McDougall, 2020, p. 262). Five breakdowns of the TRRR caused by a failure of the pump seven days prior to fatal incident went undiagnosed; it 'should have been sufficient to shut down the ride until a deeper investigation had been conducted' (McDougall, 2020, p. 265). Instead, it was regarded as 'no more than an inconvenient and intermittent issue' (McDougall, 2020, p. 265).

The Inquest referred to multiple prior incidents which were of a 'similar nature' to the one that killed four people in 2016 (McDougall, 2020, p. 257). For example, on 18 January 2001, just prior to loading guests onto the ride, three rafts collided with two stationary rafts, causing one to flip. After hitting the emergency stop button, the conveyor stopped, but the rafts were unable to be freed (McDougall, 2020, p. 60). The incident was identified as a 'dangerous event', but Dreamworld primarily blamed the Ride Operator, even though it had long been known that the ride was 'cognitively draining' for Ride Operators (McDougall, 2020, p. 68). Coroner McDougall (2020, p. 63) noted that recommendations from the internal incident report were not followed:

> Despite the recommendations of this incident, no practice scenario-based training for emergency situations was even provided for the TRRR, or any other ride at Dreamworld prior to the subject tragedy. A thorough review of this incident would have presented a timely and graphic reminder to all safety staff as to what, potentially, could have occurred once a raft blocked the passage of following rafts coming down the conveyor. It is fortunate there were no passengers in the rafts at the time.

The Coroner also noted the failure to investigate the design of the ride and the failure to conduct a thorough engineering or risk assessment of the ride in response to the incident. This should have been undertaken to ensure that a similar incident did not occur.

Despite multiple collisions of the rafts on the TRRR watercourse there was an absence of reporting or risk and hazard assessment of the ride (McDougall, 2020, p. 258). The Coroner describes it as 'unfortunate' – rather than negligent or reckless – when noting that 'Dreamworld never engaged [someone qualified to conduct a risk and hazard assessment] and as such these risks were never mitigated' (McDougall, 2020, p. 258). The Court accepted that Dreamworld 'failed to take any steps to rectify' shortcomings in the auditing process (McDougall, 2020, p. 257), and this meant that past 'near misses' were either not reported, or if they were reported, no one qualified was brought in to address the risks.

The ride had long been recognised by staff and management as complicated and requiring experience and focus. While the Coroner acknowledged that ride operators performed their tasks with 'dedication and in accordance with their training', they did not have the 'requisite qualifications or skill set to identify such hazards' (McDougall, 2020, p. 260). This represents a failure in Ardent's recruiting and training strategy. For one of the employees, the fatal day of 25 October 2016 was her first day as a Ride Operator on the TRRR for which she received two hours training that morning. The emergency circumstances for utilising the E-Stop button were not explained to the workers. The workers were made to respond to 'various different situations and emergencies' that were 'clearly excessive' and beyond their training (McDougall, 2020, p. 266). There were no emergency drills at the theme park despite being recommended by internal and external audits. The Inquest considered reasonable steps that Ardent could have taken to stop the 'accident', by referring to experts and the standards applied by Ardent's competitor Village (McDougall, 2020, pp. 214–217). A basic, simple, cheap measure would have been to automate safety, rather than rely on staff to keep an eye on water levels – a measure that was recommended in response to an incident in 2004 (McDougall, 2020, p. 72). This would have reduced the cognitive load required of staff, reduced the likelihood of mistakes, and reduced the risks associated with the ride.

Particularly stark, it would have been cheap and easy to install a single-press emergency shut down button (p. 221).

Ardent should have introduced a single press emergency button, employed qualified staff, provided rigorous training to operate the rides, and undertaken regular safety and risk assessments, particularly after modifications had been made. Ardent had been put on notice five times in the week leading up to the homicides when the pump broke down and yet made no changes. The failures to implement basic safety standards are choices made by Ardent to minimise costs and avoid shutting down Dreamworld's 'most popular ride' (McDougall, 2020, p. 8). Yet no blame is sheeted to the Corporation for maintaining a dangerous environment for customers and workers. It is as though these 'failures' occurred randomly and without control, rather than at the hands of a highly profitable and sophisticated organisation.

