IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO. OF 2014

BETWEEN:

ANDREAS HAUG

PLAINTIFF

AND:

THE CORONER OF THE CAYMAN ISLANDS

DEFENDANT

APPLICATION FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

To the Clerk of the Court, Law Courts, George Town, Grand Cayman	
Name, address and description of applicant(s)	Andreas Haug B24 Britannia, SMB, Grand Cayman Attorney at Law
Judgment, order, decision or other proceeding in respect of	The Coroner's proceedings and the open verdict returned by the jury at the inquest into the

which relief is sought	death of Ms Lija Godenzi held in George Town, Grand Cayman, on 4 - 7 November 2013.
	Relief Sought 1. An Order of certiorari quashing the open verdict returned by the jury. 2. An Order replacing the open verdict with a verdict of suicide. 3. Such further and other relief as the Court may deem appropriate in all the circumstances. 4. Costs of these proceedings.
Name and address of applicant's attorneys, or, if no attorneys acting, the address for service of the applicant	Samson & McGrath, Attorneys-at-Law for the Applicant, whose address for service is 5th Floor, Genesis Building, PO 446 GT, Grand Cayman.
Signed	**Dated**

GROUNDS ON WHICH RELIEF IS SOUGHT

Relief is sought because the directions given by the Coroner to the jury were wholly deficient. In summary:

1.1 The Coroner misstated the standard of proof for a verdict of suicide.

1.2 The conclusion to the Coroner's summing up amounted to improper pressure on the jury to return a particular result.

1.3 The Coroner incorrectly directed the jury to disregard certain items of evidence.

1.4 The Coroner incorrectly directed the jury to have regard to items of evidence it ought not to have considered.

1.5 The Coroner erred in preventing the Applicant's Representative from making submissions to her at the end of her summing-up.

Further particulars are contained in the attached draft Notice of Originating Summons and in the affidavit of Andreas Haug dated 7 January 2014 made in support of this application.

Dated the 2014

Filed the 2014

Samson & McGrath

Samson &McGrath

Attorneys-at-Law for the Applicant

TO: The Clerk of the Courts

THIS APPLICATION was filed by Samson & McGrath, Attorneys-at-Law for the Applicant, whose address for service is 5th Floor, Genesis Building, PO 446 GT, Grand Cayman.

In The Grand Court of The Cayman Islands

THE QUEEN ON THE APPLICATION OF ANDREAS HAUG

Applicant

v

THE CORONER OF THE CAYMAN ISLANDS

Respondent

ORIGINATING MOTION

INTRODUCTION

1 The Respondent (**"the Coroner"**) opened an inquest into the death of Ms Lija Godenzi ("Ms Godenzi") on 4 November 2013. The inquest was initially scheduled for 28 May 2013 but was removed from the Coroner's list for reasons not known to the Applicant. On 4 November 2013 a jury was convened and the substantive hearing commenced. The Coroner gave the jury directions (**"The Directions"**) on 7 November 2013 and the jury returned an open verdict later the same day.

2 The Applicant is the husband of the deceased, though they had separated approximately five months prior to Ms Godenzi's death and were seeking to divorce one another.

3 The Applicant seeks the following relief:

3.1. Certiorari quashing the open verdict returned in the inquest into the death of Ms Godenzi;

3.2. An Order replacing that open verdict with a verdict of suicide.

4 Relief is sought because the Directions were wholly deficient. In summary:

4.1 The Coroner misstated the standard of proof for a verdict of suicide.

4.2 The conclusion to the Coroner's summing up amounted to improper pressure on the jury to return a particular result.

4.3 The Coroner incorrectly directed the jury to disregard some items of evidence.

4.4 The Coroner incorrectly directed the jury to have regard to items of evidence they ought not to have considered.

4.5 The Coroner erred in preventing the Applicant's representative from making submissions to her at the end of her summing-up.

5 Despite requests made in letters dated 8 and 13 November and 6 December 2013 the Coroner has failed to release her note of the evidence, the documentary exhibits and other documentation relating to the inquest. The Applicant anticipates that the release of these documents may give rise to further grounds of review.

