

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
SWANSEA DISTRICT REGISTRY

Date: 23 October 2026

Before:

His Honour Judge Harrison
sitting as a Judge of the High Court

Between:

MRS ANN GRIFFITHS	<u>Claimant</u>
- and -	
(1) HYWEL DDA UNIVERSITY HEALTH BOARD	
(2) SWANSEA BAY UNIVERSITY HEALTH BOARD	<u>Defendants</u>

Simon Dyer KC (instructed by **JCP Solicitors**) for the **Claimant**
Jamie Gamble (instructed by **NWSSP Legal & Risk Services**) for the **Defendants**

Hearing dates: 1 - 5 June 2026 and 25 August 2026

APPROVED JUDGMENT

HIS HONOUR JUDGE HARRISON

His Honour Judge Harrison:

1. In this case the claimant, Mrs Ann Griffiths, has brought proceedings against the first and second defendants arising from their failure to treat promptly symptoms of cauda equina syndrome during the summer of 2017. The first named defendants are responsible for the clinicians who oversaw the claimant's treatment at Withybush Hospital in Haverfordwest and the second named defendants are responsible for Morriston Hospital in Swansea. The defendants have shared representation and medical experts throughout.

2. **Introduction**

The claimant was born on 15th August 1962 and is now 64 years old. She has a long-standing medical history of leg and back pain. In the spring to early summer of 2017 she was referred for physiotherapy by her GP to the Community Musculoskeletal Assessment and Treatment Service "CMATS" and through them she was referred for an MRI scan. That scan was reported in July 2017 as showing mild to moderate stenosis at the level of L4/5 and at this time no "red flag" neurological symptoms were complained of. As part of the management of her condition she was warned by her GP to attend her local A and E department if symptoms developed.

3. The claimant says that on 21st August 2017 that's what happened. She attended at Withybush Hospital's A and E department but was subsequently discharged home.
4. The next day, 22nd August 2017, she attended at Withybush A and E again. She had earlier spoken to the physiotherapy department who told her to go back in. Further MRI examination was undertaken which was said to show severe spinal stenosis at L4-5 but also described the appearances as being consistent with the previous scan undertaken

in July. Mrs Griffiths was referred to Morriston Hospital as an outpatient to be seen urgently by the spinal surgeons.

5. Mr Kett-White saw the claimant on 14th September 2017. He was concerned but felt he was dealing with a slowly progressive condition. He thought she should be dealt with urgently but not as an emergency.
6. A decompression operation was arranged for a date in October but ultimately this was cancelled. Eventually the claimant underwent surgery on 7th November 2017.
7. It is the claimant's case that her condition throughout required being treated as an emergency. The defendants argue that the position was no more than urgent and that consequently waiting a matter of weeks was appropriate or at least within the relevant band of reasonableness. Central to the defendants' contention was the lack of any radiological evidence confirming compression of the cauda equina. They argue that without such evidence emergency surgery would not have been undertaken at any venue. If emergency surgery was envisaged then in all likelihood it would not have been undertaken at Morriston Hospital but would have meant a transfer to the neurosurgical team at the University Hospital of Wales in Cardiff. In order to persuade the emergency team to take a patient then radiological evidence justifying such action would have to be available and here it is not.
8. A further complication to this case arises from the claimant's reported recovery from symptoms after surgery in November 2017. Such recovery, it is argued by the defendants, is inconsistent with compressive damage to the cauda equina. The claimant's counter such argument regarding medical causation with reference to what they identify as objective evidence of nerve injury from both urological and colorectal experts.

9. There is no real dispute between the parties as to the basic legal principles to apply as encapsulated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v City and Hackney Health Authority* [1998] AC 232. I therefore do not set them out in terms.

The cauda equina

10. Before going on to consider the relevant issues in this case, it is perhaps of some assistance to have a rudimentary understanding of the relevant anatomy. Put generally, the spinal cord is a series of 31 sections or segments and from each segment there emerges a pair of spinal nerves. The cord tapers to a conical portion at or about the level of the first and second lumbar vertebra. Some of the nerves that arise from the lower portion of the cord do not leave the vertebral column immediately. Rather they travel “downward” or inferiorly in the vertebral canal with an appearance said to resemble the coarse hair of a horse’s tail. It is this appearance that earned the cauda equina its Latin name.
11. The nerves of the cauda equina are associated amongst other things with bowel and bladder function. Injury can be caused by compression such as to restrict or occlude the blood supply to the nerves comprising the cauda equina for a sufficient period to damage the same (Ischemia). The typical blood supply to the cauda equina is by way of longitudinal blood vessels running along each nerve root and this appearance is helpfully illustrated within the report of the claimant’s neurosurgeon Mr Choksey at TB Vol 1 page 339. Compression can be the result of many things including disc prolapse or herniation. In this case there has been much evidence concerning the relevance of cerebrospinal fluid (CSF). In general terms the presence or absence of CSF within a section of the spinal column can be identified on MRI scans. Absence of CSF

is consistent with compression of the spinal cord or specifically the cauda equina. Presence of CSF is generally consistent with the absence of frank compression of the cauda equina. The relevance of “buckling” as an alternative cause to compression was controversial but for reasons that are apparent below I have not found the issue to be relevant to the resolution of this case.

12. By way of a definition, cauda equina syndrome “CES” is said to be a dysfunction of 1 or more of the sacral nerve roots at S2 or below. Symptoms that must be present for the diagnosis must include bladder or bowel dysfunction, reduced sensation in the saddle area, and sexual dysfunction. It is said that the syndrome can be incomplete (CESI) or retentive (complete) (CESR). Progress from incomplete to retentive CES probably depends upon the number of nerve roots or fibres damaged by ischaemia. Once the majority of nerve fibres of the cauda equina that supply the bowel and bladder are damaged by ischaemia then the prognosis for recovery is very poor. Mr Choksey describes how the nerve roots at S2-4 are, by a “quirk of nature”, slender and particularly vulnerable to ischaemia and it is these nerve roots that serve the bladder and bowel.

The claimant

13. As I have said by the time this judgment is delivered the claimant will have had her 64th birthday. As a fair precursor to any analysis of her evidence, it is right to point out that she is being asked to turn her mind back to the events of 2017, some 9 years ago. Discrepancy and inaccuracy in recollection is inevitable, and I pay due regard to this. Consequently, it seems to me to be particularly important to pay attention to the content of any written record made contemporaneously.

14. Nevertheless, the point that arises in this case is more nuanced. There are a number of entries in the contemporaneous written evidence whereby Mrs Griffiths now says that she may well have told the health professionals, and indeed others, things that she now regards as being plainly inaccurate. A good example of this arises from the complaint letter written by her on 26th January 2018, i.e. within a matter of months of the decompression operation being performed. In that letter TB Vol 1 982 she referred to the onset of urinary incontinence “approximately 3½ years ago” and the commencement of bowel incontinence “18 months ago”. It goes on to identify relief of symptoms following the recent surgery and it is fair to say that the complaint is of a failure to act promptly over a period of years rather than the immediate events of the summer.
15. Mrs Griffiths now says the contents of that letter are simply wrong, and that her present recollection and evidence is of the acute onset of symptoms that should have been regarded as being red flags for a cauda equina injury should be preferred as correct.
16. Indeed, it is part and parcel of the argument advanced on behalf of the claimant that in dealing with her the clinicians should have taken into account the fact that Mrs Griffiths was a poor historian who gave differing accounts of her symptoms and their onset, and that they should have approached her account of such symptoms with care, erring on the side of caution.
17. Mrs Griffiths’ back problems stretched back to the 1990s. She had both investigation and treatment regarding the same. In her statement made for these proceedings she describes a worsening of symptoms in the spring of 2017 associated with some leg weakness. As set out above she was referred by her GP to CMATS where she saw Mr

O'Hara, a physiotherapist. She remembers the physiotherapist being concerned and he referred her to the spinal team at Morriston Hospital and for an MRI scan.

