The BRI Inquiry into Paediatric Cardiac Services in Bristol 1984-1995

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Introduction

1. This statement is made in response to the Inquiry's request for information relating to evidence to be heard in "Block 4". My comments are confined to my experience gained at the Bristol Royal Infirmary. The Inquiry has already received my first statement dated 22 July 1999, which sets out a summary of my career. As stated in that statement, I am not absolutely certain of the accuracy of dates, which I have given from memory to the best of my recollection.

2. I should like to point out to the Inquiry that it has incorrectly included me under "Cardiologists, BCH". I have never worked at BCH and so have classed myself as a "Nursing Sister, BRI" for the purposes of this statement.

Issue B: The structure of paediatric cardiac surgical services at the representative sites at the BRI and BRHSC, including:

B1c: organisational set-up: lines of authority, chains of command, communication and accountability, both professionally and managerially;

3. Please see paragraphs 14 – 17, 26 and 27 of my first statement.

4. When the UBHT was formed in 1991, a leaflet was published showing the hierarchy of the management positions, together with photographs, so that nurses were able to put faces to names.

5. All nurses, new and existing, were encouraged to attend a training session which explained the new structure of UBHT. This was purely voluntary and was fitted in around their normal workload. I attended such a training session.

6. After this training had been "rolled-out" to the existing nurses, any new nurses who arrived had this training as part of their orientation programme. This was still happening up until my retirement.

B1d: the extent to which medical and nursing staff were involved in management and managerial issues;

7. I have no further comments to add to those made in my first statement at paragraphs 18 – 21.

B1f: staffing: numbers, natures of posts held, criteria for appointment and employing body, training and experience, job plans or descriptions and their review, and patterns of deployment (such as the use of shared appointments and the rotation of skilled staff);

8. In addition to what I have stated in my first statement, I recall that when I first started working in cardiac theatre, there were 5 or 6 of us, 4 of whom (including myself) only worked part time. With increasing workload more staff both medical and nursing had to be employed.

9. The introduction of clinical nurse grading in the late 1980s hindered recruitment of theatre staff. It was a fiasco and led to numerous appeals against low grades and many nurses left. It was a very unsettled period for all of us. Management's attitude was entirely cost orientated and as nobody bothered to find out what theatre nurses do, we felt very disenfranchised. Later, rather than increase our establishment, a new totally unworkable duty rota was imposed, which had to be abandoned after several months. By this time recruitment had dried up, i.e., we had very few, if any, applicants responding to advertisements. This meant increasing use of agency nurses/ODAs. Although a technical role, the grading system meant that the scope of the position was limited, which deterred nurses from applying. When clinical nurse grading was introduced, the guidelines regarding grading of nurses were very much adhered to, although this was later relaxed as recruitment of theatre staff became an ever bigger problem. Nowadays, guidelines are no longer strictly adhered to and theatre staff positions are advertised at higher grades. This is misleading because the nurse expects to have responsibilities (eg supervising) commensurate with that grade and could, therefore, feel let down by the lack of scope they have.

B1g: regulatory and disciplinary structures;

10. I have no further comments to add to my first statement.

B1h: counselling and support for staff;

11. I have no further comments to add to my first statement.

B1i: relationship with the University of Bristol and other academic centres;

12. I am unable to comment on this, save to say that the BRI had a relationship with the University of the West of England through Project 2000, as well as the ENB courses. I cannot recall when this first started. Before this, the BRI had its own School of Nursing which ran courses and lectures with both internal and external speakers, covering a broad range of topics.

Issue C: The Service Provided: Nature and Outcomes

13. I am unable to comment specifically on this issue. It was not part of the remit of theatre staff to follow up patients once they had left theatre, unless there was a personal interest, in which case they would either telephone or go onto Ward 5 ITU themselves.

14. The theatre staff did not ask for further information from the consultants or share data with other units as it was not considered part of our role. The consultants themselves had meetings with other relevant medical staff, but theatre nursing staff were not involved in those meetings.

