SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH
IN THE ALL-SCOTLAND SHERIFF PERSONAL INJURY COURT

[2025] SC EDIN 35

PIC-PN743-24

JUDGMENT OF SHERIFF WALLS

in the cause

JAMES GALLAGHER

Pursuer

against

JAMIE CLEMENT

Defender

Pursuer: McPhee, advocate; Jones Whyte Law, Glasgow
Defender: Clair, advocate; MDDUS, Glasgow

Edinburgh, 4 July 2025

The sheriff, having resumed consideration of the cause:

Finds the following facts admitted or proved:

1. On 21 September 2022, the pursuer attended for examination by the defender at a Bupa Dental Care clinic in Glasgow.

2. The pursuer reported he had been experiencing pain in the lower left-hand side of his jaw for a few weeks, focused on the angle of his mandible. The pursuer had not required painkillers, the pain had not affected his sleep, was not made worse by eating and was not worse in the morning.

3. The pursuer's oral hygiene was poor. There was calculus (tartar) present, and his teeth needed a professional clean. Three of his teeth were decayed: UR6, UR7 and LL8 (lower left wisdom tooth).

4. The pursuer's LL8 was fully erupted.

5. The defender took contemporaneous notes of his examination of the pursuer.

6. As part of his examination of the pursuer, the defender took two bitewing radiographs of the pursuer's mouth.

7. The defender provided the pursuer with two treatment options: to keep his LL8 under review, or to have it extracted.

8. The defender chose to have his LL8 extracted and made an appointment for extraction on 12 October 2022.

9. On 12 October 2022, the pursuer attended the defender for routine, planned extraction of his LL8.

10. The defender qualified as a dentist in June 2020 and as at 12 October 2022 had considerable experience of tooth extraction, having extracted approximately five teeth per week of which one third were molars or wisdom teeth.

11. Prior to extraction, the defender undertook a periapical radiograph of the pursuer's LL8, to assess the roots. He chose this form of radiograph because the image quality is generally better than an orthopantomography (OPG) and because it carries a lower dose of radiation. The periapical radiograph did not suggest that the pursuer's LL8 was involved with the inferior alveolar nerve.

12. Had the defender taken an OPG - either instead of or in addition to the periapical radiograph - he would nonetheless have proceeded with the attempted extraction of the pursuer's LL8.

13. Prior to extraction, the defender explained the risks of the procedure to the pursuer including pain, bleeding, infection and a worst case scenario that the extraction might fail and that he would be referred to a dental surgeon.

14. Over the course of an hour, the defender attempted to extract the pursuer's LL8. The extraction was very difficult. The crown of the LL8 fractured due to decay. The defender attempted and failed to section the LL8's root. The defender failed to complete the extraction. The defender placed a sedative cement dressing over the extraction site.

15. The defender referred the pursuer to the Albion Clinic, 211 Albion Street, Glasgow, G1 1RU. The Albion Clinic is a referral practice for oral surgery.

16. In accordance with his own practice and normal practice at the time, the defender advised the pursuer that he should contact him/Bupa Dental Care if he experienced problems following the failed extraction.

17. The defender made contemporaneous notes following the failed extraction.

18. The pursuer was concerned that he did not have a timescale for an appointment at the Albion Clinic and that he had not heard from them the day after his referral. He contacted the Albion Clinic on or around 13 October 2022 and was advised there had been a cancellation by another patient for an appointment on 17 October 2022. The pursuer arranged an urgent appointment with the Albion Clinic on 17 October 2022.

19. On Thursday 13 and Friday 14 October 2022, the pursuer experienced the level of pain and swelling normally associated with a procedure of the sort carried out by the defender. Had the defender contacted the pursuer on these days, the pursuer would not have reported symptoms to justify a follow up appointment with the defender.

20. The pursuer's symptoms worsened over the weekend of 15 and 16 October 2022.

21. The pursuer chose not to contact the defender on 15 and 16 October 2022 because the defender's clinic was closed and he had in any event secured an appointment at the Albion Clinic for Monday 17 October..

22. The pursuer attended the Albion Clinic on Monday 17 October 2022 and was assessed by Singithi Liyanage, Dental Surgeon.

23. The pursuer had firm swelling affecting the left-side mandible extending submandibular to the midline, which was very tender to palpate. The pursuer could open his mouth less than 1cm.