18. On 10th August 2017 she was seen by her GP. According to the claimant the upshot of the consultation was that she was already in the system to see the spinal team, and she could wait until they had seen her. Although in giving her evidence Mrs Griffiths could not recall specifically being told about cauda equina, she was told to go to A and E if her symptoms got worse.
19. On 21st August Mrs Griffiths tried to call Mr O'Hara. He could not be contacted, and she went to A and E at Withybush Hospital in Haverfordwest. She recalls that there was concern expressed about her condition, that she was examined including in her rectal and genital areas and that she needed to be referred both for another MRI scan and for surgery. Notwithstanding this concern she was discharged home.
20. On the following day, 22nd August 2017, Mr O'Hara returned her call of the previous day. Mrs Griffiths recounted her symptoms, and he told her to return to A and E. She was examined again and recounted her symptoms. Her need for another MRI scan was expedited, and she was told to come back the next day for it to be done.
21. On 23rd August 2017 the repeat MRI was undertaken. The clinician who saw her wrote a letter to Morriston Hospital seeking an urgent assessment, but she was discharged home.
22. Mrs Griffiths saw her GP on 24th August 2017 and then had an appointment at Withybush Hospital with Mr Isopescu. Mrs Griffiths says she again discussed her symptoms, but that Mr Isopescu did not seem to be particularly concerned.

23. She spoke to Mr O'Hara on 4th September 2017 and then ultimately attended for an appointment with Mr Kett-White on 14th September 2017, the spinal surgeon at Morriston Hospital. Mrs Griffiths' statement says that prior to this appointment she had not realised the severity of her condition (TB vol 1 104 para 39). In fact, she says that Mr Kett-White told her she needed urgent surgery and that the alternative was very serious.
24. Surgery was consequently arranged for 24th October 2017 but this was cancelled and rearranged for 7th November 2017. Mrs Griffiths underwent surgery but due to infection needed a further operation on 24th November 2017 to debride the wound and insert a vacuum pack to address the ongoing infection.
25. Mrs Griffiths' description of post-operative symptoms is a problem area to which I shall return. However, the claimant says that in the immediate aftermath of the operation her focus was on her wound and not on her bowel and bladder symptoms. Furthermore she says that when seen by the spinal nurse practitioner in December 2017, whilst she may have expressed happiness at having undergone surgery, she had not made the level of recovery that was recorded in the notes by the nurse. In her statement Mrs Griffiths said she was putting a positive slant on things and in her oral evidence she said she just wanted to get back to normal and that she thought that she would heal and the symptoms she continued to suffer from would go back to normal.
26. In fact, in oral evidence Mrs Griffiths said that in the aftermath of surgery she was still in a lot of pain, she was not happy with how she had been left after surgery, and she was not feeling better. Importantly she did not connect her back pain with bladder and bowel symptoms, and she was just trying to cope with these symptoms as best as she could.

27. Indeed, the claimant says that since 2018 her symptoms have worsened. More specifically in her statement (TB Vol 1 108) the claimant said that in 2018 her bowel and bladder symptoms had not got any worse but that her other pain associated with her back and leg had worsened.

28. She summed up the position as follows. TB Vol 1 109 para 63:

“Over the following years I have been back and forth to my GP and hospital regarding my back pain which has been progressive. I have been cautioned against further surgery and that my condition should be managed conservatively. Nothing has really changed since then, and my condition has essentially remained the same.”

The medical records

29. For reasons I have identified above these are important in this case. It is not feasible to set out the entirety of those records concerning the relevant hospital visits and consultations in full but they have been considered and referred to at length during the trial. What I have attempted is a summary.

30. On 25th May 2017 Mrs Griffiths went to her GP with pain in her left leg. The entry reads:

“Over the past 12 months pain more severe, sleep affected too. Inclines and steps very difficult pt unable to walk as far or as fast. Pain from lower back to foot, right leg also affected now. Lower leg seems very sensitive to the touch Pt often taking maximum amount of paracetamol which takes the edge off the pain, she declined other analgesia. Refer CMATS.”

31. On 8th June 2017 the claimant saw the CMAT physiotherapist Mr O Hara at Withybush Hospital The letter relating to the visit appears at core medical bundle “CB” 32. Mr O

Hara noted a history of nerve root compromise going back to 2010 with gradual deterioration. The pain was now said to be severe and was accompanied by pins and needles. The letter contains the following:

“The pain is accompanied by pins and needles and numbness in the same distribution. She denies any cauda equina symptoms.

.....Because of the previous MRI findings, the constant leg pain and the weakness on the left leg, I will arrange an MRI lumbar spine and review her in the CMATS clinic. I warned her that if she develops any cauda equina symptoms she needs to attend A and E.”

32. The Withybush MRI scan took place on 19th July 2017 and was reported by Mr Daram Sanjeev (an Advanced Practitioner MRI General Investigating Reporting Radiographer) CB 34, including the following:

“anterior slip of L4 to L5 noted with diffuse disc herniation indenting thecal sac anteriorly and causing mild to moderate stenosis at this level. There is a slight increase in size of the herniated disc seen in comparison to the previous scan of 23/7/2010”

33. The claimant was seemingly seen again by CMAT on or about 9th August 2017 and then saw her GP on 10th August 2017. Plainly a discussion as to what to do had taken place at both consultations. The GP noted a complaint of:

“ongoing low back pain with intermittent weakness of legs, pain is severe, no urinary or faecal incontinence, currently only taking paracetamol we agreed for slightly stronger pain relief and have given her info leaflet for cauda equina, she needs to attend A and E in that case, back exercises discussed for pressure relief until further plans become apparent.”

34. On 21st August 2017 the claimant rang Mr O'Hara at CMATS but could not make contact with him. She presented at A and E that afternoon. The relevant notes appear at CB 37.

35. The initial triage timed at 16.45 says:

"c/o worsening symptoms for a few weeks- advised by own GP to attend A and E if symptoms worsen - has loss of bowel sensation and is unable to empty bladder."

36. At 17.30 she was seen by Dr Smallwood, the A and E Consultant. His history records as follows:

"slight incontinence - dribbling and sensation of not emptying bladder properly for 2/12 - not getting worse.

Bowels - slight faecal soiling for 2/12

.....

(P) worsening control and compression lower lumbar area

-refer orthos"

37. At 18.20 that evening the claimant came under the care of the orthopaedic department. CB 39. The relevant consultant was Mr Isopescu. The notes are headed:

"(55) ? Cauda Equina"

38. The notes again contain a history taken probably by the registrar, namely

"-subjectively weaker in legs BL/ and is affecting her walking and working.

-no incontinence but Sx of urgency of urination and incomplete voiding. Abnormal anal sensations.”

39. An examination was then carried out and the same is detailed between CB 41 and CB 43. It includes reference to normal anal tone and sensation, an antalgic gait on the left side. In respect of sensation it notes: “Normal in all dermatomes no saddle anaesthesia”. The diagnosis section states, “Unlikely Cauda Equina ? worsening cord compression”. The decision as to management was discussed with a specialist registrar and the decision was for an MRI as an outpatient.
40. The claimant was discharged home.
41. On 22nd August 2017, the next day, and following her attempt the previous day before she went to A and E to contact CMAT, Mr O’Hara managed to have a phone conversation with Mrs Griffiths. He was obviously concerned, such that he wrote a letter to the claimant’s GP including the following:

“Impression

Suspected cauda equina syndrome

The patient was seen in CMAT with right leg pain on the 8/6/2017. An MRI was ordered. This showed L4/5 stenosis with a Grade 1 spondylolisthesis. She did not have any cauda equina symptoms at the time.

