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PRESS RELEASE

REASONS FOR THE RULING BY THE ODPP THAT NO CRIMINAL CHARGES TO BE LAID IN THE INVESTIGATION OF THE DEATH OF JODIAN FEARON

1. Consequent on a referral of a file provided by the Jamaica Constabulary Force Criminal Investigations Branch (CIB) pertaining to the matters touching and concerning the death of Ms. Jodian Fearon, the Office of the Director of Public Prosecutions (ODPP) has issued a ruling dated the 29th of September 2020 which was returned to the Police with the original file and a copy file. This matter was quite complex in terms of the medicolegal issues and was thoroughly researched, discussed and considered in the Chambers.

2. It is usually within the prerogative of the police authorities to release the ruling publicly, where they deem it appropriate. However, given the high public interest in this matter and the discussions in the public domain, I deem it obligatory in the interest of transparency to provide an edited version of our 11-page ruling outlining the reasons for our decision in this very tragic and unfortunate case. *(A ruling can take the form of a legal opinion which includes our recommendations.)* Please note that the names of the medical professionals involved in the care of Ms. Fearon at the different institutions have been redacted.

Allegations

3. This ruling was based on the material statements, reports and video footage from the University Hospital of the West Indies (UHWI) which were the fruits of the police investigations contained in the file referred to the Office of the Director of Public Prosecutions (ODPP).

4. Ms. Fearon became a patient of Doctor Lloyd Goldson's on February 2, 2020. At the time, she was twenty-five weeks' pregnant and due for delivery on or about May 19, 2020.

5. On or about the week before her death, Ms. Fearon was feeling uncomfortable and felt her chest tightening when she lay down and had shortness of breath. She called her private obstetrician, Doctor Lloyd Goldson who told her, her baby was growing and resting on her diaphragm and this was the reason for her discomfort.

6. On Thursday, April 23rd, 2020 Ms. Fearon went to Doctor Goldson who made the decision that the delivery of her baby was necessary due to pregnancy-induced hypertension. He recommended that she be checked into the Andrews Memorial Hospital ('Andrews') which she did at or about 5pm that same afternoon.

7. At or about 7pm on that same day, Nurse WW who was assisting Doctor Goldson with an IV sitting for Ms. Jodian Fearon heard Ms. Fearon complaining about shortness of breath. A vaginal examination was done by Doctor Goldson and it was recognized by Nurse WW that she was in distress. Nurse WW asked Doctor Goldson if he checked her chest and he indicated that he did earlier and did not do another check at that time.

8. Nurse WW then reported to Nurse B and they both checked Ms. Fearon's oxygen saturation level which was below normal and they suspected this was a possible case of COVID 19. This was brought to the attention of Doctor Goldson and Doctor Leach (the CEO of Andrews Memorial Hospital) where Doctor Leach indicated that the patient had to be transferred as Andrews did not have the facilities to treat with a COVID 19 patient.

9. Calls were made to the University Hospital of the West Indies (UHWI) and the Victoria Jubilee Hospital for the patient to be transferred however this was not successful. UHWI indicated that they would accept the patient but the maternal ward would have to accept her first as the Intensive Care Unit (ICU) could not accept her directly and the Victoria Jubilee Hospital could not accept the patient as all their beds for COVID patients were occupied.

10. Doctor Leach indicated that he would allow the patient to stay overnight and then be transferred to UHWI after delivery.

11. On Friday, April 24th, 2020 at or about 5am Doctor Goldson examined Ms. Fearon where he commenced active inducement. It was realized that even though Ms. Fearon received 15L of oxygen her level was still low and as a result a C-Section was decided to be best. At or about 10:30am Doctor Goldson got in contact with anesthetist Doctor RB who upon learning of the patient's low oxygen level and possible COVID status advised that the patient was not a good candidate to be dealt with by the Andrews Memorial Hospital as the patient would most likely need post-operative ventilatory support which Andrews was not equipped to provide.

12. Doctor Goldson contacted the UHWI where he spoke to the consultant obstetrician on duty Dr. MC who upon the direction of Dr. CR asked if the patient had done a COVID test. Upon learning that a COVID test had not been done, Dr. MC indicated that UHWI could not accept the patient.

13. The Spanish Town Hospital then agreed to take the patient and an ambulance was prepared and Dr. Goldson and two nurses left with the patient. Prior to leaving Andrews Memorial Hospital, Dr. WG, an anesthetic, offered to take the case, however, Dr. Goldson alleged that he did not follow through after what was advised by Dr. RB.

