REPORT OF THE SOLICITOR-GENERAL

REQUEST FOR SECOND INQUEST: KENNETH JOHN RICHARDS

27 MAY 2005

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SOLICITOR-GENERAL

27 May 2005

Attorney-General

Request for Second Inquest: Kenneth John Richards
Our Ref: ATT114/1389

Background

1. On 20 June 1997 the Coroner at Taumarunui, Mr T Scott, gave an oral decision concerning the death of Kenneth John Richards. Mr Richards was a bee keeper who was driving a vehicle which broke through the decking of a swing bridge over the Retaruke River at Te Rata. Mr Richards dropped some 30 metres to his death in the river below. The Coroner's oral decision was subsequently reduced to writing and distributed to the parties on 27 June 1997.

2. The bridge had been designed and built by the Army in March 1986 at the request of Mr and Mrs Berryman of Te Rata Farm, as a training project, to replace a previous bridge which had collapsed. The work was carried out under the immediate supervision of Second Lieutenant (later Major) Armstrong. On 22 March 1994, two of the transoms (or beams) supporting the decking failed under load, having lost significant strength on account of weathering or decay, and as a result Mr Richards' vehicle fell through the decking.

3. In his decision, the Coroner commented adversely about:

   3.1 The Army, on the basis that the person in charge of the construction of the bridge, Second Lieutenant Armstrong, was a junior officer with very limited practical experience and limited technical qualifications. The Coroner accepted, however, that the construction of the bridge was "completely adequate".

   3.2 Mr Richards, on the ground that he crossed the bridge at a speed in excess of 5kph, which was "more than was prudent in the circumstances".

   3.3 Mr and Mrs Berryman, on the basis that once it was constructed the bridge was their responsibility, and they did not put in place a regular and planned programme of inspection and maintenance for it and did not act on warning signs that the bridge needed attention. The Coroner accepted, however, that Mr and Mrs Berryman did not have actual knowledge of how dangerous the bridge had become.

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4. Dr R Moodie, who is acting for Mr and Mrs Berryman, alleges that the inquest miscarried as a result of wrongful conduct by, in particular, the Army. Specifically, Dr Moodie says that the Army did not advise the Coroner that it had held a Court of Inquiry which had identified structural defects with the bridge and did not make available to the Coroner a report prepared by an engineer, Mr G Butcher, for that Court of Inquiry. The suggestion is that had that material been available to the Coroner, the outcome of the inquest would have been different, and the Coroner would have exonerated Mr and Mrs Berryman.

Request

5. In light of Dr Moodie's allegations you have asked me to consider whether I should order a new inquest under s 38 of the Coroners Act 1988, or apply to the High Court under s 40 of that Act for an order that there be a further inquest. Subsequently, on 10 May 2005, Dr Moodie wrote to me confirming that Mr and Mrs Berryman were formally asking that I exercise my powers under s 38 or s 40.

6. In considering this matter I have had access to the Coroner's determination and the material before him, and to the report of the Army Court of Inquiry and the material before the Court (including the so-called "Butcher Report"). I have taken all of this material into account, whether or not it would all be admissible in an inquest.

7. For ease of reference, my conclusions are summarised at paragraphs 116 to 119 below.

Approach

8. I propose to deal with the matter under the following headings:

   8.1 Pre-inquest events, specifically the OSH prosecution and the Army Court of Inquiry.

   8.2 The inquest, and specifically the respective stances of the Army and the Berrymans at the inquest.

   8.3 Previous requests for a new inquest from Mr and Mrs Berryman.

   8.4 The Berrymans' judicial review applications.

   8.5 Principles applicable to requests for new inquests.

   8.6 Discussion of this request.

Pre-Inquest Events

9. Prior to the Inquest there were two significant events – the bringing of a prosecution against Mr and Mrs Berryman by Occupational Health and Safety ("OSH") and the holding of a Court of Inquiry by the Army. I deal briefly with each in turn.

OSH prosecution

10. Shortly after the accident occurred, OSH commenced an investigation. That culminated in the laying of three charges against the Berrymans under the Health and Safety in Employment Act 1992 ("the HSE Act"). Two of those were ultimately withdrawn, leaving one charge against Mr Berryman to be dealt with.

11. Mr Berryman was charged on the basis that as an occupier of a place of work (i.e. the bridge) he failed to take all practicable steps to ensure that Mr Richards was not harmed in that place of work, contrary to ss 16(a) and 50 of the HSE Act. The parties requested a preliminary hearing before the substantive hearing to determine two legal points, a request to which the Judge agreed. The preliminary hearing proceeded on the basis of largely undisputed facts.

12. In a decision given on 22 February 1996, Abbott DCJ ruled that while there was sufficient evidence to justify a finding that Mr Berryman was the "occupier" of the bridge within the meaning of s 16 of the HSE Act, the bridge was not a "place of work" within the meaning of that section. Accordingly, the charge against Mr Berryman could not succeed and the Judge dismissed it (*Department of Labour v Berryman* [1996] DCR 121). OSH filed an appeal against this decision, but ultimately did not proceed with it.

Army Court of Inquiry

13. The Army conducted a Court of Inquiry into "the construction of a wooden suspension bridge over the lower Retaruke River, Te Rata Station in March 1986 and its subsequent collapse during use on the 22nd March 1994". The Court's Terms of Reference required the Court to respond to 26 questions.

14. The Court conducted its inquiry during September 1994. It received evidence from 4 witnesses – Major Armstrong, Mr Vincent (a retired member of the New Zealand Army who was senior NCO on the bridge construction project), Mrs Berryman and Mr Butcher. In addition, it received a number of exhibits.

15. One of the questions put to Major Armstrong concerned the suitability of the materials used in the construction of the decking. He answered:

> "The materials were suitable for the task for which they were designed, provided that regular inspection and maintenance was carried out. It is my recollection over the course of various discussions with the farmer [i.e. Mr Berryman] that I got the impression that he viewed the materials as a short-term solution, to gain access to his property, to enable it to generate income and in time the bridge would have some components replaced with more permanent materials."

Major Armstrong was later asked about some load recalculations that he carried out. He answered:

> "To the best of my recollection on at least one occasion Mr Berryman phoned me during the procurement of materials, explaining he could not afford the materials specified but could obtain an alternative should they prove suitable. As a result I recalculated the design taking account of the characteristics of the alternative materials and when they proved suitable advised Mr Berryman that these alternatives would suffice."

16. Both Major Armstrong and Mr Vincent said they thought the timber would have been treated.

17. In her evidence, Mrs Berryman explained the background to changes made to the components of the bridge. The original design called for wooden towers. However, Mr and Mrs Berryman decided to have the towers fabricated in steel. Mrs Berryman said:

> "We took John Armstrong to see Mr Wilf Emmett of Emmett Bridge Builders in Wanganui either in December or January, because we wanted to upgrade the towers from wood to steel.
>
> The reason for changing the towers was that the original bridge had collapsed due to the wooden towers rotting at ground level.
>
> Because of the increased cost of steel towers we were forced to change to second-hand timber for the rest of the bridge. The timber was purchased from Wanganui Demolitions. I understand the timber came from the Ismlay Freezing Works in Wanganui. The Oregon was imported Canadian. This was used for the transoms and stringers, the deck was made from totara and the handrails etc., were made from macrocarpa milled off the property. We also added Oregon running boards. To the best of our knowledge the timber was not treated. There is no need to treat these timbers.
>
> ....
>
> The bridge was officially handed over at a ceremony on the 23 March. This included the signing of an indemnity document by John [Armstrong], Keith [Berryman] and a local J.P. which handed over all responsibility to us."

18. Mrs Berryman was asked what, in her opinion, contributed to the collapse of the (army-built) bridge. She replied:

> "Overloading of the vehicle and speed."

Mrs Berryman then set out the basis for her view. She also said that she and her husband had carried out some repairs to the decking and emphasised that they never had any doubts about the safety of the bridge.

19. The Court summarised its conclusions as follows:

> "25. The Te Rata Station bridge collapsed on the 22 March 1994 due to the failure in bending of a timber transom when subjected to a rear axle load of 23kN (about 2350 kg) of a vehicle crossing the bridge.
>
> 26. The transom has been determined as being capable of supporting the imposed load providing the timber was in good condition. The transom timber was Oregon which has a short life when exposed to the weather or when subject to alternate wetting and drying. The Oregon member failed as a result of loss of strength caused by weathering over a period of time.
>
> 27. The design of the deck structure can not be considered as adequate for the bridge's intended use. The inadequacies of the design procedure however did not contribute to the failure of the transom nor to the resulting collapse of the section of the bridge deck.
>
> 28. The Army members involved in the bridge's construction recognised the landowners' financial constraints and believed the bridge to be a short term solution to

> provide access to generate income and in good faith constructed the bridge using the materials supplied.
>
> 29. The landowners fully accept their responsibility in regard to the bridge and in no way hold Army responsible for its failure.
>
> 30. Of concern to the Court is the lack of Army records on the Te Rata bridge project and the lack of procedures to ensure that a design check was carried out.
>
> 31. In the Court's opinion Major Armstrong, Sgt Vincent and the members of the MAP construction troop have no liability."