24. Dr Liyanage referred the pursuer on an emergency basis to the Department of Oral and Maxillofacial Surgery at the Queen Elizabeth University Hospital, 1345 Govan Rd, Glasgow G51 4TF

25. Later that same day, the pursuer attended the emergency department of the Queen Elizabeth University Hospital and was admitted as an inpatient under the care of Ian Holland, Consultant Oral and Maxillofacial Surgeon. The pursuer had developed a left-side sublingual abscess and an OPG was taken.

26. The pursuer was transferred to theatre for incision and drainage of the sublingual abscess and surgical extraction of his LL8. He had a 2cm incision to the lower left mandible to drain pus from the sublingual space. The LL8 was extracted with the sectioned root. The procedure was completed successfully.

27. The pursuer was treated with antibiotics, paracetamol, and morphine (intravenously) and placed on a soft food diet.

28. The pursuer was discharged from hospital on 21 October 2022.

Finds in fact and law

1. As at 12 October 2022, there was no standard dental practice of taking an OPG prior to the extraction of an LL8 tooth. *Esto* there was such a practice, the defender proceeding to attempt extraction of the pursuer's fully erupted LL8 without the benefit of an OPG, where

he already had a periapical radiograph, was not a course of action that no ordinarily competent dentist, exercising ordinary skill and care, would have undertaken, having regard to the practice of many dentists at the time and the terms of the General Dental Council Selection Criteria for Dental Radiography.

2. As at 12 October 2022 there was no standard dental practice whereby there was mandatory follow up of a patient who had been given advice on worsening symptoms and referred to secondary surgical care. *Esto* there was such a practice, the defender having failed to do so, it cannot be said his decision not to follow up with the pursuer was one which no ordinarily competent dentist, exercising ordinary skill and care, would have made, having regard to the practice of many dentists at the time and to the absence of any applicable standards, guidance or protocols to that effect.

3. The pursuer sustained no reparable loss, injury or damage as a result of the defender's failure to obtain an OPG or to follow up with the pursuer following the failed extraction procedure undertaken by the defender on 12 October 2022 and is entitled to be assoilzied.

NOTE

[1] This case concerns the failed extraction of the pursuer's lower left wisdom tooth (LL8) on 12 October 2022. Parties agreed a detailed Joint Minute of Admissions, which significantly reduced the need for parole evidence. The extent of evidence was also limited by the fact that by the time the action came to proof, the pursuer was only insisting on two alleged breaches of duty – (i) the defender's failure to obtain an orthopantomography (OPG) prior to deciding whether to proceed with extraction; and (ii) the lack of follow up care in the days immediately following the extraction.

[2] I heard evidence on 3 and 4 June 2025. There were four witnesses – the pursuer, the defender and two experts. Parties prepared written submissions and there was a hearing on submissions on 5 June 2025.

Witness evidence

The pursuer

[3] The pursuer's GP suggested that he see a dentist about jaw pain. The defender examined the pursuer on 21 September 2022 and identified the LL8 as being the cause of his pain and advised that the tooth could either be extracted or left in place and monitored. The pursuer elected for the former option and attended for an extraction procedure on Wednesday 12 October 2022. The defender explained possible complications including pain, swelling, bleeding and a "worst case scenario" of referral to a dental surgeon if the extraction failed. Although no longer part of his case, the pursuer indicated that had he been offered the option of restoring the tooth, he would have paid to do so, citing the example of him having paid £1,600 to have his teeth straightened. He said that was just an example of what he would have paid and that he was not a stranger to paying for healthcare, also paying an excess for hernia surgery.

[4] The extraction was unsuccessful. The pursuer was referred to the Albion Clinic and ushered out of the practice without being given any advice on after care or what to do if he developed concerns. He felt that he was rushed out of the door as his appointment had overran.

[5] In cross-examination, he was referred to various questionnaires he had completed as part of treatment for ADHD. His answers to some questions suggested that he had difficulty retaining information. The pursuer accepted he had completed the forms, but said

that his answers were specific to the context of the questions. His ADHD would not have affected him in what he described as a high intensity situation, such as needing information after a failed wisdom tooth extraction. He was adamant that he would have recalled any after care advice given to him by the defender.

[6] On either the Thursday or the Friday after the procedure, he called the Albion Clinic. At this point, the level of pain and swelling was what he had expected. He contacted the clinic due to concerns about whether they had received the referral and how long he would have to wait. He secured an appointment on Monday 17 October 2022, due to another patient having cancelled.