BACKGROUND FACTS

6 Ms Godenzi body was found hanging from her bedroom door in her apartment in George Town on Saturday 7 April 2012 by the Royal Cayman Islands Police Service. She had last been seen alive at around 1pm on Tuesday 3 April 2012.

7 An autopsy report, written by a Dr Shravana Jyoti, dated 13 April 2012 concluded that *"The cause of death is asphyxiation due to hanging. Preponderance of evidence suggests that the manner of death appears to be self inflicted and consistent with suicide."* The autopsy found *"No signs of injury around the ligature, no injuries related to struggle or combat and no evidence of wounds"*.

8 At the time of her death Ms Godenzi was suffering from clinical depression, was being treated by a psychiatrist and a psychologist and had been prescribed anti-depressants – Ciprolex and Zopiclone.

9 The Royal Cayman Islands Police ("RCIPS") investigated Ms Godenzi's death in the usual way. Following its investigation, the RCIPS was entirely satisfied that Ms Godenzi's death was a suicide and no criminal proceedings were contemplated.

THE FIRST ERROR - STANDARD OF PROOF

10 The Coroner erred in directing the jury that before they could return a verdict of suicide *"other possible explanations [must be] totally ruled out"*. The burden of proof in cases of suicide is the usual criminal standard. This error was caused by the Coroner's reliance on the case of ***R v Essex Coroner ex parte Hopper*** [1988] COD 7. ***Hopper*** was distinguished by ***R v HM Coroner for Newbury, ex parte John*** (1992) 156 JP 456 and it is apparent that the Coroner was unaware of this later case.

11 There are two elements to a finding of suicide, first that the deceased did the act that caused their death (*actus reus*) and second that the deceased intended to cause death (*mens rea*). These elements must be proven beyond reasonable doubt

12 ***Hopper*** concerned the death of a *"happy, successful, and well balanced"* 19 year old with no evidence of depression or *"any state of mind which would render suicide in the very least likely"*. He was found sat next to a shotgun which had been discharged, the bullet penetrating the deceased's head. Parker LJ said *"The possibility of suicide was there for all to see, but the question which has to be considered is whether other possible explanations were totally ruled out."* Parker LJ went on to say that *"accidental discharge"* had on the evidence not been ruled out.

13 ***John*** concerned a seventeen year old who had hanged himself. The deceased was *"an easy-going jovial boy who was pleasant and popular"*. He had become emotional during a monastic retreat with a school party, and had been found crying earlier in the evening. ***Hopper*** was distinguished on the basis that the *"court considered that the physical cause of death might have been an accident"*. Taylor LJ then stated that:

"Where the act causing death was clearly deliberate the possibility of accident may be excluded and the circumstances may give rise to an irresistible inference of suicide even in the absence of a suicide note or a compelling antecedent history.

...

To set up a choir, climb on it, affix a ligature to the bar on the door then around one's neck and become suspended involves a degree of deliberation which The Coroner considered to exclude accident and to raise an irresistible inference of suicide."

14 ***Hopper*** only applies where there is no positive evidence of suicidal intent and then only applies to findings as to the deceased's *mens rea*. The rationale being that before a conclusion can be reached for which there is no positive evidence,

other possible explanations must be ruled out. Where the circumstances of death make it plain the death was intended, ***John*** states that these circumstances constitute evidence of intent to cause death and so there is no need to for other explanations to be *"totally ruled out"*. Requiring the jury to totally rule out other explanations beyond the narrow confines of ***Hopper*** essentially raises the standard of proof to one of complete certainty which is a higher bar than that required in criminal cases[1].

15 The Coroner further erred by failing to explain how the standard of proof could be met. In this case, to borrow the words of Taylor LJ, the cause of death was *"clearly deliberate"*. Accordingly, the only proper way a jury could reasonably doubt suicide would be if:

15.1 There were grounds to suspect that another had killed Ms Godenzi; and

15.2 These grounds were sufficient to generate a reasonable doubt as to whether the Deceased did in fact kill herself; and

15.3 There were evidence given at the Inquest capable of supporting reasonable doubt that the given death was suicide.

16 None of the above applied. Moreover, the Coroner further erred in failing to recognise that there was no evidence given at the Inquest capable of supporting reasonable doubt that Ms Godenzi's death was suicide.

