IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

Neutral Citation Number: [2019] EWHC 520 (QB)

CASE NUMBER: HQ16C01711

ROYAL COURTS OF JUSTICE

STRAND, LONDON, WC2A 2LL

Before

THE HONOURABLE

MRS JUSTICE YIP

BETWEEN:

MRS KERRY ANN SHAW

Claimant

-v-

DR ANDREW STEAD (a GP)

Defendant

Mr. Grahame Aldous QC (Instructed by **Stewarts**) appeared on behalf of the Claimant

Ms. Nicola Campbell-Clause (Instructed by **Medical Protection)** appeared on behalf of the Defendant

Friday, 1 March 2019

APPROVED JUDGMENT

MRS JUSTICE YIP:

1. This is a claim for clinical negligence arising out of a consultation on Saturday 25 May 2013 when the claimant, Mrs Kerry Shaw, saw the defendant, Dr Andrew Stead, a general practitioner, at the Grimsby Area Primary Care Emergency Centre, an out of hours surgery. It is alleged that the defendant failed to identify the warning signs of cauda equina syndrome and to refer the claimant for appropriate investigation. It is the claimant's case that this led to a delay in diagnosis and surgical treatment of the condition causing significant disability which otherwise would have been avoided or at least significantly reduced.

2. The court directed that breach of duty alone should be tried as a preliminary issue. I understand that there are also significant issues as to causation but it was considered that these would be better dealt with alongside quantum. The issues as to breach of duty are essentially factual issues. In order to determine them I heard from Mrs Shaw and her husband, Mr Paul Shaw, and from Dr Stead. I was also referred to the contemporaneous medical records and received expert evidence from general practitioners and neurosurgeons on each side. I note that there was very limited cross-examination of the experts given the issues involved at this stage.

3. I commend the parties for the excellent preparation of this case for trial. I had a well focused and manageable trial bundle. Sensible agendas had been agreed for the experts' joint statements which resulted in the issues being clearly defined. All this makes the court's task much easier and allowed the trial to be conducted very efficiently. I am also grateful to counsel on both sides for their well focused submissions.

4. There is no issue as to the legal principles to be applied in this case. Issues as to breach of duty fall to be determined according to the very well-known principles from Bolam v Friern Management Committee [1957] 1 WLR 582 and Bolitho v City and Hackney Health Authority [1998] AC 232. The defendant also relies on Thomas v Hugh James Ford Simey Solicitors [2017] EWCA Civ 1303 [2018] PNLR/5 for authority, if such is needed, that the court must concentrate upon those acts or omissions which are alleged to constitute actionable negligence.

5. The position here is very straightforward as the GP experts and Dr Stead agree about the standard of care required. If a patient consults a general practitioner with acute low back pain, the doctor must take a history and conduct an adequate examination so as to determine whether there are any "red flags". If there are any red flags the patient must be referred to hospital for further investigation. Failure to refer when there are red flag symptoms constitutes a breach of duty.

6. In this context, red flags are:

(a) any change in saddle sensation;

(b) any change in bladder or bowel function;

(c) severe or progressive loss of power in the lower limbs; and

(d) bilateral leg pain and/or sensory disturbance.

7. If no red flag symptoms are identified, the doctor must warn the patient to seek immediate and urgent medical attention should such symptoms develop. Failure so to warn would also constitute a breach of duty. However, on the facts of this case it would probably be inconsistent to reject the claimant's evidence as to her symptoms yet find that she is right that there was no warning. Further, given that the claimant did seek further medical attention it would be difficult for her to establish that any failure to warn was a causative breach.

8. Therefore, the real issue for me to determine is whether or not the claimant had any red flag symptoms by the time of her consultation with Dr Stead. If she did, it follows that he was in breach of duty in not referring her to hospital. If she did not, she cannot establish actionable negligence.