[7] Over the weekend, his symptoms worsened. By Sunday, he could barely open his mouth. He did not contact the defender because his practice was closed over the weekend and in any event, he had his referral appointment on the Monday.

[8] After examination at the Albion Clinic on 17 October 2022, he was referred on an emergency basis to hospital – it was not possible to open his mouth sufficiently to complete an extraction and there were concerns about infection. Once admitted to hospital, he was given oral painkillers before surgery that afternoon to drain the infection (via an incision in his neck) and to extract the LL8. Because he was unable to open his mouth he explained that tubes required to be passed down his nasal passage. He was discharged from hospital on 21 October 2022.

Dr Ian Kerr

[9] Dr Kerr qualified as a dentist in 1989 and has worked in general dental practice since then. Since 2020, in addition to his patient work, he has prepared reports for use in dental negligence claims.

[10] He adopted the terms of his reports dated 9 May 2023 and 3 January 2025. His reports addressed other alleged grounds of fault which the pursuer was no longer insisting on at proof. These related to an alleged failure to advise of restoration as an option, and to provide appropriate warnings regarding the possibility of nerve damage. He was not asked about this in examination in chief or in cross-examination, which meant that his evidence in court was slightly at odds with his reports, as the nerve damage issue was to some extent linked with his views regarding the need for an OPG.

[11] In his first report, Dr Kerr has relatively limited comments on the failure to obtain an OPG. In a comment on the periapical radiograph obtained by the pursuer he notes that this image "…would or should have altered [the defender] to the potentially complex removal that LL8 represented." The OPG taken after the pursuer's referral, showed the potentially close intimate relationship between the roots and the dental canal. He said OPGs are the appropriate view when considering any potentially complex extraction (citing the Faculty of General Dental Practice, Selection Criteria for Dental Radiography.)

[12] Had an OPG been taken before treatment the defender "would or should have been aware of the increased potential for complication…It is more likely than not that had [the defender] taken an appropriate radiographic view of the LL8 at the pre-treatment stage he would have referred the extraction without attempting it first. A referral to a suitably skilled oral surgeon would, more likely than not, [have] avoided the complications that occurred on this occasion."

[13] His January 2025 report was in the form of a letter to his instructing solicitor and its main purpose appears to have been to identify the areas of agreement and disagreement between him and Dr Boyle. It also records his view that in relation to obtaining an OPG

prior to attempting extraction "…a difference of opinion exists here with no strong authoritative guidance that applies to the specifics of this case."

[14] At the outset of his evidence, he made it clear that his opinion was based solely on a review of the available records. He had not spoken to the pursuer or the defender and could not comment on his skills as a dentist. Further, and unusually in cases of this sort, his evidence was given without him having heard the evidence of the pursuer or defender.

[15] The pursuer's symptoms were moderate and there was no urgent need for LL8 extraction. The treating dentist would want a clear view of the roots and the dental canal even although the tooth was erupted, to ensure that the patient was not at unexpected risk. The available guidance is not tooth specific so there was a grey area regarding the appropriate form of radiography. The periapical radiograph taken by the defender ought to have alerted him to potential complications with extraction as it showed extensive decay, a curved mesial root and did not identify the position of the inferior dental canal and its relationship with the LL8 roots. Given the number of unfavourable factors, he considered that the defender ought to have taken an OPG to obtain greater clarity, prior to deciding whether to proceed with an extraction.

[16] In terms of the ordinary and usual practice for extraction of teeth such as the pursuer's LL8 following a periapical radiograph, he explained that it would depend on the experience of the general dental practitioner. If he was very experienced, and regularly had removed similar teeth then he would expect them to give an appropriate warning then carry on, given that they would be able to deal with the patient if it became "surgical." However, most dentists were not in that category and if the removal was not urgent then they should refer it to a dental surgeon.

[17] The OPG taken on 17 October 2022 prior to surgical extraction showed the close potentially intimate relationship between the routes of the LL8 and the underlying inferior dental canal. His opinion was that had the defender taken an OPG, then the potential complications would have been apparent. Taken with the decay in the tooth and the attendant risk of fracture during extraction, he concluded that it was more likely than not that the defender would have referred the extraction to a specialist surgeon.