Issue D: Referrals

15. I am unable to comment specifically on this issue with the exception of D5.

D5: Whether there is evidence to suggest that clinicians based outside the BRI but within its "catchment area" were deciding to refer children to centres other than the BRI; and, if so, why.

16. There was no hard evidence, but there were "coffee room" discussions about the fact that Cornwall sent children requiring heart surgery to London instead of Bristol. This was discussed amongst the theatre and perfusion staff but the subject was not raised with the consultants as to why this was so – we did not believe it was our place to question the consultants as to why this was happening. As far as we knew, it may have been due to the length of the waiting list. We had quite enough work as it was.

Issue E: Pre-Operative Management of Cases

E1: The arrangements and services available to manager the transfer of sick children from referring hospitals to the BRI.

E2: Where children were managed, pre-operatively; and under which clinical speciality.

E3: The re-assessment of the clinical condition of children admitted for elective surgery following admission.

E4: The manner in which decisions to recommend surgery for a child were discussed between paediatric cardiologists and paediatric cardiac surgeons, and other members in the cardiac surgery team; and the means by which such decisions were taken.

E5: Who bore the ultimate responsibility of deciding whether and what surgery was appropriate for a child, who should perform it, and when it should take place.

17. I am unable to comment on these issues in any detail as I have no knowledge. Theatre staff would not see children until they arrived pre-medicated at theatre. The type of surgery to be undertaken had already been discussed between the clinicians involved, the way forward discussed with the parents, and appropriate consent given. Theatre staff were not involved in any of these meetings.

E6: The organisation and management of theatre lists.

18. A monthly meeting would take place between surgeons where the monthly theatre list would be made. This was passed to the Theatre Sister who would arrange the theatre staff duty roster around the theatre list. However, each list would invariably undergo a multitude of alterations. These may have been due a shortage of beds in the ITU, a more urgent/emergency case being presented, or the fact that because an operation had overrun the previous day, there was no scrub nurse or anaesthetic assistant available to assist in that morning's operation.

19. Daily theatre lists were compiled by the Senior House Officer in cardiac surgery and sent to us the afternoon before. These were more detailed than the monthly lists so that theatre staff were able to prepare the theatres according to the type of operation to be undertaken.

E7: The mechanisms in place in order to ensure that surgery (whether elective, urgent or emergency) took place at a time regarded by the clinicians at the time as clinically optimal or appropriate.

20. It was the medical staff who decided when an operation would take place. As part of their role, theatre staff had to be "on call", and could respond to urgent or emergency cases if called upon by the surgeons to do so. Please see my first statement at paragraph 23.

E8: Whether operations (particularly elective ones) were carried out at a time regarded by the clinicians in charge of the child's care as appropriate; or whether the timing of operations was affected by matters such as limitations in the number of beds available in the ICU, availability of nursing staff or other staff, or the requirements of adult cardiac surgery.

21. I believe I have answered this. On the whole theatre staff "bent over backwards" to accommodate every patient, in particular children, whether the operation was elective or emergency, and whether it was carried out during normal operating hours or out of hours or at weekends.

22. There was an informal rule of thumb amongst the theatre staff that if an operation continued past normal operating hours but was finished before midnight, then staff who were rostered for the following morning were expected to arrive on time, ie for 7.30am. If, however, the operation continued past midnight, then they came in at a correspondingly later time. For example, if the operation finished at 1.00am, they were to come in by 8.30am.

23. Although this was generally the case, if it was found that there were not enough staff the following morning, some staff would come in for 7.30am anyway, so that that morning's operation would not be delayed. If it was appropriate, ie there were no further operations, that nurse may then have been allowed to leave earlier in the day. We were able to do this because, working in such a small team, we supported each other. As a result, the team built up a lot of goodwill.

E9: If there were delays in surgery, the effect (if any) of such delays upon the outcome for the children affected.