THE SECOND ERROR - IMPROPER PRESSURE

17 The Coroner erred by concluding the Directions in such an unbalanced fashion that it placed improper pressure on the jury to return an open verdict. In ***R v Mears*** **(1993) 1 WLR 818** Lord Lane said (at p.822):

[1] See for example ***Miller v Minister of Pensions*** **[1947] All ER 372**

"[a judge's comments cannot be] so weighted ... as to leave the jury little real choice other than to comply with what are obviously the judge's views or wishes.

...

the decision must be that of the jury and not of the judge using the jury as something akin to a vehicle for his own views.

...

A judge ... is not entitled to comment in such a way as to make the summing-up as a whole unbalanced."

18 ***Mears*** was cited in the English Court of Appeal in ***R v Wood*** **[1996] 1 Cr App R 207** (at p.215). There Staughton LJ (at p.217) described the judge's improper comments as advocacy. The principles which apply to jury directions in a criminal context apply equally to the Coroner's Court. (See for example ***R (Anderson) v HM Coroner for Inner North London*** [2004] EWHC 2729 (Admin) and ***Re Bithell*** **(1986) 150 273** where the coroner was criticised for *"virtually"* telling the jury to return an open verdict).

19 In the conclusion to the Directions the Coroner breached these standards. She started by telling the jury that Ms Godenzi was *"recovering"* from her depressive illness and that *"she was looking ahead"*. This is inconsistent with the expert evidence given by Dr Lockhart. The Coroner then said:

"Finally, I cannot leave without voicing some concerns which I am sure are at the forefront of all of your minds. Where is the missing laptop? Why the discrepancy in the report from the tracking device? Two persons who had keys to her place, one she knew about, one we are not so sure she knew about. Since Mr Haug had evidence from the tracking device that the vehicle had not been

turned on, why did he not check on Ms Godenzi or why the car wasn't moving before he left the island on Thursday [5 April 2012]? The Deceased had no life insurance. But who was to gain from her death? No divorce, no settlement issues.

Member of the Jury, also remember that hanging is not the usual method used by women to end their lives. Of the suicides Dr Jyoti has dealt with, five were men and two were women – and presumably one of these women was Ms Godenzi."

20 The manner in which the Coroner marshalled these facts and presented them to the jury amounted to advocacy and improper pressure. The jury members were virtually told to return an open verdict. The alternative that Ms Godenzi had killed herself was not put fairly before them.

21 This manner of giving directions would be a material misdirection even if the *"concerns"* expressed by the Coroner were valid. In fact, as set out below, they were not.

THE THIRD ERROR - EVIDENCE IMPROPERLY INCLUDED

Female Suicide By Hanging

22 The Coroner erred in directing the jury that *"hanging is not the usual method used by women to end their lives"* because no evidence was heard at the Inquest to support this conclusion. A representative of Ms Godenzi's family asked Dr Jyoti about *"the statistics on women hanging themselves"*. Dr Jyoti was *"unaware"* of what was being referred to and so he offered his personal experience that of the six hangings he had previously dealt with in the Cayman Islands (apart from the death of Ms Godenzi) five were men. The Coroner immediately commented that *"this still makes a point"*.

23 The Coroner failed to recognise that it is logically fallacious to move from a single doctor having seen more male hangings than female hangings to the conclusion that in general women do not *"usually"* commit suicide by hanging. Quite apart from the logical failure, empirically Dr Jyoti's personal experience is too small a sample from which general conclusions can be drawn about the prevalence of suicide by hanging amongst women, especially when not accompanied with any analysis of whether more men commit suicide (by whichever means) than women.

24 Even if evidence were offered to support the conclusion that *"hanging is not the usual method used by women to end their lives"*, this would be of limited probative value. Plainly there are some women who do commit suicide by hanging, and the jury ought to have been directed to consider the particular circumstances surrounding the death of Ms Godenzi. Thus the great emphasis the Coroner placed on this item of evidence was a further error.