9. I acknowledge Ms Campbell-Clause's submission that strictly the claimant must prove not only that there were red flag symptoms at the relevant time, but that they would have been elicited during a properly conducted consultation. That is right but the whole tenor of the general practitioner's expert evidence is that if there were red flags a reasonable doctor would have identified them. Dr Stead also appeared to agree with that. I do not consider that there is any evidential basis upon which I could find that there were red flags but that not picking them

up was not negligent. That is why I express the issue for me to decide as I do.

10. Although the issue can be expressed in such simple factual terms, this does not mean that it is unnecessary to consider the evidence as to what Dr Stead did or did not do. On the one hand, if I find Mrs Shaw had red flag symptoms at the time, Dr Stead's history taking and/or examination must have fallen below the required standard. Equally though, if I am satisfied that Dr Stead did all he should have done, that must mean that it is unlikely that there were red flag symptoms at that time. Therefore, I must look at the evidence of symptoms and the evidence about the consultation together when making findings of fact.

11. The claimant of course bears the burden of proving her case and must do so on a balance of probabilities. In reality, that means that I must decide, having regard to all the evidence in the case, whether it is more likely or not that the claimant had any red flag symptoms by the time of her consultation with Dr Stead.

12. I have had regard to all the evidence placed before me, including the expert evidence. My findings depend predominantly on consideration of the factual evidence and interpretation of the medical records. However, the expert evidence, in particular the joint statement of the general practitioners, has assisted in my consideration of the factual evidence and the records.

13. Within that framework then I turn to the facts and shall begin with those that are not controversial.

14. In May 2013 Mrs Shaw, who was then aged 35, was working as a teaching assistant. On Thursday 23rd May she was squatting on the floor to pick something up when a child with special needs kicked her. She fell forwards then immediately got herself up, twisting as she did so. She immediately felt pain in her back. She remained in considerable pain throughout that day and the next day and so consulted her GP, Dr Ray, on the Friday afternoon. She was prescribed painkillers.

15. Her pain continued into Saturday 25 May. At 15.16 she rang her GP's out of hour service and spoke to a nurse, Ruth Thompson. Miss Thompson made a note including a history as follows: "History of trauma to back on Thursday - seen by GP yesterday and prescribed tramadol and paracetamol - today legs have gone numb, tingling, feels dizzy and weak and nauseous, unable to get out of bed to go to toilet."

16. Not long after, at 15.42, Mrs Shaw called the out of hours service again. This time she spoke to Lorraine Giles, who noted the history in the previous triage notes and recorded that Mrs Shaw "states that she feels dizzy and clammy". Mrs Giles advised her to attend the out of hours GP surgery located at the Diana Princess of Wales Hospital next door to the hospital A&E department.

17. Mrs Shaw was taken to the surgery by her husband. They had to wait some time to be seen, they estimate between an hour and two hours. This was the consultation with Dr Stead the record for which begins at 18.50. Dr Stead's note

appears both in the out of hours records and in the claimant's GP notes. It has been entered on to an electronic system and there is a slight variation in how the data appears between the two sets of notes. This is of no significance though. The history is set out as follows:

"Two days ago whilst crouching down was kicked in the back by a 5 year old pupil.

"twisted her back as she stood up quickly.

"over the next 24 hours developed severe low back pain with radiation down left leg.

"given tramadol by GP yesterday.

"since then has been nauseated and light headed.

"back pain no better.

"no red flags.

"Past medical history as per system 1."

18. Dr Stead recorded the claimant's temperature, pulse rate and blood pressure. All were normal. Within the examination section he also recorded the following:

"tender lower back especially left sacro iliac area.

"unable to perform straight leg raise either leg reflexes equal and normal.

"sensation normal".

19. Dr Stead recorded a diagnosis of sciatica and recommended a change of painkillers for which he gave Mrs Shaw a prescription. He also noted as part of the plan "for gentle mobilisation" and "call back if no improvement".