Sentencing

In sentencing the offences under the *WHS Act*, the Magistrate applied the *Penalties and Sentences Act* (1992) and considered the High Court decision in *Wong v The Queen* (2001, p. 611) and *Nash v Silver City Drilling (NSW) Pty Ltd* (2017) (*Guilfoyle v Ardent* 2020, p. 2 [35]). The objectives of the *Penalties and Sentences Act* (1992) are stipulated under section 9(1) (emphasis added):

(a) to *punish* the offender to an extent or in a way that is *just in all the circumstances*; or
(b) to provide conditions in the court's order that the court considers will help the offender to be *rehabilitated*; or
(c) to *deter* the offender or other persons from committing the same or a similar offence; or
(d) to make it clear that the community, acting through the court, *denounces* the sort of conduct in which the offender was involved; or
(e) to *protect the Queensland community* from the offender; or
(f) a combination of 2 or more of the purposes mentioned … .

The Southport Magistrates Court in sentencing Ardent noted that 'greater culpability attaches to the failure to guard against an event, the occurrence of which is probable, rather than an event the occurrence of which is extremely unlikely' (*Guilfoyle v Ardent* 2020, p. 1), concluding that this was a case in which there was a risk of 'catastrophic' consequences and yet preventative steps available that 'were not that complex or burdensome and only mildly inconvenient and really were inexpensive' (*Guilfoyle v Ardent* 2020, p. 2). This contributed to a penalty of $A3.6 million – which fell short of the maximum available fine of $A4.5 million but was considered by the Court to be substantial. The Magistrate noted, '[t]he significant penalties which are available are indicative of the objectives seriousness of the offences' (*Guilfoyle v Ardent* 2020, [30]). The Judicial Officer regarded the maximum penalty as reflecting the 'objective seriousness of the offence'.

However, the public outcry demonstrated that the lives of the deceased were not honoured by the fine (Ransley, 2020; see also Matthews, 2019 for an analysis of the response of families of the deceased to OHS homicides). The public did not perceive the sentence

as giving appropriate weight to the harm to the victims or holding Ardent to account through punishment and denunciation. Indeed, the Sentencing Court minimised the culpability of the Corporation and the harm it caused. Instead, the Court emphasised Ardent's 'self-initiated' measures reduced the need for specific deterrence and indicated the Corporation's good character. The analysis that follows considers the application of the sentencing principles:

- **Punish offender in a way that is just in all the circumstances**: punishment should be proportionate to the gravity of the crime (*Veen v The Queen (No 2)* 1988, p. 472). Magistrate Dowse stated that 'punishment', along with denunciation, are 'paramount considerations' (*Guilfoyle v Ardent* 2020, p. 3), but did not explain how the sentence was proportionate or discuss the gravity of the crime.
- **Rehabilitation**: this is not directly addressed. It is likely that the consideration was folded into 'specific deterrence' – see below. Clough (2005, p. 118) notes that sanctions both deter and rehabilitate by inducing 'the corporation to change its internal structures and procedures to ensure future compliance with the law'.
- **Deterrence**: the Magistrate noted that specific deterrence was not needed due to 'post-incident measures', although general deterrence was regarded as relevant (*Guilfoyle v Ardent* 2020, p. 3). However, this interpretation of specific deterrence is short-term and relies on the ongoing good will of the corporation. It neglects the longer-term role that penalties play in the corporation's risk analysis (see ALRC, 2020, [8.16]).
- **Denunciation**: this is referred to in passing as a 'paramount consideration', along with punishment. No detail is provided.
- **Community protection**: this is only addressed in terms of the *WHS Act* serving to prevent the public being put at risk and to protect the health and safety of people affected by work. Its application to the current circumstances and sentence is not stipulated.