14. Upon arrival at the Spanish Town Hospital, there was some miscommunication and the isolation room for the patient was not prepared and Ms. Fearon had to wait in the ambulance for approximately one hour and forty-five minutes (1hr 45mins) before she was admitted. Dr. Goldson handed over the patient to Dr. SRW where he gave her an oral report of the patient as he did not have any documents with him due to the rush in leaving Andrews Memorial Hospital.

15. Ms. Fearon gave vaginal birth to a healthy baby with assisted vacuum extraction. She was diagnosed and treated for heart failure by Dr. B at the Spanish Town Hospital and

transferred to the ICU at the UHWI at or about 5:47pm as Spanish Town Hospital did not have an ICU.

16. Upon arrival at the UHWI Ms. Fearon was interviewed by the ICU team consisting of Doctors LS and LD along with consultant on duty Dr. MS. Based on the notes received and the history of the patient, she was admitted to the ICU A section. This room is designated for COVID patients and suspected cases. There is a monitoring station for doctors and nurses at the E-ICU (Electronic ICU) where the patients are monitored from another room via cameras.

17. At or about 10:06pm Dr. LD received a call from the E-ICU that the patient had gotten out of bed, unplugged her vitals and was no longer in view of the camera. The team got dressed in their personal protective gears and upon entry, they realized Ms. Fearon was slumped over against the ventilator. She was found to be unresponsive. She was placed flat on the floor and Cardiopulmonary Resuscitation (CPR) was done however to no avail. Ms. Jodian Fearon was pronounced dead at 10:24pm on Friday, April 24th, 2020.

Issue

18. In determining whether the conduct rises to the threshold of criminal liability, the issue is whether the actions/inactions of Doctor Lloyd Goldson as Ms. Jodian Fearon's obstetrician or any of the doctors at either Andrews Memorial Hospital, Victoria Jubilee Hospital, Spanish Town Hospital or the University Hospital of the West Indies amounted to **Manslaughter by way of Gross Negligence** making Doctor Goldson or any other person criminally liable for her death.

The Law

19. It is therefore best to begin with the law on **Negligence** which can be broken down into three or four elements as follows:-

[i] The defendant has a duty to others, including the claimant or complainant to exercise reasonable care;

[ii] The defendant has breached that duty through an act or culpable omission;

[iii] As a result of that act or omission, the claimant/complainant suffers an injury or damage or both; and

[iv] There is causation. That the injury to the claimant or complainant is a reasonably foreseeable consequence of the defendant's act or omission.

20. The law on medical negligence has been judicially decided in the seminal case of **R v Bateman [1925] All ER Rep 45** and aptly summarised by Lord Hewart LCJ as follows:

"If a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. ***If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence care, knowledge, skill and caution in administering the treatment.*** *No contractual relation is necessary, nor is it necessary that the service be rendered for reward. It is for the judge to direct the jury what standard to apply and for the jury to say whether that standard has been reached. The jury should not exact the highest, or a very high, standard, nor should they be content with a very low*

standard. ***The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned.*** *If the patient's death has been caused by the defendant's indolence or carelessness, it will not avail to show that he had sufficient knowledge; nor will it avail to prove that he was diligent in attendance if the patient has been killed by his gross ignorance and unskilfulness. No further observation need be made with regard to cases where the death is alleged to have been caused by indolence or carelessness. As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man.*

21. In **Bateman's** case the facts revealed that the appellant, who was a qualified medical practitioner, was indicted for having on 30 July 1924, unlawfully killed one MAH. He was called in by the midwife on the night of July 23, when MAH was in the throes of labour and found a very unusual and difficult presentation. He administered chloroform and attempted unsuccessfully to effect delivery of the child by the use of instruments. When that failed, he then proceeded by using his hands to perform the operation known as "version" using of necessity, considerable force. He worked at this operation for an hour and then delivered the child, which was dead. In removing the placenta, he by mistake, removed along with a portion of the uterus. The patient was much exhausted, and the appellant did not expect her to live. He visited her twice daily until the 28th, on which day he wrote a letter to the superintendent. On admission to the infirmary she was found unfit to undergo an operation. She grew gradually weaker, and died on the 30th. On a post mortem examination the bladder was found to be ruptured, the colon was crushed against the sacral promontory, there was a small rupture of the rectum, and the uterus was almost entirely gone. The charges of negligence that were made against the appellant were, in substance: (i) causing the internal ruptures in performing the operation of "version"; (ii) removing part of the uterus along with the placenta; (iii) delay in sending the patient to the infirmary.

22. The jury returned a general verdict of "Guilty" and the accused was sentenced to six months' imprisonment. Against this conviction and sentence he appealed. In Bateman, the appeal was allowed and the conviction was quashed.

