IN THE SUPREME COURT OF NEW SOUTH WALES

COURT OF APPEAL

STEPHEN TAYLOR

Appellant

v

IAN WOODGATE

Respondent

PROCEEDINGS NUMBER: 2025/00127431

APPELLANT'S WRITTEN OUTLINE OF SUBMISSIONS

Introduction

1. These proceedings arise from medical treatment the appellant received from the respondent, an orthopaedic surgeon, between August 2010 and March 2019.

2. At 14 years of age in around 1984, the appellant was diagnosed with a slipped upper femoral epiphysis in his left hip. He underwent some surgery, but by age 40 when he first saw the respondent in 2010, he was interested in receiving a left hip replacement to manage increasing pain and limitations with that hip. He had been an active sportsman and had played squash at representative level. He wanted to continue to be active.

3. At the first consultation in August 2010, the respondent recommended installing a 'MSA short stem device'. One feature that made this device different from conventional hip replacement devices was that the three key components of the device, being the stem, neck and ball, could be detached from each other and adjusted. Another feature was that the stem component of the device did not penetrate as far into the patient's femur as a conventional device would.

4. Illustrations of the relevant hip and thigh anatomy can be seen at Blue 2:598-602. An illustration of the 'MSA short stem device' and its components can be found at Blue 2:601. Photographs of a modular MSA stem, resembling the appellant's device, installed by the

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Solicitor responsible for filing — Dated 16/10/2025

respondent on 10 May 2011, can be found at Blue 2:591-593. The replacement with a conventional stem on 29 April 2019 was performed by a different surgeon, Dr Michael Neil.

5. One of the issues before the primary judge was whether the respondent was negligent in failing to provide adequate advice and warnings about the type of device he recommended: "**Issue 1**", J[30]-[61]. The primary judge rejected this part of the appellant's case: J[42] & [61]. There is no appeal from this part of the judgment.

6. After installation of the device on 10 May 2011, the appellant continued to present with symptoms in his left leg including pain and restriction. This led to numerous radiological investigations and consultations with the respondent from May 2011 onwards.

7. It was not in dispute that, by 22 June 2011, the stem had moved relative to the left femur, as is shown by the x-ray imaging at Blue 1:91. This led to revision surgery on 30 August 2011 performed by the respondent. In the revision surgery, the respondent replaced the ball and neck components of the device, but not the stem. At issue before the primary judge was whether at the time of the revision surgery: (i) the stem was loose or had stabilised into its new position; (ii) if loose, whether the respondent should have detected that; and (iii) if so, whether the respondent would have replaced the stem: "**Issue 2**", J[62]-[77]; "**Issue 4**", J[139]-[155].

8. For convenience this can be described as the appellant's '**intraoperative case**'. The primary judge rejected this part of the appellant's case. Appeal Grounds 1, 2 and 3 concern this part of the judgment.

9. After the revision surgery on 30 August 2011, the appellant continued to see the respondent regularly for many years, until 23 March 2019. At issue before the primary judge was whether on each of the consultations up to the last on 28 March 2019: (i) the stem was loose or had stabilised into its new position; (ii) if loose, whether the respondent should have detected that; and (iii) if so, whether the respondent would have recommended replacing the stem: "**Issue 3**", J[78]-[138]; "**Issue 4**", J[139]-[155].

10. For convenience this can be described as the appellant's '**ongoing management case**'. The primary judge rejected this part of the appellant's case. Appeal Grounds 1, 2 and 4 concern this part of the judgment.

11. Also at issue before the primary judge was whether the appellant would have achieved a materially better outcome if the stem of his device had been replaced at the revision surgery

on 30 August 2011, or at any time up until the last consultation on 28 March 2019 – being a period of up to 8 years earlier than when the device was in fact replaced by Dr Neil on 29 April 2019: "**Issue 5**", J[156]-[160]. The primary judge rejected this '**causation**' aspect of the appellant's case. Appeal Ground 5 concerns this part of the judgment.

12. Having found for the respondent on all issues in relation to liability, the primary judge did not go on to carry out a provisional assessment of damages: J[161]-[166].

APPEAL GROUND 1

The primary judge erred in overlooking or rejecting radiological evidence as to what imaging obtained during the period from August 2011 to 2017 showed as to loosening or movement in the appellant's femoral stem.

