Neutral Citation Number: [2024] EWHC 2633 (KB)

Case No: QB-2022-001915

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21 October 2024

Before :

NEIL MOODY KC SITTING AS A DEPUTY JUDGE OF THE HIGH COURT

- -

Between :

MRS ALISON WINTERBOTHAM	**Claimant**
- and -	
DR ARASH ZAKER SHAHRAK	**Defendant**

- -
- -

Camilla Church (instructed by **Anthony Gold Solicitors**) for the **Claimant**
Liam Duffy (instructed by **Dental Protection**) for the **Defendant**

Hearing dates: 16th -19th July 2024

Approved Judgment

This judgment was handed down remotely at 10.30am on 21 October 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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NEIL MOODY KC:

Introduction

1. This is an action for damages for clinical negligence. On 27th November 2020, at his dental surgery in Cambridge, the Defendant, Dr Arash Zaker Shahrak, extracted the lower right wisdom tooth of the Claimant, Mrs Alison Winterbotham. Unfortunately, in the course of the procedure, he damaged her lingual nerve with the result that she suffers constant pain and discomfort in her tongue and mouth. It is not suggested that the extraction was carried out negligently; it is accepted by the Claimant that damage to the lingual nerve was a risk of the procedure. However, it is alleged that the risks were not properly explained to her, and she was not told about a coronectomy (removal of the crown) which would have been a suitable and lower risk alternative. It is alleged therefore that she did not give informed consent to the extraction. She alleges that if the risks and alternative treatment had been properly explained, she would have undergone a coronectomy, and the damage to the nerve would have been avoided. In the alternative it is alleged that she would not have undergone the extraction on that day. Mrs Winterbotham says that, but for her injury, she would have worked full-time as a speech and language therapist and as a counsellor, but now she can only work in a very limited way on a part-time basis. The Schedule puts her claim at £956,523.

2. The Defendant denies negligence and argues in the alternative that, even presented with additional information as to the risks and coronectomy, Mrs Winterbotham would have undergone the same procedure on the same day and suffered the injury in any event.

3. I set out my conclusions at paragraphs [154] – [157] below.

4. The Claimant was represented by Ms Camilla Church and the Defendant by Mr Liam Duffy. I am grateful to them both for their helpful and well-focused submissions.

Background

5. Before addressing the narrative, I will set out the basic anatomy and describe the relevant procedures. The relevant tooth was Mrs Winterbotham's lower right wisdom tooth (LR8 in dental notation). The wisdom teeth are also described as third molars. There is an issue in the case as to whether Mrs Winterbotham's LR8 was distoangularly impacted. "Distoangular" means that the tooth grows at an angle towards the back of the mouth. Impaction means that there is a failure of the tooth to erupt to a functional position.

6. There are two nerves which are relevant in this case. The inferior alveolar nerve runs in the inferior dental canal which is located in the mandible (lower jaw). This supplies sensation to the lower lip and chin. The second relevant nerve is the lingual nerve which is the nerve that was injured. It runs on the inside of the mandible in a variable position in proximity to a lower wisdom tooth. This nerve provides sensation to the side of the tongue, lingual gingiva (gum), and tissues to the floor of the mouth. Taste fibres are also carried in this nerve. Extraction of a lower right wisdom tooth may give

rise to a risk of injury to both nerves. The nature and extent of the risk is in issue in this case.

7. The Claimant underwent an orthopantomogram ("OPG") which is a dental X-ray. An additional investigation which may be appropriate in some cases is cone beam computed tomography ("CBCT"). Mrs Winterbotham's wisdom tooth was extracted. An alternative procedure which may be appropriate in some cases is a coronectomy, whereby the crown is removed and the roots are left in situ. There are issues in this case as to whether a coronectomy would have been appropriate, whether it should have been offered to Mrs Winterbotham, and whether she would have chosen it if offered.

The Facts

8. Mrs Winterbotham is now aged 55. At the time of the relevant events, she was retraining to be a counsellor, having previously worked part-time as a speech and language therapist ("SLT"). She combined this with a busy life volunteering, bringing up three children and running the family home.

9. She had a partially erupted lower right wisdom tooth for many years. From about May 2020 she suffered several episodes of pericoronitis which were treated with antibiotics, topical measures and mouthwash by her dentists at the Apple Tree Dental Practice in Cambridge. In August 2020 she was sent for an OPG which was reported on 10th September 2020 by her general dental practitioner, Dr Charles Pontikis, as follows:

    - normal anatomy
    - bone ok. **LR8 roots in close proximity to ID canal.**
    - **High risk for XLA** [extraction under local anaesthetic]
    …
    - next course of action if still affecting patient is to refer for a surgical extraction/ **Possible CT scan first as ID canal in close proximity to apex of LR8**

    [bold added]

10. At a further attendance on 11th November 2020, it was recorded:
    - LR8 pain again
    - as discussed previously referral if occurs again for XLA
    - **OPG shows high risk as close to ID nerve**
    …
    - P[atien]t interested in PVT [private] referral for XLA LR8 as long waiting list under the NHS.
    - Referral agreed to FH [Falkner House]

    [bold added]

11. Mrs Winterbotham said that the OPG findings were not discussed with her at the time. In particular, she was not told that an extraction would be "high risk", that the roots of

her tooth were in close proximity to the inferior dental canal, or that a CT scan might be indicated.

12. Mrs Winterbotham's evidence was that by this time she was suffering pain and discomfort, it was starting to frustrate her and she "wanted to get it sorted". The relevant events took place during the Covid pandemic and there was a long waiting list for an NHS hospital appointment, so Mrs Winterbotham requested a private referral. She was referred to Dr Shahrak at the Cambridge Minor Oral Surgery Service situated within the Falkner House Dental Practice at Swanston, Cambridge. Since she was a private patient the claim is brought in contract as well as tort, but nothing turns on this as it is common ground that Dr Shahrak owed a contractual and tortious duty to exercise reasonable care and skill. Mrs Winterbotham attended at Dr Shahrak's surgery on 27th November 2020. There was a sharp dispute between them as to what transpired at the consultation, and I address this issue below.

13. Dr Shahrak is a highly experienced specialist oral surgeon. He has been practising since 2000 and has been registered as an oral surgeon with the General Dental Council since 2013. He does not undertake general dentistry. He said in evidence, and I accept, that he carries out about two to five lower wisdom tooth extractions per day. Dr Shahrak's surgery had produced a Guidance Note which set out information about the procedure and its risks. There is a dispute between the parties as to when or if it was provided to Mrs Winterbotham. At this stage I note that, across four sides of A4, it provided the following information:

> **GUIDANCE NOTE – THE REMOVAL OF WISDOM TEETH**
>
> This leaflet has been designed to improve your understanding of any forthcoming treatment and contains answers to commonly asked questions. If you have any other questions that the leaflet does not answer, or you do not understand what you are reading or what we have told you and would like further explanation, please ask your surgeon or a member of staff.
>
> NICE (National Institute of Clinical Excellence) has issued guidance regarding removal of wisdom teeth. For ease of reference, the URL is appended below…
>
> ….
> **What does the treatment involve?**
> When taking out a wisdom tooth it is sometimes necessary to make a cut in the gum over the tooth. Sometimes it is also necessary to remove bones surrounding the crown (upper portion) or root of the wisdom tooth. Not infrequently the tooth needs to be cut into pieces to remove it. Once the wisdom tooth has been removed the gum is put back into place with stitches. In most cases dissolving stitches are used.
>
> The technique of coronectomy is also practiced by some surgeons. In this technique the upper portion of the wisdom tooth is removed leaving some of the tooth roots behind to minimise the risk of nerve damage. Studies suggest that there may be a reduced risk of inferior dental nerve injury (the nerve

giving sensation to the lower lip and skin over the chin, and lower jaw) using this technique.

However, there can be up to a 15% complication rate due to migration of the retained root or delayed healing resulting in a need for further surgery.

…

What are the possible problems and complications?

1. **Swelling and pain.**
   …
2. **Nerve injury when removing a lower wisdom tooth**

There are several potential complications in the removal of a lower wisdom tooth:

Altered sensation of the lower lip, chin and tongue, and altered taste - lower wisdom teeth can sit close to two nerves. One nerve supplies the sensation for the lower lip, chin, lower teeth and gums. Another supplies the sensation for the tongue. Injury can occur to these nerves as a result of lower wisdom tooth removal either as a result of the local anaesthetic injection (rare) or the actual removal of the tooth. For most patients, the risk of nerve injury is very small but for some the risk can be high. Nerve injury is usually temporary but, in some cases, can be permanent. Injury to these nerves can cause altered sensation on the lower lip, the chin, the lower teeth, the gums around the lower teeth and/ or the tongue and the skin around the lower jaw. This altered sensation may take the form of a light 'pins & needles' sensation through to total numbness and loss of sensation and or reduced/ altered taste. On very rare occasions injury can result in neuralgia (nerve pain) associated with these areas. The area of loss of sensation and function may affect a small area of the jaw around the affected wisdom tooth to the whole lower jaw and face around that wisdom tooth, i.e. loss of sensation to the facial skin in the lower third of the face, including the chin and lower lip, loss of sensation to the teeth and gums on the side of the affected wisdom tooth, and loss of taste function on the side of the affected wisdom tooth. An injury to the lingual nerve may result in alteration/ loss of taste in the front 2/3rd of the tongue.

A coronectomy is undertaken where only part of the wisdom tooth is removed to reduce the risk of nerve damage, leaving the root remnants close to the nerve. Up to 15% of patients who have this procedure done have complications afterwards in relation to pain and infection of the root remnants. These can then be subsequently removed when the procedure is usually simpler. This option can only be considered if the wisdom tooth is not decayed at the outset.

….

Falkner House Dentistry
[address]

Cambridge Minor Oral Surgery Service

Part of the Antwerp Dental Group

[bold in original]

14. It is common ground that, during the consultation, Mrs Winterbotham was supplied with a consent form, which she signed. I have italicised the handwritten entries below. It stated as follows:

Cambridge MOS
ORAL SURGERY SERVICES

EXTRACTIONS AND WISDOM TEETH REMOVAL WRITTEN INFORMED & CONTINUED CONSENT

Patient Name: Mrs Alison Winterbotham D.O.B. 30/07/1969

Clinician taking consent: Dr Arash Zaker Shahrak
Staff Present: Olga and Sarah Extraction Date 27/11/2020
Reason for the surgery that the dentist has explained *pain*

The dentist has explained alternative treatment(s) [left blank]

The following treatment will be performed [Upper 8 Right circled]

Other procedure(s) being performed: [left blank]
Anesthesia: local anesthesia [circled]

What are the risks associated with the procedure?

- Pain or soreness for up to 48 hours
- Swelling worst for the first two days, sore throat and difficulty opening your mouth and jaw joint pain or stiffness, muscle pain
- Bad breath from the clot and sensitivity of teeth adjacent to extraction socket
- Socket may still have a hole in the gum for up to three months

What are the complications associated with the procedure?

- Dry socket which presents as intense persistent pain 3-10 days after surgery in 5% of patients. You will need to have your socket irrigated as soon as possible. Please telephone for an appointment.
- Damage to adjacent teeth and bony structures may occur if they are heavily restored.
- Some parts of the roots of teeth may be left in the jaw or be displaced towards the maxillary sinuses or tissue spaces in the lower jaw.
- There may be a communication between your sinus and mouth ("oro-antral fistula"), which will require further treatment
- I confirm that I have never been prescribed [certain medications]
- **FOR LOWER WISDOM TEETH**: Inferior alveolar and lingual nerve injury (pain, altered sensation [pins and needles][1] or numbness of your tongue or lower lip and teeth and altered/loss of taste): Temporary 2% Permanent 0.5%
- If high risk lower wisdom tooth: Temporary 20% Permanent 2%

[1] These square brackets are in the original. All other square brackets are mine.

