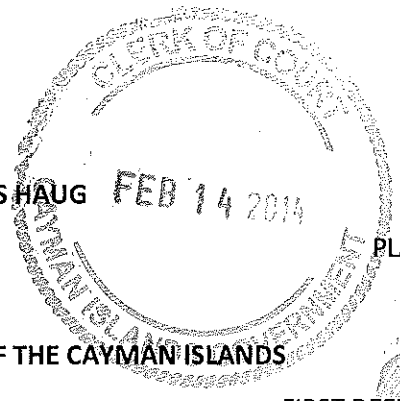
No. 53

Application for Leave to Apply for Judicial Review (0.53, r.3)

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO. 25 **OF 2014**



BETWEEN:

ANDREAS HAUG PLAINTIFF

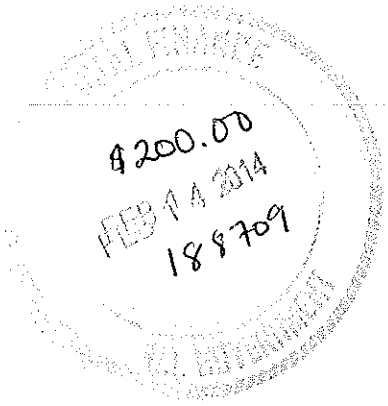
AND:

THE ACTING CORONER OF THE CAYMAN ISLANDS

FIRST DEFENDANT

ATTORNEY GENERAL OF THE CAYMAN ISLANDS

SECOND 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 plaintiff(s)	Andreas Haug 824 Britannia, SMB, Grand Cayman Attorney at Law

Judgment, order, decision or other proceeding in respect of which relief is sought	The First and Second Defendants' illegal and irrational refusal to release documents relevant to Cause No. 3 of 2014 ("**Primary Judicial Review**"), a judicial review of the First Defendant's conduct in relation to the inquest into the death of Ms Lija Godenzi ("**Ms Godenzi**") held on 4 – 7 November 2014.
Relief Sought	An order of Mandamus requiring the Defendants to release the relevant documents, which are described at paragraph 3 of the attached draft Grounds for Review. Such further and other relief as the Court may deem appropriate in all the circumstances. An order that the costs of and incidental to the application be paid by the Defendants.
Name and address of plaintiff's	Samson & McGrath, Attorneys-at-Law for the Plaintiff, whose

attorneys, or, if no attorneys acting, the address for service of the plaintiff	address for service is 5th Floor, Genesis Building, PO 446 GT, Grand Cayman.	
Signed Samson and McGrath		**Dated** 14 February 2014

GROUNDS ON WHICH RELIEF IS SOUGHT

Relief is sought because the Defendants' refusal to release the relevant documents is irrational and illegal.

Full particulars of the grounds on which relief is sought are set out in the attached draft Grounds of Review and in the Plaintiff's affidavit in support of this application.

Dated the 14 day of February 2014

Filed the 2014

Samson and McGrath

Samson &McGrath

Attorneys-at-Law for the Plaintiff

TO: The Clerk of the Courts

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

In The Grand Court of The Cayman Islands

ANDREAS HAUG

Plaintiff

v

THE ACTING CORONER OF THE CAYMAN ISLANDS

First Defendant

ATTORNEY GENERAL OF THE CAYMAN ISLANDS

Second Defendant

[DRAFT] GROUNDS OF REVIEW

INTRODUCTION

1. The First Defendant ("**Coroner**") presided over the inquest into the death of Ms Lija Godenzi on 4 – 7 November 2013 ("**Inquest**"). On 4 February 2014, Henderson J granted the Plaintiff leave to apply for judicial review of the Coroner's conduct of that hearing, and in particular her directions to the jury ("**Primary Judicial Review**"). The Notice of Originating Motion in the Primary Judicial Review, dated 11 February 2014, is appended.

2. This application for judicial review arises from the Defendants' illegal and irrational refusal to release documents relevant to the Primary Judicial Review.