13. Both the intraoperative case and the ongoing management case relied on establishing that, from the revision surgery on 30 August 2011 onwards, the stem of the device was loose. The respondent's case was that although the stem moved after installation, by the time of the revision surgery it had stabilised in its new position and was not loose until after 2017.

14. Before the primary judge were three sources of evidence for the determination of this issue, being: (i) contemporaneous radiology as interpreted by expert witnesses; (ii) the respondent's observations of the stem during the revision surgery, as recorded contemporaneously or as recalled at trial 13 years later; and (iii) inferences drawn from the appellant's functional capacity, as recorded in clinical notes or recalled at trial by him and corroborating witnesses.

15. The primary judge dealt with the first of those sources, the radiology, at J[139]-[154]. Critically:

    a. At J[145] and [151], the primary judge referred to the evidence of the orthopaedic experts, Dr Doig and Dr O'Sullivan, as being to the effect that "there was no radiological evidence of movement in the stem from August 2011 to 2017"; and

    b. At J[151]-[154], the primary judge preferred that opinion over the contrary opinion of expert radiologist Dr Thomson, seemingly because the relevant test for breach was the standard expected of an orthopaedic surgeon, not of a radiologist.

16. Both aspects of this reasoning are problematic.

17. As to the first aspect of the reasoning, the primary judge appears to have misunderstood the evidence of the orthopaedic experts.

18. In their joint report dated 31 January 2024, the orthopaedic experts did not conclude that there had been no radiological evidence of movement of the stem from 22 June 2011 to August 2017. Nor did they conclude that there was no looseness of the stem during that period. In particular:

a. Both experts agreed that when comparing the x-rays of 31 May 2011 and 22 June 2011, it is not difficult to see that the lateral part of the stem had moved and was impacting the lateral cortex of the femur. The stem appears to have collapsed into varus and had subsided: Blue 1:134R-135G.

b. Both experts agreed that they did not have enough facts nor were there adequate surgery notes as to the steps taken by the respondent during the revision surgery to assess stability to describe what the respondent actually did or to assess the adequacy of any steps taken by him: Blue 1:137G.

c. Both experts agreed that the numerous x-rays taken from 22 June 2011 until 4 August 2017 demonstrated lucency adjacent to the lateral femoral stem; and that this finding means that there has been a loosening: Blue 1:139F-L.

d. Dr Doig observed that those x-rays (i.e. 22 June 2011 to 4 August 2017) "*do not show a **marked** difference, except for the longer head after the revision procedure that still show that the stem is still there*". Dr O'Sullivan agreed and noted that "*there has been no real material change in the x-rays, and that the actual position of the implant has **not shifted much** and, specifically it has not shifted since the initial x-rays*": Blue 1:138G-M [emphasis added]. This was in answer to Question 8, which was not even directed to the issue of whether these x-rays showed that the stem was loose.

e. Whether this limited movement (when comparing different x-rays done over time) was inconsistent with the stem being loose was not then explored in the evidence.

f. Both experts agreed that according to the x-rays dated 14 October 2011, 8 March 2012 and 14 August 2015, "*radiologically the stem was loose*": Blue 1:140U.

g. Both experts noted however that the radiological evidence needs to be correlated to the clinical presentation in any proper assessment as to the need for

revision/intervention. In other words, clinical presentation does not detract from the existence of stem looseness. Clinical presentation might however diminish the need to intervene. This is made clear at Blue 1:143R.

h. In his reports, Dr Doig opined that there is radiological evidence of loosening on the 9 August 2012 x-ray (Blue 1:4L); that there are a number of signs of loosening shown on the 14 August 2015 x-ray (Blue 1:2L); and that the pull-away from the lateral aspect of the femoral prosthesis is very obvious on the 28 July 2016 and 4 August 2017 x-rays (Blue 1:22O). He did not depart from this opinion in the joint report. Nor was he challenged on it in concurrent evidence.

