

10 Things Every Solicitor Should Know About *Cauda Equina Syndrome*

Cauda Equina Syndrome (CES) is one of the most common, and most misunderstood, areas in clinical negligence and serious injury work.

Many cases focus heavily on delay. But in practice, timing alone rarely determines outcome. The cases that succeed tend to turn on something more nuanced: how the patient actually presented, whether deterioration was recognised and acted upon, and whether earlier intervention would have made a meaningful difference.

These are not always straightforward questions. They require careful analysis of the records, a clear understanding of how CES develops in practice, and a realistic view of how outcome is shaped over time.

This guide brings together ten practical insights drawn from real medico-legal experience. It is designed to help you assess CES cases more confidently, identify where breach and causation arguments are strongest, and recognise where a claim may be more difficult to sustain. It also highlights an area that is often overlooked: the impact of long-term symptoms on prognosis and valuation.

This is not a clinical overview. It is a focused, case-driven resource to help you cut through conflicting opinions and concentrate on what actually matters when building or defending a claim.

In CES cases, the key question is rarely whether there was a delay. It is whether that delay made a difference

Produced by INNEG based on key clinical and medico-legal insights shared during our webinar on Cauda Equina Syndrome led by Poorna Veerappa, Advanced Spinal Physiotherapist on 21st April 2026

CES often develops gradually, not suddenly.

CES is often associated with a sudden and dramatic onset. In reality, many patients present over a number of days or weeks, with symptoms that evolve rather than appear all at once.

It is common to see repeated attendances, with increasing pain, emerging neurological symptoms, or early bladder and bowel changes. When these attendances are considered in isolation, rather than as part of a developing clinical picture, opportunities to escalate are missed.

From a medico-legal perspective, these patterns are significant. They allow a clear timeline of deterioration to be established, and often highlight points where earlier intervention should have been considered.

When this strengthens a claim

A claim is strengthened where there is clear evidence of progression across multiple attendances, particularly if worsening symptoms were documented but not acted upon. The absence of escalation, referral, or safety-netting in the face of deterioration is often persuasive evidence of breach.



When the case is weaker

Where symptoms appear stable across attendances, or where the patient presents at a late or already advanced stage, it becomes more difficult to argue that earlier action would have altered the outcome. In those cases, the link between delay and harm is less clear.

What to look for in the records

The focus should be on how the patient's presentation changed over time. The number and timing of attendances, the development of new symptoms, and whether those changes were recognised are all key indicators of how the case is likely to be viewed.



Absence of back pain does not exclude CES.

There is a persistent assumption that back pain is a defining feature of CES. In practice, this is not reliable.

Patients may present primarily with neurological symptoms, including altered sensation, weakness, or changes in bladder and bowel function. Where the clinical focus remains on pain, these features can be overlooked or under-assessed.

This is often where cases turn. The issue is not that CES was difficult to diagnose, but that the assessment did not properly explore the relevant symptoms.

When this strengthens a claim

A claim is strengthened where CES has been dismissed due to minimal or absent back pain, without a full neurological

assessment being carried out. If key symptoms were not actively explored, the conclusion reached is unlikely to be considered robust.

When the case is weaker

Where a structured neurological assessment was undertaken, and red flag symptoms were specifically considered and documented, it becomes more difficult to argue that CES should have been suspected earlier.

What to look for in the records

Attention should be given to whether neurological symptoms were actively enquired about, rather than assumed. Documentation of bladder, bowel and sensory changes is particularly important in understanding whether the assessment was complete.

Focusing only on bladder symptoms leaves a critical gap.

Bladder dysfunction is often treated as the primary indicator of CES. While important, it is only one part of the clinical picture.

Bowel symptoms and saddle sensory changes are equally relevant, yet are frequently under-assessed or not documented. It is not uncommon to see detailed urinary history recorded, with little or no reference to these other areas.

From a legal perspective, this creates a significant gap. If those symptoms were not explored, their absence cannot later be relied upon to support a clinical conclusion.

When this strengthens a claim

A claim is strengthened where urinary symptoms are documented in detail, but there

is no evidence that bowel function or saddle sensation were assessed. This supports an argument that the overall assessment was incomplete.

When the case is weaker

Where all relevant symptom groups have been explored and documented, including bladder, bowel and sensory changes, the assessment is more likely to be considered thorough and defensible.

What to look for in the records

The key issue is whether the assessment was selective or complete. Records should show a consistent approach to exploring all relevant CES symptoms, rather than focusing on one area alone.

CES must be suspected clinically, not confirmed by imaging.

One of the most common failure points in CES cases is the reliance on imaging before escalation.