> [A handwritten asterisk was marked in the left hand margin adjacent to these last two indents.]
>
> Referral for Cone Beam CT scan required for assessment or for coronectomy? Y/N [Neither Y nor N was circled or marked]
>
> Additional Printed information provided: (indicate by circle)
> [No circle was marked]
>
> IV Sedation, wisdom teeth, extraction, post op care, Apicectomy, Biopsy, cyst removal.
> If you have any concerns, talk these over with your sedationist/ surgeon.
> Patient Questions? Y/N [neither Y nor N was circled]
> Additional Notes [left blank]
>
> I hereby confirm that I have been provided with sufficient information and given a **reasonable amount of time** to consider and fully understand the implications of the information before making my final decision
>
> Patient's name: Alison Winterbotham Date 27/11/2020 *[signature]*
>
> Clinicians name: Dr Arash Zaker Shahrak Date 27/11/2020 *[signature]*

[bold in original]

15. At this stage, I note that the risks to the lingual nerve and inferior alveolar nerve were treated compendiously. There was no attempt in the Guidance Note or the consent form to ascribe specific risks of injury to each nerve. I note also that the completed consent did not include a circle around the words "Additional Printed information provided", and nor was Y or N circled adjacent to "Patient Questions", or "The dentist has explained alternative treatment(s). By contrast, "Upper 8 Right" was circled, as was "local anaesthesia".

The Claimant's evidence

16. Mrs Winterbotham's account, as explained in her witness statement and in evidence was as follows. She said that she did not receive the Guidance Note at any time. It was not sent to her in advance of the consultation and nor was it provided at the surgery. She said that shortly after she arrived and before she sat down, Dr Shahrak said that he could take the tooth out that day. She said he was "very casual" about it and he gave the impression that it was "run of the mill treatment". There was no discussion at all about the consent form or the risks. She denied that she was taken through the consent form or that Dr Shahrak completed parts in pen in front of her. She said that she read it in silence. She "skimmed over it" but "didn't really pay any attention."

17. When it was pointed out to her that she signed a form which expressly referred to risks of nerve injury she said "I didn't think it would apply to me. I'd expect him to point out something specific to you." She said that he never said: "This applies to

you." She said that she trusted medical professionals and thought that if it applied to her, he would talk to her. She thought it did not apply to her as "he was so self-assured". She said that she would "not think a risk of 0.5% would be fine". Her assumption was that there was no risk to her as nothing was discussed. She contrasted Dr Shahrak's approach with her later surgery when the surgeon sat her down and explained in minute detail what would happen and drew diagrams.

18. Mrs Winterbotham said that she was not shown the OPG and it was not discussed. She denied that they discussed her occupation as a speech and language therapist; her recollection was that this was discussed at a later consultation. The next thing that happened was that Dr Shahrak said "you'll feel this", as he inserted the anaesthetic needle. Her husband was waiting for her in the car outside dealing with paperwork and making a phone call. He was able to calculate that the consultation lasted no more than 37 minutes.

The Defendant's evidence

19. Dr Shahrak said that he was very sorry that Mrs Winterbotham had suffered an injury, but said that this was the first time that it had happened in 24 years. His account in his witness statement was that the Guidance Note had been sent to Mrs Winterbotham in advance. This was also set out in the Defence which he signed with a statement of truth, and repeated in his witness statement. In his statement he said that he asked Mrs Winterbotham whether she had read it and she confirmed that she had. He asked her whether she had any questions about it and she said that she did not. In advance of the trial, Mrs Winterbotham's solicitors challenged this account and sought evidence that the Guidance Note had been posted or emailed to her. None was forthcoming. In an email dated 9th January 2024 from Dr Shahrak's solicitor a different account was provided. It said that Dr Shahrak gave Mrs Winterbotham the document in the front room of his premises, left her with it and then called her in to his surgery. In evidence he said that he did not remember this clearly, and he does not remember because of the "sheer volume of patients".

20. In his witness statement, Dr Shahrak said that – as well as taking Mrs Winterbotham through the Guidance Note – he took her through the OPG and went through the consent form in detail. He said that he explained the lingual and inferior dental nerve and where they were located in relation to the teeth. He said that he talked about the lingual nerve and Mrs Winterbotham said she knew about this because she was a speech and language therapist. He said that he went through the other risks that were explained in the leaflet, asked Mrs Winterbotham whether she had any questions and she confirmed that she did not. He said that it was his usual practice after going through the consent form to ask whether the patient has any questions.

21. In evidence Dr Shahrak said the content of the Guidance Note was no different to the consent form. He said the meaning was "exactly the same". This is plainly wrong. As was pointed out in cross-examination there is nothing on the Consent Form about (for example) coronectomy. He explained that when marking the consent form he circles Y if the answer is yes, but leaves it blank if the answer is no.

22. He conceded that he did not have a clear memory of the consultation. He accepted that he did not discuss coronectomy. When asked whether he was aware that the

referring dentist had categorised the extraction as "high risk" he said that he might have been aware of this but "it makes no difference as I have to assess it for myself". He denied that it was a high risk case. Whilst he thought that he would have discussed a CBCT because he discusses it "with every patient", he could not recall discussing it in this case.

23. Dr Shahrak said that he carried out the extraction in the same way that he carries out all such procedures, first by removing the crown and then removing the roots. He then sutured the wound. His note of the consultation recorded:

> Pat has been referred to OS services for the removal of LR8
> MH: Checked
> Valid continued and informed consent obtained.
> Consent verbally re-confirmed.
> Pat understood the risks involved in the surgical extraction.
> Infiltration/ ID block 2.2ml Lignospan 1:80000
> Extraction of LR8
> Post operative instructions given
> Pat discharged
> parts of the tooth (apcal quarter) might be in situ or may be it has been aspirated through the suction
> quantity (ml) 0.0
> Anaesthetic Used Articaine 45 1:100,000

24. It is notable that the method of extraction was not recorded. It is admitted in the Defence that this was a breach of duty.

Assessment of the lay witness evidence

25. In my judgment Mrs. Winterbotham was a careful and thoughtful witness. Her account of the consultation has remained consistent throughout. Her account that she was not supplied with the Guidance Note in advance has been shown to be correct.

26. Dr Shahrak is a highly experienced oral surgeon. In my judgment, no doubt with some justification, he has a high degree of confidence in his own abilities. When giving evidence he struck me was somewhat dismissive of the Claimant's case. On occasions, he talked over the Claimant's counsel and I had to intervene to ensure that she could complete her questions. (I also intervened to ensure that he was able to complete some answers.) Mrs Winterbotham described him in the consultation as "so self-assured". Ms Church's submission in closing was that he was "borderline arrogant".

27. When assessing the evidence as to what happened at the consultation, I bear in mind that the consultation was a routine event for Dr Shahrak, whereas for Mrs Winterbotham it was an unusual occasion and therefore more memorable. This cuts both ways. Dr Shahrak is less likely to recall the details of a consultation which was (for him) entirely routine, but there are certain procedures which he is likely to have followed as a matter of course or as part of his "modus operandi". So, for example, I

accept his evidence that he asked Mrs Winterbotham about her occupation because this is something which he said he always did because it was relevant to aftercare.

28. Dr Shahrak signed a statement of truth in relation to an account about the provision of the Guidance Note which turned out to be false. Furthermore, the consent form was materially incomplete; he did not indicate on the form that additional printed information had been provided, nor whether or not the Claimant had any questions. I consider that Ms Church's submission that Dr Shahrak was "borderline arrogant" is fair. I have no doubt that Mrs Winterbotham's characterisation of him as "so self-assured" is accurate. In my judgment there was a casualness about Dr Shahrak's approach to the procedure and informed consent, and this is probably explained by the fact that he carried out this procedure routinely and successfully many times a week. His casualness is illustrated by his failure to record the method of extraction, a failure fully to complete the consent form, his failure to ensure that Mrs Winterbotham had been supplied with the Guidance Note and had an opportunity to consider it, and his failure to check that she had been sent it before signing a statement of truth to that effect. In my judgment, the failure to supply the Guidance Note and the failure to complete the consent form fully provide strong support for Mrs Winterbotham's account that the risks of the procedure were not discussed with her. Thus, on the central issue as to what took place at the consultation, and specifically in relation to the discussion about risks and consent, I am quite satisfied that where Mrs Winterbotham's account conflicts with that of Dr Shahrak I should accept her account. This is subject to one point which (as explained above) is that I find he probably did ask her about her occupation because this was a standard question relevant to aftercare.

29. I find therefore find that Mrs Winterbotham was not supplied with the Guidance Document at any time. Her evidence on this point is strongly supported by the fact that that the consent form wording "Additional Printed information provided" was not circled despite the instruction on the form to "indicate by circle". In my judgment this can only be explained by the fact that Dr Shahrak felt that Mrs Winterbotham did not need to see it, and he did not need to check that she had seen it. I consider that Dr Shahrak's approach in this respect is probably explained by his high estimation of his own abilities, and the fact that he thought he was dealing with a straightforward procedure. In my judgment this led him to cut corners and not pay attention to detail. This is in turn supported by the fact that he did not make a note of the operation. It is also supported by the fact that he did not circle either Y or N in answer to the question "Patient questions?" or in answer to the question about referral for a CBCT. Dr Shahrak's evidence was that he circles Y if the answer is yes, but leaves it blank if the answer is no. I do not regard that as a proper way of recording the patient's answers.

30. I further accept Mrs Winterbotham's evidence that Dr Shahrak did not tell her that Dr Pontikis had noted that the extraction was "high risk", that he did not take her through the OPG, and that he did not take her through the consent form. I find that the asterisk next to the information about risks had been marked by him beforehand. The upshot was that Mrs Winterbotham was given the consent form to read without any additional explanation at the time and without having first received the Guidance Note.

31. I find that Dr Shahrak did not tell Mrs Winterbotham that hers was a "high risk" case, or that there was an increased risk of injury to the lingual nerve or the IAN, and this was because he did not think that it was a high risk case or that there was such an increased risk of injury. I find that there was no discussion of the risk of speech impairment (whether temporary or permanent) in the context of Mrs Winterbotham's occupation as a SLT. Indeed these points were admitted. Overall I find that there was no discussion as to the risks at all. I also find that the possibility of a coronectomy was not discussed, and the potential need for a CBCT was not discussed. Dr Shahrak could not recall talking to her about a CBCT and he admitted that a coronectomy was not discussed. This is because he did not think that a coronectomy would have been a suitable procedure for Mrs Winterbotham.

The allegations of breach

32. The allegations, as particularised in the Particulars of Claim are that Dr Shahrak:

    a. Failed to have regard to the OPG showing that the LR8 roots were in close proximity to the inferior dental canal and consequently that there was a high level of risk of damage to the IAN;

    b. failed to have regard to the OPG which showed distoangular impaction of LR8 and consequently an increased risk of damage to the lingual nerve;

    c. failed to identify that the Claimant's tooth was a high risk lower wisdom tooth as defined in the consent form;

    d. failed to obtain informed consent, specifically by failing to explain the procedure, explain the risk of nerve damage, inform the Claimant that she fell in to the category of high risk as defined in the consent form, failed to discuss coronectomy, and failed to find out what the Claimant wanted to know;

    e. Failed to carry out a CBCT scan;

    f. failed to offer or recommend a coronectomy.