19. In concurrent evidence, the issue of whether the stem was loose in the period from 22 June 2011 to August 2017 was not definitively answered. In particular:

a. Both experts agreed that the movement of the femoral stem between May 2011 and June 2011 amounted to radiological evidence of loosening: Black 2:615B-F.

b. Both experts agreed that the x-rays from June 2011 to 4 August 2017 showed "pedestal formation" which occurs when there has been some movement or some subsidence of the prosthesis, so is consistent with loosening in a symptomatic patient: Black 2:617S-618G.

c. Both experts agreed that if a patient is complaining of pain in the inner and outer thigh on the leg in which a hip replacement has been performed, in such a patient the lucency seen in the imaging in this case could be consistent with loosening: Black 2:618H-P.

d. Both experts agreed that the ability to play high-impact sports (such as squash) might be inconsistent with the presence of a loose femoral stem, but that would depend on how much restriction the patient has in playing that sport, how much pain the patient suffers afterwards, and the patient's stoicism: Black 2:618U-620S; Black 2:625E-632K. Dr Doig further observed that if the patient has a limp and has significant pain after playing squash, even for a short period of time, then the implication is that the hip is not functioning properly, most likely because it is loose: Black 2:619E.

20. Properly understood, the evidence of the orthopaedic experts was that the radiology *did* demonstrate signs of looseness in the stem. Those signs persisted throughout the period from 22 June 2011 to 4 August 2017. According to Dr O'Sullivan, the radiology did not show "*much*

movement" of the stem from x-ray to x-ray, but neither expert suggested that this was inconsistent with looseness. The primary judge's error was to conflate stem "looseness" and stem "movement". In the confined space within the femur where the stem sat, significant movement from x-ray to x-ray would be strong evidence of looseness (as was the case when comparing the x-rays of 31 May 2011 and 21 June 2011); but the subsequent absence of "much movement" (whatever that means) does not mean the stem was stable, only that it did not move as much as it had before when measured from x-ray to x-ray. Whether the extent of looseness was clinically significant, necessitating intervention, then depended on an assessment of the appellant's precise functional capacity, pain, and tolerance for pain.

21. This misunderstanding of the orthopaedic expert evidence then infected the primary judge's conclusion that it was inconsistent with the evidence of the expert radiologist Dr Thomson.

22. In summary, Dr Thomson's evidence was that:

    a. The stem was loose at the time of the 22 June 2011 x-ray, because there was a 3.5mm gap appearing between the lateral margin of the stem and the adjacent bone that can only be explained by loosening: Blue 1:91D-92D.

    b. The gap **increased** to about 4mm on the x-ray of 14 October 2011, and further to about 4.5mm on the x-ray of 8 March 2012, and still further to about 5.2mm (on the same anterior-posterior view) on the x-ray of 9 August 2012. By the time of the 14 August 2015 x-ray it was 5.5mm on the same AP view: Blue 1:92E-H.

    c. This progressive increase in the gap showed progressive loosening after the revision surgery of 30 August 2011: Blue 1:92H.

    d. In a supplementary report, Dr Thomson also noted that (Blue 1:102P-R):

> *I am not qualified to comment on the operative method Dr Woodgate applied to convince himself that the femoral stem of the prosthesis was not loose. However, his comments related to the examination dated 9 August 2011, that the lucency lateral to the femoral stem of the prosthesis was unchanged is clearly incorrect as it had continued to widen measuring 4.7mm, there is a new lucency on the medial aspect of the prosthesis and there is endosteal reaction at the tip of the prosthesis. These features, irrespective of any appearance of the lateral or axial images indicate loosening of the femoral stem of the prosthesis.*

23. The respondent did not adduce evidence from an expert radiologist to challenge that of Dr Thomson. Nor did the respondent cross-examine Dr Thomson. The judgment does not refer in any detail to Dr Thomson's evidence, nor grapple with its substance (especially the reference to progressive widening of the gap) before rejecting it in favour of the supposedly different evidence of the expert orthopaedic surgeons: J[145], J[151]-[154]. It is unclear if the primary judge appreciated that critical aspect of Dr Thomson's evidence – as to the increasing gap between the lateral margin of the stem and the adjacent bone that can only be explained by persistent loosening.

24. Properly understood, that evidence was not inconsistent with Dr O'Sullivan's evidence in the joint report. The progressively widening gap between stem and bone is consistent with both orthopaedic surgeons' conclusion that "*radiologically the stem was loose*". To the extent there is any inconsistency between the progressively widening gap and Dr O'Sullivan's evidence that there was not "much movement" from x-ray to x-ray, that was not clarified or explored by the respondent during the trial. The closest the evidence came to inconsistency was in concurrent evidence when the orthopaedic surgeons said there was no "radiological movement" of the stem after August 2011 until 2017 (Black 2:624R-U), but here they appear to have been drawing a distinction between the situation after August 2011 and the considerable movement that had occurred between May and June 2011. They were not taken to, and did not specifically address, Dr Thomson's observation of gradual widening of gap as measured in millimetres over many years.