[18] In relation to post procedure care, in his first report, Dr Kerr said that in the days immediately following the attempted extraction, the defender ought to have had a follow up review of the extraction site, implying an in person appointment. At points, he also suggested that the obligation was to telephone the patient. It was "standard guidance," that responsibility for a patient does not end after a referral, but continues until hand over to the accepting clinician. The failure to arrange such an appointment left the defender vulnerable to infection.

[19] However, in evidence, his emphasis was on the need to call the patient and to check on any symptoms, with an in person appointment only if needed. It was normal and usual practice for a dentist to pro-actively contact patients and check up on them after any invasive procedure. Had the defender contacted the pursuer 48-72 hours after the procedure, he considered it likely that the pursuer would have told the defender about symptoms, leading to follow up care and the complications avoided.

[20] In cross-examination he accepted that he was not aware of the defender's experience in relation to extraction of teeth and that there was no "tooth by tooth" guidance or standard practice, because the decision on whether to extract or not was always a question of clinical judgment. He agreed that the Selection Criteria is a statement of "good practice" and sets out guidelines rather than a prescriptive course of practice. He accepted that any

radiograph performed on a patient carries a risk associated with radiation, and so the selection of appropriate radiography must be based on a patient's history, rather than routine screening.

[21] Dr Kerr was taken through the Selection Criteria in detail. He agreed that there was wide variation in practice as to which radiographs are exposed in primary dental care. He accepted that there are still gaps in evidence regarding which radiographs are appropriate and whether there is a need for a radiograph pre-extraction. In relation to OPGs, he accepted they provide approximately double the radiation dose of a periapical radiograph. He also agreed that there is continuing evidence of poor image quality in panoramic radiographs (such as an OPG) and that panoramic radiological examinations can be used as an alternative, or supplement to intraoral radiography.

[22] While it was necessary to balance risk – this would be the pursuer's fourth radiograph – it would have been "judicious" to take an OPG given the potential complications. Patients were entitled to expect that their dentist would know everything about the extraction site so that the best possible care was provided. He denied this was an expression of best - rather than standard - practice.

[23] In relation to post procedure care, he agreed that there were no guidelines mandating or recommending routine follow up with patients. However, a follow up phone call ought to have been arranged particularly where a patient was left vulnerable to complications. Patients would expect this out of nothing more than human kindness, but it was also part of the dentist's duty of care. He denied that he was advocating a gold standard.

The defender

[24] The defender qualified as a dentist in June 2020 and has worked at the Bupa practice since 2021. As at 12 October 2022 he had extracted an average of five teeth a week of which one third were molars.

[25] The pursuer attended complaining of jaw pain. On examination, he noted poor oral hygiene and caries on UR6, UR7 and LL8. Two bite-wing radiographs were taken and he discussed treatment options with the pursuer. In relation to the LL8 he did not consider it was restorable and advised it could be extracted or left in place and monitored.

[26] On 12 October 2022, the pursuer attended for his LL8 extraction. The defender explained the risks associated with extraction including pain, bleeding, infection, jaw stiffness and the need for surgery if the tooth broke during extraction. He took a periapical radiograph to assess the roots and inform his approach to the extraction. If the tooth had been mobile, he would not have needed the image. The decision to obtain a periapical radiograph was informed by his wish to keep radiation doses as low as possible and because it typically provides better images than an OPG. Following a review of the radiograph, he attempted LL8 extraction.

[27] He was shown the OPG image taken prior to surgical extraction and said that because the tooth was fully erupted and he could see the full crown and structure of the mouth, he would also have proceeded with extraction based on this image.

[28] His contemporaneous notes confirmed that the procedure was difficult and unsuccessful. He dressed the extraction site with a temporary filling and referred the pursuer to the Albion Clinic with advice to manage pain with paracetamol and ibuprofen, but to contact the practice if there were issues with bleeding or other concerns.

[29] In cross-examination, he accepted that the roots of the LL8 appeared to be long and curved and that the tooth was grossly decayed. There was a risk of fracture during extraction of any tooth.

[30] The defender had a standard rough template he used for his clinical notes, which included a statement that after care advice was given. He could not specifically remember giving this advice, but was confident he would have as it was his usual practice. He did not accept there was a need to call all patients after extractions to see how they were doing, or that routine follow up appointments should be arranged, as there was no obvious clinical benefit.