The Magistrate, however, did discuss in detail the lenience afforded to the defendant for the 'early guilty plea, their clear demonstration of remorse and contrition, its unreserved apology, its significant post-incident remediation'. In the Court's sentencing remarks, it emphasised the lack of the defendant's criminal record to demonstrate its good character. This representation obscures the ongoing Union concerns about serious non-compliance issues over many years. The sentencing courts need to come to terms with the fact that law enforcement is weak in relation to corporate culpability for breaches of safety standards (see ALRC, 2020, ch. 3). Therefore, the absence of criminal history is a weak indicator of the good character of a corporation and greater efforts need to be made to scrutinise the history of complaints made against the corporations.

The Magistrate stated that Ardent felt remorse by accepting 'the failings particularised in the complaints' (*Guilfoyle v Ardent* 2020, p. 5). Further, her Honour asserted that this had been 'demonstrated' through its 'thorough approach to learn from the past' (*Guilfoyle v Ardent* 2020, p. 5). Her Honour cited the immediate 'three-tier safety review and engineering review of all amusement devices and attractions across Dreamworld and WhiteWater World', following the deaths (*Guilfoyle v Ardent* 2020, p. 5). While significance is placed on remorse, Clough (2005, p. 118) points out, '[b]y its very nature the corporate entity does not, and cannot, suffer or feel shame'. Tangney and colleagues

emphasise that while remorse indicates guilt, 'shame is typically the more painful, disruptive emotion because the self, not simply one's behaviour, is the object of judgment' (Tangney et al., 2011, p. 707). Cynically, one might suggest that the immediate strategies to review safety are as much a branding exercise – to remediate its commercial reputation – as reflecting on guilt and learning from the past. The Magistrate continued to provide a lengthy account of the fabulous work Ardent had undertaken in terms more reminiscent of an advertising brochure rather than a critical analysis by a sentencing court (*Guilfoyle v Ardent* 2020, p. 5):

> They developed a safety case embracing the government's new major amusement park safety regulations. Ardent's safety case outlines how they will manage safety in both Dreamworld and WhiteWater World parks to the highest standard. Also, safety assessment processes have been developed, which is a holistic assessment process for each assessment device and attraction, which has been endorsed by the regulator.
>
> A new leadership team has been installed to drive its focus on continuously enhancing safety. The team comprises numerous experienced and well-regarded executives from theme park industry, with its engineering and safety teams led by professionals from Australian commercial aviation industry.
>
> They have a safety governance framework, a safety management system, which is supported by a globally recognised IT system. A document managing system. A platform which enables the park to effectively and centrally track, manage and store documents from all departments, to ensure integrity and safety assessment processes. Also, the emergency procedures have been re-written. Its park-wide emergency management plan improved evacuation procedures are for each amusement device.

This laboured consideration of Ardent simply maintaining the safety standards required by law occupies a substantial component (over one-third) of the relatively short remarks. These activities should have been carried out prior to the deaths (and punishment should have been applied for breaching safety standards for failing to undertake this broader safety work). Nonetheless, the Court's characterisation of Ardent's 'remedial' work indicate that sentencing is not so much focused on punishing the seriousness of the crime as accounting for subsequent remediation. This narrative runs against the grain of homicide cases committed by human actors in which the killings are given paramount attention, and any attempts at subsequent rehabilitation are treated as not compromising the 'objective gravity' of the offence (see, e.g., *R v Droudis (No 16)* 2017, [115]).

Fines

The pecuniary penalty of $A 3.6 million downplays the significance of the harm and the consequences. Ardent's Annual Report (2016, p. 39) documented that Ardent had revenue of $US 668,615,000 and a yearly net profit, after tax, of $US 42,387,000. The fine therefore has a negligible impact on disrupting corporate activities that enable reckless conduct and contribute to fatalities (Tombs & Whyte, 2009, pp. 145–146). Tombs and Whyte (2009) point out that corporate fines are characteristically a miniscule proportion of revenue. They point to the UK Cadbury salmonella outbreak in 2006 due to cost-saving measures on health checks, leading to an 'unprecedented' £1,152,000 fine, which represented a mere 0.0145% of revenue. They wrote, '[t]o put it another way, this is equivalent to a fine of £4.35 for someone earning, in 2007, what was the

UK average gross income of £30,000' (p. 147). Applying the same calculation, the Ardent fine of $A 3,600,000 is 0.539% of its yearly revenue. For the average Australian income earner ($A 43,422 gross), this would amount to a fine of $266.38 for four deaths.