20. In addition to the oral evidence, the Court had before it engineering reports prepared by Works Consultancy Services and by Mr G Butcher. I now deal with those reports.

Works Consultancy Services

21. Works Consultancy Services prepared two reports on the instructions of Mr and Mrs Berryman. Mrs Berryman made these reports available to the Court of Inquiry when she gave evidence before it.

22. The first Works Consultancy Services report, prepared by Mr Charles and dated 5 April 1994, examined "the capacity of the structure, the cause of the failure and the necessary remedial work to reinstate the structure to its original load rating". The report assessed the design and construction of the bridge against the relevant New Zealand Standards.

23. Having identified the bridge's design parameters, Works Consultancy Services carried out a design check. It revealed that:

> "The 75x150 totara decking and the 300x150 Oregon transoms are **capable** of safely supporting a 10kN (1 tonne) wheel load (note the originally detailed 200x200 transoms were substituted with alternative 300x150 transoms during construction).
>
> The 150x75 Oregon stringers spanning 2.65m (note the originally detailed 150x100 stringers were substituted by alternative 150x75 stringers during construction) are **not capable** of safely supporting a 10kN wheel load or 1 tonne wheel load.
>
> All members are capable of supporting the distributed load of 5 tonnes along the bridge.
>
> ....
>
> These calculations indicate that the **least likely member to fail** due to inadequate strength is the transom followed by the decking and stringer."

In other words, the report identified a significant design defect with the bridge as built, namely that the stringers were incapable of supporting the design load. The report went on to say:

> "This bridge was constructed from second-hand untreated timber. The age of this timber is uncertain. Assuming that all timber members were in good order at the time of construction the working life of untreated timber is severely limited.

> The current appearance of the timber deck is poor. Moss overgrowth and surface debris is present on all timber elements. The transoms and stringers show signs of rot and dampness."

24. In terms of the causes of the failure of the deck, the report said:

> "Two transoms supporting the timber decking and associated traffic load have failed in bending.
>
> The estimated maximum wheel load at the time of failure was 8.5kN (0.85 tonne). This represents an Equivalent Axle Load of 17kN (or 1.7 tonnes) for a Nissan 4x4 Diesel Land Cruiser with 750kg of surcharge.
>
> A wheel load of this magnitude suggests the member most likely to fail is the stringer (when the wheel load is directly above the stringer, as is the case with the position of the running boards). Accepting that a small amount of load sharing will occur this member has not failed.
>
> The transom is well capable of taking the 17kN (1.7 tonne) imposed axle load providing the timber is in good condition. **The member has failed as a result of loss of strength caused by weathering over a period of time.**
>
> This valley experiences little wind and is often subjected to heavy fog for periods of six months at a time. Such exposure over time has weakened the transom to a condition where it can no longer sustain loads it was designed for."

25. The report later said that the transoms had suffered a significant reduction in strength during their working life. This makes it clear that the design defect (under-strength stringers) did not cause the failure of the decking.

Mr Butcher

26. Mr Butcher, a civil engineer and Colonel Commandant of the Corps of Royal New Zealand Engineers from 1986 until 1993, was asked by the Court of Inquiry to comment on certain questions in its terms of reference from an engineering perspective. By the time that Mr Butcher was asked to undertake this work (September 1994) the bridge had been rebuilt, so that Mr Butcher (unlike Works Consultancy Services) was not able to see the bridge in its original, but damaged, state. Instead, Mr Butcher relied on the work done by Works Consultancy Services, the available photographs and his discussions with the Berrymans and Army personnel.

27. Like Works Consultancy Services, Mr Butcher concluded that the design of the deck was not adequate for the bridge's intended use but that this had not contributed to the collapse of the decking. He said:

> "I understand from Mr Berryman that the final design prepared by Lt Armstrong was subject to review by Mr Berryman and Mr W Emmett, a Wanganui Bridge Contractor and some changes were made to the towers, cables and the connection of the cables to the anchorages. The decision was also made at about this time to use second-hand Oregon from the Imlay Freezing Works and available from the Wanganui Demolition Co for the construction of the timber deck structure. This was in place of the more expensive treated Pinus radiata allowed for in the earlier designs prepared by SME. Totara was however used for the decking.
>
> ....

> There were several technical errors and errors of judgment in the design calculations, two of which involved the design of the transoms and by good fortune were self cancelling.
>
> ....
>
> In my opinion the design procedure for the timber deck structure was unsatisfactory and resulted in variable load factors and stringers that were undersized. It was fortuitous that the owner elected to install substantial running planks over the stringers during construction of the deck and kept them well nailed throughout the life of the bridge. Full or partial composite action with the stringers was thus possible and together with greater transverse load distribution provided additional stringer load capacity not taken into account in the design.
>
> As a result, I can only conclude that the design of the deck structure could not be considered as adequate for the bridge's intended use. The inadequacies of the design procedure however did not contribute to the failure of the transom nor to the resulting collapse of the section of the bridge deck."

28. Mr Butcher said that the collapse occurred as a result of the failure of a transom which, although initially adequate in terms of its nominal strength against bending, had lost strength as a result of decay. Mr Butcher did not consider that the use of second-hand Oregon timber was appropriate for the deck structure of a bridge which was intended to be permanent or semi-permanent.

29. Mr Butcher analysed the design process and concluded:

> "It can be seen that significant changes were made to the structure between the Oct/Nov 1985 design and the time of construction. Not only were timber species of lesser durability introduced but also member sizes reduced despite the increase in the live loads. Undoubtedly the Owners as suppliers of the materials influenced many of these changes.
>
> ....
>
> The concept of the structure and construction, apart from the durability of the species used, were in my opinion appropriate and applicable. I am not in a position to comment on the construction methods employed at the time in the building of the bridge."

30. Mr Butcher concluded his report by identifying two additional factors which contributed to the collapse. They were:

> "(a) The decision to use two 300x75 beams bolted together for the transoms in place of a solid 300x150 member. The interface was not flashed and permitted the entry of water to the centre of the laminate which, with the oxygen available in the gap, encouraged fungal growth and accelerated the rate of decay. The effective life of the member would have been significantly reduced as a result.
>
> (b) The importance of a regular inspection and maintenance programme for the bridge as a whole and the structural components of the timber deck-structure in particular, does not appear to have been recognised by the owners of the bridge."

31. In summary, then, both Works Consultancy Services and Mr Butcher:

    31.1 Noted design faults with the bridge, but said that they had not contributed to the collapse of the decking;

    31.2 Identified the failure of one or more transoms under load as the immediate cause of the collapse;

31.3 Said that decay or weathering caused the transoms to fail;

31.4 Raised issues about the longevity (and therefore suitability) of second-hand untreated Oregon for the deck structure in the particular environment.

The Inquest

32. Mr Richards died on 22 March 1994. The inquest did not begin until 7 February 1997. The principal reason for this lengthy delay was that, as contemplated by s 28 of the Coroners Act, the inquest was deferred until the OSH prosecution was resolved. There were then difficulties over the grant of legal aid to the Berrymans for the inquest, which caused further delay.

33. By way of overview, the inquest began on 7 February 1997 with the taking of evidence, which continued on 14 February and 18 April 1997. On 2 May 1997, in accordance with his obligations under s 15(2), the Coroner advised that he intended to make potentially adverse comments about the Army, specifically Second Lieutenant Armstrong, about the deceased, Mr Richards, and about Mr and Mrs Berryman. On 9 June 1997 the Coroner wrote further to the parties indicating that he might make adverse comment about the evidence of Mr and Mrs Berryman, which he considered to be "guarded and self-serving". The parties filed closing submissions in writing (by 12 June 1997), and presented oral submissions to the Coroner on 20 June 1997. Following that, the Coroner gave his decision.

