

CITATION: *Gibson v Northern Territory of Australia* [2026] NTSC 60

PARTIES: GIBSON, Adele

v

NORTHERN TERRITORY OF AUSTRALIA

TITLE OF COURT: SUPREME COURT OF THE NORTHERN TERRITORY

JURISDICTION: SUPREME COURT exercising Territory jurisdiction

FILE NO: 2024-00341-SC

DELIVERED: 23 July 2026

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JUDGMENT OF: Huntingford J

CATCHWORDS:

NEGLIGENCE – Medical Negligence - Scope and content of the defendant’s duty of care – Claim dismissed .

Personal Injuries (Liabilities and Damages) Act 2003 (NT)

Albrighton v Royal Prince Alfred Hospital (1980) 2 NSWLR 542; *EMI (Australia) Ltd v Bes* [1970] 2 NSW 238; *Chappel v Hart* (1998) 195 CLR 232; *Kent v Darwin City Council* [2018] NTSC 3; *Lawrence v NTA* [2001] NTSC 37; *March v Stramere* (1990-01) 171 CLR 506; *Metro North Hospital and Health Service v Pierce* [2018] NSWCA 11; *Rogers v Whitaker* (1992) 175 CLR 479; *Young v Central Australian Aboriginal Congress Inc* [2008] NTSC 47; *Wyong Shire Council v Shirt* (1980) 29 ALR 217 referred to

REPRESENTATION:

Counsel:

Plaintiff:	K Sibley
Defendant:	H Baddeley SC

Solicitors:

Plaintiff:	Piper Grimster Jones Lawyers
Defendant:	Hutton McCarthy

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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Gibson v Northern Territory of Australia [2026] NTSC 60
No. 2024-00341-SC

BETWEEN:

ADELE GIBSON

Plaintiff

AND:

**NORTHERN TERRITORY OF
AUSTRALIA**

Defendant

CORAM: HUNTINGFORD J

REASONS FOR JUDGMENT

(Delivered 23 July 2026)

Introduction

- [1] On 14 July 2020, the plaintiff, Ms Adele Gibson, underwent a procedure at the Alice Springs Hospital (ASH) to inject cortisone and local anaesthetic into her neck, shoulder and left hip. The plaintiff seeks damages for loss she says she suffered as a result of the negligent care she says she received at ASH immediately after the procedure and in the days following. She says that the negligence of the defendant caused an injury to her left hip which led to the need for her to undergo a total hip replacement, which has left her with ongoing pain and loss of function. She also claims to have suffered a consequential mental injury.

- [2] At the time that he carried out the procedure, Dr Koshy was the Director of Anaesthetics and Pain Medicine at ASH. There is no dispute that the defendant was the operator of ASH and the employer of Dr Koshy and all of the other staff involved in the plaintiff's care and is vicariously liable for any negligence on their part. There is also no dispute that the defendant owed the plaintiff a direct non-delegable duty of care in relation to all of the treatment provided.¹

What was the nature and scope of the duty of care (standard of care) required?

- [3] The content of the duty of care owed to Ms Gibson by the defendant and whether the duty was breached are an issue in this proceeding. The general standard of care required of the defendant, and its employees, was to exercise the care and skill of a reasonably competent medical doctor, nurse, physiotherapist and administrative coordinator, and hospital provider (ASH). The plaintiff argues that the defendant fell below the standard of care required because it failed to:

- (a) warn the plaintiff that there was a risk of a temporary nerve neurapraxia (palsy) which may affect her leg function, particularly where two injections were made into the region of the left hip;

¹ *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542 at 561-2, applied in *Young v Central Australian Aboriginal Congress Inc* [2008] NTSC 47, [158].

- (b) warn the plaintiff that she should have a support person to take her home following the procedure;
- (c) take steps to ensure that it was safe for the plaintiff to stand following the procedure;
- (d) take steps to examine and assess the plaintiff for any harm that may have occurred as a consequence of her fall when attempting to stand after the procedure;
- (e) take steps to examine and assess the plaintiff for any harm she may have suffered when she was observed mobilising with difficulty when exiting the hospital; and
- (f) make immediate arrangements to have the plaintiff assessed by a suitably qualified medical practitioner when the plaintiff reported significant pain and difficulties mobilising.

[4] This is not a “failure to warn” case in the way in which that is usually understood. There is no suggestion that had the plaintiff been warned about the risk of temporary numbness or loss of function in her leg she would not have gone ahead with the procedure.

[5] The allegations fall broadly into two categories. Failure to ensure safe mobilisation after the procedure and failures relating to follow up care.

Ms Gibson's medical conditions before 14 July 2020

- [6] The plaintiff, Ms Adele Gibson, is an intelligent and accomplished woman. She has had a career as a professional violinist, violin teacher and music therapist. She also has qualifications in sociology and business management and has undertaken studies in public health. Ms Gibson has extensive work experience including working with people with disabilities and in public health, including health advocacy roles. She is also a person who has lived with significant musculoskeletal and mental health challenges throughout her life.
- [7] In 2020, at the age of 60, Ms Gibson was living in Alice Springs. She had a long history of back and shoulder problems which had been treated with surgery and strong pain killers over many years. Ms Gibson was a patient at a general medical practice in Alice Springs. In the period from around October 2019 to February 2021 her general practitioner was Dr Kate Savage. Dr Savage had both a treatment and a coordination role in relation to Ms Gibson's care.
- [8] Ms Gibson had also been a patient at ASH outpatients on and off since around late 2014 and at the pain clinic at ASH from at least March 2018, where she had been consulting Dr Koshy. The exact details of Ms Gibson's long history of serious problems with her neck are not particularly relevant, except to note that she has for many years suffered from chronic pain from her neck injury which is thought to be related to violin playing.

- [9] Medical records show that at the time of the corticosteroid injections on 14 July 2020, Ms Gibson continued to suffer pain in her neck and shoulders for which she was taking prescribed pain medication as well as utilising other strategies, such as physiotherapy and corticosteroid injections. The records also indicate that she was very actively involved in her own care and was never recorded as using pain medication inappropriately.
- [10] Ms Gibson also lives with diagnosis of bipolar affective disorder type 1, an illness which has been present since her teenage years. The symptoms of that illness have waxed and waned over her life involving both long periods of remission and periods of relapse. As of 14 July 2020, Ms Gibson was under the care of Dr Blomeley, psychiatrist, who had been seeing her on an approximately monthly basis since about November 2019. Dr Blomeley did not give evidence in this proceeding but his various reports to Dr Savage formed part of the agreed court book.
- [11] Dr Blomeley's letters to Dr Savage in the period 6 November 2019 to 1 July 2020 generally state that Ms Gibson's mental health was stable. Although her condition persisted it appeared to be as largely in remission. At various times Dr Blomeley reported to Dr Savage that Ms Gibson was experiencing life stressors which impacted her mental health with some increase in reported symptoms, particularly anxiety.
- [12] Ms Gibson's mental health has been impacted by her experience of chronic pain. On 4 February 2020 Dr Blomeley wrote that Ms Gibson had an

exacerbation of symptoms for three or four days in the context of being bedridden with increased pain which had now settled. This is coincident with the first report by Ms Gibson of pain in her hips which was noted by Dr Savage in her notes of the same date. On 10 March 2020 Dr Blomeley reported to Dr Savage that although Ms Gibson had not had any pervasive major mood episodes in the previous month she was struggling with increased pain. He said it was clear that her suicidal thoughts were significantly exacerbated at times of acute pain and that this increased her depressive symptoms and difficulties with everyday function.

[13] On 7 April 2020 Dr Blomeley wrote that Ms Gibson was managing well. He also noted that he would write a report to the National Disability Insurance Agency (NDIA) to support her application for support under the National Disability Insurance Scheme (NDIS) commenting that she had a lifelong neuro degenerative illness (bipolar disorder) and was deserving of increased support.

[14] When Dr Blomeley reviewed Ms Gibson on 5 May 2020, he reported to Dr Savage that she had been struggling with depressive symptoms in the context of personal challenges and family issues and a recent increase in physical pain. However, Dr Blomeley said that Ms Gibson was managing those symptoms appropriately. A minor and temporary change to the frequency of her medication was recommended to stabilise her mood. On 2 June 2020 Dr Blomeley noted that Ms Gibson was well, and her pain was better controlled than on the previous attendance. On 1 July 2020

Dr Blomeley reported that Ms Gibson's mental state remained unchanged although she had difficulties relating to ongoing and worsening pain. The approach was described as "holding the fort" taking one day at a time and monitoring Ms Gibson's mental state.

The left hip

- [15] It is not known exactly when Ms Gibson first experienced pain in her left hip. A record from ASH outpatients' clinic dated 4 November 2014, states that her primary complaint was the left knee, but also records that she was experiencing pain over the greater trochanter but does not state on which side. It appears that an ultrasound and cortisone injection to the bursa were recommended however there is no evidence that that treatment was undertaken.
- [16] On 4 February 2020 Ms Gibson consulted Dr Savage complaining of pain in both hips, worse on the right, radiating down the groin and into the legs after lifting a pool cleaning robot. Ms Gibson said that she was bedridden for two days, but the pain had improved from the previous week although she was still uncomfortable, particularly on the right side, when walking. Dr Savage noted that Ms Gibson was tender over both lateral legs and mid lumbar spine and was walking with a limp.
- [17] On 24 March 2020 Dr Koshy advised Dr Savage that she should prescribe transdermal opioid patches for Ms Gibson to keep her pain controlled. Dr Savage saw Ms Gibson on 31 March 2020 and prescribed the patches.

Dr Koshy's note of his consultation with Ms Gibson on 28 April 2020 records that she complained of troubling pain to the left hip after working around the house. He observed, after palpating the area, that she had a very tender trochanteric bursa.

[18] On 29 April 2020 Ms Gibson told Dr Savage that she was experiencing pain in the lower back and hip following moving things from a shed in preparation for the start of construction of a music studio at her property. She had run out of transdermal opioid patches and had been using alternative medication. In the clinical note of that visit Dr Savage records that Ms Gibson had consulted Dr Koshy on the previous day and reported that he had suggested that Ms Gibson may have left hip bursitis.

[19] There were no ultrasound or other radiological investigations done around this time, although Dr Savage requested an ultrasound of Ms Gibson's left hip on 26 May 2020. On that day, Dr Savage noted that Ms Gibson had pain in the left hip and buttock which had been worsening over the last couple of months and was preventing her exercising.

[20] Ms Gibson consulted Dr Savage again on 23 June 2020 and reported significant pain in the left hip. Dr Koshy reviewed Ms Gibson on 30 June 2020 and noted that her main issue was pain in the left hip, although he also recorded that she also had pain in the right hip and was walking with a limp. It was at this consultation that Dr Koshy recommended that Ms Gibson have a corticosteroid injection to her left hip (bursa) to relieve the pain.

The consent and the procedure

- [21] Before the procedure on 14 July 2020 Dr Koshy completed the consent form with Ms Gibson. He explained that the risks of the procedure were:
- (a) infection as a result of the needle piercing the skin; (b) bleeding at the site; and (c) numbness of the outer aspects of the thigh and neck area along the site of the injections lasting two to three hours.
- [22] Dr Koshy did not discuss any other risks of the procedure with Ms Gibson. Ms Gibson then signed the consent form. Dr Koshy's evidence was that he does not remember discussing the need for a support person to assist Ms Gibson to return home but said that he thinks he would have done so because it is his usual practice. He said it is preferable that patients do not drive themselves home.
- [23] In accordance with usual practice, the procedure commenced with the injection of local anaesthetic to numb the skin before each steroid injection. Dr Koshy said that the drugs injected into the bursa were a mixture of 20ml of .25 percent Bupivacaine, a local anaesthetic, and 11.4mg of Betamethasone, a steroid.
- [24] The number of steroid injections administered to the plaintiff's left trochanteric bursa was an issue in the proceeding. Ms Gibson took some photographs of her left hip area after the procedure which shows two dressings side by side. In her affidavit of 29 May 2025 Ms Gibson says that she recalls receiving two cortisone injections to her left hip. She said that

the administration of the first cortisone injection was very painful, causing her to jolt and to apologise to Dr Koshy for moving. She said that Dr Koshy told her not to worry and that he would administer another injection. She said that he went on to do that, after first administering further local anaesthetic, and that the second injection was not as uncomfortable.

[25] In his affidavit of 15 July 2024 Dr Koshy describes the procedure for the injection of steroid to the plaintiff's left bursa. The procedure record does not indicate that more than one injection was administered. The consent form describes the procedure as "left sided trochanteric bursa injection and multiple trigger point injections neck", which could be taken as an intention to administer only one injection to the left trochanteric bursa.

