Neutral Citation Number: [2014] EWHC 690 (QB)

Case No: TLQ/14/0039

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/03/2014

Before :

MR JUSTICE LEWIS

- -

Between :

MR JOHN LU	**Claimant**
- and -	
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	**Defendant**

- -
- -

Mark Sutton QC and Ben Cooper (instructed by **Weightmans**) for the **Claimant**
Damian Brown and Ming-Yee Shiu (instructed by **Mills & Reeve**) for the **Defendant**

Hearing dates: 24th, 25th, 26th 27th 28th February & 3rd March 2014

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE LEWIS

Mr Justice Lewis:

INTRODUCTION

1. The Claimant, Mr John Lu, is a consultant cardiac surgeon employed by the Defendant, the Nottingham University Hospitals NHS Trust ("the Trust") at a specialist unit for the treatment of heart disorders at the Trent Cardiac Centre ("the Centre"). In July 2009, a cluster of cases of infection, known as prothestic valve endocarditis or PVE, was identified. The source of the infection was ultimately identified as being Mr Lu. A strain of antibiotic-resistant bacteria had, unknowingly and without any negligence on Mr Lu's part, embedded itself in Mr Lu's skin. That bacteria was transferred to patients undergoing surgery to replace a heart valve. Tragically, 11 patients became infected. Five died and others required further operations or medical treatment. Mr Lu ceased practising heart valve surgery immediately and, in October 2009, ceased all surgery. There have been investigations into the outbreak. The Trust decided in August 2012 that Mr Lu could return to surgical practice subject to certain conditions. Mr Lu has not yet been able to return to surgical practice.

2. This claim concerns the arrangements relating to his return. It is agreed that, given Mr Lu's absence from surgery for some time, there will need to be a programme devised to enable him to begin to resume surgical duties in collaboration with others prior to commencing independent practice. Mr Lu contends, in summary, that the Trust agreed a suitable programme in September 2012 which would enable him to recommence surgical practice but subsequently resiled from that. He contends that the programme now proposed by the Trust is inappropriate in terms of its content, the lack of a clear timetable and the fact that the refamiliarisation process in relation to one type of surgical procedure will have to be undertaken at a different hospital not within the Centre. He contends that there has been delay on the part of the Trust in making appropriate arrangements to facilitate his return to surgical practice. He also contends that the process devised by the Trust to obtain consent by patients to his involvement in, or performance of, surgery is not required by law and is unjustified. He contends that these, and other matters, are either breaches of express terms of his contract of employment or are breaches of the implied term of mutual trust and confidence. He has affirmed the contract and wishes to return to practice. He seeks declaratory or injunctive relief aimed, in essence, at enabling him to resume surgical practice. The Trust denies that it has acted in breach of Mr Lu's contract of employment. The Trust contends that the steps taken are appropriate steps, in what it describes as the unique and challenging circumstances of this outbreak, to enable Mr Lu to return safely to surgical practice. The Trust counterclaims for a declaration in relation to the provision of certain information to patients. Both Mr Lu and the Trust are anxious to work together for the future to ensure that Mr Lu can return to surgical duties. They seek by this litigation to resolve certain outstanding issues that may currently be impeding progress in achieving that aim.

3. By way of background, I heard evidence from Mr Lu himself, Mr Surendra Naik, who is a consultant cardiac surgeon also employed by the Trust and Mr Brian Fabri

who was a consultant cardiac surgeon in Liverpool from 1986 until his retirement on 31 December 2012. Mr Lu had been one of his trainees prior to being appointed a consultant cardiac surgeon himself. I also heard evidence from Dr Peter Homa who is the Chief Executive of the Trust, Dr Stephen Fowlie who is the Medical Director of the Trust and Mr David Richens who is a consultant cardiac surgeon and has been employed by the Trust since 1982.

4. This judgment firstly deals with the material facts. In many instances, facts are not in dispute or are evidenced by the contemporaneous record. In some instances, however, there are factual issues in dispute and I set out my conclusions on those factual issues. Secondly, the judgment deals briefly with the law. The legal principles are not in dispute. It is their application to the facts that is in issue. Thirdly, this judgment then deals with the question of whether or not any of the alleged breaches of contract are established.

THE FACTS

The Centre and Its Work

5. The Centre undertakes most types of adult cardiac surgery. There are five cardiac surgeons employed to work at the Centre. They include Mr David Richens, Mr Ian Mitchell, Mr Surendra Naik and Mr Lu. Mr Lu qualified as a doctor in 1995. He subsequently specialised in cardiac surgery. He was one of the trainees on a seven year higher surgical training course at Liverpool which he undertook between 2000 and 2007. He worked as a locum consultant in Liverpool for his final three months there. He took up the post of consultant cardiac surgeon at the Centre in October 2007.

6. The surgery undertaken at the Centre includes coronary artery bypass graft surgery and also heart valve replacement surgery. The bypass surgery occurs when an artery is blocked or damaged or restricted. The surgery, broadly, involves one of two procedures. The procedure used by the majority of cardiac surgeons involves stopping the heart and using a cardiopulmonary bypass machine or "pump". Blood is diverted to the pump, oxygenated in the pump and then pumped into the aorta in order to circulate around the body. This means that the patient's heart is excluded from the process of circulating the blood whilst the patient is being operated upon. Sections of vein, taken from elsewhere in the body, are then grafted on to the artery to bypass the blockage. This is referred to as "on pump-surgery". An alternative procedure used by a smaller group of cardiac surgeons is known as "off-pump surgery". In this technique, the heart is not stopped and continues to circulate blood around the body. A section of artery (or, in some instances, venous material) is then grafted on to the artery to bypass the blockage. In the Centre, only Mr Naik and Mr Lu perform off-pump surgery. In the case of heart valve surgery, valves controlling the flow of blood become diseased or malfunction and need to be replaced. A prosthetic valve is then inserted in place of the original valve. Antibiotics are used at the start of the process to prevent infection of the prosthetic valve. Again, a cardiopulmonary bypass machine

is used in heart valve surgery. Coronary artery bypass graft surgery may need to be combined with heart valve surgery (and approximately 50% of cardiac operations at the Centre involved such combined surgery). Such combined operations are done using the cardiopulmonary bypass machine and so involve on-pump surgery. There are also occasions when on-pump coronary artery bypass graft surgery (rather than off-pump surgery) is clinically indicated for a particular patient or on-pump surgery may become required during an operation which began using off-pump surgery. Consequently, any cardiac surgeon performing off-pump surgery must also be able to perform on-pump surgery.

The Outbreak

7. Prosthetic valve endocarditis or PVE is an infection of the prosthetic or replacement heart valve. It is usually caused by a bacterial agent. The infection usually, but not always, occurs during the operation to replace a diseased heart valve with a prosthetic valve. Between 2 November 2007 and 25 November 2008, Mr Lu had carried out 43 heart valve replacement operations. There were no cases of PVE infection.

8. In July 2009, however, a cluster of cases of PVE were identified in patients operated upon by Mr Lu. Mr Lu immediately decided to cease carrying out heart valve replacement surgery. In October 2009, Mr Lu also agreed to cease carrying out other surgery. Mr Lu remains employed by the Trust. He continues to receive his usual salary and other entitlements. He undertakes other responsibilities. He does not, however, carry out any surgical duties.

9. The outbreak had tragic consequences. In total, 11 patients operated on by Mr Lu between December 2008 and July 2009 were infected with PVE. Five of those patients died as a result of the infection (two after undergoing further surgery). A further five underwent further surgery (involving seven operations in total). It was the worst recorded outbreak of PVE to have occurred anywhere in the world.

10. There were investigations carried out into the outbreak. Mr Lu co-operated fully with those investigations which included microbiological testing and examination of his surgical procedures. Mr Lu is a consultant who is, clearly, dedicated to the care of his patients and to his profession. He wished to do all he could to identify the source of the outbreak.

The Serious Untoward Incident Inquiry

11. An investigation, known as a Serious Untoward Incident Inquiry, was carried out by a panel. The panel's initial report ("the SUI report") was completed in about May 2010. In summary, it found that the cases were caused by the same strain of bacteria, a strain of *Staphylococcus epidermis*, which had been resistant to the antibiotics given routinely to protect against infection before heart valve surgery at the Centre. The outbreak strain was on Mr Lu's skin and had become embedded in the skin or, as it

was described had "colonised" Mr Lu. That was not known to Mr Lu. The SUI report found that the cause of the outbreak was the transmission of that strain of bacteria from Mr Lu to patients. Among the conclusions were the following:

> "Despite extensive investigation, neither the mechanism nor the time of transmission has been firmly established. There is however compelling microbiological evidence that the infection was acquired in the operating theatre."

12. The SUI report considered that, whilst there was no compelling evidence to define the precise mode of transmission, the two most likely mechanisms were either dispersal of the organisms from the surgeon's skin to elsewhere during surgery or contamination of the surgical site (that is, the area of the patient's body where the operation was being carried out) after micro-puncture of surgical gloves or after changing surgical gloves.

13. The SUI report concluded that Mr Lu's technical abilities were not in doubt, that his statistics for outcomes prior to the outbreak were good and included the following, among other, conclusions in relation to Mr Lu (who is indentified in the extract only as Surgeon D):

> "18.6.1 Surgeon D's technical abilities have not been called into doubt his outcome statistics prior to this outbreak were entirely satisfactory, and his cardiac revascularisation outcomes are good, with not infective complications.
>
> 18.6.2 Surgeon D's practice differs somewhat from his colleagues, but is, if anything, more consultant-delivered and more thorough, almost to the point of single-handed practice, with limited input by junior staff.
>
> 18.6.3 While Surgeon D's practice differs in some elements from that of his colleagues, each element is well within the range of acceptable and 'standard' UK cardiac surgery practice.
>
> 18.6.4 The Panel neither heard nor found evidence of shortcomings in Surgeon D's infection, prevention and control techniques and practices. Indeed there is much evidence that these were robust.
>
> 18.6.5 Surgeon D's approach to clinical care is exemplary, but even if his reputation is unharmed, his confidence is damaged and his clinical skills are unused at a time when he is still gaining experience and confidence for more complicated cases.
>
> 18.6.6 Surgeon D has dissected his own practice, sought assurance from other units, co-operated fully with the investigation, and subjected himself to detailed microbiological

> scrutiny, occupational health assessment and attempts at decolonisation.
>
> 18.6.7 At some point Surgeon D became colonised by the antibiotic-resistant, outbreak *Staphylococcus epidermidis*.
>
> 18.6.8 Surgeon D remains colonised with this organism, despite attempts to eradicate it from him. While such eradication may be achieved, he might be recolonisation with this organism (or other flora). For this reason physical and microbiological barriers to the transmission of infection will remain the mainstay of measures to prevent this and similar infections in future."

14. The SUI report recommended that certain specific, practical infection prevention and control measures be adopted by all theatre staff in the Centre. These included the use of two sets of gloves (known as double gloving) or thicker gloves or both. That would minimise the possibility of perforation of the gloves leading to transmission of infection from the hand of one of the surgical team to the patient. The SUI report recommended that Mr Lu did not return to heart valve surgery until any identifiable risks of PVE were reduced to levels acceptable to patients, clinicians and the wider National Health Service community. The SUI report considered that there was no evidence that Mr Lu's cardiac revascularisation procedures (that is, the off-pump and on-pump bypass surgery) carried any greater risks for patients than any other UK cardiac surgeon, including the other cardiac surgeons at the Centre. The SUI report therefore recommended a phased return to this part of his practice.

15. Dr Fowlie suggested amendments to drafts of the SUI report. Some of his recommended changes were accepted, some were not. Mr Lu, in his evidence, indicated that he understood that Dr Fowlie had amended the report and that the SUI panel were not content with the report in its final form. Dr Fowlie gave evidence. He explained that he was the Medical Director at the Trust and given the gravity of the outbreak and the nature of the inquiry, he considered that it was appropriate for him to make suggestions and he had done so on other occasions. I found Dr Fowlie to be an honest and truthful witness. In my judgment, his actions in response to the draft reports were appropriate. Furthermore, I am satisfied from the contemporaneous evidence (see, for example, the e-mail of Mr White, chairman of the panel dated 12 May 2010) and the evidence of Mr White to Professor Finch on 24 August 2011, that Dr Fowlie was only making suggestions and comments on the draft report. The panel determined whether or not to accept any proposed amendment. The SUI report was the report of the panel and the panel was satisfied that the SUI report reflected their views.

The Period Following the SUI Report

16. Following the completion of the SUI report, internal meetings were held to discuss the report. Advice was taken from the National Clinical Assessment Service, known as

NCAS. That is part of the National Health Service and advises on clinical matters. By letter dated 19 May 2010, NCAS indicated that the Trust should consider a gradual, heavily-supervised return to surgery starting with the least risk surgery first. There was correspondence and meetings between Mr Lu and his adviser and various employees of the Trust, including Dr Fowlie, as to the best way forward. There was a meeting on 9 September 2010 between Mr Lu and Dr Fowlie to discuss the continuation of limitations on Mr Lu's practice. The discussion at the meeting is summarised in a letter from Dr Fowlie to Mr Lu dated 9 September 2010. That letter noted that Mr Lu wished to return to clinical practice and the Trust's view that, in order to maintain the confidence of patients and the public in Mr Lu, the Centre and the NHS, a return could not reasonably take place until after the conclusion of the coroner's inquests into the deaths of the patients and the supplementary SUI report. The letter noted that the Trust's view at the time was that a return to coronary artery bypass surgery was feasible but that a return to heart valve surgery was not given the continuing uncertainty about the method of transmission from Mr Lu's skin to the patients' heart valves. Similar exchanges occurred at a meeting between Mr Lu and Dr Fowlie in late October 2010 and in a letter dated 4 November 2010.

17. Mr Lu continued to undergo microbiological testing to determine whether he remained contaminated or "colonised" with the outbreak strain of bacteria. On 5 July 2010, it was confirmed that the outbreak strain of the bacteria had been completely eradicated. On 18 October 2010, it was confirmed that Mr Lu had not tested positive for the outbreak strain of the bacteria since April 2010.

18. In October 2010, the supplementary SUI report was completed dealing with an investigation into whether or not the outbreak of PVE had been detected at the earliest opportunity or whether there had been delay. On 30 November and 1 December 2010, a coroner's inquest was held. The coroner concluded that micro-perforation of the gloves used during surgery was unlikely to be the route of transmission of the infection from surgeon to patient. The coroner did not have available expert reports and views that become available later including a report dated 24 March from Mr J.A. Hutter on the appropriateness of the surgical practices used by Mr Lu which considered the evidence on micro-perforations in gloves.

19. A further meeting was held on 26 January 2011 between Mr Lu, his advisers, Dr Fowlie and Mr Mortimer, the Director of Human Resources at the Trust to discuss the restrictions on Mr Lu's surgical practice. The meeting discussed a number of possible options in an attempt to determine whether it was possible to agree a way forward, the alternative being the instigation of the process for assessing capability for ill-health under the Trust's Disciplinary Procedure: Medical and Dental Employees ("the Procedure"). It was agreed that Dr Fowlie would contact NCAS and brief the Chief Executive. He did. NCAS advised that the Trust may wish to consider an independent report into the risks of Mr Lu returning to his previous practice.

20. The process of identifying an independent investigator was put in train. On 25 February 2011 (the letter is wrongly dated 2010), Mr Mortimer wrote to Dr Lu. He explained that the Trust were proposing appointing an independent case investigator.