In practice, CES is a clinical diagnosis first. MRI is used to confirm what should already be suspected based on the patient's presentation. Problems arise where clinicians delay escalation until imaging is available, or where CES is not considered early enough to trigger urgent investigation.

From a medico-legal perspective, the issue is rarely whether an MRI was eventually performed. The focus is on whether it was requested at the point it should have been, based on the symptoms described.

Where clinical suspicion is not documented despite clear red

flags, this often indicates a failure in prioritisation rather than a limitation in resources.



When this strengthens a claim

A claim is strengthened where symptoms consistent with CES are present, but there is no documented clinical suspicion and a delay in requesting urgent imaging. This is particularly persuasive where the symptoms clearly warranted immediate escalation but were not recognised as such.

When the case is weaker

Where symptoms are ambiguous, non-specific, or evolving in a way that does not clearly indicate CES at the time, it becomes more difficult to argue that imaging should have been requested earlier. Similarly, where CES is actively considered and imaging is arranged within a reasonable timeframe, the assessment is more likely to be defensible.

What to look for in the records

The key issue is not simply whether imaging was performed, but the timing and reasoning behind it. Records should show whether CES was considered as a potential diagnosis, how urgently imaging was requested, and whether the clinical presentation justified that level of urgency.



The “24-hour rule” is often misunderstood.

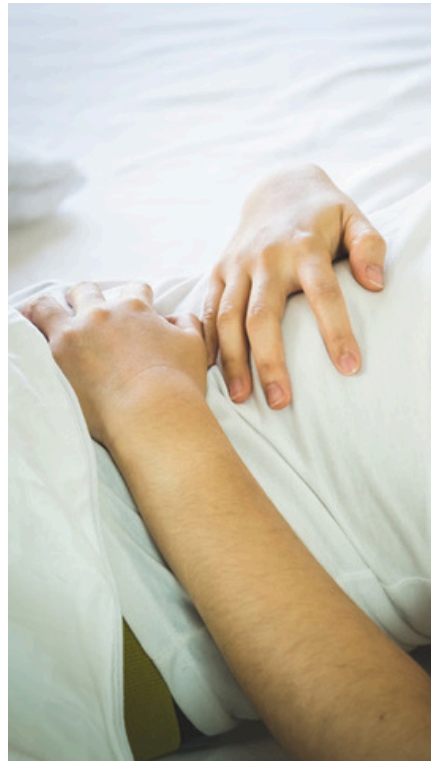
There is a widely held assumption that CES requires surgical decompression within 24 hours in all cases. In practice, this is an oversimplification.

The timing of surgery must be considered in the context of symptom progression and stage of presentation. The key medico-legal question is not whether surgery occurred within a specific timeframe, but whether earlier intervention would have altered the patient’s outcome.

This distinction is critical. Many claims focus heavily on delay as a standalone issue, when in reality the success of a case depends on demonstrating that the delay made a material difference.

Strong cases tend to involve

clear evidence of deterioration that was not acted upon. Weaker cases often involve patients who had already progressed to a stage where recovery was unlikely, regardless of timing.



When this strengthens a claim

A claim is strengthened where there is clear evidence that the patient's condition was worsening during the period of delay, and that earlier intervention could have prevented further deterioration. In these cases, the link between delay and outcome is more readily established.

When the case is weaker

Where symptoms were static, or where the patient presented at a late stage with established neurological deficit, it becomes more difficult to argue that earlier surgery would have changed the outcome. In these scenarios, causation is often the main point of challenge.

What to look for in the records

Attention should be given to the timing and progression of symptoms, rather than relying on arbitrary timeframes. The stage of CES at presentation, evidence of deterioration, and the point at which intervention became necessary are all central to assessing causation.



Poor history-taking is often the real failure point.

In many CES cases, the central issue is not a lack of access to investigation, but a failure to obtain a sufficiently detailed history.

Patients may attend multiple times, but if key symptoms are not actively explored, the significance of their presentation is missed. Bladder, bowel and sensory changes are particularly important, yet are frequently under-enquired or inconsistently documented.

This creates a pattern where each individual attendance appears reasonable in isolation, but collectively demonstrates a failure to recognise a developing condition.

From a legal perspective, this shifts the focus from isolated error to a broader issue of inadequate clinical assessment.



When this strengthens a claim

A claim is strengthened where there is inconsistency in the history recorded across attendances, or where key symptoms are omitted entirely. A pattern of missed opportunities to identify red flag symptoms is often highly persuasive evidence of breach.

When the case is weaker

Where a structured and consistent history has been taken at each attendance, and symptoms have been actively explored and documented, it becomes more difficult to argue that the condition was missed due to inadequate assessment.