GPS device

25 At around the time of her death, Ms Godenzi had the use of a motor car purchased by Mr Haug. A GPS security device had been fitted to the car by the Security Centre. On 4 April 2012, the day after Ms Godenzi was last seen alive, the device recorded that Ms Godenzi's car had moved from her address at 53 Sunshine Boulevard to 51 Sunshine Boulevard and back again. In the conclusion to the Directions the Coroner suggested that this *"discrepancy"* was a *"concern"* that she was sure was at the *"forefront"* of the jury members' minds.

26 This *"discrepancy"* is of no probative value when seeking to determine if another person was involved in Ms Godenzi's death and the Coroner made no attempt to explain how it was relevant. The Coroner erred in directing the jury

to consider the *"discrepancy"* and this error is made more acute by the particular emphasis the Coroner placed on it.

27 This error also further exacerbates the Coroner's erroneous directions as to the standard of proof. The impression given to the jury would be that any evidence which was odd in a general sense was evidence which cast doubt on whether Ms Godenzi committed suicide, an impression which would tend to raise the standard of proof in the jury members' minds.

The Suggestion The Applicant Killed Ms Godenzi

28 In the conclusion to the Directions (extracted at ¶17 above) the Coroner directed the jury that a *"concern"* at the *"forefront"* of their minds ought to be the possibility the Applicant killed Ms Godenzi *"The Deceased had no life insurance. But who was to gain from her death? No divorce, no settlement issues"*.

29 The Coroner erred in doing so because at no point during the Inquest was evidence offered to suggest the Applicant was involved in Ms Godenzi's death, the matter was never put to the Applicant and there was no evidence arising from the circumstances of death indicating anything other than suicide.

30 In the conclusion to the Directions the Coroner stated that *"Since Mr Haug had evidence from the tracking device that the vehicle had not been turned on, why did he not check on Ms Godenzi or why the car wasn't moving before he left the island on Thursday [5 April 2012]?"* Evidence was given during the Inquest that the Applicant had left the Cayman Islands for a holiday with his children on 5 April 2012 and that the Applicant had access to the records produced by the GPS device.

31 During the Inquest the Applicant was not asked why the device had been installed. He was not asked whether he had checked the records from the GPS device before *"he left the island"* or whether he had considered checking on Ms Godenzi before he left to go on holiday. The Coroner simply assumed that the Applicant had looked at the GPS records, directed the jury to make the same assumption, directed them that this was of probative value and then suggested that from this assumption they draw the adverse inference that the Applicant may have killed his wife. By doing this the Coroner fell repeatedly into error.

32 The Coroner made similar errors in expressing *"concerns"* about the *"missing laptop"* and that *"Two persons who had keys to her place, one she knew about, one [Mr Haug] we are not so sure she knew about."* In each case the jury is directed to have a matter of limited probative value at the *"forefront"* of their minds and it is suggested that these matters are grounds to suggest the Applicant may have committed murder.

THE FOURTH ERROR - EVIDENCE IMPROPERLY EXCLUDED

Dr Farley's Report

33 A note was found in the room Ms Godenzi hanged herself in. The note read *"Just do it!"* This note was analysed by a handwriting expert, Dr Farley. The Coroner did not call Dr Farley to give evidence:- instead his report was read. Dr Farley stated that the note *"fits comfortably"* with a known sample of Ms Godenzi's handwriting and that the two samples *"display significant characteristics"*. The report stated that no definitive conclusion could be reached because of the limited quantity of text but concluded that the note was *"probably"* Ms Godenzi's writing.

34 Immediately after reading Dr Farley's report the Coroner directed the jury to give no weight to it. In her summing up the Coroner said Dr Farley's report was *"inconclusive"* that for the jury to rely on the report it would have to be *"definitive"* concluding that *"we cannot rely [on this report]"*.

35 This was a misdirection based on a fundamental misunderstanding. The Coroner seems to have proceeded on the basis that because the standard of proof for a verdict of suicide was *"beyond reasonable doubt"* each single item of evidence which tended to show that Ms Godenzi killed herself also had to be proven beyond reasonable doubt. The jury were entitled to consider Dr Farley's expert opinion that the note was *"probably"* written by Ms Godenzi. This evidence was improperly excluded from their deliberations.