[26] In his affidavit of 12 June 2025 Dr Koshy confirmed that the dressings in the photographs taken by Ms Gibson were of the type applied in the hospital, including after steroid injections. He was unable to precisely identify the part of the body on which the dressings were located from the photographs. Dr Koshy said that while he cannot remember administering a second injection to the left bursa it is possible that he did so. He said that would not be unusual if multiple trigger points causing pain were identified. Dr Koshy explained that where a patient has been experiencing pain for an extended period and has an altered gait, further trigger points can develop, usually below the trochanteric bursa. Dr Koshy said that the second trigger point injection would have also been on the lateral (outside) of the hip, either above or below the original injection. He also said that if a further

trigger point was identified it was his practice to seek verbal consent of the patient to administer a further injection during the procedure.

- [27] In his affidavit of 12 June 2025 Dr Koshy also confirmed that he did not recall Ms Gibson complaining of, or otherwise expressing, that she was experiencing pain, or jolting, during the procedure. He said that extreme pain is something he and the nurses look for, would be unusual, and would be recorded in the notes in accordance with his usual practice.
- [28] Dr Koshy's usual practice of seeking verbal consent during the procedure for a second injection, as described in his affidavit is broadly consistent with Ms Gibson's account of there being a conversation about a second injection. Unfortunately, the nurse who was present, Angelica Moralde, had no recollection of the procedure. However, she said in her affidavit that had she noticed that a patient was in extreme pain during a procedure she thinks she would have remembered that as it was unusual, and it would have been recorded in the medical records.
- [29] Ms Gibson did not state that she experienced significant pain when the first injection was administered when describing the procedure in her initial affidavit in this proceeding. When she was cross-examined about that she said that she thought that some pain on the injections was normal and she does not normally "flinch" even though the injections are not comfortable. She said that she thought it was her fault for moving which is why she apologised to Dr Koshy. She agreed that Dr Koshy never said anything

about her moving at the time and said that that is why she did not initially think anything of it and did not mention it.

[30] Ms Gibson was cross-examined about the fact that she told Dr O'Hare, psychiatrist, that she had "levitated" off the bed as a result of the pain from the injection and said that was just a figure of speech. When it was put to her that it was only after one of the other doctors suggested that Dr Koshy might have hit the femoral nerve that she said that the first injection was extremely painful, she agreed that might have been the case, because that was when she "put two and two together". However, she said that did not change what happened and she was not exaggerating when she said that the first injection into the bursa was extremely painful.

[31] It is likely that Ms Gibson experienced some pain and discomfort during the administration of the first steroid injection. Dr Kapur, pain physician, said in cross-examination that if the bursa is inflamed and tender the injection can be painful. He went on to say that if that were the case then the injection administered would address that pain, due to the local anaesthetic, and there would be no need to administer a second injection to that area. This opinion is broadly consistent with Ms Gibson's evidence in cross-examination that the pain was only for a second and she got over it fast. Ms Gibson may have felt like she "jolted", that is apparently how she remembers it, however if that was the case, I do not think it was to the point where she moved such that it was obvious to Dr Koshy, at least to the extent that it was unusual or caused him any concern. I am also satisfied that if something unusual such

as extreme pain was observed during the procedure it would have been recorded by either Dr Koshy and/or the nursing staff.

[32] Dr Kluver, pain physician, agreed in evidence that it appeared that Dr Koshy may have administered a second injection to a different, adjacent area. I also note that although Dr Koshy did not separately record the administration of the injections to the left hip, that was also the case in relation to the undisputed “multiple” injections to the trigger points in the plaintiff’s neck.

[33] Based upon the photographs, the evidence of Ms Gibson and Dr Koshy and the expert evidence, I think it is more likely than not that Dr Koshy administered two injections to Ms Gibson’s left hip, one to the left bursa, and one to a closely adjacent trigger point above or below the greater trochanter. I also find that the brief pain experienced by Ms Gibson was due to her bursa being inflamed and sensitive.

[34] Dr Journeaux, orthopaedic surgeon, said in his evidence that if a needle contacted a nerve during an injection procedure that would be extremely painful. Although I accept that Ms Gibson likely experienced some transient pain on administration of the first steroid injection, as stated above. I do not accept that she exhibited any symptoms or reaction to an extent which would have indicated to Dr Koshy or the nurse present that there was any cause for concern. In view of that, and the expert evidence, it is very unlikely that Dr Koshy hit the femoral nerve or any other nerve, with the needle during the procedure.

How much anaesthetic was administered?

- [35] The administration of two injections raises a question about how much local anaesthetic was used. The record of the procedure notes that Dr Koshy used 5ml 1 percent Lignocaine, 20ml .25 percent Bupivacaine and 11.4mg Betamethasone in the left hip and then performed multiple trigger point injections in the neck for which he used 20ml .25 percent Bupivacaine and adrenaline and 5.7mg Betamethasone. The 5ml of 1 percent Lignocaine was to numb the skin area before the steroid injection and was not administered to the bursa. It can be assumed that that did not have a significant effect upon the post procedure sensation in the left leg. The total amount of Bupivacaine used according to the notes was 40ml. Dr Koshy was not cross-examined about whether he administered two doses of 20ml of Bupivacaine into the left hip, however I consider that very unlikely.
- [36] Dr Kapur gave evidence that the volume of anaesthetic used for the hip injections, at 20ml, was above what was necessary for that type of procedure. Dr Kapur said that the amount of anaesthetic was around twice what he would use for the same procedure. However, it was four times the volume because Dr Kapur's practice was to use 5ml of .5 percent local anaesthetic, not the .25 percent used by Dr Koshy.
- [37] Dr Kapur also said that the bursa is small and, once penetrated, cannot expand very far. Therefore, even with a very low volume injection there will inevitably be some "leakage" of the local anaesthetic into the local tissues.

Dr Kapur's evidence was that an area of numbness over the outer skin in the lateral part of the thigh would be expected, but loss of sensation would not spread further than that. He said that numbness over the lateral aspect of the thigh was likely, but would not have given rise to motor weakness in the leg.

[38] Dr Kapur said that 60ml of .25 percent solution of Bupivacaine would be a potentially toxic dose. He said that the largest amount that any anaesthetist would inject would be 40ml of .25 percent solution. Overdose was said to potentially cause systemic effects including upon consciousness and heart rhythm. There is no evidence that Ms Gibson experienced altered consciousness or abnormal heart or other signs after the procedure. The observations taken by Nurse Joseph after the procedure were normal and Ms Gibson did not report any abnormal effects, other than numbness of her left leg.

[39] For the multiple injections into the neck Dr Koshy also recorded that he used 20ml of .25 percent solution. It can be taken that this was an overall amount and that he did not record the amount of anaesthetic used for each injection separately. This is also how Dr Kapur appears to have interpreted Dr Koshy's notes in his first report. It is more likely than not that Dr Koshy adopted the same procedure and note keeping practice in relation to the hip injections as he did for the neck injections. Therefore, it is more likely than not that the total amount of local anaesthetic injected during the procedure was 40ml of .25 percent; 20ml for the hip injections and 20ml for the neck injections.

[40] Although all of the medical experts who gave evidence said that the volume of anaesthetic injected into the left hip was higher than they would have used, there was no evidence that this was of itself an inappropriate practice. Nor was there any suggestion that the administration of two injections was inappropriate in the circumstances.

What happened in the recovery room?

[41] The particulars of injury in the plaintiff's statement of claim allege that she suffered a temporary neuropraxia affecting the whole of her left leg after the procedure which meant that she was unable to stand when attempting to mobilise, causing her to fall onto the bed. In her affidavit of 4 June 2024, Ms Gibson said that when she stood up and attempted to put weight on her left leg she spun 180 degrees so she was facing the bed. She said that there was a twisting motion on her left leg as it gave way. She said that the leg was not just numb, it was "dead", completely paralysed, like it "did not exist". Ms Gibson explained that she had to perform a "full twist" or she would have hit the floor. She said that she was able to catch her arms on the bed and use her right leg. She was clear that she did not fall to the floor. Ms Gibson said the motion was "quite violent" because she was not expecting it. She said that she felt a sensation in her hip and "something gave way" and that she heard a sound like a "pop" but that it was not painful.

[42] In cross-examination Ms Gibson said she was initially lying semi-reclined on the bed and used her arms to lift her body weight. She said that she supposed she lifted her left leg over the side of the bed with her left hand, but agreed she did not remember doing that. Ms Gibson said that she was not conscious of the fact that her leg was numb and unable to weight bear when she swung her legs over the side of the bed, until she went to stand. She said she could not feel her foot. She agreed that in her initial written account about what happened she did not mention hearing a “pop” but maintained that she had heard that at the time.

[43] There was some cross-examination, and some mention in the documents in the court book, about the plaintiff falling to the floor. However, Ms Gibson said, in her contemporaneous reports including to Ms Kirwan and Dr Savage, that she had fallen onto the bed. The version that she fell to the floor found its way into the plaintiff’s lawyer’s pre-action letter to the defendant, and Dr Kluver’s report. That is unfortunate, but I am satisfied it was never part of the plaintiff’s story. Ms Gibson has always described the twist and fall as being onto the end of the bed, and I accept that that is what she meant, although others may, perhaps understandably given the use of the word “fall”, have interpreted it differently.

[44] Ms Gibson said that she attempted to stand a few more times and on the third try a nurse who had been watching from a distance came and put her hands on Ms Gibson’s arm and helped her hop to the bathroom to get changed. In her affidavit Ms Gibson said this nurse was in a bad mood and

was initially standing “on the other side of the room”, made no offer to assist and did not come “anywhere near” her when she was attempting to stand. Ms Gibson said that when it became apparent to the nurse that she could not walk, the nurse asked if she wanted a wheelchair but Ms Gibson refused because she wanted to get away from the nurse.

[45] In cross-examination Ms Gibson said that the nurse was more than one metre, but no more than two metres away, standing next to the bed adjacent to hers when she attempted to get off the bed. Ms Gibson did not concede in cross-examination that the two accounts, one of the nurse being on the other side of the room and the other that she was within one to two metres were different.

[46] Ms Gibson said that the nurse involved when she went to get off the bed was a “new nurse”, with dark hair. There is no dispute that the nurse was Nurse Joseph. Ms Gibson said that she saw “multiple nurses” in the recovery area and that previously another nurse had given her a cup of tea and taken her blood pressure. She said that the first nurse had short blonde hair. The nurse with the short blonde hair had not been mentioned in any of Ms Gibson’s previous descriptions of what occurred.

[47] Ms Gibson said that after she got changed, she hopped to the carpark holding on to the wall in the corridor to steady herself as she left the hospital. She said that as she was near the elevator Dr Koshy called out to her from behind saying “That doesn’t look right that you are limping like

that”, to which she replied, “How much anaesthetic did you put in”, and he said, “As much as I could”. She said that she was joking as she asked this, as she couldn’t feel her leg.

[48] Dr Koshy agrees that he saw the plaintiff near the lift and said that she did not look right. He described her as limping. He says that he offered her a wheelchair, which she declined and told him that she was “fine”. Ms Gibson agrees that occurred. However, Dr Koshy denies that the plaintiff asked him how much anaesthetic he used and strongly denies that he said, “As much as I could”. He said he would never respond to a patient in that manner, even in jest. Although the accounts as to the anaesthetic comment are different, nothing of substance turns on this. I have already found the amount of anaesthetic likely used, as set out above, and it was never suggested that Dr Koshy used an unsafe amount. Even if the comment was made, it is not a fact from which I could draw any inference as to the state of the plaintiff’s leg.

[49] Nurse Joseph was in charge in the recovery area of the ASH day procedure unit on 14 July 2020. In cross-examination she said she did not remember how many nurses were present that day, but there were usually two or three nurses in the area. It was part of Nurse Joseph’s job to prepare patients for discharge once they had recovered and it was safe to do so. She described in her affidavit the procedure upon receipt of a patient into the recovery area after a pain injection which included a handover from Dr Koshy and reviewing the Day Attendance Form which records what procedure was

done, who did it and how the procedure went. Ms Gibson's form had instructions from Dr Koshy which said "Lie semi-recumbent 15m; one set of obs; if stable, can go home".

[50] Nurse Joseph said that records showed that Ms Gibson was received into the recovery area at 2.05pm and was discharged at 2.40pm. She confirmed that she personally filled out both the observation chart and the clinical pathways assessment document. She said that she carried out two assessments: the first at 2.05pm and a second one at 2.20pm. After the second assessment Nurse Joseph formed the view that Ms Gibson was ready to be discharged. She said that after the second assessment Ms Gibson was getting changed and that is why she was actually discharged at 2.40pm.

