Neutral Citation Number: [2025] EWHC 175 (KB)

Case No: KB-2021-002009

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31 January 25

Before :

HIS HONOUR JUDGE SIMON
(SITTING AS A JUDGE OF THE HIGH COURT)

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Between :

CAROLINE BAILEY	**Claimant**
- and -	
(1) MONICA BIJLANI	**Defendants**
(2) MBNA Ltd	

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Hugh Rimmer (instructed by **Devonshires Claims**) for the **Claimant**
The First Defendant appeared **in person** (with the assistance at times of a McKenzie Friend)
Louisa Sherlock (instructed by **Eversheds Sutherland**) for the **Second Defendant**

Hearing dates: 13 – 17 May & written submissions concluding 18 June 2024

Draft judgment circulated: 16 December 2024

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Approved judgment

HIS HONOUR JUDGE SIMON:

1. The Claimant, Mrs Caroline Bailey, seeks to recover damages for dental treatment said to have been carried out negligently by the First Defendant, Dr Monica Bijlani at appointments in May 2018. The First Defendant ran a dental practice called Brilliant Dental Limited (BDL), trading as Dr Monica's Dental Clinic, in central London.

2. The Second Defendant, MBNA Ltd, is the card issuer for the credit card with which the Claimant paid for the treatment. The Claimant alleges that the Second Defendant is jointly and severally liable, under section 75 Consumer Credit Act 1974, for any breaches of contract in relation to the dental care provided by BDL and carried out by the First Defendant.

Preliminary matters

3. There was a number of preliminary applications that required determination at the beginning of the trial, most notably D1's application to adjourn the trial to allow her to obtain expert evidence. In brief, D1 explained that she had engaged solicitors following the setting aside of default judgment and they had been on record until the end of February this year. Those solicitors were no longer acting and the First Defendant faced conducting this trial on her own, if there were no adjournment. If the Court were not to adjourn the trial, the First Defendant applied to delay the start until the following day to allow a Mackenzie Friend, with whom she had consulted in advance of the trial and who had already provided some assistance. The Mackenzie Friend was unable to attend on the first day of trial. Both the Claimant and the Second Defendant opposed the application to adjourn the trial to another date, but were more neutral on the short delay to the following morning to allow the Mackenzie Friend to be at court.

4. For the reasons I gave in detail at the time, I refused the application to adjourn the trial to another date. I did, however, conclude that in the circumstances it was in the interests of justice to delay the start of the evidence until the following morning.

5. An application was made by the Claimant to amend the Claim Form by increasing the value to limited to £120,000. The figure had been £80,000 on issue, but the Schedule of Loss exceeded this figure and account needed to be taken of the claim for general damages. Permission had been granted at the CCMC on 28 February 2023 to increase the value, but the amended Claim Form was not in fact filed in accordance with the order. A further application for permission was filed, following receipt of Professor Harding's report. In the circumstances, I granted the amendment.

6. A late application was made by the Second Defendant to clarify the legal basis upon which they would be able to recover any damages should they be awarded against the First Defendant. Having heard from the Second Defendant (and considered the skeleton submitted in support) and from the First Defendant, I granted the application for the reasons I gave in detail at the time.

7. On Day Three of the trial, the Mackenzie Friend, Henry Hendron, and the First Defendant applied to the Court for Mr Hendron to be permitted to act in the capacity of representative for the First Defendant and address the Court. The Court considered the Guidance on Mackenzie Friends. In particular in this case, the Court took account of the fact that Mr Hendron was at the time suspended from practice as a barrister and permitting him to address the Court and question witnesses risked seriously undermining the regulatory decision in force at the time. For the reasons I gave in detail at the time, I refused the application for Mr Hendron to address the Court. He remained

as Mackenzie Friend, assisting the First Defendant in her questioning of witnesses and in the presentation of her case.

8. On Day Four of the trial (Thursday 16 May), an application was made to vary the Trial Phase of the Claimant's budget to cover the extra days that the expert witnesses were present at court. This was necessary, on the Claimant's submissions, because the evidence stage extended longer into the trial than had been budgeted for. Mr Rimmer submitted that the Hearing Notice had stated a 10.30am start on Day 1, the afternoon of that day had been lost for reasons connected with the applications by the First Defendant for an adjournment and, upon refusal, for the court to await the attendance of her Mackenzie Friend. Other events in the trial had meant that the experts had to be present at Court on Days Three and Four. The Court took account of the chronology of the trial, which did involve a number of delays to the progress of the trial, such as: deferring the start of the evidence to Day Two, to allow the First Defendant to prepare when her adjournment application was unsuccessful; additional time for the First Defendant to consult with her Mackenzie Friend following the conclusion of her oral evidence; and the determination of the Mackenzie Friend application itself. The Court was mindful, however, that the parties had all been informed the week before trial that the start time would be 2pm on Day One to allow for some judicial reading. Time was also taken up with determining the Second Defendant's late application, referred to in paragraph 6 above. In all the circumstances, the Court concluded that an extra £5500 should be added to the Claimant's budget in respect of expert's trial attendance fees.

9. The evidence had concluded by Thursday 16 and the Court adjourned to Friday 17 May for closing submissions. When the Court reconvened, the First Defendant explained that Mr Hendron had promised to provide her overnight with a document that she could

read to the Court as her closing submissions. She had been reliant on that document being provided in good time for the start of the hearing. It did not materialise and her enquiries of Mr Hendron revealed that he had suffered some form of crisis or difficulty that had prevented him from meeting the agreed arrangement in relation to submissions. The First Defendant understandably felt disadvantaged by being let down in this way at the last minute. Having heard submissions from the other parties, I concluded that the only fair way in which to proceed was to give directions by way of a timetable for the service of written closing submissions in the order in which they would have been delivered in Court.

10. The First Defendant's written submissions extended to 90 pages and included documents which had not previously been in evidence nor been put to the experts. Having been submitted in this way, the Claimant in closing submissions has responded by highlighting the way in which some of the documents undermine the First Defendant's case. Making allowances for a litigant in person does not extend to allowing the introduction of new evidence within written submissions, even if other parties have had the opportunity to comment on them. The trial hearing was the time for consideration of all relevant evidence properly before the Court in accordance with the CPR. I have noted, though I have not read beyond the beginning of some of the documents, that there may be documents arguably subject to legal privilege. In all the circumstances, I have limited myself to reaching conclusions based on the evidence presented at trial and the submissions of the parties on that evidence and that evidence alone. For clarity, the evidence presented at trial does not include documents that the First Defendant produced and sought to rely on from dental practitioners who had not seen the papers in the case or if they had, had not provided any opinion in compliance with the CPR. There was permission for the service of expert evidence on the part of

the Defendants. Neither served such evidence and they did not therefore present any expert evidence to counter that relied on by the Claimant. Both Defendants had the opportunity to cross-examine the Claimants' experts and my assessment of the expert evidence is set out below.

11. It was in evidence at trial that the First Defendant was the subject of professional regulatory proceedings. I have not found it necessary to determine the arguments as to admissibility of the documents disclosed from those proceedings into the claim. I reiterate that I have reached all of my conclusions based solely on the evidence called and challenged at trial and the submissions thereon.