34. Turning now to the detail, Billings (the New Plymouth law firm acting for Mr and Mrs Berryman) wrote to the Coroner on 17 January 1997 raising the question of the scope of the Coroner's Inquiry. Their letter (which was copied to the lawyers for OSH and Ms Thomason) read in part:

> "In one sense the establishment of the items referred to in s.15(1)(a) of the Coroners Act 1988 is a very straightforward and self-evident matter requiring virtually no more evidence than already appears in the report prepared by the Police for you (although we should mention that our clients dispute some of the contents). It is quite obvious that Mr Richards died, what his identity was, when and where he died, what the immediate cause of death was and the immediate circumstances of his death.
>
> If however you consider it part of your task to go further back up the chain of causation which led to the death and to embark on an investigation into <u>why</u> the vehicle fell through the bridge then several other issues inevitably arise including:
>
> (a) The condition of the bridge;
> (b) The weight of the vehicle at the time;
> (c) The speed at which the vehicle was being driven; and
> (d) The general manner in which the vehicle was being driven.
>
> Our clients suspect that a combination of these factors lead to the accident but they seek directions on the extent to which you consider it is appropriate to investigate those matters. Your view on this has a significant impact on the nature of the evidence which you might be willing to consider and on the time which the hearing will take. If matters such as those above are to be considered then clearly expert engineering evidence would be admissible and appropriate. Whether such evidence would ultimately allow you to do more than conclude that several contributing factors were involved is debatable.

> It seems to us to be quite a difficult line to draw between investigating the circumstances of the death in the strict sense (and investigating what preceded it to the extent of examining the various factors which may have been involved) on the one hand and considering the responsibility of the various parties involved in those circumstances on the other hand.
>
> Our clients are concerned that the hearing may end up focusing either directly or indirectly on the state of the bridge and their responsibility for that even though strictly speaking the finding of fault is not one of the issues to be resolved. We suspect that on behalf of her deceased partner Ms Thomason probably feels that she may need to "defend" him against any suggestions there may be that the vehicle was overloaded or being driven too fast or otherwise in an inappropriate manner."

35. The Coroner wrote back advising that the items outlined at points (a) to (d) in the passage quoted above were clearly matters which he must address and also said that he took careful note of the three paragraphs which followed those points. The Coroner later added to this that he would expect evidence to be led in relation to:

> "Backgrounding the matter, with evidence possibly from Mr or Mrs Berryman, from Mr Richards' former partner [i.e. Ms Thomason] ... and from the relevant Labour Department Inspector.
>
> Technical evidence if appropriate as to the state of the bridge and the vehicle."

These letters were also sent to the Police and the representatives for OSH and Ms Thomason. Consequently they, and Mr and Mrs Berryman, were aware that the state or condition of the bridge was an issue about which the Coroner wished to hear.

36. In the event, evidence was given by:

36.1 Detective Constable Anstis;

36.2 Major Armstrong of the Royal New Zealand Engineers;

36.3 Mr P D McConkey, a Health and Safety Inspector with OSH;

36.4 Mr P J Armitage, a Registered Civil Engineer employed by OSH;

36.5 Ms Mary-Anne Thomason, Mr Richards' partner;

36.6 Mr Berryman;

36.7 Mrs Berryman;

36.8 Mr C C O Marks, a Mechanical Engineer retained by Mr and Mrs Berryman;

36.9 Mr M J Vincent, formerly of the New Zealand Army;

36.10 Dr H M I Liley, who was not called but provided letters dealing with the cause of death.

37. In broad terms, besides the immediate cause of death, the evidence covered:

37.1 *The background to the design and construction of the bridge, and the deck structure.* On the latter aspect, the evidence was that the transoms and other

elements of the deck had been constructed of second-hand untreated Oregon (rather than the Macrocarpa or treated Pinus radiata specified). This was essentially to save cost, as a result of the greater expense of having the towers fabricated in steel, although Mr Berryman also claimed that timber in the sizes specified in the plans was not available from timber merchants. Mr Berryman gave evidence that he had received advice about the second-hand Oregon from a carpenter friend, Mr Toy, and that Major Armstrong had approved its use prior to or at the time of purchase. This point was not put to Major Armstrong as no party required him to be present for questioning; but obviously the Army built the bridge using the Oregon timber. The evidence showed that the transoms were made of two lengths of Oregon bolted together. Mr Berryman explained this as follows:

> "Some of the timber sizes specified in the plans were simply not available from the timber merchants but any timber changes made were for larger and not smaller sizes, e.g. instead of 200x200 transoms we used 300x150, understanding that the deeper the timber the stronger it is. In fact what was done was to have 2 300x75mm timbers bolted together to achieve this overall size of 300x150."

37.2 *The immediate cause of the accident.* It was clear that the immediate cause of the accident was the failure of two of the transoms due to decay.

37.3 *The condition of the decking at the time of the accident.* The evidence of Mr McConkey and the engineer, Mr Armitage, both OSH employees at the time of the accident, was that the decking was in poor condition and showed obvious signs of being in need of maintenance and repair. Mr Armitage said:

> "Overall the appearance of the bridge in question was of a "very old" bridge, badly in need of maintenance. I consider that a key factor relating to the collapse of this portion of the bridge was the inspection and apparent lack of maintenance of the bridge."

Mr McConkey said that the transoms showed signs of decay along the line where the two parts were joined and around the bolts. Photographs were adduced in evidence which showed the general condition of the bridge. It was covered in lichen, some of the decking planks were obviously rotten, and on at least one transom there was vegetation growing from the join where the two lengths of timber were bolted together. Mr Marks, the Berrymans' expert witness, said that the transoms which failed had clearly suffered a significant loss of strength over time and, sooner or later, were going to fail. Under cross-examination, Mr Marks said:

> "From what I can see and the brief calculations I made relating to bridge strength it appeared that the deterioration of the timber was a major factor."

However, Mr and Mrs Berryman contested the evidence as to the state of the bridge, and emphasised that they and their family had continued to use it.

37.4 *The responsibility for the maintenance of the bridge.* When the Army handed over the bridge to the Berrymans, Mr Berryman signed an agreement whereby he acknowledged that he was assuming full responsibility for the bridge as from 23 March 1986. He agreed (among other things) that he was "satisfied

with the materials used in construction of the bridge", that he was aware that maintenance of the bridge was his responsibility, and that "the effective life of the bridge will be limited by maintenance of components". In his evidence at the inquest, Mr Berryman acknowledged that in practical terms he accepted responsibility for maintaining the bridge. He also said that from the outset there were improvements and upgrades to the bridge that he had intended to carry out, including replacing the wooden transoms with steel ones. Mr Vincent's evidence was:

> "From time to time during the construction process the issue of maintenance was talked about with Mr Berryman and there was discussion about the need to replace items of the bridge where inspection revealed deterioration."

The evidence disclosed that Mr Berryman had done some repair and maintenance work to the bridge over the years, and had made an enquiry of the bridge building firm, Emmetts, about a year before the accident concerning the replacement of the Oregon transoms with steel transoms. However, he had not followed up that inquiry. Mr Berryman did not have a programme for inspection and maintenance of the bridge, apart from his observations when he used it. There were no signs on the bridge concerning allowable weight or speed.

37.5 *The content of discussions before the accident concerning Mr Richards' proposed use of the bridge.* Mr and Mrs Berryman gave evidence about conversations with Mr Richards and with Ms Thomason on the morning of the accident. They said that they had advised each of them that, unlike the previous year, Mr Richards should not drive his heavy truck across the bridge but should use his lighter vehicle and keep the overall weight and speed down. Mr Berryman also told Mr Richards that if he had doubts about the safety of the bridge he should use an alternative access route.

37.6 *The speed at which Mr Richards had crossed the bridge, and the weight of the load on his vehicle.* Mr and Mrs Berryman called Mr Marks to give his expert opinion that Mr Richard's vehicle was travelling at 15-20kph when it crossed the bridge. There was also evidence about the combined weight of the vehicle and its load.

38. Three matters which were not addressed either at all or in any detail in the evidence were:

38.1 Design faults with the bridge. The OSH engineer, Mr Armitage, did say that he considered the construction of the bridge to be "rather light". When asked about this by the Coroner, Mr Armitage identified the stringers as being light for the bridge's load limit, but the point was not taken further.

38.2 What working life could be expected of the second-hand untreated Oregon used in the deck structure, although Mr Armitage did emphasise the critical importance of periodic inspection and maintenance processes generally in relation to such a structure.

38.3 The lack of flashing on the transoms.

I return to these aspects at paragraphs 110-115 below. I deal now with the respective positions of the Army and the Berrymans at the inquest.