3. The Plaintiff seeks Mandamus requiring the Defendants to release the following documents:

3.1 All documents put in evidence at the Inquest, including all witness statements, summaries of live evidence and exhibits.

3.2 All notes of evidence taken at the Inquest, including the Coroner's manuscript notes of the hearing and any manuscript notes taken by the Coroner's clerk.

3.3 Copies of correspondence between the Coroner and other participants in the Inquest, and in particular correspondence between the Coroner and the Godenzi family and/or Ms Kelly Rees, a witness at the Inquest who also asked questions of other witnesses on behalf of the Godenzi family, and the Royal Cayman Islands Police Service ("**RCIPS**").

3.4 Notwithstanding the specificity of 3.1, 3.2 and 3.3, a full record of the hearing and other relevant documents on the court file.

BACKGROUND FACTS

4. The Plaintiff first began requesting copies of the material to be used at the Inquest before the Inquest took place. The Plaintiff first requested copies of the evidence to be called at the Inquest by letter dated 1 March 2013, and by letter dated 6 March 2013 the Coroner refused. The Plaintiff repeated his request by letter dated 16 April 2013 and explained why he wanted the disclosure; the Coroner again refused by letter dated 14 May 2013, but did state: *""once the statements become evidence and part of the record, you may request copies on payment of the appropriate fee."*

5. The Plaintiff made a further request on 19 June 2013 citing ***R(Ahmed) v HM Coroner for South and East Cumbria*** **[2009] EWHC 1653 (Admin)** in which Irwin J stated *"it is often advisable that there should be disclosure of material central to the Inquest"*, the Plaintiff asked for reasons if the Coroner refused to provide the requested documents. The Coroner replied on 24 June refusing the Plaintiff's request. The Coroner offered no reasons, stating *"copies of evidence and*

statement (sic) intended to be used at the inquest will not be released until after the hearing." Despite further requests on 5 July 2013, 13 August 2013, 16 September 2013 and 16 October 2013, the Coroner continued to refuse to provide reasons.

FACTS GIVING RISE TO THIS APPLICATION

6. The jury returned a verdict in the Inquest on 7 November 2013. The Plaintiff wrote to the Coroner on 8 and 13 November 2013 requesting disclosure of:

   "1. All documents put in evidence at the inquest, including all witness statements and exhibits."

   2. All notes of evidence taken at the inquest."

7. The material was requested on the basis that the Inquest was a public hearing (at which the Plaintiff was present and represented by counsel) and that the material was therefore a matter of public record.

8. On 15 November 2013, the Deputy Clerk of the Court (Criminal) wrote to the Plaintiff, on the direction of the Coroner, refusing to release the requested documents.

9. On 9 December 2013, the Plaintiff sent the Coroner a letter before action and repeated his request that the Coroner disclose the documents set out at ¶3 above.

10. The Second Defendant was subsequently instructed by the Coroner to contest the proposed application and sent a holding letter on 9 January 2014. On 17 January 2014, the Second Defendant responded substantively to the Plaintiff's letter before action and enclosed the following documents: (i) a standard opening direction and jury direction said to be used by the Coroner for the purposes of directing the jury at the Inquest; (ii) a typed document purporting to be the Coroner's note of the

Inquest; (iii) two statements belonging to the same witness (Tekeel Cowan, an RCIPS police officer involved in the investigation into Ms Godenzi's death); (iv) Mr Haug's witness statement; and (v) an email sent by Mr McKie QC (Mr Haug's counsel at the Inquest) to the Coroner regarding the burden of proof in a jury direction of suicide.