33. Additionally it was alleged that Dr Shahrak failed to record the method of extraction. As I have noted above, this is admitted to have been a breach of duty. It is not alleged that this was causative of any injury. There were also allegations that Dr Shahrak made false records at two consultations when Mrs Winterbotham returned to see him after the extraction, and that there was a delay in referring her to a maxillofacial surgeon for remedial treatment, but these allegations were not pressed at trial.

Breach: the legal principles

34. The legal test for breach of duty was unsurprisingly common ground. It was famously set out by McNair J as a jury direction in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583 at 587 thus:

> "…[A surgeon] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… a man is not negligent, if he is acting in accordance with

such a practice, merely because there is a body of opinion who would take a contrary view."

35. Where the *Bolam* test applies, the reformulated question in this case therefore is whether no reasonably competent oral surgeon would have acted and exercised judgment as Dr Shahrak did.

36. In *Maynard v West Midlands RHA* [1984] 1 WLR 634 at 638, Lord Scarman elucidated the *Bolam* test in this way:

> "Differences of opinion and practice exist and will always exist in the medical and other professions. There is seldom only one answer exclusive of all others to problems of professional judgement. A court may prefer one body of opinion to the other; but that is no basis for a conclusion of negligence."

37. However, it is important to note that the *Bolam* test (also referred to as the professional practice test) is not applicable where the relevant allegation is that the clinician failed to obtain informed consent: see *Montgomery v. Lanarkshire Health Board (General Medical Council intervening)* [2015] UKSC 11. In *Montgomery* the Supreme Court distinguished *Bolam* and departed from *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871. Lord Kerr of Tonaghmore and Lord Reed JJSC delivered the leading judgment. Lord Neuberger of Abbotsbury PSC, Lord Clarke of Stone-Cum-Ebony, Lord Wilson and Lord Hodge JJSC all agreed and Baroness Hale of Richmond DPSC delivered a concurring judgment. Lord Kerr and Lord Reed held:

> "[82]. In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which you would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.
>
> [83] The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of medical members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment. The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.
>
> …

> [87] The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce* [1999] PIQR P53, subject to the refinement made by the High Court of Australia in *Rogers v. Whitaker* 175 CLR 479… An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.
>
> …
>
> [89] Three further points should be made. First it follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have on the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.
>
> [90] Secondly, the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form."

38. In *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 at [33] Hamblen LJ explained (by reference to the numbered paragraphs in *Montgomery*) that the test has two limbs:

> "(1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals [83].
>
> (2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine [83]. This issue is not therefore the subject of the *Bolam* test and not something that can be determined by reference to expert evidence alone [84-85]."

39. In *McCulloch v Forth Valley Health Board* [2023] UKSC 26, the Supreme Court addressed the requirement, established by *Montgomery,* that the clinician should advise the patient as to "any reasonable alternative or variant treatments". The single

judgment was given by Lord Hamblen and Lord Burrows JJSC with Lord Reed PSC, Lord Hodge DPSC and Lord Kitchin JSC agreeing. The Court held:

> "[56] In our view... the correct legal test to be applied to the question of what constitutes a reasonable alternative treatment is the professional practice test found in *Hunter v Hanley* 1955 SC 200 and *Bolam*…
>
> [57] A hypothetical example may help to explain, in more detail, how we regard the law as working. A doctor will first seek to provide a diagnosis (which may initially be a provisional diagnosis) having, for example, examined the patient, conducted tests, and having had discussions with the patient. Let us say that, in respect of that diagnosis, there are ten possible treatment options and that there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. Let us then say that the doctor, exercising his or her clinical judgment, and supported by a responsible body of medical opinion, decides that only four of them are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative treatments. The narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgment to which the professional practice test should be applied. The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the other three reasonable alternative treatment options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options.
>
> [58]. It is important to stress that it is not being suggested that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers. Rather the doctor's duty of care, in line with *Montgomery*, is to inform the patient of all reasonable treatment options applying the professional practice test."

40. In this case, as in all cases of professional negligence, the parties have adduced expert evidence supporting their positions. But I remind myself that, even where the *Bolam* test is applicable, the question as to whether breach has been established is ultimately a matter for the Court, not the experts. In this regard, the task of the Court is to "see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby assess its logic": see *C v Cumbria University Hospitals NHS Trust* [2014] EWHC 61.

41. Where the *Bolam* test is applicable, I must consider whether the body of opinion relied upon is "responsible, reasonable and respectable" and whether it has "a logical basis": see *Bolitho v. City and Hackney HA* [1988] AC 232 per Lord Browne-Wilkinson at 241:

> "These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence

> (I am not here considering questions of disclosure or risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily pre-supposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

42. When approaching the expert evidence I bear this all in mind.

Professional Guidelines

43. Both parties relied on professional guidelines. I was referred to *Parameters of care for patients undergoing mandibular third molar surgery, 2020.* This was produced by The Faculty of Dental Surgery of the Royal College of Surgeons of England. The summary states that it aims to provide "a comprehensive guideline for the clinical management of patients undergoing third molar surgery." It provides:

> **"…**
>
> **Assessment of patients with M3Ms[2]**
>
> Where conventional imaging has shown a close relationship between the third molar and the inferior dental canal, cone beam computed tomography (CBCT) may be of benefit. On plain film the three most significant radiological signs are diversion of the IAN canal, darkening of the root and interruption of the cortical white line. If CBCT is unavailable, then computed tomography (CT) can be used instead, but the limited field of view of CBCT is advantageous in terms of image reconstruction and radiation dose. The key information to be ascertained, is whether there is direct contact between the inferior dental canal contents and the third molar, or whether a bony wall exists between them. There is evidence that preoperative CBCT does not offer any benefit to

[2] Mandibular third molars, or wisdom teeth

patients in terms of reducing the incidence of inferior alveolar neurosensory disturbance. As the radiation dose and financial costs are higher than for conventional imaging, CBCT should not be used routinely when assessing M3Ms.

Where conventional imaging has shown a close relationship between the M3M and the IAN canal, CBCT may be considered in carefully selected cases where the findings are expected to alter management decisions.

…

Coronectomy

Coronectomy is an alternative method for management of M3Ms that are in close approximation to the inferior dental canal and is effective in minimising inferior alveolar nerve injury. However there are strict criteria on patient selection. The risks of coronectomy include the possibility of infection and pain, and the potential future need for removal of the roots…

Valid Consent

It is difficult to predict the long term outcome for asymptomatic third molars that are disease free. It is reliant upon the clinician's experience and expertise in collating the information gathered from the assessment process and then, weighing up the probability and severity of the risks. The clinician is required to communicate and explain the risks and benefits accurately and effectively to the patient, in order to obtain valid and informed consent.

Patient involvement is paramount when making the decision about third molar management. The findings of the assessment, the risk status, and the options along with their risks and benefits all need to be communicated at a level the patient can understand to assist in their decision making. Clear and comprehensive documentation is essential. Clinicians must now ensure that patients are aware of any 'material risks' involved in a proposed treatment and of reasonable alternatives, including conservative management, following the *Montgomery v. Lanarkshire Health Board* judgment. The Bolam test no longer applies to the issue of consent.

Any difficulty in comprehension of the risks and benefits of the proposed care, must be addressed. The patient must be appraised of potential complications and sequelae, for example; a dry socket or nerve injury. There are several patient leaflets available…"

44. The Claimant's expert, Professor Harding, also relied upon "*Standards for the Dental Team"* issued by the General Dental Council. This stated:

"3.1.1 You must make sure you have valid consent before starting any treatment or investigation…

3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in

verifying that a patient has given consent, it is the discussions that take place with the patient that determines whether the consent is valid.

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

- Options for treatment, the risks, and the potential benefits;
- why you think a particular treatment is necessary and appropriate for them;
- the consequences, risks, and benefits of the treatment you propose;

…

3.1.4 You must check and document the patients have understood the information you have given.
…"

The expert evidence on liability

45. On questions of breach, the Claimant relied upon the evidence of Professor Stewart Harding. He holds a number of dental academic appointments. He is a specialist in implantology. Unlike Dr Shahrak he is not registered in England as an oral surgeon, but he does undertake extractions and coronectomies, mainly in Dubai.

46. Professor Harding's view was that the OPG showed a distoangular impacted LR8, and distoangular impaction of LR8 is associated with an increased risk of damage to the lingual nerve as it often entails removal of overlying bone. He considered that the OPG showed that it was obvious that the location and orientation of the Claimant's LR8 meant that any surgery would have required removal of the distal overlying bone and a "need to work in that area" which would in turn give rise to an increased risk of injury to the lingual nerve.

47. He further considered that the OPG showed a narrowing of the inferior dental canal which indicated a close proximity between the impacted LR8 and the inferior alveolar nerve. Whilst he declined to put a precise percentage on the risk, this meant that it was a high risk extraction within the terms of the consent form. He considered that Dr Pontikis was correct in concluding that this was a high risk extraction. His view was that, where the referring dentist had assessed the extraction as being high risk but the treating dentist disagreed, it would be "mandatory" when obtaining the patient's consent to explain that the referring dentist had assessed the risk as high risk and the reasons why the treating dentist disagreed, and this should be recorded in the notes. He thought that the *Rood* paper (relied upon by Professor Watt-Smith) was out of date and had been supplemented by more recent information including the use of CBCT imaging in appropriate cases.

48. Noting the Claimant's evidence as to how the consent procedure was undertaken, he commented: "Simply being given a piece of paper and being asked to sign it is inadequate consent. This falls below a reasonable standard and is breach of duty." He accepted that, if the Guidance Note had not been seen by the Claimant but the risks outlined on the consent form were discussed with her, that would be a sufficient discussion in relation to nerve injury.

49. His view was that, in light of the OPG, no reasonable body of oral surgeons would have failed to discuss coronectomy. A CBCT would be required to assess whether a coronectomy would be appropriate.

50. The Defendant relied upon the evidence of Professor Stephen Watt-Smith. He is a retired Emeritus Consultant Maxillofacial Surgeon employed until 2014 by the Oxford Radcliffe NHS Trust. He now has an academic appointment at the Eastman Dental Institute at University College London. Whilst he teaches extractions, he has not undertaken one himself for six years.

51. His view before cross-examination was that LR8 was not distoangularly impacted and so there was no increased risk to the lingual nerve. On the basis of the OPG he thought there were no radiological signs which suggested that the IAN was at an increased or high risk of injury as a result of proximity to the LR8 roots. In this respect he relied heavily upon a paper by *J P Rood et al* (1990) which concluded that the signs which were diagnostic of an increased risk of IAN injury were darkening of the roots, diversion of the canal, and interruption of the cortical white line. He thought that there was no justification for a CBCT, especially in light of the additional radiation risk that this would entail. His view was that the information on the consent form was appropriate, although he accepted that the discussion was important.