Army's stance at the Inquest

39. Under s 23(1) of the Coroners Act, the Coroner who is to hold an inquest must fix a date, time and place for it, and must instruct the Police to advise those details to everyone who has a sufficient interest in the inquest or its outcome, or anyone else whom the Coroner considers should be notified. Section 23(2) provides a list of those who must be notified under s 23(1). This list includes "every person whose conduct, in the opinion of the senior member of the Police in the place where the inquest is to be held or the Coroner, seems likely to be called into question".

40. As far as I am able to determine from the file, the Coroner did not instruct the Police to advise the Army of the details of the inquest. OSH, Mr and Mrs Berryman and Ms Thomason were advised, however. As a consequence, the Army was not party to the pre-inquest correspondence, including that about the scope of the inquest.

41. The Police did have dealings with Major Armstrong in connection with the inquest, however. As he was responsible for the design and construction of the bridge, OSH proposed to call him as a witness in the prosecution of Mr Berryman. In that capacity he had prepared a brief of evidence which was available to Abbott DCJ. For the purposes of the inquest Major Armstrong was asked by the Police to prepare a brief of evidence, which he did. The Police tendered this brief to the Coroner formally at the hearing on 7 February 1997. Major Armstrong was not required by any party to attend the inquest for cross-examination or further questioning. On 11 February 1997 the Coroner sought details of Major Armstrong's qualifications and experience at the time the bridge was designed and constructed. Major Armstrong provided these by letter dated 12 February 1997.

42. The Army was not represented at the inquest on 7 or 12 February 1997. On 18 February 1997 the Army wrote to the Coroner asking to be notified of the date on which the inquest would be resumed and indicating that it wished to appear, especially if the Coroner was considering whether to make any adverse comment about the Army. The Coroner replied on 19 February 1997, indicating that there had to that point been two days of hearing but that he would advise the Army when the inquest was to resume and that he had no objection to the Army, or Major Armstrong personally, being represented. As a consequence, the Army was represented by counsel when the inquest resumed on 18 April 1997 and called some additional evidence from Mr Vincent who, as a Staff Sergeant, was the senior NCO in charge of the construction of the bridge. The Army also filed written closing submissions and supported them orally before the Coroner on 20 June 1997.

43. The Army did not inform the Coroner that it had held a Court of Inquiry, nor did it provide the Coroner with the Court of Inquiry's report, or with any of the evidence or expert reports presented to the Court. Rules 158 and 159 of the Armed Forces Discipline Rules of Procedure 1983, made under s 150 of the Armed Forces Discipline Act 1971, are relevant in this context.

44. Rule 158 deals with admissibility. Rule 158(1) provides:

> "(1) Subject to the succeeding provisions of this rule, the record of proceedings, and any evidence in respect of the proceedings, including any confession, statement, or answer to a question made or given by a person during the proceeding, shall not be admissible in evidence against any person in any other proceedings, judicial or otherwise."

Rule 159 deals with disclosure. It provides:

> "The record of proceedings shall not be disclosed to persons not subject to the Act without authority from a superior commander of the service concerned, nor shall it be disclosed to persons subject to the Act unless such persons need to be aware of the contents to enable them to perform their service duties, or are entitled to a copy under Rule 155 of these rules."

45. The importance of the Court of Inquiry process was emphasised by the Courts Martial Appeals Court in *Neave v R* (1995) 9 PRNZ 40:

> "The Court of Inquiry has been part of the regular procedures of the armed forces for many centuries. We agree with Mr Stainton's submission that the present day provisions in the Act and the Rules of Procedure when read together disclose an intent to give a superior commander an expeditious fact finding procedure so that a matter can be promptly investigated and if necessary, prompt, remedial action can be taken. Expedition, frankness, and the minimisation of legal niceties are the underlying themes. Accepting the validity of these points we see RP 158 as an essential provision in the achievement of these aims." (at p 51 *l* 40 – p 52 *l* 4)

46. Wild J held in *Berryman v Solicitor-General* (Unreported, Wgtn HCt, CIV 2003 485 1041, 18 February 2005) that the effect of Rule 158 was that Mr Butcher's expert report was not admissible at the inquest against any person (at paras [72]-[74]). The Berrymans have not appealed that decision, and so it must be accepted as stating the correct legal position.

47. The Army's written submissions contained a number of general observations and then dealt with the specific points of criticism that the Coroner had advised (in his letter of 2 May 1997) that he was considering making in relation to Second Lieutenant Armstrong.

48. Among the written submissions was the following:

> "8. Apart from an issue raised by one of the witnesses concerning incorrectly fitted clips on the dropper cables (which did not in any way cause or contribute to the accident) the conclusion is that the bridge was properly designed and constructed and fit for its intended use when it was handed over."

49. In his costs judgment in *Berryman v Solicitor-General* (Unreported, Wgtn HCt, CIV 2003 485 1041, 11 May 2005) Wild J notes other similar passages from the Army's closing submissions and concludes:

> "... I agree with Mr Moodie that the Army's submission to the Coroner that it had built the bridge in a proper manner, and that nothing in the entire construction of the bridge had contributed to the accident, was wrong, and that the Army either knew, or ought to have known, that it was wrong." (at para [54])

50. I also agree. While the Army's submissions must be viewed in the context in which they were made, namely that the evidence had established that the bridge had become the Berryman's responsibility on completion and showed that the deck

structure had weathered and decayed over time to the point that the deck had become unsafe, they were not consistent with the findings of the Army Court of Inquiry and should not have been made. Rule 158 imposed restrictions on what material from the Court of Inquiry was admissible at the inquest. But that does not justify the advancing of a submission which the Army, as an organisation, should have known was inaccurate or misleading - see *In re Captain C J Kelly* (1997) 161 JP 417 per Pill LJ.

Mr and Mrs Berryman's stance at the Inquest

51. The law firm Billings represented Mr and Mrs Berryman at the inquest, as they had in the OSH prosecution. As it turned out, the legal aid grant made to Mr and Mrs Berryman for the inquest was insufficient to cover the four days of hearings, so that they had legal representation on 7 and 12 February and 18 April 1997 but not on 20 June 1997 when closing submissions were delivered. Rather, Mr Berryman prepared written submissions for himself and Mrs Berryman and filed them with the Coroner. He also delivered oral submissions on 20 June.

52. The Berrymans' case throughout, both before the Army Court of Inquiry and at the inquest, was that the cause of the accident lay not in the condition of the bridge but in the way that Mr Richards crossed it. Specifically, Mr and Mrs Berryman's case was that Mr Richards had driven too fast across the bridge and his vehicle was overloaded. As Mr Berryman put it in his written submission to the Coroner:

> "I believe our feelings that Ken [Richards] was the hazard and not the bridge are fully justified, as we now know that he did travel at an excessive speed on this bridge, despite our warnings and had we not been so emphatic regarding the weight, then the vehicle undoubtedly would have been grossly overloaded."

In addition, Mr and Mrs Berryman placed some emphasis on the fact that Mr Richards was not wearing a seatbelt at the time of the accident.

53. In support of their view that Mr Richards was travelling too fast across the bridge, Mr and Mrs Berryman called an expert witness, Mr Marks, a mechanical engineer. On the basis of his calculations he expressed the opinion that Mr Richards' vehicle was travelling within the range 15-20kph per hour when it crossed the bridge. In addition, Mr and Mrs Berryman conducted various experiments themselves in an effort to provide support for their contention.

54. Mr Berryman was critical of the Coroner for not ordering a post-mortem. He argued that, without a post-mortem, possibilities such as whether Mr Richards had had a heart attack, or was suffering from the effects of alcohol, could not be discounted.

55. At the time of the inquest, Mr and Mrs Berryman were aware from the material available to them of the following matters:

    55.1 The design of the bridge was faulty in that the stringers specified were undersized but that design fault had not caused or contributed to the accident. This was apparent from the Works Consultancy Services report prepared for them shortly after the accident.

55.2 The second-hand untreated Oregon was not suitable for use in the deck structure, given the particular locality, for more than a few years. This was also apparent from the Works Consultancy Services report.

55.3 The Oregon transoms which had failed as a consequence of decay were not flashed as Mr Berryman says was originally intended. Mr Berryman has recently acknowledged that this was the position (see paragraph 68 below).

55.4 The Army had held a Court of Inquiry, at which Mr Butcher had given evidence. They knew this much at least, because Mrs Berryman had given evidence at the Court of Inquiry and Mr Butcher had visited their farm and talked to Mr Berryman when preparing his evidence.