There was also a proposal that Dr Fowlie cease to act as the case manager under the Trust's Maintaining High Professional Standards policy and that Mr Mortimer act in that capacity. Mr Lu's representative replied on 14 March 2011 agreeing to the obtaining of independent expert advice. For reasons that Mr Lu was not familiar with, the legal representative objected to Mr Mortimer taking on the role of case manager and, in fact, Dr Ryder was appointed to that role. The letter of 14 March 2011 also requested that Mr Lu be allowed to re-integrate to non-valve surgery. The substantive reply came by letter dated 21 April 2011, indicating that the assessment of risk in relation to valve surgery should also be applied to coronary artery bypass graft surgery.

The Finch Report

21. Professor Roger Finch was appointed as an independent expert. He was, until retirement, a professor of infectious diseases at the University of Nottingham. Professor Finch began his investigation in about mid-May 2011. He had hoped to be able to deal with the inquiry fairly speedily over the summer period. He interviewed a number of individuals including Mr Lu. He also received evidence from other experts in the field of microbiology. These included reports that he requested be prepared and a report by Professor Eykyn which had been commissioned on Mr Lu's behalf.

22. Professor Finch reported on 29 November 2011. The terms of reference were as follows:

> "Consider whether Mr Lu can continue to practise invasive cardiac surgery without risk to patients. The investigation will involve the participation of the Trust's Occupational Health Service and an independent microbiological report to determine the level of that risk and the Trust will, with advice from National Clinical Assessment Service (NCAS), then determine whether that risk is acceptable and decide upon the position going forward."

23. Section 8 of the report proceeds by identifying a series of critical questions, providing answers and further comments. The report noted that bacteria, *Staphylococcus epidermidis*, was present in the Centre prior to the appointment of Mr Lu and 17 individuals were found to be carrying antibiotic resistant strains but none, other than Mr Lu, was found to be carrying the exact outbreak strain. The report noted that:

> "John Lu acquired the outbreak strain between his appointment in October 2007 and recognition of the first cases of prosthetic valve endocarditis (PVE) in July 2009. The organism had been present in the Trust, notably the TCC and CICU for some time before his appointment. Strains similar to the outbreak strain have also been isolated from patients since the outbreak was recognised.

> In conclusion the evidence suggests that John Lu became colonised with the outbreak strain following his appointment. At the time of the outbreak there was clearly something unique about the biology of the organism, John Lu and his insertion of prosthetic heart valve material that conspired to cause infection in so many patients. The exact nature of this biological interaction between John Lu and the host valve material remains uncertain."

24. The report considered the evidence in relation to the mechanism of transmission to patients undergoing heart valve surgery. It commented that:

> "Despite the exemplary thoroughness of the investigation the exact mechanism whereby the outbreak strain contaminated the inserted cardiac valve remains uncertain. However, the most likely route of transmission would be from John Lu's hands, which were shown to be colonised with the outbreak strain, to the operative site as a result of unrecognised perforation of the thinner (Biogel ® Super-Sensitive ^{TM}) gloves occurring during an operation which takes some 3-4 hours."

25. The report also considered the possibility of Mr Lu retraining in another speciality. In that context, the report referred to the fact whatever Mr Lu's decision on retraining, there would be an ever present requirement for him to explain his historical association with the outbreak to patients under his care. The report made 15 recommendations, the first three of which were:

> "1. John Lu should return to full operative practice including prosthetic valve surgery. This should be managed as a staged process that will need to be planned and supervised by the cardiac surgical team and a mutually agreed mentor to allow John Lu to retrain and re-skill after a significant absence from operative practice. This process should be agreed and supported by Trust management and NCAS and proceed in accordance with recommended practice and with all necessary support. Allied to this will be the need to develop an appropriate communications and publicity management strategy to support this return to work.
>
> 2. This return of John Lu to surgical practice should initially exclude prosthetic valve surgery in order to monitor skin samples at monthly intervals to check for the possibility of his acquisition of the outbreak strain, recognising that this organism continues to circulate within the Trust. It is recommended that this period of monitoring be for 6 months. This monthly screening might most conveniently be completed during the period of retraining and before he commences valve surgery. He should then be screened at 3 monthly intervals for a further 18 months. It is recognised that screening John Lu at

> such intervals will provide only partial reassurance hence the importance that all practical and effective barrier precautions be adopted, in conjunction with other sound surgical practices within the theatre suite in order to provide optimal safeguards against post-operative infection.
>
> 3. The barrier precautions recommended by the SUI Report should be implemented and adopted by John Lu as far as is practical. In particular this applies to the use of thicker gloves, double gloving and down gloving during glove changing procedures."

26. The report recommended that in the unlikely event that Mr Lu was linked to a further outbreak of PVE, which was said to involve two or more cases, then he should cease valve surgery. The report considered that, in that situation, continued conduct of heart valve surgery of any sort would be an unacceptable risk to patients and the Trust.

27. On 30 January 2012, Professor Finch provided further responses to three points that had been raised. In brief, he indicated that, on the balance of probabilities, the chance of Mr Lu becoming recolonised by the outbreak strain of bacteria was low. In relation to obtaining consent of patients to particular operation, he indicated that patients be informed of general risks of the operation and risks specific to that patient and that operation. He also recommended that Mr Lu should address his historical association with the outbreak strain in 2009 and 2010 and indicated how that might be done. He also addressed the communications and publicity strategy that he recommended the Trust to adopt.

28. There was a meeting between Dr Ryder (who was now the case manager), Mr Mortimer, and Mr Lu and his advisers on 8 February 2012. The discussion at the meeting is summarised in the letter of 15 February 2012 from Dr Ryder. The letter records agreement that any programme for a return to practice would be most likely to require an initial period of support at a different unit, not the Centre, whilst having regard to Mr Lu's personal and family commitments, followed by a period of transition to the Centre. Subsequently, the Trust contacted Mr Cooper, the secretary of the Society of Cardio-Thoracic Medicine regarding potential arrangements for the programme. The question of the appropriate approach to obtaining the consent of patients was also discussed at the meeting and Dr Ryder indicated that advice would be sought on this matter. In fact, counsel was instructed in relation to the question of patient consent on 24 February 2012. The meeting also noted the view of Dr Homa, the Trust's Chief Executive, and Dr Ryder that they doubted that it would be possible for Mr Lu to carry out heart valve surgery as the risk of PVE could not be quantified. Mr Lu took the view that the most likely transmission route was micro-perforation of gloves and he would now double glove and that other preventative measures had been taken.

29. Mr Lu's advisers replied by letter dated 23 February 2012 setting out Mr Lu's views. The letter made a number of points, including, in particular that Mr Lu wished to

return to full duties, including heart valve surgery, after an appropriate programme. Mr Lu now took the position that he did not wish to commence re-training in a different establishment. He referred to the fact that off-pump coronary artery bypass surgery was not widely practised in the United Kingdom but was performed by Mr Naik at the Centre. Mr Naik had agreed to act as a mentor and supervisor. Dr Ryder replied on 5 March 2012, noting his disappointment that Mr Lu had altered his view that commencement of the retraining would take place at another unit.

The Quality Assurance Sub-Committee and the Trust

30. The Trust then considered its response to the report of Professor Finch. The Trust Board met on 1 March 2012 and agreed that a particular sub-committee the Quality Assurance Committee, would consider the matter. For convenience, I refer to that sub-committee as QuAC. A meeting of QuAC was held to discuss the position of Mr Lu. They had a number of documents before them including the SUI report, the Finch report, the report from Professor Eykyn commissioned by Mr Lu and a commentary written by Dr Fowlie on behalf of Dr Homa. That commentary set out the view that Dr Fowlie had previously expressed, namely that a return to heart valve surgery was not feasible as the risk posed by Mr Lu was too great. Dr Fowlie considered that the level of risk that Professor Finch was prepared to accept was greater than that which would be considerable acceptable by most professionals, patients and the public.

31. Complaint has been made that Dr Ryder had given an undertaking in his letter of 15 February 2012 that Dr Fowlie, Dr Homa and Mr Mortimer (who were members of QuAC) would not take any part in the discussion at QuAC and the written commentary breached that undertaking. In fact, the three individuals did not attend the meetings of QuAC and did not participate in the discussions at QuAC. Dr Homa gave evidence, which I accept, that he was asked by the chair of QuAC to submit views and he asked Dr Fowlie to prepare the commentary. In my judgment, it is understandable that the QuAC would wish to know the position of the Trust's Chief Executive. The submission of a written document does not, in my judgment, amount to a participation in the discussions and does not breach the undertaking given. Even if did, it is quite clear that the QuAC considered the matter independently and, as will ultimately appear, did not accept the view expressed in the commentary written by Dr Fowlie on behalf of Dr Homa. Further, the ultimate-decision maker was the Trust Board itself (on which Dr Homa and Dr Fowlie did sit and where there was no undertaking not to participate and where the Board again did not accept the views of Dr Fowlie). I do not consider therefore that there was a breach of the undertaking, or if there was, that it was material to the consideration of the matter. In my judgment, the submission of the commentary did not amount to a breach of the undertaking or a breach of any express or implied term in Mr Lu's contract of employment.

32. The note of the discussion at the QuAC includes the following comments:

> "3.1 Of particular concern to the committee, articulated first by Mrs Tabreham, was that none of the reports supplied had given a definitive answer on the risk of Mr Lu infecting patients if he

> returned to prosthetic valve surgery. It was unclear to committee members whether a definitive answer could be given, but it was felt that the experts should be pushed to quantify the risks as patient safety was of paramount importance.
>
> 3.2 The committee acknowledged the uniqueness of the situation that had arisen and the enormity of the decision it was being asked to make, both in relation to Mr Lu's career as a cardiac surgeon and for the safety of patients to which the Trust owed a duty of care. The Committee, through the Chairman, expressed enormous sympathy for Mr Lu and the very difficult situation being faced by a highly skilled surgeon that was not of his making.
>
> 3.3 None of the investigations to date had been able to give a concrete answer as to how the outbreak occurred and what mitigating actions would ensure no recurrence in the future. This made it doubly important to have some quantifiable risks to guide the committee's decision making."

33. Against that background, the QuAC decided that it wished to procure more detailed information on a number of specific topics. It noted its wish to work with the Medical and Dental Defence Union of Scotland who were advising Mr Lu. The notes of the meeting concluded as follows that:

> "The committee was anxious not to introduce further delay in reaching its decision, but unanimously felt that in order to reach the correct decision for the safety of the patients in the care of NUH, it should seek to have its specific concerns addressed."

34. The QuAC received further information. This included further responses from Professor Finch in relation to the points raised by the chairman of QuAc on 17 April 2012. Dr Ryder had also contacted Mr Lu's advisers to ask if Professor Eykyn, the expert commissioned by Mr Lu to prepare a report for Professor Finch's investigation, could assist with the matters raised. A response was made to QuAC by advisers on behalf of Mr Lu in relation to the topics referred to in the note of the discussion of the QuAC meeting after they had consulted Professor Eykyn.

35. The QuAc met on 7 July 2012. There were four members, Dr Barrett (the then chairman of the Trust), a non-executive director, the deputy chief executive of nursing and midwifery, and the director of finance. There were others in attendance, including a representative of Mr Lu, Professor Eykyn, Professor Finch, and Dr Boswell, the Trust's consultant microbiologist. The minutes identify the key issue as "whether the Trust could support the return of Mr Lu to prosthetic cardiac valve surgery, after considering the principal risk to patient safety of him doing so". The minutes record the information that was before the QuAc. The QuAC heard from a number of those attending, including Professor Eykyn, Dr Boswell and Professor Finch. There was an

extensive discussion on the possibility of Mr Lu being recolonised by the outbreak strain, the mode of transmission of the bacteria from Mr Lu to patients and the safeguards that would be needed. The QuAC's view was:

> "The evidence received by the committee from the three expert microbiologists suggests that the risk to patients of Mr Lu returning to cardiac surgery, including valve surgery, is minimal, provided he agrees to adhere to all practical measures recommended by the expert microbiologists, including the testing regime to ensure he remains free of the outbreak strain of *Staphylococcus Epidermidis.*
>
> The risk to patients with the control measures in place is estimated to be the same as for all the other cardiac surgeons in the TCC.
>
> The Committee members unanimously agree that based on the expert evidence received, there was no clinical reason why Mr Lu should not be allowed a phased return to cardiac surgery, subject to all practical recommendations being implemented.
>
> Before returning to work, the committee would require Mr Lu to be rescreened, in order to ensure that he currently remains free of the outbreak strain of *Staphylococcus Epidermidis.* Also, as recommended in Professor Finch's report (para 9.2.2), following return to non-valve surgery, Mr Lu's skin samples should be monitored at monthly intervals to check for the possibility of his acquisition of the outbreak strain and this should continue for a period of six months.
>
> After returning to work, the committee would require a report at the end of six months, and three monthly thereafter for a period of 18 months, of Mr Lu's colonisation status (the screening intervals recommended by Professor Finch). In the remote possibility that Mr Lu becomes recolonised by the outbreak strain, the committee would be urgently reconvened to agree an appropriate course of action to ensure patient safety."

36. The matter was then considered by the Trust Board on 30 August 2012. Present on that occasion were the four members of QuAc, Dr Fowlie, Dr Homa, and 3 other non-executive directors. There was a lengthy discussion. The Board were informed that good progress had been made regarding a training programme. Dr Homa stated that he had been persuaded by the expert evidence and that Mr Lu should be allowed to return to duties in due course and it would be important to give careful thought to all aspects of the transition plan. Dr Fowlie made clear that he took a different view from the experts. He considered that the mode of transmission had not been established and he considered that it was not possible to say that Mr Lu posed no greater risk than his colleagues. Following discussion, the Trust Board decided that it was not necessary to take a formal vote but noted Dr Fowlie's dissent. The minutes record that,

> "The Board then formally resolved that Mr Lu should be allowed to undertake a transitional return to full-duties, subject to his agreement to, and compliance with, the prerequisites and on-going requirements advocated by Professor Finch."

37. In my judgment, it is clear that the Trust Board determined that Mr Lu should be able to return to full surgical duties in due course. Given the background, in that Mr Lu had been away from all surgery for almost 3 years, the references in the minutes to the retraining programme and a need for a transition plan, and the reference to "a transitional return to full duties", the Board, in my judgment, contemplated that there would be a programme to enable Mr Lu to return gradually and safely to full surgical duties by enabling him to re-familiarise himself with the necessary skills, and to demonstrate that he had done so. The minutes, read as a whole, indicate that the Trust Board had accepted the view that Mr Lu did not present a greater risk than any other colleague provided that the recommendations of Professor Finch were implemented.

38. That reading of the Trust Board's decision and minutes is confirmed by the letter sent by Dr Ryder to Mr Lu on 3 September 2012. The material parts of the letter read as follows:

> "I write to confirm that the Trust Board received at its meeting on 30th August 2012 the view of the special committee convened in March to consider the clinical risk of your returning to valve surgery. You are aware of the rigorous process the committee followed: four meetings were held, advice and assistance was received from counsel, all relevant reports were reviewed and the committee met directly with Professor R Finch, Professor S Eykyn and Dr T Boswell.
>
> The Board received and accepted the view reached by the committee that the evidence they received from the three expert microbiologists suggests that the risk to patients of your returning to Cardiac Surgery, including valve surgery, is minimal, provided you adhere to all practical measures recommended by the expert microbiologists, including the testing regime to ensure you remain free of the outbreak strain of Staphylococcus Epidermis. The risk to patients, the Board heard, with the control measures in place, is estimated to be the same for you as for all the other cardiac surgeons in the TCC. Based, therefore, on the expert evidence received, there was no clinical reason why you should not be allowed a phased return to cardiac surgery, subject to all practical recommendations being implemented.
>
> To be clear therefore the Board accepted that you should be able to return to the full range of cardiac surgical practice, subject to the recommendations set out by Professor Finch in his original report – certain of these were stressed by the Board in its conclusion. I recognise that this is an outcome which you have sought for some time but it is one which should, for a

> short time, be treated as confidential by both the Trust and you. The Board stressed that the planning of your return to practice must proceed with proper care and attention, particularly with regards to the need to carefully communicate the circumstances and way forward to commissioners, other units, fellow clinicians, patients and the public. They also noted the importance of the completion of the agreement of your return to work programme and our discussions regarding informed consent.
>
> It is important therefore that we work together with you to agree the way forward before any wider announcements are made by either you or the Trust. I am meeting your Consultant colleagues on Tuesday 4th September and I would ask that you allow them to be briefed via this forum: the same requirements requiring discretion and confidentiality will be placed upon them.
>
> I have arranged for us to meet on Tuesday 4th September at 3pm in the Trust HQ, City Hospital. Daniel Morimer, Director of Workforce will be present as will Dr K Girling, Clinical Director – DIRC. Mr R Mohammed, MDDUS Advisor has confirmed that he is able to phone in to join the discussion."