The claim

12. Throughout the trial the issues of breach of duty, causation and quantum remained in dispute. The Second Defendant sought to put the Claimant to proof on all matters, including whether or not the Claimant had contracted directly with the First Defendant

13. Before addressing the evidence, it is important for the sake of clarity and consistency, to set out the nomenclature to be used for the teeth that are central to this claim, because they are referred to variously by different witnesses and in different documents. The complication arises due to the fact that the Claimant only had one (false) tooth where two teeth would normally be. Those two teeth would be LL1 (lower left quadrant 1) and LR1 (lower right quadrant 1). These are the teeth at the midline, that is the central teeth, in the lower jaw. The teeth either side of the space are therefore LL2 and LR2.

14. As will become clear from the evidence section below, the claim arises from the removal of a longstanding bridge that the Claimant had in place of LL1 and LR1 and

its attempted replacement with an implant. Both procedures are alleged to have been conducted negligently, in summary, because the First Defendant:

(a) Failed to keep adequate/comprehensive records;

(b) Failed fully to assess and plan the treatment, including failure to carry out appropriate pre-operative scans;

(c) Failed adequately to advise about the risks and benefits of the intended treatment and of any alternatives and thereby to obtain informed consent;

(d) Failed to identify and advise the Claimant that an implant was an inappropriate treatment, given the inadequacy of space/bone and the implant site and/or that an implant risked damage to the adjacent teeth;

(e) Placed the implant post in such a way that it invaded the root of the adjacent left tooth (LL2), causing sufficient damage that it required extraction;

(f) Caused such damage to the adjacent right tooth (LR2) that it had to be extracted, whether through inadequate root treatment and/or infection arising as a consequence of the negligent treatment.

15. As a result of the alleged negligent treatment, the Claimant suffered:

(a) Considerable physical pain;

(b) Surgical removal of the implant, bone loss in her jaw and the loss of the two adjacent teeth (LL2 & LR2);

(c) Considerable past remedial dental consultations and treatment and a need for future remedial treatment;

(d) Ischaemic colitis as a result of the medication that the Claimant took to control her dental pain, which has developed into consequential persistent dietary intolerances.

Evidence - introduction

16. There was live factual evidence from the Claimant, her husband and daughter, and from the First Defendant. Professor Harding, dental expert, and Dr Leigh, gastroenterologist, also gave evidence. It was clear from the written submissions of the parties that their notes of the oral evidence of witnesses did not always coincide. I have set out the evidence in the case below, drawing on the written evidence and my notes of the oral evidence. I have not provided a full transcript of either, but rather sought to include the central evidence. The breadth of disputed issues among the parties has meant that the resume of evidence is quite lengthy. Despite this, if I have not recorded a specific exchange from the trial it does not mean that I have not taken it into account.

17. The following points of evidence are either not in dispute or were clarified during the course of the oral evidence:

(a) The Claimant had had a three-tooth bridge in place at the front of her lower jaw for many years;

(b) The bridge had been fitted by the placement of crowns on the two teeth either side of the gap at the front of the Claimant's mouth and then having a single false tooth in the middle of the others, the gap not being wide enough for two teeth that ought to have been there;

(c) The Claimant attended the First Defendant's practice in May 2016 with a discount voucher for the purpose of obtaining veneers on certain teeth (the 2016 procedure);

(d) The First Defendant undertook a panoramic scan of the Claimant's mouth at this appointment;

(e) The 2016 procedure to attach the veneers proceeded without incident;

(f) The Claimant was satisfied with the First Defendant's work in the 2016 procedure, which was the catalyst for her returning on 26 May 2018, albeit with another discount voucher;

(g) The dental treatment to be completed following the Claimant's return to the First Defendant's practice in May 2018 was removal of the bridge to be replaced with an implant (the 2018 procedure);

(h) It was agreed at the 2018 appointment that four further veneers would be carried out;

(i) The First Defendant did not undertake a panoramic scan of the Claimant's mouth at the 2018 appointment;

(j) During the 2018 appointment, the First Defendant did not discuss the advantages and disadvantages of the proposed course of treatment (the Claimant and First Defendant differ on the reasons for this);

(k) The Claimant paid for the 2018 treatment in advance of it and in full by using her credit card, issued by the Second Defendant;

(l) The original plan had been for the Claimant to return the following day for the implant procedure to be completed;

(m) The procedure to remove the bridge took longer than anticipated and therefore the plan was changed so that the Claimant would return on 30 May 2018;

(n) When the Claimant returned on 30 May 2018, no x-rays were undertaken, but the procedure began with the injection of an anaesthetic, followed by drilling for the implant;

(o) The anaesthetic was topped up more than once during the procedure;

(p) The Claimant was exhibiting pain and distress that did not appear to be controlled adequately by the anaesthesia and she was moving around, unable to maintain a settled position in the chair.

Claimant's evidence

18. The Claimant's evidence addressed her recollection of the appointments she attended with the First Defendant both in 2016 and then in May 2018. There were some areas of dispute, for example, it was put to the Claimant that detailed discussions had occurred with the First Defendant in 2016 about bridge removal and the implant, including "pros, cons, complications".

19. The Claimant reiterated her evidence that the recommendation of her NHS dentist to have the bridge removed only came about in 2017 or 2018. This was due to its age and hygiene difficulties. She did not recall discussing removal of the bridge and the implant prior to the 2018 appointment, but the Claimant could not say it did not happen. The entry in the clinical records about price would have been for something for the future. She had been satisfied with the First Defendant's treatment in 2016, otherwise she would not have come back.

20. The Claimant's evidence described in detail her best recollection of the 2018 appointment, procedure and its aftermath. She described the absence of any x-rays being taken, there being no discussion about treatment alternatives or their advantages or disadvantages and the course of difficulties experienced by the First Defendant in removing the bridge, including certain language used by the First Defendant during the procedure, such as a reference to the bridge being put in with "cement". The Claimant recalled seeing the dental assistant's worried look as matters proceeded. She said that removal of the bridge took between five and six hours, with one short toilet break. Some of the equipment being used seemed to be ineffective and parts were coming off. The Claimant recalled that her daughter, who worked locally, had to wait until nearly 7pm before the procedure was complete and that her daughter was surprised at this. By this stage, the Claimant says that she was in tears and distress. During the journey home, the Claimant became increasingly unwell and in pain. The Claimant was clear that she had never been dental phobic and could say categorically that she never said she was. She had always attended her dentist when needed.

21. When the Claimant returned on 30 May 2018 for the implant to be inserted, she described in detail the way in which, shortly after it began, the First Defendant's drilling began to cause the Claimant extreme pain. She spoke of gripping the chair and trying to raise her left hand to indicate that she was in pain, but the First Defendant reached across and pressed her arm down. The Claimant rejected the suggestion that this was the nurse holding her hand in a reassuring way. Despite the topping-up of the anaesthetic, the Claimant continued to be in "excruciating pain", which was relentless and did not subside. She said she was in agony. She recalled the First Defendant telling her to move her tongue out of the way, but she could not feel her tongue as it was anaesthetised. The Claimant was told that the anaesthetic had reached the maximum

dose, so she was told that she would just have to put up with the pain. The drilling lasted more than an hour and the First Defendant attempted to place the implant post into the Claimant's mouth several times over the course of more than an hour. The Claimant noticed the state of the dental nurse, Maria, who looked quite worried or distressed. Once the post was in place, the Claimant repeated that she was in pain, but was advised to take painkillers and rest. A temporary tooth to cover the post was proposed whilst awaiting the permanent tooth to go on the post. Neither could be ready immediately, and the Claimant left the appointment with the post exposed, but due to return a few weeks later. The Claimant was categoric that there was no post-operative OPG during this appointment because of the pain, but there was an x-ray after the implant – not before – and the implant was said to be a little close to the adjacent tooth.