What to look for in the records

The emphasis should be on consistency and completeness. Differences in symptom reporting between attendances, gaps in documentation, and

failure to explore key areas can all indicate that the assessment was not sufficiently thorough.



Bladder scans provide critical objective evidence.

Bladder scanning is a relatively simple investigation, but it plays a significant role in the assessment of suspected CES.

It provides objective evidence of urinary retention, which is strongly associated with CES. Despite this, it is not always performed, even where urinary symptoms are reported.

Where assessment relies solely on subjective reporting, without



objective measurement, the reliability of the clinical decision-making can be questioned.

From a medico-legal perspective, the absence of a bladder scan in the presence of relevant symptoms can weaken the overall assessment.

When this strengthens a claim

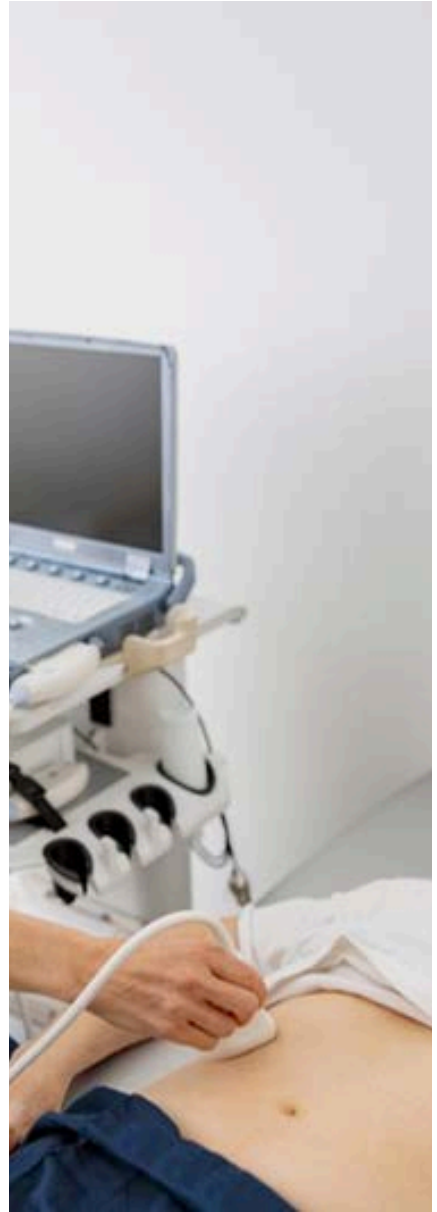
A claim is strengthened where urinary symptoms are documented but no bladder scan is performed. This suggests that a key investigation was omitted, particularly where it may have supported earlier escalation or diagnosis.

When the case is weaker

Where a bladder scan has been performed and results are clearly documented, and those results align with the clinical decision-making, the assessment is more likely to be considered appropriate.

What to look for in the records

The presence or absence of objective testing is key. Records should show whether a bladder scan was performed, what the findings were, and how those findings influenced the clinical pathway.



Prognosis depends on stage at diagnosis.

Outcome in CES is closely linked to the stage at which the condition is identified and treated.

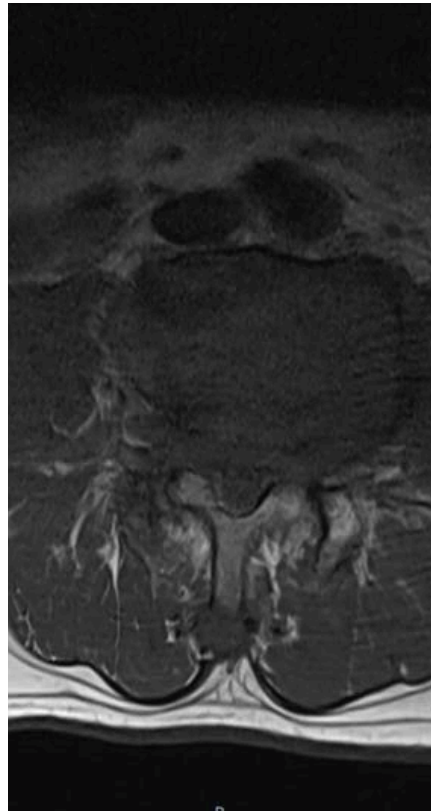
Patients diagnosed at an early or incomplete stage often have a significantly better prognosis. Those who have progressed to retention or complete CES are much more likely to experience long-term impairment, regardless of intervention.

This distinction is central to causation. The question is not simply whether there was a delay, but whether the patient was still in a recoverable stage during that delay.

When this strengthens a claim

A claim is strengthened where there is evidence that the patient was in an early or

incomplete stage of CES, and that progression to a more severe stage occurred during a period of delay. In these cases, causation is more clearly established.