Yesterday at around 12:30 she called the CMAT office asking for advice regarding saddle paraesthesia (she had previously been advised to go to A&E if she developed any cauda equina symptoms). I called at around 14:30 that day but there was no answer. She went to A&E that evening and was discharged.

I have spoken to her this morning. She tells me she is having saddle paraesthesia and is currently experiencing bilateral leg numbness as well as problems voiding when urinating. She tells me she has had some faecal soiling also.

I have advised the patient to go back to A&E. I advised her regarding the nature of cauda equina syndrome. I have also spoken to the on call orthopaedic SHO and explained the situation.”

42. In accordance with the advice from Mr O’Hara, Mrs Griffiths re-presented at Withybush A and E at 11.11am on 22nd August 2017. The notes begin at CB45.

43. The triage at 11.31 CB 47 notes:

“Seen in A and E last night c/o pain to lower back extending down leg to left foot. Has tingling in back passage. Increasing tendency to be incontinent of faeces”

44. The SHO in A and E saw her at about 11.50. Another history was taken including a note that the patient attended with a history of low back pain and left leg pain with perianal tingling (CB 48). The history also notes that the patient had been seen in A and E by the orthopaedic department last night and that she had been discharged home. A worsening of pain and paraesthesia since last night was noted. Specifically, the doctor taking the history (Dr Carmichael) records:

“urinary urgency (2/12) + faecal soiling (2/12) No incontinence Able to walk but weak and painful”

45. The claimant was referred on to the orthopaedic department at 12.10.

46. At 12.50 the claimant was seen by the orthopaedic SHO who again took a detailed history (CB 49). Of relevance the doctor notes:

“presented to A and E last night with worsening symptoms – discharged with o/p MRI booked

Referred back to A and E by her physiotherapist following a phone call.

PT reports worse pain down left leg.

Subjectively weak but no difficulty weight bearing reports numb sensation in buttocks.

Increased urinary urgency and sensation of incomplete voiding

Moving bowels normally”

47. The orthopaedic SHO carried out an examination which seemed to identify virtually normal power and sensation. Mrs Griffiths was reassured but reminded of red flag symptoms and the need to return urgently.
48. Somewhat unusually it appears that later in the day the A and E consultant who had seen her the previous day, Dr Smallwood, wrote in the notes that he disagreed with the suggestion that the patient had normal power, he felt that Mrs Griffiths needed to be seen the following day, and he appears to have contacted the orthopaedic department to arrange for her to be seen the following day at fracture clinic.
49. On 23rd August 2017 the claimant was seen at the fracture clinic at Withybush Hospital by Dr Jadhav, the Locum Registrar in Trauma and Orthopaedics. He wrote a letter to the claimant’s GP (CB 54) in which he set out his clinical findings including the following:

“on examination she walks full weight bearing with a slight antalgic gait. She has tenderness in the lumbar spine with restricted lumbar spine range of movement. She

has a positive nerve root impingement sign on the left side to 40 degrees with no cross SLR test. In terms of her neurological examination she has a grade 5 power in all myotomes in both lower limbs with intact reflexes bilaterally namely the knee and ankle jerks as well as downgoing plantars. She has 40% hypoesthesia in the left L4 and L5 dermatomes. I have done a PR examination on her today. She has normal perianal sensation and normal anal tone.

Due to increase in left lower limb radiculopathy along with increase urgency of bladder function, we have repeated her MRI scan today which continues to show severe spinal stenosis at L4-L5 level. These changes remain unchanged from her last MRI scan from July 2017.

On balance, as her symptoms have significantly increased in intensity and she has had urgency of bladder function, I believe she warrants an urgent spinal referral as she may be in impending cauda equina syndrome due to her bladder function urgency which she has had for the last 2-3 months. She does not suffer or exhibit any acute clinical features of cauda equina syndrome today. We shall be sending this referral by an urgent fax to the spinal surgeons at Morriston hospital in view of her bladder function urgency along with her 2MRI scans via IEP to their PACS system. To ensure that she is not lost in the system, we shall bring her back to clinic in 1 weeks time to re check her symptoms. She is advised to present to her local A and E urgently if she suffers from any acute bladder/bowel red flags in the interim as she will then need to be re-examined and discussed with the spinal surgeons at Cardiff.”

50. Mr Jadhav’s letter to the Morriston Spinal surgeons is dated 24th August 2017 and appears at CB57. He said:

“we would be grateful if you would see Ann Griffiths who is a 55 year old patient who has had low back pain for several years but of late has been experiencing an exacerbation in this low back pain with left lower limb radiculopathy. She has been experiencing increased urgency in terms of her bladder symptoms which she has had for the last 2 to 3 months.

From a clinical point of view, she has low back tenderness with painful low back range of movements. She has positive nerve root tension sign at 40 degrees on the left side with no cross SLR.

In terms of her neurological examination she has grade 5 power in all the myotomes in both lower limbs with normal reflexes bilaterally namely knee as well as ankle jerks with downgoing plantars. She has 40% hypoaesthesia in the L4 and L5 dermatomal distribution. She has normal perianal sensation and normal anal tone.

However her MRI scan which was done in June 2017 as well as August 2017 both show severe canal stenosis at the L4/5 level with mild to moderate stenosis at the L2/3 level.

We would be grateful if you would see this patient on an urgent basis.....”

51. Mrs Griffiths went to a scheduled orthopaedic clinic appointment on 1st September 2017 with Mr Stefan Isopescu. In a letter (CB 62) sent to the claimant’s GP after the clinic, he noted:

“she has got urinary urgency she was telling me and the feeling that she is not fully emptying her bladder and she is also aware of numbness in the perianal and perineal area when wiping her bottom. She has got no evidence of incontinence however. The symptoms she is describing have been present for the last few months and have

worsened and in particular the numbness of the perianal area over the last 1-2 months.....

There is reduced sensation to the perineal area to touch and there is blunting to pin prick in the left perianal area. Anal tone however, is preserved both right and left of I+.

I was told by the orthopaedic secretary that the referral has been received at the Spinal Unit and is awaiting to be graded I will forward a further letter to reinforce the urgency of the upcoming appointment. I have explained this to Mrs Griffiths and also warned her that if her water and/or bowel symptoms should worsen that she should present urgently to Casualty, and she is aware of that.

52. The letter from Mr Isopescu emphasising the need for an urgent appointment is dated (CB 64) and was sent on 5th September 2017.
53. In the meantime, Mrs Griffiths attended at CMAT again on 4th September 2017. Mr O'Hara wrote to the GP as follows (CB 61):

"I reviewed this patient in the CMATS clinic today. Her signs and symptoms are unchanged. I arranged an MRI of her lumbar spine. This shows spondylolisthesis at L4/5 and what seems to be some neural compromise.

I explained the results to the patient today.

The plan is to discuss this with the Morriston spinal surgeons."

54. CB 65 seems to record the grading as urgent, i.e. 0-6 weeks and as we know Mr Kett-White saw Mrs Griffiths on 14th September 2017.

55. The consultation included the claimant completing a “Spine symptoms questionnaire” (CB 67). Part of the assessment involved the claimant writing down a description of her current problem. The questionnaire invites the patient to put the most serious one bothering her first. In her own handwriting the claimant has written

PAIN IN LEFT LEG AND BOTTOM OF BACK.