52. Professor Watt-Smith made important concessions in cross-examination. He agreed that if Dr Shahrak had not gone through the consent form, and discussed Mrs Winterbotham's employment and the risks, then that would not be a proper way to consent her. He accepted that it would be appropriate for the Claimant to see the Guidance Note and that this would be a good standard of practice. He agreed that if she was not given the document, she was not validly consented. He agreed that the Claimant was entitled to know that, having regard to her anatomy, there was a specific risk of injury to her lingual nerve and of the need to "work in that area". He did not expressly concede that there was an increased risk to the lingual nerve but that is the logical implication of this evidence. He further accepted that Mrs Winterbotham should have been advised as to the alternative treatment of coronectomy, and he accepted that this would have been a safer treatment and less likely to damage the lingual nerve. There was then this exchange:

> Q: Had things gone how they ought to have gone, before Mrs Winterbotham opened her mouth, she would have known about the specific risk to her lingual nerve, the IAN and the treatment option of coronectomy.
> A: She was entitled to it.
> Q: She was entitled to decide what to do with that information.
> A: Yes

53. Professor Watt-Smith was however clear that he would not have carried out a coronectomy on Mrs Winterbotham himself. This was because he did not favour coronectomies at all, seemingly in any case. He appeared later also to retract his concession that Mrs Winterbotham should have been offered a coronectomy. He did not ultimately accept that there was an increased or high risk of injury to the IAN, and this was because the three key *Rood* signs were not present on the OPG.

54. On issues of causation, condition and prognosis, the Claimant relied upon the evidence of Mr Laurence Newman, a consultant oral and maxillofacial surgeon at the

Queen Victoria Hospital, East Grinstead. The Defendant relied upon Professor Watt-Smith. It was agreed between Mr. Newman and Professor Watt-Smith that the risk of lingual nerve injury would have been lower if a coronectomy had been performed. Mr Newman explained in evidence that, with a coronectomy the bone could be removed on the buccal (cheek) side, and the crown can be removed from the buccal side. With an extraction the distolingual bone may have to be removed so as to facilitate the removal of the roots. This was agreed by Professor Watt-Smith in cross-examination.

Assessment of the expert evidence on liability

55. I am quite satisfied that all three experts were suitably qualified to opine on the issues in the case and were doing their best to assist the Court. Ultimately, in light of Professor Watt-Smith's concessions, the differences between him and Professor Harding were significantly narrowed. Where their views differ, I prefer the evidence of Professor Harding. His evidence remained broadly consistent throughout whereas, as I have explained, Professor Watt-Smith made important concessions. He conceded that the Claimant should have been offered a coronectomy and then retracted the point. The fact that he readily altered his opinion on key points suggests to me that there was a lack of clarity and rigour in his analysis. I formed the clear view that Professor Harding was more up-to-date and this is evidenced by the facts that Professor Watt-Smith has not undertaken an extraction for six years and seemingly would not favour a coronectomy in almost any case, whereas the *Parameters* document makes it clear that coronectomy is an appropriate alternative treatment in suitable cases. Furthermore, in my judgment Professor Watt-Smith's initial views on consent did not take full account of the Claimant's evidence and to some extent appeared to reflect an older practice which prevailed before *Montgomery.* This was evidenced by the fact that when considering informed consent, he emphasised that Mrs Winterbotham could be expected to have relevant knowledge (a) because she had undergone previous extractions (although they were many years previously) and, (b) because, since she was a SLT, she could be expected to have some understanding of the risks to her nerves. In my judgment, this approach failed to have proper regard to the *Montgomery* requirement that it is for the clinician to find out what the patient needs and wants to know. In my judgment the clinician should not make assumptions about the patient's knowledge or understanding.

Breach: Analysis

56. I deal first with the risks. Following *Montgomery* as explained in *Duce,* the assessment of the risks is a matter falling within the expertise of medical professionals.

The risk to the lingual nerve

I find first of all that Mrs Winterbotham's LR8 was distoangularly impacted. This was Professor Harding's view and it was essentially conceded by Professor Watt-Smith. I find that the extraction therefore involved an increased risk of injury to Mrs Winterbotham's lingual nerve. This was Professor Harding's view and I accept it. He did not seek to put a percentage on the risk, but he was clear that there was an increased risk. Distoangular impaction meant that it may have been necessary to remove distolingual bone and "work in the surrounding area". In my judgment

Professor Watt-Smith impliedly accepted that there was an increased risk to the lingual nerve because he accepted that Mrs Winterbotham should have been told of the risk to the lingual nerve and of the need to "work in that area". Furthermore, he accepted that coronectomy would have presented a lower risk to the lingual nerve than an extraction because it would not have been necessary to remove distolingual bone.

57. Mr Duffy relied upon the fact that Mr Newman said in the course of cross-examination that he was not aware until this case that distoangular teeth have the highest incidence of lingual nerve damage. The point was not followed up. But assuming that is correct, it does not follow that distoangular impaction does not cause an increased risk to the lingual nerve.

The risk to the inferior alveolar nerve

58. Professor Harding concluded that the OPG showed a narrowing of the inferior dental canal and a close proximity between the roots of LR8 and the inferior alveolar nerve. Professor Watt-Smith agreed that the roots were in close proximity to the inferior alveolar canal, but he did not accept that the inferior dental canal was narrowed. The OPG was not presented in Court. I was not asked to decide what it actually showed, and I am not in a position to do so.

59. Professor Harding's conclusion was that there was a high risk to the IAN, whereas Professor Watt-Smith thought it was an ordinary risk. Professor Watt-Smith's view that there was no increased risk of injury to the IAN was based upon his interpretation of the OPG. This conclusion relied in turn upon the *Rood* signs alone. I prefer Professor Harding's view. This is because I consider that there is good evidence that reliance upon the *Rood* signs alone is out of date. As Mr Newman pointed out, an OPG is a two dimensional image of three dimensional anatomy. Mr Newman said that many junior practitioners would not have heard of *Rood* and indeed Dr Shahrak was not aware of the paper. It is true that the *Parameters* document referred to the *Rood* signs as the three most significant radiological signs, but it also explained that "the key information to be ascertained is whether there is direct contact between the inferior dental canal contents or the third molar, or whether a bony wall exists between them." Furthermore (at p83) it identified additional information which could be derived from CT and CBCT imaging:

> "Features associated with an increase in neurosensory damage include narrowing of the IAN canal, direct contact between the IAN canal and the root, fully formed roots, a lingual course of the IAN canal with or without cortical plate perforation and an intraroot course of the canal. The strongest indicators are narrowing of the IAN canal and direct contact of the roots with the canal…"

60. I have given careful consideration to Professor Watt-Smith's opinion that it was reasonable to conclude on the basis of the OPG alone that the risk to the IAN was an ordinary risk. I am not confident that I can place weight on this opinion. I have already noted that he has not undertaken an extraction for six years, that there was a lack of clarity in his analysis, and his approach to consent held echoes of an older practice. Professor Watt-Smith explained that the *Rood* paper is on the curriculum as

the Eastman Institute where he teaches and I accept that the three *Rood* signs are referred to in the *Parameters* document as being key OPG signs. It does not follow however that it was reasonable to advise that there was an ordinary risk to the IAN based upon interpretation of the OPG alone. I am satisfied on the evidence overall that, in advancing that opinion, Professor Watt-Smith relied upon an outdated practice which has been overtaken by advances in imaging technology. In my judgment the close proximity of the root to the IAN as shown on the OPG would have led all reasonable practitioners to require (or at least offer) a CBCT scan. To the extent that is necessary to do I conclude that Professor Watt-Smith's view was not reasonable and hence (per *Bolitho*) could not be a view held by a reasonable body of practitioners. I conclude therefore that it was not reasonable for Dr Shahrak to conclude on the basis of the OPG alone that the risk to the IAN was an ordinary risk.

Informed consent

61. I turn next to deal with the question of informed consent when judged against the *Montgomery* standard. In light of my findings of fact, it is quite clear that Dr Shahrak failed to obtain Mrs Winterbotham's informed consent. Specifically, he failed to provide her with the Guidance Note, failed to discuss the material risks with her, failed to find out what Mrs Winterbotham needed to know, and failed to discuss coronectomy as a suitable and safer alternative treatment. These were all identified as failings by Professor Harding and essentially conceded by Professor Watt-Smith.

62. What should have happened is that Mrs Winterbotham should first have been supplied with the Guidance Document in advance. At the consultation she should have been taken through the consent form by Dr Shahrak. This should have entailed a meaningful opportunity to ask questions and a discussion of the material risks that were relevant to her. The material risks in this case were the increased risk to the lingual nerve and the high risk to the IAN. The specific adverse consequences of nerve injury and its potential effect on her tongue and speech should have been discussed in the context of her occupation as a speech and language therapist. This is because (per *Montgomery* at [87]) Mrs Winterbotham was likely to attach significance to the risks and Dr Shahrak was or should reasonably have been aware that she would be likely to attach significance to it.

63. The Defendant relies upon the signed confirmation on the consent form to the effect that Mrs Winterbotham had been given sufficient information and a reasonable period of time within which to consider it. I reject this submission. The reality is that she was in no position to confirm that she had been given sufficient information or time because she did not know what information she should have been given. In my judgment, this was a clear case of Dr Shahrak "routinely demanding her signature on a consent form", the very practice criticised in *Montgomery* at [90]. It cannot amount to informed consent.

64. On the question as to what Mrs Winterbotham should have been told as to the risks, I am satisfied on the evidence overall that she should have been told that her lingual nerve was at increased risk of injury because of the need to work in that area and remove distolingual bone. Mrs Winterbotham should have been taken through the OPG and she should have been told that the roots were in close proximity to the IAN and that this was a high risk extraction for the IAN.

65. Even if I am wrong in rejecting Professor Watt-Smith's opinion that she could reasonably have been told that the risk to the IAN was an ordinary risk, Mrs Winterbotham should have been told that Dr Pontikis regarded this as a high risk extraction, although Dr Shahrak could then have explained why he disagreed, assuming that was the case.

66. But, regardless of whether the risk to the IAN was high risk or ordinary risk, the increased risk to the lingual nerve meant that this extraction was a "high risk" one within the terms of the consent form. This is because the consent form did not distinguish between risks to the lingual nerve and the IAN but treated them compendiously. The Guidance Note adopted the same approach. It was therefore not possible to treat this as an "ordinary risk" procedure. Dr Shahrak appeared to believe that the risks would have been lower in his hands. If there was any basis for that belief (for example by auditing his practice) it was not advanced in evidence. Accordingly Mrs Winterbotham should have been told that her extraction was a high risk one within the terms of the consent form and accordingly that it carried a 2% risk of permanent nerve injury, and a 20% risk of temporary injury.

67. Finally, Mrs Winterbotham should have been told of coronectomy as a reasonable alternative treatment. Professor Watt-Smith accepted this point, though he later seemed to retract it. In my judgment, he was right to accept it; coronectomy is specifically addressed in the surgery's own Guidance Note and in the *Parameters* document and so there is no doubt that it should have been discussed with Mrs Winterbotham. The risks associated with a coronectomy should have been explained (specifically the 15% risk of a revision procedure), but she should also have been told that it would reduce the risks of injury to both nerves as compared with an extraction. It follows that she should also have been told that a CBCT would be required before a coronectomy could be undertaken.

68. Accordingly, I conclude that Dr Shahrak was in breach of duty in that he failed to (a) provide the Guidance Note, (b) provide a meaningful opportunity to ask questions and discuss the procedure; (c) explain the material risks, specifically (i) that there was an increased risk of injury to the lingual nerve, (ii) that there was a high risk of injury to the IAN, (iii) and that (whether or not there was a high risk to the IAN) this would be a high risk extraction within the meaning of the consent form. He further failed (d) to explain that a coronectomy would be a reasonable alternative procedure with a lower risk of nerve injury.