20. The claimant next sought medical advice on Monday 27 May. She again called out of the hours service and spoke to Lisa Taylor, a community nurse. Miss Taylor noted that she had been seen in the out of hours unit on Saturday. She then recorded: “states pain is now in both legs and is struggling to mobilise as legs feel cold and like jelly. Passing urine but is having to strain to do so, slight constipation." An appointment was made for the claimant at the out of hours surgery. Mrs Shaw saw doctor Al-Hamarneh,, at 14.54 on the Monday afternoon. The history in his notes reads: "back injury 4 days ago. kicked by a learning disability pupil in back while leaning forward. had severe pain initially. seen by own GP and was given tramadol.

"24 hours later pain started radiating to both lower legs. attended OOH 2 days ago and was given naproxen and DHC.

"since last night unable to move both lower legs -- feel cold and jelly. struggling to pass urine (has to force strongly)."

After examination, which found loss of power and sensation but good tone per rectum and normal perianal sensation, he referred to the on call surgical registrar who advised that Mrs Shaw needed to go to A&E immediately.

21. The A&E department was next door and the claimant was taken there on a trolley, arriving around 15.30. Later that afternoon she underwent an MRI scan of the lumbar and sacral spine which found a large central disc prolapse at the L3/4 level. Incomplete cauda equina syndrome was diagnosed and the claimant was taken to Hull Royal Infirmary as an emergency where she underwent surgery.

22. Against that factual background, I must consider the disputed evidence about the consultation with Dr Stead and Mrs Shaw's symptoms at the time. In doing so I have had the benefit of seeing and hearing the claimant and her husband and Dr Stead give evidence. All were cross-examined at some length. The impression I had was that all were genuinely trying to assist the court with evidence they believed to be truthful and accurate.

23. Dr Stead frankly accepted that he could not recall the consultation at all. He was therefore limited to recounting his usual practice and interpreting his note of the consultation. Mr Aldous described this as supposition, although he made it clear this implied no criticism of Dr Stead. Dr Stead accepted that he had attempted a reconstruction from his own note and from other records he had seen when responding to this claim. An answer given by Dr Stead perhaps sums up his approach. He said: "I cannot remember the consultation but all I can say is I do not believe that I would have ignored signs or symptoms that would have been significant."

24. I note that this answer was given when Mr Aldous was putting to Dr Stead that he had demonstrated a lack of professional curiosity. That was a phrase used by Mr Aldous a number of times during the trial. However, I make it clear that there is no evidence whatsoever that Dr Stead generally displayed such an approach in his dealings with patients.

25. Dr Stead's evidence was that it was his usual practice to ask patients with low back pain questions to exclude red flag symptoms suggesting possible cauda equina syndrome. This includes asking about problems passing urine and questions such as whether the patient feels her legs will not take her weight, or whether pain is restricting her walking. He says that his note "no red flags" means that there was nothing in the history given by the patient to require referral and that he would not write such an entry in the notes without asking about each of the red flag symptoms. I note that the GP experts accept that a reasonable GP may use this as shorthand rather than noting the response to each red flag question. Dr Stead said that recording "sensation normal" meant that he had checked the sensation in both legs by running a finger along the claimant's bare skin. In relation to the advice given to the claimant he suggests that although he has written "call back if no improvement", he would specifically have advised about red flags to look out for and told Mrs Shaw to seek further medical advice if any emerged.

26. The events of May 2013 were life-changing for Mrs Shaw. Naturally therefore she and her husband had a better memory of them. However, it is fair to say that the passage of time has inevitably had a bearing and that a perfect recollection of a progressively deteriorating situation would not have been expected even at an earlier stage.

27. The evidence of Mr and Mrs Shaw was not perfect. There are aspects on which they were vague, or where inconsistencies could be identified. However, I found

them both to be honest witnesses and no submission to the contrary is made on behalf of the defendant. Both accepted that some things are clear in their memories but other things less so. I consider that there has been a degree of reconstruction on their part too. As with Dr Stead, this implies no criticism of them. It is simply a consequence of looking back with hindsight.