39. Dr Homa had indicated at the Trust Board meeting on 30 August 2012 that officers would provide periodic updates to the QuAC. On 23 April 2013, QuAC established a committee, referred to as the task and finish committee, to determine when what it called the cardiac surgeon re-entry committee had completed its work. The documents envisage there would be arrangements in place to implement the Trust Board decision. These minutes refer to these arrangements as the re-entry committee. The task and finish committee would ensure that the Trust Board decision had been implemented. That accords with the evidence given by Mr Richens as to how the arrangements were envisaged to work. He was to be the assignment director and there would be a re-entry programme in place. He would determine if the re-entry programme had been completed satisfactorily. That would be confirmed by an external reviewer. The task and finish committee (or group as it became known) would confirm that the arrangements, when completed, had satisfactorily implemented the Trust Board decision,

Mr Lu's Proposed Re-entry Programme

40. Solicitors for Mr Lu wrote a letter before action on 18 May 2012 stating, amongst other things, that Mr Lu did not voluntarily agree to any further restriction on his practice other than as part of an agreed, staged and supervised return to full clinical practice which he wished to commence immediately. Solicitors for the Trust replied. Dr Ryder also replied on 8 June 2012, indicating that he would now wish to meet with Mr Lu in his role as case manager to discuss the next steps in relation to current working arrangements. The letter indicated that this meeting would build on earlier

discussions including the approach made by Mr Mortimer, to Mr Cooper, who was the secretary of Society of Cardio-Thoracic Surgeons. (Mr Mortimer had e-mailed Mr Cooper in February 2011 asking if he and Dr Ryder could discuss with Mr Cooper the matter of how the Trust might devise a structured programme of training and support to facilitate Mr Lu's return.) There was further correspondence between solicitors for Mr Lu and the Trust dealing with this proposed meeting and with the QuAC meeting scheduled to take place in July 2012. The correspondence confirmed that the meeting with Dr Ryder would give Mr Lu and his representative a full opportunity to provide input into the proposed programme and that it was hoped that, wherever possible a jointly agreed programme would be decided upon.

41. In fact, on 27 July 2012, Mr Lu sent Mr Cooper a copy of certain documents for Mr Cooper's consideration. These documents included a draft programme prepared by Mr Lu. The proposals involved Mr Naik acting as a mentor in weekly activities. It envisaged that this would continue for one year. Other documents were also included. The Trust were not involved in the preparation of these proposals or documents. In August 2012, Mr Lu sent the proposals to Mr Livesey who was the chairman of the Carodio-Thoracic Special Advisory Committee. Mr Lu copied in Mr Mortimer (the director of human resources at the Trust).

42. Mr Livesey e-mailed Mr Lu on 23 August 2012 stating that he thought the timescale Mr Lu proposed (one year) was reasonable and stating that he was delighted that Mr Lu had found a colleague (Mr Naik) who was able to help Mr Lu re-familiarise himself. Mr Livesey expressed the view that Mr Lu would have to be in a position to show evidence of progression through retraining and achievements of the standards commensurate with a new cardiac constultant. He suggested using the workplace based assessment on the Intercollegiate Curriculum Surgical Programme ("ICSP). Mr Livesey said that he thought those measures would be appropriate but, however "it is your employers who need to be satisfied that you are ready to return".

43. On 22 August 2012, Mr Mortimer e-mailed NCAS sending them correspondence from Mr Lu and noting that Mr Lu had sought the advice of the Society and an external mentor. Mr Mortimer said that the Trust:

> "would be grateful for any comments from NCAS on the attached, and in particular any advice regarding the effectiveness of the proposals in supporting a return to practice.
>
> We expect a decision on valve surgery by the end of the month."

44. On 22 August 2012, Dr Rothery replied indicating that she could not comment on the timetables and considered that it may be advisable, given the time away from clinical practice, to have a fuller action plan. In particular, she considered that it would be sensible to have more clearly defined objectives and a description of the evidence

which would be accepted as demonstrating those objectives had been reached. She offered to send examples of return to work plans. Those examples were sent to Mr Mortimer on 30 August 2012 and forwarded to Mr Lu on 4 September 2012.

45. On 30 August 2012, as indicated above, the Trust Board resolved that Mr Lu should be allowed to undertake a transitional return to full duties subject to agreement to and compliance with Professor Finch's recommendations. On 3 September 2012, Dr Ryder wrote to Mr Lu to confirm that decision.

46. On 4 September 2012, there was a meeting between Mr Lu and Dr Ryder. Others were present or joined the meeting by telephone. A follow-up letter was sent indicating that there had been discussion on four areas including a retraining programme. Various actions were agreed for the coming weeks, including Mr Lu doing further work on the retaining proposals and sharing that with Mr Livesey and Mr Naik who had agreed to act as trainer/mentor. A further meeting was to be arranged for 24 September 2012.

47. Also on 4 September 2012, there was a meeting later in the day attended by Dr Ryder, Mr Mortimer, Mr Lu, and some of Mr Lu's consultant colleagues from the Centre, namely Mr Richens and Mr Naik and one other. Mr Richens questioned the robustness of the re-training programme and the appropriateness of Mr Naik being the supervisor and whether the retraining should be done outside the unit.

48. Mr Lu continued work on his version of the proposals. He e-mailed Mr Livesey on 19 September 2012, and Mr Livesey replied on 20 September 2012 and said that the proposals looked comprehensive to him, and addressed the areas that Mr Lu would need to demonstrate competence in before returning to full practice and suggested "you forward it to the Trust (and NCAS) for final approval".

49. Also on 20 September 2012, Mr Naik sent Mr Mortimer a copy of a letter dated 20 September 2012 to Mr Cooper. That indicated that Mr Naik was pleased to see that Mr Cooper had agreed to be the external reviewer. Mr Naik noted that "the re-familiarisation programme has been guided and approved by Steve Livesey (SAC chairman) and forwarded to the Trust for approval".

50. On 26 September 2012, a further meeting took place between Dr Ryder and Mr Lu. Also in attendance were Mr Mortimer, Mr Lu's representative and Dr Girling, the Clinical Director. The discussion at that meeting was summarised in a letter of 9 November 2012 from Dr Ryder to Mr Lu. The letter said, in part, the following:

> "Our discussion focused on two particular areas relating to your return to work: consent of patients and your re-entry to surgical practice programme ('re-familiarisation'). These factors were discussed in the context of an acceptance by all parties referred to in this letter of the conclusion were reached by the Trust Board regarding your return to surgical practice.

> In relation to the area of consent, we agreed that the Trust would agree an instruction to Mr Michael Mylonas QC, with the input of your advisors (Mr Mitchell provided this on 12th October). This would comment on the approach to consent that you had set down, following discussions with colleagues including Mr Ian Robertson, Chair of the Trust's Consent Committee. Mr Mylonas' response would of course be shared with you.
>
> We discussed the response of your colleagues to your programme of re-familiarisation. I noted that they had welcomed the resolution of matters, particularly for you and your family, at our meeting with them on 4th September. There was however a discussion which pointed out the need for the re-entry programme to withstand any future scrutiny. Concerns were raised by two of your colleagues that Mr Naik was not an accredited trainer; that the mentorship arrangments were the same as the time of the outbreak: and that re-training elsewhere might be desirable. In relation to the last of these points I had explained to your colleagues (an am happy to confirm again to you) that the Trust accepted that it would not only be difficult for you to work elsewhere, but that Professor Finch's recommendations required for you to be working in the Trent Cardiac Centre. We also noted that the involvement of Mr G Cooper from Sheffield Teaching Hospitals FT ensured that there was a different mentorship arrangement than in 2009.
>
> Whilst a number of elements of the concerns raised by your colleagues had been addressed we did agree that it was important for the programme to command their confidence involvement and support. We agreed, therefore, that a meeting of the consultant cardiac surgeons would be convened to discuss the programme and to seek consensus as to the way forward. Mr Cooper would be invited to attend the meeting as would Dr Girling as Head of Service. Mr Mohammed and you supported the step of meeting with your colleagues, and Mr Mohammed reminded us that the MDDUS would vigorously challenge any steps which sought to prevent your return to work.
>
> Subsequently, Mr Mortimer has written to Mr Cooper confirming the Trust's approach to his indemnity (you received a copy of this letter)."

51. On 17 October 2012, Mr Mortimer wrote to Mr Cooper thanking him for agreeing to provide external review and support to the re-entry to practice programme for Mr Lu. The letter notes that the "commencement of this programme of re-entry has received approval from the Trust Board". An indemnity was also provided to Mr Cooper.

52. On 19 November 2012, Mr Lu, Mr Naik and Mr Cooper met and produced what were described as notes of the meeting with the external reviewer. The meeting appeared to have discussed Mr Lu's proposals. The note refers to Mr Naik as the Trust Mentor. The note referred to the next meeting to be held between month 2 and month 3 of the re-familiarisation programme. In fact, at that stage, Mr Lu had been told that Mr Naik would not be acceptable as he did not have the requisite approvals to be a trainer. Furthermore, the Trust had not approved the re-familiarisation programme at that stage. It is not easy to understand the basis or the purpose of this meeting between Mr Lu, the colleague that he preferred to have oversight of the re-entry programme, and the external reviewer.

53. A further meeting took place on 19 December 2012 between Dr Ryder and Mr Lu. Also in attendance was Mr Lu's representative and Dr Girling. The meeting is summarised in the letter from 2 January 2013 from Dr Ryder to Mr Lu. The meeting confirmed that Mr Lu had received a copy of the advice from leading counsel which had been provided on 29 November 2012 in relation to the information that would need to be provided to patients in order to ensure that they had given informed consent to any surgical procedure. The letter confirms that at the meeting the concern had been raised that Mr Naik was not an accredited trainer. The letter also said the following:

> "Having reviewed all the information available, it is clear that the recent history in relation to training for the Trent Cardiac Centre has been difficult. Indeed, there was some risk that training accreditation could be withdrawn entirely three to four years ago. This was averted, but recognition of status as a trainer was withdrawn from all consultants apart from Mr Richens. Other consultants have had this position reversed subsequently, but not Mr Naik. To be clear: Mr Naik may have attended the relevant courses but he is not recognised by the regional medical educational system as a trainer.
>
> My primary concern remains to ensure that your re-entry programme is resilient both now, and in any future scenario where it might be reviewed. There are several factors in supporting this resilience:
>
> - The content of the programme: this appears of suitable breadth and depth, and confirmation of this has been given by your professional society and NCAS.
>
> - The availability of external mentorship and review: Mr G Cooper of Sheffield Teaching Hospitals has kindly committed to provide this input to you and the Trust.
>
> - The assessment of your progress: I remain of the view that this must be done by an individual who is recognised as a proficient and competent trainer. Such qualities are evidenced not merely by completion of

> study but by sustained practical activity over many years and by recognition by external parties.
>
> Accordingly, I confirm that your re-entry programme will commence in the week of 14th January 2013. You will necessarily work alongside all your colleagues – including Mr Naik – during this programme. Your assessor for the various components of the programme must, I am clear, be therefore Mr David Richens, Consultant Cardiac Surgeon. I have asked Mr Richens to contact you to make the necessary arrangements to take this forward."

The September 2012 Proposed Re-Entry Programme

54. There are a number of factual issues that arise in relation to Mr Lu's proposed re-entry programme. The first is whether the Trust agreed or approved that programme. Mr Sutton, on behalf of Mr Lu, explained that it was not said that the September 2012 re-familiarisation programme constituted a formal agreement in the sense of a binding collateral contract or contractual variation. However, he submitted that, as a matter of fact, the September 2012 programme had been approved by the Trust or did represent the settled understanding of both Mr Lu and the Trust and that that fact would be relevant to the assessment of whether there had been a breach of the implied term of mutual trust and confidence or the express term of co-operation in the contract of employment. Mr Sutton relied upon the fact that the programme had been prepared using templates supplied by NCAS, approved by Mr Livesey and Mr Cooper, that Mr Mortimer had been sent the documents and had agreed with Mr Cooper that he would be the external reviewer and Mr Mortimer had arranged an indemnity. The alternative submission was that, as a matter of fact, the September 2012 proposed re-entry programme had been approved at the meeting of 19 December 2012 with the sole change that Mr Richens, not Mr Naik, would be person responsible for confirming that Mr Lu had demonstrated that the requirements in the programme had been achieved.

55. The practical significance to Mr Lu of establishing these facts would include the following. First, if the September 2012 agreement had been agreed by the Trust, then Mr Naik would be the person responsible for supervising the re-entry and confirming that the arrangements had been satisfactorily completed by Mr Lu. Secondly, the September 2012 (or that arrangement as allegedly modified in December 2012 by the substitution of Mr Richens for Mr Naik) would include the programme as set out in those documents (rather than the more detailed draft subsequently prepared by the Trust) and would provide for a specified time for completion, i.e. it would take 12 months.

56. First, I find as a fact, that the September 2012 proposals were not agreed to or approved by the Trust. They did not represent a common understanding between the parties as to the content, and personnel responsible for, the re-entry programme. They were proposals that Mr Lu wished to be adopted or agreed to by the Trust but they

were not in fact adopted by the Trust. I reach that conclusion for the following reasons. No person from the Trust approved the arrangements. It is true that Mr Livesey indicated that he was content with them but he was not the person responsible for approving them on behalf or the Trust and he expressly indicated that the Trust would have to approve them. Similarly, Mr Cooper was appointed as an external reviewer. His role would be to provide external validation of the programme. He was not able to act on behalf of the Trust in approving the terms of the re-entry programme. NCAS would offer advice and guidance, but they could not approve the programme on behalf of the Trust. The fact that they provided templates to serve as examples of possible versions of a re-entry programme did not amount to approval on behalf of the Trust. The fact that Mr Lu copied Mr Mortimer into some of the correspondence, that Mr Mortimer made arrangements for the appointment of Mr Cooper as external reviewer and had dealings with NCAS did not confer authority on Mr Mortimer to approve the arrangements. In relation to the last point, Mr Cooper was be the external reviewer. That did not mean that the Trust had approved the September 2012 arrangements. Indeed, in the letter of 18 October 2012, Mr Mortimer expressly says that the Trust Board had agreed to the commencement of Mr Lu's re-entry programme. That must be a reference to the decision of the Trust Board to allow re-entry of 30 August 2012 not the re-entry programme proposed by Mr Lu in September 2012.