Clough (2005, p. 120) also notes that workplace safety offences 'often seem derisory both in relation to the fact that a worker has been killed, and also in comparison to the wealth of the corporate offender'. He refers to the Australian example in which a $2 million fine was imposed on Esso Australia Pty Ltd, which was, at the time, the largest fine for a workplace offence in Australian history. However, the corporation earnt approximately $1 million per day from one operation, and its parent company, Exxon Mobil Corp, reported net income of approximately $US 18 billion the previous year. The result is that there is scant deterrent effect from the fine and a lesser burden on larger, more profitable corporations – those that can also be responsible for larger-scale crimes. Clough (2005, p. 120) concludes that there is 'a danger that for some corporations a fine will simply be seen to be a cost of doing business; a "public morality tax"' (Clough, 2005, p. 120).

While Clough (2005, p. 121) points out that sentencing imposes fines relative to the harm rather than the income of the perpetrator, the *WHS Act* provisions that were prosecuted were in relation to the breaches rather than the deaths. Sentencing courts therefore privilege the seriousness of the non-compliance of safety measures rather than the seriousness of the harm to the victim. This is evident in the Queensland Magistrate's remarks that focus on the fine reflecting the failure to implement safety measures rather than the deaths (*Guilfoyle v Ardent* 2020, p. 3):

> Whilst the defendant directed resources towards safety and implemented some control measures and improvements over time, its efforts were grossly below the standard that was rightly expected of it. A variety of control measures were available which would have minimised or eliminated the relevant risk. It was a company which had available to it resources to implement those control measures.

Even here, there is a minimisation of responsibility. Despite the imposition of a legal duty to ensure safety and the long-term failure to do so in the quest for profit, Ardent was not framed as a culpable agent.[9]

Business as usual

Guilty corporations cannot be sent to prison. This means that in the absence of meaningful penalties, corporations are able to return to 'business as usual' without structural change and accountability, while the families and friends of the victims of homicide continue to suffer (Tombs & Whyte, 2019). While imprisonment of responsible officers can promote scapegoats that conceal the criminality of the corporation's motives and cultures (Whyte, 2016), the sentence outcome and the immediate response of Dreamworld indicates that the penalty did not disrupt the life course of the corporation in the way that prison disrupts the life course of an individual.

In the 48 hours following the horrific deaths, the Board was focused on the financial impact on the company, which 'occupied a lot of the thinking', according to the

[9]On the harms generated by corporations in their quest to cost-cut and generate profits, see generally: Tombs and Whyte (2015).

Chairperson (Chung & Burke, 2016). In the following week, Ardent proceeded to hold its annual Board meeting to consider its share price and rebranding. The CEO refused to consider relinquishing a bonus that was approved on the day the four lives were taken at the hands of Dreamworld (Chung & Burke, 2016). Less than a week after the tragedy, with the family and loved ones of the victims still in a state of shock, Dreamworld decided to open its doors. This decision had to be retracted after Dreamworld was informed that it would pervert the investigation.

Resonating with the internal reporting on the Dreamworld deaths, Tombs and Whyte (2009, p. 147) describe Cadbury's Corporal and Social Responsibility Report as containing two paragraphs on the salmonella outbreak that maintained that the company 'had acted in good faith'. In Ardent's Annual Report (2017, p. 3), the deaths were benignly described as 'an incident on the Thunder Rapids River ride'. The reporting of the deaths was primarily in financial terms; as contributing to 'an impairment of goodwill of $0.8 million', a decline in property valuation, and an 'adverse impact' on income 'results' (Ardent, 2017, p. 2). Ardent congratulated itself on its 'successful completion of a multi-tiered mechanical and operational safety review' that enabled the reopening of the theme park (Ardent, 2017, p. 2), the establishment of a Community Advisory Committee to oversee the recovery from the incident, and its 'wellness and support programs [that] were established to assist individual team members with resilience and coping with challenging environments' (Ardent, 2017, p. 6).