Causation

69. The question is what, on the balance of probabilities, Mrs Winterbotham would have done if Dr Shahrak had obtained her informed consent before proceeding. The circumstances were that she had been suffering from recurrent troublesome symptoms since June 2020. She had repeated episodes of pericoronitis. In her own words, it had started to frustrate her and she "wanted to get it sorted". Mrs Winterbotham clearly wished to have the situation resolved and she was unwilling to wait for treatment on the NHS.

70. I bear in mind that whilst Mrs Winterbotham should have been given the appropriate information about the risks and coronectomy, Dr Shahrak could nonetheless still reasonably have offered an extraction, and this would have been the simplest and cheapest option. It would have been reasonable to explain also that a coronectomy would entail delay while a CBCT was obtained.

71. The Claimant's primary case is that, but for the negligence, she would have undergone a CBCT, following which, on the balance of probabilities, she would have had a coronectomy and would have avoided all nerve damage. Her alternative case is that she would not have consented to extraction on the day, (because she would have gone away to think about it) and so she would have avoided all nerve damage.

The Claimant's primary case: she would have had a coronectomy

72. In her witness statement Mrs. Winterbottom addressed the question as to what she would have done if she had been made aware that she was at higher risk of damage to the lingual nerve due to the proximity of her tooth to the inferior dental canal. That was a misunderstanding of the position because it was the inferior alveolar nerve, not the lingual nerve, that was at risk due to the proximity of the tooth roots. In examination in chief she clarified that this should have been a reference to nerves generally rather than the lingual nerve, and that she would have been concerned about a higher risk of injury to any nerve. In her statement, she went on to say that she was certain that she would not have proceeded with an extraction on that day. She would certainly have requested a CT scan if this had been discussed with her, and she would have asked about having the extraction done under general, rather than local, anesthetic. She said that, as an experienced speech and language therapist, she was already aware of the potential impact and implications of damage to the lingual nerve in terms of sensation, pain, eating and speech, so she would not have taken the extraction so lightly if she had known about the increased risk of the procedure. She said "I'm not a risk taker in life, I tend to be cautious and carefully consider my options." She said she would have asked Dr Shahrak about any alternative treatments and it would have put her off proceeding with the extraction on that day. She would have wanted to go home and discuss the situation and options with her husband before making a decision.

73. In her oral evidence Mrs Winterbotham was adamant that she would not have proceeded with the extraction in the chair if she had been told that there was an increased risk of nerve damage, regardless of which nerve was involved. She said that the cost of a CBCT and the additional dose of radiation would not have put her off if it had been proposed, and she would definitely have had a CBCT scan if it would have shown more accurately whether her nerves were at risk. The 15% risk of a revision procedure which coronectomy entailed would not have put her off. She did <u>not</u> say that she would definitely have sought a coronectomy, but she was clear that she would not have gone ahead with an extraction at the time.

74. Now that it is known that Mrs Winterbotham suffered a nerve injury as a result of the procedure, I am acutely aware of the need to guard against hindsight when assessing what Mrs Winterbotham would have done if she had been properly advised and her informed consent had been obtained. She would have been told of a 2% risk of permanent injury, as opposed to a 0.5% risk. This was a fourfold increase in risk but a

relatively small risk nonetheless. I bear in mind that her wisdom tooth was causing pain and discomfort and she was plainly anxious to have this resolved.

75. In my judgment Mrs Winterbotham is a careful, thoughtful and deliberative person. Her evidence in relation to her career and life choices supports this. She discusses important decisions with her husband. He was waiting outside in the car for her. She said that she is not a risk taker in life, and I accept that. In my judgment, on the balance of probabilities, faced with the information to which she was entitled, she would have wanted to consider and discuss it further. I accept the Claimant's evidence on causation as credible and plausible. She did not go so far as to say that that she would have sought a coronectomy, and it is perhaps to her credit that she did not feel able to say that she would definitely have sought a coronectomy. In *Chester* at [40] Lord Hope noted the trial judge's observation that it was a sign of the Claimant's truthfulness that she did not attempt to claim that she would never have undergone the operation if properly advised of the risks. The same point applies here.

76. I find that if Mrs Winterbotham had been given the information to which she was entitled she would have asked for a CBCT scan.

77. Upon the assumption that Mrs Winterbotham sought a CBCT, then she would have returned to Dr Shahrak to discuss the results. On the question as to what a CBCT would have shown, the Claimant relied upon the expert evidence of Mr Newman. He thought that the CBCT would have confirmed the close proximity of the LR8 to the inferior alveolar canal as suggested by the OPG. In evidence he described this as a "warning sign". Professor Watt-Smith (relying on *Rood*) thought that this was not a sufficient reason to avoid extraction. I have already expressed my misgivings about Professor Watt-Smith's evidence and on this point I prefer the evidence of Mr Newman.

78. Dr Shahrak does not undertake coronectomies, and he may still reasonably have proposed an extraction in light of the CBCT findings. But he should have dispassionately explained the pros and cons of a coronectomy. Ms Church submitted that, objectively a coronectomy was a much better choice for Mrs Winterbotham given that it reduced the risk of damage to <u>both</u> nerves and it would have been just as likely to solve her pericoronitis because the crown would have been removed. I accept this submission. As Mr Newman put it, a coronectomy "kills two birds with one stone" because (a) crown removal is simpler, and (b) it reduces the risk of nerve damage because the roots are not removed. It is true that a coronectomy would involve additional expense and a 15% risk of a revision procedure. It would also involve delay in circumstances where Mrs Winterbotham was anxious to have the situation resolved. But, on the basis that Mrs Winterbotham had known that there was a 20% risk of temporary nerve injury and a 2% risk of permanent nerve injury, a risk to her lingual nerve due to the distoangular impaction of her tooth, that the roots of her tooth were close to the inferior alveolar nerve, and a coronectomy would have reduced the risk of injury to both those nerves, then I find on balance that she would have decided upon a coronectomy. In my judgment this is a logical and sensible train of reasoning which is entirely explicable on the basis of the information which should have been made available to her at the time, and does not have regard to hindsight. It is consistent with the cautious, deliberative and risk averse approach which I find that she would have adopted.

79. It was agreed between Mr Newman and Professor Watt-Smith that on the balance of probability the lingual nerve injury was caused by a surgical instrument, most likely the burr attached to the dental drill, penetrating the lingual plate of bone.

80. Dr Shahrak denied that it was necessary for him to cut the bone. Rather he described the bone "breaking off". It was not entirely clear what he meant by this and Mr Newman said that he had never seen that in 40 years unless the bone had first been weakened by a surgical instrument. I accept Mr Newman's evidence on this point.

81. Mr Duffy submitted that, even if Mrs Winterbotham had undergone a coronectomy, then it is likely that she would still have suffered the same injury to her lingual nerve in any event. This submission was based upon the factual evidence as to how the nerve was damaged by the dental burr when removing distolingual bone. I reject that submission for two reasons. First, a coronectomy is a different procedure which carries a lower risk. It would have been carried out on a different day by a different surgeon and the risk of injury would not have been the same as for an extraction. Secondly, I accept the evidence of Mr Newman that it is very unlikely that it would have been necessary to remove the distolingual bone in the course of a coronectomy.

82. It follows therefore that I find that, but for the Defendant's breaches, Mrs Winterbotham would not have undergone an extraction at all and on the balance of probabilities she would have avoided all nerve injury.

The Claimant's secondary case: she would have deferred her surgery

83. It follows therefore that Mrs Winterbotham succeeds on breach and her primary case on causation. Strictly speaking, the Claimant's secondary case on causation does not arise but, since the point was fully argued, and in deference to Mr Duffy's careful submissions on the law, I will state my conclusions.

84. The Claimant's alternative case was that, even if she would not have chosen a coronectomy, if she had been properly warned about the risks, she would in any event have wished to consider her options further and she would not have undergone an extraction on 27th November. On that basis, it was submitted that the principle in *Chester v Afshar* [2004] UKHL 41, [2005] 1AC is engaged.

85. Putting on one side the question as to whether Mrs Winterbotham should have been told about a coronectomy, I find as a fact that if she had been told (as she should have been) that this was a high risk procedure as identified in the consent form, then that alone would have been sufficient for her to decline to undergo an extraction on 27th November. I find that she would have wanted to go away, think about it and consider her options. I turn now to consider the legal consequences of that finding.

86. The ordinary principle is of course that where there is a negligent failure to give advice as to a risk, the Claimant must prove on the balance of probabilities that, if properly advised, she would have taken steps to avoid or reduce the risk: see *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134*C* at [29] per Lord Hoffman. However, where the relevant breach relates to a failure to advise the patient about the risks of surgery then the ordinary principle is subject to the modification fashioned by the

House of Lords in *Chester*. That case concerned a surgeon's failure to warn of a 1-2% risk of cauda equina syndrome which eventuated at surgery. The trial judge did not find that the claimant would never have undergone the surgery if properly warned, but he did find that she would have deferred it. In other words, but for the negligence, she would have undergone the same procedure carrying the same risks but on a different day. At [87] Lord Hope held:

> "I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty."

87. The principle which may be extracted from this case is that where there has been a failure to explain a material risk and the patient suffers an injury which is a result of the risk which should have been warned about but, if properly advised of the risk, she would have undergone the same procedure on a later date, causation is established. *Chester* has attracted a good deal of controversy: see for example Leggatt and Hamblen LJJ (as they then were) in *Duce,* and the powerful dissenting speeches of Lords Hoffman and Bingham of Cornhill in *Chester*, but there is no doubt that it is binding on me.

88. It is important to note that the principle relates to a failure to warn of a material risk which subsequently eventuates. It does not apply to other failures in relation to consent, for example a failure to advise as to alternative treatment options. In that situation the ordinary causation principle applies. This is clear from the decision of the Court of Appeal in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356. In that case the *Chester* principle was held not to apply in a case concerning surgical treatment of recurrent neuroma where the alleged failure was one to warn that planned surgery may not be carried out in full. Referring to *Chester* Simon LJ held at [24]:

> "Each of Lord Steyn, Lord Hope and Lord Walker endorsed the opinions of the other; and in my view the ratio of the decision is contained in [87] of Lord Hope's opinion. If there has been a negligent failure to warn of a particular risk from an operation and the injury is intimately connected to the duty to warn, then the injury is to be regarded as being caused by the breach of the duty to warn; and this to be regarded as a modest departure from established principle of causation."

89. Mr Duffy emphasised that the principle applies where the failure to warn applies to the risk that eventuates. He relied upon the decision of the High Court of Australia in *Wallace v Kam* [2013] HCA 19. In that case the claimant was not warned of the risks of temporary neuropraxia and paralysis following spinal surgery. If properly advised he would have accepted the former but not the latter. He went on to suffer a temporary neuropraxia. The Court held that the claimant could not be compensated for the eventuation of a risk which he was prepared to accept: see [39]. This is not binding on me, but it is consistent with the approach adopted by the House of Lords in *Chester* as explained in *Correia.* I accept this proposition of law.

90. Mr Duffy next submitted that the alleged shortcoming in the explanation of the risk related to the enhanced risk of injury to the IAN, but an injury to the IAN did not eventuate, and thus *Chester* is not applicable. I reject this submission for two reasons. First, there was on the basis of my findings of fact a clear failure to advise of the enhanced risk of injury to the lingual nerve, and that was precisely the injury which eventuated. Secondly, whilst it is not strictly necessary for me to go this far, I would hold that the principle in *Chester* is engaged anyway because the consent form referred to nerve injury risks compendiously and did not distinguish between the two nerves. The distinction in the form was between ordinary and high risk of nerve injury. Neither party has suggested that an alternative approach to quantifying the risks would have been appropriate. The relevant breach was a failure to advise that this was a high as opposed to ordinary risk procedure when looking at the lingual nerve and IAN together. Nerve injury eventuated and that was precisely the injury which should have been warned about.