22. The Claimant remained in "unbearable pain" and could not sleep. She tried to get an emergency appointment during the night, but the earliest she could get was 8am on 31 May 2018, which turned out to be with her usual dentist. The dentist diagnosed a bad infection, prescribed antibiotics and painkillers and instructed the Claimant to return to the First Defendant as the post needed to be removed. He was not equipped to perform this procedure. Upon contacting the First Defendant, the Claimant was told that discomfort was normal but that she should come anyway. The Claimant had to travel to the clinic by taxi. The First Defendant was dismissive of the diagnosis by the other dentist and that there was no infection, but rather signs of healing. The Claimant recalled the First Defendant saying her dentist was "an idiot" for thinking it was an infection. The Claimant said that the clinical notes suggesting she refused removal of the post are simply not true. Rather, the First Defendant said this was not the cause of the pain, removal was futile and it would only have to be reinserted. On her advice, the Claimant agreed not to have the post removed, although this was an option presented.

The First Defendant then suggested two options, being monitoring of the implant or root canal treatment (RCT) to the two neighbouring teeth. The First Defendant recommended the latter option. The Claimant was clear that the dental notes suggesting three very different options were untrue.

23. The pain of the RCT was not subdued by the anaesthetic and the Claimant said so several times. She described the First Defendant becoming agitated and said things about not having had a patient like this for over 25 years. The Claimant stated that the procedure lasted about two hours "and was one of the most horrendous, painful and traumatising experiences" of her life. Due to the pain, the First Defendant said she would not complete the procedures, which left them unfinished. An x-ray was taken, the First Defendant indicating that she wishes to check the placement of the implant given the Claimant's pain. The First Defendant prescribed painkillers and another antibiotic in addition to that which the Claimant was already taking. When asked why she prescribed antibiotics if there was no infection, the First Defendant replied that it was "just in case" and that she would have prescribed them in any event. An appointment to complete the root-canal treatment was arranged for 4 June 2018. There was no charge for this appointment (or subsequent appointments) and no advice as to what to do in the interim.

24. The Claimant instead booked an emergency appointment at another dentist, being hesitant to return to the First Defendant given her recent experience. This dentist could not obtain an x-ray due to the pain the Claimant was in. The dentist was concerned about the amount of swelling and the infection. He extended the course of one of the antibiotics and added another (the previous additional one having been completed). The Claimant saw her General Practitioner, who prescribed stronger painkillers. On 7 June

2018, the Claimant attended a further emergency appointment at the Cambridge Dental Hub. As a result of tests and examination, she was referred urgently to Addenbrookes Hospital as the implant had been drilled into the adjacent tooth. The hospital prescribed Oramorph but could not drain the infection due to the level of pain, so the Claimant was asked to come back the following day. An appointment with a maxillofacial consultant on 8 June 2018 led to surgery on 11 June 2018 to remove the implant and the damaged tooth.

25. On 7 June 2018 the First Defendant sent a text to the Claimant asking how she was and to call her as she was concerned. The Claimant replied with details of the pain and infection and requested the model and implant number for the post used. There was no further communication from the Claimant, despite receiving messages from the First Defendant. On 8 June 2018, the Claimant remained in significant pain and was taking a number of painkillers, in addition to the antibiotics. The medication was adjusted to try to control the pain. On 9 June 2018, the Claimant awoke in the middle of the night with extreme pain in her abdomen, pelvis and lower back. She was experiencing rectal bleeding, sweating and vomiting. She went to Accident and Emergency. She was very weak. She underwent an x-ray and a CT scan, the latter revealing ischaemic colitis and necrosis in her intestine. The Claimant was admitted to hospital, where she remained for ten days. Attempts to treat the colitis were successful, although the alternative involving significant surgery was only narrowly avoided. Following discharge, the Claimant required care and assistance from her husband and daughter in relation to all tasks, personal and household. This lasted for two to three weeks. The inability to tolerate NSAI medications meant that the Claimant had to take copious amounts of antibiotics which caused unpleasant side effects. Colitis-related issues continued, although they are now well-controlled by diet and the Claimant can still have flare-ups.

The Claimant explained about her earlier abdominal pain episode and what she told Dr Leigh about it. There was no obvious connection to colitis.

26. On 17 July 2018, the implant post and LL2 were removed. On 17 August 2018, LR2 was removed due to heightened sensitivity caused by the incomplete root canal treatment. The Claimant was left with a very large gap at the front of her mouth. In the subsequent months, the Claimant received advice and significant remedial treatment. The precise details were contained in the Claimant's statement. The statement also addressed the consequences of having developed colitis in terms of food intolerances that have required significant changes to diet. Bowel problems, which developed only after the onset of colitis, have continued. The statement referred to other health issues by way of context. The Claimant's statement also described her work and the plans to move to Cambridge in October 2018 and seek work locally. The experiences around the dental treatment detrimentally affected the Claimant's ability to seek work, especially due to her appearance and she was finding it difficult to speak and pronounce words. A pre-booked holiday in the summer of 2018 had to be cancelled. She had not experienced difficulties with pain management in subsequent treatments and procedures.

27. Mr Jim Bailey, the Claimant's husband, adopted his statement and gave evidence that his wife had been generally in good health and although she had attended the general practitioner for various reasons, there had been nothing that required ten days' hospitalisation. Very shortly after his return from America, which is where he was when the Claimant was being treated by the First Defendant, she was admitted to Addenbrookes. He became her carer in a sense after discharge. The Claimant's daughter, Holly Bailey, also gave brief evidence, having adopted her statement.

First Defendant's evidence

28. The First Defendant qualified as a dentist in the early 1990s, subsequently training in oral and maxillofacial surgery and then completing a three-year post-doctoral programme in implant dentistry. Her statement detailed her various qualifications and awards. The First Defendant is the sole director of Brilliant Dental Limited (BDL) trading as Dr Monica's Dental Clinic, and by which she was employed. She only gets a percentage of fees paid to BDL, by way of dividend or salary. She has had a special interest in dental implants and cosmetic dentistry and has been carrying out such treatments since 1998. She has used the 3D CEREC method of producing 3D scanned, designed and milled/printed veneers, crowns and restorations. She referred to having surgically placed and restored several thousand implants, and even more veneers and crowns.