57. Furthermore, the Trust Board decided on 30 August 2012 to support Mr Lu's transition into full time duties. Mr Lu was sent a letter on 3 September 2012 confirming that that would happen. A meeting took place on the 4 September 2012 indicating that further work would need to be undertaken on the proposed re-entry programme. A further meeting took place later that date at which colleagues of Mr Lu made it clear that the person responsible for confirming that the re-entry arrangements had been satisfactorily completed had to be an accredited trainer and Mr Naik could not fulfil that role as he was not an accredited trainer. It was, in my judgment, clear to Mr Lu that the arrangements had not been approved as at 4 September 2012 and it was clear that there were difficulties over Mr Naik being the person responsible for confirming that the arrangements had been satisfactorily complied with. Further, that point was made clear again at the meeting on 26 September 2012. It was also made clear that the re-entry programme needed to be able to withstand scrutiny and command the confidence of colleagues. There was to be further meetings attended by Trust representatives and others, including Mr Cooper (as the external reviewer). All of this is, in my judgment, inconsistent with the suggestion that the proposals prepared by Mr Lu were agreed or formed the basis of a settled, common understanding between Mr Lu and the Trust as to the basis upon which he would begin the transition to work.

58. Secondly, in my judgment, the Trust did not agree those proposals in December 2012 with the sole modification that Mr Richens replaced Mr Naik. Mr Lu relies in particular on the phrase in the letter of 2 January 2012 that in relation to the content of this programme "this appears of suitable breadth and depth, and confirmation has been given by your professional society and NCAS". That, it is suggested on behalf of Mr Lu, means that the content of the programme had been agreed with the change of Mr Richens for Mr Naik. In my judgment, the letter must be read in context and as a whole. The letter makes it clear that the re-entry programme had to be resilient. It

made certain observations about the content of the programme, the external reviewer and the assessment of progress. It made it clear that Mr Richens would be the assessor and that Mr Richens would contact Mr Lu to make the necessary arrangements to take this forward. Read as a whole, and in context, the meeting of the 19 December 2012 did not amount to an acceptance of the content of Mr Lu's programme. Mr Richens would be the assessor. He would meet Mr Lu and make the necessary arrangements. That may necessarily involve clarification or changes in the re-entry programme. Whilst it appeared to Dr Ryder to be of suitable breadth and depth, no one could have contemplated that Mr Richens would have to work with the proposal as set out in Mr Lu's documents if he was not content with it. In any event, for reasons that will become apparent, the content of the programme (as refined by Mr Richens) contains requirements that Mr Lu accepted in evidence that he was content to work with and set out the competencies that Mr Lu would have to demonstrate that he possessed in order to return to full-time practice.

59. In my judgment, the attitude of the Trust between September and early December 2012 is best summarised in the evidence of Dr Fowlie and Dr Homa. As Dr Fowlie said in evidence, he now appreciates, that is with the benefit of hindsight, that the Trust should have been more assertive in describing to Mr Lu that the Trust would need to be the principal architect of the re-entry programme and that the programme would have to involve consideration of a number of interested persons both internal and external. Similarly, Dr Homa said that, with hindsight, he believed that the Trust did not necessarily approach the issue the of re-entry programme correctly at this initial stage. Mr Lu was asked to draft his re-entry programme (albeit with support from Mr Livesey). As the Trust's management team considered the re-entry programme, they realised that they could not delegate these tasks to Mr Lu. I am satisfied that this evidence demonstrates the reality of what happened. In the initial period, Mr Lu did begin the process of preparing a re-entry programme. The Trust, however, did not approve or agree that re-entry programme and, in particular, came quickly to the view that Mr Naik could not be the person to assess whether or not Mr Lu had demonstrated that he possessed the relevant competencies. Furthermore, Mr Lu knew, or ought to have known that, the Trust had not accepted his draft proposals.

60. The third factual issue concerns the reasons why the Trust were not prepared to accept a re-entry programme where Mr Naik was the assessor. Mr Sutton, on behalf of Mr Lu, submitted that the real reason for this change in approach was not ultimately to do with the fact Mr Naik was not an accredited trainer. Rather, he submits that the real reason was a disagreement on the part of some of those who were involved in implementing the Trust Board decision of 30 August 2012, with the view that Mr Lu presented no greater risk of infection to patients than any other colleague in the Centre. Mr Sutton submitted that the reasons for the change in approach were that Dr Fowlie and Mr Richens in particular did not accept that the basis for the Trust Board decision was evidentially or logically sound and that they considered that Mr Lu did, or may, present a greater risk to patients. That was in large part, it was submitted, because they did not accept that the mode of transmission of the bacteria from Mr Lu to patients had been firmly established and, given that uncertainty, they did not consider that the return of Mr Lu to surgical practice would be consistent with patient safety.

61. In my judgment, it is clear from the contemporaneous evidence and the evidence of Dr Fowlie, Mr Richens and Dr Homa, that the reasons for not accepting Mr Lu's proposals that Mr Naik be his assessor was the fact that Mr Naik was not an accredited trainer. I reach that conclusion for the following reasons. The contemporaneous evidence demonstrates, in my judgment, that the background was that all those involved on the part of the Trust were concerned that any re-entry programme was robust and could withstand public scrutiny. All those persons considered that that was in the best interests of Mr Lu and the Trust. It would contribute towards ensuring that if there were any questions about the resumption by Mr Lu of surgical duties, the Trust would be able to show that Mr Lu had demonstrated that he possessed the relevant competencies to enable him to perform the duties of a cardiac surgeon. Having heard the evidence of Mr Richens, Dr Fowlie and Dr Homa, I consider that they were honest, reliable witnesses who were fairly and accurately explaining why they considered that a proposed re-entry programme with Mr Naik as the person acting as assessor and responsible for confirming that Mr Lu had satisfied the re-entry programme was not suitable. That reason was that they did not consider that Mr Naik was suitable for that task as he was not an accredited trainer. Dr Homa confirmed that that was the unanimous view of Dr Ryder, Dr Fowlie and himself. Dr Fowlie confirmed that that was his view. Mr Richens confirmed that that was his view also.

62. Their evidence is also consistent with the contemporaneous correspondence and the context. In terms of the contemporaneous evidence, Mr Richens wrote a letter on 6 September 2012. The material part is as follows:

> "As a new consultant who has been unable to operate for around 3 years (twice as long as his experience as a practicing consultant surgeon) John will surely now require an exceptional retraining programme which is sensitive to his particular set of circumstances. This will be a very stressful time for him and he will be exposed to unprecedented levels of scrutiny. I would hope therefore that the retraining would require, at the very least, mentoring and training from an experienced, credible and accredited trainer(s). We do have a range of training experience amongst the consultant surgeons here, as in most units. At one end of this training spectrum is a surgeon who is not, and has never been, an accredited trainer and who has a local and national profile as a surgeon who does not train. In my opinion it would not therefore be appropriate to ask this individual to have a role in the retraining programme."

63. That letter, in my judgment, confirms that Mr Richens was concerned at the outset with ensuring that the re-entry programme be under the supervision of an experienced and credible trainer. The letter continues by explaining that, whilst Mr Naik is a surgeon with a national and local profile, he has no experience of training. Mr Lu has focussed on other parts of the letter which he considers indicates that Mr Richens does not accept the validity of the technique of off-pump surgery and Mr Lu believes that in some way Mr Richens wishes to reconstruct Mr Lu's surgical techniques. In my judgment, read as a whole, the letter is not intended to convey that message. The letter

is primarily concerned with indicating that any re-entry programme should be conducted by an experienced and accredited trainer and that when Mr Lu recommences surgical duties, he should begin with the less complex surgery rather than the more complex off-pump surgery. That last point, incidentally, was also the view of NCAS earlier in the process. Mr Richens e-mailed Mr Lu on 27 September 2012 indicating his view that a return to work plan with Mr Naik named as mentor, supervisor or with responsibilities for monitoring and signing off would not be credible because Mr Naik had no experience of this in 20 years as a consultant and Mr Richens considered that Mr Lu would need a person with recognised and highly developed skills as a trainer. The letter from Dr Ryder dated 9 November 2012 (summarising the meeting of 26 September 2012) also referred to the concerns of colleagues that "Mr Naik was not an accredited trainer".

64. In terms of the context, the importance of having an accredited trainer appears also from the evidence of Mr Fabri. He had been a programme director previously. He had trained Mr Lu in Liverpool. He had agreed to become Mr Lu's external mentor. He gave evidence on behalf of Mr Lu. He gave evidence that an accredited trainer would have to fulfil certain criteria and complete certain courses and demonstrate satisfactory results in those courses. Then the person could gain approval as a person suitable, and qualified, in determining whether others had demonstrated the necessary competencies to act as a surgeon.

65. The Trust had had difficulties in relation to training in 2009 when cardiac training in the Trust was considered to be inadequate in terms of trainee surgical activity and levels of educational supervision in the Centre. There had been concerns that approval for training would be withdrawn. Eventually, it appears, that Mr Richens was left in place as the only accredited trainer at the Centre. It is, in my judgment, inherently likely that the motivation of those involved was concern over allowing Mr Naik to have responsibility for this task rather than having the task carried out by an accredited trainer given the difficulties the Trust had already experienced over training, and given the circumstances of Mr Lu's case, where the Trust would want to be able to demonstrate that the re-entry programme was overseen by a suitably qualified person.

66. Finally, all those who gave evidence testified to the skills of Mr Naik as a surgeon. He is highly regarded by his colleagues. His work involves highly complex surgery. All those who gave evidence on behalf of the Trust were at pains to emphasise that they regarded Mr Naik very highly as a cardiac surgeon and a colleague. However, Mr Naik has not indicated any interest in training. He has not obtained any of the relevant approvals or accreditation from relevant professional bodies. Mr Naik confirmed in his evidence that he believed that he has trained only three, or possibly fewer, students since 1995. That is confirmed by the figures produced by the Trust. Furthermore, Mr Naik confirmed that he has not applied to any relevant body for accreditation.

67. For all those reasons, in my judgment, the decision not to accept Mr Lu's proposal that Mr Naik would be the assessor was, as a matter of fact, based on the view of those involved that Mr Naik was not an accredited or approved trainer and so was not

suitable for that role. I recognise that Mr Livesey had indicated that, for him, the fact that Mr Naik was not accredited would not be a problem. But Mr Livesey was not the person responsible for deciding who should be the assessor. He was not the person who would bear the responsibility of being able to ensure that the re-entry programme could be shown to be robust. The decisions fell to the Trust and its appropriate officers. As a matter of fact, in my judgment, all those involved on behalf of the Trust in the process in September 2012 onwards considered that the person acting as assessor should be an accredited trainer and Mr Naik was not an accredited trainer and so, for that reason, could not act as the person responsible for assessing that Mr Lu had satisfied the requirements of any re-entry programme.

68. It is the case, as will appear from the discussion below on what information must be provided to obtain informed consent from patients, that Dr Fowlie and Mr Richens do not accept the logic of the Trust Board's decision. That has affected the patient consent issue. Those views have not however affected the question of whether Mr Naik was suitable to carry out the duties of assessor of any re-entry programme for Mr Lu. The views of Mr Richens has not influenced the remainder of the content of the re-entry programme, save in one respect. That one respect concerns the practical arrangements for implementing the resumption of duties in relation to heart valve surgery. Mr Richens anticipates that he would wish Mr Lu to follow his procedures if he, Mr Richens, has any doubts about Mr Lu's existing surgical practices in this regard. I return to this topic later in assessing whether or not this amounts to a breach of any express or implied term of Mr Lu's contract of employment.

Subsequent Events

69. Following Mr Richens' appointment as assessor, the intention was that Mr Lu be able to commence a return to surgical duties in the week beginning 14 January 2013. On 8 January 2013, there was a meeting between Mr Mortimer and Mr Lu. The meeting was to discuss the Trust's plans to communicate the commencement of Mr Lu's re-entry to surgical duties with other interested parties including patients and the public. Mr Mortimer indicated that re-entry would be postponed to the week beginning 28 January 2013 to allow time for communication with other interested persons. In view of the fact that the report of Mr Francis Q.C. was due to be published shortly, the Trust also subsequently decided to postpone the recommencement of surgical duties to the week beginning the 25 February 2013. Dr Homa explained in evidence that the aim was to ensure that the re-entry programme would be consistent with anything that the Francis report might recommended. Furthermore, part of the concern was that the return to practice of Mr Lu would be likely to generate further interest. If the Francis report was published after that date, there might be a second round of media coverage which might generate adverse publicity for Mr Lu. The aim was to ensure the best possible chance for the re-entry programme to succeed and that was best achieved by delaying the re-entry until after the Francis report rather than having re-entry first, and then the Francis report.

70. Considerable work was undertaken on the process of how Mr Lu's re-commencement of surgical duties would be communicated to the wider public and patients. On 14

February 2013, Dr Homa wrote to Mr Lu to ask for another meeting to discuss delaying re-commencing surgical duties. Dr Homa, in his evidence, explained that a detailed communication strategy had been prepared and further time was needed to communicate with interested parties both within the Trust and externally. Mr Lu in his evidence confirms that Dr Homa outlined the communications strategy and provided a copy to him at the meeting. Mr Lu confirms that Dr Homa's view was that by meticulously preparing the ground work, the Trust would be in a good position to defend the Trust's decision to implement the recommendation that Mr Lu be allowed to re-commence surgical duties. I accept this evidence as indicating the content of the meeting. Dr Homa gave evidence that Mr Lu agreed that his return would begin in the week beginning 15 April 2013. Mr Lu did not, in his evidence, express a different view. I accept Dr Homa's evidence in this regard and I find as a fact that Mr Lu and Dr Homa agreed to defer Mr Lu's re-commencement on surgical duties to the week beginning 15 April 2103. Further meetings took place on the communication strategy.

71. On 21 March 2013, Mr Lu met Dr Homa and Mr Mortimer to hold a final discussion on the re-entry programme prior to a meeting with Mr Lu's colleagues at the Centre scheduled for the next day. Mr Lu's representative was away on leave so he did not attend. At this meeting, Mr Lu expressed his concerns about Mr Richens' role in the re-entry programme primarily in relation to off-pump coronary artery bypass graft surgery (which Mr Richens did not perform). Dr Homa confirmed that a suitable assessor would be identified for this aspect of the programme. Dr Homa gave evidence that Mr Lu agreed at this meeting that Mr Richens would undertake the role of internal mentor and assessor with external support from Mr Cooper.

72. Shortly after that meeting, Mr Lu e-mailed Dr Homa. Mr Lu stated that he wished to record again his concerns about Mr Richens undertaking the role of mentor and assessor. Those two concerns were again the fact that Mr Richens did not undertake off-pump surgery and Mr Lu did not consider that Mr Richens could be his mentor and assessor. In relation to an external assessor, Mr Lu indicated he would not object to that but he would still need to be able operate with a colleague who was comfortable with off-pump surgery. Secondly, Mr Lu indicated that he wished to work in an environment where all members of the team wore double gloves but that Mr Richens wore a single pair of thicker gloves. The e-mail ends in bold by saying:

> "In these circumstances, and given my concerns, I must please ask that my colleagues should not be told tomorrow that David Richens is going to be my mentor and assessor"

73. In my judgment, Mr Lu's stance at this stage is clear. He was not prepared to accept Mr Richens as his assessor despite the fact that he had agreed to that earlier in the day and despite the fact that the Trust had made it clear that Mr Richens would have to be the assessor as he was the only accredited trainer in the Centre. In my judgment, Mr Lu is in reality insisting on Mr Naik as his assessor. Mr Naik is the only colleague that performs off-pump surgery at the Trust. He is the only cardiac surgeon who follows the practice of double gloving.