11. These documents by no means constitute full disclosure of the requested material. Accordingly, the Plaintiff wrote to the Second Defendant again on 21 January 2014 requesting the release of the following items:

> *"1. Copy of the Coroner's contemporaneous hand written notes made during the inquest;*
>
> *2. Copies of the signed versions of all witnesses statements and/or copies of the signed information for each and every witness at the inquest, whether or not they gave live evidence; and*
>
> *3. Copies of all documentary exhibits.*
>
> *...*
>
> *All correspondence received by the Coroner from "interested parties" including, but not limited to, the Godenzi family. "*

12. The Second Defendant replied on 22 January 2014 stating that:

> *"...the record of the inquest is currently being prepared and will be disclosed to you in due course. We are conferring with the Office of the Director of Public Prosecutions regarding any documentation that should be withheld."*
>
> *"The Coroner's handwritten notes have been typed and disclosed to you, along with the standard opening and closing directions utilised in this case. In light of this we do not see the relevance of her handwritten notes..."*
>
> *"We do not see the relevance of correspondence from other interested parties to the current application."*

13. The Plaintiff wrote a further letter to the Second Defendant on 31 January 2014 stating that the disclosure provided to date was incomplete and repeating his request that the relevant documents be disclosed. This correspondence also put the Defendants on notice of the amenability of their decision to refuse to release the material to judicial review, stating that:

> *"If the Coroner maintains her refusal to produce these documents then our client reserves the right to seek judicial review of that refusal. Additional judicial review proceedings would further increase costs and delay and distract from the efficient disposal of the proceedings already commenced. We therefore invite the Coroner to reconsider her decision."*

14. The Plaintiff has not heard from the Defendants since.

GROUNDS OF REVIEW

15. The refusal to release the documents set out at ¶3 above is both irrational and illegal.

Illegality

Duty of Candour

16. The Defendants' refusal to release the documents requested by the Plaintiff is a breach of their duty of candour. The duty of candour has been summarised by De Smith[1] as follows:

> *"Once a claim for judicial review is afoot, the defendant public authority is subject to the "duty of candour". The duty of candour requires that the process of judicial review be "conducted with all the cards face upwards on the table" and acknowledges that "the vast majority of the cards will start in the authority's hands... **The duty extends to documents and other information which will assist the claimant's case and/or which may give rise to further grounds of challenge** which might not otherwise occur to the*

[1] De Smith's Judicial Review 7th Edition, 16-027.

claimant. ***The duty arises as soon as the public authority becomes aware that someone is likely to challenge a decision*** *affecting them and continues until the proceedings are resolved." (Our emphasis)*

17. In ***Secretary of State for Foreign and Commonwealth Affairs v Quark Fishing Ltd*** **[2002] EWCA Civ 1409 [50]** Laws LJ said:

> *"[t]here is – of course – a very high duty on public authority Defendants, not least central government, to assist the court with full and accurate explanations of all the facts relevant to the issue the court must decide."*

18. The Primary Judicial Review makes complaints about the Coroner's misdirections both during and at the end of the Inquest. A full record of the Inquest, including all the documents set out at ¶3 above, is plainly necessary to provide a *"full and accurate explanation of all the facts relevant to"* the Coroner's misdirections to the jury, particularly given that the Inquest was neither recorded nor transcribed.

19. Equally, a full and accurate explanation of the manner in which the Coroner directed the jury and conducted the Inquest necessitates the release of correspondence between the Coroner and at the participants in the Inquest, and, in particular, the Godenzi family, Ms Rees and the RCIPS. That correspondence will have informed her approach to the Inquest.

20. The duty of candour is not limited to documents dealing with the grounds of review set out in the Notice of Originating Motion but extends to documents and other information *"which may give rise to further grounds of challenge*[2]*."* The Coroner's conduct of the Inquest is being challenged, and as such she is obligated to release all documents relating to her conduct of the hearing.

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[2] See for example ***R v Barnsley MBC, ex p Hook*** **[1976] 1 WLR 1052** at p 1058 Denning MR.