Dr Gordon Boyle

[31] At the beginning of the proof, I granted Dr Boyle permission to sit in court while the other witnesses gave evidence. He qualified as a dentist in 1987 and has prepared medical-legal reports since 2015. He adopted the terms of his report dated 19 October 2023.

[32] His experience was that radiographs could be poor predictors of whether an extraction will be easy or difficult. The periapical radiograph taken by the defender showed a large cavity in the LL8, good bone support and no obvious indication that the nerve was near the roots. This radiograph was appropriate and any other view would not have changed the plan of action for any reasonable dental practitioner. He noted that the OPG taken after hospital admission also showed a fully erupted LL8 with gross caries into the pulp and no nerve involvement.

[33] Obtaining any radiograph had to be clinically justified. There is generally no evidence to support radiographic examination prior to routine extractions. Radiography may be required for the extraction by a general dental practitioner of an impacted tooth, or

where there was likely to be a close relationship with important structures. Generally, periapical images would be appropriate although one view is that for third molar extractions an OPG was required. However, given that not all dentists have the necessary equipment to take an OPG (his own practice does not) and the increased exposure to radiation, it was his opinion that for the routine extraction of a fully erupted LL8, a good quality, periapical radiograph is sufficient for a dentist to make an appropriate assessment. He had regularly extracted molar teeth without any radiography at all, and believed other dentists would have done the same given the terms of the Selection Criteria.

[34] Even if there was an established practice of obtaining an OPG prior to a planned general practitioner extraction of a wisdom tooth, it could not be said that no reasonable dentist exercising ordinary skill and care would have failed to comply with this practice. He would have proceeded to extraction after reviewing the periapical radiograph and he believed others would do the same.

[35] In any event, the medical records of the pursuer's subsequent treatment did not disclose any concerns arising from the OPG eventually taken. There were no reported complications with the extraction.

[36] In terms of post procedure care, he said following a failed extraction, it was standard practice to refer the patient to specialist care, who would then assume the duty of care. There was no guidance that he was aware of mandating follow up care after a referral to a specialist such as the Albion Clinic. While in some instances he had called patients after procedures, this was not standard practice.

[37] In cross-examination he maintained that there was nothing in the periapical radiograph to rule out extraction. He accepted that it was not possible to see the inferior

nerve in the image, but that its absence was itself significant. He accepted that for an impacted wisdom tooth, an OPG is the preferred radiograph.

[38] Asked whether a failure to give any post procedure advice would change his position on the need for pro-active follow up by the defender, he said a failure to give such advice would not be acceptable, but he would be very surprised if it had not been given. However, it would not change his opinion. Once a referral had been accepted the duty of care to a patient passed to the referral clinic, but that during the intervening period the original dentist would retain a duty of care. However, he would expect patients to have a level of common sense regarding their symptoms.

Submissions

Pursuer

[39] Parties were in agreement regarding the law on breach of duty in clinical negligence cases. Both cited the well-known dicta of Lord President Clyde in *Hunter* v *Hanley* 1995 SC 200 and the judgment of Lord Hodge in *Honisz* v *Lothian Health Board* 2008 SC 235. To succeed, the pursuer must demonstrate that (i) there was a normal and usual practice; (ii) that the defender did not adopt that practice; and (iii) that the course which the defender adopted was one which no dentist of ordinary skill would have taken if acting with ordinary care.

[40] The pursuer accepted that given Lord Hodge's opinion in *Honisz,* it was necessary for him to establish that Dr Boyle had failed to properly apply his mind to the facts and that his opinion did not bear logical scrutiny.

[41] The pursuer submitted that there were obvious "red flags" evident from the periapical radiograph, which indicated that the pursuer's decayed LL8 had a clearly

foreseeable risk of fracture on extraction. It also showed a close relationship between the LL8 roots and the inferior dental canal. Dr Kerr's opinion was that an OPG was appropriate for planned LL8 extractions where the roots are likely to have a close relationship to anatomical structures such as the dental canal. The additional radiation exposure was low and appropriate in the circumstances. Determining appropriate radiography was always a matter of clinical judgement, but in the facts of this case, the usual and normal practice would have been to obtain an OPG.

[42] In relation to follow up care, I was invited to prefer the pursuer's evidence regarding the lack of post-operative advice and Dr Kerr's opinion on the ongoing obligations the defender owed to the pursuer until he was seen by the Albion Clinic. The usual and normal practice was to telephone a patient within 48-72 hours of a procedure, and this was not done.

