

Stephen Taylor v Ian Woodgate

New South Wales Court of Appeal 2025/00127431

RESPONDENT'S WRITTEN SUBMISSIONS

Introduction

1. The respondent largely accepts the appellant's observations as to the background of these proceedings set out from paragraph [1] to [12] of his written submissions dated 21 August 2025 (AS).
2. Notably, the appellant concedes at AS[52] and [57] that Ground 3 and Ground 4 only arise for consideration if he succeeds on Ground 1 and Ground 2. However, even if the appellant succeeds on Ground 1 and Ground 2, it is of no moment unless he also succeeds on either Ground 3 or Ground 4 and also Ground 5.
3. In addition, for the reasons set out below, even if the appellant succeeds on Ground 1 and Ground 2 it does not follow (as submitted) that Ground 4 is made out.
4. The appellant also does not challenge the primary judge's finding at J[115] (Red 72E) that he did not accept his evidence, except where it is either corroborated or against interest. That unchallenged finding is particularly relevant to Ground 2 and fatal to Ground 5.

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

5. Even if the radiological evidence did demonstrate loosening of the stem, that evidence is not determinative of whether the stem was in fact loose, so as to require surgical intervention.¹

¹ So much is conceded by the appellant at AS [20] – “*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.*”

6. Dr Thomson’s evidence that the stem was loose at the time of the x-ray dated 22 June 2011 (Blue 1:92E) can only be evidence (given his speciality as a radiologist) of the fact that there was *radiological* evidence of looseness.
7. That looseness was detected by the respondent which led to the revision surgery in August 2011: Blue 1:135V-W, 136E.
8. Contrary to AS[18], the evidence of the orthopaedic experts was that after the initial subsidence in 2011:
 - (a) the x-rays do not show a “marked difference” (Dr Doig): Blue 1:138G-H;
 - (b) the actual position of the implant had not shifted and there had been no further stem subsidence (Dr O’Sullivan): Blue 1:138G-H, 138I-L;
 - (c) although radiologically the stem was loose, the position of the implant remained largely unchanged: Blue 1:140V; and
 - (d) there was no radiological movement of the stem after August 2011 until 2017: Black 2:624P-U.
9. The orthopaedic experts identified lucency adjacent to the lateral femoral stem. “Lucency” is a radiological feature and means that the prosthesis had pulled away from where it was inserted into the bone: Blue 1:139J.
10. Dr Thomson’s further evidence as summarised at AS[22] does not advance the issue.
11. First, lucency may mean some loss of bone in the area and there can be isolated pockets of lucency (Black 2:576L-M).
12. Second, isolated lucencies (as identified by Dr Thomson) can be present in the presence of a stable stem – see especially Dr O’Sullivan’s evidence that the significance of the lucency depends on “*the extent of the lucency, and whether the lucency is circumferential, or only over, you know, a limited part of the prosthesis... It is thought that greater than 2 centimetres is - is of a concern if it’s contiguous, and sort of goes right around the prosthesis.*”: Black 2:618K-L.

13. Third, an x-ray is only a two-dimensional representation of a three-dimensional structure which means there is a requirement to look at multiple imaging studies to see if bone is growing in all surfaces: Black 2:407W-X.
14. Fourth, an implant can be stable with just a “*spot weld*”: Black 2:407X.
15. Notably, Dr Thomson’s evidence that there was an increase in the “gap” was based on imaging studies in the AP and lateral views of the appellant’s hip: Blue 1:92D-H.
16. Dr Thomson’s evidence rises no higher than there being radiological evidence of progressive loosening. It does not rule out that there was otherwise adequate fixation of the stem on planes of the device not seen on the imaging studies he considered.
17. The appellant’s submission conflates the concept of radiological signs of loosening with actual movement of the stem. The absence of movement of the device after 22 June 2011 suggests that it was not definitely loose² and the joint evidence of the orthopaedic experts was that a definitely loose stem is likely to be moving inside the canal of the femur in which it implanted (Black 2:623-624). That submission is also made good by Dr O’Sullivan’s evidence about what he observed on the radiographs taken in 2017 compared with those in 2019: Black 2:602Q-X. In any case, not all loosening requires surgical intervention – see the respondent’s evidence: “*To absolutely know that you’re going to do good for your patient, it has to be definitely loose*”: Black 1:346S-V.
18. As the evidence established, the only way to determine if the stem was in fact loose and that it required surgical intervention is to correlate radiological evidence of loosening with other clinical signs and then to assess the implant intraoperatively. As found by the primary judge, radiological evidence is no more than an important diagnostic tool: J[144] (Red 77P-S).
19. There is nothing problematic about the reasoning of the primary judge at J[145] (Red 77 U-W) or J[151] (Red 78P-U). First, as conceded by the appellant at AS[13]-[14]:

² Notably, there is further support for that conclusion in the evidence relevant to the appellant’s level of function which is considered in relation to the other appeal grounds.

- (a) his case relied on establishing that from the revision surgery on 30 August 2011 (**the Revision Surgery**) and thereafter, the stem of the device was sufficiently loose to require surgical intervention;³ and
 - (b) the radiological evidence was only one of three sources of evidence for the determination of this issue.
20. Second, in light of the evidence set out at [17] above, the criticism of the primary judge at AS[20] should not be accepted. In preferring the opinion of the orthopaedic experts over that of Dr Thomson on this issue, the primary judge was clearly making a distinction between radiological evidence of looseness and whether the stem was in fact loose.
21. Third, when understood that way, the primary judge did not find any inconsistency between the evidence of the orthopaedic experts and that of Dr Thomson. He simply preferred the opinion of the orthopaedic experts as to what a reasonable orthopaedic surgeon would do in response to radiological signs of loosening: J[154] (Red 79D). It was well established that the first question identified at AS[26] - namely, whether the stem was in fact loose in the period 22 June 2011 to August 2017 – could not be answered on the basis of the radiological evidence alone.
22. Having regard to the above, Ground 1 is not made out.
23. Even if this ground of appeal is made out, it does not change the outcome. To establish that the respondent had breached his duty of care, the appellant was required to satisfy the Court that either the respondent should have:
- (a) replaced the stem during the Revision Surgery (i.e. the “intraoperative case”); or
 - (b) recommended replacing the stem at some time after the Revision Surgery up until 2017 (i.e. the “ongoing management case”).

³ The appellant’s submissions generally do not take into account the qualification established by the evidence of possible, probable and definite loosening – see the respondent’s evidence at Black 1:346T-U and the orthopaedic experts’ evidence at Black 2:622H-J.

24. As the orthopaedic experts agreed, radiological findings alone do not constitute a need to act, whether at the time of the Revision Surgery in August 2011, or in the care and management of the appellant thereafter: Blue 1:140N-P.
25. For the reasons set out below, there is no basis to find that the respondent should have replaced the stem during the Revision Surgery, or between 30 August 2011 and 2017.

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

26. As noted above, whilst there was no dispute that there were radiological signs of loosening, the evidence also established that there was no movement of the femoral stem after the initial subsidence. What was in dispute was whether the stem was sufficiently loose so as to require replacement during the Revision Surgery, or in the period thereafter until 2017.
27. The submission at AS[30] conflates the difference between radiological evidence of loosening and whether the stem was in fact loose, which can only ever be confirmed intraoperatively.
28. It is not clear if the appellant challenges the finding that the respondent followed his usual practice during the Revision Surgery: J[66] (Red 61X). Assuming such a challenge is made, the appellant erroneously relies on the radiological evidence as being largely determinative of whether the stem was in fact loose.

Looseness in the revision surgery of 30 August 2011

29. The primary judge accepted the respondent's evidence as to the steps that he took during the revision procedure: J[66] (Red 61X). That finding is not expressly challenged on appeal.
30. The orthopaedic experts agreed that if the respondent undertook the steps during the Revision Surgery as described in his evidence at Black 2:633-634, that was a reasonable way to assess if the stem was loose or not: Black 2:634O-Y.
31. The complaint made by the appellant at AS[29] as to the primary judge's reliance on the operation record - that unequivocally recorded that the stem was not loose - is misplaced.