56. Although they were aware of the Coroner's interest in the state of the bridge, Mr and Mrs Berryman did not advise the Coroner of any of these points. Nor, as far as the record reveals, did they make the Works Consultancy Services reports available to the Coroner, or even advise the Coroner that they existed. The first Works Consultancy Services report was particularly useful. Because it was prepared shortly after the accident, its author had access to the bridge in its original but damaged condition. It contains an eyewitness account of the state of the bridge immediately after the accident and gives an expert assessment of the reasons for the collapse.

57. The second Works Consultancy Services report (which is simply a set of calculations with a conclusion drawn from them) dealt with the estimated speed of Mr Richards' vehicle. On the basis of their calculations, Works Consultancy Services estimated that speed to be 19kph. Excess speed was an important aspect of Mr and Mrs Berrymans' argument to the Coroner. However, Mr and Mrs Berryman did not use the Works Consultancy Services report (provided in 1994) to support their argument but rather called another expert, Mr Marks, who was first involved in the matter in 1997.

58. In making these points, I do not mean to suggest that Mr and Mrs Berryman acted improperly in a legal sense in adopting the stance that they did at the inquest, or in not making the Works Consultancy Services reports available to the Coroner. The point is simply that Mr and Mrs Berryman had material available to them which would have enabled them to argue that the Army was wholly or partially responsible for the state of the bridge at the time of the accident. They could also have alerted the Coroner to the fact that the Army had held a Court of Inquiry. But, for what I assume were tactical reasons, they did not seek to focus on the state of the bridge or to place any responsibility on the Army, a point which the Court of Inquiry recorded in its conclusions. Rather, Mr and Mrs Berryman chose, for their own reasons, to argue that it was not the state of the bridge that had led to the accident but the conduct of Mr Richards in driving too fast and in overloading the vehicle.

Coroner's Conclusions

59. In the result, the Coroner made adverse comments about the Army, Mr Richards and Mr and Mrs Berryman. The comments about the Army concerned Second Lieutenant Armstrong's inexperience and lack of training. While he accepted that Mr Richards had been driving too fast, and that that had contributed to the failure, the

Coroner found that the principal cause of the collapse lay in the state of the bridge ("an accident waiting to happen") and that, as the people who had responsibility for the maintenance of the bridge, Mr and Mrs Berryman were to some extent responsible. The Coroner said:

> "With the greatest respect to Mr and Mrs Berryman the Court has to conclude that there have been efforts to minimise the condition of the bridge at the time of the incident. The Court has had the benefit of hearing all the evidence and seeing many coloured photographs of the bridge. The Court considers that a degree of deterioration is self-evident in those photographs. It is not a cosmetic thing like lichen or lack of paint or things of that nature which would merely be cosmetic. It is things that go much deeper than that like the condition of the runner boards for example [reference to exhibits]....
>
> Overall however the impression the Court has here is that here was a bridge in need of repair. The Court believes that Mr and Mrs Berryman had become aware of the need for repair, after all they were closely associated with the bridge."

60. The Coroner went on to say that their warnings to Mr Richards about the weight on the bridge, about speed and about using the alternative route if he had concerns about the bridge, while appropriate, were indicative of Mr and Mrs Berryman's strong concern that the bridge was becoming in need of repair. He said that he was not suggesting that Mr and Mrs Berryman were aware of the imminent danger of collapse:

> "The Court accepts that had Mr and Mrs Berryman believed for one minute that here was a tragedy about to unfold they would have immediately upgraded the bridge or if funds did not allow this they would have closed the bridge and used the other less convenient but alternative route to the farm. Here lies the unfortunate tragedy however in the situation. A situation where the bridge was deteriorating. There were signs there to be seen and either Mr and Mrs Berryman saw them or ought to have seen them. The issue really is when was the upgrading required and when was it necessary. Mr and Mrs Berryman had not determined to upgrade at that point of time for whatever reason. They gave evidence of financial restraint. It may have been that financial restraint prevented them from upgrading, there may have been other reasons. They may have simply decided that the bridge was quite safe at that point of time, that upgrading although it was going to be necessary was not something that needed to be looked at as a matter of urgency.
>
> ....
>
> The essential lesson here to be learned is that in respect of a potentially dangerous structure warning signs have to be acted on promptly. There must be a regular and planned programme of inspection and maintenance which must be implemented."

It seems that from the Coroner's perspective, the key issue was when it had become obvious that the decking required immediate remedial work.

Previous Requests for a Further Inquest

61. I have received three requests previously on behalf of Mr and Mrs Berryman that I exercise my powers under ss 38 or 40 to order, or to apply to the High Court for, a new inquest.

62. The first request was made by Till Henderson King, who were at that time solicitors for Mr and Mrs Berryman, by letter dated 23 July 2001. The application raised numerous grounds, specifically:

62.1 The Coroner's failure to recognise the full range of potential parties;

62.2 A conflict of interest on the part of counsel for OSH;

62.3 The role of OSH at the inquest;

62.4 The failure of Police to investigate properly the absence of a post-mortem;

62.5 A breach of rules of natural justice relating to Dr Liley's second report;

62.6 The Coroner's failure to accept the evidence of Mr Marks;

62.7 The Coroner's failure to appoint a technical assessor;

62.8 The Coroner's failure to appoint independent counsel to conduct the inquest;

62.9 The Coroner's failure to consider the legal aspects of ownership of the bridge.

63. The application was dealt with under delegation by Deputy Solicitor-General, Ellen France (now France J). She sought independent advice from Mr White QC. Ultimately she declined the application for reasons outlined in detail in a letter to Till Henderson King dated 2 November 2001.

64. The second application was made by Buddle Findlay, who took over as Mr and Mrs Berryman's solicitors, by letter dated 3 July 2002. That application raised issues arising out of:

64.1 The report of the Court of Inquiry held by the Army, which had become available under the Official Information Act. It was argued that the report raised new facts, specifically design faults with the bridge and inappropriate use of Oregon timber;

64.2 The ownership of the land on which the bridge was constructed. The argument was that the bridge was built by the Crown on Crown land, so that the Coroner had erred in concluding that Mr and Mrs Berryman were responsible for the inspection and maintenance of the bridge;

64.3 The speed of the vehicle, and the failure of Mr Richards to wear a seatbelt.

65. That application was declined by Deputy Solicitor-General, Helen Aikman, acting under delegation from me, by letter dated 11 October 2002 for the reasons set out in that letter.

66. By letter dated 13 December 2002, Buddle Findlay challenged elements of Ms Aikman's reasoning and asked that she reconsider her decision to decline the request of Mr and Mrs Berryman for another inquest. Ms Aikman did reconsider her decision, and wrote on 19 February 2003 responding to the various matters raised by Buddle Findlay and declining the application.

Berrymans' Judicial Review Applications

67. In May 2003 Mr and Mrs Berryman applied for judicial review of:

67.1 My refusal to order a new inquest under s 38 or to apply to the High Court for an order for a new inquest under s 40; and

67.2 The Coroner's decision.

These proceedings were discontinued following the decision of Wild J which is referred to at paragraph 46 above.

68. In the course of these judicial review proceedings, Mr Berryman filed affidavit evidence in which he said that, at the time the bridge was built, he had provided damp course (3-ply malthoid) to the Army to place over the transoms and on other parts of the deck structure to keep moisture out. He said that after the bridge was built he was surprised at the amount of damp course that appeared to be left over, but gave it no further thought. Mr Berryman then deposed that he was surprised when the decking of the bridge was dismantled for replacement after the accident to see that none of the damp course had, in fact, been used.

69. Mr Toy filed an affidavit saying that he had advised Mr and Mrs Berryman prior to construction of the bridge that damp course should be used over the transoms and at other points of the decking as this would shed water and prolong the life of the timber. He then supplied Mr Berryman with sufficient damp course for that purpose.

70. Mr Butcher (the author of the Butcher Report) also filed an affidavit in the proceedings. He said:

> "Whether or not damp-proof course had been used would have been quite obvious even after completion of the bridge, as the transoms project beyond the bridge deck to the supporting hangers and are clearly visible."

71. In addition, it is clear from the evidence before the Coroner that Mr Berryman was present throughout much of the construction of the bridge and often helped with the work. Mr Berryman accepted that he discussed the need for maintenance with Army personnel as the bridge was being constructed. Given his close interest and involvement in the project, it is difficult to see how Mr Berryman did not know from the outset that the malthoid was not in fact used in the construction of the deck. It is also difficult to see how he did not appreciate that the failure to install the flashing would have affected the rate of deterioration of the transoms as he had been advised on that issue by Mr Toy.