25. Even if there was inconsistency between the evidence of Dr Thomson and that of the orthopaedic surgeons, a further error lies in each of the primary judge's three reasons for preferring that of the latter: see J[148], J[149], J[151]-[154]. Those reasons were: (i) Dr Thomson's opinion is generated with the benefit of hindsight; (ii) Dr Thomson was asked to assume the correctness of information set out in a letter from Dr Neil dated 18 April 2019; and (iii) the relevant standard of care was that of orthopaedic surgeons.

26. In reasoning thus, the primary judge appears to have conflated two separate questions. The **first** question is whether the stem was in fact loose in the period 22 June 2011 to August 2017. That calls for an objective inquiry, using the best evidence available whether radiological and orthopaedic, with the benefit of hindsight. If the answer to the first question is 'yes', the **second** question is whether the respondent, exercising reasonable care and skill, ought to have detected the looseness. It is this second question that needs to be considered in foresight, with the application of orthopaedic expertise, working only off the information available to

the respondent at that time. It is unclear from J[139]-[155] which of these two questions the primary judge was attempting to answer when rejecting Dr Thomson's evidence. The reasoning cannot stand if applied to answering the first question.

27. For those reasons, the primary judge erred in misunderstanding or rejecting the radiological evidence of stem looseness in the period 22 June 2011 to August 2017.

APPEAL GROUND 2

The primary judge erred in finding that there was no loosening or movement in the appellant's femoral stem from August 2011 to 2017.

28. As observed in paragraph [14] above, radiological evidence of stem looseness comprised one of the three sources of evidence for determining this issue. The primary judge's misunderstanding or rejection of that radiological evidence infected his Honour's assessment of the other two sources of evidence. As Leeming JA observed in *Bezer v Bassan* [2019] NSWCA 50 at [132], the whole of the evidence relevant to an issue must be weighed before determining whether the party bearing the legal onus has succeeded on that issue.

Looseness in the revision surgery of 30 August 2011

29. One of those other sources of evidence was the respondent's Operative Record for the revision surgery on 30 August 2011. The record states: "*Cup not loose, stem not loose*". The record does not refer to what (if any) steps were taken by the respondent to reach this conclusion. It was unclear if the respondent had any specific recollection of the operation among the many hundreds of such operations he had performed, let alone a specific memory of testing for stem looseness: Black 2:404E, 545X. The respondent gave evidence as to his usual practice for checking whether the stem was loose: Black 2:395P-404Q.

30. The expert orthopaedic surgeons agreed that if the respondent followed that usual practice in the revision surgery on 30 August 2011, that would have been a reasonable way to assess whether the stem was loose: Black 634O-Y. However, especially in circumstances where the objective and contemporaneous radiological evidence that the stem was loose not only on 30 August 2011 but for years afterwards, there is a difficulty in using evidence of the respondent's usual practice to prove that it was not loose. The respondent may or may not have followed

his usual practice on this occasion. He may or may not have followed every aspect of his usual practice on this occasion with care and rigour.

31. Contrary to the primary judge's comment in J[73], the respondent *was* squarely cross-examined as to whether he followed his usual practice. It was put to the respondent that:

    a. His evidence about removing soft tissue from the lateral, medial, anterior and posterior surfaces was a reconstruction rather than a recollection (Black 547B-E);

    b. He did not apply a slap hammer to the stem itself after removing the neck (Black 548E); and

    c. He did not identify on the booking request form dated 1 August 2011 (Blue 2:364) a request for a conventional femoral stem because it was not in the respondent's contemplation that he was going to replace the femoral stem (Black 2:529T), because he believed the stem to be stable at the time (Black 2:529X).

