Case number: 118DC085

IN THE COUNTY COURT AT NORWICH

Before Recorder Gibbons 22nd and 23rd June 2026

BETWEEN

MRS JOSEPHINE DOWNES

Claimant

-v-

DR JOANNA OSTROWICKA

Defendant

Draft Judgment

This draft was circulated in accordance with Practice Direction 40E and this final version incorporates suggested amendments from the parties' counsels.

1. This is a claim in negligence brought by the Claimant against the Defendant, the latter being at the time of the alleged cause of action and up to the present a dental practitioner now of some 30 years' experience. It concerns the treatment offered to the Claimant in October 2019, including the various options that were offered to or discussed with her.

2. The case was heard over a period of two days. I was greatly assisted by counsel for the parties: Mr Clifton-Thompson for the Claimant and Mr Kinnear for the Defendant. Both submitted succinct and helpful skeleton arguments. I am most grateful to them for their assistance.

Background

3. The Claimant had consulted the Defendant on multiple previous occasions. Those consultations, dating from the year 2000 as evidenced by the notes in the bundle, evidence extensive treatment and consultations. Prior to the present issue the Claimant had had five implants. On the 3rd May 2017 the Claimant consulted the Defendant. The notes of that consultation read:

   "pt given opt for referral for private RCT but informed that it may be rejected by the specialist due to the anatomy of the tooth. dv to have the root extracted then either a bridge, denture or implant pt says she is happy go ahead with an implant and is aware of the £2000+ cost as she has had implants previously"

4. This entry illustrates the information entered into the patient record; it is mirrored by similar information recorded about options given to the Claimant at previous appointments.

5. The Claimant consulted the Defendant on the 15th of October 2019 about a fractured tooth, referred to in the pleadings as UL2. The patient notes record this as an emergency appointment. The Claimant's pleaded case records that she was given two options for treatment, those two options being recorded in the Claimant's clinical notes prepared at around the time of her consultation. Those notes are contained in the bundle and read as follows:

   "OE – ul2 fractured, discussed with pt about ul3 ul4 heavily filled restorations weak teeth

   opts:

   1) post crown for ul2

   2) ceramic 3 unit bridge ul234

   pt will think about it

   1 x PA xray taken to assess

   Grade 1

   Shows: ul2 fractured, good root structure for crown and seperate [sic] post to be done

   Adv – return for rct and crown prep with post"

6. The notes therefore refer to the two options: a post crown for UL2, or a bridge spanning UL2, 3 and 4. It is also recorded in the notes that the Claimant went away to consider these two options. There were a number of consultations thereafter starting in the November in order to fit the bridge, which was the Claimant's treatment of choice. The final appointment was in February of 2020 which was of course shortly before the first COVID lockdown.

7. Around the 7th of November 2020, having tried and failed to get an appointment at the Defendant's dental surgery to have a review of the bridge, the Claimant consulted another dentist, a doctor Smit. The Claimant had seen him before when the previous implants were performed. Doctor Smit advised that the bridge was not fitting well. At paragraph 13 of the particulars of claim the Claimant records Dr Smit's advice as being that "in time it would fail." It was apparent at trial that the problem was a gap between the post and the root of the UL2 which could trap food. The court did not hear from doctor Smit so it is not possible to gauge the strength of his conviction as to a future failure, still less was it possible to know when he thought that failure might take place. However, rather than wait for the bridge to possibly fail the Claimant decided on Dr Smit's advice to have the bridge removed and an implant be put in its place. This last implant the Claimant had was the sixth.

8. It is not part of the Claimant's pleaded case that the bridge work was undertaken negligently. Indeed, it was accepted by the two experts in their joint report that the bridge work was satisfactory.

9. At paragraphs 22 and 23 of the particulars of claim, the Claimant alleges against the Defendant a failure to provide the Claimant with adequate advice regarding the risks and benefits of the treatments and options available to her. Much of the Claimant's case is based on her apparent wish to have a "permanent solution". At no point does the Claimant alleged that the issue specifically of what might be or might not be a permanent solution was discussed with the Defendant.

10. It is right to mention that shortly before trial I heard an application by the Claimant for permission to amend the particulars of claim, the effect of which would have been to remove the words "permanent solution" in favour of an alternative formulation. I refused that application since it seemed to me it would change the entire basis on which the claim was being brought.

The Evidence

11. At trial I had evidenced from the Claimant, the Defendant, the Claimant's husband and from two expert witnesses, Dr Dilip for the Claimant and Professor Barker for the Defendant. The two experts produced a joint report for the court. I found that both the Claimant and the Defendant gave essentially honest evidence and carried a high level of credibility. I say this despite the fact that in my view the Defendant at times became combative in cross examination.