[43] In relation to both alleged breaches of duty, Dr Boyle's position did nor bear logical scrutiny.

[44] Each of the two breaches materially contributed to the pursuer developing an acute, rapidly developing dental infection. Had they not occurred, he would not have suffered pain, discomfort, hospitalisation, surgery and scarring to his neck.

[45] In relation to solatium, the pursuer submitted that the appropriate level was £6,000 for the infection (citing *McInulty* v *Alam* 1995 SLT (Sh Ct) 56)) and £4,500 for the scar (citing the Judicial College Guidelines, chapter 10(B)(d) for Facial Injuries, Less Significant Scarring; and chapter 11, Scarring to Other Parts of the Body). Given the overlap, an appropriate award was £9,500 with interest at 4% from 12 October 2022 to the first day of proof.

Defender

[46] The defender submitted that in some respects, the pursuer was not a reliable witness and that where his evidence clashed with that of the defender, the defender should be preferred. The pursuer had become irritated at questions regarding his ADHD questionnaires, which he had said were borderline discriminatory. Allegations regarding the failure to offer rehabilitation of his LL8 and a warning about nerve damage no longer featured as part of his case, yet he spoke to both in evidence and suggested he might have spent considerable amounts of money to salvage a tooth that was not visible.

[47] For reasons known only to the pursuer, Dr Kerr was led as witness before the pursuer. His evidence therefor suffered from the problem warned against by Lord Reed in *McConnell* v *Ayrshire and Arran Heath Board* 2001 Rep LR 8. Dr Kerr was at pains to point out he had proceeded based only on records, and the court should not be confident that he would have remained critical of the defender if he had the full factual picture. It was also plain that while it may be permissible to use hindsight in considering matters of causation, he had also done so in considering breaches of duty, which is impermissible (*Tucker* v *Griffiths* [2016] EWCH 1214).

[48] Despite citing it in his report as the basis for his opinion, the Selection Criteria had to be lodged by the defender as a production. In cross-examination it became clear that Dr Kerr was not familiar with the entirety of the document. His insistence that the pursuer required a fourth radiograph was illogical. His statement that he could not recall ever having extracted any wisdom tooth without first having taken an OPG appeared to offend against the Selection Criteria and his own opinion that clinical judgement was required in each case.

[49] There was no basis to find that there was a normal and usual practice applicable to the circumstances of the pursuer's LL8. Even if there was, based on the Selection Criteria it was not possible to say that a responsible body of dentists, exercising ordinary skill and care would not have acted as the defender did. On the contrary, Dr Boyle indicated that he would have proceeded as the defender had – and this opinion was offered after having heard the defender's evidence. Indeed, Dr Boyle indicated that he had removed a number of wisdom teeth without radiography at all, or only with the benefit of a periapical radiograph.

[50] In relation to post-operative follow up, Dr Kerr accepted there were no guidelines or protocols to support his position. He was advocating a gold standard rather than a normal and usual practice

[51] The pursuer also had problems with causation. The defender was entirely credible and well-reasoned when he said that he would have proceeded to extraction even if the OPG had been available. With regard to the second alleged breach, the pursuer's symptoms did not worsen until the Saturday or the Sunday. His evidence was that he did not call the defender because the practice was closed and he had an appointment at the Albion Clinic on Monday 17 October 2022. Even if he had received a follow up call on Friday 14 October 2022, he would not have had any concerns to report. Further, there was no evidence regarding what the defender would have done if, on the Friday, the pursuer had reported symptoms.

[52] In relation to solatium, any award should be no greater than £850 as set out within the range of Minor Injuries set out in Chapter 14(a) (Minor Injuries) of the Judicial College Guidelines.

Decision

[53] I found all of the witnesses in this case to be credible and generally reliable. The only meaningful issue of fact where there was conflicting witness evidence was in relation to whether or not the defender had given any post treatment advice to the pursuer. On this question, I preferred the evidence of the defender. His contemporaneous notes record that appropriate safety netting advice was given. He answered questions about this carefully. He was open in saying that he could not specifically remember giving advice to the pursuer over two and half years ago, but that it was his usual practice, and he therefore believed that he had. I consider that this answer added to rather than undermined his credibility. At the outset, he said his evidence was based on a mixture of recollection and contemporaneous notes. It would have been incongruous if he had a clear recollection of this one aspect of his interaction with the defender.