[51] Nurse Joseph said that it is her usual practice that, as a patient is getting off the bed, she positions herself no more than one arm's length away so that she can assist if necessary. She said that when a patient stands, she asks them if they are feeling dizzy or have any unusual or negative symptoms, which she said was not uncommon. She said that she watches patients closely in the recovery area, including to assess their gait, as steady gait is one of the criteria which is required to be assessed before a patient can be discharged.

[52] Nurse Joseph said that Ms Gibson was the only patient she was caring for in the recovery area at the time. She said Ms Gibson came into the recovery area on a trolley, awake and not sedated. Nurse Joseph observed that

Ms Gibson did not appear to be in pain. She said that she spoke to Ms Gibson and spent quite a bit of time with her because she had no other patients. Nurse Joseph said that she offered Ms Gibson tea and asked how she was feeling.

[53] Nurse Joseph said that she completed the “Clinical Pathways” pre-discharge document after she was told by Ms Gibson that she was not experiencing nausea or any negative symptoms. When the initial set of observations were taken at 2.05pm all were within normal range. They were recorded on the form. Ms Gibson scored nine out of ten on the first assessment because Nurse Joseph had not yet assessed her ability to mobilise.

[54] For the second assessment at 2.20pm, Nurse Joseph said that she focused upon stability of gait. She asked Ms Gibson to sit up, which she did. Ms Gibson said that she felt alright and she wanted to change in the bathroom. Nurse Joseph said that as Ms Gibson got off the bed she stood directly in front of her, facing towards her, no more than an arm’s length away. Nurse Joseph said she placed her arms out in front of Ms Gibson before she got off the bed, ready to steady her.

[55] Nurse Joseph said that as Ms Gibson got up off the bed she stumbled slightly forwards towards Nurse Joseph as she placed her full weight on the floor but immediately regained her balance. Nurse Joseph said she then placed her hands under Ms Gibson’s arms to hold her. She then asked Ms Gibson to sit back on the bed and assisted her to do so. Nurse Joseph

described what occurred as a “stumble”. In cross-examination Nurse Joseph denied that she was not close to Ms Gibson when the stumble occurred.

[56] While Ms Gibson was sitting on the bed after the initial attempt to get up, Nurse Joseph said that she saw Dr Koshy in the vicinity and said to Ms Gibson that she would call him over. However, Ms Gibson said that was not necessary, and that she wanted to get dressed. Ms Gibson denies this account and says that at no point did Nurse Joseph suggest calling Dr Koshy. Nurse Joseph said that she asked if Ms Gibson was in any pain, and she said that she was not. Ms Gibson agrees that she did not feel any pain at this time.

[57] Nurse Joseph said that after about one minute, Ms Gibson stood up from the bed a second time, with Nurse Joseph standing in the same position. This time Ms Gibson did not stumble; she walked to the bathroom, a distance of about 15 steps, with Nurse Joseph walking next to her. Nurse Joseph said Ms Gibson walked “quite quickly and without her help”. Nurse Joseph observed that Ms Gibson was walking with a slight limp, but was steady on her feet. Nurse Joseph said Ms Gibson later came out of the bathroom and then left the recovery area carrying her belongings. Nurse Joseph again observed Ms Gibson walking with a slight limp.

[58] Notwithstanding the limp, Nurse Joseph scored Ms Gibson ten out of ten, including having a “steady gait” and ready for discharge, on the second assessment. Despite recording that score, Nurse Joseph said that she offered

Ms Gibson a wheelchair, which was declined. Ms Gibson agrees that this occurred. Nurse Joseph said that she did not see Ms Gibson hopping at any point. On Nurse Joseph's recollection, Ms Gibson was weight bearing on both legs when she moved to the bathroom and later on leaving the recovery area. Nurse Joseph denies seeing Ms Gibson leaning on the walls of the hospital for support.

[59] Nurse Joseph said that she did not record in the notes that Ms Gibson had stumbled upon alighting from the bed because she considered it a minor occurrence; a "slight misbalance". She did not consider it a "fall".

Nurse Joseph denied the event occurred as described by Ms Gibson.

Nurse Joseph also denied hearing a popping sound.

[60] When Nurse Joseph was cross-examined about why she filled in the form to say that Ms Gibson had a "steady gait" when she observed her limping, she found it difficult to answer the question. Ultimately, she agreed that her understanding of a steady gait was a "normal walk" but said that Ms Gibson told her she was "alright" and therefore she recorded her gait as "steady" notwithstanding the limp.

[61] Nurse Joseph was also cross-examined about why she offered Ms Gibson a wheelchair if she was walking almost normally with only a slight limp.

Nurse Joseph's answer was that although it is not necessary to have a support person for the pain injection procedure, she offered a wheelchair only because Ms Gibson did not have a support person and not because of

concerns for her mobility. She said that was hospital policy, but no policy document was produced. Nurse Joseph said that because Ms Gibson did not have a support person, if she had a wheelchair an orderly would have come and picked her up in recovery and taken her to the parking area. That response did not adequately address the question.

[62] The obvious purpose of getting a wheelchair is to assist someone who is not mobilising well. Whether they have a support person or not might be relevant but is not a complete answer. A support person is unlikely to be able to safely assist someone who cannot walk to the carpark. If Nurse Joseph offered a wheelchair to Ms Gibson, and, on her evidence, twice offered to ask Dr Koshy to review the patient, then it seems to me that Nurse Joseph must have had at least some concerns for Ms Gibson's mobility at that point, notwithstanding recording a "steady gait" on the Clinical Pathways form. Those concerns would be logical and sensible given the "stumble" and the limp which she observed. It is also what would be expected of a caring and professional nurse.

[63] Nurse Joseph appeared to be very nervous when she was giving evidence. That is not unusual, giving evidence is stressful for most witnesses. Additionally, although she appeared to understand and speak English well, at times she seemed to be struggling to answer the questions. It may be that English is a second language for her and/or that the way in which language is used in court was not familiar. That is also not unusual. Even allowing for

these factors, however, I find it difficult to accept that Nurse Joseph was not in any way concerned for Ms Gibson's mobility in the recovery area.

[64] Ms Gibson said that she refused the wheelchair and wanted to leave because she thought that Nurse Joseph was not interested in helping her and perceived that Nurse Joseph had acted in a rude and dismissive manner towards her. She said that she refused a wheelchair twice (once when offered by Nurse Joseph and again when offered by Dr Koshy) because she thought that Nurse Joseph would push her to the carpark and she just wanted to get away; and also because she did not want to be a nuisance. It is completely unbelievable that a person with a completely immobile leg would refuse a wheelchair only because it might be pushed by a nurse she thought was unhelpful, but who had on her own evidence, assisted her to mobilise to the bathroom, or because it was too much trouble. Leaving aside the fact that, as Nurse Joseph said, it is the job of the orderly to push wheelchairs, the refusal of a wheelchair when it was offered independently by Dr Koshy also makes Ms Gibson's explanation less believable as there is no reason to suppose that Nurse Joseph would have been involved at that point.

[65] Dr Koshy was clear that Ms Gibson was not hopping when he saw her in the corridor. He said that he was concerned and he watched her for a while and was satisfied that she was walking satisfactorily, albeit with a limp. Ms Gibson's evidence that she hopped out of the hospital to the carpark, pausing to steady herself on the gate post when her right leg became tired from hopping, is unbelievable and conflicts with the evidence of Dr Koshy

and Nurse Joseph. It is not plausible that a woman of Ms Gibson's age, with her acknowledged musculoskeletal problems would have the strength to hop on her right leg, her left leg being "dead" and "useless", all the way out of the hospital to the carpark with no assistance from a crutch or stick, even allowing for breaks to steady herself on the way. I therefore reject Ms Gibson's evidence that she was hopping and that her left leg was immobilized, but find that she was walking with a limp as she left the hospital.

[66] I have carefully considered the plaintiff's submission that the lack of record keeping should affect the assessment of the evidence of the defendant's witnesses. There were various lapses of record keeping identified. They included that there was no reference to a second injection adjacent to the hip, no reference to the "stumble" of Ms Gibson in the recovery area, no record of Dr Koshy's conversation with Ms Gibson on 16 July 2020 and no discharge summary or report of the procedure forwarded to Dr Savage. I have also taken into account that it appears that the second set of observations were done at 2.20pm but Ms Gibson was not discharged until 2.40pm. For at least part of that period, Ms Gibson was moving to the bathroom and getting changed. Although the record keeping lapses are of concern, I do not consider that individually or collectively they are such that they should lead me to reject the core parts of the evidence of Dr Koshy or Nurse Joseph. As Dr Kapur said, the lack of very accurate records is likely to be a product of the fact that the staff were working in a busy hospital. The

records do note the essential parts of the procedure, observations and assessment. The incident when Ms Gibson got off the bed was not recorded. It should have been, but that is not a reason to reject Nurse Joseph's evidence.

[67] Ms Gibson's evidence that she heard a "pop" when she twisted back onto the bed is not convincing. Nurse Joseph's evidence that she heard no such noise is more likely to be correct. Ms Gibson has been inconsistent as to the hearing of a "pop". It did not feature in her initial report to Ms Kirwan, or her initial complaint to ASH on 9 August 2020. On 10 September 2020 in a written complaint to ASH she refers to Dr Savage having a "theory" that her hip dislocated. In cross-examination she agreed that it was actually her own theory that that had occurred and said that the first doctor to mention it was Dr Shahrokhi.²

[68] The evidence of Dr Journeaux and Dr Low, orthopaedic surgeons, was that a dislocated hip could make a "popping" sound when it occurred. However, they both said that such an event would be extremely painful, such that the local anaesthetic Ms Gibson had would not stop the pain. They also both said that a dislocation would not have occurred in the circumstances of a twist and fall onto a bed, even if it was as described by Ms Gibson. In my view there is no doubt that a dislocation of the hip did not occur. However, Ms Gibson has at least in the past believed that it was an explanation for her

² Orthopaedic surgeon who operated on Ms Gibson on 1 October 2020. Dr Shahrokhi did not give evidence in the proceeding.

symptoms. It is very unlikely that there was any audible “pop”, as Ms Gibson asserted in her evidence. This is likely to be an example of Ms Gibson, perhaps understandably, reconstructing evidence to attempt to make sense of what happened. I think that she believes that the evidence she has given about this is true. However, I think that she is mistaken.

[69] The plaintiff identified a number of specific inconsistencies which she said meant Nurse Joseph’s evidence should be rejected entirely. Nurse Joseph presented as a witness who was very keen to be seen in a good light and not to be found to have done anything wrong. As I have explained above, she was unwilling to make the reasonable concession in cross-examination that she was aware that there were some difficulties with Ms Gibson’s mobility after the procedure. There is no explanation for that as it would not have reflected badly upon her. In addition, her evidence that Ms Gibson walked quickly to the bathroom and with only a little limp, and that she had a “steady gait” after, is not consistent with the objective evidence of Dr Koshy who said that Ms Gibson’s limp “did not look right”, from which I infer that it was clearly noticeable. Further, Nurse Joseph’s reason for suggesting that Ms Gibson use a wheelchair was unconvincing. However, I do not consider that those matters are such that I should reject Nurse Joseph’s evidence entirely, although they raise questions as to credibility and there is a need for caution. However, the matters I have referred to are peripheral. The important evidence is Nurse Joseph’s account of what she did when Ms Gibson was getting off the bed.

[70] Nurse Joseph's evidence was that Ms Gibson's body moved forward when she got off the bed in what she described as a "misbalance" or "stumble". In Dr Savage's letter to the physiotherapist of 5 August 2020 she records that Ms Gibson "lunged forward" before twisting to save herself from falling. This version presumably came from Ms Gibson, her patient. Ms Gibson then sat back on the bed. It is quite possible that she used her hands to do so. It is also possible as her body moved forward and she attempted to steady herself that she experienced a twisting force on the left leg.

[71] Although Nurse Joseph said that Ms Gibson did not twist, it is quite possible that she did experience a twisting motion, either immediately before or as she sat down on the bed. This is not something which Nurse Joseph would necessarily have noticed. It is not in my view very likely that Ms Gibson spun in mid-air, became airborne for a split second, and caught herself by falling onto the end of the bed, as she describes. That may be how Ms Gibson perceived it, but I do not think that is what occurred. That description is unbelievable, and I think is an exaggeration. It is however believable that Ms Gibson stood, lost her balance due to altered sensation, but not complete numbness, in the left leg twisted somehow and sat down on the bed before trying again and managing to walk to the bathroom, albeit with a limp, a few minutes later.

