Witness Statement Ref. No. WS-321/2

NAME OF CHILD: RAYCHEL FERGUSON PRELIMINARY (LUCY CRAWFORD)

Name: A W Boon

Title: Doctor

Present position and institution:

Retired Consultant Paediatrician

Previous position and institution:
[As at the time of the child's death]

Consultant Paediatrician, Royal Berkshire Hospital, Reading

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since January 2000 to present]

See WS-321/1

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

WS-321/1

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

(1) Please address the following questions with regard to your qualifications, experience and occupation and/or posts held, and provide a copy of your CV:

(a) State your medical and professional qualifications, and the date on which they were obtained;

(b) Specify in chronological order the various professional/medical posts which you have held, and the name of your employer in each case;

(c) Describe your role within or your association with the Royal College of Paediatrics and Child Health ('RCPCH') during your professional career.

(2) In 2002 you co-authored a report with Dr. Moira Stewart as part of a RCPCH External Review which examined issues relating to a Dr. J. O'Donohoe (Consultant Paediatrician) at the Erne Hospital.

In the report you and Dr. Stewart reached the following conclusion:

"The prescription for the fluid therapy for LC was very poorly documented and it was not at all clear what fluid regime was being requested for this girl. With the benefit of hindsight there seems to be little doubt that this girl died from unrecognised hyponatraemia although at that time this was not so well recognised as at present." **[Ref: 036a-150-312]**

Arising out of that conclusion please address the following questions:

(a) Explain what you meant in this context by the phrase, *"with the benefit of hindsight."*

(b) Explain what you meant when you concluded that hyponatraemia was *"not so well recognised"* as it was at the time you were writing your report.

(c) Explain what you meant when you concluded that LC *"died from unrecognised hyponatraemia."*

(d) Identify all of the factors that you took into account when concluding that LC died from hyponatraemia. In particular, please identify any note, record, document, information or expression of opinion which led you to reach this conclusion.

Further to WS-321/1 the factors Dr Stewart and I took into account were based on her acute neurological deterioration in association with a fall in serum sodium which is consistent with acute cerebral oedema resulting from hyponatraemia *"Called by mum buzzing. Child rigid in mother's arms"* [Ref: 043-037-078] *"13/4/00 2:58 Called to see Lucy who had a fit…." "13/4/00 3:20 the patient had developed respiratory arrest…..Pupils fixed and non responding to light"* [Ref: 027-010-024] From the time of her admission, Lucy's serum sodium fell from 137 to 127 at about the time of the acute deterioration [Ref: 027-010-022; 027-010-023; 027-012-031; 027-012-032]
In the Post Mortem report under Central Nervous System there is the following statement *"The brain weighs 1060g. It shows the features of generalized cerebral oedema with evidence of mild uncal herniation and* some *grooving in the tonsillar regions."* [Ref: 027-002-006]

(3) In a draft of the report prepared by yourself and Dr. Stewart the following conclusion appears:

***"…more attention to the detail of the fluid therapy might possibly have avoided this girl's cerebral oedema and fatal outcome."*(WS-298/3, page 7)**

(a) Do you stand by this conclusion?

(b) Please explain why this conclusion did not appear in your final report?

(c) Was this conclusion communicated to anyone else, apart from yourself and Dr. Stewart? If so, please identify the person(s) to whom it was communicated. If it wasn't so communicated, fully explain why this was the case.

(d) Identify all of the factors that you took into account when reaching the conclusion. In particular, please identify any note, record, document, information or expression of opinion which led you to reach this conclusion.

As stated in our report: *"The prescription for fluid therapy for LC was very poorly documented and it was not at all clear what fluid regime was being requested for this girl."* I remember that Dr Stewart and I chose our words with care in stating that *"…more attention to the detail of the fluid therapy might possibly have avoided this girl's cerebral oedema and fatal outcome"*

Further to WS-321-1 the factors Dr Stewart and I took into account were as follows: Daily Fluid Balance Charts [Ref: 027-019-062; 027-019-063; 043-039-083 (which appears to be an amended version of 027-019-062); 027-027-080. Dr O'Donohoe's note of 14/4/00 also seems very vague about the fluids which Lucy was receiving [Ref 027-010-014]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: ***A W Boon*** **Dated: 15.03.2013**