72. In his affidavit, Mr Butcher sets out in some detail his discussion with Mr Berryman on 24 September 1994 when he inspected the (by then reconstructed) bridge. Of particular importance in the present context is Mr Butcher's evidence that Mr Berryman told him that he was well aware that the transoms were in poor condition at the time of the collapse and that, sometime before the collapse, he had contacted Emmetts to arrange replacement of the transoms. Mr Berryman also said that Works Consultancy Services had been asked to design replacement transoms in structural steel, but the job had stayed "at the bottom of their in-tray".

73. In this context it is noteworthy that in her statement to OSH three days after the accident occurred, and in her brief of evidence for the OSH prosecution, Ms Thomason (Mr Richards' partner) said that she and a co-worker had had a

conversation with Mr Berryman on the morning of the accident, during which Mr Berryman had indicated that he did not want more than three or four tonnes taken over the bridge, and that he was concerned about some Oregon beams and felt he should put some steel in to strengthen the bridge. He also talked about insuring the bridge. (See *Department of Labour v Berryman* [1996] DLR 121 at 126). Ms Thomason's evidence before the Coroner was not presented by way of a written brief of evidence, and her evidence concerning this meeting at the inquest was more equivocal.

74. Finally, in his affidavit Mr Butcher said that the decay in the transoms would have been readily detectible on the surface of the wood.

Applicable Principles

75. The power of the Solicitor-General to order an inquest is set out in s 38 of the Coroners Act. Section 38(2) deals with the position where an inquest has already been held. It provides:

> "If satisfied that since an inquest was completed new facts have been discovered that make it desirable to hold another, the Solicitor-General may order another to be held, and in that case another shall be held."

This provision contemplates that the Solicitor-General must be satisfied that:

75.1 new facts have been discovered;

75.2 which make it desirable to hold another inquest.

76. Section 40 provides that the Solicitor-General may also apply to the High Court for an order that there be a further inquest. Section 40(3) provides:

> "If satisfied, on application under this section, that –
>
> (a) one or more inquests have been held into a death; but
>
> (b) another should be held –
>
> (i) by reason of fraud, rejection of evidence, irregularity of proceedings, or discovery of new facts; or
> (ii) for any other sufficient reason,
>
> – the High Court may order another to be held; and in that case another shall be held."

77. As the Solicitor-General's powers must be exercised within the context of the Act as a whole, it is necessary to consider what the purpose of a coronial inquest is. That is governed by s 15. Section 15(1) provides:

> "A Coroner holds an inquest for the purpose of –
>
> (a) establishing, as far as is possible, –
> (i) That a person has died; and
> (ii) The person's identity; and
> (iii) When and where the person died; and
> (iv) The causes of the death; and
> (v) The circumstances of the death; and

(b) Making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any person should act in such circumstances, that, in the opinion of the Coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances."

78. The authorities highlight two important aspects of this description of a Coroner's function:

78.1 An inquest is an inquisitorial fact-finding exercise. It is not a method for apportioning guilt or blame. The procedures and rules of evidence which are suitable for one purpose are not suitable for the other. For example, a Coroner may admit such evidence as he or she thinks fit, "whether or not it would be admissible in a Court of law", provided that he or she is satisfied that admission of the evidence is "necessary or desirable" for the purpose of establishing any matter specifed in s 15(1)(a) of the Act (s 26(5) and (6)).

78.2 Any comments or recommendations made by the Coroner must be consistent with s 15. As Heron J said in *Matthews v Hunter* [1993] 2 NZLR 683:

> "Such recommendations and comments are to be about the avoidance of circumstances similar to those in which the death occurs. The word avoidance suggests that the recommendations and comments must have a causative flavour so that the recommendations and comments will lead people away from circumstances because death might otherwise result. Those circumstances must be *similar to those in which* the death occurs. The use of the words "in which" suggests only that the similarity need not have the same direct causative element as the death under consideration and all that must be shown is a discernible need for warning arising from the circumstances of the case. It does not confine the Coroner to recommendations and comments on the avoidance of circumstances which directly caused the death under consideration but allows him to recommend and comment on all the other implications of the similar circumstances surrounding the death." (at p 687 *ll* 38-50)

Similar observations were made by Ronald Young J in *Solicitor-General v The Coroner at Kaitaia* (Unreported, Wgtn HCt, CP 258/01, 13 March 2003) at para [12].

79. Although a Coronial inquest is not concerned with apportioning guilt or blame, the Act does recognise that a Coroner's comments or findings may impact upon people's reputations. Section 15(2) allows a Coroner to comment on a person's conduct but provides that no adverse comment may be made about a person, living or dead, unless certain specified steps are taken. In the case of a living person, s 15(2)(b) requires that the Coroner take all reasonable steps to notify the person of the proposed comment, and give him or her reasonable opportunity to be heard in relation to the proposed comment.

80. There have been many cases dealing with the principles applicable to the ordering of further inquests. The overriding consideration is that it must be necessary or desirable in the interests of justice that a new inquest be held (see *Re Sutherland (Dec)* [1994] 2 NZLR 242 at 250 *l* 40). That will depend upon an assessment of the circumstances of the particular case. As Wild J said in *Berryman v Solicitor-General* (CIV 2003 485 1041, 18 February 2005), in considering whether to exercise the

power under s 40(3) to apply for a further inquest, the Solicitor-General must satisfy him or herself that a sound basis for an application exists (at para [39]). His Honour also noted that the Solicitor-General must take a range of factors into account, such as "the length of time since the death, the disquiet of relatives or the public and what a further inquest might potentially achieve" and must have regard to the provisions of s 15(1)(a)(v) (at para [40]).

81. The powers conferred by ss 38 and 40 are exercisable where there are new facts (although s 40 also applies where there are other grounds). Because of its importance in this case, I deal now with the approach to "new facts".

New Facts

82. The test for identifying what qualifies as new facts or evidence has been summarised as follows:

> "In my judgment, evidence will qualify as new evidence if it was not available at the time of the original inquest, would have been admissible had it been available, is credible and relevant to an issue of significance in the inquisition. It must also be shown that it might have made a material difference to the verdict recorded at the original inquest....
>
> When the new evidence is discovered some years after the original inquest, an important question is whether it is still possible to hold a fair inquiry into the facts. Where these depend on the recollection of witnesses, or witnesses are no longer available, the Court may well conclude that it is not desirable in the interests of justice to hold a new inquest." (*R v H M Coroner for Derbyshire (Scarsdale), ex parte Fletcher* (1992) 156 JP 522, per Beldam LJ)

83. Clearly, then, the existence of new facts does not necessarily mean that there must be a further inquest. *Kelly's* case involved an internal Army report that was not disclosed to the Coroner at an inquest. Pill LJ, having noted that the Coroner himself was seeking a further inquest, and that the deceased's family had reasonable concerns, said:

> "The court must however form its own view as to whether 'it is necessary or desirable in the interests of justice that another inquest should be held'. I do not accept that the emergence of fresh evidence, even if it is part evidence which the Ministry had and should have disclosed to the coroner at the inquest, is determinative of the question whether there should be another inquest. The emergence of fresh evidence, and the coroner's wish to conduct further investigation, do not relieve the court of its responsibility to keep in mind the public interest involved and the purpose served by an inquest as a fact-finding exercise and not a method of apportioning guilt or a general public inquiry into the army's safety procedures."

84. In the same case, Newman J said:

> "The 'discovery of new facts or evidence' may justify the ordering of a fresh inquest, but the court has to be satisfied that 'it is necessary or desirable in the interests of justice that another inquest should be held' (s.13(1)(b) [of the Coroners Act 1988 (UK)]).
>
> In my judgment the particular factors relevant to the interests of justice and the exercise of discretion in this case include:
>
> (1) the public interest which the inquest was established to serve;
> (2) the possibility of a different verdict being returned ...;

(3) the interests of the family of the deceased;
(4) the interests of witnesses who will be required to give evidence again and the passage of time since the events occurred;
(5) the scope and potential for fresh inquiry into body armour and the extent to which there will be a rehearing of evidence unrelated to this topic;
(6) the fact that the coroner has requested a fresh inquest."

In the result, no new inquest was ordered.

85. It is clear from *Kelly's* case, and also from *Re Rapier (Deceased)* [1988] QB 26, that facts may qualify as "new" facts even though a party appearing at an inquest was aware of them and did not raise them because, for example, the facts were not thought to be relevant (*Rapier*) or were deliberately suppressed (*Kelly*).