24. If more of the theatre staff were working late and rostered together the following morning, this had an impact on the following morning's list. If this occurred, that morning's operation would be postponed until the theatre staff arrived. I don't believe that delaying an elective operation by a few hours had an impact on the outcome of the surgery.

E10: The qualifications, training, experience and skills of the paediatric cardiologists.

25. I am unable to comment.

E11: The service provided by paediatric cardiologists in diagnosing or describing:

a. the structure and anatomy of the child's heart and lungs;

b. the clinical condition of the child;

c. the nature of the surgical procedure required, and any complications that might be encountered by the surgeon;

d. the speed or urgency with which any intervention was required.

26. I am unable to comment except that all cardiological investigations were recorded in the patient's notes, which accompanied them to theatre.

E12: The protocols or clinical guidelines, machinery, equipment or technical services (e.g. radiological interpretation) available to cardiologists to assist them in this task.

27. I am unable to comment.

E13: Pre-operative assessment and preparation procedures, including meetings at which treatment and operations were discussed and planned.

28. As I have stated previously, theatre staff had no input into pre-operative assessment of patients.

E14: Pre-operative observation, assessment and care by the nursing staff and other professions (such as physiotherapists).

29. I am unable to comment. Theatre staff had no input into pre-operative observation.

E15: Liaison of staff with parents; and the participation of parents in the assessment and care of their child.

30. There was, I believe it was in the 1990s, an attempt to institute a system of pre-operative visiting by theatre staff to the ward. It was not maintained due to practical difficulties, eg patients not admitted until the day before their operation, too many people needing to make contact with the patient and their parents, and the shortage of theatre staff. Having too many people visiting the patient and their parents was seen as increasing stress, rather than acting as a reassurance.

31. After this system discontinued, the only time theatre staff met parents was when they accompanied their child to theatre, after the child had been pre-medicated. This was not an occasion to talk with the parents, who were quickly taken away as soon as their child had been anaesthetised.

32. I am unable to comment on the participation of parents in the assessment of their child, as I have no knowledge.

Issue F: Management of Surgery

F1: The qualification, training, experience and skills of the paediatric cardiac surgeons at the BRI.

33. I am unable to comment.

F2: The qualifications, training, experience and skills of the anaesthetists assisting at paediatric cardiac surgery at the BRI.

34. I am unable to comment.

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

b. The support and assistance given by such members of the surgical team.

35. As I have stated previously, nurses recruited to work in theatre were fully qualified, although they may not have had specific theatre experience. Theatre experience was taught "on the job" by an experienced theatre nurse who would act as a supervisor. If a career working in theatre was something the new recruit felt he/she wanted to pursue, then they were encouraged to attend the ENB 176, which was a theatre course.

36. There were certain anaesthetists, Dr. Baskett, Dr. Davies, Dr. Monk, Dr. Masey, Dr. Underwood, who were very happy to teach nurses during an operation. An anaesthetist had less to do when a patient was on bypass and so it was a good opportunity for the nurse to gain some extra tuition, and the anaesthetist was usually more than willing to help.

37. Mr Dhasmana, however, was not keen on having inexperienced theatre nurses assisting while he was operating. He complained that they were too slow and they, knowing of his attitude from other nurses, were not keen on being assigned to work in his theatre.

38. One specific incident springs to mind. Mr Dhasmana and Alison Reed, a member of the theatre staff, made a good team. For one particular operation, I rostered a nurse who had gained experience by assisting Mr Wisheart to assist Mr Dhasmana and Ms Reed was to work in the other theatre. Mr Dhasmana saw that Ms Reed was not assisting him and had strong words with me, to the effect that he was not at all happy with the situation and knowing they made a good team, why had I not put him and Ms Reed together. I had to point out to Mr Dhasmana that she was just next door if he needed her and it was only fair and proper that the other nurse should gain as much varied experience as possible, and that included assisting different surgeons. Also, that we needed to train up other nurses as Ms Reed could not always be available.