23. Lord Hewart LCJ in giving the judgment for the Court held that in cases of manslaughter by gross negligence **it is most desirable that in trials for manslaughter by negligence it should be impressed on the jury that the issue is not negligence or no negligence, but felony or no felony**.

> *"It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is, in a sense, a question of degree, and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime....*
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> *In the criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be* ***mens rea" (the mental element to commit the crime)***
>
> **explanation and emphasis added*

24. In **Regina v Adomako [1995] 1 AC 171**, the conviction arose out the conduct of an eye operation. The short facts are that the appellant was an anaesthetist, who should have been monitoring the machine, failed to notice that a disconnection had occurred at the enotracheal tube connection. The supply of oxygen to the patient had therefore ceased and the patient went into cardiac arrest and subsequently died. At no stage before the cardiac arrest did he check the integrity of the endotracheal tube connection. The disconnection itself was not discovered until after resuscitation measures had been

commenced. He was convicted and appeal. The appeal was subsequently dismissed and conviction affirmed whereby Lord Mackay of Clashfern LC applied the test laid down in **Bateman**. It was stated:

"On this basis in my opinion, the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal."

25. The principles to be gleaned from the case law indicate that the Prosecution must, in cases like this, prove:

    [i] That the accused owed to the deceased person a duty to take care;

    [ii] That that duty was not discharged;

    [iii] That the default of the accused caused the death of the deceased; and

    [iv]* That the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.

26. In all criminal cases, it is the Prosecution and no one else that has the burden to prove the case beyond a reasonable doubt in any prosecution that is brought. In order for a viable charge to be prosecuted, the evidentiary material must disclose **all** the elements of the offence.

27. Accordingly, to prove the manslaughter by gross negligence, the Crown must meet a very high and exacting burden to establish the elements of the offence. It is a very high standard that has to be met and **all four elements must be present** for a charge or case to be viable. The case law, in this area of gross negligence involving medicolegal issues, indicate that it is for this very reason why these offences are hard to prove and these cases are usually not charged.

Conclusion

28. In the Jodian Fearon matter, our detailed examination showed that as a matter of law, there was no evidentiary material on file to establish the fourth limb of the test (referred to in paragraph 25). In other words, there was no material to establish the negligence or incompetence of any doctor or any other person went the putative accused(s) went beyond a matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.

29. In light of the clear absence of this most critical element (Limb 4) no useful purpose would be served in respect of a discussion of whether there was sufficient material to ground Limbs 1-3 as understood by the case law.

30. Accordingly, the ODPP has ruled that no criminal charges are to be laid against Doctor Lloyd Goldson or any of the medical personnel named in the statements at Andrews

Memorial Hospital, Victoria Jubilee Hospital, Spanish Town Hospital or the University Hospital of the West Indies.

31. We further ruled that no useful purpose would be served in remitting this matter to the learned Coroner as a Coroner's jury properly directed in law would inevitably as a matter reach the same conclusion as outlined in the ruling.

32. We take note and respect the public debate and the discussions within the court of public opinion as facilitated by the electronic and print media. However, as prosecutors, we are governed by Codes of Conduct which are prescribed in case law, our protocols such as our Prosecutor's Protocol and Decision to Prosecute Protocol where it is quite clear, as a matter of law, that a recommendation or ruling for a charge to be made for prosecution can only take place where all the elements of the offence have been made out on the available evidentiary material. If the test fails on that first limb, then ethically and as a matter of law we cannot go onto a consideration of the second limb, that is, whether it is in the public interest to bring the prosecution.

33. It is clear from the material on file that the unease occasioned by the Covid-19 pandemic and the uncertainty surrounding Ms. Fearon's status may have contributed to what appears to be the uncoordinated, indecisive efforts and tardy response by the health institutions/medical personnel in Jamaica's public health sector or from her personal physician. This state of affairs would have exacerbated and blurred the circumstances surrounding Ms. Fearon's untimely demise.

34. The issues surrounding possible breaches of duty of care to Ms. Jodian Fearon in her interface with either her private physician or the public health institutions would be best answered by a Court of Law exercising its civil jurisdiction and would therefore be outside the purview of the Office of the Director of Public Prosecutions. So that we have no other recurrence of this very unfortunate and sad episode, we feel sure that the public interest would benefit, as has been signalled in the public domain from the health authorities, from a review of the protocols of the Ministry of Health administrators governing the transfer of patients from private physicians to public health entities or the transfer of patients form public health institutions to other public health institutions whether we are in normal times or in the embrace of a pandemic.

Paula V. Llewellyn, QC (Ms.)
Director of Public Prosecutions