Statutory Duty

21. Section 9 of the Coroners Law 1975 (1995 Revision) ("**Coroners Law**") provides that:

> *"The Coroner, holding an inquest under section 4, shall record the evidence of all the witnesses appearing or summoned before him and shall cause all exhibits produced to him in connection with the inquest to be identified, marked and preserved until the final disposal of the case and of any other proceedings arising thereout." (our emphasis)*

22. The English Coroners Rules 1984 ("**English Rules**") also require coroners to retain documents and exhibits (see in particular rules 55 and 56). Rule 57 of the English Rules requires a coroner to permit any properly interested person, such as the Plaintiff, to have copies of any notes of evidence, or of any document put in evidence. The Coroners Law does not have an equivalent to rule 57 of the English Rules. However, a requirement to release those documents for the purposes of such proceedings is implicit in the section 9 requirement to preserve the record of evidence and exhibits until proceedings arising out of the Inquest are finally disposed of. The Primary Judicial Review is such a proceeding. Indeed, as set out at ¶4 the Coroner informed the Claimant that he could have copies of the evidence offered at Inquest after the hearing had finished.

Irrationality

23. The Defendants have the power to release the documents should they choose to do so. Their failure to do so is irrational. The Second Defendant has offered a number of explanations for their refusal to release documents and none of them stand up to logical scrutiny. In particular:

23.1 The Second Defendant's delay in releasing the record of Inquest is inexplicable. The purported reason is that the record *"is currently being prepared"*. The documents the Plaintiff requests require no

preparation: they are contemporaneous notes written during the Inquest and documents produced during the hearing. All of these documents ought to be on the court file and it ought to simply be a matter of sending them to the Plaintiff.

23.2 The Second Defendant claims to be consulting with the Director of Public Prosecutions ("**DPP**") as to which documentation from the Inquest ought to be withheld. There is no proper basis on which the DPP could object to materials from the Inquest being released and indeed no proper basis has been offered. The Plaintiff is seeking the record of a public hearing, the conduct of which he is judicially reviewing. There is no rational basis on which the Second Defendant, or anyone else, can withhold any part of the record of the hearing from the Plaintiff.

23.3 The Second Defendant's refusal to release the Coroner's handwritten note on the basis that it is not relevant is irrational. As explained at ¶18, above, the Inquest was neither recorded nor transcribed. In such circumstances the Coroner's contemporaneous note of the proceedings is highly relevant. The Second Defendant has sent a typed note purportedly replicating the handwritten note; however that is not contemporaneous to the hearing and is not an adequate substitute for a contemporaneous note.

24. The irrationality of the Defendants' refusal to release a full record of the hearing is particularly acute given that the Inquest was a public hearing at which the Plaintiff was present and represented by counsel.

25. As set out at ¶15 above, the Second Defendant's refusal to release correspondence between the Coroner and other participants in the Inquest on the grounds that it is not relevant is plainly wrong and therefore irrational.

Legitimate Expectations

26. As set out above, in a letter dated 14 May 2013 the Coroner confirmed that *"once the statements becomes evidence and part of the record, you may request copies on payment of the appropriate fee."* On 24 June 2013 the Coroner wrote stating *"copies of evidence and statement (sic) intended to be used at the inquest will not be released until after the hearing."*

27. The Coroner made an express promise to the Plaintiff that he would have access to the evidence and statements offered at tribunal after the hearing. As Laws LJ said in ***R(Nadarajah) v Secretary of State for the Home Department*** **[2005] EWCA Civ 1363** [68]: *"Where a public authority has issued a promise ... which represents how it proposes to act in a given area, the law will require the promise or practice to be honoured unless there is good reason not to do so..."* There is no good reason for the Defendants to resile from their promise to release the evidence offered at the inquest.

RELIEF

28. Mandamus is the appropriate relief where there has been a breach of duty and where, in the circumstances, it appears to the court that it is an appropriate form of relief[3]. The Defendants are under a duty to release the documentation the Plaintiff has requested. No hardship will be caused if the court obliges them to do so and disclosure of the material is necessary in order for the Primary Judicial Review to be properly heard. In the circumstances, mandamus is the appropriate relief.

OTHER MATTERS

29. The Defendants' decisions are susceptible to judicial review. They are the decisions of public bodies exercising public functions. Specifically, the Defendants are custodians of the court file and the decision as to whether its contents ought to be released or not is a public law decision.

[3] De Smith, 7th Edition, 18-024.