39. In the 1990s, I recall an in-house anaesthetics course was organised by Alison Whiting, lasting 6 weeks, teaching nurses anaesthetic techniques and the role of the anaesthetic assistant in theatre. It was meant to be an ongoing course, although I recall it only ran once or twice. I cannot now recall why it was not very successful, but one of the reasons may have been that it was not a recognised course and so nurses were not gaining a formal qualification by attending. Also, as usual, it was difficult releasing staff for 6 weeks.

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

40. Managerially, the perfusion team and the theatre nurses were separate entities, although we co-operated well with one another and had a good working relationship. This also applied to anaesthetists and surgeons, bearing in mind that occasional personality clashes were inevitable, but very rare.

41. Occasionally there were tensions in theatre, but this was probably due to, as I have stated previously, complaints regarding new nurses who were slower than those with more experience. These occurrences lasted at most only for the duration of the operation. The staff were taught not to answer back to the surgeon whilst he was operating because of the level of concentration he had to maintain, and so arguments did not develop. These tensions were very few in number and were not detrimental to the patient in any way.

F5: The factors affecting performance in the theatre. Such factors might include familiarity with tasks; design and performance of equipment; hours of work; error management; and so on.

42. If a member of the theatre team was not familiar with a certain task and they were in the process of learning that task, then this would slow down their performance until it had been mastered. This is true of any profession – that is why the learner would be supervised. As a nurse became more familiar with a task, it did not mean they would become complacent about it. Although the process may be the same, each patient is an individual, and so there would be variations on a theme. A nurse would not become complacent even though they were familiar with a task.

43. In relation to equipment, there may have been teething problems with new items of equipment, i.e. a new diathermy constantly cutting out. I do not recall that any equipment malfunction caused complications during surgery. Any malfunction was quickly remedied. Equipment is maintained by the MEMO Department, which means that equipment is checked before use and serviced every 3 months to ensure that it remains in good working order.

44. Staff who were recruited to work in theatre were made aware of the hours of work. I am not aware of any problems to the patient caused by a member of the theatre staff working long hours.

45. If a member of the theatre staff was having a particular difficulty, they would ask the other member of the theatre staff present at the operation to help before any serious problem arose. After the operation the event was discussed amongst the theatre staff group, together with the person concerned. If the error had proved to be serious, then disciplinary procedures may have needed to be instigated. I do not recall that this ever happened.

46. The theatre staff had no qualms about calling the consultant to theatre if a Registrar encountered difficulties during an operation. This happened in paediatric cardiac surgery cases, but not often, as usually the consultant was called to theatre as soon as the patient was on the operating table.

F6: a. The existence, extent 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.

47. Theatre staff were not aware of any material differences in the way surgery was carried out at the BRI as we did not have information from other units to compare. I spent one day at the cardiac theatre in Oxford and was impressed at the speed of surgery. On reflection, though, I realised that on that one day all operations were carried out by consultants and no teaching had taken place.

48. When Mr Dhasmana visited Birmingham, he was followed later on by two theatre staff, Alison Reed and Onyx Brewin. They found the surgeon, Mr Brawn, very impressive and noted that operations were carried out more quickly than those at the BRI. Consequently, certain theatre techniques were changed so as to speed up parts of the operative process. The two theatre staff made sure they had perfected the new techniques first by performing it continuously themselves for a period before passing on their knowledge to other staff through on the job training.

49. From the start, I noticed that Mr Wisheart was a slow operator, although my recollection was that Mr Dhasmana was not that much quicker. If I was rostered to assist in a morning operation on a child, I would have a good breakfast because I knew that I would probably be there for a long time.

50. The length of the operation must have had an effect on the mortality/morbidity rates, although I did not have any hard evidence to prove this. We were told that by-pass lasting more than 3 hours was undesirable, as was cardiac arrest for more than 1 hour.

51. If a surgeon had to re-do a procedure during an operation, he became very upset. If I began to feel that the outcome might not be very good, I would try to stop thinking about it, and perform my duties to the best of my abilities. I did not want to upset the surgeon any more than he was already. Over the years, this happened quite a few times.

