25-OCT-2004 08:44 FROM:COLIN DEANE [redacted]

TO:90262233 [redacted]

4/12

CM/JM 2003
26th Sept. 2004

Mr T. Leckey
Old TOWNHALL BUILDINGS
VICTORIA STREET
BELFAST.

Dear Mr Leckey

ISSUES REGARDING THE INQUEST OF CONOR MITCHELL.

There are a few queries we have regarding your summing up by Coroner's inquest.

Firstly we cannot understand why there was no mention of any implication or any kind of regarding Craigavon Area Hospital's treatment on May 8th 2003 which resulted in Conor's death.

You mentioned all the salient points that Conor was refused admission to a paediatric ward, that it was significant that Mr Kell noticed but did not record or feel it important that Conor suffered an atypical seizure in A+E.

You also mentioned during the inquest the possibility that Rubella Bullas misdiagnosed the seizure Conor was suffering as 'drowsy'. This was certainly the case. She also mentioned in her witness statement + later in her deposition in court that she did see a rash. There when it is patently obvious to all

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is a contradiction then when you said that NO one saw a seizure on a video, as Mr Kerr saw a seizure & Ruth Burns saw seizures (although she insisted on calling them 'spasms') and the video. Does this) mean that despite these observations To and I were not taken seriously & that the seizures & blotchy look were a figment of our imagination? Doctor Summers agrees that a patient & family should be treated as a unit & that a parent knows her child best. So why when we were ignored was this not mentioned in your summing up as criticism of the nursing care resulting in Conor's death?

Dr Hicks & Dr Summers both agreed that Conor had been having seizures during the afternoon which had been unobserved & therefore untreated; this surely shows the substandard care afforded to Conor when pts shows no doctor come to alleviate his suffering, let alone a consultant.

The sense of feeling ~~is~~, not wish by our family but the media also, was that C.A.H. was exonerated from any responsibility despite the obvious area of neglect & error resulting in his death.

I cannot imagine that if you were in our position you would be satisfied that no mention of substandard care had been apportioned to the hospital when it is patently obvious to all

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that our pleas for medical help for our beloved Conor were ignored, resulting in his death.

Your final comment was that Conor's fluid management was 'acceptable'. I wonder whose statement it was brought you to that conclusion; certainly not Dr Hicks' or Dr Sumner's & I'm sure since receiving his letter you now realise that Conor's rehydration rate was decided without consultation & was unnecessarily high. It seemed to be a very low-key issue during the inquest; perhaps 'the fact' that Conor had cerebral palsy was made more of an issue than his actual care & treatment which should have been particularly precise & accurate.

Conor had a disability but after 15 years of disciplined, intensive, structured therapies he was overcoming this frustrating handicap. He was a boisterous, noisy, strong, healthy & determined young man who should not have died. All of us including Conor were delighted about his physical progress & development & the foreseeable possibility of independence.

If Conor's treatment cannot be termed substandard then may God help all of us when we need hospital care, particularly those of us with any kind of disability.

I hope for a reply to this letter and an explanation & answers to the questions asked.

Yours Sincerely,

Judy Mitchell.

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