That submission was made in the Court below (Black 2:648O-650T) and was specifically considered and rejected by the primary judge in accepting the respondent's evidence that "*the report was an overall review of what happened during the operation*": J[70] (Red 62T-X, 63B-C).

32. In any event, the appellant's submissions fail to appreciate that the respondent had a specific recollection of what he observed in terms of the stem during the Revision Surgery: Black 2:404G-Q.
33. The alleged "inconsistencies" of the respondent's various accounts of what he did during the Revision Surgery identified at AS[32]-[33] were squarely addressed in the respondent's evidence – see Black 2:547C-K (removing soft tissue) and Black 2:548C-F (use of the slap hammer). Furthermore, the respondent had a specific recollection (as opposed to relying on his usual practice) of using the smaller slap hammer: Black 2:548K-L.
34. Properly understood, there were no inconsistencies in the respondent's evidence.
35. That submission also ignores the reasons given by the primary judge for acceptance of the respondent's evidence of usual practice at J[67]-[69] (Red 62B – 63S).
36. The appellant does not challenge the primary judge's finding at J[71] (Red 63D-E) that the relevant part of the operation report was authored by Dr Grieve immediately following the procedure, or the fact that his Honour did not draw an inference adverse to the respondent from the failure to call Dr Grieve: J[74] (Red 63S-V).
37. As the respondent's evidence was accepted as to what he observed during the Revision Surgery in terms of the stability of the stem (see paragraph 32 above) there was no basis to find that the stem was in fact loose at the time of the Revision Surgery, particularly noting the agreement of the orthopaedic experts that the steps undertaken by the respondent performed were reasonable to the assess stability of the stem: J[72] (Red 63G-L).
38. Finally, the submission at AS[35] does not advance the appellant's case. It ignores the respondent's evidence as to what he wrote on the form (Black 2:584B-D) and that

ordering a replacement stem was not necessary as they “*existed on the shelf at St Vincent's Private Hospital*”: Black 2:584I-J.

Looseness after the revision surgery on 30 August 2011

39. The respondent saw the appellant on numerous occasions after the Revision Surgery up until 2019. However, there were often lengthy periods between consultations, some even more than one year – see for example: J[132] Red 75R-S.
40. Despite the submission at AS[38]-[39], there were no problems with the primary judge’s approach. Radiological evidence of looseness after the Revision Surgery is not determinative of whether the stem was in fact loose. The orthopaedic experts agreed and emphasised that the determination of whether the stem was in fact loose involved correlating the radiological picture with the clinical presentation: Blue 1:144H-I. The experts also agreed that based on the assumptions given to Dr O’Sullivan as to the appellant’s level of activity and function (as found by the primary judge), there was a clinical picture that the appellant’s implant was well functioning and stable up until August 2017, and that the radiology ought be interpreted in line with those clinical findings: Blue 1:145O-P.
41. The appellant’s focus on the evidence recorded at AS[41]-[44] does not advance his case. The appellant does not expressly challenge the primary judge’s finding that the respondent undertook an appropriate clinical examination on each occasion upon which he saw him: J[82] (Red 64X). There is no suggestion in the evidence (nor was it put to the respondent) that he failed to elicit the information identified as being necessary by the expert orthopaedic surgeons on any or all of the occasions he saw the appellant.
42. The respondent’s notes record various aspects of the clinical examination undertaken on each occasion that he saw the appellant after the Revision Surgery – for example he recorded that the appellant’s Trendelenburg test was negative: Black 2:582G-K.⁴
43. There is no challenge to the findings that:

⁴ The expert orthopaedic surgeons were asked about the significance of that test at Black 2:624W-625D.

