

The incident occurred on an amusement ride at a carnival site in Austin, TX. The carnival had been set up for two weeks and the incident occurred on the last evening of operation; at which time, they were going to store the rides at their winter quarters and not operate them again until spring.

The 9-year-old female decedent and her 8-year-old brother had previously ridden this ride earlier that evening without incident. The first time they rode the ride, the decedent sat on the outside of the tub. The 9-year-old decedent measured 55" in height and weighed 85 pounds. There is no known medical history.

Riders must be at least 42" tall to ride with an adult and 52" tall to ride without an adult. The decedent exceeded the manufacturer's rider height specifications.

On Sunday, December 18, 2005 at approximately 2126 hours, the decedent and her brother were riding the involved ride for the second time that evening. However, this time the decedent sat on the inside of the tub. They were in a blue tub and during operation; the ride's centrifugal force caused her to slide on the seat into her brother. In an effort to brace herself, the decedent gripped the lap bar and put both feet up on the rim of the foot tub.

The decedent came out of her seat and slid under the lap bar with her hands above her head. She landed on the steel deck of the trailer causing a loud crashing sound. The ride operator immediately stopped the ride, but not before a lower main sweep hit the decedent on the side of her head.

Emergency medical personnel were called to the scene. EMS transported the decedent to a local hospital with CPR in progress. Upon arrival, hospital staff continued resuscitation efforts to no avail. The decedent was pronounced at 2219 hours.

According to the medical examiner's investigator, the decedent's injuries were as follows: contusions to the upper left arm, the humerus appeared to be broken, her left

eye was swollen and she was bleeding heavily from both ears.

The autopsy was performed by the county medical examiner's office on December 21, 2005. The medical examiner's findings were as follows: Cranio-cerebral trauma with extensive skull fracture, including hinge fracture of base, scalp hematoma, intracranial hemorrhage, and direct contusion of cerebral hemisphere.

The decedent died as a result of craniocerebral trauma sustained in a carnival ride accident. The autopsy report and medical investigator's reports were obtained and are attached as exhibits #8 & #9.

The amusement ride owner stated that he had not had any similar incidents involving this ride. The owner purchased this ride used in approximately 1980. The owner believes the ride was approximately six years old when he purchased it.

Although the ride passed inspection post incident and the independent inspector released the ride, the owner stated that he was not going to operate this ride again. According to the Texas Department of Insurance (TDI), the owner plans to sell the ride.

On Monday morning, December 19, 2005, the owner of the amusement ride contacted the independent inspector and informed him of the incident. According to the TDI regulations, immediately after any injury or death on an amusement ride involving equipment failure, structural failure, or operator error, the ride shall be closed for public use until a new inspection is performed and an Inspection/Re-inspection certificate is submitted to TDI.

Also, in accordance with Chapter 2151, "Amusement Ride Safety Inspection and Insurance Act of the Texas Occupation Code", a quarterly injury report must be submitted to the Texas Department of Insurance to report a death or injury that required medical treatment. This report was obtained from the TDI and is attached as exhibit #3.

On October 6, 2005, this inspector had performed the annual inspection for this ride in order for this carnival to obtain a permit to operate this ride in Texas. It passed as being "satisfactory at time of inspection for operation" and the inspector submitted the Certificate of Inspection/ Re-inspection to TDI. This certificate and the Certificate of Liability Insurance were obtained from the Texas Department of Insurance and are attached as exhibits #2 & #4.

On December 19, 2005, the inspector made the scene at approximately 12:00 p.m. At 5:00 p.m., the police detective and a metallurgical engineer also arrived on the scene. The police department had hired the engineer as an expert for this investigation.

They observed blood stains on the steel trailer deck, on the steel sweep above the deck and on the grass next to the deck. Except for these blood stains, the inspector noted that this ride appeared to be in the same condition as it was during his prior inspection in October.

Witnesses stated that the decedent's brother was still sitting in the ride with the lap bar locked in place when the ride was stopped. The inspector observed that the lap bars and latches were in good working condition.

The lap bar consisted of a top bar that extended across the front of the tub and a lower bar, approximately 6" below the top bar that angled up to the top bar near the center of the tub opening. The fiberglass seat flared up approximately 4" to limit the opening under the lower bar.

At the time of the incident, the ride was running at 11 RPM per the manufacturer's specifications. One blue tub was not in operation with its foot tub locked up with large wire ties, so riders could not enter.

The inspector noted that the ride braked normally when the brakes were activated. The operator stated that there were riders in every seat at the time of the incident except for the one blue tub mentioned above. With the ride almost

being at full capacity, it would have slowed the brake time.

The braking system consists of a tire that rubs on a steel drum at each sweep. An inspection of the three tires showed that they were inflated properly and were not worn.