29. The First Defendant described the 2016 appointment with the Claimant. Although the general dental notes for that appointment are not dated they were done on 25 May 2016. She insisted that there was discussion about the bridge and an implant. Notes in green pen were done at the same time – this is something the First Defendant said she had been doing for years, to make the writing stand out. She did not note the discussions about the bridge and the implant in 2016 because that was not a procedure that the Claimant had come for. The bridge was just chatted about but not so formally, but implant procedure planning was done at the 2016 appointment. The First Defendant's evidence was that the decision to replace the bridge with an implant was made in 2016, to be done on the next occasion, even though sometimes she might never see the patient again.

30. As to the appointment on 25 May 2018, the First Defendant said that she checked the medical history as it had been two years since the previous visit. The Claimant wished the removal of the bridge and replacement with an implant as well as a number of crowns. The First Defendant said that the options, with associated risks and benefits, were made known to the Claimant. As the Claimant wished to proceed with CEREC veneers and crowns, the First Defendant drew up a treatment plan and quote for removal of the bridge and replacement with two crowns and an implant. The First Defendant read out the contents of the consent form, which she eventually accepted was a generic consent form for implantology, receiving express verbal consent. A paper copy of the consent form was handed to the Claimant, which she signed and dated. The First Defendant denied that she failed to obtain informed consent. The First Defendant described the analgesia and the work done to prepare veneers/crowns.

31. The First Defendant said she conducted her usual diagnostic assessment and pre-treatment investigations, including an eight-point ridge/bone mapping as an alternative to a CBCT scan, as this was a single implant placement in the anterior mandible. She said that bone-mapping in the way she described is a recognised and accepted alternative, allowing her to be satisfied with the integrity of the sectional bone profile. Relying on her 25-years of experience, the First Defendant concluded that a 3D CBCT scan was not required and it would have exposed the Claimant to additional radiation and cost. In oral evidence, she said she did recommend a CBCT scan, and gave the Claimant the option of having it done close by. It was asserted that the Claimant said she trusted the First Defendant's advice and accepted "the added risk as she did not like x-rays". In hindsight, the First Defendant recognised that perhaps she should have insisted on the sectional CT tomogram and generated a rigid 3D surgical template based

on the scan. Her statement said that "this would probably have prevented the slight angulation error of the implant".

32. Again in oral evidence, the First Defendant said that the 2016 clinical examination and treatment plan were enough to go ahead with the procedure, because of her experience in dental implants and x-rays showed adequate bone. An OPG was ample for a simple case like this. She could have taken a PA radiograph, but she "did not see the need". A 3D scan was not required as this was not a difficult site and there was excellent access. She said she could feel with her hands that there was no concern about bone width. The First Defendant described the bone mapping she undertook, which was not measuring, but feeling the whole bone profile. She did not record the results of the bone mapping as she would only do this if there was something untoward. The fact that is it not recorded means that it was done and she was happy with it. The First Defendant said that she could not recall specifically advising the Claimant that the implant procedure could damage adjacent teeth. Asked whether she advised of the risk of the implant being likely to fail, the First Defendant responded that "anything in dentistry can fail". She said that she definitely conducted a periodontal examination in 2018, but it was not documented in the clinical notes. She recalled that the readings were two or below, compared with the readings recorded in her 2016 periodontal examination, as there had been improvement in oral hygiene. The possibility of RCT was also not documented, but would have been advised about. The performance of vitality tests was also not documented. The First Defendant was not saying that her planning was gold standard, but it was adequate with her experience. Although the plan had been to insert the implant at the same appointment, the Claimant "looked tired" after the bridge-removal procedure and it was agreed to complete the implant the following week.

33. At the appointment on 30 May 2018, the First Defendant said she reassessed the Claimant, and administered prophylactic antibiotics and then anaesthetic, as documented in the records. She repeated the detailed bone mapping assessment. She recalled the procedure, carried out she insisted in sterile conditions, took longer than usual as the Claimant was experiencing pain, requiring pauses to administer additional anaesthetic or to reassure her. The First Defendant's diary indicated that the appointment was two hours, but she did not specifically challenge the Claimant's evidence that it was more like six hours. Even if it was, the First Defendant described this as "not an unreasonable amount of time to complete the work", although she appeared to accept in evidence that it was eight to ten times longer than a single implant should take. Although ideally one required 1.5mm either side of the implant, the First Defendant said that one can actually manage with 1mm either side, so 5.7mm was adequate. The distance between LL2 and LR2 was roughly 6mm from her measurement, although this was not documented. Asked whether she had advised the Claimant about there only being 1mm and any greater risk, the First Defendant said "no, definitely not", this was not something she discussed with the patient. Nevertheless, she considered the advice given and consent obtained was adequate.

34. She had warned the Claimant that she may experience some discomfort. She instructed the Claimant to raise her left hand if the pain became too severe. She said the Claimant kept stopping her "claiming to be in excruciating pain from the outset". However, every time the First Defendant checked the site for numbness, there was no response from the Claimant, so she provided reassurance and continued. The First Defendant surmised that the Claimant's pain was perhaps "psychological" or psychosomatic and although she accepted that she could have administered more local anaesthetic, she did not think this was in the Claimant's clinical best interests at the time. The Claimant was given

Ibuprofen and antibiotics, in addition to the medication from the emergency dentist, of which the First Defendant was aware. She accepted "on reflection and in hindsight" that a periapical x-ray should have been taken, but the Claimant was in a lot of pain and "adamant" that she would not allow any intraoral radiograph. She apologised for the damage to LL2, which she described as "unintentional human error" in not managing to place the implant fixture straight as planned. In oral evidence, she said the error was not due to a lack of planning, but because the Claimant was "very mobile, non-compliant" and her moving too much was the problem. The First Defendant was asked about stopping the procedure if the patient is not compliant, but she said she did continue although it was not ideal. It was a very difficult procedure but not one that she felt she could not do. The First Defendant accepted that she did not conduct a 3D CBCT scan, whilst asserting that she offered this twice to be taken in a next door office, but that it was the Claimant who declined. She said the Claimant also refused a PA radiograph. As to pain, all patients, she said, have discomfort after surgery. She accepted that the implant post into the root of the neighbouring tooth would be painful. There was no indication that implant itself failed, only that it was likely to compromise the neighbouring tooth.

35. In respect of the appointment on 31 May 2018, the First Defendant responded to the Claimant's email about being told of an infection by the emergency dentist, that this was "scientifically impossible". She advised the Claimant to come in immediately and reorganised her diary to help ease the Claimant's pain. She advised the Claimant of treatment options as in the clinical records. She again reassured the Claimant that there was no infection, which was "in any case not likely" one day after the implant procedure. The First Defendant checked the Claimant's pain level, which she described as demonstrating "an extremely low and exaggerated pain threshold". She considered

that LR2 was less sensitive than LL2. She highlighted "how easily the implant could be removed". She denied saying that removal of implant would be futile. The Claimant wished to stop the pain, but, the First Defendant said, did not want the implant removed unless absolutely necessary. Elective RCT could be used on the symptomatic teeth, removing the nerve to take away the pain. The First Defendant stated that the Claimant opted for RCT on LL2 and monitoring of LR2.