91. Mr Duffy further submitted that *Chester* is distinguishable because that was a case where no warning was given in relation to the risk which eventuated, whereas in the present case there was at least a warning of potential nerve injury, including injury to the lingual nerve. I reject this submission. It is common ground that the principle in *Chester* is a modification of the ordinary rules of causation. But I see no principled basis for distinguishing between a case where there has been no warning and a case where there has been an inadequate warning. In both cases there was a negligent failure to warn and, but for the failure to warn, the procedure would not have taken place when it did.

92. Accordingly I conclude that the Claimant succeeds on both her primary and alternative cases on causation. I find that, but for the negligence she would have undergone a coronectomy. In the alternative, I find that if she had been properly advised about the material risk of nerve damage (which risk eventuated), she would at the very least have deferred her surgery, *Chester* applies and causation is established.

Quantum

93. I turn now to consider quantum. There is little agreement between the parties. The Schedule puts the claim at £956,523 including general damages and interest whereas the Counter-schedule concedes £76,670.

94. The parties have helpfully agreed a Schedule which summarises the Court's award. It is attached to this Judgment.

The evidence as to condition and prognosis

95. In relation to condition and prognosis, the Claimant relied upon the evidence of Dr Newman and the Defendant relied upon Professor Watt-Smith. The parties also adduced the following additional medical evidence: pain medicine (Dr Richard Sawyer for the Claimant and Dr Andrew St Clair-Logan for the Defendant); psychiatry (Dr Pablo Vandababeele for the Claimant, and Dr Trevor Turner for the Defendant); and speech and language therapy (Dr Sylvia Taylor-Goh for the Claimant

and Ms Robena Dhadda for the Defendant). The speech and language therapy experts gave evidence; the other evidence was agreed.

96. In March 2022 Mrs Winterbotham underwent microsurgical neurolysis of her right lingual nerve with the aim of easing her symptoms. It was established during the procedure that the nerve had been almost completely severed in the course of the extraction. Unfortunately, neurolysis made no real difference to Mrs. Winterbotham's symptoms. She has tried a number of different pain management medications to treat the pain. Her evidence is that the current position is that she has constant and severe burning pain, numbness and pinprick-like tingling on the upper right side of her tongue and numbness on the right underside of her tongue. She also describes a dull ache nerve pain in the lower inner right gum which becomes a sharp pain when touched. She says that this pain and altered sensation have been unremitting and constant ever since the anaesthetic wore off after her wisdom tooth was removed. The pain is exacerbated by talking and eating. It makes her tired, tense, frustrated and unhappy. It is painful to brush her teeth on the right. She has lost the ability accurately to feel the position of her tongue in her mouth. She often bites her tongue when eating or speaking. She describes chronic pain. Her sleep is disturbed. She tries to avoid biting her tongue by making smaller, slower and more careful movements of her tongue and jaw. This makes talking more effortful and increases the muscle tension around her jaw. Mrs Winterbotham believes that the altered sensation has given her a slight lisp. In the witness box she described great pain and discomfort and said her mouth felt like it was “on fire”.

97. Mrs Winterbotham has difficulties with hot drinks and very cold drinks. Spicy or salty foods make the pain and burning sensation worse. She avoids going out for a meal as it is difficult to eat in public. She believes that the taste sensation on the right side of her tongue has been reduced. She avoids foods which are crumbly or which may leave debris in her mouth. She has to pace herself and limits how much she can talk. Her social life is not as busy as used as it used to be. She says that she has lost hope that her symptoms will improve. For a period of time when the injury first happened, she felt suicidal. She still has episodes when she feels very low, and she describes suicidal ideation. She feels exhausted at the end of each day.

98. I accept Mrs Winterbotham’s account of her symptoms. When she gave evidence I did not notice a lisp or any outward sign of marked discomfort. She declined breaks.

99. Mr. Newman and Professor Watt-Smith agreed that there has been a loss of sensation in the tongue, and continuing dysesthesia causing pain in the right side of the tongue. They accepted that the Claimant has altered taste. From the maxillofacial viewpoint, they considered that the Claimant had reached a plateau and that her symptoms should be regarded as permanent.

100. The pain medicine experts agreed a diagnosis of chronic post surgical or post traumatic pain and chronic neuropathic pain. They agreed that the chronic neuropathic pain has an impact on the Claimant's psychological well-being and that psychological distress such as depression and anxiety increases the perception of chronic pain. They agreed that the Claimant’s chronic pain had affected the quality of her sleep, her ability to eat and drink and her ability to speak and work. They agreed that the Claimant is disabled within the definition of the *Disability Discrimination Act 1995*.

They recommended pain management psychotherapy of 10 to 15 sessions. As for the prognosis, they agreed that the Claimant will have permanent right sided lingual nerve neuropathic pain. They considered the pain symptoms have plateaued and will not deteriorate further, although it is recognised that the impact of chronic pain experience may diminish with time as the patient becomes used to or tolerates the symptoms. They agreed that there are some "reversible factors" that may reduce the Claimant's pain perception. These include "resolution of the litigation, improved sleep quality, reduced pain catastrophising and successful return to work (work acts as a form of pain distraction therapy)." They concluded: "We agreed that whilst it is difficult to quantify the improvement in the Claimant's actual perceived pain, any improvement is likely to be minimal. We agreed that any improvement in pain symptoms would be of the order of 10-20%."

101. Turning to the psychiatric evidence, Dr Vandenabeele diagnosed a depressive disorder that was initially of a mild to moderate severity and at the time of examination was of a mild severity. Dr Turner diagnosed an adjustment disorder of moderate severity with persisting depression of mild severity. The experts agreed that the impact of her psychiatric difficulties is significant but they are also relatively common mental health conditions and that the severity of her psychiatric difficulties would fall towards the milder end of the spectrum.

102. They agreed that the presence of neuropathic pain should be regarded as the most significant contributing factor to her ongoing mental health difficulties. They further agreed that it is well recognised that poor mental health can in turn contribute to a reduced threshold or tolerance for pain. They agreed that the persistence of neuropathic pain would not prevent Mrs. Winterbotham from making a full recovery in terms of her mental health. They considered that the Claimant's psychiatric difficulties would not prevent her from working as a speech and language therapist or a counsellor. They recommended cognitive behavioural therapy for eight to twelve sessions. They agreed that there was no reason to suggest that Mrs. Winterbotham would not make a full recovery from her mental health difficulties following treatment and that the completion of the litigation would probably benefit her mental health.

103. Turning next to the evidence of the speech and language therapy experts, Dr Taylor-Goh identified a slight reduction in jaw opening. Ms Dhadda did not observe this, and nor did Dr Newman, and so I find that any such reduction is marginal. The experts agreed that there was increased tension in the neck and laryngeal muscles. Dr Taylor-Goh thought this was probably attributable to the altered mechanics of jaw opening, whereas Dr Dhadda emphasised an emotional and psychological component. They agreed that Mrs. Winterbotham has a mild lisp. They agreed that her ability to undertake work as a speech and language therapist has been affected. However they disagreed on the extent of those difficulties and the impact on her professional capabilities. Ms Dhadda thought that the main difficulties which Mrs Winterbotham may have with work related to her confidence, self esteem and self expectation perception. She expected her to make a recovery and manage her perceived limitations. In her report Dr Taylor-Goh concluded that the Claimant could not return to work as a speech and language therapist due to the pain and numbness and the significant amount of talking involved in being a SLT. She could work as a counsellor but she would need breaks of 60 minutes between patients. Ms Dhadda emphasised

that Mrs. Winterbotham did not need breaks, take sips of water, nor report any pain despite talking for 90 minutes during her assessment. Ms Dhadda thought that the Claimant would be able to manage with 30 minute breaks between patients. This would be sufficient to enable her to rest her mouth and tongue from speaking activities. I note that Dr Taylor-Goh saw Mrs. Winterbotham in person whereas Ms. Dhadda saw her via Zoom.

104. In her report Ms Dhadda proposed that the Claimant should focus on SLT clients with dysphagia (swallowing difficulties) which may be less verbally demanding. Her caseload would need to be strategically managed. She thought that the Claimant could realistically aim to regain approximately 70 to 80% of her pre-incident work functionality in the field of speech and language therapy. She thought that transitioning into private practice could provide the Claimant with an opportunity to manage a smaller and less demanding caseload. She was sceptical as to whether it would ever have been possible for Mrs. Winterbotham to manage two different professional roles, ie working as a counsellor at the same time as a SLT.

105. In cross-examination Dr Taylor Goh conceded that Mrs Winterbotham may be able to work as a SLT in private practice because she would be able to be selective as to the patients she took on, as opposed to working in the NHS where she would have a mixed caseload. She maintained her position that 60 minute breaks would be required.

106. In cross-examination Dr Dhadda noted that, when giving evidence, the Claimant demonstrated control and declined a break. She thought that there was no restriction on the number of patients the Claimant could see as long as she took regular breaks. She noted that the Claimant had not tried to go back to speech and language therapy despite the fact that her husband has a clinic and so she could have tried. She thought this supported her view that confidence and self esteem were significant parts of the problem. She said that working as a SLT was not a highly verbally taxing job like teaching or lecturing. She thought that psychological overlay impacted on how much pain Mrs. Winterbotham felt.

Condition and prognosis: assessment

107. Standing back, the salient features of the medical evidence are that Mrs Winterbotham suffers significant pain and discomfort and pain in her mouth and tongue. She also suffers from a mild to moderate psychiatric illness. The pain affects her mood and her mood affects her perception of pain. The prognosis for the psychiatric illness is good with treatment. Thereafter, Mrs Winterbotham's perception of pain may improve by 10-20%. The impact of the litigation is to be borne in mind and its resolution should have a positive effect.

108. To the extent that it is necessary to decide between the SLT experts, I prefer the evidence of Ms Dhadda which seemed to me to take a more realistic approach to Mrs Winterbotham's limitations. In particular, I accept that confidence and self-esteem are part of the explanation for Mrs Winterbotham's presentation. Noting that the prognosis for the psychiatric symptoms is good and the pain symptoms are expected to improve by 10 to 20%, and having carefully observed Mrs Winterbotham in the witness box, I find that a 60 minute break between patients (whether they are counselling or SLT patients) will not be required. I find that a 30 minute break

between patients would be reasonable, and this would be sufficient time to apply pain relief and to have a cold drink if necessary. I further find that Mrs Winterbotham will be able to work as a SLT and that she could realistically aim to regain 70-80% of pre accident functionality in SLT. This was Ms Dhadda's view and it was broadly supported by Dr Taylor-Goh's view that Mrs Winterbotham could return to SLT within limits.

General Damages

109. I turn to the question of general damages. Ms Church referred me to *Wormald v South Tees Hospital NHS Foundation Trust* (2013, Lawtel). The claimant, a 31 year old woman, received general damages of £21,000 for an injury to her lingual nerve sustained during a wisdom tooth extraction. The symptoms appear to be similar, but the case is of limited assistance as it was settled on a global basis and there does not appear to have been an admission of liability. This would now be worth £33,000.

