

in 1991, with the appointment of Dr. Underwood and then Dr. Pryn in 1992. This helped in the availability of paediatric trained anaesthetists to at least four days a week, as compared to the period before 1988, when paediatric cases could be operated on only two days a week with the availability of Dr. Masey and Dr. Burton. Further details about their qualifications and training should be available from anaesthetists in their statements to the inquiry.

**Issue F3 a) The qualifications, training, experience and skills of all other members of the surgical team (e.g. Nurses and perfusionists).**

1. Nurses and Perfusionists helping with the operations, were organised in their own organisation, which was run and managed by their leader or manager. Each of these groups had their own training programmes, run according to national guidelines, on which they should be able to comment.

2. There used to be some problems with the availability of paediatric trained nurses in the operating theatre. However, a small core of such nurses was formed and their availability, or unavailability, could affect the scheduling of operations. The nurses used to visit other hospitals to improve their skill and experience. I arranged for them to visit Birmingham during the re-training of myself and the team in the Arterial Switch Programme during 1992-3. I am aware that they have been to the G.O.S., London and Oxford for similar visits.

3. Communication was an important factor in receiving support and assistance from these teams, especially in view of the shortage of paediatric trained staff in the operating theatre. Specific days of the week would be earmarked for paediatric cases i.e. Mondays, Tuesdays and Thursdays in the 90's; so that nursing rota could be organised accordingly. This also helped anaesthetists and perfusionists. In emergency cases I needed to talk to individual teams in order to make suitable arrangements. Each of these teams were supported by their own staff, i.e. Registrars/Senior Registrar's for the surgical and anaesthetic team, second member of perfusion team as assistant and a 'runner' to help the scrub nurse. Communication between teams was an important on-going process during the conduct of an operation.

1. I believed that it was important to have a team of nurses and perfusionists who knew their role clearly during the conduct of an operation. This was very clear when I visited Birmingham and was the reason for their re-training and visit to Birmingham.

**Issue F4 How the team in the operating theatre was constituted and co-ordinated, and its performance as an integrated team.**

1. Cardiac Surgical work is a product of successful teamwork. The teams consisted on Surgeons, Anaesthetists, Nurses, Perfusionists, supporting laboratory staff and technicians working with high-tech monitoring and life-support systems. Any problems with any of these could adversely affect the outcome of surgery.

1. Mr Wisheart has presented, in a tabular form, the role of various teams working together in the operating theatre during surgery over the page WIT 0120 0168. I have nothing more to add, except for supporting his statement that every team was an integral part of the whole service and communication and co-ordination between different teams was essential in order to achieve successful outcomes.

**Issue F6 a) The existence and awareness of any material differences in the manner (including speed) of carrying out surgery at the BRI, when compared to surgical practices current at the time, and b) the impact (if any) of such factors upon mortality and morbidity rates.**

1. The practice and conduct of surgery develops from the period of training and also from periodic visits to other hospitals. During part of my training I worked at Bristol, U.A.B. (U.S.A) and G.O.S hospital London. I learned to work with due care and attention on these sick babies. It was considered important to progress in a methodical manner during surgery and the repair was planned properly. Procedures needed to be performed safely without cutting corners. At U.A.B I had an opportunity to observe and work with two surgeons of International repute (Drs. Kirklin and Pacifico). One of whom was known to be a slow surgeon and the other fast and speedy. Both of them operated with excellent results. If surgery is performed at a comparatively slow rate, the myocardium needs to be protected properly, i.e., by frequent administration of