36. The First Defendant denied performing any RCT on LR2, although this was one of the options presented. She said the Claimant would not know if she was working on one or both teeth. She accepted that the x-ray from 30 May showed no RCT on LR2, but that it was present on 4 June, but neither her notes nor her recollection was that she carried out the second RCT. The Claimant was advised to see her GP and seek advice on pain control. Despite recommending endodontists, the First Defendant continued the agreed treatment because "the Claimant insisted". The RCT was conducted in accordance with the First Defendant's usual practice, but only stage 1 was completed, with the Claimant due to return a week later (although the First Defendant's statement also stated that she wished to complete the treatment on the day). The procedure was offered free of charge as a gesture of goodwill. The Claimant was said to have been grateful when she left after the treatment. The First Defendant apologised for the discomfort, which she had not experienced in a patient in over 25 years. Whatever medication the First Defendant did or did not prescribe, she said she was unaware of the Claimant's having seen four other dentists and receiving medication from each. The First Defendant accepted that the loss of LL2 was directly related to the implant, but she had no idea why LR2 or any other tooth was lost.

Expert evidence

37. Dr Timothy Leigh is a Consultant Gastroenterologist and Hepatologist. He examined the Claimant remotely and provided a report dated 19 January 2022, following a full review of dental expert reports, hospital medical notes and radiology reports. He did not consider a physical examination necessary or he would have said so. For the first report he did not have the general practitioner records. He noted that, whilst in Addenbrooke's Hospital following admission on 9/10 June 2018, ischaemic colitis secondary to the use of NSAIDs was raised as a possible diagnosis. There was slow progress while an inpatient but, after a few days, there was a steady improvement. The Claimant was discharged on 19 June 2018. Thereafter there was a further five-week course of antibiotics in order fully to treat the dental infection.

38. It was Dr Leigh's opinion that, on the balance of probabilities, the episode of ischaemic colitis was precipitated by NSAIDs used as an analgesic in the weeks before admission. The need for the NSAIDs was brought about as a consequence of the dental work and subsequent, related infection. Without the excessive pain caused by the dental work and infection and requiring the NSAIDs, the Claimant would not have developed ischaemic colitis, suffered associated pain and been hospitalised. Ongoing bowel disturbance is a direct consequence, described as post-traumatic and stress-related irritable bowel syndrome. Care and treatment at Addenbrookes Hospital was timely and competent. The condition and prognosis section of the report described specific aspects of bowel changes, which have also led to significant stress and anxiety. The Claimant's past history revealed no other cause for the colitis. Dr Leigh's examination noted the Claimant to appear quite self-conscious about her appearance in relation to her lower jaw.

39. Dr Leigh explained that NSAID-induced ischaemic colitis is a rare but well-recognised clinical condition. With the correct dietary and gastroenterological input, he opined that the Claimant's symptoms should improve substantially over the two to three years following his examination.

40. The Second Defendant posed additional questions for Dr Leigh, in accordance with Part 35 CPR, arising from entries in the Claimant's medical records from 2009 and 2016. These made reference to abdominal and/or bowel difficulties. Further questions were posed seeking clarity about Dr Leigh's opinion on matters of NSAIDs and any connection with ischaemic colitis. Dr Leigh responded by explaining that at the time of his first report he had not had sight of the Claimant's General Practitioner medical records. He highlighted entries from 2005/6, 2009/10 and 2015/16, but expressed the opinion that the symptoms associated with her episode of ischaemic colitis were quite different in nature from the earlier problems she experienced, and more consistent with a functional diagnosis of irritable bowel syndrome. In answer to the NSAID-related questions, Dr Leigh stated that ischaemic colitis can occur even if the NSAIDs are taken in the correct dosage, depending on the sensitivity of the individual to them. A clinician prescribing medication ought to be aware of any other medications being taken. Dr Leigh had seen no evidence that the Claimant had not followed the correct dosing regime and instructions. Asked specifically about pseudomembranous colitis due to infection, Dr Leigh described the evidence as "strongly in favour" of ischaemic colitis. He stated in evidence that his opinion had not changed following receipt of the general practitioner records. He clarified that he had asked about previous bowel problems and whether the Claimant had any prior to the dental treatment. There was one short-lived bowel disturbance that did not reveal a severe underlying condition. Neither this nor other abdominal complaints were, in Dr Leigh's opinion, the same condition as the

colitis, at least on balance of probabilities. Although ischaemic colitis is a very rare complication, Dr Leigh has himself witnessed NSAIDs causing it. It is a condition which is often misdiagnosed, but once diagnosed the treatments are well understood. He repeated that on the balance of probabilities the NSAIDs caused the ischaemic colitis and he explained how he came to that opinion in some detail. He did not consider that hypertension was the likely cause. He added that the clinicians at Addenbrookes also thought that NSAIDs were the cause.

41. Dr Roger Goulden is a Dental Surgeon and a specialist in restorative dentistry, who provided a report dated 30 December 2020. He recorded that a denture fitted in November 2018 as part of remedial treatment had fractured more than a year before his appointment with the Claimant, and she can only wear it on a temporary basis, which she does when in company. There appeared to be no medical history relevant to the delivery of dental treatment. The Claimant reported significant embarrassment from the lack of lower front teeth as well as the difficulties in eating certain foods. There was also some tenderness in the lower gum. Dr Goulden was clear that the Claimant required urgent replacement of her missing lower front teeth and he provided details of a number of treatment options, together with likely costs.

42. Professor Harding is a Professor of Dentistry, as well as Dean of the City of London Dental School. In his report he recounted the history of the First Defendant's treatment of the Claimant in 2016 and then the appointments in May 2018. The report undertook a review of the Claimant's clinical records from her regular dentist, Epping Dental. The report then considered the First Defendant's clinical records, which were described as "handwritten in black or green ink and some of the entries being illegible". There were two OPG radiographs available, which were photographs taken from a computer screen

and difficult to read. Professor Harding's report noted the findings of examination in 2016, including the OPG radiograph, for which there was no report of the findings, but did not show any obvious pathology associated with LL2 and LR2. However, superimposed was a tracing of an implant between these teeth, which showed that the implant diameter and trajectory would be close to the roots of both teeth with the impression of cutting into the root of LR2.

43. On 25 May 2018, the records state that consent was given to the removal of the lower bridge and the placement of an implant. In evidence, Professor Harding made the point that the failure to conduct a proper assessment, including measurement of the bone, meant that the Claimant was not properly advised about risks and therefore not properly consented. The absence of details in the records also undermined the consent – the First Defendant acknowledged that everything was not documented, saying "it is what it is". No periapical radiographs were taken. On 30 May 2018, bone mapping was carried out at the site of LL1/LR1 with an implant placed. A post-operative OPG was taken, reporting the implant position as "ok". The Claimant was to return for review after one month, but she returned on 31 May 2018, following an emergency appointment with her general dentist. The records list the options presented to the Claimant. RCT commenced at this appointment on LL2, the notes saying that advice was given that it may be necessary on LR2, which was also tender to percussion. The radiograph from Blue Sky Dental of 4 June 2018 showed the tip of the implant to be associated with radiolucency. The implant body was in very close proximity to the neighbouring tooth and gave the impression of touching the side of the LL2 root. The LR2 had a partial root filling that did not reach the apex of the tooth and was poorly condensed. Professor Harding also reviewed the records from the Cambridge Dental Hub on 7 June 2018. The Claimant was advised about the need for a CT scan, which showed that the implant

was large and was touching LL2, with radiolucency seen around the implant. The Claimant was told that it would be very difficult to remove the implant and this should be done only in hospital. Subsequently, the implant and both LL2 and LR2 were removed. Professor Harding's report reviewed the subsequent treatment of the Claimant by various dentists.