74. As a result of Mr Lu's refusal to accept Mr Richens, Mr Lu could not recommence surgical duties in April 2013. As Dr Homa said in a letter of 22 May 2013, he had no choice in the circumstances but to suspend re-commencement of Mr Lu's re-entry programme and the planned communication strategy.

75. Finally, on 22 May 2013, there was a further meeting between Dr Homa and Mr Lu. Also in attendance were Mr Mortimer and Mr Lu's representative. The letter of 31 May 2013 summarises that meeting. The letter explains that Dr Homa wished to avoid any ambiguity about the respective roles of Mr Naik and Mr Richens. It was accepted that Mr Naik would play some supporting role but "plainly, Mr Richens will be in charge of the re-entry programme and the allocation of duties to support that programme". The letter made it clear that any role played by Mr Naik or any other colleague would be at the direction of Mr Richens. A suitably qualified individual would be sought by Mr Richens to complete the assessment of the off-pump surgery aspects of the re-entry programme. The letter says this in part:

> "Following an adjournment, when you consulted with Mr Mohammed, you confirmed your agreement as follows (and I quote your words as indicated):
>
> 1. The need for a 'robust' re-entry programme
> 2. Mr Richens would be 'in charge' of all aspects of your re-entry programme
> 3. Mr Naik would have 'no formal role', and would provide 'help only'
> 4. An external expert would be identified to address off-pump specific assessments."

76. The letter also noted that a number of practical issues had been discussed regarding the re-entry programme. These included describing the progress of the re-entry programmes in terms of the completion of competencies rather than being in two six month parts and Mr Richens would outline that to Mr Lu. The letter records that Mr Lu's representative specifically welcomed that approach. The letter confirmed that Mr Richens would now be appointed as Assignment Director and a list of his main duties were attached to the letter. The duties included development of the re-entry programme, allocation of surgical and other duties to Mr Lu, regular discussion with Mr Lu regarding his progress, and observation, assessment and certification of the satisfactory completion of competencies described in the programme. They included other duties such as identification of a suitably qualified individual to confirm the assessment of Mr Lu's competence in off-pump surgery and facilitating the quarterly review of Mr Lu's programme.

77. Mr Richens was then appointed as the Assignment Director. He undertook the task of reviewing the documents prepared by Mr Lu in September 2012 and developing the re-entry programme. He had been provided with those documents by Mr Lu in February 2013. There were various drafts prepared and circulated internally but not provided to Mr Lu.

78. On 17 September 2013, a draft re-entry programme was sent to Mr Lu. A meeting was arranged between Mr Richens, Dr Girling and Mr Lu. Further, Mr Lu was also to have the opportunity to provide a written commentary on the draft programme. There would also be a further meeting on or around 15 October 2013 between Mr Lu and Dr Homa. Mr Lu was told that if he required more time to consider the draft he should inform the relevant person.

79. Mr Richens has explained the reasoning behind the revised draft programme in evidence. The draft re-entry programme refers to the competencies identified in the ICSP that cardiac surgeons are expected to demonstrate they possess as they progress through their training and before they begin independent surgical practice (and Mr Lu's draft had also drawn on ICSP). Mr Richens' draft is more specific in a number of respects than Mr Lu's proposed draft. By way of example, Mr Lu's objective 2 referred to good clinical care, operative and technical skills without identifying what that meant in practice. Mr Richens's draft programme provided more detail. Furthermore, Mr Lu's programme was time-based comprising two six month blocks. Mr Richens explained that modern training was now more competency based. Mr Lu may take less (or more) time to re-familiarise himself with, and demonstrate possession of, certain skills and competencies. Mr Richens' programme therefore did not include a time element. As Mr Richens explained in evidence, Mr Lu was a relatively junior colleague having practised as a cardiac consultant surgeon for approximately 18 months or so prior to ceasing surgical duties. He had not been undertaking surgical duties for, at that time, about 4 years. It was not clear where Mr Lu would be on the spectrum of competencies. It may be that, given his level of skill and competencies, he would move much quicker through the process of re-familiarising himself with and demonstrating the relevant competencies than someone who was an ordinary trainee. Mr Richens considered that this was the best framework for re-integrating Mr Lu into surgical duties. There were also two appendices dealing with patient consent which I deal with below.

80. Mr Lu was contacted to ask to confirm arrangements for the meeting to discuss the draft re-entry programme and he indicated that he was discussing the draft with his legal advisers, that he hoped to be able to respond shortly and asked that any further steps or meetings await that reply. On 24 October 2013, he indicated that he thought he would be in a position to respond by 29 October 2103 and probably sooner than that.

81. On 28 October 2013, solicitors acting for Mr Lu sent a letter before action. They contended that the Trust was in breach of express or implied terms of Mr Lu's contract of employment. They set out the alleged breaches and indicated that they fell into four areas (1) alleged delay and procrastination in facilitating the return of Mr Lu to surgical practice (2) the departure without good reason from Mr Lu's September 2012 re-familiarisation process alleged to have been approved by the Trust and the proposed replacement with a new draft which was alleged to be unreasonable and irrational (3) the proposed arrangements for seeking patient consent and (4) the communication strategy. On 19 November 2013, a claim was issued against the Trust on behalf of Mr Lu. That claim was heard over 5 days in late February and 3 March 2014.

The Issue of Patient Consent

82. One of the issues that has arisen during consideration of the re-entry programme is the question of what information needs to be provided to patients to obtain their informed consent to Mr Lu participating in surgery concerning them. The issue is particularly acute in relation to heart valve surgery as opposed to coronary artery bypass graft surgery. The infection was transmitted during heart valve surgery onto the prosthetic heart valve.

83. By way of background, the Trust had obtained legal advice from leading counsel in November 2012 and disclosed that advice to Mr Lu. The advice was that the need to inform a patient of the risks of undergoing a procedure includes an obligation only to inform of the present risks of the procedure. The advice was that the courts had not held that there was an obligation to inform a patient of historical issues. Counsel advised that if the evidence of all three experts were that the Mr Lu posed no greater risk to patients than his colleagues, then there would be no justification for requiring the disclosure of any additional information. If the experts were not unanimous, then it may be necessary to consider an alternative way forward. Counsel advised on obtaining certain specific information from Professor Finch (on risk if his recommended control measures were adopted) and Dr Boswell if surgical hoods were not worn during surgery.

84. The Trust's consent committee met on 4 January 2013 to discuss the matter. The discussion noted the following:

> "Discussion was had about these issues in some depth. Based on the evidence presented to them and the resulting discussion, the committee felt that Mr L should not have to specifically tell patients about his part in the outbreak as external advisors to the Trust had concluded that the risk to patients undergoing this type of surgery was now estimated to be same for whichever cardiac surgeon was performing the procedure, given that Mr L was no longer carrying the outbreak strain and had agreed to adhere to all the recommendations made by the external advisors."

85. The committee reached a number of conclusions, including the following:

> "It was reasonable for Mr Lu not to identify himself as the surgeon responsible for the PVE outbreak each time that he consented a patient for valve surgery, noting his agreed intention of disclosing this information if asked directly by a patient. "

86. The consent committee also considered that it would be sensible to seek patient views through the national or royal college panels available on the materiality of disclosing the role of an individual surgeon in an outbreak such as the one at the Centre in 2009.

87. The QuAC considered the question of risk. The view of the QuAC in July 2012 was that the evidence of the experts was that the risk to patients of Mr Lu returning all cardiac surgery, including heart valve surgery, was minimal assuming that Mr Lu adhered to the practical measures recommended by the expert microbiologists. The risk to patients with the control measures in place was estimated to be the same as for all other cardiac surgeons in the Centre.

88. The Trust Board decided on 30 August 2013 to accept that view. The minutes of that meeting record that the QuAC was specifically charged with considering the clinical risk if Mr Lu returned to cardiac surgery and reproduced the views of the committee summarised in the previous paragraph. The chairman noted that the committee wished to raise broader issues, including the reputation of the Trust, the views of surgical colleagues and external bodies and individuals who referred patients to the Trust, the views of patients and the public (including relatives of those who had died) and informed consent, in particular, whether it would be reasonable for Mr Lu to declare his history when seeking consent from future patients or whether a generic approach was required. There was a discussion. Dr Fowlie took a different view from the experts and disagreed with the conclusion that Mr Lu presented no greater risk than other surgeons in the Centre. He considered that there was uncertainty over the position, and, while it may be that any risk might not be a lot greater, it was difficult to argue that there was no greater risk. The Trust Board did not accept Dr Fowlie's views and recorded that he dissented from the decision. The Trust Board then resolved to allow Mr Lu to undertake a transitional return to full duties subject to compliance with Professor Finch's recommendations. Dr Fowlie again raised the need to resolve the consent issue. The Board agreed that this was to be progressed as an employment issue.

89. In my judgment, the Trust Board accepted that Mr Lu was no greater risk than any other cardiac surgeon in the Centre. That is clear from the fact that the contrary view, expressed by Dr Fowlie, was not the view of the Board and he was recorded as dissenting. Furthermore, in my judgment, the Trust Board did not consider from the Trust's perspective, that any greater or enhanced consent process was necessary in relation to Mr Lu. The Trust Board did not, for example, resolve that the re-entry programme was to be conditional on surgeons with whom Mr Lu would be working during the re-entry period (or Mr Lu himself) volunteering the history as part of the process of obtaining consent. The logic of the Trust Board decision is that, from the Trust's perspective, the information that needed to be provided to patients would be the same in Mr Lu's case as in the case of other cardiac surgeons. That is the logic of the decision that Mr Lu, so far as the Trust Board is concerned, presents no greater risk than any other cardiac surgeon.

90. That view is confirmed, in my judgment, by the letter of 3 September 2012. set out above. That letter records that the Board received and "accepted the view" reached by QuAC that, in the light of the expert evidence, the risk to patients of Mr Lu returning to cardiac surgery, including valve surgery, was minimal provided that he adhered to measures recommended by the expert microbiologists. The letter records that the Board heard that, with control measures in place, the risk presented by Mr Lu was the same as for all other cardiac surgeons in the Centre. The letter then confirms that the

Board accepted that Mr Lu should be able to return to the full range of cardiac surgical practice subject to the recommendations set out in the original report by Professor Finch. That is a clear acceptance, in my judgment, of the view that, so far as the Trust is concerned, Mr Lu presents no greater risk than any other cardiac surgeon in the Centre. The letter does not suggest that the Trust considers that, from its perspective, there is to be any different or enhanced process for obtaining the consent of patients to surgery in relation to Mr Lu. There is a reference to the recommendations of Professor Finch. That reference is phrased to refer to the original report (not the supplementary response to questions given by Professor Finch) and to the recommendations in that report. The recommendations in the report do not include any suggestion that an enhanced consent procedure is necessary. The body of the text records Professor Finch's view that there would be an ever present requirement to explain his historical association. Professor Finch does not elaborate on that in the original report. A requirement for disclosure of Mr Lu's historical association was not a formal recommendation made by him. In my judgment, the letter of 3 September 2012 is a carefully drafted letter which is consistent with the minutes. The Trust Board is satisfied that Mr Lu presents no greater risk than any other surgeon. The Trust Board does not require, from the Trust's perspective, that the re-entry programme needs to be conditional on an enhanced or different consent process for Mr Lu as compared with other cardiac surgeons.

91. Notwithstanding the decision of the Trust Board, on 25 January 2013 (the letter is dated 2012 but must have been written in 2013), Dr Ryder wrote to Mr Lu. He stated that the Trust had received further advice from leading counsel and the benefit of the views of the consent committee. The letter continued that Dr Ryder, in agreement with Dr Homa, had decided that Mr Lu would adopt an approach to seeking the consent to patients undergoing valve surgery which made clear Mr Lu's particular history with regards to the fact and consequences of the PVE outbreak in 2008 to 2009. The position of Dr Ryder, Dr Homa and Dr Fowlie has remained the same thereafter in relation to the process of obtaining patient consent to valve surgery although Dr Homa in evidence indicated that the position could be reviewed at some stage in the future. Mr Lu's position also remains the same. He considers that it would be necessary to inform patients generally about the risk of contracting PVE during heart valve surgery and any specific risks relating to that patient. It would not be necessary for him to volunteer the historical information about the 2008 to 2009 outbreak or his association within it as that is not necessary as it does not reflect any current risk arising from such surgery. Mr Lu will provide full information about the outbreak and his involvement in it to any patient who asks about the outbreak.

92. Following the consent committee meeting, steps were not taken to obtain views through the national bodies referred to by the consent committee. Instead, representatives of the Trust decided that patient forums would be established. The first of these took place on 21 March 2013. The individuals who agreed to participate were given information about the 2009 outbreak. Other such meetings took place. Views were expressed by those attending the various meetings including views that patients should be told at certain stages about the outbreak and Mr Lu's association with it. On 6 September 2013, the Trust's consent committee considered the patient forums. The committee noted, amongst other things, that they considered that the repeated mention of Mr Lu by name was unfair and leading, and that mention should

also be made of investigations and external opinions sought and given to the Trust that Mr Lu was fit to operate and an emphasis on what has been done to protect patients when he returned. The information sheets used for patient forum meetings after this date were amended in an attempt to respond to the criticisms made.

93. The draft re-entry programme prepared by Mr Richens and sent to Mr Lu in September 2013 has two appendices, Appendix 3 and 4, dealing with patient consent. These appendices apply both to valve surgery and coronary artery bypass graft surgery. Appendix 3 includes a section headed additional consent measures for patients involved in the re-entry programme. There will be a consultant cardiac surgeon responsible for the surgery. Mr Lu will be participating in that surgery. The patient is to be given an information pack and required to sign an additional consent form. Appendix 4 sets out the information to be provided in the form of an information sheet. It explains that eleven patients contracted PVE in 2009 and five died. It states that all relevant patients were operated on by one surgeon and names that surgeon as Mr Lu. Further information is then given about the infection, the findings of the investigations and other matters. A special consent form is included.

94. In addition, patients may have to undertake additional blood tests and microbiology swabs. The swabs are intended to be swabs of the operative site in valve surgery, that is, in practice, swabs of the prosthetic heart valve. The blood tests are tests to be carried out on a number of patients undergoing coronary artery bypass graft surgery.

95. The Trust Board, when deciding to allow Mr Lu to undertake a transition to full surgery, did not indicate that it considered it necessary or appropriate to require surgeons working with Mr Lu to require patients to undergo further blood tests or microbiological swab tests. None of the external experts who gave their opinions to the Trust or QuAC recommended these tests. The reason for requiring additional blood and swab tests was explained in evidence by Mr Richens. Dr Boswell, the Trust's microbiological expert, it seems thought there would be merit in carrying out these additional tests. They were therefore incorporated into the draft re-entry programme. The consent obtained from patients would include consent to these additional procedures. They were not considered to be research but part of the normal clinical audit following surgery.

96. The reasons underlying the requirement that patients be given information about the outbreak and Mr Lu's involvement with it were as follows. Dr Homa considered that there was a moral duty on the Trust to provide the information. He said that, in his view, describing the existing risk – that Mr Lu was not a greater risk – would not comply with the Trust's moral duty. He said that he had taken notice of what he thought patients would want and the Trust would not be discharging its moral duty if it did not refer to the background. He considered that patients would view the provision of this information as necessary and it should be provided to respect the trust placed in doctors by patients.

97. Dr Fowlie considers that the information should be provided as he does not accept the logic underlying the Trust Board's decision that Mr Lu does not present a greater risk than any other cardiac surgeon in relation to heart valve surgery. That has been his consistent view. He therefore considers that the provision of information about the outbreak and Mr Lu's involvement is necessary in order to enable patients properly to judge risk. In relation to coronary artery bypass graft surgery, his evidence is that the rationale for requiring the provision of this information is that it is what he feels patients would want to know and that he considers that it would be wrong to conceal information about the outbreak period.