12. The Claimant's case in oral evidence was essentially that she was not advised of an implant or of an extraction and denture as treatment options, which is a different case from the one put in her particulars of claim. It is right to set out the Claimant's allegations, as they define their case and its limits. At paragraph 22 of the Particulars of Claim the Claimant says:

> *On 15 October 2019, the Defendant failed to provide the Claimant with adequate information about the risks and benefits of all the treatment options available to her.*

13. At paragraph 23 of the Particulars of Claim, the allegations are listed as follows:

> *(a) Failed to properly appreciate that the Claimant wanted a permanent solution to the fractured UL2;*
> *(b) Failed to advise of the risk of a poor outcome for a bridge that uses a post-retained crown as an abutment tooth; and*
> *(c) Failed to advise of the risk of the bridge not providing the permanent solution that the Claimant required; and*

(d) Failed to advise of alternative treatment options, namely extracting UL2 and replacing it with either an implant or a denture.

(e) Failed to advise that an implant was the only option that would provide the permanent solution the Claimant required.

14. It was put to the Claimant in cross examination that she had essentially changed her case because, first, the experts' opinions were that the bridge was installed in a satisfactory manner and further that there was no such thing in dentistry terms as a "permanent solution." The Claimant in answer to this latter point expressed the sentiment that they were "just words" and that she wanted "something more long-term." Confusingly, the Claimant added that she was not saying that the bridge should never have been fitted. She also said that she did not ask about an implant because UL2 had a good root structure, she was told. It seems to me that this piece of information could only have come from the Defendant and arisen from the Defendant's examination at the emergency consultation on 15th October. Of significance is its absence from the Claimant's witness statement.

15. In reply to a question from me the Claimant said that she knew that the UL2 had a good root structure and that accordingly an implant did not really come into consideration in October 2019. In further re-examination she said that she would have had an implant if advised of the risks associated with a bridge.

16. The Defendant's case was that the Claimant was advised of the option of having an implant, which would have entailed removing UL2, a tooth with a good existing root. In oral evidence the Defendant said that the Claimant was aware of the risks associated with an implant. Furthermore, she did not wish to patronise the Claimant by telling her what she already knew. I do not consider that a patient's assumed prior knowledge is a reason for not mentioning a type of treatment at all, though I can see that it would be acceptable to tailor the advice to the individual.

17. The Defendant's position was that the Claimant was concerned at her husband's reaction to the cost of this treatment, set against the background of five previous

implants and other aspects of dental treatment which came to in the order of £11,800 between 2015 and 2020, not including the cost of the sixth implant carried out by doctor Smit. Mr Downes' evidence supported to small degree only that of his wife, since although he had travelled with his wife to the surgery he was not present when discussions took place between his wife and the Defendant. All he could really do was give what amounted to hearsay evidence of the conversation which the Claimant told him she had had with the Defendant in the surgery.

18. I treat with caution evidence given about a brief conversation which occurred some seven years ago. Furthermore, I think it is highly relevant that when the Claimant initially made her complaint to the practice manager at the surgery over the threatened failure of the bridge work the Claimant said nothing at all about any failure to fully advise her of the respective risks of the various treatment options. The Defendant recounted that the Claimant was, when she spoke to her in October of 2019, concerned at her husband's reaction to the likely cost and I consider this to be consistent with the fact I have already referred to, namely the considerable expenditure on dental treatment over a six year period.

19. The Defendant was cross examined at length regarding the failure of the clinical notes, made in the October of 2019 and later, to make any reference to either the implant as a solution, nor to the likely cost, or to the Claimant's financial concerns. The Defendant said that she had known the Claimant as a patient for a number of years and was well aware of her extensive history of treatments, including five previous implants. Her notes from October 2019 she said only included those treatment options which were under active consideration and which the Claimant was to go away and consider before deciding how she wished to proceed. Although the question of implant had been mentioned at their first meeting the Claimant had, said the Defendant, discounted it already and for that reason it was not included in the clinical notes. The Defendant maintained that she had an excellent memory despite the literally hundreds of patients she had seen since.

The Law

20. The legal principles are well known and are further not in dispute between the parties. To quote from *Bolam v Friern Hospital Management Committee [1957] WLR 583:*

> *"a doctor 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... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view."*

21. In *Montgomery v Lanarkshire Health Board [2015] UKSC 11* it was held that:

> *"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."*

22. I turn at this point to the expert evidence. I was concerned at the standing of Doctor Dilip as an expert witness. He qualified around 2011, and has worked in private and NHS dentistry. His length of experience is almost one third of that of the Defendant. This of itself does not necessarily prevent him being positioned as an expert. However, I was concerned at his lack of any understanding of the essentials of the decision in *Bolam*. When asked about the grounds for belief that UL2 was not suitable for a bridge support he was unable to put forward a rational basis for his opinion other than a bare, uncited, reference to Schillinberg's text book for dental students. When it came to the vaunted advantage of an implant over a bridge his

report selectively did not consider the disadvantages, including the continuing maintenance requirements, of an implant.

