STATEMENT OF WITNESS

STATEMENT OF: Dara O'Donoghue
Name *Rank*

AGE OF WITNESS *(If over 18 enter "over 18"):* [redacted]

To be completed when the statement has been written

I declare that this statement consisting of page, signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated this 4 day of MARCH 2005

William R Cross
SIGNATURE OF MEMBER by whom statement was recorded or received

William R. Cross
PRINT NAME IN CAPS

Dara O'Donoghue
SIGNATURE OF WITNESS

I, Dara O'Donoghue MB BCh MRCP MRCPCH DCH make this statement to the best of my knowledge and belief in response to the issues I have been asked to address by Detective Constable Billy Cross of the PSNI, as to my role in the 'events surrounding the hospitalisation of Lucy Crawford (deceased).'

At the time of admission of Lucy Crawford to The Royal Belfast Hospital for Sick Children (RBHSC), I was a Senior House Officer (SHO)/Acting Registrar in Paediatrics and had been assigned to the Paediatric Intensive Care Unit (PICU) in RBHSC for a six-month period commencing February 2000. My general duties were principally in the care and treatment of sick children in PICU. I was answerable to the Consultant Paediatric Anaesthetist, who at that time varied on a daily basis.

On the morning of 13th April 2000 my recollection is that I commenced my duties at approximately 9.00am. When I came on- duty, Dr Crean, Consultant Paediatric Anaesthetist, was on-duty and was my immediate superior. I recall that Lucy Crawford had been admitted to PICU prior to the commencement of my duties that morning. Lucy had been clerked-in by Dr McLoughlin, the on-call SHO. It was common practice for me, in order to obtain a background knowledge of all patients in PICU, to have checked on their condition and treatment upon admission by referring to the letter of transfer, which in this instance was addressed to Dr McKaigue- the Consultant-on-call at the time of Lucy Crawford's admission to RBHSC. In addition, I would have consulted the clinical notes to update myself on her clinical course since admission to PICU.

Dara O'Donoghue
SIGNATURE OF WITNESS:

38/36
7/04

STATEMENT OF: Dara O'Donoghue

On the morning of 13th April 2000, I accompanied Dr Crean on the morning PICU ward round. This usually commenced at approximately 9.15am and would last 1-2 hours. This would have involved Dr Crean, an SHO, a nurse and myself. There would usually have been 6 patients in PICU at any given time. I believe that that particular morning would have been no different. I note, upon checking the clinical notes, that there is a typed entry signed by Dr Crean, which would have been dictated by him at the time of the ward round,

'Eighteen-month old girl, transferred from the Erne Hospital this morning .....
I am awaiting faxes of her notes from the Erne Hospital and she is to be reviewed by a Paediatric Neurologist this morning' (page 65)

From the time of admission of Lucy Crawford to RBHSC in the early morning of the 13th April 2000 and over the course of that particular day, a number of Consultants, namely Drs Crean, McKaigue, Chisakuta and Hanrahan were involved in her treatment and care. In relation to my own involvement, I prescribed intravenous medication (DDAVP) in the medication record and on the fluid chart, and prescribed 0.45% Sodium Chloride/2.5% dextrose on the fluid chart. This was consistent with the earlier drug and fluid management from admission. During this time Lucy remained intubated and on the ventilator. From the records it appears that, following his consultation with Lucy Crawford at 10.30am, Dr Hanrahan requested further investigations. I finished my duties on that particular day at approximately 5.00pm.

The clinical notes record that two sets of brain-stem tests were conducted on the 14th April 2000 and these were negative. Lucy was extubated at 1.00pm and 15 minutes later was pronounced life extinct.

On the 4th May 2000, I believe I was contacted by a representative of the Crawford family regarding the necessity for the production of the Death Certificate, for the purposes of the burial of the remains of Lucy Crawford. Given that I was on-duty and had previously been involved in the treatment of Lucy Crawford, and given the fact that the family were understandably keen to have Lucy's remains returned for burial, I consulted with Dr Stewart and Dr Hanrahan in order to facilitate this. I contacted Dr Stewart (Dr Hanrahans's Registrar) as she had written the most recent notes in the chart. I then spoke with Dr Hanrahan. Having spoken with Dr Hanrahan, I completed the Death Certificate for Lucy Crawford. Such consultation would have been standard practice in order to ascertain the cause or causes of death from the Consultant. In this

Dara O'Donoghue

38/36a
11/03

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instance, I spoke with Dr Hanrahan. He provided the causes of death, which I duly recorded in the Death Certificate. I considered these to be accurate.

I was also aware from the clinical notes of Lucy Crawford that the Coroner had been contacted, although I was not aware of the nature or content of this communication, other than what is recorded in the clinical notes. It is common practice that, had there been any concern over the Coroner requiring an inquest, then a Death Certificate should not be issued. There was nothing to my knowledge, upon signing the Death Certificate that would have led to that conclusion, nor have given me reason to believe that the content of the Certificate was other than accurate. I completed the Death Certificate in the utmost good faith and had no reason to question the cause or causes of death that were provided. A number of my senior colleagues had been involved in the treatment and care of Lucy Crawford at the RBHSC, and I was not aware of them having concerns as to the cause or causes of death. I was at no time in contact with the Pathology Department or the Coroner's Office and I assume that the causes of death provided to me were the same as those provided to the Coroner. I am aware from having read the clinical notes that were written up by Dr Stewart on 14th April 2000 that,

'Coroner (Dr Curtis on behalf of coroners) contacted by Dr Hanrahan –case discussed, coroners p.m. is not required, but hospital p.m. would be useful to establish cause of death and rule out other diagnoses.' (page 61)

This post-mortem was conducted by Dr O'Hara.

I make this statement to the best of my knowledge and wish to state that I, at all times, acted in good faith in my duties as Senior House Officer/Acting Registrar in the care and treatment of Lucy Crawford. In completing the Death Certificate for the Crawford family in the weeks after her death, I did so without any pressure being brought by any colleague and I did so in the discharge of my professional duties in the belief that upon signing the Death Certificate, I had no cause or reason to question the content of same.

38/36a
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SIGNATURE OF WITNESS

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Dara O'Donoghue 03.03.05

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