[72] In view of the matters noted above I have carefully considered Nurse Joseph's evidence about the assistance she says she gave Ms Gibson in alighting from the bed. I accept that she was aware, as she said in her

evidence, of the need to avoid falls when patients were mobilising after procedures, including due to effects such as dizziness, which she said was not uncommon. I also accept that she had a conversation with Ms Gibson, took observations including blood pressure, and was satisfied that Ms Gibson was not feeling any ill effects before attempting to stand. I also accept that Nurse Joseph was nearby, around an arm's length away and ready to assist when Ms Gibson started getting up off the bed and that when Ms Gibson showed some signs of difficulty, Nurse Joseph moved to assist her. I largely prefer Nurse Joseph's account of what occurred because it is more believable and I reject Ms Gibson's evidence as unreliable due to the inconsistencies in her account and her tendency to exaggerate and reconstruct, as I have described.

Contact with the pain clinic in the days following the procedure

- [73] There was not a great deal of disagreement between Ms Gibson and the other witnesses as to the key elements of what occurred next. Ms Gibson said that she was in excruciating pain the next morning, 15 July 2020, and she telephoned Ms Kirwan the coordinator of the pain clinic at about 8.30am. Ms Gibson said to Ms Kirwan that she had increased pain in her hip and buttock since the injection which she described as eight out of ten or nine out of ten pain. She also told Ms Kirwan that when she got off the bed her leg had given way and she caught herself on the edge of the bed to stop herself falling. She further told Ms Kirwan that the nurse in the recovery area was "surly". Ms Gibson believes that Ms Kirwan did not take her

concerns seriously. In cross-examination, it became apparent that this was particularly the case in relation to Ms Kirwan's recommendation to use "mindfulness" techniques, which Ms Gibson said she did not believe in and had never practised, and also because Ms Kirwan said to her that it was very unlikely that anything had gone wrong with the procedure.

[74] Ms Gibson was taken to the detail of Ms Kirwan's account of the conversation on 15 July 2020 in cross-examination. She said that she told Ms Kirwan that she would try the mindfulness exercises she suggested because she was "telling her what she wanted to hear". Ms Gibson agreed that Ms Kirwan said that Dr Koshy was not available for three weeks but that she would arrange for him to call and discuss a prescription for a pain killer until Ms Gibson saw Dr Savage on 21 July 2020. Ms Gibson also agreed that Ms Kirwan said she would call back to see how she was doing in the next day or two. Ms Gibson ultimately said that she generally agreed with the gist of Ms Kirwan's account and that, apart from the mindfulness recommendations, which made her feel dismissed and disbelieved, she may have thought that the rest of the conversation was reasonable.

[75] Ms Kirwan's evidence was that when she spoke with Ms Gibson on the morning of 15 July 2020 Ms Gibson said that she was "hobbling" as she left the hospital and the nurse saw her doing that. She said that Ms Gibson told her that the pain might be due to the way she hobbled to the car, that the pain was worse when she put weight on it and was deep in her buttock. In addition to mindfulness exercises Ms Kirwan recommended hot and cold

packs and gentle mobilisation, to the extent that could be achieved without pain. Ms Kirwan did not fully document the call at the time, but she did make a note of it in her diary.

[76] Dr Koshy called Ms Gibson the next day, 16 July 2020. Dr Koshy said in his affidavit that when he spoke with Ms Gibson on the telephone, they discussed her symptoms. Dr Koshy said that he thought Ms Gibson was potentially experiencing a steroid flare, but he did not say that to her. He did not document the conversation. Dr Koshy said that Ms Gibson said she was happy to be reviewed by her general practitioner, Dr Savage, as scheduled on 21 July. Dr Koshy prescribed a small amount of a pain medication to get Ms Gibson through to her next appointment with Dr Savage.

[77] On 17 July 2020 Ms Gibson had a further telephone call with Ms Kirwan. Ms Kirwan said that Ms Gibson told her that she had been doing the gentle exercises Ms Kirwan had recommended, and they were helpful. Ms Gibson agreed in cross-examination that she had said this but said it was not true and in fact she could not do the exercises. She said that she was again telling Ms Kirwan what she wanted to hear. She accepted that she told Ms Kirwan that the pain could be as good as six out of ten but was sometimes eight out of ten. Ms Gibson said that she was taking a strong pain killer at the time and that was why there was a reduction in pain. Ms Gibson agreed that she was joking with Ms Kirwan about her husband making her a sandwich. She also agreed that Ms Kirwan told her that she was booked for a follow-up visit in the pain clinic in six weeks.

[78] Ms Gibson does not dispute that she had no further contact with the pain clinic after 17 July 2020. She said that was because she gave up on them and did not want any further contact. She said that was the case when she consulted Dr Savage on 21 July 2020 and the reason why she did not request a review by Dr Koshy at that stage. Ms Gibson said in cross-examination that there was a discussion between her and Dr Savage at this appointment about whether she should go back to Dr Koshy for another appointment and she said that she told Dr Savage that she could not get an appointment for six weeks and she was not sure she wanted to go back. Ms Gibson agreed in cross-examination that by 17 July 2020 she had decided that she would not consult the pain clinic further.

[79] The plaintiff argued that the management of Ms Gibson by Dr Savage after 17 July 2020 was an impermissible delegation of duty by the defendant. I do not agree that that was the case. There was no attempt to delegate the defendant's duty. The pain clinic had carried out the treatment which was agreed. Dr Savage was the treating general practitioner and had referred Ms Gibson to the pain clinic. The transfer of Ms Gibson's care back to Dr Savage, was what everyone expected would happen. It was appropriate on the information known to Dr Koshy at the time, subject to Ms Gibson having the opportunity to contact the pain clinic if she needed assistance, which was offered to her and which on her own evidence she was not interested in doing after 17 July 2020.

[80] Ms Gibson's symptoms did not abate. She experienced increased pain in her lower back, left hip, groin, buttock and the back of her thigh in the weeks following the procedure. Dr Savage referred her for an ultrasound and CT scan. The ultrasound of the left hip was performed on 27 August 2020 and found that the bursa was thickened, in keeping with bursitis. There was an additional finding of left hamstring tendonitis. Ms Gibson was referred for physiotherapy. A letter from Jacqueline Decker, physiotherapist, dated 31 August 2020 to Dr Savage noted Ms Gibson's reduced range of motion in the left leg, swelling in the left hip, inability to weight bear and walking with a limp, and suggested additional investigations to rule out femoral head fracture.

[81] An x-ray of the pelvis and left hip taken on 2 September 2020 found no fracture and no significant abnormality.

[82] On 10 September 2020 an MRI was conducted. The findings were a localised area of bone marrow swelling in the front part of the femoral head just beneath the joint surface. There was some hardening of the bone just under the cartilage parallel to the front or top of the femur and just behind the acetabulum (hip socket) and labrum (cartilage surrounding the hip socket). The radiologist reported that the most likely finding was that there was a minor impaction injury of the bone beneath the cartilage on the left hip. Alternative diagnoses were said to include a stress fracture or avascular necrosis (death of bone tissue due to loss of blood supply). A small split tear in the cartilage rim at the front of the left hip joint (labrum) was also found.

- [83] On 16 September 2020 Ms Gibson was taken to ASH by ambulance for investigation of possible septic arthritis. Dr Chen recorded in the notes hyperalgesia and allodynia (feeling pain from something that would not normally cause pain) in the skin overlying the hip joint. Tests were done which showed no inflammatory markers. The hospital notes record that Dr Chen concluded that the likelihood of septic arthritis was very low. Ms Gibson was discharged without further treatment at her request. On the same day, about an hour after she returned home, Ms Gibson spoke to Dr Shahrokhi, orthopaedic surgeon.
- [84] Dr Shahrokhi diagnosed suspected avascular necrosis based upon the findings from the MRI of 10 September 2020, in particular flattening of the femoral head (top of the femur which fits into the hip socket), evidence of subchondral collapse (loss of bone strength causing it to flatten), and subchondral oedema (swelling caused by excess fluid just under the cartilage joint surface). He recommended a total hip replacement.
- [85] On 1 October 2020 Ms Gibson underwent a total left hip replacement performed by Dr Shahrokhi at a hospital in Adelaide. Post operation the head of the femur was examined and the histopathology report concluded that there was patchy osteonecrosis (death of bone tissue usually due to lack of blood supply) with some features suggestive of avascular necrosis although poorly developed in the representative sections. On 9 October 2020 Dr Shahrokhi reported to Dr Savage that pathology results confirmed osteonecrosis of the femoral head and opined that this was further evidence

that acute onset of avascular necrosis was most likely as a result of the fall that Ms Gibson experienced post injection of anaesthetic into the left hip. In his letter to the Director of the ASH on 14 December 2020 Dr Shahrokhi described the fall as “she tried to stand up and she had to catch herself on the edge of the bed”. He therefore does not appear to have been under the impression that Ms Gibson fell to the floor.³

[86] In the months following the total hip replacement Ms Gibson made generally good progress. X-rays on 12 November 2020 and 17 February 2021 and an ultrasound on 24 February 2021 found that the total hip replacement was in situ and there was no abnormality. There was a further incident at home in about February 2021 in which Ms Gibson twisted and experienced increased pain in the hip as a result. An MRI on 3 June 2021 found a small collection of bursal fluid but no other abnormality. Notwithstanding that, Ms Gibson continued to report pain in the left hip. She also continued to suffer from pain associated with her neck and shoulder and underwent a cervical spinal fusion on 2 August 2023. She also experienced increased back pain in 2023 and at the time of this hearing in late 2025 was scheduled to have an operation on her back.

3 Dr Shahrokhi’s reports were admitted as part of the agreed Court Book in this proceeding, but he did not give expert evidence in the proceeding.

Summary of the expert medical evidence about Ms Gibson’s left hip

Dr Journeaux, orthopaedic surgeon

- [87] Dr Journeaux, orthopaedic surgeon, reviewed Ms Gibson for the purpose of this proceeding and produced reports dated 9 June 2021, 4 August 2021 and 10 April 2025. He also gave oral evidence.
- [88] When he examined the plaintiff in May 2021, Dr Journeaux noted that there was significant tenderness over the trochanteric bursal area and abductor tendon on the left side and over the insertion of the small external rotators of the hip into the posterior trochanter. She also had weak active hip abduction secondary to pain with grade four out of five power. Her range of movement of the hip was otherwise normal.
- [89] In his first report, Dr Journeaux opined that it was likely that Ms Gibson had suffered a femoral nerve palsy, which later in the report he described as a “temporary neurapraxia”, as a result of the local anaesthetic injection. He based his opinion largely on Ms Gibson’s evidence that she had fallen and inadvertently twisted her left lower limb causing an injury to the left hip. Dr Journeaux directly reviewed the MRI images from 10 September 2020 and formed the view that they did not suggest avascular necrosis but instead were likely to show sequelae of an impact type injury to the lateral aspect of the femoral head. He did not concur with the diagnosis of Dr Shahrokhi as to avascular necrosis and did not agree that an urgent hip replacement was required. In cross-examination on this topic, Dr Journeaux

clarified that he would not say that a hip replacement was not required, just that he would not have proceeded with that so quickly.

[90] Dr Journeaux's evidence was to the effect that a nerve palsy and a neurapraxia are "to all intents and purposes" the same thing. He explained that a neurapraxia⁴ is a temporary injury to a nerve, which will fully resolve. A nerve palsy on the other hand is an overarching or general term which could include a mild or a more serious nerve injury, including one which does not fully recover. He further explained that a neurapraxia is an injury to the nerve sheath, whereas a nerve palsy could occur as a result of the local anaesthetic interrupting the biochemical process in the nerve. He also said that there is a lack of clarity in the way that neurapraxia is used in medicine and it can sometimes be applied to what happened in this case, (which he said was nerve palsy due to the effect of anaesthetic) although he agreed that the description was not strictly accurate.

[91] In his first report Dr Journeaux said that the treatment provided to Ms Gibson at ASH was not of a reasonable standard because the complication of femoral nerve palsy was not recognised and appropriate management and care for that injury was not provided. Dr Journeaux said that Ms Gibson should have been admitted overnight and further investigations undertaken. He said that appropriate treatment and management should have been offered, including a clinical assessment

4 Alternatively, and some say incorrectly, spelled "neuropraxia".

before discharge, to ensure that she did not come to any harm, particularly in terms of reducing the risk of a fall. It is not entirely clear when this treatment should have been offered as Ms Gibson did not experience any fall other than the incident in the recovery room. His opinion as to the failure to diagnose and treat was also predicated upon the fact Ms Gibson had suffered a femoral palsy.

[92] Dr Journeaux did not explain when or how the fact that Ms Gibson had suffered a femoral nerve palsy should have been recognised or exactly what steps could or should have been taken to do that. Nor did he explain after the weakness was identified at the point that she alighted from the bed in the recovery room, what treatment was appropriate beyond further investigations or how that might have affected her future prognosis.