28. It is important when considering their evidence to look closely at the medical records. Ms Campbell-Clause urges that this is the most reliable source of evidence. There is though a balance to be struck. On the one hand the notes contain a contemporaneous record. They are not affected by hindsight and/or the passage of time. On the other hand, the authors of the notes have not been called and there has been no testing of the content. Very often medical records do provide the best evidence of what was happening at the time. However, they are not infallible, and they must be weighed and tested just as other evidence is. There are in this case some internal inconsistencies within the notes.

29. It is helpful then to start with known or undisputed facts. We know that Mrs Shaw had an accident leading to acute pain on Thursday. She saw her GP, Dr Ray, on Friday. At that time she had severe pain with pain down her legs and upper thighs. Dr Ray recorded "bowel/bladder movement today". Mrs Shaw accepts that she had emptied her bladder. She does not think she had a bowel movement that day but it would not be usual for her. Therefore, she would have had no concerns to report about bowel or bladder function at this time.

30. On the Saturday afternoon the claimant told Ruth Thompson that her legs had gone numb and she had tingling. She felt dizzy, weak and nauseous and Miss Thompson has recorded she was unable to get out of bed to go to the toilet. She called back a short time later and told Mrs Giles that she felt dizzy and clammy.

31. The last three entries were printed for Dr Stead when Mrs Shaw attended him. So we know that he was aware that she had complained of bilateral pain on the Friday and a bilateral numbness and tingling in the legs that day.

32. The unchallenged evidence of the claimant and her husband is that she attended the consultation in a wheelchair and had to be helped on to the examination couch by Mr Shaw and Dr Stead. While unable to confirm the use of a wheelchair because of his lack of recollection, Dr Stead was quite prepared to accept what the claimant said. I find as a fact that she was in a wheelchair and did require considerable assistance to get on to the couch.

33. Dr Stead's note does not record the use of a wheelchair, although the letter of response to the letter of claim suggests that Dr Stead's usual practice was to record if a patient was in a wheelchair. Further, the GP experts agree that these features of the presentation should have been recorded in the history and that it would be important to differentiate between difficulties caused by loss of power and those caused by pain. This would require further questioning and examination and the recording of findings.

34. I agree with Mr Aldous that the evidence about the use of a wheelchair is of some significance in looking at the assumptions made by Dr Stead based upon his note. As is clear from the letter of response, and the defence, he initially interpreted his note as demonstrating that the claimant was not in a wheelchair. The defence, which he signed, said this: "The absence of any record relating to the reason why she was in a wheelchair suggests that she was not in one at the time of the defendant's examination."

35. By the time of his witness statement Dr Stead did not maintain that line of reasoning, but instead said that it would not be surprising if Mrs Shaw had been in a wheelchair and he now suggests this may not have been clinically significant. However, it is quite clear that both Dr Stead and the experts accept that good practice required a record to be made of the use of a wheelchair and the reason for it. In this regard Dr Stead's notes do not accord with his usual practice. His initial assumption about the wheelchair can be shown to be wrong. There must therefore be a degree of caution about assumptions he makes based upon his usual practice.

36. Equally there are known facts that conflict with some of the claimant's evidence. She and her husband gave evidence that Dr Stead's examination was very limited. They did not recall her blood pressure, temperature or pulse being checked. They thought the examination was very brief. She was wheeled straight into the room and immediately got on to the couch with no discussion before. The only test they could recall was reflex testing of the knees. Mr Shaw said that the consultation lasted only about four or five minutes.

37. However, Dr Stead's note begins at 18.50 and records the prescription being printed at 19.02. Dr Stead explained how the system worked. He would open the record before calling the patient in. This might account for a couple of minutes. But equally the consultation would not have finished the moment the prescription was printed. So it seems likely that the consultation lasted around ten to 12 minutes at least. There are entries for blood pressure, pulse and temperature that I am satisfied, having heard Dr Stead, would only appear in the records if tested. Therefore the recollection of the claimant and her husband of the consultation is plainly incomplete. I do however accept their evidence that Mrs Shaw's pyjama bottoms were not removed during the examination. I believe that this is something they would have remembered. Further, I note Mr Shaw's evidence that he was surprised when the doctor examined her with her pants down on the Monday as Dr Stead had not done that. I note the evidence of the claimant's GP expert Dr Warner that general practitioners often have to make do or improvise and that an adequate, albeit not ideal, examination can often be done through light clothing.