44. Professor Harding's opinion began by noting that the Claimant's account was consistent with the records he reviewed. He was concerned that some aspects of the First Defendant's records may have not been contemporaneous but added to later. Even if this was not the case, the records do not satisfy the General Dental Council requirements for detail. He also highlighted discrepancies in the records that caused him to conclude that they could not be factually relied upon. These included a lack of mention of any distress or pain management, including an absence of dosages for top up anaesthetic. The 2016 BPE score and presence of bleeding and calculus indicated periodontal disease, which should have been diagnosed and treated appropriately. Implant treatment was contraindicated until such disease was stabilised. A competent assessment by a dental surgeon specialising in implant dentistry ought to have found that such treatment was not appropriate for the Claimant. In response to the First Defendant's assertion that in 2018 the BPE was 212 212, Professor Harding responded that this was not documented and it would not have mattered if the BPE was 0. Implantology is appropriate for carefully selected and assessed patients, but that the Claimant was not suitable for it. He said in the Claimant's case, he did not think that an implant would make a significant difference to oral health and a bridge remained a better option. The referral by the other dentist was for a second opinion from a specialist. He rejected the suggestion that a number of dentists would have put in an implant as the First Defendant had.

45. The implant tracing superimposed on the 2016 OPG showed the implant diameter and trajectory would be close to the roots of LL2 and LR2, if not actually cutting into them. A radiograph from Addenbrookes showed that the space between LL2 and LR2 was 5.92mm. The implant diameter to be inserted was 3.7mm, requiring a minimum space of 6.7mm. In addition to the periodontal disease, there was insufficient space safely to accommodate the implant. As there had never been a tooth at the LL1/LR1 space, the alveolar ridge width would on the balance of probabilities have been very narrow and unlikely to have been the 7mm needed. Professor Harding did not agree with the First Defendant that 1mm either side of the implant site was sufficient. Although narrower implants are available, they are considered in some circles to have a lower success rate. Given the lack of bone width and space between the existing teeth, a CBCT scan should have been taken properly to plan the case and determine the amount of available bone safely to house the implant and minimise the risk to adjacent teeth. The First Defendant's assessment through superimposing an implant template on the 2016 OPG should have alerted her to the need for a CBCT scan and to the significant risk of damage to LL2 and LR2. The OPG radiographs were not reported on in the notes and the lack of width was not recorded or calculated. A competently conducted clinical examination of the Claimant would have flagged up the discrepancy in tooth widths and obvious lack of space at LL1/LR1 for an implant. Without a proper assessment it would not have been possible to explain and discuss the risks of benefits of implant treatment and to advise the Claimant of the best options in her specific case.

46. Professor Harding disagreed with the First Defendant's suggestion that she was not wrong to rely on the 2016 panoramic x-ray. He said two years had elapsed and building a whole new treatment plan on such an out of date x-ray was wrong. Even if treatment had been discussed in 2016, nothing was actually done. Pathology may have developed

around the bridge teeth over that time, which may not be apparent from a mere clinical examination. The OPG radiograph was also not providing the necessary view to assess bone. Any reasonable dentist would have taken a PA radiograph to check for the health and pathology around the relevant teeth. This could have been done in the clinic, it did not require going elsewhere. These were also not spelt out in the generic consent form. The report set out appropriate options for the Claimant.

47. Having embarked on the implant procedure on 30 May 2018, there was ineffective management of pain during the procedure. The severe pain described by the Claimant was unsurprising given the "low dose of local anaesthetic given". The First Defendant topped up the anaesthetic to what she said was the maximum, but did not record the dosage of each top-up. Lack of pain control would be one reason why it would be prudent to abandon implant treatment and, before insertion of the implant, without detriment to the patient. Continuing the procedure with a patient moving and in pain is dangerous as it increases the chances of complications, such as poor implant positioning, implant failure or harm to the patient. In the circumstances of the Claimant, the First Defendant should have stopped the procedure. It was not possible to confirm whether the pain felt by the Claimant was due to infection but on the balance of probabilities there would have been pain due to the damage caused to LL2 from the implant cutting into its root.

48. On the balance of probabilities the sensitivity of LR2 arose because of bone and gum loss caused by the inappropriate and poorly executed implant treatment and post-operative management of the complications. The OPG radiograph of 30 May 2018 should have resulted in a PA radiograph to determine the extent of the damage caused to LL2. The correct course of treatment would have been removal of the implant,

avoiding unnecessary prolonged stress and pain for the Claimant. This would on balance have reduced the amount of bone loss from the ridge. The First Defendant put to Professor Harding that she provided the Claimant with various options at this stage, to which he pointed out that the Claimant did not have the experience to know which option to choose. Had things been explained properly, most reasonable patients would have said to remove the implant to avoid risk of being in continuing pain.

49. Due to the damage to LL2 and the possibly unnecessary and inadequate RCT of LR2, they had to be removed. The use of LL3 and LR3 as supports for a long span bridge was reasonable in the Claimant's circumstances, though there is a slightly increased risk of nerve death in such teeth. This happened with LL3 which was root filled following removal of a fractured instrument, a recognised complication of the procedure. This has also led to tooth weakening, and although it is presently supporting the bridge, there is an increased risk of fracture in the future. Therefore, to preserve LL3, the bridge should be replaced with an implant supported bridge. Bone grafting will also be needed where there has been bone loss. Professor Harding also dealt with long-term prognosis and future treatment costs.

50. As to liability, Professor Harding opined that the First Defendant's treatment of the Claimant was below the standard she could reasonably have expected under a number of headings:

(a) The Claimant was advised to undergo implant treatment which was not a viable treatment option;

(b) A failure to make, keep and make available full, comprehensive and accurate clinical records;

(c) A failure to assess fully and plan the proposed implant treatment;

(d) A failure to obtain the necessary pre-operative radiographs;

(e) A failure to obtain informed consent from the Claimant;

(f) A failure to recognise that the placement of an implant at LL1/LR1 would inevitably fail;

(g) A failure to assess the risks and consequences associated with the provision of implant treatment;

(h) A failure to report on the OPG radiographs;

(i) Unnecessary and inadequate RCT to LR2;

(j) A failure to manage the Claimant's interoperative and postoperative complications and pain;

(k) A failure to remove the failed implant once the poor positioning had been seen on the OPG radiograph and given the Claimant's symptoms.