30. Pursuant to Order 53 r.3(7) of The Grand Court Rules 1995 the Plaintiff has a *"sufficient interest"*. The illegal and irrational refusal of the Defendants to release the requested documents inhibits the Plaintiff's ability to properly prosecute the Primary Judicial Review.

CONCLUSIONS

31. The Coroner's conduct of the hearing and directions to the jury were littered with errors. Most egregiously she directed the jury that the Plaintiff may have been involved in the death of his then wife. The Plaintiff is entitled to the documents he has requested to be able to properly judicially review the Coroner's conduct. The court is invited to compel the release of the documents because the refusal to release them is irrational and illegal.

Richard Lissack QC

Samson & McGrath

14 February 2014

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO. 3 OF 2014

BETWEEN:

ANDREAS HAUG

Plaintiff

AND:

ACTING CORONER OF THE CAYMAN ISLANDS

Defendant

NOTICE OF ORIGINATING MOTION

TAKE NOTICE that the Court at the Law Courts, George Town, Grand Cayman will be moved on at or as soon thereafter as counsel can be heard by counsel on behalf of Andreas Haug for an order of Certiorari to quash that part of the verdict returned on 7 November 2013 by the jury in the inquest into the death of Ms Lija Godenzi ("**Ms Godenzi**" or "**Deceased**") stating that an open verdict as to how the death was brought about had been reached, and replacing that part of said verdict with a verdict of suicide.

And for such further and other relief as the Court may deem appropriate in all the circumstances.

And for an order that the costs of and incidental to this application be paid by the Defendant.

AND FURTHER TAKE NOTICE that the grounds of this application are as follows:

1 **INTRODUCTION**

1.1 The Plaintiff was at all material times the husband of the Deceased, however at the time of Ms Godenzi's death they had been separated for approximately five months and had commenced proceedings to divorce one another.

1.2 The Defendant ("**Coroner**") is and was at all material times a Coroner of the Cayman Islands.

1.3 The Coroner opened an inquest into the death of Ms Godenzi on 4 November 2013 ("**Inquest**"). The Inquest was initially scheduled for 28 May 2013 but adjourned for

reasons stated by the Coroner on 4 November 2013 to be difficulties caused by the listing of another, unrelated inquest on the same day. On 4 November 2013, a jury was convened and the substantive hearing commenced. The Coroner gave the jury directions on 7 November 2013 ("**Directions**") and the jury returned an open verdict later the same day. Insofar as the verdict recorded the name and description of Ms Godenzi and the physical cause of death, no issue arises.

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

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

(b) The conclusion to the Directions amounted to improper pressure on the jury to return a particular result.

(c) The Coroner incorrectly directed the jury to disregard some items of evidence.

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

(e) The Coroner erred in preventing the Plaintiff's counsel from making submissions to her at the end of the Directions.

1.5 Despite repeated requests, the Coroner has failed to provide complete disclosure of the Inquest documents. The Plaintiff anticipates that the disclosure of these documents may give rise to further grounds of review and reserves his right to amend this motion following disclosure of that material.

2 FACTUAL BACKGROUND

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

2.2 An autopsy report dated 13 April 2013 ("**Autopsy Report**"), prepared by Dr Shravana Jyoti ("**Dr Jyoti**"), 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."*

2.3 The autopsy also found:

> *"No signs of injury around the ligature, no injuries related to struggle or combat and no evidence of wounds."*

2.4 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-anxiety and anti-depressant medications - Ciprolex and Zopiclone.

2.5 The 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.

3 GROUNDS FOR JUDICIAL REVIEW: THE FIRST ERROR - STANDARD OF PROOF

3.1 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.

3.2 There are two elements to a finding of suicide:

(a) That the deceased did the act that caused their death (*actus reus*); and
(b) That the deceased intended to cause death (*mens rea*).

These elements must be proven beyond reasonable doubt.