As to when it started she has written

SINCE 2005 PAIN GETTING WORSE

In response to a specific question about urinary symptoms (e.g. urgency frequency incontinence) she has written

URGENCY

56. Mr Kett-White’s conclusions are set out in a letter to Mr Isopescu dated 14th September 2017, (CB 69).

“Thank you for referring this lady who has progressive left L5 pain syndrome that is slowly getting worse. Of concern, she has started noticing worsening bladder and bowel control over the last year. It has been a slow progressive story. She did say that she has recently noticed numbness around her back passage.

On examination she appears well. Her gait is normal. There are no upper motor neurone features of ischaemia.

The MRI scan in August shows degenerative spondylothesis with canal stenosis at L4/5. There is clearly compression on both L5 nerve roots with the left obviously more

symptomatic. There is also concern that she is developing a slow progressive cauda equina compression.

I have recommended surgery, an L4/5 decompression on an urgent basis. I think it is likely to help her leg pains and will reduce the chance of her developing incontinence.”

57. Mrs Griffiths attended the admissions clinic for surgery on 27th September 2017. Another questionnaire was completed by her, and she was consented for lateral L4/5 decompression and fusion surgery. The questionnaire completed by the claimant largely repeated the previous one including the description of urinary symptoms being limited to “URGENCY SOMETIMES” (CB 74).
58. In fact we know the surgery was cancelled and then re-arranged for 7th November 2017. The operation note is at (CB 82).
59. We also know that the wound broke down and that the operation site was revisited by Mr Kett-White on 21st November 2017. A vacuum assisted closure device was deployed and the wound closed (CB 226). There was obviously an ongoing problem with the wound such that on 24th November 2017 Mr Kett- White undertook surgical debridement.
60. Having been discharged, Mrs Griffiths attended for an outpatient follow up appointment at Morriston Hospital on 14th December 2017, i.e. 6 weeks post-surgery. She was seen by Janet Evans who was a nurse practitioner associated with Mr Kett-White. She recorded at (CB 291):

“Today she walked into the clinic looking very well. Her wound has now healed completely. Mrs Griffiths is delighted with the result of her surgery and she tells me

now that she has a very low level of intermittent left leg pain.”

61. Following that attendance, the claimant was discharged from clinic with advice to return if there were further problems.
62. The claimant’s complaint letter to “The Concerns Team” at Hywel Dda University Health Board falls into the chronology at this point. Whilst not a medical record, it is in my judgment helpful to place it within the appropriate context. It contains the following important paragraphs that I set out in full:

“Over the past 12 years I have been in horrendous pain. I have been back and forth, been given painkillers, told to keep mobile and the presumption was that the pain was emanating from my leg which I had broken as a young girl resulting in several operations into adulthood. I had to take numerous periods off work because of the pain, and at times I could hardly walk.

About 3 ½ years ago, I started to suffer with urinary incontinence. I would be out of the house and just seem to have accidents. This got worse and eventually I started to wear incontinence products. Then about 18 months ago, I started to suffer with bowel incontinence.

In about August last year (2017), I finished work one evening and I had terrible pain in my back, I had no strength in my legs and I was starting to lose the feeling in all 4 limbs. I was really concerned. I went straight to A and E at Withybush and was asked if I had been suffering with any incontinence. I of course confirmed I had. As a result, an MRI scan was carried out and this revealed a slipped disc.

The letter goes on to deal with the post-surgical position as follows:

“Since I had the surgery, my back pain has greatly improved. I’m no longer in constant pain, just seem to have a feeling of weakness. As for the incontinence this has stopped. I just seem to suffer with a bit of urgency and I’ve not had a single accident since the surgery was carried out.”

63. The claimant visited her GP and she was signed off work (CB 5). On 15th February 2018, 13th March 2018 and 20th March 2018 they noted that Mrs Griffiths was complaining of a slow recovery and that she was working towards a phased return to work in about 2 months’ time. By 9th April 2018 she was said to be getting stronger and more active. She was going out for walks and was working through the pain barrier. The GP made the following specific record:

...no significant remaining neurological problems, does not feel quite ready to go back to work, but will consider return on reduced hours in 1 month.

64. On 8th May 2018 she was due to return to work in 2 weeks’ time on reduced hours and was said to be feeling fitter.

65. On 24th May 2018 the GP noted:

“Patient reviewed med 3 for another 4 weeks, however in about 2 weeks can start to return to work, asking for another sick note, having aches and pains all over, no significant neurological symptoms, trying to stay active, I advised that she starts talking to employer about best strategy to get her back to work, the longer she waits the harder it will be.”

66. By 18th June 2018 the claimant was said to be pleased that she had returned to work for 5 hours a week but that she wanted to pace herself. At that stage her plan was to increase

her weekly hours slowly up to 16 hours a week because she could then continue to receive benefits.

67. In August 2018 the GP wrote to Mr Kett-White (CB 282). She wrote

“She initially had a good result from the surgery but has since developed problems: pain lower back mainly when standing for longer period, she gets severe back pain when walking for more than ½ mile. She has returned to work for 5 hours a week, which she spends sitting down. She is reporting a tingling sensation down both her legs. Bladder and bowel function is currently not affected.”

68. Mr Kett-White saw her on 12th October 2018 and wrote back to the GP (CB 286). The spine symptoms questionnaire is at (CB 287). He described the position thus:

“this lady had an L4/5 decompression and fusion for degeneration spondylolisthesis causing a severe canal stenosis one year ago. It was initially very successful despite a wound dehiscence, but over the last few months, she has noticed a gradual recurrence of symptoms to such that she gets pain below her knees to the feet on standing and walking for about a quarter of a mile.”

On examination there is no neurological deficit or ischaemia.”

69. As part of this review process Mr Kett-White ordered another MRI scan. The scan is reported at CB 289 and regarding the lumbar spine notes:

“Following surgery the canal is now adequately capacious at L4/5. There is however a moderate canal stenosis at L3/4 due to the facet joint and ligamentum flavum hypertrophy, and this is more prominent than on the previous imaging.”

70. The claimant then seems to have sought a private appointment with Mr Navin Verghese in April 2019 due probably to the time taken to receive a follow up appointment, and he wrote a letter the GP dated 17th April 2019 (CB 295).

Mr Verghese records:

“As you know she underwent L4/5 decompression and posterolateral fusion for degenerative spondylolisthesis causing severe central canal stenosis in 2017. She was developing cauda equina syndrome prior to the surgery and following it she had significant improvement in her bilateral claudicant leg pain as well as her bowel and bladder dysfunction.

....

Over the last 6 months or so however she has re-developed her pre operative claudicant leg symptoms mainly in the buttocks and calves. She denies any femoralgic type pain. Her bowel and bladder is still disturbed but far better than it was preoperatively. She has not noticed any deterioration with regard to this.

She has noticed however a subjective weakness in both her ankles and occasional episodes of falling over which she does feel has gradually progressed over the past half a year or so.”

71. Mr Verghese’s view was that further surgery was not indicated and that the claimant should be referred to the pain clinic. The pain clinic referral letter is at CB 298 and includes the following:

In July 2017 seen by CMATS and diagnosed with L4/5 spinal stenosis. This was slowly progressive. In November 2017 she had primary decompression of L4/5 under Mr Kett-

White in Morriston Hospital. She had a very traumatic postoperative period with wound dehiscence and break down, which required 2 surgical debridements. Once this had resolved she had a good result from the surgery with significant reduction of her pain.”

72. The waiting time to see someone in the pain clinic was apparently 6 months. Dr Kauschinger, the GP wrote trying to expedite the appointment at CB 301:

“I referred this 56 year old patient with a complicated history of back pain for further pain management in May and she has a wait of at least 6 months.