When the case is weaker

Where the patient had already progressed to a severe stage at the time of presentation, it becomes more difficult to demonstrate that earlier intervention would have improved the outcome. In such cases, the prognosis may have been poor regardless of timing.

What to look for in the records

The key issue is identifying the stage of CES at different points in time. Documentation of symptom severity, progression, and classification can provide important insight into whether the patient remained in a recoverable phase.



Surgery does not define outcome.

There is a common assumption that once decompression surgery has been performed, the outcome is largely determined.

In practice, this is not the case. Many patients continue to experience persistent symptoms, including pain, fatigue, bladder and bowel dysfunction, and reduced functional capacity long after surgery.

For solicitors, this has important implications for valuation. The presence of surgery does not limit damages. In many cases, it is the long-term impact of symptoms that drives the value of the claim.

Assuming a good outcome based solely on the fact that surgery occurred can lead to significant undervaluation.

When this strengthens a claim

A claim is strengthened where there is clear evidence of ongoing symptoms and functional limitation following surgery, particularly where these impact employment, independence, or quality of life.

When the case is weaker

Where recovery is well documented and symptoms have resolved or significantly improved, the overall value of the claim may be reduced.

What to look for in the records

Attention should be given to long-term follow-up, rather than immediate post-operative outcome. Ongoing symptoms, functional assessments, and impact on daily life are all key indicators of how the case should be valued.

Rehabilitation and fatigue directly affect claim value.

Recovery from CES does not end with surgery.

Rehabilitation, pain management, and patient engagement all play a significant role in determining long-term outcome. Fatigue, in particular, is a commonly under-recognised factor that can limit a patient's ability to engage with rehabilitation and regain function.

This creates a cycle where reduced activity leads to deconditioning, which in turn contributes to ongoing pain and further limitation.

From a medico-legal perspective, these factors are highly relevant to future loss. Where rehabilitation is delayed, inadequate, or ineffective, this can significantly increase long-term care needs and overall claim value.

When this strengthens a claim

A claim is strengthened where there is evidence that rehabilitation was delayed, insufficient, or limited by fatigue or other factors, resulting in ongoing impairment and increased support needs.



When the case is weaker

Where rehabilitation was timely, appropriate, and well engaged with, and recovery progressed as expected, it becomes more difficult to argue for significant future losses.

What to look for in the records

The focus should be on the rehabilitation pathway as a whole. Timing of intervention, patient engagement, evidence of fatigue, and ongoing care requirements all provide important insight into long-term outcome.

Cauda Equina Syndrome cases rarely turn on a single issue.

As this guide has shown, the outcome is shaped by a combination of factors: how the patient presented, how symptoms progressed, whether deterioration was recognised, and critically, whether earlier intervention would have made a difference.

In practice, the strongest cases are those where these elements align. The weakest are those where delay is assumed to matter, but the underlying evidence does not support it.

What also becomes clear is that outcome is not defined by surgery alone. Persistent symptoms, rehabilitation, and long-term functional impact often play a far greater role in determining prognosis and valuation.

These are not straightforward issues. They require careful analysis, and often, input across multiple clinical disciplines.

Why the right expert matters

CES cases rarely rely on one opinion.

They typically require coordinated input across diagnosis, imaging, surgery, and long-term outcome. Where that evidence is incomplete or misaligned, it can weaken both causation arguments and overall valuation.

Getting the right expert evidence in place early is often the difference between a case that progresses with clarity, and one that needs to be revisited.



Access specialist neuro and spinal expertise.

INNEG's Neuro & Spinal panel includes **3,707+ experts across key disciplines, including:**

- **Neurology (297 experts)** advising on neurological deficit, symptom progression, and long-term outcome
- **Neuropsychiatry (71 experts)** assessing complex symptom validity and neuropsychiatric impact
- **Neuroradiology (51 experts)** interpreting MRI findings, compression, and timing
- **Neurosurgery (214 experts)** advising on decompression, complications, and re-operation risk
- **Orthopaedic Spinal Surgery (268 experts)** providing opinion on spinal pathology and surgical management
- **Pain Medicine (159 experts)** assessing chronic pain and long-term functional impact
- **Physiotherapy (261 experts)** advising on rehabilitation, recovery, and mobility limitation
- **Paediatric Neurology (87 experts)** supporting paediatric and adolescent CES cases
- **Neurophysiology (54 experts)** interpreting nerve conduction and neurological testing
- **Neurorehabilitation (18 experts)** advising on complex rehabilitation and long-term care needs

In CES claims, the question is rarely whether there was a delay. It is whether the evidence clearly shows that delay changed the outcome.

Search our expert panel [here](#).