3.3 ***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 dead, his body sitting next to a shotgun which had been discharged. The pellets from the shotgun had penetrated his 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."*

3.4 Parker LJ went on to say that *"accidental discharge"* had, on the evidence, not been ruled out.

3.5 ***John*** concerned a 17 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, in ***Hopper***, the *"court considered that the physical cause of death might have been an accident"*. Taylor LJ 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 chair, 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."

3.6 *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 totally to 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].

3.7 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:

(a) There were grounds to suspect that another had killed Ms Godenzi; and

(b) Those grounds were sufficient to generate a reasonable doubt as to whether the Deceased did in fact kill herself; and

(c) There was evidence given at the Inquest capable of supporting reasonable doubt that Ms Godenzi's death was suicide.

4 None of the above applied, and 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 a suicide.

5 **GROUNDS FOR JUDICIAL REVIEW: THE SECOND ERROR - IMPROPER PRESSURE**

5.1 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. As Lane LJ stated in ***R v Mears* [1993] 1 WLR 818:**

"[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."

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

5.2 *Mears* was cited in the English Court of Appeal in ***R v Wood*** **[1996]** 1 Cr App R 207. In ***Wood***, Staughton LJ described the judge's improper comments as "advocacy". The importance of a judge expressing any personal opinions in a moderate and balanced way in a summing up was similarly emphasised by the Privy Council in ***R v Randall v R*** [2002] CILR 254, in which Lord Bingham of Cornhill stated:

> *"It is the responsibility of the judge to ensure that proceedings are conducted in an orderly and proper manner which is fair ... [He] must neither be, nor appear to be, partisan."*

5.3 The principles which apply to jury directions in a criminal context apply equally to the Coroner's Court[2].

5.4 In the conclusion to the Directions the Coroner breached these standards. The Coroner told 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 Ms Godenzi's psychiatrist, Dr Mark Lockhart ("**Dr Lockhart**"), which the Coroner failed to summarise as part of her Directions (in relation to which see further paragraphs 7.6 to 7.9 below). The Coroner then concluded her Directions with the following remarks:

> *"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 [Mr Haug] 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 Lija 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...*
>
> ...
>
> *Members 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."*

5.5 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.

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[2] See, for example, *R (Anderson) v HM Coroner for Inner North London* [2004] EWHC 2729 (Admin) and *Re Bithell* (1986) 150 JP 273 where the Coroner was criticised for "virtually" telling the jury to return an open verdict.

5.6 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.

6 GROUNDS FOR JUDICIAL REVIEW: THE THIRD ERROR - EVIDENCE IMPROPERLY INCLUDED

Female suicide by hanging

6.1 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 counsel of Ms Godenzi's family asked Dr Jyoti about *"the statistics on women hanging themselves"*. Dr Jyoti had "*no knowledge*" of these statistics 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"*.

6.2 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.

6.3 Further and in any event, 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, including at least the one other in the Cayman Islands, 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

6.4 At around the time of her death, Ms Godenzi had the use of a vehicle purchased and owned by the Plaintiff. A GPS security device had been fitted to the car by The Security Centre. During the Inquest, the Plaintiff was not asked why the device had been installed. On Wednesday 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 without the engine having been started. 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. However, no evidence was heard at the Inquest at all in relation to the GPS device technology.

6.5 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.

6.6 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 or unexplained 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 that the Plaintiff was involved in Ms Godenzi's death

6.7 In the conclusion to the Directions, the Coroner directed the jury that a *"concern"* at the *"forefront"* of their minds ought to be the possibility that the Plaintiff was involved in the death of Ms Godenzi. The Coroner stated that: *"The Deceased had no life insurance. But who was to gain from her death? No divorce, no settlement issues..."*

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

6.9 Evidence was given during the Inquest that the Plaintiff had left the Cayman Islands for a holiday with his children on 5 April 2012 and that the Plaintiff had access to the records produced by the GPS device. In the conclusion to the Directions, the Coroner questioned:

> *"Since Mr Haug had evidence from the tracking device that the vehicle had not been turned on, why did he not check on Lija or why the car wasn't moving before he left the island on Thursday [5 April 2012]?"*

6.10 The Plaintiff 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 Plaintiff 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 Plaintiff may have been involved in Ms Godenzi's death. By doing this, the Coroner fell repeatedly into error.