[54] The pursuer's evidence on this point was, on the other hand, quite strident, but in the immediate aftermath of a failed hour-long dental procedure, I can see how he may have been mistaken. Unlike the defender, I am unable to test his evidence with reference to contemporaneous material. I wish to be clear that the pursuer's ADHD has no bearing on my assessment of this part of the evidence. In any event, the pursuer's case relies on a failure to follow up in the days *after* discharge, not what was said immediately post treatment.

[55] Dr Kerr is a very experienced and diligent general dental practitioner. However, there was a mismatch between his reports, the pursuer's pleaded case, and his evidence in court. His May 2023 report does not address the two grounds of claim still relied on by the pursuer in detail. It was marked "not for disclosure" and at one point, he commented that he was not sure why it was lodged, given that it was still in draft form. It does not

specifically address the question of whether there was a common and accepted practice in relation to how the defender ought to have proceeded and if so, what that practice was.

[56] The pursuer's pleadings regarding the duties breached are somewhat opaque. There are averments to the effect that the periapical radiograph does not identify the relationship between the inferior dental canal and the LL8 root, and that this ought to have alerted the defender to potential complexities and the need for an OPG given the lack of urgency and the potential for the extraction to be beyond the defender's capabilities. It is then said that the lack of an OPG materially contributed to the failed extraction. The specific duty averred is that "No ordinarily skilled and competent dentist would have failed…in adequately assessing the pursuer's underlying nerve canal by performing only a periapical radiograph and not an OPG radiograph."

[57] Dr Kerr was asked questions designed to set up the first part of the test identified in *Hunter* v *Hanley*. However, the questions asked and answered appeared designed to add an additional alleged breach beyond the failure to obtain an OPG. Dr Kerr also said there was an ordinary and usual practice for a dentist to consider whether the extraction was within his abilities, when faced with a risk of the LL8 being unfavourable for extraction.

[58] The pursuer does not have a pleaded case in relation to this duty. The pursuer's case is that inappropriate radiographic assessment of the defender materially contributed to the failed extraction.

[59] There was no objection to this line of questioning, perhaps because the defender viewed it as relating to causation rather than breach of duty. There was no evidence regarding the level of experience needed to attempt such an extraction other than Dr Kerr indicating he would have expected only the most experienced dentists to attempt it. Dr Boyle's opinion on the other hand was that many dentists, including him, would have

proceeded with the extraction of this fully erupted LL8. The defender qualified in 2020 and gave evidence regarding the number of extractions he had carried out. In cross-examination he accepted the limits of his experience, having qualified in 2020, but his evidence was that he felt able to attempt the extraction of the pursuer's fully erupted LL8.

[60] Dr Kerr gave detailed and careful evidence, but ultimately it appeared to me that he was expressing what he would have done or what he might have expected others to do in the situation the defender found himself in. That is quite different from identifying an ordinary and common practice. The passages from the Selection Criteria that he was referred to, and accepted by him, confirm that there is no mandated standard practice in relation to required radiography for the removal of an LL8.

[61] I have come to the conclusion that the pursuer has failed to a prove the existence of a standard dental practice of taking an OPG prior to the extraction of an LL8 tooth presenting in the same way as that of the pursuer.

[62] Even if there was an established practice of the sort claimed by the pursuer, standing the evidence of Dr Boyle, it cannot be said the course of action pursued by the defender was one that no ordinarily competent dentist, exercising ordinary skill and care, would have undertaken.

[63] Further, and in any event, I do not accept that Dr Boyle failed to turn his mind properly to the question. On the contrary, he was also a careful and considered expert. In this case, Dr Boyle has said that he and other dentists would have adopted the same course as the defender. Accordingly, the following passage from *Honisz* is particularly relevant:-

> *"[38] The main area of contention between parties as to the law was what was the proper approach for the court to take to the evidence of the consultant orthopaedic surgeons led by the defenders that they would have adopted the same practices as those which the consultants and senior registrars, against whom negligence is alleged, in fact adopted. Again, however, the*