[93] In his second report, Dr Journeaux was asked to comment upon Dr Shahrokhi's opinion that the histological diagnosis confirmed avascular necrosis. Dr Journeaux noted that his area of expertise is not histopathology and a histopathologist was required to comment definitively upon whether there was true avascular necrosis of the femoral head verses an osteochondral impaction injury. However, he favoured the later diagnosis based upon the mechanism of injury and continued to express doubt concerning Dr Shahrokhi's diagnosis. Dr Journeaux said that the histopathology evidence was not in itself sufficient to make a diagnosis of avascular necrosis. No histopathology expert gave evidence in the proceeding.

- [94] In his final report of 10 April 2025 Dr Journeaux was asked to comment on the reports of Dr Kapur of 6 November 2024 and 28 January 2025, and Dr Low of 28 January 2025. Contrary to his earlier opinion, Dr Journeaux agreed in this report that a neurapraxia, being a particular type of nerve injury involving physical damage to the nerve, would not have occurred. However, he maintained that there was, based upon the contemporaneous reports of Ms Gibson, and “to a certain extent supported by the contemporaneous documentation”, evidence of a temporary nerve palsy “of some description” after the procedure, due to local anaesthetic.
- [95] In cross-examination Dr Journeaux confirmed that he did not think that Dr Koshy caused any physical injury to the nerve by hitting it with the needle during the procedure. Such an incident would be painful, whereas a nerve palsy caused by anaesthetic dispersion would not. He further confirmed that the reference to “contemporaneous documentation” was a reference to medical records which recorded the incident as recounted by Ms Gibson, and not independent medical verification of what had occurred.
- [96] Dr Journeaux further opined, contrary to his earlier reports, that it was unlikely that the femoral nerve was involved given its anatomic location, although it could not be completely ruled out. Instead, Dr Journeaux said that either a gluteal nerve palsy or possibly a sciatic nerve palsy caused Ms Gibson’s leg to feel either numb and/or weak and contributed to the event. He went on to say that he agreed with Dr Kapur and Dr Low that an isolated well-performed trochanteric bursal injection should not cause a

femoral nerve or other nerve palsy, while at the same time noting that there were likely two injections, one of which was likely higher than the trochanteric bursa, which would have increased the risk of pain, limb weakness and “relative immobility” after the procedure. He further said that a higher volume of local anaesthetic would increase the possibility of a nerve paralysis occurring. Dr Journeaux said that a standard amount of volume of the injection would be 10ml, 8ml of anaesthetic and 2ml of steroid.

[97] In this third report, Dr Journeaux confirmed his view that a nerve paralysis (not neurapraxia) occurred and played a material role in the onset of increased pain, weakness, limitation of movement, and left leg and hip pain. He opined that the superior gluteal nerve was more likely “paralysed” (his quotation marks) and/or possibly the sciatic nerve “in some way”, but not the femoral nerve. Dr Journeaux said that he was generally in agreement with the reports of Dr Kapur and Dr Low, although he thought that both had failed to reflect that more than one injection was performed.

[98] In cross-examination Dr Journeaux said that on reading the letter of instruction from the plaintiff’s lawyers, he would have assumed that Ms Gibson had fallen to the floor on getting up from the bed. As to the presence of an impaction injury, Dr Journeaux said that in order to sustain an injury to the femoral head Ms Gibson would have had to fall and hit something, such as falling to the floor from a standing height. He said that

was very unlikely to have resulted from a twisting injury in which she fell onto a bed.

[99] However, Dr Journeaux also confirmed that when he took a history from Ms Gibson as to what occurred in the recovery room, she said that she had stood and noticed her leg was weak, and as she attempted to walk, she collapsed. He said that she told him she got out of the right side of the bed and he understood she attempted to weight bear on the left leg. He said that weakness of the leg was not complete paralysis, and he did not think that was what had occurred. He said that as she attempted to walk, she said that she twisted to the left side somewhere near the side of the bed. Dr Journeaux confirmed that when he wrote in his report “fell in a twisting motion to the left side of the bed” he was assuming that she fell onto the bed, not the floor. When asked whether he had assumed that the leg was completely paralysed he said that was not his assumption because all of the nerves in the leg would not have been compromised, but there would have been weakness. Dr Journeaux was asked about the significance of whether the plaintiff was “hopping” or “hobbling” after the procedure. He said that the important point was that she was not walking normally.

[100] Dr Journeaux also confirmed in cross-examination that it was his understanding that the symptoms which Ms Gibson was experiencing at the time that he saw her were as a result of a further injury to the hip she had suffered three months before his examination, which would have been

approximately February 2021, while bending down and getting up and twisting in some way at home.

[101] Dr Journeaux was cross-examined about the photographs of the bandages.

He said that they were located on the outer thigh, which is where the greater trochanter is and that, although he could not say for certain, based on the location of the groin crease, he thought that the lower bandage was over the greater trochanter and the upper one in the region of the “glutes on the outside”. Dr Journeaux agreed that a gluteal nerve palsy was unusual as a result of a bursal injection but said that nerve is much closer to the injection site than a femoral nerve. He said that a nerve palsy affecting the superior gluteal nerve would result in a partial rather than a full paralysis. It would affect the hip abductors and would partially paralyse the glutes but would not have any effect upon sensation to do with that nerve.

[102] In re-examination Dr Journeaux said that an impact to the superior gluteal nerve would affect the ability to walk but that a sciatic nerve palsy would make the leg feel like a dead weight because the sciatic nerve is both sensory and motor and would affect ankle movement and about 60 percent of the lower limb.

[103] As to the causes of avascular necrosis, Dr Journeaux said that there could be several causes and, sometimes, no known cause. He agreed that the changes in Ms Gibson’s hip shown on the MRI could have pre-existed the events of 14 July 2020. He went on to say that avascular necrosis would typically

cause groin pain, not usually outer hip pain although that was possible. He agreed with the proposition that if Ms Gibson had groin and buttock pain prior to 14 July 2020 the condition could have been pre-existing, although he was not sure about what symptoms she had.

[104] As to the possibility of a dislocated hip, Dr Journeaux said that it was highly improbable that had happened. The reason is that the mechanism of injury described by Ms Gibson would be insufficient to cause a dislocation. He also said that such an injury would be extremely painful and a person who suffered that sort of injury would fall to the floor and be unable to get up. He confirmed that a person who suffered a hip dislocation might hear a “pop” sound, but that no such sound would be heard on an impaction injury.

[105] As to the significance of buttock pain, noting that the exact area of the pain was not clear, he said that was more likely to be trochanteric than coming from within the hip joint, but could also have been contributed by problems with the lower back and was consistent with that cause. Dr Journeaux said that only 50 percent of patients find that trochanteric bursa injections alleviate their pain. Some patients do not respond and some get worse. Therefore, the presence of the same pain after the procedure did not, in his view, indicate that the problem was not the trochanteric bursa. He also said that pain in the hours or days after the procedure, when the local anaesthetic wears off, can be a phenomenon known as a “steroid flare” that is a temporary increase in pain as a result of the procedure. He said that this was an uncommon complication which would settle on its own within a few

weeks. He agreed that it appeared that Ms Gibson had failed to respond to the bursa injection.

[106] Dr Journeaux remained of the opinion that the treatment administered was unusual for trochanteric bursa pain because of the fact that there were two injections and because of the “unusually generous” amount of local anaesthetic used, at 20ml. However, he also agreed that a gluteal nerve palsy or sciatic nerve palsy was an unusual, even rare, complication of the procedure as described.

Dr Low, orthopaedic surgeon

[107] Dr Low, orthopaedic surgeon, provided a report dated 28 January 2025. He did not examine the plaintiff but took Ms Gibson’s history from the reports and other material he was given. He also gave oral evidence.

[108] In relation to the injections to the bursa given by Dr Koshy, Dr Low said that the usual complications of the procedure are haematoma and infection, with some local numbness. He said that ultrasound guidance is not necessary for this procedure which is “extremely safe”.

[109] Dr Low’s opinion was that a nerve neuropraxia was “virtually impossible to occur” as a result of the procedure because the distance between the trochanteric bursa and the femoral nerve is such that the anaesthetic could not possibly travel anywhere near the femoral nerve. Dr Low said that not a lot of local anaesthetic is required and opined that the amount required

is 5ml “at the most” which would not travel around to the medial anterior area and paralyse the femoral nerve.

[110] As to whether Ms Gibson should have been assisted to stand in the recovery room, Dr Low said that a person should not need assistance after this procedure “unless you’ve got some underlying musculoskeletal comorbidity which this lady might have had”.

[111] In relation to the MRI findings from 10 September 2020, Dr Low said that the fact that oedema was seen indicated an acute rather than a chronic injury. He explained that avascular necrosis is interference with the blood supply to the femoral head and can be partial or complete and severity can vary depending upon what part of the femoral head is involved. Complete avascular necrosis results in dead bone being replaced by soft bone which deforms and collapses and does not support the articular cartilage leading to osteoarthritis and, ultimately, a hip replacement. Avascular necrosis which is partial and does not involve the critical weight bearing part of the joint can resolve on its own. Dr Low said that although there are known risk factors, such as excessive alcohol or long-term steroid use, avascular necrosis can occur when there is no known cause.

[112] Dr Low’s opinion was that Ms Gibson most likely had pre-existing avascular necrosis which was the cause of her left hip pain both before and after 14 July 2020. He said that he did not believe that an impaction injury as described by Ms Gibson, that is a fall or twist impacting the femoral head

against the acetabulum causing some osteochondral damage, would be such that it would cause someone with a completely asymptomatic hip with some trochanteric bursitis to become so bad that a hip replacement was required. He said that the osteochondral fracture suggested by the acute changes (swelling) seen on the MRI would have been of a minor nature and treated with conservative measures. It was not his opinion that the fall described by Ms Gibson was likely to have resulted in the need for the hip replacement. Rather, in his view the hip replacement was required due to the underlying condition. Dr Low further said that trochanteric bursitis can itself be a presentation of a disease process inside the hip.

[113] Despite those views, Dr Low did not ultimately dispute Dr Shahrokhi's decision to proceed with the total hip replacement. He opined that it is possible that Ms Gibson suffered a twisting injury which caused a slight osteochondral fracture in the presence of pre-existing avascular necrosis. He said that the fracture would have made her symptoms worse than otherwise expected because of the partial areas of avascular necrosis in addition to the osteochondral fracture. He said that, in that situation, a hip replacement was "the only option".

[114] Dr Low agreed in cross-examination that in the extensive notes he had reviewed he did not see any evidence of pre-existing hip problems before April 2020 and that the presentation at that time was consistent with trochanteric bursitis. He also confirmed that he had no criticism of the diagnosis and treatment of that problem. In relation to the procedure itself,

Dr Low said that it was clinically appropriate. He referred to the fact that given there were two dressings close together there may have been two injections rather than one. He said that usually, one or two injections were administered, but the presence of two injections did not change his opinion.

[115] Dr Low also said in cross-examination that the only nerves which would be anywhere near the injection sites would be the terminal branches of the superior gluteal nerve which are very small and would not be involved in any significant motor palsy. He said that the sciatic nerve and the gluteal nerve are in the inner and lower quadrant and the greater trochanter is in the outer and upper quadrant of the hip area. Therefore, it is safe to inject that area without fear of nerve damage. He was very firm in his view that the injections could not have directly impacted those nerves.

[116] As to the amount of anaesthetic injected, Dr Low said that 20ml was more than he would have used, which was about 5ml. He was asked whether the volume given could have impacted the axon sheets in the nerve and he said that large amounts of anaesthetic could diffuse to the front or back but there would have to be other unusual circumstances such as hitting a blood vessel and developing a large haematoma, which would cause a large amount of swelling, for that to have occurred. There is no evidence of such an event.

[117] As to Ms Gibson limping on leaving the hospital, Dr Low said in cross-examination that would be expected because she had had an injection into her acetabulum, the local anaesthetic would be wearing off, and she would

have some pain around that area. However, Dr Low said that the description of limping given by Dr Koshy did not amount to gross motor loss. He agreed that she “wasn’t 100 percent” but said that there was nothing “spectacular” wrong. She was as he would have expected her to be given her history.

[118] In cross-examination Dr Low confirmed his view that the fall onto the bed, and the sub-chondral fracture, if that resulted from that event, was insignificant compared with the underlying diagnosis of avascular necrosis. He said that a subchondral anterior femoral head fracture and bone marrow oedema would only be representative of the underlying problem of avascular necrosis. He further said that the fact that the trochanteric bursitis injection did not alleviate that condition only meant that that was not the diagnosis in the first place. His view was not altered by the ultrasound finding of 27 August 2020 that the left hip bursa was thickened and tender. He said that on its own that did not prove that trochanteric bursitis was the problem because those findings can be present in asymptomatic people. He said that avascular necrosis takes many months or years to develop and slowly becomes symptomatic. The condition can co-exist with other conditions, including trochanteric bursitis.