32. The primary judge appears to have overlooked, or at least dismissed without consideration, these matters. Indeed, the primary judge makes no reference to (and one must assume did not factor into his determination) the inconsistencies in the respondent's various accounts of what he did in the revision surgery to check for stem looseness. In particular:

    a. In September 2022, after the appellant's proceedings were commenced, the respondent prepared a document in which he set out his recollection of everything that occurred during the revision procedure (Black T542W; 544W). This was his recollection as of September 2022 as to what occurred (Black 545I):

        > *The interface of the stem with bone was cleared of debris prior to assessment for loosening. To confirm the technique of determining if the stem was loose whilst the modular neck was in situ, this is toggled to see if there's any micro motion or fluid. A slap hammer is used to disimpact the modular neck component.*

    b. In the assumptions prepared for the joint expert conference between Dr Doig and Dr O'Sullivan the respondent stated that he did the following (Blue 1:157C-L-158C-L:

        > *To confirm the technique of determining if the stem was loose....whilst the modular neck was in situ it was toggled ....and then separately during disimpaction of the modular neck component from the stem a slap hammer was used and the stem did not simultaneously extract. The interface of the stem with bone was cleared of debris....*

33. That version of events materially differs from the evidence the respondent gave at trial, because:

a. There is no reference in the earlier accounts to removing soft tissue from the lateral, medial, anterior and posterior surfaces *prior* to using the slap hammer to check whether the stem was loose; and

b. There is no reference in the earlier accounts to applying a hand or a slap hammer to the stem itself *after* removing the neck.

34. As the expert orthopaedic surgeons explained in the joint report, removal of all of the soft tissue, particularly from the lateral aspect of the femoral prosthesis, is "essential" in order to assess stability. Dr O'Sullivan added: *'but I think the soft tissue exposure is critical here, and then to be able to see that implant bone interface, and if you've got a good view of that you should be able to make an adequate assessment of the stability'* (Black 2:634W-Y). Dr Doig's report of 24 March 2022 also refers to the need then to try to move the stem after removal of the neck: Blue 1:12T-13F. Stability can only be confirmed if the stem remained "rock solid" after these two steps: Blue 1:13H.

35. As to the fact that the respondent appears not to have ordered a replacement stem to have on hand for the revision surgery, Dr O'Sullivan opined that if there is a situation where an orthopaedic surgeon is exploring whether a stem may possibly be loose, then *'you have to have implants available'* and *'you would always go into a situation like this with implants available to implant in the event that the stem was loose at the time of the revision'* (Dr O'Sullivan Black 2:616T-X).

36. Against that evidence, the primary judge cannot simply find that the respondent followed his usual practice in testing for looseness based only on an impression that the respondent was *"an organized and methodical individual"*: J[69]. As Brereton JA observed in *Dhupar v Lee* [2022] NSWCA 15 at [106] (McCallum JA and Simpson AJA agreeing), evidence of a doctor's usual practice *'has to be weighed with other evidence from which inferences are available.'*

37. The primary judge's determination to *"unhesitatingly accept"* the respondent's evidence that he followed his usual practice on 30 August 2011 can only stand if there were no objective radiological evidence to the contrary. For the reasons discussed under Appeal Ground 1, that is not the case. In the least, the primary judge needed to understand and grapple with the radiological evidence, as well as the inconsistencies between the respondent's evidence and

his written versions of events. The primary judge did not do so and thereby fell into error in concluding that the stem was not loose at the revision surgery on 30 August 2011.

Looseness after the revision surgery on 30 August 2011

38. The primary judge appears to have approached this issue solely as a contest between the reliability of the appellant's evidence as to his function and activity in the years 2012-2017, versus the clinical records of the respondent of that activity as reported by the appellant: J[86]-[138].

39. There are several problems with this approach.

40. **First**, that approach is only sound if the primary judge had correctly rejected or put aside the radiological evidence of stem looseness after 30 August 2011. For the reasons set out in Appeal Ground 1, his Honour had not.

41. **Second**, as noted in paragraph [19(d)] above, in concurrent evidence the orthopaedic surgeons stressed that whether the appellant's function and activity was inconsistent with the stem being 'clinically' loose depended on a precise assessment of what movements he could do with his left hip and leg, how often, for how long, with how much pain, and with how much pain tolerance bolstered by pain medication: Black 2:618U-620S; Black 2:625E-632K. The effect of that evidence was not, with respect, accurately summarised by the primary judge at J[123].