- (a) the respondent, on each occasion of a consultation after the Revision Surgery, took a history from the appellant of his level of function and activity which was accurately reflected in the respondent's medical notes: J[136] (Red 76N-P);
 - (b) the primary judge did not accept the appellant's evidence which contradicts the respondent's notes in relation to his level of function and activity: J[137] (Red 76Q-R); and
 - (c) if the appellant was in fact experiencing the lack of functionality in the period as he claimed in his evidence (which was not accepted), then he was conveying the opposite impression to the respondent: J[137] (Red 76R-T).
44. In light of the above, any "corroborative" evidence from Mr Hennock or Mr Rossi does not advance this issue, particularly when considered in the context of Ground 4, as referred to below.
45. In any event, Mr Hennock's evidence as to the appellant's ability to play squash (Black 1:239D-H) was not consistent with what Dr Doig described in terms of someone playing with a loose femoral stem requiring revision: Black 2: 627M-X.⁵ Similarly, Mr Rossi's evidence was that the appellant was playing squash, even if he was in pain afterwards: Black 1:250D-G.
46. Properly characterised, that "corroborative" evidence does not support a finding that appellant had a loose stem requiring surgical intervention at any time after the Revision Surgery and before 2017.
47. The appellant submits at AS[51] that if the Court is not satisfied that the radiological evidence alone is sufficient to find that the stem was loose during that time, the matter should be remitted for re-trial. As detailed above, there is simply no basis for this Court to make a finding that the stem was in fact loose, on the basis of radiological evidence alone.

⁵ Notably, Dr Doig's evidence in that regard was consistent with respondent's evidence at Black 1: 347Q-348E.

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

48. The appellant concedes at AS[52] that Ground 3 only arises if he succeeds on Ground 1 and Ground 2.
49. For the reasons set out above, this ground does not arise – see especially paragraphs 32, 33, 36 and 37 above.

Ground 5 (referred to as Ground 4 in the AS) - 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 [sic?] in each consultation between that period not detecting, investigating or recommending revision surgery to treat signs of loosening or movement in the femoral stem

50. Like Ground 3 above, the appellant concedes at AS[57] that Ground 4 only arises if he succeeds on Ground 1 and Ground 2.
51. For the reasons set out above, this ground does not arise – see especially paragraphs 40, 43 and 45 above.
52. Furthermore, contrary to the submission at AS[61], even if the primary judge erred in finding that the femoral stem was in fact loose between August 2011 to 2017, it does not follow that the finding that the respondent did not breach his duty of care in managing the appellant after the Revision Surgery must be set aside.
53. As noted by the primary judge at J[137] (Red 76R-T), there is a distinction between the appellant’s actual level of functioning and activity and what he told the respondent about his level of functioning and activity, as recorded in the clinical notes.
54. There is no challenge to the finding that the respondent’s clinical notes recorded an accurate summary of what the appellant told the respondent during the numerous consultations: J[89] (Red 66D-F).

55. Therefore, even if there was corroborative evidence that the appellant was not functioning to the extent reported to the respondent (which has not been established) such evidence is not relevant when assessing whether the respondent discharged his duty of care in relation to his ongoing management of the appellant.

Ground 6 (erroneously referred to as Ground 5 in the AS) - The primary judge erred in finding that the appellant would not have achieved a materially better outcome even if a conventional femoral stem had been implanted during the period from 30 August 2011 until 27 May 2019