86. A caution must be expressed, however. Where a person who deliberately withholds relevant evidence from the Coroner for tactical reasons is the subject of adverse comment by the Coroner in relation to the death at issue, that person will not necessarily be able to mount a strong case for an order for a new inquest on the basis that the material withheld constitutes "new facts" that may have affected the outcome. In such circumstances the evidence may be material, in the sense that had it been available it may have affected the Coroner's view. But there is a public interest in finality, and parties appearing before Coroners should not be encouraged in the belief that withholding relevant evidence may place them in an advantageous position in terms of obtaining a new inquest should the first inquest produce comments which they do not like.

87. To summarise, then:

87.1 Under s 38(2) I am able to order a further inquest if I am satisfied that since the completion of the inquest new facts have been discovered that make it desirable to hold another inquest. A new inquest is "desirable" where it is in the interests of justice that a new inquest be held. The "interests of justice" test brings a range of considerations into play.

87.2 In addition, under s 40(3) I have a discretion to apply for a new inquest on various grounds, including discovery of new facts. Where I apply, the Court, of course, makes the final decision. When I apply I act in the public interest, and so must be satisfied that the application is a proper one, in the sense that the grounds advanced are sufficiently substantial to mean that it is seriously arguable that it is desirable in the interests of justice that a further inquest be held.

The Current Request

88. As will be apparent, Till Henderson King and later Buddle Findlay raised many matters on behalf of Mr and Mrs Berryman in the earlier applications. Having reviewed the files, I am satisfied that the decisions made by my Deputies on the basis of the material presented to them were appropriate.

89. I have, however, considered the matter afresh on the basis that the Coroner did not receive any, or any significant, evidence about:

89.1 The design faults with the bridge;

89.2 The suitability of second-hand untreated Oregon for use in the deck structure of the bridge;

89.3 The lack of flashing on the transoms.

The question is whether these matters, taken individually or in combination, provide a sufficient basis for me to order a new inquest under s 38, or apply to the High Court for an order that there be a new inquest under s 40(2).

90. Before addressing these points, I should first deal with the more general considerations that go to the "interests of justice" issue.

Public Disquiet

91. There is obviously some disquiet amongst sections of the public as to whether Mr and Mrs Berryman have been properly treated. This has been increased by the allegations of Dr Moodie and Mr and Mrs Berryman that the Army and other institutions have acted corruptly. The existence of such public disquiet is a significant factor supporting the holding of another inquest, if only to provide reassurance. It would fall within s 40(3)(b)(ii), which empowers the High Court to order a further inquest "for any other sufficient reason", but is also relevant to the interest of justice analysis under s 38(2).

92. Public disquiet cannot be the determinative factor, however. There are other legitimate interests to be considered. In light of these interests, it would not be right for me to seek a further inquest simply on the basis of, for example, a public concern about the outcome of an inquest where that concern was based on misinformation. Accordingly, I must reach some view as to whether the public disquiet has a legitimate basis, and raises issues that may appropriately be addressed by a Coroner.

The Deceased's Family

93. As the Coroner noted, the inquest concerned the death of Mr Richards. Mr Richards' partner, Ms Thomason, was working with Mr Richards on the Te Rata Farm when the accident occurred. She and a co-worker were the first persons on the scene. Obviously, Mr Richards' death and the aftermath were most distressing for her and other family members. They should not be put through a process which will undoubtedly be contentious and controversial without proper reason. In this context, I note that during the course of the first inquest the Coroner felt it necessary to indicate to Mr Berryman on two occasions that he regarded Mr Berryman's comments to the media as constituting contempt of Court. On the second occasion, the comments concerned a three week adjournment granted by the Coroner to accommodate Ms Thomason.

The Public Interest in Proper Process

94. Clearly there is a public interest in proper process. This is reflected in the provision enabling an application to be made for a new inquest where there has been fraud or

irregularity of proceedings, but it is wider than that. There is an obvious public interest in having a Coroner report accurately on the circumstances of a death.

95. Dr Moodie has alleged that there was corruption on the part of the Army at the inquest, specifically in relation to the non-disclosure of the Butcher Report. That report was, however, not admissible at the Coroner's inquest against any person by reason of Rule 158 of the Armed Forces Discipline Rules of Procedure 1983 (see paragraph 46 above). The Army did not, of course, advise the Coroner that there had been a Court of Inquiry, and made a submission which was inconsistent with the Court's findings. That may perhaps be explained partly by the fact that the Army only became formally involved in the inquest part way through; but in any event it should not have happened.

96. However, as already noted (see paragraph 55.4 above), Mr and Mrs Berryman knew that the Army had held a Court of Inquiry and that Mr Butcher had given evidence at it. They also chose not to mention these matters.

97. Dr Moodie has identified factual information that he believes was important and was not made available to the Coroner. I address that aspect in more detail at paragraphs 110-115 below. But, in essence, the factual information identified by Dr Moodie was available to Mr and Mrs Berryman at the time of the inquest and they could have raised it with the Coroner if they wished, independently of anything said or done by the Court of Inquiry. In these circumstances, and given the effect of Rule 158, I cannot conclude that there was fraud or corruption on the part of the Army, although I do agree with Wild J and Dr Moodie that the Army should not have made the submission that there was nothing wrong with the design and construction of the bridge, and it is a concern that they did so.

Possibility of a Different Outcome

98. It is not always necessary to show that there may be a different outcome before a Court will order a further inquest. As Barker ACJ said in *Re Sutherland (Deceased)*:

> "It is clear from the English authority ... that the Court will order a new inquest, if an order is desirable in the interests of justice, even if the fresh inquest will not result in a different verdict. A fresh inquest can be ordered, if only to allay the disquiet of relatives; e.g. *Re Napier (Deceased)* [1998] 1 QB 26." (at 250 *ll* 38-43)

Similarly, in *R v HM Coroner for West Berkshire, ex parte Thomas* (1991) 155 JP 681, where the Court concluded that there had been irregularity of proceedings but did not order a further inquest, Bingham LJ accepted that there may be circumstances where a further inquest could properly be ordered even if there was no likelihood of a different outcome. In such a case, the public interest in a full and proper inquiry would prevail.

99. However, as I have noted in paragraph 84 above, the English cases have identified the possibility of a different outcome as a factor which should be considered on an application for a new inquest, and have declined to order a new inquest on the basis, in part, that a different outcome was not a realistic possibility.

100. In the present case, the Coroner made adverse comments about the Army, about Mr Richards and about Mr and Mrs Berryman. Based on my review of the material in the light of the various points made by Dr Moodie, it seems to me inevitable that a Coroner on a further inquest would again make adverse comments about the Army, about Mr Richards and about Mr and Mrs Berryman. There may be differences of emphasis, but the essential point, in my view, is that there is no realistic possibility that Mr and Mrs Berryman will be exonerated.

101. By way of explanation, all those involved with the bridge knew that second-hand Oregon timber was being used in the construction of the decking. Major Armstrong told the Army Court of Inquiry that his recollection was that the use of this material was a short-term solution and that Mr Berryman intended to replace it with a more durable structure over time. Mr Berryman said in his evidence to the Coroner that from the day the bridge was built there were improvements and upgrades to the bridge that he intended to carry out, including replacing the wooden transoms with steel transoms. Indeed, he had made inquiries about doing that a year before the accident.

102. Accordingly, as the Coroner noted (see extract quoted in paragraph 60 above), the essential issue was when it was apparent that the deck structure needed to be upgraded or repaired. The Coroner said that the need for remedial work had become obvious by the time of the collapse. Mr and Mrs Berryman were the people who were responsible for the bridge and for carrying out any necessary repairs and upgrading. The Coroner considered that they ought to have realised, and would have realised had they instituted an appropriate programme of inspection and maintenance, that the bridge had reached the stage where it required immediate remedial work.

103. In my view, in any inquest based on the "new" facts, that would remain the essential issue. Inevitably, it would be answered in the same way. There is nothing in the "new" facts that would significantly affect the Coroner's analysis on this aspect. That is a powerful factor against a further inquest, although not a decisive one.

104. In his costs judgment dated 11 May 2005, Wild J concluded that if the Coroner had had the report of the Army's Court of Inquiry or the Butcher Report it is likely that he would have attributed blame to the Army for initial faulty construction of the bridge, in particular in relation to the transoms (Judgment para [61]). I do not agree that that outcome is likely, although clearly it is possible. The reason for this is that the Coroner was well aware of the way in which the transoms had been constructed. He was also aware from the evidence of the OSH witnesses of the fact that there was decay around the bolts and along the line where the two components of the transom were joined. Whether he would attribute any blame to the Army on that account would depend upon what view he took of Major Armstrong's explanation of his understanding of the Berrymans' intentions when the bridge was built.