42. Specifically, that evidence included the following:

    a. In concurrent evidence, Dr Doig said '*so, in other words, if the patient was playing squash for four hours a week without any pain, without any significant ongoing symptoms, that's the single most important thing is to depend on whether a revision occurs or not.* ***If the patient was having significant problems with it, that also is very important as to whether a revision occurs or not, no matter what the radiology shows'*** (Black 2:608F-H) [emphasis added].

    b. Dr Doig and Dr O'Sullivan accepted that the appellant would have been able to:

        (i) go indoor rock climbing with a definitely loose femoral stem, if the wall was a 'simple one' (Black 2:625N); and

(ii) ride an exercise bike, but dependant on pain levels and the length of time spent riding the bike (Black 2:625V-626O).

c. Dr Doig expressed the opinion that the appellant would have been able to play squash with a loose femoral stem requiring revision surgery, but if the appellant was just hitting a squash ball around a court and not running, jumping, pivoting and twisting (Black 2:627T).

d. Both Dr Doig and Dr O'Sullivan agreed that the expectation of what a patient may be able to do with a loose femoral stem requiring surgery *very much depended on the stoicism of the patient* (Black 2:628V).

43. As to the experience of pain, Dr Doig and Dr O'Sullivan agreed that it would be necessary for a treating orthopaedic surgeon to elicit from a patient a history of:

a. When pain occurs,

b. Whether the pain occurs with activity,

c. The level of pain the patient experiences,

d. How the pain is affecting the patient's activities of daily living,

e. The nature of the pain, such as 'start up' pain (Black 2:620.D-S).

44. Although the respondent's clinical notes make occasional references to the appellant playing squash and undertaking other activities over the period 30 August 2011 to 30 August 2017, those brief references fall well short of the detail necessary to enable the assessment the expert orthopaedic surgeons say they require to determine if the stem was 'clinically' loose.

45. For example, a reference to playing squash for three hours (noted on 2 October 2014) is ambiguous as to whether the appellant was running and freely moving on the singles court like the State squash representative he used to be, or whether he instead turned up on some Saturdays, limped around towards the ball on the doubles court for two 20-minute sessions over about three hours, and then required treatment afterwards because of his pain. The appellant's evidence supported the latter, and it was corroborated by the unchallenged evidence of one of his squash partners Mr Hennock (Black 1:238S-241C), and of his massage therapist Mr Rossi (Black 1:247J-249M).

46. Mr Rossi treated the appellant from 8 September 2012 to 16 February 2013 (Black 1:245U), and then for a second period from 10 October 2015 to 8 April 2016 (Black 1:250I). When Mr Rossi assessed the appellant during the second period of treatment from October 2015, he found the appellant's limp was '*remarkable*' and '*particularly noticeable*.' The appellant was in greater pain generally (Black 1:252G) and the pain was constant. The appellant reported no lasting relief from Mr Rossi's treatments (Black 1:252I). The appellant had a similar style of moving his left leg when he walked and he bent his whole torso to the left when he walked, but he walked with 'more of a lurch than before' (Black 1:252T). A new symptom reported by to Mr Rossi was the appellant found it painful sitting down for long periods performing work as a graphic artist (Black 1:252W).

47. Another piece of corroborative evidence not referred to by the primary judge was the appellant's use of orthotics and the evidence of same (Blue 2:582-584). Indeed, the respondent said that he had no recollection of the appellant showing him his orthotics, but if he was shown orthotics with a differential of about 20mm between the feet, that would '*be of concern*' (Black 2:563T). The appellant gave evidence that he told the respondent about his use of orthotics (Black 1:74P).

48. The judgment makes no reference at all to any of this corroborative evidence. Nor does it make precise findings as to the appellant's function and activity over the period 30 August 2011 to 30 August 2017 sufficient to determine whether that function and activity is inconsistent with the stem being 'clinically' loose, or at least being sufficiently 'clinically' loose to justify more surgical intervention. Instead, the primary judge presents the issue as a contest between accepting the appellant and accepting the respondent's clinical notes (see J[136]-[137]), overlooking the limited information actually contained in those clinical notes as to function and activity.

49. **Third**, had the primary judge correctly understood the expert orthopaedic *and* radiological evidence as showing stem looseness, that piece of objective evidence would presumably have gone on to affect: (i) the primary judge's assessment of the appellant's credit and the reliability of his evidence as to function and activity in the period August 2011 to August 2017; and (ii) the primary judge's apparent assessment of the respondent's clinical notes as being a thorough and accurate reflection of the appellant's function and activity in that period. Put another way, the appellant's evidence as to restricted movement and pain is much more difficult to discredit on demeanour alone, if there is objective radiological evidence that there was stem looseness which would explain that restricted movement and pain.