Unfortunately she is now developing more severe pain on exercise and at night and is therefore taking steps backwards on her progress.

Pain is down both legs and where she could walk for 1 mile before, she is hitting a wall much sooner.”

Analysis

73. One of the few matters upon which the parties wholeheartedly agree is that this case is complex. Counterintuitively another matter upon which they agree is that despite its complexity there is a simple answer or route to a conclusion that can be based upon facts that can readily be found. Unsurprisingly the parties part company in relation to which simple conclusions the court should reach in order to unlock the issue of liability.

The claimant’s case

74. I shall summarise the competing contentions advanced beginning with the claimant’s case. In submissions the claimant focussed upon orthopaedic breach of duty along with a subsequent potential breach by Mr Kett-White the treating spinal surgeon. For reasons

that became apparent during the course of the trial, and whilst not abandoned, the extent to which any alleged breach in relation to the reporting of scans became much less important. The claimant submits that the initial core finding to be made in this case is the failure of the orthopaedic team at Worthybush hospital to identify the claimant's worrying symptoms as acute. They submit that in accordance with the evidence given, clinicians at Worthybush in dealing with someone in the claimant's position can place someone in one of three lanes; namely slow, medium or fast. Here they submit that her presentation, along with the clearly expressed concerns of Mr O'Hara the physiotherapist at CMAT, merited Mrs Griffiths being placed in the fast track. If that had been done and she had been placed in the proper category by the orthopaedic department then it is submitted there would have been a different approach. Specifically it is contended that if Mrs Griffiths had been dealt with appropriately then rather than sending a fax to Morriston Hospital for consideration by the spinal surgeons there (Mr Kett-White et al), i.e. the medium lane, a phone call should have been made to the neurosurgeons at the University Hospital of Wales at Cardiff (UHW) who would have accepted her as an urgent patient, take her case and operate immediately upon her arrival at hospital or at least very promptly.

75. The point emphasised on the part of the claimant is that once the court finds a breach of this sort on behalf of the orthopaedic department, then the question becomes one of factual causation and what would have happened on the balance of probabilities and therefore not a matter tempered by the question of *Bolam* reasonableness.
76. The claimant's argument is that having regard to the acute symptomatology and the developing symptoms, then, taken together with scans that would identify a surgical target identified then the court can readily be satisfied that the neurosurgery team at the

UHW in Cardiff would have accepted that Mrs Griffiths needed to be dealt with by them as an emergency.

77. Further or alternatively, in any event when Mrs Griffiths was seen by Mr Kett-White, then with the symptoms described and a surgical target identified, it is submitted that there was no logical basis for delay. Mr Kett-White having identified a danger from progressive symptoms from the cauda equina could not logically justify any delay in taking action to decompress the cauda equina and thereby avoid the potentially catastrophic consequences of a cauda equina injury.

The defendant's case

78. The defendant's submission is that a key finding to be made in this case is radiological. Moreover, it is submitted, such a finding is uncontroversial. Whereas the radiological evidence may differ as to how to describe the degree of stenosis, it is in agreement in relation to whether or not compression of the cauda equina is present and the experts agree that it is not. The defendants submit that without compression of the cauda equina being evidenced radiologically then emergency surgery would not be undertaken, consequently even if a referral was made to Cardiff, then the surgeons at UHW would not have accepted the case and the matter would have proceeded as it did with a referral to the Morriston neurosurgeons.
79. The defendants submit that such an approach by the UHW surgeons would be consistent with the National Suspected Cauda Equina Pathway (Getting It Right First Time "GIRFT"), a flow chart version of which appears at Literature Bundle (LB) page 64. That document was produced after the relevant events but was accepted by the medical experts as describing the approach at the time. The defendant specifically relies upon the part of the flow chart beneath the "Hospital Presentation and Diagnosis" column

that identifies the presence of radiologically confirmed cauda equina compression as opposed to other neural compression as justifying emergency surgery in a patient presenting with recent onset of cauda equina symptoms.

80. In any event the defendants argue that irrespective of any findings made in relation to breach of duty there is a factual finding to be made that fundamentally undermines the claimant's case that any delay in surgery was causative of damage. Put shortly the defendants submit that if there was a noticeable recovery in the claimant's condition in the immediate aftermath of the surgery undertaken by Mr Kett-White, then on the agreed state of the medical evidence, damage to the cauda equina consequent upon delay cannot be established. In that respect the defendant relies upon the contents of the medical records and perhaps most importantly the claimant's own letter of complaint made in the immediate aftermath of the surgery.

The actions of the orthopaedic department and the classification of Mrs Griffiths within the same as requiring urgent but not emergency surgery

81. One of the unfortunate aspects of this case was the absence of Dr Jadhav, the trauma and orthopaedic registrar identified in the notes. He had provided a statement dated 17th June 2025 but ultimately was unavailable to attend. His evidence is therefore admissible but untested by cross examination. This goes to weight. In fact, as might be expected the content of the statement is largely made by reference to the clinical notes and Dr Jadhav has no recollection of the claimant.
82. As this case developed much of how the claimant now advances her case relies upon paragraph 17 of Dr Jadhav's statement at TB Vol 1, 169. It is that section that identifies the 3 lanes of approach at Withybush Hospital to a person with cauda equina type presentation in 2017. Dr Jadhav says:

“In terms of the referral system back in 2017, the practice was that if a patient had obvious acute signs then we would contact Cardiff (University Hospital of Wales) by way of urgent telephone call to refer the patient. However if the patient did not have acute signs of cauda equina then we would dictate a referral letter and that would go by post to the local spinal service at Morriston Hospital, in Swansea. If the patient fell between the two, and we wanted the spinal surgeons to assess the patient sooner rather than later, then we would do a letter and then fax that over to Morriston, to avoid any postal delays.”

83. At paragraph 18 of his statement Dr Jadhav went on to say:

“the claimant had symptoms of urinary urgency for a few months and her MRI was unchanged from July 2017. Her PR examination confirmed normal anal tone. Mr Isopescu therefore did not consider an urgent telephone referral was necessary, however he did advise to fax the referral letter, rather than send it by post.”

84. In considering the actions of the orthopaedic department at Withybush Hospital it is appropriate to note at the outset that this is not a case where the question of cauda equina injury was dismissed or ignored. Rather it is clear that it was on all of the clinicians’ minds. This is unsurprising. The identification of cauda equina injury is important and the consequences severe. Hence, as in this case, whenever the patient was discharged it is unsurprising that the clinicians were at pains to give “safety netting” advice about returning to hospital.

85. It is equally important to note that clinicians have to some extent rely upon what they are told by their patient. Of course, some patients are better historians than others and whilst a clinician cannot ignore or turn a blind eye to obvious errors in what they are

told when examining or taking a history from a patient, what a patient says is important.

86. It is an inescapable fact that the claimant has given an inconsistent account of her symptoms to various clinicians. The claimant urges me to approach the matter as follows. On the basis of the medical records for the spring of 2017, there were no complaints of symptoms of the sort that ultimately warranted referral for spinal surgery. Consequently and particularly by reference to the contents of the CMAT physiotherapy noted there was a change in the summer of 2017 and that should have been identified by those treating her and she should have been placed on the fast track for surgery.
87. The first problem with that argument is that it is not what was said in the complaint letter and furthermore is not what is recorded contemporaneously within the majority of the records made in the orthopaedic department after taking a history and examination. There is, in my judgment a degree of consistency in the records that identify complaints of chronic symptoms in particular urinary and bowel. Bearing in mind that there is no doubt that the clinicians were at the relevant time alive to and looking for cauda equina symptoms, the digest of medical recordings identifies the following points that are noteworthy. On 21st August 2017 Dr Smallwood, an A and E consultant at Withybush recorded slight incontinence and bowel soiling over a period of 2 months, not getting worse. That evening the orthopaedic department identified bilateral weakness, incomplete voiding and on examination normal neurology with no saddle paraesthesia. On 22nd August the A and E SHO again recorded urinary urgency and soiling over a period of 2 months. On examination by the orthopaedic SHO it was noted that power and sensation were normal. (Although this was potentially

undermined by the entry made by Dr Smallwood, that entry related primarily to power not sensation.)