98. Mr Richens accepts and agrees with the Board's decision that Mr Lu should be able to return to full time surgical duties. He accepts that it is the Trust Board's view that Mr Lu presents no greater risk in relation to heart valve surgery. However, he, personally, cannot accept that in relation to heart valve surgery there is necessarily no greater risk. He considers that there is an element of uncertainty and he does not accept the logic of the Trust Board's view in the light of his reading of the expert opinions that have been provided. Mr Richens had read the expert opinions of Mr Hutter, Professors Finch and Eykyn and the coroner's inquest and the SUI report. He had not been provided with the minutes of the QuAC committee. Mr Richens' evidence was that, in relation to coronary artery bypass graft surgery (as opposed to heart valve surgery) his view, and he understood, the view of Dr Boswell, was that any risk of PVE was very low indeed.

THE LEGAL FRAMEWORK

The Contract of Employment

99. The relevant legal principles are agreed between the parties and can be summarised relatively briefly. Clauses 3 and 17 of Mr Lu's contract of employment are the material provisions and provide the following:

> "3 General Mutual Obligations
>
> Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgments and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:
>
> - To co-operate with each other;
> - To maintain goodwill;

- To carry out our respective obligations and operating a Job Plan;

- To carry out our respective obligations in accordance with appraisal arrangements;

- To carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols."

And

"17 Disciplinary Matters

Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures (which will be consistent with the 'Maintaining High Professional Standards in the Modern NHS' Framework), subject to the appeal arrangements set out in those procedures."

100. In relation to clause 17, the Trust had adopted the Procedure. It is common ground that that Procedure is the applicable procedure which is being followed in the present case and that that procedure reflects, accurately, the Maintaining High Professional Standards in the Modern NHS document referred to in clause 17.

101. Section 1 of the Procedure indicates that it outlines the process for handling concerns about doctors' and others conduct and capability. Section 2.1 provides that all employees, and others, should be treated fairly. Section 3.1 provides that where concerns about a practitioner's performance can be identified, that must be reported to the Chief Executive and a case manager appointed. In the case of consultants, the Medical Director is to be the case manager and is to be responsible for appointing a case investigator. In the present case, Dr Fowlie was the case manager and then was replaced in that role by Dr Ryder. The case investigator was Professor Finch. Section 3 deals with the action to be taken in identifying the problem and the case investigation. There is provision for the involvement of NCAS at various stages. Section 4 deals with temporary restrictions on a practitioner's practice. Mr Lu is subject to restrictions at present in that he cannot undertake surgical duties. He continues to perform other duties. Section 6 sets out a procedure for dealing with issues of capability. Section 6.4.1 provides that the practitioner must be given the opportunity to comment in writing upon the report of the case investigator. Here, Mr Lu was given the opportunity to comment upon Professor Finch's report.

102. Section 6.4.2 provides as follows:

> "The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. The case manager will need to consider urgently:
>
> - Whether action under part 3 of the procedure is necessary to exclude the practitioner; or
>
> - To place temporary restrictions on their clinical duties.
>
> The case manager will also need to consider with the Medical Director and Director of Human Resources whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments."

103. That is the stage of the process which has currently been reached. The Trust and Mr Lu are seeking to resolve capability issues by local action, in this case, by a return to surgical duties under a re-entry programme. That stage of the process has not yet been concluded. In the event that this local action does not resolve the problem, the matter must be referred to NCAS for it to consider whether to carry out an assessment and provide assistance in drawing up an action plan. In certain circumstances, NCAS may not be able to provide that assistance and then a capability hearing may be conducted. Furthermore, if the practitioner does not consent to the referral of the matter to NCAS, a capability hearing may be held: see section 6.4.3 of the Procedure. There is a prescribed procedure for capability hearings involving, amongst other things, notification of the hearing date, exchange of documents, calling of witnesses, and the hearing itself.

104. It is an implied term of Mr Lu's contract of employment that the employer will not, without reasonable cause, act in a way that is calculated or likely to destroy or seriously damage the relationship of trust and confidence between employer and employee. The position is summarised in the following two passages of the judgment of Lord Nicholls of Birkenhead in *Malik v Bank of Credit and Commerce International S.A* [1997] A.C. 606 at pages 610F-G and 610H-611A:

> "This implied obligation is no more than one particular aspect of the portmanteau general obligation not to engage in conduct likely to undermine the trust and confidence required if the employment relationship is to continue in the manner the employment contract implicitly envisages"

and

> "The conduct must, of course, impinge on the relationship in the sense that looked at objectively, it is likely to destroy or seriously damage the degree of trust and confidence the employee is reasonably entitled to have in his employer. That requires one to look at all the circumstances".

105. The test for determining whether there has been a breach is objective. The obligation may be breached whether or not the employer subjectively intends to undermine the relationship. It is common ground that the court must look at all the circumstances, including the context, the conduct of the employer and, in appropriate circumstances, the employee's own conduct. Breach of the implied term may occur by way of a single act or through the cumulative effect of a series of acts: see *Lewis v Motorworld Garages Ltd.* [1986] ICR 157 at 169F-G. The court should not in general intervene to remedy minor failures and its role is not to seek to manage in detail the employment relationship. As Lord Hodge expressed it, in the context of failures in relation to the conduct of a disciplinary procedure, at paragraph 39 of his judgment in *West London Mental Health NHS Trust v Chhabra* [2013] UKSC 80:

> "As a general rule it is not appropriate for the courts to intervene to remedy minor irregularities in the course of disciplinary proceedings between employer and employee – its role is not the 'micro-management' of such proceedings: *Kulkarni v Milton Keynes Hospital NHS Foundation Trust* [2010] ICR 101, para. 22".

106. Further, section 2.1 of the Procedure provides that employees are to be treated fairly. The requirements of fairness will depend on all the circumstances, including the nature of the decision or decision-making process in question. As Cranston J. observed at paragraph 82 of his judgment in *Yapp v Foreign and Commonwealth Office* [2013] EWHC 1098 (QB) fair treatment is "fact sensitive and its requirements turn very much on context".

Patient Consent

107. The position in relation to the information to be provided to a patient in order to obtain the patient's consent to surgery is also common ground between the parties. The position, for present purposes, can be briefly summarised as follows. Surgery performed without the informed consent of the patient is unlawful. A surgeon owes a duty to a patient to warn him or her in general terms of possible significant risks involved in the surgical procedure in question. The duty is concerned with the current risks involved in the procedure: see generally *Chester v Afshar* [2005] 1 AC 134, especially Lord Steyn at paragraphs 14 to 16 and Lord Walker of Gestinthorpe at paragraphs 91 to 92. For present purposes, it is sufficient to record the observation of Lord Woolf M.R. at paragraph 21 of his judgment in *Pearce v United Bristol Healthcare NHS Trust* [199] E.C.C. 167:

> "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of the doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."

THE ISSUES

108. Against that background, the principal issues that arise, in my judgment are as follows:

(1) Did the Trust approve Mr Lu's proposed re-entry programme in September 2012 and then, in breach of contract, fail to implement that programme?

(2) Is the Trust acting in breach of express or implied terms of Mr Lu's contract of employment by

(a) proposing a draft re-entry programme in the terms contained in the draft prepared by Mr Richens in September 2013 rather than the draft prepared by Mr Lu in September 2012?

(b) acting in a way which constituted delay either (a) in respect of Mr Lu's return to coronary artery bypass graft surgery after May 2010 or (b) the return to that surgery and heart valve surgery between January 2013 and September 2013?

(c) by failing to consult Mr Lu, or NCAS, or other bodies, or by establishing a task and finish group, including as members Dr Fowlie, Dr Homa and Mr Mortimer?

(d) by acting in the way it did in respect of the proposed communication strategy? and

(e) by requiring (a) surgeons during the re-entry programme period to provide information to the historical association of Mr Lu with the outbreak of PVE in 2008

to 2009 to all cardiac patients in whose treatment he participated and (b) requiring Mr Lu thereafter to provide that information in relation to his patients in respect of heart valve surgery.

THE FIRST ISSUE - MR LU'S SEPTEMBER 2012 PROPOSED PROGRAMME

109. The Trust and Mr Lu both accept that there will need to be a re-entry programme to facilitate Mr Lu' return to full cardiac surgery. He has been absent from surgical duties for a number of years. He was, in fact, a relatively junior consultant at the time he ceased surgery, having been a consultant for approximately 2 years. One of the principal practical problems for the Trust and Mr Lu has been the identification of an appropriate re-entry programme.

110. In relation to the first issue, I have already found as a fact that the Trust did not approve, agree or accept that the draft re-entry programme proposed by Mr Lu in September 2012 was an appropriate programme. Those reasons are set out at paragraphs 56 to 57 above. Furthermore, I have already found as a fact that the Trust did not accept or agree in December 2012 or subsequently that Mr Lu's proposed re-entry programme was acceptable save for the substitution of Mr Richens as assessor in place of Mr Naik. Those reasons are set out at paragraphs 58-59 above.

111. In those circumstances, in my judgment, the Trust did not fail to implement the September 2012 programme or resile from any agreement that the September 2012 programme was suitable. There was simply no agreement and no acceptance by the Trust that the September 2012 programme was suitable or acceptable. Consequently, the fact that Mr Lu's proposed programme was not implemented did not involve any breach of clause 3 of Mr Lu's contract and did not involve any actions likely to destroy or seriously damage the trust and confidence of the employment relationship.

THE SECOND ISSUE – THE TRUST'S PROPOSED RE-ENTRY PROGRAMME

112. The second issue concerns the arrangements that have been proposed for securing the return of Mr Lu to full time surgical duties. At one level, there is a difference of view between the Trust and Mr Lu. The Trust envisages a re-entry programme whereby Mr Richens is the assessor. He will be responsible for arranging Mr Lu's participation in on-pump coronary artery bypass graft surgery, and, in due course the heart valve surgery, and assessing whether Mr Lu demonstrates the relevant skills and competencies in relation to those areas of surgery. Another suitable individual from outside the Centre will be identified to perform the same task in relation to off-pump coronary artery bypass graft surgery. An external reviewer, Mr Cooper, will provide external validation that Mr Lu possesses the relevant skills and competencies.

113. Mr Lu would prefer Mr Naik to be the person responsible for facilitating his return to full-time practice. In particular, he wished Mr Naik to be responsible for the process of him resuming off-pump surgery.

114. At another level, there are a series of practical issues that arise. These concern, firstly whether the re-entry programme should stipulate a time-frame within which the programme would be completed. Secondly, there is the issue of whether the contents of the Trust's proposed programme are suitable for facilitating re-entry (with the exception of appendices 3 and 4 dealing with additional testing of patients and patient consent which I deal with separately in a later section of this judgment). The third is the arrangements for resumption of off-pump surgery.

The Trust's General Approach

115. Dealing with the main issue, the Trust has determined that the re-entry programme should be carried out under the supervision of an experienced, accredited trainer. Mr Lu has been absent from surgery for some years. He was a relatively junior consultant with relatively little experience of independent practice in surgery. The Trust's view is that the re-entry programme would need to be under the supervision of an accredited trainer. Mr Richens was an experienced, accredited trainer and, indeed, was the only such trainer at the Centre. Mr Richens did not practise off-pump surgery but that could be dealt with by identifying a suitable, qualified person to undertake supervision in relation to the resumption of that aspect of Mr Lu's practice. Furthermore, the Trust was concerned to ensure not only was the re-entry programme robust, it would be demonstrably so. Ensuring the re-entry programme was supervised and implemented by experienced, accredited trainers would contribute to the Trust's ability to demonstrate that the programme was robust. It would assist the Trust to deal with any questions about the suitability of Mr Lu returning to practice. I have set out my findings of fact, and the reasons for them, on this issue at paragraphs 60 to 67 above. In my judgment, the Trust were acting properly and appropriately in approaching the re-entry programme in this way. Viewed objectively, the Trust are not acting in a way which would be likely to undermine or seriously damage the employment relationship. In my judgment, the reverse is true. Viewed objectively, approaching the proposed re-entry programme in this way should facilitate Mr Lu's presumption of surgical duties and should contribute to the mutual trust and confidence of employer and employee. Similarly, the Trust's decision to proceed in this way does not involve any breach of any express obligation, including the obligations in clause 3, of Mr Lu's contract of employment.

116. By contrast, I regard the proposal by Mr Lu that Mr Naik be the person responsible for facilitating his resumption to surgery as hopelessly naïve and unrealistic. I understand Mr Lu's wish to have a supportive and confidence building environment in which to resume his surgical duties. I understand the fact that he has always enjoyed a good relationship with Mr Naik who, as an experienced and senior colleague, has acted as a source of advice and guidance to Mr Lu. I recognise the fact that they both perform the complex off-pump surgery. Everyone who gave evidence has paid tribute to Mr Naik's skill as a surgeon. He is clearly very highly regarded in

this complex and demanding field of cardiac surgery. However, the fact of the matter is that Mr Naik has very little experience of training. He has never undertaken the relevant courses to equip him with the skills (very different from surgical skills alone) to train and supervise colleagues. He had not demonstrated that he has the skills or meets the criteria of persons who act as trainers. Furthermore, I had the opportunity to hear Mr Naik giving evidence at first hand. In terms of cardiac surgery, Mr Naik was an impressive witness with a full grasp of what is obviously a difficult and demanding field of surgery. But in my judgment, he demonstrated little or no idea of the demands or requirements of training or the way in which a process of facilitating the resumption of surgical duties could be carried out. The preferred option of Mr Lu would involve a relativly junior consultant resuming surgical duties, after a number of years' absence from surgery under the supervision of a consultant who, although a highly skilled surgeon, has little or no experience of the kind of demands or training that that process would involve. Viewed objectively, in my judgment, the Trust has not acted inappropriately or improperly by declining to follow Mr Lu's proposal, and has not acted in a way which would be likely to destroy or seriously undermine the trust and confidence necessary in an employment relationship. Nor does the Trust's refusal to accept this proposal involve a breach of the express obligation in clause 3 of Mr Lu's contract of employment.

117. I also bear in mind that Mr Lu wishes to commence his return to work in an environment where he, and all others in the surgical team adopt the practice of double gloving, that is wearing two sets of gloves so that if the upper set has to be removed during surgery, the underlying second set of gloves will remain in place and act as a barrier to transmission. But, contrary to what Mr Lu said in evidence, Professor Finch did not recommend that cardiac surgeons adopt the practice of double gloving. He recommended surgeons either adopt a practice of double gloving or wearing a single set of thicker gloves. All the relevant clinicians in the Centre comply with the recommendations of Professor Finch and either double glove or wear thicker gloves. The Trust is not, in my judgment, acting in breach of contract by taking the view that the need to ensure that the re-entry programme is undertaken under the supervision of an experienced and accredited trainer outweighs Mr Lu's preference that others with whom he will be working adopt the practice of double gloving.

The Details

118. I turn next to the detailed concerns expressed by Mr Lu. First, he said in evidence that the absence of a timeframe in the re-entry programme for completion was "crucial". First, the reason for the change from two six month periods (as envisaged by Mr Lu's programme) was that modern training and assessment is expressed in terms of competencies. The aim is to ensure that the person concerned demonstrates the relevant skills and competencies required rather than imposing a time frame within which those must be acquired. Secondly, the change may well be beneficial to Mr Lu. If he is able to demonstrate that he continues to possess the relevant skills and competencies more quickly, he will complete the programme and be able to resume independent surgery more quickly. Thirdly, Mr Fabri also gave evidence that it was preferable if the re-entry programme was not time limited. Mr Lu may need more, or he may need less, time and the key question was whether he had demonstrated that he

possessed the relevant competencies. In my judgment, the switch to competencies instead of a fixed timetable does not involve any breach of any express or implied term of the contract of employment.