Conclusion on Appeal Ground 2

50. For those reasons, the primary judge's apparent finding that the femoral stem was not loose either at the revision surgery on 30 August 2011 or in the six years afterwards, was in error and should be set aside. In the least, to adopt the words of Simpson AJA in *Cavanagh v Manning Valley Race Club Ltd* [2022] NSWCA 36 at [59], the primary judge's reasons in respect of the totality of the evidence on this issue were inadequate to discharge the function for which reasons for judgment are required, in that they fail to show that the primary judge had grappled with the evidence and in failing to record specific findings of fact necessary for the outcome of the proceedings.

51. If this Court is not satisfied that the radiological evidence alone is sufficient to find that the stem was loose during that time, then the matter should be remitted to the Court below for retrial.

APPEAL GROUND 3

The primary judge erred in finding that the respondent discharged his duty of care to the appellant, when checking the femoral stem for loosening during the revision procedure on 30 August 2011.

52. This appeal ground only arises if the appellant succeeds on appeal grounds 1 and 2 above.

53. If this Court is satisfied that the femoral stem was loose during the revision procedure on 30 August 2011, it must follow that the respondent did not carry out adequate testing for looseness in accordance with: (i) what he described in evidence as his usual practice (Black 2:395P-404Q); and (ii) what the expert orthopaedic surgeons described as the necessary steps that a surgeon should take (see paragraph [34] above).

54. Neither the respondent nor the expert orthopaedic surgeons suggested that looseness could be missed despite the taking of those steps. The respondent did not advance a case below, even in the alternative, that he could have missed the looseness during the revision procedure despite performing checks in a manner that at the time was widely accepted in Australia by peer professional opinion as competent professional practice: s 5O of the *Civil Liability Act* 2002; *Dean v Pope* [2022] NSWCA 260.

55. Accordingly, if the appellant succeeds on appeal grounds 1 and 2, the primary judge's conclusion in J[66] – that the respondent took those steps – must be in error.

56. The expert orthopaedic surgeons were then in agreement as to what a surgeon would have done if looseness was discovered. The stem would have been removed and a long stem prosthesis put in: Black 2:622S-623M; Blue 1:03T; 1:04J; 1:13I.

APPEAL GROUND 4

The primary judge erred in finding that the respondent discharged his duty of care to the appellant in consultations between the revision procedure on 30 August 2011 and prior to the last consultation on 28 March 2019, despite the response in each consultation between that period not detecting, investigating or recommending revision surgery to treat signs of loosening or movement in the femoral stem.

57. This appeal ground only arises if the appellant succeeds on appeal grounds 1 and 2 above.

58. There was agreement between the expert orthopaedic surgeons that at each of the consultations in the period 30 August 2011 to 29 March 2019, the respondent should have taken the following steps:

a. Elicit from the appellant during consultations when his pain is occurring, with what activities, what level of pain and how is it affecting his activities of daily living (Black 2:620D-K).

b. Clinically assess and measure the appellant's leg length discrepancy, by (for example) standing on a book or a piece of wood of a different height to see if he could equalise his legs (Black 2:621B-G) and then take a measurement from the piece of wood or books.

c. Correlate the radiological evidence with the appellant's clinical presentation in any proper assessment to determine the need for revision/intervention (Blue 1:140O).

59. If this Court is satisfied that the femoral stem was loose after the revision procedure on 30 August 2011, then for the reasons set out in paragraph [38]-[45] above, the primary judge's findings as to the appellant's function and activity during the period 30 August 2011 to 29 March 2019 cannot stand.

60. However, without precise findings as to the appellant's function and activity during that period, it was impossible for the primary judge to determine (under the standard in s 5O) in

respect of each consultation during that time the adequacy of: (i) the respondent's clinical notes, (ii) his assessment of the appellant's presentation including activity, pain and leg length discrepancy; and (iii) his repeated decision not to carry out further revision surgery on suspicion of ongoing stem looseness, despite (on the appellant's case) no improvement in the symptoms.

61. Accordingly, if the appellant succeeds on appeal grounds 1 and 2, the finding at J[138] – that the respondent did not breach is duty of care in the appellant's management from 30 August 2011 to 28 March 2019 – must be set aside.

62. If the appellant succeeds on appeal ground 3 (in relation to the revision surgery) and has judgment with damages to be remitted for assessment, it may be unnecessary to remit for retrial the issue of liability for management after 30 August 2011.