It is irrefutable that Dreamworld suffered adverse publicity from the deaths of four people at the amusement park and an immediate drop in customer revenue. The Sentencing Court referred to the significant measures that the Corporation had to undertake in reviewing rides and enforcing safety measures. However, the activities of Ardent and the recovery of Dreamworld in recent years indicates that the fine itself has not had the type of ongoing punitive impact that applies to human actors. The deaths were a blip on the profit record, which was subsequently overshadowed by loss of sales from COVID-19 measures before the more recent recuperation of revenues. This shows that there was no prolonged impact on business activity and arguably no prolonged deterrent from causing injury and deaths in the future. Indeed, Ardent's Annual Report (2022, p. 7) noted:

> The Theme Parks business, consisting of Dreamworld, WhiteWater World and SkyPoint, reported trading revenue of $49.5 million for the year, up 37.3% on the prior year. This was mainly due to higher pass sales and attendances in the current period … The business is optimistic that the recovery in domestic and international tourism, as well as various guest initiatives implemented by management will continue to attract visitation to the venues and drive continued recovery momentum.

Conclusion

Our main point of critical intervention in analysing the deaths caused by Ardent at Dreamworld is to argue that the representations of the corporation in the inquest and sentencing downplay and neutralise Ardent's criminality. The relevant occupational health and safety provisions did not adequately characterise or account for the criminality and culpability of Ardent's crimes. This is a product of a grossly inadequate penal framework and the pecuniary penalty regime, which trivialise the significance of the Corporation's role in killing four innocent people. It is also a product of the ascription

of the crimes to the realm of 'failure' and 'tragedy' in the coronial findings and sentencing remarks, which undermine the Corporation's blameworthiness. Consequently, the legal outcomes fall short of disrupting corporate activities that enable dangerous conduct and can lead to deaths – including in the face of previous failures, incidents, and trade union warnings (Tombs & Whyte, 2009, pp. 145–146). This dangerous conduct was not accidental or isolated, but a result of cost-saving measures and choices that were made across many years in many different ways by the Corporation.

This article argued, based on an analysis of the Dreamworld inquest and sentencing, that legal hearings and judicial remarks fail to conceive of corporations responsible for the most serious of harms as criminally culpable. Instead, Ardent's harms were framed as collateral damage for otherwise responsible corporate conduct. The Sentencing Court perceived that Ardent's misconduct leading to the deaths could be remediated by simple corporate compliance, with minimal encumbrance on profits or disruption to business. While safety crimes continue to be treated less seriously than interpersonal harms, even where death occurs, there is impetus to re-examine how homicide laws can be reformed to bring corporations within the ambit of broader criminal law and hold corporations to account (Hebert et al., 2019; Tombs & Whyte, 2017).

We have argued that corporate damage is not a 'tragic' or 'accidental' consequence of corporate business; it is intrinsic to *core business*. In the endeavour to cost minimise, offset trade unions, and grow profit margins, safety takes a backseat. The law must provide a framework to recognise and express the culpability, violence and criminality of corporations that account for the harms caused by corporations that are well-resourced to minimise their occurrence. Instead, the safety framework of the *WHS Act* focuses on banal health and safety issues that are breached due to failures, which downplays the harms caused by corporations, including homicide (Hebert et al., 2019). This is reinforced in inquests and sentencing remarks, as we have demonstrated in relation to the Dreamworld deaths, that avoid reference to choices relating to cost minimisation and the overriding corporate goal to generate shareholder profits and managerial bonuses. Our conception of 'criminality as core business' means that fines must be set at levels that are threatening to business operations, otherwise human and environmental life will continue to be treated as expendable externalities in the drive for profits. Likewise, sentencing remarks must more clearly articulate the culpability of corporations as agents that make choices, leading to the actions and omissions across time that increase risks of homicide.

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