51. As to causation, Professor Harding was of the opinion that the above breaches of duty directly caused the Claimant:

(a) To undergo an unnecessary surgical operation which caused her pain and suffering both during and after the procedure;

(b) Tooth LL2 required root treatment solely due to the damage caused by the implant and for the same reason eventually required extraction;

(c) Tooth LR2 required extraction as it was painful and associated with periapical infection, due to the substandard RCT, which was not required;

(d) Loss of bone and gum tissue from the anterior mandible resulting in tooth sensitivity and the inability to wear or tolerate a removable denture;

(e) A long span bridge had to be inserted to restore the lost incisor teeth, placing the abutment teeth at LL3 and LR3 at risk of nerve death;

(f) LR3 became sensitive and painful;

(g) LL3 nerve died and required RCT;

(h) The Claimant will require an implant supported restoration which would not have been the case;

(i) The Claimant will require a bone graft prior to implant placement which would not otherwise have been the case;

(j) The Claimant underwent a long period of pain as a result of the inadequacies identified, in addition to having two teeth removed (LL2 and LR2). These had been free of pathological change prior to the First Defendant's intervention and should have functioned for a lifetime;

(k) The Claimant also required LL3 and LR3 to be crowned so they could be used as support for her long span bridge. They would otherwise never have been involved in supporting the bridge, had LL2 and LR2 not needed extraction, and they should then have had normal function for a lifetime.

52. In relation to the above findings, Professor Harding accepted that if the First Defendant did not perform the RCT on LR2 then point (i) under liability and point (c) under causation would not apply. LR2 could then be removed from points (k) and (l) under causation. He pointed out, however, that the loss of LR2 was according to Addenbrooke's because of infection, which was not present prior to the First Defendant's work on the Claimant's teeth.

53. As to psychosomatic pain, this was possible, but if having exhausted anaesthesia options a patient is still not able to lie still and be compliant then it is not safe to proceed. In these circumstances, the dentist is in charge and must make the call to stop the procedure.

Factual conclusions

54. In reaching factual findings in this case, I have reminded myself of the need for the Claimant to establish her claim on the balance of probabilities against either or both of the Defendants. In assessing the oral evidence of witnesses I have taken account of what they said in writing and during the trial in the context of all the evidence, for example how consistent it is with other evidence not in dispute or which I find to be reliable. I have also taken into account how well the witness' evidence withstood challenge in cross-examination.

55. Having listened with care to the evidence of the Claimant and the First Defendant, I am satisfied that I prefer the Claimant's evidence wherever there is a conflict. The Claimant's ability to recall, at times with vivid detail, her appointments and experiences at the First Defendant's clinic in 2016 and 2018 is to be contrasted with the First

Defendant's reliance on her usual practice as well as on factual assertions that, on her own admission, should have been but were not documented in her clinical records.

56. As to the expert evidence, although the First Defendant made reference to some opinions from other clinicians, there was no formal, properly admissible evidence to counter the detailed opinions of, in particular, Professor Harding and Dr Leigh. Both of these experts were cross-examined in some detail about the conclusions they had reached and I am satisfied that their opinions were cogent, balanced and informed by all the available and relevant professional records.

57. With these introductory remarks, I have reached the following conclusions:

(a) For the appointments in May 2018, the Claimant contracted with BDL for the provision of dental services. The documentary evidence supports the contracting parties being the Claimant and BDL, as does the First Defendant's evidence about the way in which she is remunerated by the company. The fact that she is the sole director of the company does not detract from this finding.

(b) The dental services were provided on behalf of BDL by the First Defendant, as a qualified dentist and dental surgeon (and arguably by such dental nurses as were employed by BDL, although no negligence is alleged against them);

(c) As a result, the First Defendant owed a duty of care to the Claimant in the provision of dental services; any suggestion to the contrary is untenable. The necessary contractual relationship was established to make the Second Defendant potentially liable for any breach, pursuant to the implied contractual term under section 49 Consumer Rights Act 2015 and section 75(1) Consumer Credit Act 1974.

(d) The First Defendant breached her duty of care in a number of significant respects, causing pain, suffering and loss of amenity as well as other losses to the Claimant. The First Defendant specifically failed to undertake a full and proper assessment of the Claimant's suitability for the proposed implant procedure. The suggestion that some general undocumented discussions had in 2016 about an implant, together with reliance on a scan taken at that appointment two years earlier, could found a proper assessment and treatment plan was completely unsound and professionally unjustifiable. Had there been any substance in the First Defendant's account of her reliance on what happened in 2016, the BPE results would have made the Claimant an unsuitable candidate for an implant at that time. I accept Professor Harding's evidence as to the need to have up-to-date scans for the reasons he gave. Furthermore, the very specific presentation of the Claimant with a small, single tooth space where two teeth would normally have been, was another contraindicator to the suitability of an implant and certainly to suitability without the most careful and detailed contemporaneous assessment of the intended site.

(e) By her own admission, the First Defendant did not inform the Claimant that the proposed implant procedure, which normally requires 1.5mm clearance either side of the implant post, was to be attempted with the lower 1mm clearance on either side – and not with the reduced diameter post of 3.3mm but the more usual 3.7mm post. This alone vitiates any consent obtained as there would be an increased risk of failure and or damage to the adjacent teeth about which the Claimant had not been informed. The First Defendant eventually in evidence accepted that the consent form was merely generic, without any specificity directed to the Claimant and her personal situation.

(f) The First Defendant therefore failed to advise the Claimant properly or at all about the inappropriate nature of an implant in her circumstances and failed to advise properly or at all about the actual risks inherent in the procedure for this Claimant. The First Defendant therefore failed to obtain informed consent for the removal of the bridge and for the implant procedure.

(g) In respect of the bone mapping that the First Defendant undertook to be satisfied about bone integrity and size to take the implant post, she accepted with hindsight that what she did may not have been enough. Professor Harding's view is that what was done, whatever it is called and whether or not it is a generally recognised technique for some forms of bone assessment, was quite inadequate in the circumstances of the Claimant to be satisfied that the procedure was safe and could proceed as intended. I accept his evidence on this point. Just because the concept of bone mapping may be a technique used by some professionals in some circumstances does not mean that its use in all circumstances will be defensible under the Bolam test. What the First Defendant did to assess bone in the specific situation presented by this Claimant is what must be judged, not whether a technique used is or is not one in general use.

(h) Having nonetheless proceeded with the poorly planned treatment, the First Defendant inserted the post in such a way that it was angled and impinging on the root of LL2. Whether the poor positioning of the post was due to the First Defendant's lack of sufficient planning, due to the lack of sufficient care in carrying out the procedure, due to the Claimant's understandable inability to remain static due to the significant pain she was experiencing or due to a combination of these and/or other reasons, matters not. They are all the responsibility of the First Defendant as she was the one who should have appreciated that one or more of the risks involved must be manifesting

itself/themselves. The First Defendant in oral evidence seemed to ascribe responsibility to the Claimant for not staying still, but her dismissive attitude to what she called psychosomatic pain and the Claimant's vivid description of the procedure on 30 May 2018 lead me to find that the First Defendant ignored the obvious signs of pain and distress that continued to be shown by the Claimant, despite increased anaesthesia. As Professor Harding said, if the patient cannot stay still so that the procedure can be undertaken safely, the onus is on the dentist to stop the procedure. The failure of the First Defendant to cease the procedure resulted in the damage to LL2 and much of the excruciating pain suffered by the Claimant at the time.

(i) The First Defendant was equally dismissive, if not more so, of the suggestion that the Claimant developed infection. I am satisfied that she did refer to the Claimant's dentist as an "idiot" for making the suggestion. This is not something the Claimant misremembered. The First Defendant's reaction was over the telephone, before she had even had the chance to examine the Claimant and to see for herself whatever it was that gave cause for concern. This was most unprofessional and, indeed, her absolute assertion about the impossibility of it being an infection turned out be misguided. The Claimant did indeed develop an infection, which in due course contributed to the demise of LR2 as well as to significant pain and discomfort.