> *matter is one decided by authority which may be summarised briefly in the following propositions.*
>
> *[39] First, as a general rule, where there are two opposing schools of thought among the relevant group of responsible medical practitioners as to the appropriateness of a particular practice, it is not the function of the court to prefer one school over the other (Maynard* v *West Midlands Regional Health Authority, Lord Scarman at p.639F-G). Secondly, however, the court does not defer to the opinion of the relevant professionals to the extent that, if a defender lead evidence that other responsible professionals among the relevant group of medical practitioners would have done what the impugned medical practitioner did, the judge must in all cases conclude that there has been no negligence. This is because, thirdly, in exceptional cases the court may conclude that a practice which responsible medical practitioners have perpetuated does not stand up to rational analysis (Bolitho* v *City and Hackney Health Authority, Lord Browne-Wilkinson at pp.241G-242F, 243A-E). Where the judge is satisfied that the body of professional opinion, on which a defender relies, is not reasonable or responsible he may find the medical practitioner guilty of negligence, despite that body of opinion sanctioning his conduct. This will rarely occur as the assessment and balancing of risks and benefits are matters of clinical judgment. Thus it will normally require compelling expert evidence to demonstrate that an opinion by another medical expert is one which that other expert could not have held if he had taken care to analyse the basis of the practice. Where experts have applied their minds to the comparative risks and benefits of a course of action and have reached a defensible conclusion, the court will have no basis for rejecting their* v*iew and concluding that the pursuer has proved negligence in terms of the Hunter* v *Hanley test (paragraph [36] above). As Lord Browne-Wilkinson said in Bolitho (at p.243D-E), "it is only where the judge can be satisfied that the body of expert opinion cannot logically be supported at all that such opinion will not provide the benchmark by which the defendant's conduct falls to be assessed."*

[64] There was no "...compelling expert evidence to demonstrate that [Dr Boyle's]… opinion… is one which that other expert could not have held if he had taken care to analyse the basis of the practice." (*Honisz*, ibid.) As he has properly applied his mind, there is no basis for rejecting his view and concluding that the pursuer has proved negligence in terms of the *Hunter* v *Hanley* test.

[65] In relation to the second strand of the pursuer's claim, broadly the same analysis applies. Dr Kerr and Dr Boyle had different opinions, but I cannot say that Dr Boyle had failed to consider properly the issue. In any event, Dr Kerr accepted that while his opinion was that any dentist would have followed up with a phone call 48-72 hours after discharge, there was no available guidance to support this. Again, I felt that Dr Kerr was speaking to

his own experience and preferences in general dental practice, rather than ordinary and common practice. For these reasons, I also conclude that the pursuer has failed to establish his claim based on a failure to follow up appropriately with the pursuer after the procedure on 12 October 2022.

[66] For completeness, had it been necessary, I would have preferred the position of the defender in relation to causation. In relation to the claim based on the failure to obtain an OPG, the LL8 was fully erupted, no root involvement with the dental canal was indicated in in the periapical radiograph, and the defender had removed a considerable number of teeth previously. The evidence of the defender, which I accept, was that even with an OPG, he would have proceeded to attempt an extraction, in all the circumstances of this case.

[67] As for the second alleged breach, the pursuer's evidence was that he called the Albion Clinic because he was worried about when he might get an appointment and he wanted to check if they have received his referral. It was not prompted by his symptoms, which did not develop until over the weekend. He said he did not call the defender's practice over the weekend because it was closed and he was seeing the Albion Clinic on Monday. Had the defender called the pursuer on Friday 14 October 2022, I am satisfied on the evidence that the pursuer would not have reported symptoms requiring follow up, at that stage.

[68] No directly analogous cases or references in the Judicial College Guidelines were cited in relation to infection, but the pursuer's infection was severe and the experience of emergency hospital treatment would have been unpleasant. He was unable to open his mouth for a time, swallowing was difficult and he required surgery to drain the infection. He was left with a small scar. In relation to the scar, no evidence was presented other than

the pursuer gesturing to it in court. He suffered pain and swelling for a couple of weeks after leaving hospital.

[69] Had the pursuer established liability, I would have assessed his entitlement to solatium for the small scar at the mid-range of the Judicial College Guidelines for Minor Injuries (Chapter 14). When taken in conjunction with the infection, I would have made an award for solation of £4000.

Conclusion

[70] The pursuer has failed to prove his case and I will grant decree of absolvitor in favour of the defender. I was not addressed on the question of expenses, but a hearing can be arranged if necessary.