38. As I have already said, there was lengthy cross-examination of the factual witnesses. That is understandable in a case such as this that turns on the factual evidence. It has provided me with an opportunity to assess the reliability of the evidence.

39. I do not accept Ms Campbell-Clause's submission that the Shaws' recollection was

"limited". I do accept that their recollection was not complete and that parts of their evidence were vague or inconsistent. I agree with Ms Campbell-Clause that this is unsurprising given the passage of time and the circumstances. Mrs Shaw is recalling events when she was in severe pain, distressed and feeling very unwell. It seems to me that initially Mr Shaw did not appreciate the seriousness of the situation. Later, he must have been very worried about his wife. All these factors may affect memory.

40. I do not propose setting out each and every inconsistency or inability to recall detail. I accept though that I must take a cautious approach. I certainly cannot rely unreservedly on the accounts given by the claimant and her husband and I do not do so.

41. Some things are bound to stick in the memory more than others. It seems to me that there are two important matters about which the claimant gave clear evidence. The first is her account of having a urinary accident on Saturday morning before seeing Dr Stead. The second is her description of leaving her house to go to the consultation with Dr Stead when she said: "I felt like Bambi when I was trying to walk, like I couldn't properly coordinate my legs."

42. As to the urinary accident, the claimant told me that on the Saturday morning she had felt like she needed to pass urine and went to the toilet but found that she could not do so. On her way back to bed, she had wet herself causing a wet patch on the floor, partly on the tiled floor of her en-suite and partly on the carpet of her

bedroom. She recalled a towel being wrapped around her before she got into bed although she could not say what happened to her wet knickers or who cleaned her up. There were therefore details that were lacking, but, as Ms Campbell-Clause accepted, she had a vivid recollection of wetting the floor.

43. The claimant was sure that this happened on Saturday. She recalled that Saturday was a sunny day and her husband was outside mowing the lawn and that her children were going out that day. She remembered the accident happening while her husband was outside.

44. I do not think Mr Shaw's recollection of this incident is as strong, but that is understandable. He was not present when it happened. He was told about it by the claimant or her daughter. He had understood that Mrs Shaw had fallen over. In his statement he said that he could not recall whether it happened on Friday night or Saturday morning. However, he also said that he had been told about it after he had been outside mowing the lawn, which was on the Saturday.

45. I consider that the evidence of the Shaws about this incident fits together. Mrs Shaw is directly recalling a significant event that happened to her. Mr Shaw is recalling something he was told and the memory is less vivid for him.

46. I am left in no doubt that there was an occasion where Mrs Shaw wet the floor. In reality, to find otherwise would involve a finding that she was lying. Ms Campbell-Clause quite properly does not invite such a finding. She did her

very best in submissions to deal with this evidence. She sought to avoid speculating, but when I pressed her as to possible alternative explanations she suggested that confusion may have arisen about a wet patch on the floor due to cleaning up vomit. That quite simply is unsustainable on the evidence before me.

47. I agree that it is possible that a confusion could have crept in about the timing of the urinary accident, or about its precise nature, in particular whether it happened on the way back from the toilet, or on the way there. It is suggested on the defendant's behalf this may not have been a case of true incontinence but rather a case of not making it on time due to pain and restricted mobility. However, I am required to assess not what is possible, but what is probable. The evidence of the claimant and her husband establishes a strong prima facie case that she suffered a urinary accident as she described on Saturday morning. I must then consider whether there is evidence that would tip the balance the other way.