110. The Schedule seeks £50,000, to include an award for loss of congenial employment. The Counter-schedule offers £35,000. In my judgment the neurological injury falls within bracket 9(B)(b) of the *Judicial College Guidelines*. The salient features are that Mrs Winterbotham continues to suffer from constant disabling pain and discomfort. The prognosis is for a reduction in pain symptoms of 10-20%. I consider that the psychiatric injury falls within bracket 4(A)(c) of the *Guidelines.* The key feature in this respect is that the prognosis for the psychiatric injury is for a full recovery following treatment. I should not simply add together awards for the two conditions; rather I should assess damages having regard to the overall level of pain and suffering and loss of amenity. I also take into account when assessing general damages the claim for loss of congenial employment. As I explain below, I consider that Mrs. Winterbotham will be able to continue working as a speech and language therapist, albeit on a part time basis and in a more limited way. Taking all these matters in to account, I assess general damages at £42,000.

111. Interest at 2% is recoverable from the date of service of the proceedings.

Loss of Earnings

Pre-injury employment history

112. The Claimant attended Reading University where she studied geography and met her husband. They married in 1996. She worked full-time as a speech and language therapist between 1996 and 1999, when her first child was born, and she then worked part-time. Her second child was born in 2001 and her third in 2003. From 2004 until 2019 Mrs Winterbotham worked as a SLT in the community. This involved working with adults with a range of communication, swallowing, eating and drinking disorders mostly from neurological conditions such as Parkinson's Disease or stroke. She would typically work around 14 hours per week. During the school term she would work 14 hours over two days, and in the school holidays she would generally work for one long day. She also did some private SLT work and some volunteering. As I have already noted, she was also fully engaged bringing up her children, running the family and volunteering.

113. In April 2017 she decided to retrain as a counsellor and volunteered with a bereavement charity. She completed levels two and three of her counselling qualification whilst continuing her NHS SLT work. Her NHS appraisal in 2018/2019 noted that Mrs. Winterbotham was a dedicated and valued member of the team and was willing to work flexibly and take on new challenges. It also noted that she found it difficult to balance the increasing demands of her role with her part-time hours, although this was in the context of IT or "admin issues" which were said to have a greater effect on part-time staff. Mrs Winterbotham resigned from the NHS in September 2019 and her last day was in December 2019. When asked to give a reason for her departure, she recorded "work life balance". In September 2019 she started a two year part-time level 4 Diploma in Counselling. Whilst studying for her counselling qualification, she volunteered with bereavement and counselling charities.

Post injury employment history

114. She completed the diploma and qualified as a counsellor in 2021 notwithstanding the injury she suffered in November 2020, but a colleague delivered Mrs Winterbotham's presentation for her. From March 2022 to November 2022 she saw counselling clients for Choices (a charity for survivors of childhood sexual abuse). In October 2022 she started an online private practice. (She says that it was not cost effective to rent a room because of the low number of sessions she could offer.) From February 2023 she started to provide in-person counselling for Lifecraft (a mental health charity for people bereaved by suicide). She subsequently took on one in-person long term client for Choices and two telephone clients for Camsight (a sight loss charity). The current position is that she is usually able to see about nine clients in a week over four days and she says that this is the most she can manage. On the other day she schedules counselling supervision, personal counselling and any daytime socialising.

115. Mrs Winterbotham says that she is now unable to work as an SLT because it involves hour long sessions where she is required to demonstrate a long succession of sounds, sentences and phrases for clients to imitate. She may have to demonstrate fine precision tongue positions. She has therefore decided not to return to work as an SLT. She proposes to continue with counselling as she finds it less arduous than SLT because counselling involves a moderate level of talking. She says that she can cope with three clients a day, as compared with the peers with whom she trained who have mostly set up in private practice and are seeing up to six clients a day.

116. She anticipates that, as a result of the pain and fatigue, she will most probably retire in her early 60s, rather than in her early 70s as she had intended.

117. In my judgment, the fact that Mrs Winterbotham completed her counselling qualification after her injury and has developed a counselling practice demonstrates a good level of motivation and commitment and some stoicism.

The Claimant's case as to her employment but for her injury

118. Mrs. Winterbotham says that if she had not suffered her injury, she intended to return to a SLT role, similar to her previous role of about 14 hours a week, either in the NHS or in private practice through Cambridge Neuro-physiotherapy (which is her

husband's business). She says that, upon completion of her diploma in September 2021, she would have developed her counselling career. She would have worked five days a week, probably two days in SLT and three days in counselling. Her intention was to return to full-time work once her youngest child was at university (which I take to be in about 2021). She says that it would not have been difficult for her to return to the NHS. She would have worked for Choices and might have worked for Lifecraft for about a year, but she would not have worked for Camsight. She would have seen far more private counselling clients than she has been able to, and she would have hired a room in order to do this. She thinks that she would have seen an additional 8 to 9 clients each week, so around 18 clients a week in total. She would probably have worked into her early 70s, although she may have reduced her workload in her late 60s to about three days a week. She said that she would have been able to manage the continuing professional development required for two careers and denied that it would have been difficult to have more than one professional focus.

119. Mrs Winterbotham's account of her symptoms and her work was supported by a witness statement from her husband Mr. William Winterbotham, and his evidence was agreed. He says that he would have been able to provide private speech and language therapy work via his own business; indeed he has now engaged some of Mrs Winterbotham's former colleagues. Mrs Winterbotham also relied upon the agreed witness statements of colleagues who work as counsellors or SLTs, Karen Johnston, Karen Pickin, Louise George, Chloe Brooker and Kay Rogers. I bear all this evidence in mind.

The Defendant's case on loss of earnings

120. The Defendant's position is that, but for the injury, the Claimant would have worked as a counsellor, averaging three days a week and seeing no more than 18 patients. She would not have returned to work as a SLT and would have worked as a counsellor until a normal retirement age. It is submitted that the Claimant is not now prevented from working as a SLT, that the maximum number of counselling patients she would have seen in one day is six, and that, with suitable breaks she will still be able to see five patients per day.

Loss of earnings: assessment

121. Before turning to the claim for loss of earnings, I note that the Claimant's tax position is complicated because she has been in receipt of dividend income from her husband's company, and income from a rental property. Accordingly I here make findings as to the gross past and future loss of earnings. I circulated a draft judgment to the parties which contained my findings and the parties have helpfully agreed the net figures and interest. These are set out in the Schedule attached to this Judgment.

Past Loss of Earnings

122. The claim for past loss of earnings in the Schedule is put at £76,320. The claim is put on the following basis. It is said that, but for her injury, the Claimant would have undertaken the same work with Lifecraft and Choices, but she would have commenced her private counselling practice earlier in January 2022 (as opposed to

October 2022), that she would have seen 14 clients until December 2023 and then increased the number to 18 clients per week from January 2024. In addition it is said that she would have resumed working as a SLT from October 2021, the work being split between the NHS and private clients referred via her husband's firm. She would have worked for two hours per week with private SLT clients at the rate of £75 per hour, and spent 14 hours per week doing her NHS work, as she did until 2019.

123. The Defendant's position as set out in the Counter-schedule is that, but for the injury, the Claimant would have worked as a counsellor, averaging three days a week and seeing no more than 18 patients. She would not have returned to work as an SLT.

124. The claim is thus put on the basis that the Claimant would essentially have returned to full-time work. In my judgment, this was unlikely. Mrs Winterbotham had not worked full time since 1999 and she combined part-time work with volunteering and a busy family life. She did not increase her hours as her children grew older. I note that the counselling witnesses relied upon by the Claimant all work for a maximum of three days a week. In my judgment, Mrs Winterbotham's work-life balance would have continued to be important to her (as reflected in her comment on leaving the NHS). This is not to suggest that, as Mrs Winterbotham remarked, she would be "watching *Richard and Judy"*; rather it is a recognition that Mrs Winterbotham had other important priorities in life which included volunteering, supporting her family, helping others and seeing friends. In my judgment, Mrs. Winterbotham would have worked for about three or four days a week, which I take to be 3 ½ days per week as an average. In my judgment it is unlikely that she would have worked in to her early 70s. I consider it most likely that she would have worked to ordinary retirement age of 67.

125. I address next to the question as to whether Mrs Winterbotham would have returned to work as a SLT. On one view it was an odd decision to resign from her NHS career in 2019 if (as is now said) she intended returning to it in 2021. Given that she was employed part-time for 14 hours a week, it might be thought that Mrs Winterbotham would have continued with her work whilst studying for her counselling diploma. Furthermore, as the Defendant points out, working in two separate capacities would have meant that Mrs Winterbotham needed two requirements for professional registration, training and CPD. Her case is put on the basis that she would have returned to the NHS rather than worked primarily in a private capacity, notwithstanding the higher rates that could be charged privately and the apparent ready supply of such work via her husband's business. Given that she had left the NHS just two years earlier and retrained for a new career in counselling, I find on balance that Mrs Winterbotham would not have returned to the NHS. I accept that she may have wanted to continue working as a SLT, but I find that she would have done this in a private capacity, and on an ad-hoc basis as and when work was offered or she sought it via her husband's company. The Claimant claims for 2 hours per week at £75 per hour for such private SLT work, and I consider that this is reasonable.

126. Turning to counselling, I accept the basis for the Claimant's calculation, namely that, but for her injury, she would have seen 14 private clients per week from January 2022 until December 2023, and would have increased the number to 18 per week from January 2024. This is consistent with the evidence of the other counselling

witnesses who saw up to six clients per day and worked for three days a week. (My assessment that the Claimant would have worked on average for 3½ days per week would therefore be accounted for by two private SLT patients seen on one half day.)

127. I calculate the past lost SLT earnings to be £150/ week x 46 weeks x 2.78 = £19,182 gross.

128. As for the loss of counselling work, I accept the Claimant's calculation at paragraph 2.2.1.1 of the Schedule, namely that there was a loss of 14 private counselling clients per week from January 2022 to September 2022, a loss of five clients from October 2022 to December 2023, and a loss of nine clients from January 2024 to the date of trial. I accept the pleaded rate of £50 per session, and I accept the Claimant's estimate that she would have worked for 46 weeks per year. I therefore accept the Claimant's estimate of her past gross loss of counselling earnings to be £47,480.25 as pleaded.

129. The Defendant submitted that these are likely to have been face-to-face counselling sessions, and so the cost of renting a room should be deducted from this figure. The Defendant referred to the figure of £600/month paid by Karen Johnston, and I note that Louise George paid £8-£10 per hour for a room. Although the Claimant mentioned that she had a room at home that she might be able to use, she appeared to accept that she would need to rent somewhere if she developed a private practice to the extent claimed. In closing Ms Church submitted that the cost of a room could be offset against the increased rate which the Claimant could charge as her practice developed. It seems to me that the Claimant is less likely to have needed a room when she embarked on her practice, and more likely to have needed one as it developed. Looking at the matter broadly, I consider it reasonable to deduct £600/month from the gross claim but not for the entire period. The period which is the subject of the claim is 131 weeks, which I take to be 30 months, and I consider it reasonable to make the deduction for 20 months, so £12,000 falls to be deducted. This gives a gross loss of £35,480.25.

Future Loss of Earnings

130. I turn next to the claim for future loss of earnings. The claim is put on the basis that the Claimant would have continued to work for two days per week doing SLT and three days per week counselling seeing 18 private clients per week. It is claimed that the Claimant would have worked until at least age 70.