Issue G: Post-Operative Care

52. I am unable to comment on this as it was not my role as a theatre nurse to care for patients post-operatively.

Issue I: Treatment of Families, including the Bereaved

53. I am unable to comment on this.

Issue J: Post-Mortems and Inquests

54. I am unable to comment on this save to say that if a patient died in theatre, a post mortem was always carried out. It was the role of the theatre staff to clean up the patient. Lines would be left in situ although they would be stopped off to prevent leakage. The body would be wrapped in a paper shroud, and then a sheet. A mortuary note would be handed from the Senior House Officer to accompany the body to the mortuary. A call would be made to one of the hospital porters to move the body to the mortuary or to the chapel of rest for viewing by the deceased's relatives. If the latter was the case, then the endo-trachial tube would be removed. I was not involved in viewings.

Issue K: Training and Retraining

K1: The support and assistance made available to all members of staff, to help them keep abreast with developments in clinical practice; and the use made of such facilities.

55. Generally, notices regarding a list of available in-house courses were posted on notice boards as they were published. If a nurse was interested in a particular course they would speak to their line manager. The nurse was allowed to attend, depending upon availability of remaining staff to cover her post. This method of publishing in-house training happened in one form or another since I started at the BRI.

56. The onus was very much on the individual to keep abreast of developments in clinical practice. Only recently, I cannot recall the exact date, the UKCC has said that a nurse must have at least 5 study days in 3 years in order to stay on the register.

57. Training was also given "on the job" in theatre. If a nurse was interested in a career in theatre, then they were encouraged to study for the ENB qualification.

58. Attending training could be a problem due to a shortage of staff able to cover for the absent nurse. However, if a nurse was very keen to attend a particular course, they would arrange to go on their day off from work. It was compulsory for all nurses to attend the yearly fire lecture, manual handling, and life support courses.

K2: The process of appraisal and training required of a paediatric cardiac surgeon in 1984-1995, before embarking on an advanced operative procedure not previously performed by him.

59. I am unable to comment.

K3: The extent to which those obligations were affected by the fact that:

a. the procedure was new, and not well-established elsewhere, or (conversely) that it was well-established elsewhere;

b. there was an absence of "local" skill or advice, so that any assistance must necessarily have been obtained from outside the institution in question.

60. I am unable to comment.

K4: The professional or contractual obligations regarding such appraisal and training imposed upon a paediatric cardiac surgeon (both at the BRI, and generally within the UK).

61. I am unable to comment.

K5: The professional obligations or duties (if any) placed upon the person or persons carrying out, or assisting with, the retraining of a professional colleague.

62. I am unable to comment.

K6: The responsibility borne by:

a. a paediatric cardiac surgeon;

b. an anaesthetist;

c. other members of the surgical team (perfusionists, nurses, etc.); or

d. referring cardiologists

for ensuring that all members of the surgical team were properly trained to assist at new procedures not previously carried out at an institution.

63. I am unable to comment save for K6c.

64. Generally, the more a nurse carried out a procedure, the more experienced they became.

K7: The professional or contractual standards or obligations (if any) regarding the organising or undertaking of such further training imposed upon the individuals listed at (a) - (d) above.

65. Theatre staff were encouraged to undertake the ENB 176, although this has recently changed and now the course is the ENB 183. This is a revised course which now divides itself equally between anaesthetic and theatre techniques. Nurses wishing to undertake this course would have to apply for a place, usually limited to 6 or 8, and quite often have to wait for a year. Conditions about who paid; keeping a post open, etc., changed continuously.

K8: The nature and extent of any further training undertaken by all members of the paediatric cardiac surgical team at the BRI, before embarking on any new surgical procedures.

66. Please see my comments at paragraphs 42 and 48 regarding new theatre staff techniques.

K9: Whether such further training met the requirements of the professional or contractual standards or obligations.