APPEAL GROUND 5

The primary judge erred in finding that the appellant would not have achieved a materially better outcome even if a conventional stem had been implanted during the period from 30 August 2011 until 27 April 2019.

63. As noted in paragraph [56] above, the expert orthopaedic surgeons agreed that if the respondent had detected that the appellant's femoral stem was loose during the revision procedure on 30 August 2011, the appropriate course would have been to replace it with a conventional femoral stem. This was what ultimately occurred on 29 April 2019, about a month after the appellant stopped seeing the respondent and consulted instead with Dr Neil.

64. At issue before the primary judge was whether earlier replacement of the stem, either at the revision surgery on 30 August 2011 or at least at some earlier time before 27 April 2019, would have resulted in a materially better outcome for the appellant. This was a question of factual causation to be assessed in accordance with s 5D(1)(a) of the *Civil Liability Act* 2002.

65. The primary judge dealt with this issue in two paragraphs: J[158]-[159]. The primary judge found that even with stem replacement in August 2010, the appellant would have had the same result as he did when he underwent the surgery in April 2019. The primary judge relied on the supposed evidence of Drs Doig and O'Sullivan that since 2019, the conventional stem implanted by Dr Neil had also moved into varus. The primary judge found that such subsidence

"can be causative" of the leg length discrepancy and scoliosis about which the appellant complains.

66. This finding is erroneous for two reasons.

67. **First**, it ignores the evidence that the long-term presence of a loose femoral stem resulted in permanent scoliosis which has persisted despite subsequent replacement of the stem and an otherwise good functional and pain-free outcome from that replacement. This evidence included the joint report of the orthopaedic experts Dr Doig and Dr O'Sullivan (Blue 1:146F-W); their opinion in concurrent evidence (Black 2:604X-605F; Black 2:606B-E); and the unchallenged opinion of orthopaedic surgeon Dr Negus that *'over time, the degenerative changes cause it* (scoliosis) *to be less correctable'* (Blue 1:61V; Blue 1:57F), and that had the leg length discrepancy been corrected within 2 years of it first occurring (following the revision procedure in August 2011) *'there would have been little to no degenerative change and therefore his spine curvature would have corrected back to normal with no long term scoliosis'* (Blue 1:62G).

68. The judgment does not grapple with any of that evidence. The primary judge's reference to the conventional stem having moved into varus since 2019 is based on a misunderstanding of evidence given by Drs Doig and O'Sullivan at trial: Black 2:623H-P. Their evidence was that in 2019 Dr Neil chose to insert the replacement stem in varus (to accommodate the space left by the previous loose stem) rather than straight down, which avoided the need to remove lateral bone. It was not suggested to them, and they did not opine, that as a consequence the appellant suffers any ongoing leg length discrepancy, or problems with function or pain.

69. **Second**, the primary judge appears to have assumed without basis that movement of the replacement conventional stem since April 2019 is the cause of ongoing problems with the left hip. This was not the evidence. In particular:

a. Dr Neil observed that the appellants leg length discrepancy had entirely resolved following the insertion of the conventional stem by Dr Neil in March 2019 (report Dr Neil dated 13 June 2019 (Blue 2:507L) *'his leg lengths appear perfect...leg lengths are clinically equal'* (Blue2:407M) and 15 April 2020 *'leg lengths are equal'* (Blue 2:505M).

b. That accords with the appellant's unchallenged evidence that he no longer had pain in his hip, he no longer had a lack of movements that that his leg lengths were equal following the revision performed by Dr Neil (Black 1:127H).

70. There was no evidence at all to support the primary judge's finding that the symptoms the appellant suffers from following the insertion of the conventional stem in March 2019 are 'broadly similar' to those he suffered from between August 2011 and April 2019. In the least, the applicant has achieved a materially better outcome from the April 2019 surgery than his condition before, and so it follows that if the surgery had been done earlier, he would have achieved that materially better outcome earlier.

71. For those reasons, the primary judge erred in finding that causation was not established. The measure of damages is the extent of detrimental difference occasioned by any breach found. Because the primary judge did not carry out a provisional assessment of damages, even if there is no need for a retrial for liability the proceedings would need to be remitted to the District Court for assessment of damages.

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31 August 2025

I certify this document is suitable for publication pursuant to the Practice Note SC CA 01.

Solicitor responsible for filing — Dated 16/10/2025