131. For the reasons set out above, I consider it unlikely that the Claimant would have worked for five days per week, and I consider it unlikely that she would have returned to the NHS. I find that she would have continued to do some SLT work, probably seeing two private patients per week at £75 per patient, a total for 46 weeks a year of £6,900. However, in my judgment the Claimant will soon be capable of seeing two SLT private patients per week. This is because, with CBT and the resolution of the litigation, it is to be expected that her perception of her pain will improve and so she will be capable of SLT work within limits as proposed by Ms Dhadda and accepted by Dr Taylor-Goh. I therefore allow this loss for one year which yields a figure of £6,900 gross.

132. Once again, I accept that, but for the injury, the Claimant would have worked for three days a week as a counsellor seeing 18 private clients. She currently charges £50 per session. However she may soon be able to charge up to £95 per hour on the basis that she recently completed the REWIND course which is a specialist counselling technique for people with trauma and phobias. According to her witness statement this would enable her to charge "up to" £95 a session. Karen Johnston charges £50/ session and so does Louise George. Karen Pickin charges £50/ session but says that others "in the area and particularly closer to London" charge between £70 and £100. Taking account of this and the Claimant's current charging rate, I allow £75/hour. Thus her annual counselling earnings, but for her injury, would have been £75 x 18 x 46 = £62,100 pa gross. From this would have to be deducted her expenses. I accept that Mrs Winterbotham would incur the pleaded costs of supervision (£810pa), a BACP membership fee (£246pa), and advertising (£228pa). It is pleaded that the cost of a room would be £100 per month. This seems to me to be too low, and I allow £600/month (as paid by Karen Johnston) for 46 weeks, ie £7,200 as provided for in the past claim. Thus the total expenses would be £8,484, leaving gross earnings after expenses of £53,616.

133. According to the Claimant's Schedule, her net self-employed earnings for the tax year ended 2024 were £9,203.52. The gross figure has not been given and I cannot determine how this figure has been made up. The Schedule sets out a compendious calculation which includes the Claimant's dividend and property income.

134. The Defendant submits that the better approach is to consider what work the Claimant has lost because of a need to take longer breaks between patients. That involves working out what the lost profit is by reference to the number of lost patients, less the additional business expenses needed to obtain that profit. In my judgment this is a fair and straightforward way of approaching the future loss, and I adopt it.

135. The Claimant's evidence is that she currently sees nine clients per week and this is the most that she can manage. I accept that the Claimant is and will remain restricted in the number of patients she can see. In my judgment, she is unlikely to be able to see more than four patients a day for three days a week, ie 12 patients a week at £75/ hour for 46 weeks a year. The same expenses will be incurred. Thus her residual earning capacity is £41,400 - £8,484 = £32,916.

136. Thus the gross annual loss is £53,616 - £32,916 = £20,700.

137. The multiplier for the "but for" earnings to age 67 is 11.93. The table C adjustment (employed, level 3, not disabled) is 0.82 and so the adjusted multiplier is: 9.78 which yields "but for" gross earnings of £53,616 x 9.78 = £524,364.

138. There was a dispute between the parties as to whether the disabled multiplier should be applied to the Claimant's actual projected earnings and the non-disabled multiplier should be applied to the "but for" earnings. The pain management experts agree that the Claimant is disabled within the definition of the 1995 Act. The Defendant submitted that the disabled multiplier should not be used since the Claimant's disability would not impinge on her retirement age. I accept this this was the evidence of Dr Sawyer, and I accept that the likelihood is that the Claimant will be

able to work to normal retirement age. However the adjustment does not just reflect the impingement of her disability on the Claimant's retirement age. It also reflects the effect of her disability on her field of work. The commentary at paragraphs [89] to [91] of *Facts and Figures* sets out when a departure from the table A to D figures is appropriate. As the editors explain:

> "[90] When considering whether it is appropriate to depart from the suggested Table A to D reduction factors, it is important to consider how the degree of residual disability may have a different effect on residual earnings depending upon its relevance to the claimant's likely field of work. In this regard there is a distinction between impairment and disability. For example, a lower limb amputation may have less effect on a sedentary worker's earnings than on the earnings of a manual worker. Likewise, cognitive problems may prevent someone from continuing to work in a professional or knowledge capacity where the same problems may not prevent continuing employment and job roles with low cognitive demands. In this context, disability is defined in relation to work and is specific to the skills that are required in a particular job and also to the outstanding effects of the impairment where barriers have not been overcome. Disability is more closely related to employment outcomes than is impairment. So, whilst occupation is irrelevant to impairment in this context, disability is defined in relation to work it is specific to the skills that are required in a particular job and also to the outstanding effects of the impairment where barriers have not been overcome. Disability is more closely related to employment outcomes than is impairment. So, whilst occupation is irrelevant to impairment (an amputation is the same regardless of the occupation), it is crucial to disability. Disability is the better predictor of employment prospects than the impairment itself and close regard must be given to the effects of the claimant's impairments on his or her future intended occupation.
>
> [91] Where a departure is considered to be appropriate, it could be in either direction and it would normally be expected to be modest. Interpolation using a midpoint between the disabled and non-disabled reduction factors is not advised. Disability results in substantial employment disadvantage and therefore applying a midpoint between the pre and post injury reduction factors will normally be too great a departure."

139. Mr Duffy's primary position was that there should be no reduction to take account of disability. He did not advance an alternative approach based on interpolation. In my judgment the Claimant's tongue is the tool of her trade (both as a SLT and a counsellor) and so her disability is intrinsic to her work. On this basis, and having regard to the guidance in *Facts and Figures,* I consider that the disabled multiplier should be applied to the residual earning capacity without any reduction.

140. The adjusted multiplier for the Claimant's residual earning capacity is therefore 11.93 x 0.62 (employed, level 3, disabled) = 7.27 which yields £32,916 x 7.4 = £243,578.40.

141. Thus the gross loss of counselling earnings is £524,364 - £243,578 = £280,786.

Special Damages

142. There is a claim for £480 which is the cost of Dr Shahrak's treatment on a private patient basis. The Defendant points out that, had the Claimant opted not to proceed with the extraction, she would still have paid the £65 consultation fee and the enhanced health compliance charge of £65. These points are sound and I award £350.

143. There is a claim for maxillofacial surgery which is admitted in full at £4,694.

144. There is a claim for over-the-counter medication and prescription medication totalling £1,034.70. The Defendant admits the cost of prescription certificates, being £304 and allows £215 for over-the-counter medication calculated at £5/ month. This is on the basis that receipts have not been produced. The claim for over-the-counter medication appears to have been estimated at £17/month. I award £304 for prescription certificates and £10 per month for over-the-counter medication for 43 months, giving £430 plus £304, a total of £734.

145. There is a claim for 21 private counselling sessions totaling £1,155. The Defendant offers £770 on the basis that this sum is supported by invoices. I accept that the Claimant has attended for 21 sessions at £55 per session, and I award £1,155.

146. There is a claim for travel and transport expenses estimated at £450. No particularised mileage or receipts have been presented. On this basis the Defendant offers the sum of £250 which I consider to be reasonable, and I award £250.

147. A claim for accommodation of £77.40 is admitted

148. The Claimant is entitled to interest at half the special account rate from the date of injury to trial. I invite the parties to agree a calculation.

Future Losses

149. There is a claim for psychological support. The expert psychiatrists recommend eight to twelve sessions of cognitive behavioural therapy. Dr Turner for the Claimant estimates the cost at between £100 and £200 per session. Dr Vandenabeele for the Defendant anticipates that the cost would be between £80 and £120. I award the cost of ten sessions at £120, being £1,200.

150. There is a claim for pharmacotherapy/ medication which is now agreed at £111.60 per annum. The Defendant proposes a 10 year multiplier on the basis that a prescription certificate should be required in the Claimant's lifetime in any event and this is now agreed at £1,131.

151. There is a claim for future over-the-counter medication totalling £17 per month or £204.00 per annum. The Defendant offers £5 per month. I award £10 per month, consistent with the past loss award. This gives £120 per annum x 33.57, giving a total of £4,028.40.

152. There is a claim for the advice of a nutritionist. The Claimant claims six one-hour sessions. This is on the basis that she has difficulties with certain types of food. I consider that the advice of a nutritionist is reasonable and recoverable in principle but six sessions would not be justified in order to address issues which fall within a narrow compass. I award the cost of two one-hour sessions: £300.

153. There is a claim for weekly laryngeal and neck massage. This is put at £2,160 per annum totalling £72,511.20. Dr Sawyer, the Claimant's consultant in pain medicine, recommends the ongoing provision of neck massages until such time as the Claimant has undergone pain management psychotherapy and has better self-management strategies. Dr Logan, the Defendant's consultant in pain management, considers that there is a lack of evidence for the effectiveness of such treatment, it is reasonable for it to continue if the Claimant perceives that there is a benefit. They agree that, in the context of pain management, neck massages are not a recognised treatment and they are not supported by NICE. They note that neck muscle tension is often associated with stress or anxiety. I am persuaded that there is some therapeutic benefit to massage and that accordingly it is reasonable for Mrs. Winterbotham to recover the cost, but I consider that this should be restricted (as Dr Sawyer proposes) until such time as the Claimant has completed pain management psychotherapy. I reject the Defendant's submission that the Claimant should massage her own neck. I also reject the submission that the massage should be provided gratuitously by the Claimant's husband; if the reasonable need is otherwise established, I see no reason why the commercial cost should not be recoverable and the Claimant should instead be required to rely upon the goodwill of her husband. Looking at the claim broadly, I award the cost of fortnightly massages for one year, being £1,080. Thereafter, to the extent that there is a continuing need to mitigate muscle tension, I consider that the Claimant will be able to engage in self-directed daily relaxation techniques as proposed by Ms Dhadda.

Conclusion

154. I conclude that Dr Shahrak was in breach of duty in that he failed to (a) provide the Guidance Note; (b) provide a meaningful opportunity to ask questions and discuss the procedure; (c) explain the material risks, specifically (i) that there was an increased risk of injury to the lingual nerve, (ii) that there was a high risk of injury to the IAN, and (iii) and that (whether or not there was a high risk to the IAN) this would be a high risk extraction within the meaning of the consent form. He further failed (d) to explain that a coronectomy would be a reasonable alternative procedure with a lower risk of nerve injury. See paragraphs [56] – [68] above.

155. I find that, but for the Defendant's breaches, Mrs Winterbotham would not have undergone an extraction at all and would have requested a coronectomy. I find therefore that she would have avoided all nerve injury. See paragraphs [69] – [82] above.

156. In the alternative, I find that if Mrs Winterbotham had been properly advised about the material risk of nerve damage (which risk eventuated), she would at the very least have deferred her surgery. On that basis, *Chester* applies and causation is established. See paragraphs [83] – [92] above.

157. I assess damages at £265,000. See paragraphs [109] – [153] above and the attached Schedule.

SCHEDULE TO JUDGMENT

SCHEDULE OF DAMAGES	
General Damages	
PSLA	£42,000.00
Interest	£1,940.05
Total General Damages	**£43,940.05**
Special Damages	
Past Loss	
Dental Surgery, Medication and Therapies	£6,933.00
Loss of Earnings	£40,996.69
Travel and Transport	£250.00
Accommodation	£77.40
Subtotal Past Loss	£48,257.09
Interest on Past Loss	£2,546.40
Total Past Loss	**£50,803.49**
Future Loss	
Loss of Earnings	£162,517.06
Medical Treatment, Medication and Therapies	£7,739.40
Total Future Loss	**£170,256.46**
GRAND TOTAL	**£265,000.00**