23. Of equal concern was the manner in which his expert report was prepared. It appears that he received instruction from the Claimant's solicitors via a portal. He said that he answered a series of questions which seem to have been posed. What the consequence of this approach seems to have been that his report was unsigned. More importantly, he had drawn conclusions without apparently considering the dental notes. This was particularly relevant to the Defendant's analysis of the x-ray taken on 15th October 2019. Doctor Dilip does not refer to either. He said in cross-examination that he had considered them. I do not accept his evidence on this point. It is fundamental that any expert in any field would set out the evidence considered, as well as referencing relevant technical literature, to show how a conclusion is reached.

24. Doctor Dilip was also driven to accept that some of the conclusions in the joint report were at variance to his earlier conclusions. In particular, he and Professor Barker agreed that:

    24.1. The bridge had not failed at the time it was inspected by Doctor Smit.

    24.2. The average life of an implant fixture was 15 – 20 years

    24.3. The average life of an implant crown is 10 – 15 years.

    24.4. It is not possible to guarantee a "permanent solution"

    24.5. There are too many variables to say whether an implant crown would last longer than a bridge.

25. Conversely, Professor Barker impressed as an expert witness. He maintained that the bridge which the Defendant had put in was mechanically sound and had not failed. The decision therefore to remove it in favour of an implant was elective. He could not say how long any particular treatment would last, there being too many variables. Fairly, he said that either bridge or implant was an option, though the reasonable amount of tooth available at UL2 meant extraction was less suitable or

sensible, a point Doctor Dilip had to concede when asked about the amount of super-gingival tooth available. However, not to offer one or other would be a breach of duty in Professor Barker's view. His evidence was that the bridge structure was not compromised by having a short post. He was not drawn into conceding that the life of the bridge was at the lower end of the 10 – 15 year range and so poorer than the life of an implant.

Conclusions

26. On balance, I am satisfied that at the meeting on the 15th of October 2019 the question of an implant was raised by the Defendant but discounted almost immediately by the Claimant, not only because of her concern over costs but more importantly because, as she emphasised in her own evidence, there had been a discussion over the good state of the root. This accords closely with Professor Barker's evidence that an extraction might have been less sensible. I am further satisfied that the Defendant discussed with the Claimant the remaining practical option for treatment, given that not only had UL2 fractured but UL3 and UL4 were heavily restored. This provided a mechanism for the locating of the bridge, using two previously restored teeth at the same time.

27. I am further satisfied that at the 15th October 2019 meeting there was no discussion of either the Claimant wanting a "permanent solution" nor of the Defendant telling the Claimant that such a solution existed.

28. The parties' counsel prepared a helpful list of issues, to which I will now refer. My findings are the following:

    28.1. An implant was a reasonable treatment option, as per *Bolam*, though I consider that, as stated by Professor Barker, it was a less suitable option than the bridge given the condition of the root and the amount of super-gingival structure.

    28.2. The implant option was discussed at the 15th October consultation, albeit briefly, in my view. This is shown by the Claimant's knowledge of the condition

of the UL2 root. I think that the Defendant did make assumptions about the Claimant's knowledge and experience, which would not have excused not discussing the options at all, but which led to any mention of this discussion not appearing in the clinical notes.

28.3. The bridgework did not have a material risk of "a poor outcome." This conclusion is supported by Professor Barker's evidence, which I prefer as being more credible than that of Doctor Dilip.

28.4. There was no discussion regarding a "permanent solution." The Claimant admits to not having communicated this. Such a thing does not exist in dental terms, a point agreed by the experts in their joint statement and in evidence.

29. It follows from what I have said that this claim is dismissed.

30. I shall make clear that had I decided otherwise, I would place this claim into the minor category. The Claimant was unclear as to the degree of pain, suffering and loss of amenity she suffered. This arose from what would have been the unnecessary bridge work. In her witness statement she describes the treatment thus: "In all I had over 2 hours of dental treatment, that involved injections and drilling, spread over 6 appointments. I coped it all, but it was very uncomfortable."

31. In the schedule of loss however she describes her treatment as "painful and debilitating treatment to install a bridge during 3 appointments that took place in January and February 2020."

32. Chapter 10 A(f) of the Judicial College Guidance does not in my view apply here. There have not on any view been loss of a tooth. The Claimant would have suffered unnecessary treatment. Allowing for a three-month recovery at most, the appropriate level of damage would in my judgment be £1,850. The special damages for bridge and travel are agreed. The care claim is not made out.

33. This judgment is handed down by email in the absence of the parties. The hearing stands adjourned and the parties are encouraged to agree a final order. If this is not possible either party may apply for a one-hour hearing by CVP.

Recorder Gibbons

19th July 2026