[119] Dr Low went on to explain that in the presence of avascular necrosis, when new bone is present in the femoral head it is soft and minimally traumatic events such as walking down the street or twisting could cause a micro trabecular (soft bone) impaction fracture. He said that does not change the underlying pathology, which could easily present as trochanteric bursa pain.

He further said that the oedema seen on the MRI, which was evidence of acute injury, is not unusual in this circumstance because soft bone is easily damaged. He said that in the setting of underlying avascular necrosis the “little stumble” Nurse Joseph described in the recovery room could have resulted in the fracture seen on the MRI, but that did not change the outcome, which he said was always going to be a total hip replacement.

[120] Dr Low was of the view that the care provided by Dr Savage was “superb” and exactly what would have been expected. He did not think that there was any difficulty with Ms Gibson not seeing Dr Koshy again. Dr Low did not think that there was any need for Dr Koshy to review Ms Gibson at an earlier time based on her complaints of pain on 16 July 2020, noting that the investigations to confirm the underlying avascular necrosis had not occurred.

Dr Kluver, pain physician

[121] Dr Kluver, pain physician, prepared two reports for this proceeding dated 30 June 2023 and 14 April 2025. He assessed Ms Gibson for that purpose on 2 June 2023. He also gave oral evidence. Dr Kluver made it clear in his report that it was beyond his expertise to comment on whether Ms Gibson had avascular necrosis in the left hip and whether a total hip replacement was appropriate. He further acknowledged that he was unable to comment on whether there was, from an orthopaedic perspective, osteonecrosis of the hip or osteochondral injury from impaction. His evidence was primarily directed

to the most likely cause of weakness in Ms Gibson's leg immediately after the procedure on 14 July 2020.

[122] In his first report Dr Kluver said that based upon the material he had received, and the history he had taken from Ms Gibson, his understanding was that the fall in the recovery room resulted from a transient neuropraxia, likely involving the femoral nerve, leading to weakness in knee extension and ultimately causing her to fall when she stood up. It was his view that the ASH pain clinic should have had protocols in place to ensure safe mobilisation in order to prevent falls. Based upon the history he believed that proper protocols were not followed. Dr Kluver acknowledged in his first report that he was uncertain as to specific details about what occurred after the procedure but understood that Ms Gibson was asked to mobilise without appropriate safety protocols in place. He did not set out in detail what those protocols might be, but said that they should ensure safe mobilisation. He also said that Ms Gibson should not have driven herself home after potentially having a peripheral nerve in her leg anaesthetised.

[123] In relation to follow up care, Dr Kluver pointed to the Pain Medicine Clinical Care Standard PS 112020, which, he said, emphasises the importance of closely monitoring and promptly recognising any complications that may arise and providing appropriate follow up care. Dr Kluver was of the opinion, based upon what he was told, that complications were not promptly recognised and when they were brought to the attention of medical staff, were not effectively managed. Dr Kluver does

not appear to have recorded the full history of the actions taken by Ms Kirwan and Dr Koshy on 15 – 17 July or by Dr Savage after she saw Ms Gibson on 21 July 2020.

[124] Dr Kluver's understanding of what happened in the recovery room after the procedure was that Ms Gibson stood up from the bed without any assistance and fell to the floor experiencing a twisting motion and a popping sensation in the left hip which was not painful. He recorded that she then managed to hobble to the bathroom to get changed and slowly mobilised to the elevator to leave. He also recorded that Dr Koshy noticed that she did not look well as she was leaving the hospital and offered her a wheelchair.

[125] Dr Kluver said that delay in diagnosis and analgesia would have exacerbated Ms Gibson's pain. He also acknowledged the role of prolonged litigation in exacerbation of pain. However, Dr Kluver said that he was unable to say what Ms Gibson's prognosis would have been if she had been treated to a reasonable standard of care after the procedure from a surgical point of view, except that her suffering in the five weeks after the procedure would have been less. He said that the prolonged period of increased pain and loss of function may have contributed to her sensitisation of pain, deconditioning and psychological distress which may in turn have affected her progress. He did not say whether he thought that had actually occurred. Dr Kluver did not mention the pain relief medication which Dr Savage's notes indicate that Ms Gibson was taking.

[126] Dr Kluver assessed Ms Gibson's whole person impairment according to the American Medical Association Guide to the Evaluation of Permanent Impairment 6th edition, as 10 percent.

[127] In his second report, Dr Kluver confirmed that he thought that a femoral nerve block was possible due to an injection through the side of the hip. He said that if the needle is incorrectly angled medication may be delivered into a part of the leg closer to the midline and temporarily affect or irritate the femoral nerve. He agreed that if the needle is correctly angled the likelihood of that occurring is very low. He opined that the most likely mechanism of injury in this case was unintended diffusion of local anaesthetic into the compartment of the femoral nerve, resulting in temporary motor blockade which could lead to quadriceps weakness and, in a standing individual, a consequential fall due to loss of motor control.

[128] Dr Kluver said that in his practice trochanteric bursal injection is usually only one injection. He also said that volume of 20ml anaesthetic used by Dr Koshy is larger than is typically required and that if that volume was inadvertently delivered into the fascial plane containing the femoral nerve, it would increase the risk of motor blockade or neuropraxia. Dr Kluver disagreed with the opinion of Dr Kapur that a femoral nerve blockade was anatomically implausible, particularly where higher volumes of anaesthetic are used or needle control was suboptimal. As to the latter, Dr Kluver acknowledged that he could not comment on the skill of the clinician. However, Dr Kluver ultimately agreed that the procedure is generally low

risk and that a femoral nerve block resulting in a fall is an unlikely complication.

[129] In cross-examination Dr Kluver confirmed that his opinion was based on Ms Gibson's history as he understood it. Although he recorded in his report that she experienced pain on the first injection, fell to the floor with a twisting motion and experienced a popping sensation, he said that the most important part was the history of motor weakness in the leg after the procedure. Dr Kluver confirmed that the risk was low, but that his opinion was directed to the most likely mechanism of damage to the nerve if that was what occurred. He agreed that if Ms Gibson's leg was not affected following the injection and she did not fall then it would be highly unlikely that the injection caused a temporary neuropraxia.

Dr Kapur, pain physician

[130] Dr Kapur, pain physician, produced two reports for this proceeding dated 6 November 2024 and 28 January 2025. He also gave oral evidence. He did not examine Ms Gibson. In his first report, Dr Kapur provided an overview of the extensive history of musculoskeletal difficulties experienced by Ms Gibson before 14 July 2020, obtained from the material he received. He then documented the history of engagement with Dr Koshy in relation to the left hip pain.

[131] As to the possibility of Ms Gibson dislocating her hip in the fall in the recovery room, Dr Kapur did not consider that this was plausible, even on

the version of the fall described by Ms Gibson, as there was insufficient trauma involved to produce that result. Further, Dr Kapur was sure that Dr Koshy did not cause any mechanical damage to the nerve by inserting the needle in the wrong place during the procedure. In addition, he states that it is not plausible that Ms Gibson developed a femoral nerve paresis (partial loss of muscle strength or weakness) following the procedure. He was of the view that Ms Gibson was unlikely to have experienced any temporary loss of motor function as a result of the injections administered by Dr Koshy.

[132] Dr Kapur said that a local anaesthetic and steroid injection to the trochanteric bursa is a simple, minor procedure with low morbidity, usually performed on an outpatient basis. He said that there is no good evidence that use of ultrasound improves the success of the procedure in terms of pain relief. He noted that the volume of anaesthetic used at 20ml was larger than would usually be the case. He said that a lower volume (5ml) of a stronger (.5 percent) Bupivacaine would usually be used, however he said that the lower strength used by Dr Koshy would have resulted in a “broadly similar effect overall”.

[133] Dr Kapur said that neurapraxia is a low-level nerve injury occurring due to compression or direct trauma to a nerve. The result is some impairment of nerve function, which always recovers within a few weeks. He was of the view that there was no plausible mechanism by which the femoral nerve could have been affected in that way as a result of this procedure because

the area of injection by Dr Koshy was substantially separated from the region of the femoral nerve.

[134] As to the spread of anaesthetic affecting the femoral nerve, Dr Kapur also said this is implausible. He said that the greater trochanter and the femoral nerve are in different compartments of the thigh, a considerable distance apart and separated by substantial tissue planes. Dr Kapur said that he was confident that this did not occur because there is no plausible mechanism by which the anaesthetic could spread all the way around the thigh and transverse the separate tissue planes to find its way to the femoral nerve.

[135] Whilst acknowledging that numbness over the outside of the thigh was certainly likely, Dr Kapur was sure that this would not have given rise to motor weakness in the leg. As to an effect upon the muscles in the posterior aspect of the thigh and the medial aspect of the upper thigh supplied by the sciatic and obturator nerves Dr Kapur was also sure that there was no possible mechanism by which the anaesthetic could have spread to these areas. He said that even if small branches of peripheral nerves in the region of the trochanteric bursa were affected, that would not give rise to anything more than a local pattern of nerve disruption which would not have any effect upon muscular function.

[136] Dr Kapur said that the underlying reason for the recommended treatment (steroid bursa injection) is important. Pain over the lateral aspect of the thigh is reasonably common, he said, particularly in women and those with

altered gait patterns due to other issues. It does not necessarily result from a problem in the trochanteric bursa but can result from a number of conditions. He said that the earlier reference to pain in the left buttock in the general practice notes might indicate that the pain in Ms Gibson's case came from other sources.

[137] Dr Kapur said that it was appropriate that Dr Koshy warned Ms Gibson about the risk of temporary numbness around the site of the injection, but it was not necessary to warn of the risk of neurapraxia because it is not a recognised complication of the procedure. He further said that loss of motor function to the femoral, sciatic or obturator nerves was not a complication identified in the extensive medical literature relating to injection at the trochanteric bursa.

[138] Dr Kapur said that the approach to post procedure care outlined in Nurse Joseph's affidavit was a standard and straightforward way of managing a patient who has undergone a low-level steroid injection procedure as performed by Dr Koshy.

[139] Dr Kapur also said that the follow up care provided by the pain clinic was appropriate. He did not agree that the standard of care provided fell below that set out in the standard document PS11 2020 from the Faculty of Pain Management referred to by Dr Kluver. He said that is a document which sets out general principles which are adapted by clinicians to the situation. He said that the only significant fault he could identify on behalf of

Dr Koshy was that no information about the procedure was provided to Dr Savage after the event, however he did not think that was likely to have altered Dr Savage's clinical approach.

[140] He said that Dr Koshy's view that the increase in symptoms on 16 July 2020, when he spoke to Ms Gibson, was likely due to a steroid flare was reasonable as, although that complication is uncommon, it is "well described". Dr Kapur also said that the additional analgesia prescribed by Dr Koshy and the arrangements for follow up by Dr Savage were appropriate at that time.

[141] Dr Kapur's second report was provided after he had been shown various imaging files relating to Ms Gibson's left hip, including the MRI scans of 10 September 2020. He said that scan showed subchondral bone oedema, possibly associated with a local impaction injury and that was supported by changes in the opposing section of the labrum, consistent with a local labral tear. He said that the features were overall consistent with the effects of an impaction injury to the hip with local secondary changes in the femoral head and adjacent labrum. He considered avascular necrosis of the left femoral head unlikely and agreed with the opinion of Dr Journeaux in that respect, but did not otherwise alter the opinions in his earlier report.

[142] In cross-examination Dr Kapur confirmed that as the bursa is small even with a low volume injection there would be expected to be some leakage into the local tissue which would cause an area of numbness over the outer

skin in the area of the lateral aspect of the thigh. He confirmed that was in keeping with the warning as to local numbness noted on the consent form.

[143] Dr Kapur agreed that motor weakness after the procedure could have caused Ms Gibson to limp as she left the hospital. However, he said that that could also have been due to her chronically painful hip. He said that the fact that Ms Gibson was limping was not necessarily a reason for Dr Koshy to review her because she had also been limping before the procedure and that could be due to a range of causes. He said that if that presentation was first observed after the procedure that would be different. Dr Kapur said that if Ms Gibson was mobilising differently to what was seen before the procedure, it would be reasonable to query whether motor weakness had arisen but if it was the same, then there would be no reason for that to raise a concern.

[144] Similarly in relation to the “stumble” observed by Nurse Joseph, Dr Kapur said that whether that merited review by Dr Koshy would depend on its severity. On the account of Nurse Joseph, he thought not.

[145] As to the effect of the second injection, Dr Kapur said that if the second injection was superior to (above) the trochanteric bursa, which was not clear on the evidence, then there was no possibility of the femoral or sciatic nerve being involved. He agreed that there was a very small likelihood that there may have been some transmission of local anaesthetic into one of the gluteal nerves. He stated that it is possible to mobilise with complete paralysis of

all of the gluteal nerves, but with difficulty. An injection into the superior gluteal nerve would not cause the leg to give way, but it could cause a limp.