48. Here, the defendant points to the medical records. Ms Campbell-Clause highlights that this incident is not described in the triage notes of Miss Thompson or Mrs Giles. Miss Thompson recorded that she was "unable to get out of bed to go to the toilet". This, says Ms Campbell-Clause, is more consistent with any urinary accident being a case of not getting there in time. The defendant recorded "no red flags". His evidence is that he would not have made that entry without questioning the patient about each red flag, including asking about any difficulty passing urine or urinary incontinence. Further the defendant relies upon an entry in the hospital records, when the claimant was clerked at 15.55 on Monday

27 May, which records "no bowel/bladder accidents, having to strain to pass wee since yesterday".

49. This entry is difficult to fit with the claimant's account. However, if the proper interpretation of the note is that the claimant had not suffered the loss of control of her bladder at all since her accident, I find that it was wrong. I am sure on the evidence that I heard that the claimant did wet the floor at some time. That being so, it must have happened before this note was made, since it is an entry made on her admission to hospital. It therefore cannot assist the defendant in challenging the timing of the incident.

50. Although there could be an explanation for the loss of bladder control other than true incontinence, I would expect that to be recorded. I note that I did not hear from the author of the note. I do not know whether the history was taken directly from the claimant, who by then was flat on her back on a trolley and awaiting investigations, or whether for example it was taken from her notes or from the doctor who referred her or from her husband.

51. There is a further note timed at 22.00 hours on Monday, after the claimant's transfer to Hull, which notes that she had developed weakness in her legs and urinary retention particularly obvious to her since Saturday morning. After the words "Saturday morning" the words "36 hours ago" appear in brackets.
Ms Campbell-Clause suggests that I should rely on the reference to "36 hours ago", rather than that to "Saturday morning". However, I think it much more likely that the claimant would have said "Saturday morning" than "36 hours ago".

Therefore I consider that this note adds some, albeit limited, support to the claimant's account of her symptoms of urinary problems and leg weakness on Saturday.

52. The issue of whether the claimant had experienced difficulty in passing urine and urinary incontinence on Saturday morning is an important one. I have therefore paid close attention to all the evidence about it, including conducting a careful analysis of all the medical records. I also have it firmly in mind that the defendant's evidence is that he would not have recorded that there were no red flags without first confirming the absence of any urinary problems.

53. Having balanced all the available evidence, I am satisfied that I am able to rely on Mrs Shaw's evidence that she had a urinary accident on the Saturday morning and that the circumstances were that she found she could not pass urine when she went to the toilet, but that she then lost control of her bladder on her way back to bed and so wet the floor.

54. Whether that was a true episode of bladder dysfunction with a neurogenic cause is much less certain. The neurosurgeons did not agree about this. I did not hear oral evidence on this point since the parties agree that it could not have a bearing upon what Dr Stead as a GP should have done. There is no dispute that an account of difficulty passing urine followed by wetting the floor would be sufficient to amount to a red flag requiring referral and investigation.

55. For similar reasons I also find that I can accept the claimant's account that she felt unsteady on her feet, like Bambi, when she left to go to see Dr Stead. Again, I have carefully reviewed all the medical notes before arriving at that conclusion. Mrs Shaw had told Miss Thompson that afternoon that her legs had gone numb. I accept that this was a progressive and evolving condition and that it may be difficult to pinpoint exactly when certain symptoms commenced. I accept that specific reference to weakness and the legs feeling like jelly appears later in the notes. However, Mrs Shaw's clear evidence was that the symptoms gradually got worse and that the weakness described on Monday represented a worsening of that experienced on Saturday, rather than the sudden onset of a completely new symptom. She gave a clear account of the difficulty she had when leaving the house to go to see Dr Stead which was supported by her husband. Weighing everything in the balance, I find as a fact that she was experiencing some weakness of her legs at the time of the consultation, albeit that this had worsened significantly by Monday.