88. As already highlighted above on 23rd August 2017 Dr Jadhav's PR examination identified normal anal tone and an absence of acute cauda equina symptoms. On 1st September 2017 when seen by Mr Isopescu at the orthopaedic clinic, whilst some numbness in the perianal area was noted, there was a record of urinary urgency over a few months.
89. Against all of this, the physiotherapy notes are somewhat of an outlier. I am satisfied on the balance of probabilities that when asked by the treating clinicians in the orthopaedic department Mrs Griffiths was not describing the sudden onset of red flag symptomatology. I am satisfied that the department were aware of the need to watch out for the sudden onset of such symptoms and did not identify them. Furthermore the fact that Mrs Griffiths would have described chronic urinary and bowel symptoms would be consistent with the letter of complaint written by her relatively contemporaneously and which identifies the worsening of painful symptoms in her back as the reason for going to hospital in the summer, rather than the sudden onset of acute urinary, bowel or alteration of sensation.
90. In my judgment it is not an explanation of this to say that the letter was written for a different purpose, namely, to highlight her perceived delay over a number of years in treating her spine.

Attendance at Mr Kett-White's clinic

91. Further confirmation of the nature of the complaints of symptoms being made by Mrs Griffiths is available from the notes made by Mr Kett-White when Mrs Griffiths

attended his clinic. In summary he recorded a worsening of bladder and bowel symptoms over a period of about a year with some recent numbness. He was concerned of a slowly progressive cauda equina symptoms and says that he treated accordingly, namely urgently but not as an emergency. It is fair to say that the claimant criticises his approach from the point of view of logic. Put shortly if cauda equina injury was suspected, then the consequences of the same could be so damaging, that any delay is to run an unreasonable risk.

92. Of course, any delay in surgery carries with it a risk. However not everyone can be operated upon within 24 hours or so. Here, on my findings, I am satisfied that the clinicians were being told by Mrs Griffiths of slowly developing neurological symptoms as opposed to the sudden onset of acute red flag symptoms. Within a system whereby only true emergencies could be operated upon immediately, I am satisfied that Mr Kett-White's characterisation of slowly developing symptoms was consistent with what he was being told by his patient and consistent with what Mrs Griffiths had been telling the orthopaedic department. Of course this was a matter of judgment on his part. Whilst he did not conclude that emergency surgery was required, he equally formed the view that an urgent intervention was appropriate, i.e. the middle track. This was, of course, the same approach identified by the orthopaedic department at Withybush, who had referred her to him at Morriston as opposed to the neurosurgeons at Cardiff.
93. Feeding into any assessment was of course the radiological evidence that was available. Such evidence is, of course, not only relevant to the view formed in Withybush and Morriston but is also relevant when it comes to assessing what would have happened if Mrs Griffiths had been referred as an emergency.

Radiological evidence and compression of the cauda equina

94. At the outset of this trial the court would have been excused for thinking that, both by reason of the pleadings and the expert medical evidence obtained, there was a significant issue to resolve arising from Mr Daram Sanjeev's radiological report of the MRI scan. He had described the degree of stenosis at L4/5 as mild to moderate whereas the MRI scan obtained shortly afterwards whilst seemingly demonstrating similar levels of stenosis, characterised the same as severe. Indeed, Mr Sanjeev was cross examined on this issue in detail and conceded that perhaps an upgrade to "moderate" would have been appropriate in hindsight.
95. In fact, upon hearing the oral evidence from the experts namely Professor Whitehouse and Dr Rankine, the relevance of this apparent difference diminished substantially. Firstly, Professor Whitehouse altered his position to suggest that a categorisation of moderate would be acceptable and secondly it became apparent that, somewhat counterintuitively, the categorisation of stenosis by those reporting the same appeared neither to be standardised in any recognisable way or indeed regarded as particularly important. Furthermore, by the time of the impeached clinical decision making by the orthopaedic department the second MRI scan had been reported and was available for consideration. Consequently in fact this apparent issue was the subject of limited submissions either orally or in writing. I am satisfied on the balance of probabilities that the categorisation of the stenosis of the MRI scan in the report on 19th July 2017 had no causative effect on how Mrs Griffiths was treated.
96. That said, the expert radiologists in this case did provide important evidence regarding what the scans demonstrated in respect of the cauda equina. Here the experts agree that the scans are consistent with the presence of cerebrospinal fluid (CSF) in the relevant areas and therefore do not radiologically demonstrate cauda equina compression. This

is important not because clinical decisions are made by the radiologist but because the defendants argue that the absence of radiological evidence of compression would have informed the decision of any neuro or spinal surgeon invited to consider Mrs Griffiths case at this stage, including the neurosurgeons in Cardiff. This is especially relevant with regards to whether any decompression surgery would have to be carried out as an emergency.

Orthopaedic expert evidence

97. Mr Pearse and Professor Lavy gave conflicting evidence regarding the approach of the orthopaedic department and the failure to refer for emergency as opposed to urgent treatment. The joint statement appears within the trial bundle at TB 827.
98. In summary, the experts agree that some of the symptomatology complained of within the orthopaedic department could amount to red flag symptoms of serious pathology. They disagree as to whether emergency referral for immediate surgery was required. Mr Pearse plainly regarded the situation as that of an obvious barn door decision. Professor Lavy placed substantial importance on whether such symptoms were reported as chronic or acute onset.
99. I have dealt with the claimant's history as recorded contemporaneously at length. My conclusions in relation to the same are that whilst the claimant was an inconsistent historian she was broadly reporting neurological urinary and bowel symptoms to the orthopaedic department that were chronic, i.e. 2 months or so. This is what was recorded by clinicians who were alive to the possibility of a cauda equina issue. It is also more consistent with the contemporaneous complaint letter which does not describe the sudden onset of red flag symptoms in August 2017. From the point of view

of judging the actions of that department it is what they were told by the claimant that is relevant.

100. In my judgment whilst the orthopaedic department were of course being told of some alteration of symptomatology, they had to balance this against the version of chronic symptoms that they were being given. This is really the point being made by Professor Lavy. In fairness to Mr Pearse, he agreed as much in cross-examination. He accepted that if the court found that the relevant symptoms (neurological, urinary and bowel) had been significant for months then an urgent referral to the neurosurgeons was acceptable and an emergency referral was not required. I would slightly extrapolate this to the extent that, so long as they were not closing their eyes to the obvious, it is what they were being told by Mrs Griffiths that was important.
101. Professor Lavy put it this way in re-examination. I summarise. Patients do tell different stories. When receiving a history, a reasonable body of clinicians rely upon what they are told. It is “Bolam acceptable” to review what is available, take a reasonable history and act on the findings.
102. In considering whether or not the orthopaedic department acted in breach of duty, I agree with Mr Dyer that it is not sufficient simply to look at the “GIRFT” documentation and say that, absent radiological evidence of compression, a failure to refer for emergency surgery can never be negligent. The simple reason is that this is not what Dr Jadhav says in his statement. Of course, the fact that the accepted pathway would have placed significant weight on the absence of radiological compression evidence is a helpful cross check when considering whether what happened was reasonable. It also casts some doubt on Mr Pearse’s characterisation of the situation as a Barn Door case for emergency referral.