119. Secondly, Mr Lu complains that the draft re-entry programme does not permit Mr Naik to perform the task of facilitating his resumption of off-pump surgery. In my judgment, that position follows from the fact that the Trust, for perfectly good and valid reasons, has determined that the relevant surgeon with whom Mr Lu will be working is an experienced and accredited trainer. Mr Naik is not an experienced and accredited trainer and consequently is not suitable for this task. Mr Richens is suitable for performing the relevant tasks in relation to heart valve and on pump-surgery. He is not suitable in relation to off-pump surgery as he does not practise that technique. Consequently, he will need to identify a suitably qualified individual to perform the task of facilitating Mr Lu's return to off-pump surgery, at a suitable time, and assessing Mr Lu's competence. That involves no breach of contract.

120. Thirdly, there was initially criticism of the content of the Trust's proposed programme. This criticism, however, needs to be analysed carefully. The evidence was that the aims of the programme and the competencies described in the draft re-entry programme prepared by Mr Richens and sent to Mr Lu on 17 September 2013 were (subject to certain qualifications, and also the appendices dealing with patient consent) suitable aims and competencies. Mr Richens gave evidence that the competencies themselves were derived from the ICSP and were the ones that surgeons would need to possess. Mr Lu himself gave evidence that the aims and competencies were ones that he was content that he would need to demonstrate. He gave evidence that his draft re-entry programme and that of Mr Richens both dealt with what he called the patient journey, that is pre-operative, intra-operative, post-operative and follow-up stages. He accepted that, whichever programme he followed, he would have to demonstrate these competencies. In my judgment, therefore, the Trust has not acted in breach of contract by describing the aims in the way that is set out in section 1 of, and the competencies as described in appendix 1 to, the draft re-programme prepared by Mr Richens. Similarly, the supervision process and the assessment process is, in my judgment, unobjectionable (save that I consider that bullet points 3 and 4 under the heading of individual assessment potentially misdescribe the role of the task and finish group, a topic I deal with below). Similarly, there is no evidence to suggest that the stages of the re-entry programme are inappropriately described.

121. In part, any disagreement appears to be about the use of language and tone. Mr Lu and Mr Fabri were concerned that the tone of the document could be seen as more redolent of training a junior person whereas Mr Lu is a consultant who needs a re-entry programme to facilitate his resumption of surgical duties. They emphasise that in their view there should be a supportive environment provided whereby Mr Lu can rebuild his confidence. I understand that the use of language is important. I understand that perceptions of status may also be very important in the work place. However, having heard and considered all the evidence, the concerns expressed are, in my judgment, misplaced. The draft re-entry programme sets out the programme for re-entry, that is the aims, the means of supervision, the method of assessment and the competencies. Its content in relation to those matters is, in my judgment,

unobjectionable and does not amount to a breach of any express or implied contractual term. The day to day environment in which the re-entry programme will be carried out is the Centre. The evidence that I have heard indicates that those involved do wish to provide a supportive, confidence building environment for Mr Lu and do wish him to be able to return to surgical duties. There is nothing in the draft re-entry programme which prevents that. Viewed objectively, there is nothing in any of the evidence to suggest that the Trust has conducted itself in a way which will prevent that. In terms of language, all parties, including Mr Lu, have used different words to describe the process that Mr Lu will need to undergo. Mr Lu's representatives have themselves referred to training in some of the correspondence. The substance of the situation is clearly recognised by both Mr Lu and the Trust. Mr Lu is a consultant. He has been away from surgery for some years now. He has to undergo a process which, in substantive terms, is that described in sections 1 to 4 and appendix 1 of the draft re-entry programme. Whilst different words have been used at different times by different persons to describe that process, there is no doubt, in my judgment, that all parties fully understand what the Trust is proposing. What it is proposing, in my judgment, is entirely appropriate for the situation in this case and does not involve a breach of any contractual term.

122. There is one further issue. Mr Richens in his evidence indicated that he fully accepted that the Trust Board's decision was that Mr Lu return to surgical duties and he supported and accepted that aim. He understood that the Trust Board decision was based on the view that Mr Lu presented no greater risk than any other surgeon. Mr Richens, fairly and honestly, admitted that he could not accept the logic of that view so far as heart valve surgery was concerned. He considered that the uncertainty over the means of transmission meant that he could not be sure that Mr Lu was not a greater risk. He may not be, but Mr Richens could not be sure of that. He had that fact in mind when he drafted the programme. However, it is also clear from his evidence that that fact does not affect the way in which the draft re-entry programme is described (leaving aside appendices 2, 3 and 4) and does not affect the substance of the competencies that Mr Lu would have to demonstrate.

123. The one area where Mr Richens felt that the actual implementation of the draft re-entry programme would differ because of his view was this. In relation to valve surgery, if Mr Richens was responsible for a patient undergoing heart valve surgery, and if Mr Lu was assisting him, he would require Mr Lu to carry out the relevant surgical tasks in his, Mr Richens', preferred way. I have considered carefully whether that difference means that the Trust, through those engaged in implementing the re-entry programme, would be in breach of the implied duty of trust and confidence. I recognise that the Trust Board has accepted that there was nothing wrong with Mr Lu's surgical techniques when he was practising independently. I recognise that the Trust Board has accepted that Mr Lu presents no greater risk. However, it seems to me that the process of re-entry will necessarily involve Mr Lu working with and assisting other surgeons. In that context, I consider that the Trust Board implicitly recognises that there will be situations where the supervising or responsible surgeon will require Mr Lu, when he is assisting, to perform tasks in a way that the responsible surgeon prefers. That, in my judgment, is not inconsistent with the Trust Board decision in relation to this particular matter. Furthermore, and most importantly, Mr Lu himself gave evidence to Professor Finch in which he said that he felt one of the

four steps that he had to undertake was to mirror the surgical techniques used by the other surgeons. He also gave evidence to Professor Finch as to the conditions that he thought he would need to put in place before he could return to surgery. One condition was "to return to surgery under the mentorship of my surgical colleagues and to adopt their surgical practice". Viewed objectively, therefore, and considering all the available evidence, I am satisfied that the way that the Trust proposes to implement the re-entry programme is not in any way likely to destroy or seriously damage the mutual trust and confidence in the employment relationship.

124. I should add that I am relieved that that is the case. It does not appear to me to be appropriate for a court of law to express views on the ways in which serious, complex surgery is to be carried out in the operating theatre. A court is neither equipped nor experienced to make the kind of judgements that that situation calls for. Further, that would in my judgment be an attempt to micro- manage the employment relationship in the way that the case law deprecates. Given that the parties had instituted proceedings, and given their view that the issues, so far as they raised issues of law, had to be resolved, it has been necessary to deal with these issues. As I have indicated, the general approach of the Trust, and the details discussed above, do not, in any event, in my judgment, involve any breach of any express or contractual term on the part of the Trust.

THE FOURTH ISSUE – THE ALLEGED DELAY

125. The fourth issue concerns the question of whether there has been any delay in relation to either the recommencement of coronary artery bypass graft surgery or heart valve surgery or both such as to amount to a breach of an express term of the contract of employment or the implied term of trust and confidence.

126. In relation to coronary artery bypass graft surgery, the factual position is this. Mr Lu voluntarily agreed to a restriction on his activities and to cease performing such duties in October 2009. That occurred against a background where there had been a number of deaths in patients upon which he had carried out heart valve surgery (not coronary artery bypass graft surgery). The circumstances were such that both Mr Lu and the Trust recognised that he could not realistically carry out surgical duties whilst the causes of the PVE outbreak in heart valve patients needed to be investigated.

127. The SUI report was published in May 2010. That recommended that Mr Lu did not return to valve surgery until any identifiable risk of PVE were reduced to acceptable levels but did recommend a phased return to cardiac revascularisation surgery (the coronary artery bypass graft surgery) under close mentorship. The SUI panel were, however, continuing with their investigation in order to prepare a supplementary report on the apparent delay in detecting the outbreak. The case manager at the time (Dr Fowlie, the Medical Director of the Trust) considered that it was not feasible to facilitate a return to work on the basis of the May 2010 report when the SUI panel had indicated that its work was not, in fact, finished and it was carrying on its work with a view to preparing a supplementary report. He considered that it would place Mr Lu

and the Trust in a very difficult position to arrange a return to work, given the outbreak, before the SUI had completed its work. He considered that a continued restriction would be reasonable and proportionate at that stage. Mr Lu did not specifically request a return to coronary artery bypass graft surgery in May 2010. In my judgment, in the circumstances, there was no breach of any express provision in Mr Lu's contract of employment and, viewed objectively, the decision of the Trust to maintain the restriction on surgical practice while awaiting the final SUI report was not conduct likely to destroy or seriously damage trust and confidence in the employment relationship.

128. The SUI supplementary report was finalised in October 2010. Following that, it was decided to appoint a case investigator and Professor Finch was appointed. Mr Lu agreed to the obtaining of a further expert independent advice (as proposed by NCAS). In March 2011, Mr Lu's advisers did request that Mr Lu be allowed to return to cardiac surgery save for heart valve surgery. The case manager Dr Ryder, having taken advice from Dr Fowlie, decided that the assessment of the reduction of the risk to acceptable levels should be carried out not only in relation to heart valve surgery but other cardiac surgery. At that stage, it would not have been envisaged that Professor Finch, who was appointed to perform that role, would not be in a position to finalise his investigation report until late November 2011. Indeed, there can be no criticism of the way in which Professor Finch went about his report. He necessarily had to interview a number of people and receive expert evidence including awaiting a report from Professor Eykyn on behalf of Mr Lu which was provided in late September 2011. In my judgment, in the unique circumstances of this case with an unprecedented outbreak causing a number of patient deaths, and in a situation where all were agreed that independent expert advice was required, there was no breach of any express provision in Mr Lu's contract of employment and, viewed objectively, the decision of the Trust to maintain the restriction on surgical practice while awaiting the report from Professor Finch was not conduct likely to destroy or seriously damage the employment relationship.

129. The period after the report of Professor Finch relates both to heart valve surgery and other cardiac surgery as Professor Finch recommended a return to full operative practice. Professor Finch's report was first to be considered by the QuAC. They met and obtained legal training. They received evidence from Professor Finch, Dr Boswell and from Professor Eykyn as they were anxious to ensure a full opportunity for Mr Lu to put forward his evidence. The QuAC made their recommendation on 3 July 2012. The Trust Board met and reached its decision on 30 August 2012. Given the gravity of the decision both for Mr Lu and for patients, as well as for the Trust as a corporate body, the way in which the Trust approached this decision was, in my judgment, beyond reproach. There was no breach of any express provision in Mr Lu's contract of employment and, viewed objectively, the decision of the Trust to maintain the restriction on surgical practice while awaiting the report from Professor Finch and taking a considered view on the risks of Mr Lu returning to surgery was not conduct likely to destroy or seriously damage the employment relationship.

130. There is, in my judgment, no realistic criticism that can be made of the Trust's action between August 2012 and March 2013. There were a number of meetings with Mr Lu

and his representatives. The Trust also arranged to meet with the colleagues that Mr Lu would be working with on his resumption of duties. The Trust recognises that, with hindsight, they should not have let Mr Lu assume the task of drafting the re-entry programme. But, in my judgment, the Trust made it clear relatively quickly that the person responsible for the re-entry programme would have to be an accredited trainer not Mr Naik. Thereafter, the Trust identified the relevant person, Mr Richens, and began the task of preparing a communication strategy. The Trust deferred the commencement of the re-entry programme in order to enable work to continue on that. They deferred re-entry for a short time given the imminent publication of the Francis Report, in the circumstances described above. In my judgment, the steps the Trust took were, viewed objectively, eminently reasonable in the circumstances and did not involved a breach of any express or implied contractual term.

131. On 21 March 2013 Mr Lu refused to agree the appointment of Mr Richens. He did not agree to Mr Richens' appointment until 22 May 2013. In my judgment, any delay in this period was due to Mr Lu's unduly rigid and inflexible desire to have the re-entry programme based on Mr Naik being the person responsible for facilitating his re-entry programme. There is no basis for attributing any blame to the Trust for this period. There is no basis for any finding of a breach of contract in relation to the period 21 March 2013 to 22 May 2013.

132. Thereafter, Mr Richens prepared a draft re-entry programme. That took a little time. But it was sent to Mr Lu on 17 September 2013. The aim was to meet with Mr Lu on or about 1 October 2013, then receive written comments, and then have a final meeting on or around 15 October 2013. Mr Lu, however, spent more time considering matters with his advisers. In the event, he did not meet to discuss the draft re-entry programme but issued proceedings on 19 November 2013. In my judgment, it was appropriate for the Trust to ensure that the draft re-entry programme covered all the relevant areas and was in a position where it could be the subject of meaningful discussion. The Trust did not act in breach of its express contractual obligations and it did not act in a way which was likely to destroy or seriously damage the trust and confidence necessary for a continuation of the employment relationship in the time it took between 22 May and 17 September 2013 in preparing the draft re-entry programme.

133. Mr Sutton, on behalf of Mr Lu, invited me to accept the characterisation of the process in paragraph 228 of the witness statement of Mr Lu. Mr Lu says that it appears to him that every time a committee or individual investigates the position and recommends a return to surgery, the Trust's response is to set up another committee. In my judgment, Mr Lu does not accurately reflect and does not properly characterise the situation. The situation here is, as the Trust has said, uniquely challenging. Five patients had died and six others were infected with PVE. It is inevitable, given the concerns for patient safety, that an SUI report would need to be obtained. NCAS, the Trust and Mr Lu agreed that there needed to be further independent advice which came in the form of the report from Professor Finch. Thereafter, the Trust had to consider the SUI report, Professor Finch's report and the views of the experts. They did so properly first in a special sub-committee, the QuAC, established for that purpose. That committee reported to the Trust Board which was the proper body to

take a decision on behalf of the Trust. That Board took its decision on 30 August 2012. Since that date, the Trust has been seeking to implement that decision. In so doing, in my judgment, the Trust has not breached any express or implied term of Mr Lu's contract of employment.

134. I add one further observation. Both parties were anxious to stress that their primary concern was to seek to work together to facilitate Mr Lu's return to surgery. Mr Lu has affirmed the contract of employment. Damages, although claimed, appear not to be an issue as Mr Lu has received full salary throughout this period and no other loss has been identified. The parties recognised that retrospective analysis of alleged periods of delay would not assist the parties in their primary aim of facilitating a return to surgical duties. Both parties insisted, however, that the allegations of delay giving rise to a breach of contract had to be ruled upon. I have done so and I find that the matters alleged to amount to delay do not amount to a breach of any express or implied term of the contract of employment. In my judgment, further analysis, and further recriminations, over the details of each and every step taken, or not taken, over the past 4 and ½ years would serve no useful purpose.

THE FIFTH ISSUE – THE PROCEDURES

135. The fifth issue concerns a series of alleged failures to consult Mr Lu or enable him to participate in the process or to consult NCAS or others. I have set out the principal factual events above. I have considered in detail all the other material and all the evidence put forward by all of the parties. I am satisfied that Mr Lu has been given every opportunity to participate in all the steps taken to deal with the investigation of the outbreak and the question of how Mr Lu's return to surgery can be facilitated. Mr Lu was able to give his own evidence to the SUI panel, Professor Finch and the QuAC. He was able to commission expert evidence from Professor Eykyn. There have been numerous meetings between Mr Lu and representatives, at all levels, of the Trust dealing with all the principal issues. Even now, the Trust are seeking to involve Mr Lu fully in the finalisation of the re-entry programme. They provided him with a draft, they arranged meetings to discuss and provided an opportunity for him to comment in writing, they deferred matters to allow him to take legal advice. Even though he commenced legal action instead, the Trust has made it clear that the opportunity remains for Mr Lu to comment on the draft re-entry programme. The Trust, in my judgment, has acted fairly as required by the terms of its contract.