56. The submission at AS[65] is premised on an incorrect reading of J[158] (Red 79N-Q). The primary judge's finding as to the appellant's complaints of "*broadly similar problems with his left hip*" after the surgery performed by Dr Neil in 2019 was not solely based on the "supposed" evidence identified therein.
57. The first matter at AS[67] also ignores that Dr Doig's opinion was based on his assumption that the plaintiff had significant ongoing pain in the inner thigh and the outer thigh of the left leg, particularly after activity: Black 2:605E-F, 605L. As noted above, the appellant's evidence in that regard was not accepted by the primary judge (to which there is no challenge) and was not corroborated by any other evidence.
58. Dr Doig also accepted that some of the appellant's symptoms could be explained by psoas impingement, which was unrelated to the respondent's treatment: Black 2:606J-K.
59. The submission is also premised on the basis that the appellant had a permanent scoliosis which has persisted despite subsequent replacement of the stem and had an otherwise good functional and pain-free outcome from that replacement. Dr Negus' opinion in that regard can be put to one side, as it was based on the assumption that the appellant:
- (a) suffered from limb length discrepancy, due to the delayed diagnosis and treatment of his loose femoral stem and that as a result he had developed scoliosis: Blue 1:54O;
 - (b) had a leg length discrepancy of 30mm being present for approximately 8 years, even with partial correction through orthotics that led to a scoliosis and

subsequent degeneration within the spine caused by that scoliosis: Blue 1:57F; and

- (c) first developed his leg length discrepancy and resultant scoliosis in 2013 following his hip replacement procedure: Blue 1:61Q.

60. However, the evidence before the primary judge established that:

- (a) the appellant had a scoliosis before he had first consulted with the respondent – the appellant accepted that he had a mild scoliosis at that time (Black 1:149L-N) and the respondent identified that the appellant had a significant thoracic curve (scoliosis) as seen on his x ray taken on 2 May 2011: Black 1:365H-O;
- (b) the appellant had a pre-existing leg length discrepancy established by:
 - (i) the pre-operative CT scanogram, which showed shortening of at least 13mm (Blue 2:318M);
 - (ii) his own evidence at Black 1:149K; and
 - (iii) the respondent's confirmation of same at Black 2:556K;
- (c) at no time during the period that the respondent treated the appellant was his leg length discrepancy anything like the 30mm relied on by Dr Negus and in fact did not exceed 10mm as a result of the movement and subsidence of the femoral stem established by:
 - (i) the appellant's own evidence (Black 1:227S);
 - (ii) the measurements performed by the respondent in August 2010 (when his real leg length inequality was one centimetre and his functional inequality was approximately half a centimetre - Black 356J-K), on 22 June 2011 (the appellant was measured to have a half centimetre leg length inequality – Black 385X), on 9 August 2012 (his overall leg length was half to one centimetre – Black 417O); and
 - (iii) the respondent found no change over a progressive period of time until the significant deterioration in 2019 (Black 580S-T).

61. Expert evidence which is based upon particular assumptions which are incorrect or not ultimately proved in evidence has been said to be “*of little or no value*” or “*irrelevant*” (see *Ramsay v Watson* (1961) 108 CLR 642 at 649; [1961] HCA 65 (Dixon CJ, McTiernan, Kitto, Taylor and Windeyer JJ)).
62. The evidentiary matters above were addressed in the respondent’s closing written submissions that were before the primary judge – see Black 2:740J-K, Q-T, 741D-M.
63. Further, the evidence of the orthopaedic surgeons in the joint report at Blue 1:146F-W does not support the proposition for which it is cited.
64. The second complaint made at AS[69] is that 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. The source of that error is said to be the primary judge’s misunderstanding of the evidence of the orthopaedic experts at Black 2:623H-P.
65. Rather, as noted above the finding at J[158] (Red 79N-Q) is primarily based on the fact that the appellant continued to experience broadly similar problems with his left hip after the 2019 surgery.
66. In any event, there was no misunderstanding of the evidence of the expert orthopaedic surgeons. The submission made on behalf of the respondent was not contradicted in the Court below: Black 685C, 739G-H.
67. Even if the conventional stem implanted in 2019 was implanted in varus (as opposed to collapsing into varus) the end result is the same – namely that it could cause a leg length discrepancy, which explains the appellant’s ongoing symptoms.
68. The submission at AS[70] ignores the appellant’s own evidence as reported to Mr Ryan and Dr Negus – see Blue 1:69R-T; Blue 1:48W.⁶

Conclusion

69. For the reasons addressed above, the appeal should be dismissed with costs.

⁶ The cross-examination of the appellant on that history is at Black 1:137E-139J.

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