105. I should note here that there may be additional evidence which supports Major Armstrong's recollection. A former neighbour of Mr and Mrs Berryman, Mr Steve Carr, was reported in the Waikato Times of 6 May 2005 as saying:

> "I was present when the Army built the bridge, and they were very dissatisfied with the material. The Army said they didn't want to use it, and that the transoms should be

> replaced within five years. Everyone was quite aware of this, it was well discussed in the community."

106. If evidence of that type were to be given and accepted at any further inquest, any adverse comment about the Army is likely to be limited in scope, as it was in the Coroner's decision on the first inquest. But, whatever adverse comment might be made about the Army on a further inquest, there is, in my view, no reasonable possibility that it would be sufficient to exonerate Mr and Mrs Berryman.

Lapse of Time

107. It is obviously desirable that an inquest be held as close in time to the death of the subject of the inquest as is possible. In this case, there was a three year delay before the inquest took place, which was largely unavoidable but nevertheless undesirable. It is now 11 years since the death of Mr Richards and over 19 years since the bridge was built. There is an obvious difficulty now in establishing precisely what happened when the bridge was built and in recreating the sequence of events leading to Mr Richards' death. Given the limited role of a Coroner, and the fact that any findings and comments that he or she makes must relate to the purposes set out in s 15 of the Coroners Act, it is unlikely that the matters in dispute could be resolved satisfactorily at this stage through another inquest.

108. Second, it is clear from what Dr Moodie has said on behalf of Mr and Mrs Berryman that he sees the purpose of a further inquest as being to expose a "cover-up" and to attribute blame or responsibility for the collapse to the Army. But this is not the function of an inquest. The Courts have made it clear that the Coronial inquisitorial process, and the rules that govern it, are not well suited to attributing blame or responsibility in the sense contemplated by Dr Moodie – see *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 125, per Lord Lane CJ.

109. I now turn to the specific factual matters which were not dealt with, either at all or in any detail, at the inquest, as identified in paragraph 38 above.

Design Faults with the Bridge

110. As I have already noted, I consider that it was improper for the Army to submit to the Coroner that the bridge was adequately designed in circumstances where the Army knew that its own Court of Inquiry had reached a contrary view. However, I do not think this ground justifies a further inquest.

111. I have two reasons for this:

    111.1 None of the engineers who looked at the bridge expressed the view that the collapse of the decking resulted from a design fault. The principal design fault identified was the use of undersized stringers. Works Consultancy Services, Mr Butcher and Mr Armitage were all clear in their view that the accident did not result in a failure in any of the stringers, but resulted from a failure of the transoms.

    111.2 As a consequence, knowledge of the design defects would not have materially assisted the Coroner in reaching a view. Further, if the design

defects did not contribute to the accident, it is difficult to see what comment the Coroner could properly have made about them, given the limits imposed by s 15.

Suitability of Second-hand Untreated Oregon for the Deck Structure

112. The Coroner was aware that:

112.1 Second-hand untreated Oregon was used for the decking of the bridge to save cost given the expense of fabricating the poles in steel;

112.2 The transoms were constructed of two pieces of Oregon bolted together;

112.3 The transoms had decayed, particularly along the join line and around the bolts, to the point that they had lost significant strength;

112.4 The general appearance and state of the bridge at the time of the accident was poor;

112.5 Mr and Mrs Berryman treated the bridge as "their" bridge and, as a practical matter, accepted responsibility for its care and maintenance;

112.6 Mr and Mrs Berryman intended, over time, to replace the transoms with steel transoms, and had made enquiries about that a year before the accident;

112.7 Mr and Mrs Berryman were sufficiently concerned about the bridge to warn Mr Richards and Ms Thomason individually that Mr Richards should not use the heavier of his two vehicles for removing the honey as he had done the previous year and to be careful about speed and overloading. Mr Berryman also said that if Mr Richards had any concern about the bridge he should use an alternative route.

113. What was not covered in the evidence was the particular unsuitability of Oregon in an environment such as Te Rata where there was a high moisture content in the air for much of the time, so that the timber went through a constant cycle of becoming wet, then drying out.

114. Again, however, I do not consider that this justifies my making or seeking an order for a further inquest:

114.1 As noted in paragraphs 100-106 above, this material does not affect the central issue identified by the Coroner, or the way in which he analysed and answered it.

114.2 In any event, Mr and Mrs Berryman had sufficient information at the time of the inquest to raise this issue if they had wished. They chose not to raise it, but preferred instead to argue that Mr Richards had caused the accident. There is no compelling reason why Mr and Mrs Berryman should now be provided with an opportunity to run a different theory at a further inquest.

Lack of Flashing on Transoms

115. This issue has emerged for the first time in the recent judicial review proceedings. As is clear from Mr Berryman's affidavit (referred to in paragraph 68 above), Mr Berryman has known of the lack of flashing at least since the time at which the decking was rebuilt following the accident. Despite that knowledge, he did not raise the matter before the Coroner. Again, that was a matter of deliberate choice. To have argued that the bridge was inadequate in this respect would have been contrary to the theory or case that he and Mrs Berryman were advancing, namely that the sole cause of the accident was the conduct of Mr Richards. Again, there is no reason why Mr and Mrs Berryman should be entitled to a further inquest to enable them to run a new and different case.

Conclusion

116. On balance, I do not believe that there is a proper basis for me to order a new inquest under s 38. I accept that there is material which may constitute "new facts"; but I do not consider that it is in the interests of justice that I order a new inquest under s 38(2).

117. There are five points, in particular, which persuade me that this is the correct conclusion:

    117.1 The periods of time since first, the bridge was built and second, Mr Richards' death occurred, are such that it would be difficult for a Coroner to resolve the matters that would be in dispute, which are essentially recollections of understandings when the bridge was built in early 1986.

    117.2 In any event, the Coronial process is not well suited to resolution of what would be in issue. Given the history of this matter, a further inquest will become contentious and controversial. It will inevitably draw the Coroner beyond his or her proper role and will become focused on attributing blame or responsibility. As Heron J emphasised in *Matthews v Hunter* (see paragraph 78.2 above), the purpose of a Coronial inquiry must be assessed in terms of s 15, looked at in the context of the Act as a whole. There is little doubt that a second inquest would move beyond the legitimate role fixed for it by the Act.

    117.3 Having reviewed the available material, I do not believe that there is any realistic possibility that Mr and Mrs Berryman would be exonerated if another inquest were to be held, although I accept that it is possible that greater blame may be placed on the Army for agreeing to use the second-hand Oregon for the transoms.

    117.4 Mr Richards' family have at no stage indicated that they seek another inquest or that they are dissatisfied with the process or outcome of the first inquest.

    117.5 While, as far as I am aware, Mr and Mrs Berryman did not have a copy of the report of the Army Court of Inquiry or the Butcher Report at the time of the Inquest, they were aware of at least the substance of the "new" facts or matters said to have been concealed corruptly by the Army. These were

apparent from the Works Consultancy Services Report or from their own knowledge. Mr and Mrs Berryman did not use the information available to them because it did not suit their interests as they saw them at the time. In effect, they now seek the opportunity to run a different case at a second inquest. There is no reason of principle why they should be afforded such an opportunity.

118. As to my applying to the High Court under s 40, I consider that there is material that may constitute "new facts", and that public disquiet may constitute "any other sufficient reason" for the purpose of s 40(3)(b)(ii). I also accept that the Coroner's failure to advise the Army formally of the inquest at the outset arguably constitutes an "irregularity of proceedings" under s 40(3)(b)(i) (although I do not consider the argument to be a strong one given that Major Armstrong was involved from the outset and no one sought to question him, and the Army did ultimately participate formally in the inquest). However, I do not consider that I could properly maintain to the Court that there is a seriously arguable case that it is in the interests of justice that a further inquest be held, for the reasons given above.

119. To summarise, then, I do not feel that I can properly conclude or argue that it is necessary or desirable in the interests of justice that a further inquest be held. Even if there were to be a further inquest, I think it inevitable that a second Coroner would conclude that:

    119.1 The collapse of the decking resulted from the failure of transoms as a result of decay.

    119.2 Mr and Mrs Berryman were to some extent responsible for the collapse. This is likely to be on the basis indicated by the original Coroner, Mr Scott, but it is possible that a second coroner might be more critical of Mr and Mrs Berryman.

    I accept that a second Coroner might make stronger adverse comments about the Army than Mr Scott did, although that is by no means certain. But I do not consider that there is any reasonable basis for believing that any such comment would be sufficient to exonerate Mr and Mrs Berryman.

120. I make no comment on the desirability of some other public process to examine what happened in this case.

Terence Arnold QC
Solicitor-General