103. What in my judgment the GIRFT documentation certainly does do is to call into question the factual issue of what would have happened if a referral had been made by the orthopaedic department at Withybush directly to the neurosurgeons in Cardiff. I deal with that issue of factual causation below.

The neurosurgical evidence

104. Neurosurgical expert evidence was provided by Mr Choksey for the claimant and Mr Jacowski for the defendants. That is not a unique scenario. In their evidence to the court in writing and orally they adopted a robust approach. I am invited by each party to conclude that there are strong reasons to conclude that the other party's expert has been unreasonable or worse. I resist such invitation, and in the context of this litigation I am unpersuaded by arguments such as whether Mr Choksey's failure to disclose recent criticism in another case represents a reason to reject his analysis.
105. Despite these robust differences, the parties each again submit that a reasonably straightforward pathway can be charted through what is undoubtedly a complex neurological case, albeit that they again reach different conclusions. The first neurosurgical question for the court is whether, having had Mrs Griffiths referred to him as an urgent (not emergency) patient, Mr Kett-White should have taken a different view and either have operated himself as an emergency or requested another surgeon in Cardiff or otherwise to do so. The submission made on behalf of the claimant again depends to some extent on the history given. Mr Dyer contends that against a background of some change in symptoms, then along with the identification of a surgical target, it is indefensibly illogical (in accordance with "*Bolitho*") to wait. Mr Kett-White was obviously worried about the development of cauda equina damage and against such a background, the claimant submits that it simply makes no sense to wait

when all that can happen is for the very thing that you are trying to prevent actually occurring.

106. The defendants again ask the court to reflect on what the claimant is likely to have told Mr Kett-White not only by reference to the notes made by him but also by reference to the letter of complaint. They submit, and for the reasons set out above, I agree, that on the balance of probability Mrs Griffiths would have described mainly chronic symptoms and that Mr Kett-White was not faced with a description of significant acute red flag symptomatology. I am satisfied on the basis of the medical notes that the history described by Mrs Griffiths was consistent the slow development described by Mr Kett-White in his contemporaneous letter to Mr Isopescu on 14th September 2017 with perhaps the addition of some numbness. It follows that, in my judgment Mr Kett-White was entitled to assess the position as he did in that letter, namely a slowly developing condition and to proceed on the basis of an urgent rather than emergency pathway. The claimants handwritten answers to the questionnaire are important.
107. In any event the defendants submit that irrespective of any conclusion the court reaches in terms of whether there were relevant changes or concerns over developing cauda equina symptoms, reference to the acceptable pathway identified within the GIRFT documentation demonstrates that in the absence of radiologically established compression of the cauda equina, then emergency surgery, is not the recommended course. This is the point made by Mr Jakowski within the joint statement at TB 837 and TB 839 and developed during the course of the trial. Mr Choksey in evidence accepted both that the “GIRFT suspected cauda equina pathway” as produced to the court (Literature Bundle 60 and specifically 64) represented a reasonable and responsible body of medical opinion and furthermore that, whilst the document is dated after the

relevant events, it represented a distillation of good practice that was relevant at the material time. The short point to be made from that document is that even if there is the onset of acute cauda equina syndrome symptoms within 14 days, then the further consideration of radiographical evidence of compression of the cauda equina rather than other neural compression should be met before emergency surgery is the appropriate route.

108. Of course, the court should always pause and remind itself that pathways are not mandatory and a responsible clinician should always treat the individual before them. However, here I have accepted that Mr Kett-White was presented with a history given by the claimant of chronically developing symptoms and he had no radiographical evidence of cauda equina compression. Against that background I am unable to conclude that Mr Kett-White's decision to proceed as he did was in breach of duty. Of course, once surgery is decided upon as the recommended course then generally the sooner it is performed the better, however some measure of prioritisation is inevitable. In my judgment Mr Kett-White's decision to categorise Mrs Griffiths as urgent and not emergency fell within the boundaries of a reasonable body of medical opinion.

The counterfactual

109. The case advanced by the claimant is proposed upon the counterfactual that if Mrs Griffiths had been referred to the neurosurgeons in Cardiff, then she would have been operated on as an emergency. In my judgment, such an assertion of factual causation requires the claimant to prove on the balance of probability a significant step. It seems reasonably clear that if the orthopaedic department at Withybush or indeed Mr Kett-White at Morriston had proposed transferring a patient from West Wales to Cardiff for emergency surgery then they would inevitably have been asked to justify it. A telephone

conversation seeking such emergency surgery would be bound to have involved reference to the existing radiology and the Cardiff neurosurgeons are bound in my judgment to have been told that the radiology that existed at the time did not show cauda equina compression. Applying the logic of the GIRFT flow chart I am unable to conclude that they would have accepted Mrs Griffiths as an emergency case. Indeed, in my judgment I can positively conclude that on the balance of probability they would have not accepted her as an emergency case. I reach this conclusion even without factoring in any elements of the claimant's history that was suggestive of any chronicity in the neuro symptomatology. The extent to which such was explained to the neurosurgeons in Cardiff would in my judgment have rendered emergency treatment even less likely.

Medical causation

110. Even if the claimant were able to establish breach of duty and/or the counterfactual set out above, a further issue of medical causation arises that the defendants submit is fatal to the claimant's case. They submit that the court should conclude that in the aftermath of the surgery in 2017 the claimant made a good recovery from her main neurological symptoms. If that is the case then on the state of the medical evidence as it ended up at trial, the claimant is unable to establish any causative consequence from any delay in the surgical intervention.
111. The claimant contends that the court should approach the apparent improvement in symptomatology recorded in the medical records with a degree of caution. In fact, the court is invited to prefer the account now given by the claimant of ongoing symptoms and no real improvement in bladder and bowel function. In her evidence to the court Mrs Griffiths had said that she was happy and delighted to have undergone surgery.

She wanted to get back to normal, and she thought it would heal and it would all go away. She said that in fact she was not feeling better, she was not happy with how she had been left and she was in a lot of pain.

112. Mr Choksey, in dealing with this issue, acknowledged, as he had to, the obvious inconsistency. He postulated that the nurse who saw Mrs Griffiths post operation in 2017 does not appear to have, or may not have, undertaken a comprehensive assessment and did not ask direct questions about bladder and bowel function (eg at TB 328). Had they done so, they may have obtained a different answer.
113. The problem for the claimant in advancing such an argument about the content of the post-accident medical notes is twofold. Firstly, from the digest of medical records regarding the post operative period set out above in this judgment there are plainly repeated entries dealing with an apparent recovery and anticipated return to work by the claimant. Secondly and more damning, are again the contents of the complaint letter written by or on behalf of the claimant contemporaneously.
114. There was no real explanation advanced for the contents of the letter. The claimant just suggested its contents were wrong (at one stage she seemed to accept they were a lie). Later and drawing away from the contents of the letter being a lie, Mrs Griffiths appeared to want to emphasis her mindset at the time as being one of just focusing on getting better and that this was an explanation for the content of the letter.
115. That said proper consideration of this issue would be incomplete without reference to the evidence from both urology and colorectal surgery. The court did not hear from the pairs of experts from each side in relation to these disciplines. Their evidence was not advanced as relevant to breach of duty, rather it primarily considered whether or not symptoms complained of by the claimant were consistent with cauda equina syndrome.

Mr Reynard and Mr Lee, consultant urological surgeons, provided a joint statement dated April 2026 (TB 857). The document is headed with the acceptance by both that this is a particularly complex case.