67. I have no knowledge of whether training for new techniques met professional or contractual standards. Theatre staff always tried to be professional in their role, including keeping up to date with new technologies. If unsure of what was required, a nurse would ask to discuss it with the relevant surgeon.

K10: The steps to be taken by a paediatric cardiac surgeon to ensure that his surgical technique and/or clinical skills was and remained adequate to the task of performing procedures which he was accustomed to carrying out.

68. I am unable to comment.

K11: In particular, the steps to be taken to:

a. evaluate and assess his own performance;

b. maintain competence; and

c. embark on retraining (whether as a matter of routine, or in response to specific concerns about his ability to perform particular procedures).

69. I am unable to comment.

K12: The professional or contractual obligations (if any) regarding such evaluation and retraining imposed upon a paediatric cardiac surgeon (both at the BRI, and generally).

70. I am unable to comment.

K13: The steps that were, in fact, taken by paediatric cardiac surgeons at Bristol to ensure that their surgical techniques and/or clinical skills were and remained adequate.

71. I am unable to comment, except I do know that Mr Dhasmana went to see Mr Brawn in Birmingham for guidance regarding the switch operation.

K14: Whether such steps as were taken met the requirements of the professional or contractual standards or obligations current at the time and the extent to which those actions conformed to accepted practice.

72. I am unable to comment.

K15: The responsibility borne by members of staff (such as the paediatric cardiac surgeons, the anaesthetists, other members of the surgical team, or managers) in ensuring that all members of the surgical team were, and remained, properly trained and skilled.

73. As I have stated previously, the more a nurse carried out a procedure, the more experienced at it she became. Senior staff taught new staff by 'back scrubbing' until a new nurse felt confident to work on her own.

74. The onus was very much on the individual to ensure that they were properly skilled to carry out their role. If a nurse was struggling, then another member of the team would step in and later, maybe, speak to their line manager so that the problem could be assessed. If the problem was not overcome, then their line manager would perhaps suggest to them that a career in cardiac theatres was not for them, and suggest that they move to general theatre where the work was less stressful. I recall this happened several times.

K16: The professional or contractual standards or obligations (if any) regarding the organising or undertaking of such training imposed upon staff members, both at the BRI, and generally.

75. Please see my comments at paragraphs 67 and 74 above.

K17: The continued professional education and training undertaken by members of the paediatric cardiac surgical team at the BRI.

76. As I have stated previously, the ENB 176 (theatre) course was available, which has been replaced by the ENB 183 (anaesthetic and theatre)

77. Theatre staff were invited to the cardiac ward's weekly training sessions, if we were free to attend. The training usually started at 2.00pm when shifts would be changing over. However, the theatre would generally be in the middle of an operation and so it was generally found that none of the theatre staff were able to attend.

K18: Whether such continued education and training met the requirements of professional or contractual standards or obligations imposed at the time and the extent to which it conformed to accepted practice.

78. I was not told whether the cardiac ward training met any formal requirements. Obviously, the ENB courses met the professional standards set down by that body. My belief is that further training offered by the anaesthetists was merely because the nurse was interested in broadening his/her knowledge and did not meet (or seek to meet) any formal standards.

K19: Whether it is (a) inevitable; and (b) acceptable, that a surgeon carrying out a new procedure will experience a "learning curve" during which his competence or results may fall below the standards achieved by a surgeon who has carried out a reasonable number of these procedures.

79. I am unable to comment except to say that everyone has a learning curve when doing something new and therefore it is necessary to do this under proper supervision.

K20: The relationship between learning curves, and maintaining minimum acceptable levels of performance.

80. Generally, theatre staff would inform the consultant in charge if a registrar was encountering difficulties, so that the consultant could intervene. However, it was not the job of the theatre staff to question a consultant's performance.

81. Occasionally, when a nurse was not able to perform to an acceptable level in the cardiac theatres after a period of training and possible re-training, they were transferred to the general theatres, which were less stressful or more often they left of their own accord.