Tub #5, which was one of the blue tubs, had some vertical cracks in the fiberglass near the step of the foot tub. This had not been repaired as recommended on the October 6, 2005 inspection.

There was a rule sign posted at the entrance to the ride that said riders must be 42" high or less to ride. There was also a measuring sign at the entrance gate that said riders must be 48" to ride.

The owner of the ride advised that the signs posted at the ride's entrance were not for that ride. The owner later contacted the inspector and advised that the correct sign had been found under the ride when it was moved.

The inspector contacted the manufacturer and inquired as to the correct height limit for this ride. The manufacturer advised that riders must be at least 42" tall to ride with an adult and 52" tall to ride without an adult.

The inspector released the ride and noted on the field notes that the ride was satisfactory at time of inspection for operation. Further noted in the inspector's field report were the following conclusions:

1. There was no observable mechanical defect in the ride that contributed to this incident.
2. There was an opening in the lap bar where the lower bars angled up to the upper bar in the middle of the seat. A thin rider could slip out between the fiberglass seat and the lap bar.
3. Riders are instructed to stay seated and hold onto the lap bar while the ride is in motion. If the decedent had not taken her feet out of the foot

tub this incident probably would not have happened. Since her feet were on the rim of the foot tub, and she was wearing dress shoes that were slippery, she may have slipped when she braced herself from sliding into her brother.

4. The ride operator followed standard operating procedures in shutting down the ride as soon as he observed the incident.
5. Even though the height limits posted were not correct, the decedent exceeded the manufacturer's rider height specifications.

The inspector noted on the field notes under "Signage" the following statement: "Provide height limit sign of 42"-52" with adult and 52" to ride alone per manufacturer."

The inspector's report stated the following: "As with any inspection, the documented results are accurate only as of the time of the inspection. It is essential to have an ongoing maintenance and inspection program for all equipment in order to keep its condition at an appropriate level.

An approval by an inspector is not a guarantee or warranty of the condition of the equipment. The owner/operator has the ongoing responsibility to inspect, maintain, and operate the equipment in accordance with manufacturer's guidelines and all applicable codes, standards, and industry practices."

The inspector's field notes for the October and December inspections and the field report for post incident ride re-inspection were obtained and are attached as exhibits #5-#7.

PRODUCT IDENTIFICATION

Ride Name: "The Wisdom Sizzler"

Manufacturer: Wisdom Industries, Sterling, CO

Owner: Crabtree Amusements

Serial Number: 76124

IDI 051228CCC3222

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Date of Manufacture: 1974

Incident Location: 6301 Hwy 290 East, Austin, TX

The "Sizzler" ride consists of a main center shaft with three main sweeps that each have four tubs rotating on a vertical shaft while the main shaft rotates. The capacity of the ride is three riders per tub and twelve tubs for a total of 36 riders.

The ride is supported by the trailer resting on the ground with the axle and wheels removed. The ride operates in a 50' diameter circle with an aluminum fence on its perimeter. The center shaft rotates at 11 RPM and each sweep shaft rotates at 33 RPM in a clockwise direction on a horizontal plane. The ride cycle is usually 7-10 revolutions.

ATTACHMENTS

1. Identity of Respondents
2. TDI Certificate of Inspection, dated 10/6/05
3. TDI Quarterly Injury Report
4. Crabtree Amusements' Certificate of Liability Insurance, 3 pages
5. Inspector's Field Notes, dated 10/06/05
6. Inspector's Field Notes, dated 12/19/05
7. Inspector's Field Report & Photos, 10 pages
8. Medical Examiner's Report of Investigation, 2 pages
9. Autopsy Report, 5 pages
10. Missing Document

051228CCC3222
Attachment #1

IDENTITY OF RESPONDENTS

This case was initiated on December 21, 2005. Efforts to obtain the police report, photos and videotape were met with negative results. In addition, the police detective requested that this Investigator not contact the ride operator or other witnesses since the police investigation was still an open case.

Paul Zellar, Inspector
MAH05, Inc.
P.O. Box 1137
Zephyrhills, FL 33539
352-797-9292

Detective Doug Skolaut
Austin Police Department
715 E. 8th St.
Austin, TX 78701
512/974-5092

Texas Department of Insurance
Property & Casualty Program - Loss control Regulation
Ms. B.J. Morris, TX Amusement Ride Administrator
P.O. Box 149104
Austin, TX 78714
512/322-3437

Darlene Dunn, Office Manager
Travis County Forensic Center
1213 Sabine St.
Austin, TX 78767
512/854-9599

Pat Crabtree, Owner
Crabtree Amusements
Staples, TX 78670
512/357-6840