56. According to his note, Dr Stead was unable to perform a straight leg raise on either side. This test involves the doctor raising the patient's leg while they are lying flat. If pain occurs when the leg is raised past 30 degrees that may be a sign of nerve root impingement due to a slipped disc. If pain prevents the leg being raised even to that level, this cannot be described as a positive result. However, as the defendant's expert Dr Young confirmed, the fact that a patient with a history of recent accident was in so much pain would cause concern and would require further investigation.

57. The claimant's evidence was that she did not lie flat on the examination couch. Therefore any attempt at a straight leg raise must have been done while the back rest was raised at an angle. It is suggested on her behalf this probably accounted for flexion of 30 degrees in her spine such that when Dr Stead found he could not raise either leg without causing pain, that was in fact a positive result.

58. Dr Stead clearly said in cross-examination that he could not say one way or another whether the claimant was inclined at an angle on the couch when the straight leg raise was attempted. I clarified this with him and he said again very clearly that he could not say. He later said that he could not think of a reason why he would ever attempt the straight leg raise when the patient was not flat. He said if a patient could not lie flat due to pain that would be "obviating the ability to do a straight leg raise". It seems to me that that is consistent with Dr Stead's note "unable to perform SLR either side". It is also consistent with the claimant's evidence that he did not raise her legs off the bed but that had she been asked to she would not have been able to. I note the straight leg raise is a passive test that does not require the patient to actively raise her legs but Mrs Shaw would not know that. She has no recollection of her legs being raised from the bed.

59. It seems to me it is most probable that Dr Stead did not attempt the straight leg raise because the claimant's pain prevented her lying flat. Alternatively, if attempted, the straight leg raise on both sides was abandoned due to pain. Either way I accept that this did not amount to a positive straight leg raise result. On the

other hand, the level of pain the claimant was in was a cause for concern requiring further investigation.

77. I am conscious that my findings of fact are not only important on the issue of breach of duty which I am trying now, but potentially also for the issue of causation. I have approached them with care on that basis. The key findings of fact I make on the evidence before me are as follows:

i) On Friday, according to the notes available to Dr Stead, the claimant had bilateral leg pain.

ii) On Saturday morning the claimant suffered a urinary accident on the way back to bed having tried unsuccessfully to pass urine on the toilet.

iii) On Saturday afternoon the claimant reported bilateral numbness and tingling in her legs which was documented in the notes available to Dr Stead.

iv) When she left home to go to the surgery on Saturday she had difficulty walking because her legs felt weak. As she described it, she felt like Bambi.

v) She attended Dr Stead in a wheelchair and he and her husband had to help her on to the couch.

vi) A straight leg raise could not be undertaken on either side due to the level of pain the claimant was in. Probably she was not able to lie flat, which Dr Stead says obviates the test because it should be performed flat.

78. I have some sympathy for Dr Stead because in the absent of any recollection of the consultation, he is unable to give any direct evidence of the claimant's condition at

the time. I fully accept the genuineness of his belief that he would not have missed the signs and symptoms of cauda equina syndrome. I found him to be entirely straightforward in giving his evidence. He was perfectly frank in acknowledging that set against a background of bilateral pain, numbness and tingling as recorded in the notes, an immediate referral to hospital was required if there was any evidence of urinary incontinence or lower limb weakness.

79. He appeared to accept that if the claimant had in fact suffered urinary incontinence by the time he saw her, and/or he felt she had difficulty controlling her legs, a properly conducted consultation would have identified this.

80. Dr Stead can only rely upon his retrospective reconstruction based upon the notes. However, I am afraid I cannot accept that his own note establishes what he believes it does. I have found that the claimant did have red flag symptoms at the time of the consultation. Necessarily that means that he missed them. I find no evidential basis for saying that this happened despite all proper care on Dr Stead's part. In particular, I reject any suggestion that Mrs Shaw would not have reported her symptoms if questioned appropriately. The red flags were there to be found but were unfortunately missed.

81. It follows that on this occasion Dr Stead's standard of care fell below that to be properly expected of a reasonable GP. Accordingly I find that the claimant has established that he was in breach of duty in failing to refer her to hospital.