K21: The steps that can be taken to minimise the length of a learning curve, and to ensure that all relevant lessons are learnt as soon as possible.

82. In order to minimise a learning curve, a nurse was encouraged to carry out a new procedure as many times as possible in a short period of time, so that they became accustomed to it very quickly. Of course, the nurse would always be supervised by someone already proficient in the technique to ensure errors were not made and no harm was caused to the patient.

K22: How an acceptable learning curve may be defined, prospectively.

83. I would say the way to define an acceptable learning curve would be to watch a particular procedure say 2 or 3 times and do it under supervision several times then the assessment can be made as to how long it will take others to learn the particular technique. The nurses who went to Birmingham were very experienced and had no problem in mastering the changes.

K23: the steps that can and should be taken to protect a patient, during the term of a learning curve.

84. I have already answered this. The patient was protected at all times, because a nurse learning a new technique was supervised at all times until the nurse was happy carrying out the procedure on her own, and the supervisor was satisfied that the nurse had perfected it.

K24: The information, tools and professional guidance available to the medical profession, to assist in the task set out at (19) to (21).

85. I am unable to comment on this.

K25: The extent to which the profile of an acceptable learning curve (if such exists) may legitimately be affected by:

a. **the fact that the procedure is innovative and not well-established elsewhere;**

b. **the balance between the expected benefits of the new procedure, and the benefits likely to be obtained by the best alternative course of action;**

c. **the explanation of the risks given to the parents, guardian or child concerned.**

86. It takes a surgeon with a lot of self-confidence to carry out innovative surgery. By way of example, a surgeon, Mr Brock, pioneered hole in the heart surgery in the 1950s/1960s. I believe that he lost the first 9 out of 10 children, after which his results became much better. Nowadays, the hole in the heart corrective surgery is carried out around the world. However, arterial switch was not innovative by the late 1980's except in Bristol, which started to do the operation later than other centres.

87. I can think of only one example, that is the comparison between the Sennings procedure which is not permanent and will possibly require further surgery later on in life, and the Switch, which is a permanent procedure and should not require additional surgery. Obviously, if a patient only has to have the one, permanent, operation this must be of more benefit than undergoing two or more operations during their lifetime.

88. I have no knowledge of the explanation of risks given to parents, guardians or children.

K26: The evaluation of the likely "learning curve" made by the paediatric cardiac surgical team at the BRI, before any new surgical procedure was embarked upon.

89. Theatre staff had no input into the evaluation of learning curves relating to surgical procedures, as these were for the surgeons to evaluate.

K27: The steps (if any) taken, whether by such a surgeon or any other member of his unit, to monitor whether any adverse outcomes of a new surgical procedure were:

a. a product of the process of acquiring sufficient experience at performing a new procedure; and/or

b. whether, if so, the process of acquiring such experience or skills was progressing at an acceptable rate.

90. Theatre staff do not as a rule follow-up their patients, but in the case of the switch operations there was disquiet, especially amongst the anaesthetists (see letter signed by, amongst others, Drs. Masey, Underwood, Pryn, Davies). Mr Dhasmana was verbally encouraged, also by nursing staff, to seek help. The visits to Birmingham followed. The nurses went to Birmingham on 15 January 1993.

Issue L: Informed Consent

91. I am unable to comment on this as it is a medical matter. Theatre staff would merely check there was a properly completed, signed, consent form when the patient arrived at theatre.

Issue M: Review of Cases and Medical and Clinical Audit

92. I am unable to comment on this issue save that prior to the more formal monthly clinical audit meetings being introduced (I cannot recall when these were established), theatre staff had no involvement in medical audit as it was not part of their role. All staff were able to attend these more formal meetings if they so wished. I only attended the clinical audit meetings and cannot give any comparison to the medical audit meetings.

Issue N: The Expression of Concerns

93. This issue is covered in a separate statement.

Signed..
Mrs Mona HERBORN

Dated ....9. 11. 99....................................

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