[146] When cross-examined about the MRI scans of 10 September 2020, which he had reviewed himself, Dr Kapur said that there were abnormalities visible on the scans and one of the causes of abnormality could have been an impaction injury. He did not agree with Dr Low that bone oedema is evidence of an acute injury because he said that extensive bone oedema can be seen where there are degenerative conditions of the major joints. He said that bone oedema can persist for many months after an injury. However, he also said that the small tear in the labrum was some additional evidence that something had happened that had caused the pathology seen on the MRI scan in relation to that area. He agreed that an injury to the labrum can be caused by a twisting injury, but he thought it was much less likely that a twisting injury would cause injury to the bone. He said that would have to involve an injury such as a substantial fall and that a fall onto a bed would be unlikely to give that result.

[147] Dr Kapur said in cross-examination that if there was an impaction injury, it was unexplained. He also said that subchondral marrow oedema and labrum tears are very common in the population, particularly in people aged over 60 years. He said that it is not possible to say when the abnormality on the scan arose, particularly where there was a history of persistent hip pain going back several months prior to the procedure on 14 July 2020.

[148] It was put to Dr Kapur that the reports of Ms Gibson to Dr Savage after 14 July 2020 indicated a significant escalation in symptoms, particularly during August 2020, and he agreed that appeared to be the case overall, although he also noted there were reports of Ms Gibson experiencing severe pain in the left groin and hip well before the procedure. He agreed that based upon Ms Gibson's reports she appeared to have reduced functionality after 14 July 2020.

Did Ms Gibson suffer an acute injury to her hip on 14 July 2020?

[149] The evidence in my view establishes that Ms Gibson did suffer some sort of acute injury to her left hip before 1 October 2020, and that it is most likely to have occurred in the recovery room at ASH on 14 July 2020.

[150] There are a number of reasons for this. First, the evidence of both Dr Journeaux, Dr Low and Dr Kapur was that the findings on the MRI of 10 September 2020 showed a likely impact injury. Second Dr Kapur said that the presence of the tear to the labrum, also points to an impaction injury having recently occurred. Although that injury may have occurred at a different time, the coexistence of the "impact injury" and labral tear seem to indicate it is likely that both occurred at the same time. Third, Dr Low's opinion was that the presence of swelling on the MRI findings pointed to a recent injury which he said in cross-examination could have been explained by a low impact event due to soft bone consequent upon avascular necrosis.

[151] The mechanism of the injury, on the evidence of Dr Journeaux and Dr Kapur that avascular necrosis was not likely, is unexplained. Their evidence, with which Dr Low agreed, was that a hip fracture, even of a minor nature, could not have occurred without an impact much more serious than that which even Ms Gibson described. There was no evidence that the plaintiff's previous activities, of lifting the pool robot or cleaning out the shed would have been likely to have caused such an injury. All of the medical experts gave evidence that a fracture to the femoral head would only occur with a significant incident, such as a fall from height.

[152] Dr Low, however, thought that a much less serious event, even the stumble described by Nurse Joseph, could have been responsible for the injury in the presence of pre-existing avascular necrosis. Although there were differences of opinion between the medical experts, it seems to me that the most likely explanation for the plaintiff's injury is an acute injury suffered on 14 July 2020 on a background of pre-existing avascular necrosis.

[153] In making that finding I have given particular weight to the fact that after 14 July 2020 there was a significant increase in Ms Gibson's symptoms. She immediately and repeatedly complained to Ms Kirwan, Dr Koshy and Dr Savage of severe pain in her left hip in the days after the procedure. Notwithstanding her tendency to exaggerate and to reconstruct in some aspects of her evidence, I consider it very unlikely that Ms Gibson was making that up. The contemporaneous notes, detail and frequency of her reports support the veracity of her claims. In addition, her complaints of

pain are supported by the MRI findings. It would be an extraordinary coincidence if Ms Gibson suddenly experienced a sharp increase in pain symptoms, including much more frequent complaints of groin pain, if nothing had happened.

[154] There are a number of reasons why I prefer the evidence of Dr Low that avascular necrosis was present, to that of the other doctors. First, in my view Dr Low's opinion fits best with the chronology of events. There is evidence from the notes of Dr Savage and Dr Koshy, and Ms Gibson's evidence, that the plaintiff suffered serious pain in the left hip for some months prior to the pain injection. That pain included a report of groin pain in February 2020. Dr Low's opinion was that that report of pain and hip pain was consistent with avascular necrosis. Second, the MRI findings were consistent with avascular necrosis, although other diagnoses were possible. Third, it was the impression of Dr Shahrokhi, the surgeon who performed the hip replacement, that Ms Gibson suffered from avascular necrosis, which was why that surgery was required, a view which was to some extent supported by the histopathology report.

[155] Fourth, all of the doctors agreed that a fall onto a bed as described by the plaintiff was unlikely to have precipitated an impact on injury in an otherwise healthy bone. Dr Low's opinion fits with the evidence that Ms Gibson twisted somehow as she stumbled and sat onto the bed, a mechanism which is not inconsistent with Nurse Joseph's observations. Dr Low said that in the presence of avascular necrosis any number of

relatively innocent activities, even walking down the street, but including twisting onto a bed when attempting to get up, could cause the injury.

Was there a breach of the duty of care?

[156] The duty of care of a medical practitioner, nurse or hospital provider was described by the High Court in *Rogers v Whitaker*:

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a “single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement”, ... it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case.⁵

[157] The scope and content of the duty is in issue in this case. The question is what it is that the defendant is alleged to have failed to do that the reasonable hospital operator, doctor or nurse would have done. As Mason J said in *Wyong Shire Council v Shirt*⁶:

In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant’s position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk. The perception of the reasonable man’s response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert

⁵ (1992) 175 CLR 479 at 483, per Mason CJ, Brennan, Dawson McHugh and Toohey JJ.

⁶ (1980) 29 ALR 217, 221.

what is the standard of response to be ascribed to the reasonable man placed in the defendant's position.

[158] Whether a doctor or other professional or a hospital provider has breached their duty of care is a matter for the court to determine and is not regulated by the standards of the profession. However, expert evidence as to acceptable practices is relevant to findings as to the relevant risks involved and has a bearing on the question of materiality of a risk.⁷ A medical practitioner cannot be said to be negligent only because their conclusion or procedure differs from that of other medical practitioners. There must be a finding that there was a failure to exercise the ordinary skill of a doctor or other health practitioner practising in the field.

Failure to warn of the possibility of a neurapraxia or nerve palsy

[159] The medical evidence in this case was all to the effect that loss or impairment of motor function as a result of nerve impingement, such as nerve palsy or neurapraxia, was very unlikely to have occurred. The medical experts were aware that the volume of anaesthetic administered was up to four times larger (but half the strength) than the amount they would have used, but none of them said it was likely that Ms Gibson would suffer an injury to a nerve which would cause loss of motor function to the leg as a result of the procedure.

⁷ *Lawrence v NTA* [2001] NTSC 37, [14].

[160] Dr Journeaux said that the risk of such an event was low. Dr Kapur said that the risk was non-existent for anatomical reasons. Dr Low said that although nothing is impossible, it was highly unlikely. Even Dr Kluver who maintained that a neurapraxia could have occurred in this case as a result of the diffusion of anaesthetic, agreed that the likelihood of that occurring generally as a result of the procedure was very low. There was, on the other hand, a risk of numbness of the outside of the thigh, which Ms Gibson was warned about before the procedure.

[161] It was not alleged by the plaintiff that what Dr Koshy did was outside the usual bounds of medical practice for that sort of procedure. Although other doctors said that they would have used a lower volume of a higher concentration of anaesthetic, none of the experts said that the complication of nerve paralysis, or partial paralysis, was increased as a result of the amount of anaesthetic used. Even Dr Kluver, who was of the view that the nerve may have been impacted, said that result was unlikely, with the knowledge of the amount of drug Dr Koshy injected. Nor was there evidence of increased risk as a result of the second “trigger point” injection, such that Dr Koshy should have become aware of the need to take additional care from that point.

[162] The plaintiff argued that Dr Goodwin, Director of ASH, acknowledged in his correspondence of 9 September 2020 to Ms Gibson in response to her complaint, that Dr Koshy could have been clearer in relation to his warnings of numbness to the left leg following the procedure. That letter is not an

admission of liability and the plaintiff does not suggest that it is. The plaintiff's case was that her whole leg was numb and that is the risk which the defendant should have warned her against. However, I have not found that the plaintiff's entire leg was numb.

[163] In those circumstances I am not satisfied that there was any falling short in the standard of care by the defendant as a result of Dr Koshy not warning the plaintiff as to the risk that she could suffer a neurapraxia or nerve palsy as a result of the procedure. That risk was not foreseeable.

Failure to advise Ms Gibson to have a support person

[164] The second allegation of breach of duty was that Ms Gibson was not told that she should have a support person with her after the procedure. Dr Koshy did not keep a note as to this, but I accept that it was his usual procedure to mention a support person and that it is more likely than not that he did so on this occasion. However, it is by no means clear on the evidence that it was foreseeable that the plaintiff would be likely to suffer injury if a support person was not present.

[165] The role of a support person was not clear. Apart from providing general "support" in a social sense, it was suggested that a support person may have assisted Ms Gibson to drive home. It may well have been unwise for Ms Gibson to drive after she had had a procedure involving injection of 40ml of local anaesthetic, although there was no evidence about the likely effect upon her driving. More importantly, there is no evidence, including

from Ms Gibson, that she did not drive home safely or that she suffered any injury to her hip or leg as a result of driving, noting that she said that she had an automatic vehicle.

[166] So far as mobilising in the hospital is concerned, it was the responsibility of the defendant to ensure that Ms Gibson mobilised safely. Even if a support person had been present, it is unlikely that they were trained or equipped to avoid falls in a hospital setting, nor could the defendant have relied upon them to do so. Therefore, the failure to advise Ms Gibson to have a support person was ultimately irrelevant to what occurred.

Failure to ensure it was safe for Ms Gibson to get off the bed

[167] The next allegation of breach of duty is that the defendant failed to take steps to ensure that it was safe for the plaintiff to stand following the procedure. This is the most difficult aspect of this claim. It was made more difficult because the plaintiff did not call any evidence about what the defendant should have done to manage the situation so far as systems or policies were concerned. There was, for example, no evidence about usual nursing standards or protocols after this type of procedure, apart from that of Nurse Joseph herself.

[168] I am satisfied that numbness to the lateral aspect of the thigh was a known risk of the procedure, and the defendant should have been, and was, aware of the need to take care to ensure that Ms Gibson could safely mobilise as a result. Nurse Joseph's evidence supports that conclusion. She also referred

to the need to watch patients while mobilising due to the risk of falls arising from other causes, including from dizziness, after a procedure. Nurse Joseph readily acknowledged the need to observe the patient and to report as to a patient's condition, including their gait, as part of the recovery and discharge process.

[169] The Clinical Pathways form, and the matters set out in it which the defendant's staff were required to consider was part of the system which the defendant had in place in the recovery area. A system was necessary. It was clearly foreseeable that a patient could suffer injury, including a fall. It was also foreseeable that a patient who has had anaesthetic injected into their leg in a procedure could fall while recovering. However, the likelihood of the risk occurring in this particular case was not high, taking into account the evidence of Dr Low that it would not be expected that a person who had had this procedure would have difficulty walking afterwards.

[170] The next question is what the defendant should have done in response to the risk. I have summarised above the evidence of Nurse Joseph and Ms Gibson as to what they each say happened in the recovery room when Ms Gibson went to get off the bed and set out my factual findings. The actions taken included that Nurse Joseph observed and spoke to Ms Gibson, assessed her, and conducted observations such as taking her blood pressure. When Ms Gibson attempted to mobilise, Nurse Joseph was nearby such as to assist if there was any apparent difficulty and did assist when Ms Gibson stumbled after getting off the bed.

[171] It is clear that Nurse Joseph's actions did not prevent Ms Gibson from losing her balance and stumbling before sitting back onto the bed. Taking reasonable steps to prevent a risk does not mean a guarantee that the risk will not materialise. Nurse Joseph was unaware, and could not reasonably have been aware, that Ms Gibson was suffering from avascular necrosis of the femoral head such that even a minor stumble and twist to sit down on the bed could have caused an injury. I do not think that the specific risk was reasonably foreseeable. Had the defendant been aware of the additional risk there is no doubt that additional precautions would have been required. But she was not aware and there is no evidence to suggest that she (or Dr Koshy) should have been aware of the underlying condition.