136. The second procedural concern relates to the task and finish group. Mr Lu does not object in principle to the existence of such a group. In my judgment, Mr Lu is correct to accept that there needs to be a task and finish group. The Trust Board has decided that there should be a transitional return to full duties. That will involve ensuring that its decision is implemented. There can be no objection to a body charged with ensuring that. The existence of such a body is also fully compatible with the Procedure. It is part of the process of seeing if the issues can be resolved by local action as envisaged by section 6.4.2. In this case, it is part of the machinery of taking local action in the form of ensuring implementation of the decision of the Trust Board.

137. Mr Lu's objections are firstly to the description of the task and finish group in the subsection in section 3, headed assessment, of the draft re-entry programme. That draft says that the determination to allow Mr Lu to progress through each stage of the programme and the decision to permit Mr Lu to return to full practice rests with the task and finish group. In my judgment, the concerns raised by Mr Lu would have been far better raised directly with the Trust at a meeting rather than by the institution of legal proceedings. There is a real danger that this court is being asked by Mr Lu to micro-manage not just the employment relationship but the drafts of programmes that should properly be the subject of discussion by the parties. As I understand the position of the Trust from the evidence given, the Trust Board has decided that Mr Lu can undertake a transitional return to full duties subject to his agreement and compliance with recommendations of Professor Finch. The transition necessarily needs to be done on the basis of a re-entry programme and the Trust and Mr Lu agree on that. The draft programme is based on the methods of assessment contained within it and the Assignment Director will determine Mr Lu's progress and certify satisfactory completion. There will also be an external reviewer. The task and finish group will ensure that the Assignment Director and external reviewer have completed their tasks. It is not, as I understand it, intended that there be any substantive decision by the task and finish group as to whether or not Mr Lu has satisfied the re-entry programme. The process that is arranged will not in my judgment involve any failure to implement the decision of the Trust Board or any pre-empting of any capability hearing should such a hearing prove necessary in future. There is no basis for concluding on the evidence before me that the Trust is acting in a way that breaches any express contractual term and there is no evidence that it is acting in a way likely to destroy or seriously damage trust and confidence.

138. Mr Lu also objects to the presence of Dr Fowlie, Dr Homa and Mr Mortimer on the task and finish group. He says that Dr Fowlie and Mr Mortimer agreed that they could not perform the role of case manager under the Procedure because their prior involvement gave rise to a perception of bias. He says that that means they should not be part of the group taking the decision on progression and return to work. As I have indicated, Mr Lu's view appears to be based on the view that the task and finish group will decide whether or not he can return to surgery. On the evidence before me, that is a misunderstanding of the position. The Trust Board has already decided that he should undertake a transition to full duties. There will be a re-entry programme as all agree that Mr Lu must demonstrate certain competencies. That will be assessed by the Assignment Director and validated by the external reviewer. The task and finish group will confirm that that task has been completed. There is no basis for objecting to the presence of the Medical Director, the Chief Executive and the Director of Human Resources on the committee charged with confirming that the Trust Board's decision has been implemented.

THE SIXTH ISSUE – THE COMMUNICATION STRATEGY

139. The complaints about the communication strategy have not played a large part in this hearing and it would not be sensible to lengthen this judgment unnecessarily by a detailed consideration of the issue. Suffice it to say that, on the evidence that I have seen, the Trust has been working very sensibly towards a strategy which will inform

the potential patients, the public, and other bodies, such as those who refer patients to the Centre, about the return of Mr Lu to surgical duties. In my judgment, that is sensible and does not involve a breach of any express or implied contractual term for at least the following reasons. First and foremost, patients and potential patients who may learn about Mr Lu's return to work need to be reassured that that creates no unacceptable risk and that the arrangements for re-integration are robust. Given the severity of the 2008 and 2009 outbreak, and the deaths that followed, that is sensible. Secondly, the families of those who died and those who were infected but survived also have an interest in knowing that Mr Lu is to return to surgery and the circumstances in which that is to take place. Thirdly, it is sensible from Mr Lu's perspective. His return to surgical duties, given the circumstances of the outbreak, may be expected to generate media and public interest. It is better that the Trust is prepared to deal, so far as it can, with such interest. Fourthly, those who refer patients to the Centre, or who have other connections with it, may legitimately have an interest in Mr Lu's return to work.

140. Furthermore, from the evidence that I have seen, Mr Lu has been fully informed and been able to participate in the discussions relating to the development of the communications strategy. Ultimately, the communication strategy is a matter for the Trust to determine. It must take responsibility for explaining its decision to allow Mr Lu to undertake a transition to full duties subject to compliance with the recommendations of Professor Finch. I am satisfied, however, that Mr Lu has been given appropriate opportunities to express any views that he may have on the matter.

141. Finally, I was informed at the hearing by counsel for the parties that the likelihood is that the parties would, in fact, be agreed on the appropriate communications strategy.

142. In the circumstances, given the evidence before me, there is no basis for finding any breach of contract in relation to the development of the communication strategy. There is no basis for granting any of the declaratory or injunctive relief sought in relation to the development or adoption of the communications strategy.

THE SEVENTH ISSUE – PATIENT CONSENT

143. The seventh issue concerns the question of the information that should be provided to patients undertaking cardiac surgery in order to obtain their informed consent to such surgery. It is common ground that patients will be informed about the general risks involved in such surgery, including, in the case of heart valve surgery, the risks associated with PVE. The issue is a narrower one. The substantive question in broad terms is whether Mr Lu's historical association and role in the 2008 and 2009 outbreak should be volunteered to patients contemplating cardiac surgery or whether it is sufficient if that information is provided in a suitable form to patients who raise that question with the responsible clinician.

144. This question, in my judgment, needs to be considered from the perspective of (1) the Trust as employer of Mr Lu (2) individual consultants who are responsible for

patients and in whose surgery Mr Lu will assist and (3) Mr Lu when he ultimately returns to independent practice and he is the responsible consultant cardiac surgeon for individual patients.

145. The starting point is the decision of the Trust Board on 30 August 2012. The Board accepted that Mr Lu presented no greater risk than any other surgeon as explained in paragraphs 89-90 above. The Trust Board did not impose any requirement that Mr Lu's re-entry programme be conditional upon the surgeon whom Mr Lu is assisting during the re-entry programme providing to their patients any information additional to that which they the surgeon considered should be provided in the exercise of the surgeon's clinical judgment. The Trust Board did not seek to lay down conditions as to what Mr Lu would need to provide by way of information to patients when he ultimately returned to practice.

146. The case manager has, however, consistently made it clear since December 2012 that, when obtaining consent from patients undergoing heart valve surgery, Mr Lu would have to describe the outbreak in 2008 and 2009 and his involvement in that outbreak.

147. The draft re-rentry programme prepared by Mr Richens and sent to Mr Lu in September 2013 goes further. That will require surgeons whom Mr Lu is assisting during the re-entry programme to provide their patients with an information pack containing information relating to the outbreak and Mr Lu's involvement to it. Furthermore, that will be required for patients undergoing heart valve surgery and other cardiac surgery such as coronary artery bypass graft surgery. In addition, the draft re-entry programme envisages that surgeons carrying out coronary artery bypass graft surgery will require their patients to take additional blood tests. Patients undergoing heart valve surgery will be required to undertake additional microbiological swab tests of the prosthetic valve. Patients will need to consent to those additional blood and microbiological swab tests.

148. Viewed from the perspective of the Trust as employer, there is, in my judgment, no basis for requiring the provision of additional information, over and above that which the responsible consultant surgeon considers should be provided, to patients undergoing either heart valve surgery or coronary artery bypass graft surgery during Mr Lu's re-entry period. The Trust Board simply did not require that as part of the process of Mr Lu undertaking a transition to full duties. Similarly, there is no basis for requiring Mr Lu to confirm that when he returns to independent practice he will volunteer, as part of the consent process, information about the outbreak and his involvement in it which he, as the responsible clinician would not consider was necessary information. The Trust Board did not seek to require consultant surgeons to require patients to undergo additional blood or microbiological tests. Difficult questions arise as to whether a trust, as a corporate body, could require clinicians to carry out such tests. Those questions do not, however, arise, in this case. The Trust simply, as a matter of fact, has never required the carrying out of the additional tests envisaged by the September 2103 draft re-entry programme.

149. In those circumstances, and viewed purely from the Trust's perspective as employer, there would be a breach of the implied term of mutual trust and confidence if those responsible for implementing the Trust Board decision insisted on surgeons or Mr Lu providing information additional to that which they considered necessary and appropriate to the patient in order to obtain the patient's consent to surgery. Requiring the provision of that additional information as part of the process of obtaining patient consent to surgery would run counter to the Trust Board decision of 30 August 2012. It would be likely, in my judgment, to destroy or seriously damage the employment relationship. Instead of the decision of the employer of 30 August 2012 being implemented, additional conditions would have been added. To that extent therefore, the insistence by the case manager or other Trust officers that Mr Lu agree to provide information to patients about the outbreak even if he did not, clinically, consider it necessary to do so would be a breach of the implied term of trust and confidence. Similarly, including as a requirement of the re-entry programme, that surgeons provide additional information to patients about the outbreak, and that their patients undergo additional procedures by way of additional blood or microbiological tests, even if the surgeons did not, clinically, consider it necessary to do so, would be a breach of the implied term of trust and confidence.

150. I make it clear that this judgment is not dealing with the position of individual clinicians such as the consultant cardiac surgeons who will be responsible for patients during the re-entry programme and whom Mr Lu will be assisting in the care of such patients. Individual clinicians owe a legal duty to a patient to warn the patient of a significant risk which would affect the judgment of a reasonable patient in the way that is described above. Individual clinicians will therefore have to determine what information, in respect of which types of surgery, they should provide to their patients. This judgment does not, and is not intended to, influence the exercise of clinical judgment by any surgeon during the re-entry programme as to what information should be provided as part of the process of obtaining patients' consent to surgery.

151. Mr Sutton, for Mr Lu, sought to persuade me that any surgeon participating in Mr Lu's re-entry programme would be conducting an employment process on behalf of the Trust as Mr Lu's employer. He submitted that if they provided additional information on the outbreak that would amount to a breach of the implied term of trust and confidence. In my judgment, that is not correct. The surgeons are employees but they are also carrying out surgery on patients for whom they are responsible. They each owe a legal duty to their patients. They will be responsible for determining what information should be provided to their patients to obtain their consent to the surgery to be performed. It is not correct to say that the way they carry out their own legal duties owed as surgeons in respect of their own patients is constrained or affected by the fact that they may agree to allow Mr Lu to participate in the surgery. I recognise that this may well lead to practical difficulties. Different surgeons, including Mr Richens, may (or may not) take a different view of risk from the Trust Board. Any future difficulties cannot, however, be resolved in the context of the current proceedings.

152. Finally, the claim raises the position of Mr Lu. The legal principles governing what is necessary to obtain informed consent are agreed and are summarised above. There is no dispute as to those principles. If Mr Lu returns to independent practice, Mr Lu will need to fulfil his legal duties. He has made it clear that he fully intends to do so. The Trust Board has not required him to do more than fulfil his legal duties. So far as Trust officers seek to impose additional requirements upon him, there is no basis for doing so.

OVERVIEW

153. In terms of the pleadings, and the relief sought, the position is as follows. There is, in my judgment, no breach of contract in connection with the issues of delay, the re-entry programme or the communication strategy as alleged in paragraphs 88(i), (ii), (iii), (vi) (vii) and (viii) of the particulars of claim. Consequently, no question of any declaratory or injunctive relief arises in relation to those matters.

154. In relation to the process of obtaining patient consent, it would, in my judgment, be a breach of contract to impose additional requirements on Mr Lu, when he ultimately returns to independent practice, to provide information additional to that which, in his clinical judgment, is required to obtain a patient's informed consent to proposed surgery. I make it clear again that this judgment does not, and is not intended to, influence the different and separate question of the exercise of clinical judgment by any surgeon during the re-entry programme as to what information should be provided. My provisional view is that declaratory relief in relation to these issues is unnecessary, and injunctive relief inappropriate as this judgment sets out the relevant legal position but I will, if necessary, hear further argument on the question of remedy. The declaratory relief sought at paragraph 93 and 94(iii) of the particulars of claim, in particular, do not appear to be appropriate. The Trust's counterclaim for the declarations in paragraph 106 of the defence and counterclaim, that the consent process set out in appendices 3 and 4 to the draft re-entry programme provided on 17 September 2013 are lawful and that Mr Lu must volunteer to all and any future patients details of his connection with the 2008 and 2009 outbreak in the terms specified in those appendices, cannot be sustained in the light of this judgment.

155. For completeness, I note that a large number of documents were adduced in evidence and I received evidence on a large number of matters. A number of points were referred to by counsel in their skeleton arguments, oral submissions and closing submissions. I have sought in this judgment to deal with what I consider to be the principal points raised, and the principal evidence relating to those matters. Mr Lu and the Trust can be assured however, that I have carefully considered all the other points and all the evidence given and all the documents relied upon.

CONCLUSION

156. As indicated above, on 30 August 2012 the Trust decided in August 2012 that Mr Lu could commence a return to surgical practice subject to certain conditions. Those

conditions concern ensuring that there is a re-entry programme to enable Mr Lu to resume surgical duties after a period of absence and to demonstrate that he continues to possess the competencies and skills necessary for the practice of cardiac surgery. This claim concerns the arrangements relating to his return to surgery and, in particular, whether or not certain requirements of the Trust amount to a breach of any express or implied term in Mr Lu's contract of employment.

157. In summary, and for the reasons set out in detail above, the approach of the Trust to the draft re-entry programme proposed in September 2013 is appropriate in terms of the aims, the description of the relevant competencies and arrangements for assessment and do not involve any breach of contract on the part of the Trust. In particular, the Trust did not agree or approve the re-entry programme proposed by Mr Lu in September 2012. The Trust has not unreasonably delayed the return of Mr Lu to surgical duties and the fact that there has been considerable time taken in seeking to achieve a satisfactory return to surgical duties by Mr Lu does not involve any breach of any contractual term. The relevant procedures have been followed correctly and fairly. The steps taken by the Trust in relation to the preparation of a proposed communication strategy to inform the public and others of Mr Lu's resumption to strategy are appropriate and do not involve any breach of contract.

158. In terms of the information to be provided to patients in respect of proposed surgical treatment, the responsible individual surgeon owes a legal duty to inform a patient of any significant risks involved in the procedure, that is, any significant risk which would affect the judgement of a reasonable patient so that the patient can determine whether to proceed with the treatment. The Trust, as employer, considers that Mr Lu presents no greater risk of infection than any other cardiac surgeon and there is no requirement, from the employer's perspective, to require any individual surgeon or clinician to provide additional information over and above that which the individual clinician considers, in the exercise of his clinical judgment, should be provided to enable the patient to give informed consent to any proposed surgery. Individual surgeons and clinicians will therefore have to determine what information, in respect of which types of surgery, they can or should provide to their patients. This judgment does not, and is not intended to, influence the exercise of clinical judgment by any surgeon as to what information should be provided to patients.