(j) As to the treatment of the Claimant's presentation on 31 May 2018, I am satisfied that the First Defendant was responsible for the RCT (at least to the extent that it was attempted and partially completed) on both LL2 and LR2. The precise motivation for the First Defendant's denial of responsibility for the poor quality RCT of LR2 is unclear, but the x-ray evidence provides only a very small window of four days within which it could have been done. There is no evidence of any other dentist undertaking

the RCT of LR2, despite dental records from various dentists etc being made available. The Claimant's evidence was dismissed by the First Defendant on the grounds that the Claimant would not know which teeth were being worked on. This is another example of a confident assertion by the First Defendant that does not stand up to scrutiny. It is the First Defendant's notes that have been found to be incomplete and, as Professor Harding suggested, therefore unreliable as a comprehensive, contemporaneous record.

(k) I am satisfied that the very significant pain and discomfort and the need to keep consulting with emergency and other dentists was the direct result of the First Defendant's breaches of duty. I am further satisfied that the loss of LL2 and thereafter LR2 is directly related to the Defendant's negligence in treating the Claimant. LR2 was damaged either by infection and/or by poorly executed, attempted RCT.

(l) I am also satisfied that damage to the Claimant's bone was also a direct consequence of the negligence of the First Defendant. This applies equally to actual and planned remedial work which has and will remain significant in terms of scope and cost. This includes the word done on LL3 and LR3 to allow them to shoulder the wide span bridge.

(m) As regards the gastrointestinal matters for which the Claimant was admitted to hospital, I am satisfied on the clear and well-supported evidence of Dr Leigh that the Claimant developed ischaemic colitis and that it arose as an albeit rare but known complication from the taking of NSAIDs. I reject the Second Defendant's challenge to the Claimant's case on this, which seems to ignore the direct evidence on the point from Dr Leigh that (i) his questions were about bowel dysfunction not abdominal pain; and (ii) his opinion did not alter at all following receipt of the general practitioner records. It was open to the Second Defendant to serve expert evidence to challenge the findings

of the experts relied on by the Claimant. The Second Defendant did not do so and was unable to undermine the cogent evidence and opinion of the experts who did give evidence.

58. It follows that I find that the Claimant succeeds against both the First and Second Defendants on liability, including for the ischaemic colitis.

Quantum

59. The Claimant was 54 years and four months' old at the time of the May 2018 appointments.

60. The Claimant and Second Defendant addressed quantum in detail in their closing submissions.

General damages

61. I have considered the competing arguments as to damages relating to the loss of teeth and the ischaemic colitis and have reached the following conclusions:

(a) In respect of the Claimant's dentition, she lost LL2 and LR2, she has lost the nerve in LL3 and both LL3 and LR3 have had to be significantly altered to act as shoulders for the longer bridge. The work on these two teeth is known to weaken them and the risk of fracture is increased. There was excruciating pain during the initial treatment over an extended period of time, much remedial treatment already and a continuing need for more, all due to the First Defendant's negligence. In all the circumstances, I agree with the submission of the Claimant that the award for this aspect of general damages should be **£11,410**, that is the top of the bracket in the Judicial College guidelines.

(b) In respect of the ischaemic colitis, the Claimant developed this as a rare but known complication of the taking of NSAIDs. She did not have a pre-existing condition involving colitis and I reject the Second Defendant's submissions about a failure to disclose previous abdominal pain, which are inconsistent with the evidence of the Claimant and Dr Leigh at trial and my findings above. The Claimant was sufficiently unwell that she required a hospital admission for 9/10 days and there is a continuing condition, albeit she manages it in the main through diet and the avoidance of triggers. The rubric of the Judicial Guideline leads me to agree with the Claimant's submission that there should be an award between the two specified brackets. I acknowledge that there may be some limited crossover between the teeth award and the colitis award, and have taken this into account. In the circumstances, I assess the appropriate award for the colitis as **£30,000**.

62. The total award for general damages is therefore **£41,410**.

63. As to special damages, I deal with these in the table below:

Description	***Amount awarded***	***Reasoning***
Initial treatment cost	£3,416	Already discounted to allow for treatment that Claimant should have received and paid for. Claimant's submissions adopted.
Past remedial treatment	£7,938	Costs reasonable and recoverable, having considered individual invoices and costs. Claimant's submissions adopted.

Medication	£580	No failure to mitigate established.
Travel	£375	The Claimant accepts this is an estimated rather than detailed cost. Having considered submissions, I make this award.
Holiday transfer cost	£0	This is precisely the type of loss that is so easily capable of being supported by documentary evidence. Although the Claimant gave evidence about it, it should have been supported by documentary evidence. No explanation was given as to why it was not so evidenced.
Care	£594.30	This figure is not disputed by the Second Defendant and it does relate to the period after the Claimant's husband returned from America and effectively became the Claimant's carer. It is reasonable and recoverable.
Loss of earnings	£11,500	I accept it is likely that (a) the Claimant would have sought work; (b) would have sought and found at least part-time work, given her work history and experience; (c) would have been remunerated at at least the minimum wage, on balance part-time work being less likely to replicate her previous managerial role and income; and (d) the problems preventing her working would have persisted for a couple of years, but must be seen in the context of the onset of Covid restrictions in spring 2020 and that this may have reduced or curtailed her employment. This is a loss of chance case and I make a modest reduction to reflect this. I have calculated the minimum wage payment for 20 hours per week over the course of 18 months (= £12,807.60) discounted to £11,500.

Future remedial treatment	£16,050	I accept the Claimant's submissions based on the future treatment costs provided for by Professor Harding and based on my assessment of his evidence at trial.
Repeating costs	£5800	Once the future remedial treatment has been completed the Claimant will have broadly been put into the position that she would have been if there had been no negligence, save in respect of LL3 and LR3. As Professor Harding noted "all dental restorations have a finite life expectancy" and the Claimant would have had one type of dental restoration or another, irrespective of the First Defendant's negligence. The crowns at LL3 and LR3 will require replacement as a direct result of the negligent treatment (£900 x 2). There will be an extra cost every ten years for three-unit implant bridge instead of a one-unit one (£2000 x 2).
Possible future and repeating costs	£0	These projected costs in Professor Harding's report are based on a 25% risk that LL3 will require an implant within 10-15 years. I am not satisfied that this is recoverable as a potential future cost.
Total for special damages	**£46,253.30**	
Total damages	**£87,663.30**	

64. For the avoidance of doubt, the Second Defendant is entitled to an indemnity and/or contribution from the First Defendant in respect of damages and costs. Insofar as damages are concerned such indemnity/contribution would be on a 100% basis. In

respect of costs, the Court will need to consider the form of order, and any relevant submissions, before determining the issue (albeit in principle the Second Defendant is likely to be entitled to recoup costs that it is required to pay on 100% basis). Though jointly and severally liable, there was no suggestion that the Second Defendant was liable other than through the mechanism of the Consumer Credit Act 1974.