36 This error further exacerbates the Coroner's erroneous directions as to the standard of proof. The exclusion of the evidence and the reasons the Coroner gave for excluding it would have had the effect of further raising the standard of proof in the minds of the jury.

Ms Godenzi's Suicidal Intent

37 In her summing up the Coroner erred by failing to remind the jury of the evidence pointing to Ms Godenzi's suicidal intent. This evidence included a text Ms Godenzi had sent expressing her suicidal intent which read *"I want to die. I need to die. I need to make it look like an accident"* and the evidence of Dr Lockhart, the psychiatrist treating Ms Godenzi's clinical depression, that Ms Godenzi had expressed "suicidal ideation" on at least one previous occasion, and that *"a depression sufferer can swing back and forth between suicidal thoughts and coping/managing."* Dr Lockhart stated that had he known the true extent of the personal trauma Ms Godenzi was suffering from (i.e. including her recent termination), he would have recommended that she be sectioned for her own safety.

38 Instead the Coroner told the jury that Ms Godenzi was *"looking ahead"* and that *"her friends felt she was recovering"*. This failure to properly direct the jury on Ms Godenzi antecedent mental health would wrongly have left them with the impression that Ms Godenzi was a woman whose psychological state was not predisposed to suicide.

THE FIFTH ERROR – DENIAL OF NATURAL JUSTICE

39 After the Directions were given Colin McKie QC, the Applicant's representative, attempted to address the Coroner on the law. The Coroner refused to hear Mr McKie's submissions.

40 This refusal was an obvious procedural error (see ***R v HM Coroner for East Berkshire, ex parte Buckley* (1993) 157 JP 425**). The error is made even more inexplicable as before the substantive hearing Mr McKie had written to the Coroner asking to address her on the law.

RELIEF

Certiorari

41 Certiorari is the appropriate relief where it is *"necessary or desirable ... in the interest of justice"* (see ***R v Inner South London Coroner's Court, ex parte Douglas Williams* [1999] 1 All ER 344**, at 347).

42 The Coroner's error-strewn directions had a significant bearing on the verdict the jury came to; they made an open verdict inevitable.

43 This verdict, and the erroneous directions which led to it, sully the Applicant's reputation and deprive the Applicant, the children and Ms Godenzi's immediate family of a true verdict. A verdict so polluted by misdirection should not be allowed to stand.

Substitute verdict of suicide

44 It is appropriate for the Court to replace the open verdict with one of suicide. The Court has the power to do this (see ***R (Anderson) v HM Coroner for Inner North London*** **[2004] EWHC 2729** and Jervis[2] 19-41). As set out at ¶10-15 above there must be grounds upon which one can reasonably doubt suicide before an open verdict is returned and there are no grounds on which a properly directed jury could return an open verdict.

45 As Collins J said in ***R (Anderson)*** (at p.278) there is *"nothing to be gained from a fresh inquest"* and so the Court should order that the open verdict be replaced with one of suicide.

OTHER MATTERS

46 The Coroner's directions are susceptible to judicial review.

47 Magistrates are empowered to act as Coroners and are directed to hold inquests pursuant to the **Coroners Law 1975**. Magistrates are susceptible to judicial review (see ***Miller v Summary Court, ex parte Attorney General (1994-1995) CILR 417***) as are the exercise of Coronial powers (see ***R v Greater Manchester Coroner, ex p Tal*** **[1984] 3 All ER 240**, at 249).

48 Pursuant to Order 53 r.3(7) of The Grand Court Rules 1995 (Revised) the Applicant has a *"sufficient interest"*. The Applicant was the husband of the deceased, he was represented at the inquest, he gave evidence to the inquest and the Coroner's Directions implicated him in the death of his wife. Each of these matters on its own is sufficient to find that the Applicant has a sufficient interest; together that conclusion is irresistible.

[2] Jervis on Coroners third cumulative supplement to the twelfth edition 19-41

Richard Lissack QC

Samson & McGrath

7 January 2014