6.11 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 Plaintiff may have been involved in Ms Godenzi's death.

7 GROUNDS FOR JUDICIAL REVIEW: THE FOURTH ERROR - EVIDENCE IMPROPERLY EXCLUDED

Dr Farley's report

7.1 A note was found in a diary in the room Ms Godenzi hanged herself in. The note read *"Just do it!"* This note was analysed by a handwriting expert, Dr Farley, on the instruction of the RCIPS during the course of their investigation into Ms Godenzi's death.

7.2 The Coroner did not call Dr Farley to give evidence, but read the affidavit attaching his report out to the jury and handed them a copy of the report to review. Dr Farley's report stated that the handwriting sample taken from the note *"fits comfortably"* with a known sample of Ms Godenzi's handwriting, and stated 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.

7.3 After reading Dr Farley's report, the Coroner directed the jury to give no weight to it. Further, in her Directions, the Coroner said Dr Farley's report was *"inconclusive"* and that for the jury to rely on the report it would have to be *"definitive"*. The Coroner concluded that *"we cannot rely [on this report]"*.

7.4 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.

7.5 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

7.6 In her Directions the Coroner erred by failing to remind the jury of the evidence pointing to Ms Godenzi's suicidal intent. This evidence included a text dated 28 March 2012 that 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 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."*

7.7 Dr Lockhart also stated in oral evidence that he was, at the time he was treating Ms Godenzi, unaware that she had recently become pregnant with her boyfriend's child and had terminated the pregnancy, following which her boyfriend had ended their relationship. Dr Lockhart said that, had he known about these events and therefore of

the true extent of the personal trauma that Ms Godenzi was suffering from he would have recommended that she be "sectioned" (i.e. compulsorily admitted to hospital for mental health treatment) for her own safety. This evidence was similarly excluded from the Directions.

7.8 Instead, the Coroner told the jury that Ms Godenzi was *"looking ahead"* and that *"her friends felt she was recovering"*.

7.9 This failure to properly direct the jury in relation to 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.

8 GROUNDS FOR REVIEW: THE FIFTH ERROR – DENIAL OF NATURAL JUSTICE

8.1 After the Directions were given, Mr Colin McKie QC, the Plaintiff's counsel, attempted to address the Coroner on the law. The Coroner refused to hear Mr McKie QC's submissions.

8.2 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 QC had written to the Coroner asking to address her on the law.

9 RELIEF

Certiorari

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

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

9.3 This verdict, and the erroneous directions which led to it, sully the Plaintiff's reputation and deprive the Plaintiff, 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

9.4 It is appropriate for the Court to replace the open verdict with one of suicide. The Court has the power to do this (***R (Anderson) v HM Coroner for Inner North London*** [2004] EWHC 2729 and ***Jervis on Coroners, Third Cumulative Supplement***, at 19-41).

9.5 As set out above, there must be grounds upon which one can reasonably doubt suicide before an open verdict is returned and there are, in this case, no grounds on which a properly directed jury could return an open verdict.

9.6 As Collins J said in ***R (Anderson)*** 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.

10 **OTHER MATTERS**

10.1 The Coroner's Directions are susceptible to judicial review.

10.2 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 (***Miller v Summary Court, ex parte Attorney General (1994-1995) CILR 417***) as are the exercise of Coronial powers (***R v Greater Manchester Coroner, ex p Tal*** [1984] 3 All ER 240).

Dated the 11th day of February 2014

Samson & McGrath

Samson &McGrath
Attorneys-at-Law for the Plaintiff

TO: The Clerk of the Court

AND TO: Attorney General's Chambers
DMS House
George Town
Grand Cayman
Cayman Islands

THIS NOTICE OF ORIGINATING MOTION was filed by Samson & McGrath, Attorneys-at-Law for the Plaintiff, whose address for service is 5th Floor, Genesis Building, PO 446 GT, Grand Cayman, Cayman Islands.