116. Whilst the joint statement highlights the differing histories given by the claimant, the most relevant piece of urological evidence comes from Mr Reynard's examination in December 2021, summarised at TB 866. The insertion of a urethral catheter and tugging thereon appeared to demonstrate no sensation and the rapid filling of the bladder seemingly produced no sensation of filling. This I accept to be objective evidence of symptomatology that is consistent with cauda equina syndrome.
117. Similarly, evidence was adduced from colorectal surgeons, namely Professor Carlson and Professor Williamson and their joint statement appears at TB 879. Again, the most relevant part of their effectively agreed evidence arises from testing undertaken in January 2023. The symptoms that were considered included passive incontinence from her anus and an inability to feel a stool. She has sensory and motor denervation of the anorectum. The gastrointestinal physiology testing replicated massive rectal distension but demonstrated neither urgency nor pain. Again this is portrayed as objective evidence of symptoms of cauda equina symptoms.
118. The eloquent argument advanced on behalf of the claimant is that the court should pay far less attention to the claimant's own description of recovery than to the objective evidence in 2021 and 2023 of cauda equina damage. Consequently it is submitted on behalf of the claimant that the court should approach medical causation confident in the conclusion that Mrs Griffiths has cauda equina symptoms for which no other credible alternative explanation can be advanced other than the events of the autumn of 2017.

119. The argument is powerful but, in my judgment, too readily glosses over the contemporaneous and detailed report of recovery made by the claimant. The relevant sections of the complaint letter are set out at paragraph 62 above. Not only does it refer to symptoms of bowel and bladder incontinence having commenced many months if not years prior to the events of 2017 it also contains the words *“Since I had the surgery, my back pain has greatly improved. I’m no longer in constant pain, just seem to have a feeling of weakness. As for the incontinence this has stopped.”*
120. There is in my judgment no other way to read the letter other than to conclude that it describes a recovery from symptoms of incontinence and in the context of the neurosurgical evidence before the court that is very significant indeed. I have considered whether explanations from the claimant of inaccuracy based upon over optimism or even a misguided and ill-advised attempt to advance a complaint based upon a more general delay in her treatment of a long-standing underlying condition. Ultimately, I am unpersuaded by such arguments. I am satisfied on the balance of probability that the letter says what it says because that represented the position at the time. From the history set out above it is not a letter in isolation. I find as a fact that in the aftermath of the surgery Mrs Griffiths did make a good recovery specifically from her symptoms of incontinence.
121. If that is the conclusion then on the evidence before the court I cannot be satisfied on the balance of probabilities that any delay in surgery in the autumn of 2017 had any causative effect either directly or by way of material contribution.
122. In my judgment the fact that a clear alternative explanation for the objective urological and colorectal symptomatology or the mechanism by which symptoms worsened is not as important as the finding of fact that I have made. I accept the submission made on

behalf of the defendants that ultimately it is for the claimant to make out her case rather than for the defendants to prove an alternative cause for symptoms. The fact that the court is unable to reach a conclusion on the likely explanation for such symptoms is not irrelevant but is perhaps a function of the agreement between experts and counsel that this case represents a very complex medical position.

Summary

123. The conclusions that I have reached can be summarised as follows:

- a) On the balance of probability, the claimant told the clinicians at Withybush Hospital that she had suffered from neurogenic type symptomatology associated with her bladder and bowel for a significant period of time and in excess of 2 months leading up to August 2017.
- b) In reaching a clinical judgment as to how to treat her they were entitled to assume she was attempting to give an accurate account.
- c) The MRI scanning showed spinal stenosis that could be described as moderate.
- d) The classification by a radiologist of stenosis as mild, moderate or severe or a combination of the same is of limited importance in assessing how to treat a patient.
- e) The radiological examinations in this case did not identify cauda equina compression.
- f) In the light of the same, and in accordance with the approach to patients presenting at Withybush Hospital with such a history, it was not

mandatory for her to be referred to the neurosurgeons in Cardiff for consideration of emergency spinal surgery. Instead, it was appropriate for her to be referred to Morriston Hospital to be dealt with as an urgent case.

- g) In the light of the above, the orthopaedic department at Withybush Hospital were acting in accordance with a reasonable and responsible body of medical opinion.
- h) Even if the emergency neurosurgeons at Cardiff had been contacted, then against the background of there being no radiological evidence of cauda equina compression, the claimant has not established on the balance of probabilities, that she would have been accepted as an emergency case.
- i) Upon attending Mr Kett-White, the claimant gave a description of neuro symptomatology over a long period and in excess of 2 months. Consequently Mr Kett-White's conclusion that she was suffering from a slowly developing condition was a conclusion that was reasonable for him to form. Against the background of there being no radiological cauda equina compression, it fell within a body of reasonable neurosurgeons for her to be treated as an urgent case and was reasonable not to refer her to Cardiff for emergency surgery or to operate upon her himself as an emergency case.
- j) Even if Mr Kett-White had referred the claimant to Cardiff as an emergency case, then the claimant has not established on the balance of probabilities that the surgeons in Cardiff would have accepted her as an emergency case.

k) In the aftermath of the surgery undertaken by Mr Kett-White, Mrs Griffiths made a good recovery in the initial period including complete resolution of symptoms of incontinence.

l) In the light of the court concluding that such a recovery took place, the claimant is unable on the balance of probabilities to establish that any delay in the surgery was causative of any loss or damage.

124. In the light of the court's conclusions, the claimant fails to establish either breach of duty or medical causation.

Fundamental dishonesty

125. Finally, I am invited by the defendant to consider making a finding of fundamental dishonesty. The principles to be applied are well known and the consequences are provided by virtue of section 57 of Criminal Justice and Courts Act 2015. Following *LOCOG v Sinfield [2018] EWHC 51* the court is invited to conclude that the claimant has, in relation to a matter that goes to the heart of the case, been dishonest.

126. The burden of establishing the same to the civil standard rests upon the party asserting, namely the defendant. Here the argument advanced is that in circumstances whereby the court concludes that the letter of complaint in January 2018 was accurate, then in so far as the claimant now denies that the contents as accurate, then she is being dishonest on an issue that goes to the very heart of the case.

127. The logic of such an approach is clear. However, in my judgment it must be seen within the context of what is a complex case regarding events that occurred nine years ago. We know that the claimant suffers from ongoing significant symptoms that have been objectively demonstrated even if the cause of the same is more difficult to understand.

It is inevitable that in such circumstances when faced with having to give an account of what are on any version varying records of her symptoms a person in the claimant's position will to some extent reconstruct recollections in their mind. Indeed, it is generally accepted that sometimes a witness can convince themselves that a certain factual matrix is correct when ultimately it is proved not to be. The court is rightly reminded that in assessing the factual account of events given by a witness a court should be slow to rely upon subjective factors and where possible weight should be placed upon objective matters such as documents. Demeanour of a witness is not irrelevant but the weight to be attached to such a factor is rightly limited. That has been my approach to this case in dealing with the disputed facts. However, when it comes to whether the claimant is being deliberately dishonest then, in this case in particular, seeing the witness give her evidence has been important. Having seen her and notwithstanding rejecting her explanation for many of the documentary entries I am not persuaded by the defendants that a finding of fundamental dishonesty should be made.

128. I do not go on to consider issues of quantum. Notwithstanding that the case was listed for consideration of the same, the parties helpfully indicated at the oral submissions hearing in August that determination of the same would not be required from the court at this stage.
129. The parties are invited to agree an order in consequence of this judgment and to file the same at court within 14 days. In the absence of agreement a short consequentials hearing will be arranged.