[172] Dr Kluver said the care was inadequate, but he did not explain in detail on why that was the case. His opinion was of course based on the account of Ms Gibson, which I have not accepted in important respects. The evidence of Dr Kapur was that what was done was appropriate and that the clinical standards document referred to by Dr Kluver was of a general nature and did not provide procedures or protocols to be followed. I prefer Dr Kapur's evidence to the evidence of Dr Kluver in this respect because the basis of Dr Kluver's opinion as to protocols or procedures was unclear, and it was substantially based on Ms Gibson's account of Nurse Joseph's actions.

[173] Dr Journeaux also said in his report of 26 May 2021 that the care provided to Ms Gibson was not appropriate because she had an obvious side effect of the local anaesthetic causing a femoral nerve palsy. As I have explained I do

not accept that Ms Gibson had a femoral nerve palsy. Therefore the injury was not obvious and I do not accept Dr Journeaux's opinion in that regard.

[174] In my view, the steps taken by the defendant including providing a handover with instructions, and then requiring observations and assessment of the plaintiff in the recovery room and taking steps to ensure that she could mobilise by the nurse standing nearby were a reasonable response to the risk in view of the nature of the procedure and the known risks, including the risk of numbness to the outside of the left leg. I am not satisfied that the defendant's actions fell below the standard of care required.

Failure to diagnose and treat injury suffered in the fall

[175] The next allegation of breach of duty was that the defendant failed to diagnose and treat the impaction injury to the left femur which occurred in the hospital. The plaintiff alleges that the defendant was required to:

- (i) take steps to examine and assess the plaintiff for any harm that may have occurred as a consequence of the fall;
- (ii) take steps to examine and assess the plaintiff for any harm when she was observed mobilising with difficulty when exiting the hospital; and
- (iii) make immediate arrangements to have the plaintiff assessed by a suitably qualified medical practitioner when the plaintiff reported significant pain and difficulties mobilising.

[176] The first question is whether it was foreseeable that Ms Gibson required further urgent investigations and/or treatment. There are two times when that could potentially have been required, immediately after the incident in the recovery room and later in the corridor before she left the hospital and in the period 15-17 July 2020 when the plaintiff reported significantly increased pain to Ms Kirwan and Dr Koshy.

[177] As to the incidents in the recovery room and the corridor, Ms Gibson refused the offer of a wheelchair from Nurse Joseph, and later Dr Koshy, and refused Nurse Joseph's offer to call Dr Koshy to review her. She told Nurse Joseph that she was "fine" and left the recovery area. She was limping but was ambulant. Although I think that Nurse Joseph probably did have some concerns, I do not think that it was unreasonable for Nurse Joseph to take Ms Gibson at her word at that point. The incident on getting up from the bed appeared to be minor, and Ms Gibson was moving and not complaining of pain. On her own account Ms Gibson was not in pain at that point. There was no evidence that it would have been appropriate for Nurse Joseph to have insisted that Ms Gibson remain for further assessment, or call Dr Koshy notwithstanding Ms Gibson's assurance.

[178] Ms Gibson saw Dr Koshy in the corridor. She told him that she was not in pain. Her perception is that she was hopping, however I have found that that is incorrect, and she was limping. Dr Koshy commented that something did not look right, so it is reasonable to infer that at that point he had a concern. Dr Koshy knew that Ms Gibson was limping before the procedure.

Ms Gibson refused a wheelchair when Dr Koshy offered it to her and told him she was fine. He says that he watched Ms Gibson walk away to reassure himself that she was weight bearing and saw that she was. I do not think that Dr Koshy was required to do anything further at that point. Given that he knew that Ms Gibson walked with a limp before the procedure, and having spoken to and observed Ms Gibson, he had no reason to think that anything was seriously wrong at that time.

[179] When Ms Gibson spoke with Ms Kirwan on 15 July 2020 and with Dr Koshy on 16 July 2020, she said that she was in severe pain. Dr Koshy prescribed a pain killer. Dr Koshy said that he thought that Ms Gibson was possibly experiencing a steroid flare, although he did not tell Ms Gibson that and there was a discussion about a muscle strain. The medical evidence was that a steroid flare is a known risk of this procedure, although Dr Kapur said that it only occurred in 10-15 percent of patients. The evidence was also that a steroid flare usually settles without treatment within a relatively short period of time. I accept that pain associated with a steroid flare was a reasonable hypothesis on 16 July 2020, 48 hours after the procedure. It was at that time still not foreseeable that Ms Gibson has suffered a serious injury as a result of the incident in the recovery room. The plan for Ms Gibson to be reviewed by Dr Savage, who had been coordinating her care, on 21 July 2020 was therefore appropriate.

[180] When Ms Kirwan followed up the next day, 17 July 2020, Ms Gibson told her that she was doing the gentle mobilising and mindfulness exercises that

Ms Kirwan had suggested and they were helpful. Ms Gibson now says that was not true, but Ms Kirwan was entitled to accept the plaintiff's statements at face value. Ms Gibson also told Ms Kirwan that the pain was now six out of ten, sometimes, which was less than she reported in their initial conversation on 15 July 2020. That was probably not surprising, given the pain medication, but even so, Ms Kirwan was entitled to believe that the pain was "moving in the right direction" based upon what Ms Gibson told her. She encouraged Ms Gibson to call back if she had further concerns and said she would book a six week review with Dr Koshy. I do not believe that it was foreseeable to either Dr Koshy or Ms Kirwan that Ms Gibson had suffered a serious injury at that time.

[181] There was no breach of the duty of the defendant to follow up Ms Gibson's case in those circumstances. Doctors Low and Kapur said that it was not inappropriate to refer her back to the care of Dr Savage, the general practitioner who was managing her case and who had referred her to the pain clinic. Dr Kapur said that Dr Koshy should have provided a letter advising Dr Savage what he had done as a matter of best practice but also said that that would not have changed Dr Savage's management in any way, and therefore that is not a significant matter. I agree.

[182] As to the period after 17 July 2020, Ms Gibson was under the care of Dr Savage four days later. She had been told by Ms Kirwin that she could contact the pain service at any time. She did not do so. On Ms Gibson's own evidence, she did not contact the pain clinic further because she wanted

nothing further to do with them. In those circumstances I do not think that it was incumbent upon the defendant to take any further steps after that date.

[183] Therefore, I am not satisfied on the balance of probabilities that the plaintiff has shown that there was any breach of the duty of care owed by it to the plaintiff as pleaded.

Causation

[184] Although I have concluded that the defendant did not breach its duty of care to Ms Gibson, for completeness I will also consider the question of causation. That is, if the defendant had breached its duty of care to Ms Gibson by failing to ensure her safe mobilisation in the recovery room, and/or failing to immediately investigate her limp and/or pain, is it more likely than not that she suffered any loss or damage as a result. While causation must be assessed in light of the expert medical evidence, causation in law does not require scientific certainty, it is assessed on the balance of probabilities.⁸ Causation must be approached in a commonsense way. An inference as to causation may be drawn at law when medical evidence states that an outcome is possible, even though it is not proven to a level which a scientific standard would accept. However, if an outcome is excluded by medical evidence, then it cannot be proven by inference.⁹

⁸ *March v Stramare (E & MH) Pty Ltd* (1991) 171 CLR 506, 509, 522, 530-31; *Chappel v Hart* (1998) 195 CLR 232, [6] – [7]; *Metro North Hospital and Health Service v Pierce* [2018] NSWCA 11, [143].

⁹ *EMI (Australia) Ltd v Bes* [1970] 2 NSW 238, 242.

Although the question remains useful, the limitations of the “but for” test of causation were described by the High Court in *March v Stramare*.¹⁰ One circumstance where the test is not helpful is where there are multiple causes for an injury or loss. A defendant’s breach of duty need not be the sole cause to satisfy the test of causation. In this case, assuming there had been a breach of duty, the question would ask whether “but for” the fall in the recovery room and/or failure to provide immediate assistance the plaintiff have suffered the injury leading to the hip replacement on 1 October 2020. However, I have also found that there was pre-existing avascular necrosis which on Dr Low’s evidence would have meant that the plaintiff required a total hip replacement in any event.

Why did the plaintiff need a total hip replacement on 1 October 2020?

[185] As I have said, in my view it is more likely than not that the fracture to the left femoral head seen on the MRI of 10 September 2020 occurred in the recovery room incident. Causation as to that injury is therefore established. The next question is whether that fracture materially contributed to the need for the total hip replacement which the plaintiff underwent on 1 October 2020.

[186] Dr Low said in his report that he did not believe that the need for the total hip replacement arose because of the twisting injury of 14 July 2020.

¹⁰ (1990-01) 171 CLR 506.

He said that the plaintiff “probably had a twist”¹¹ but that the injury was minor and that it would not have “tipped the scales” in favour of a hip replacement. Dr Low’s opinion was that that injury could have been treated conservatively for 6-12 months. He referred to the decision to operate as “speedily made” and said that he agreed with Dr Journeaux in that respect. However he also said that it was necessary to defer to the treating doctor and his ultimate opinion was that Ms Gibson was in enough pain to justify the total hip replacement and that treatment was appropriate. Dr Low said in his report that the presence of the slight osteochondral fracture in the presence of avascular necrosis would have made the symptoms worse than expected. He went on to say that the total hip replacement became the “only option”.

[187] However, Dr Low’s evidence was that the real cause of Ms Gibson’s symptoms was the avascular necrosis and the fracture was insignificant compared to that cause because it was only a representation of the underlying disease. In cross-examination Dr Low said this about the likely relationship between the avascular necrosis and the fracture:

But what - what the - what a microtrabecular impact injury is, is a manifestation of the underlying problem, which is avascular necrosis. What avascular necrosis does is it takes away the blood supply to the bones. The bone is replaced by new bone - in other words, the femoral head tries to heal itself, and it heals itself by producing new bone. That new bone is soft, therefore, just walking down the street or just twisting - anything at all - can cause a microtrabecular impaction fracture. But you’ve got to look at the underlying problem, which is avascular

11 He also said that Dr Journeaux was “probably correct” that the plaintiff had a twisting injury causing a slight osteochondral fracture.

necrosis. And that's the diagnosis all along. Which could easily present as trochanteric bursar pain, and it's obvious to me this is what the problem is. And Dr Koshy did a local cortisone injection into the greater trochanter, and it didn't take the pain away, and she was worse. It's not due to the fracture; it's due to the fact that the underlying problem is avascular necrosis. I see - I've seen this scenario over and over again for the last (inaudible) years I've been doing this problem.

Doctor, you said in your report that oedema is evidence of an acute injury rather than the chronic injury?---Yes, there's an acute injury because the bone, as I've explained to you in layman's terms, the bone that replaces the dead bone is soft, so soft bone is easily damaged. In other words, the bone supports the cartilage and if the bone is fractured it doesn't support the cartilage, therefore the cartilage is what stops the hip from being painful for break and fragments and degenerates and the hip will become painful and this is why the new doctor was brought to assess the situation and he diagnosed severe pain, avascular necrosis, (inaudible) hip replacement, which is the right solution. Eventually, she had the right solution, which was a hip replacement. It's not due to any fracture that occurred from any incompetence from anybody, it's due to the fact her underlying problem was avascular necrosis, which wasn't diagnosed.

Doctor, one of the differential diagnoses that was provided by Dr Heysen, in his MRI, was - was post traumatic impaction injury in the phases of healing. And now an impaction injury, doctor, isn't a hip dislocation, it's just a head of the femur hitting the (inaudible) - -?--- Yes. As I - the point that I tried to make before, is the fact that the bone is replaced by soft bone and it doesn't take very much force to fracture the bone - which is probably what's happened here, but in a normal situation a little stumble is not going to cause an impact fracture - in a normal situation. It's because there's an abnormal situation here and the bone is soft, that is the reason why a very minor fall will fracture the bone. And that's what's happened.¹²

[188] Dr Low's evidence is that from a medical point of view the cause of the problem was avascular necrosis not the injury. On his opinion, that was why the plaintiff was in pain prior to the procedure, and why she suffered pain after the procedure. However, Dr Low did not disagree with the proposition that the injury would have caused an increase in symptoms in Ms Gibson's

left hip. Nor did he ultimately disagree that with the level of pain she was suffering, and the presence of avascular necrosis, it was inappropriate to perform a total hip replacement.

[189] Dr Journeaux said that the requirement for the total hip replacement based upon the findings of the MRI was “potentially questionable” and that a period of conservative management, possibly including steroid injections to the hip, should have been tried first. This opinion is in the context that Dr Journeaux did not consider it likely that Ms Gibson had avascular necrosis of the left femoral head.

[190] Dr Kluver said that the requirement for the total hip replacement was outside his field of expertise.

[191] Dr Kapur said in his report of 28 January 2025 that avascular necrosis was “unlikely” and that he generally agreed with Dr Journeaux’s opinion in that regard.

[192] For the reasons I have explained above, I prefer the opinion of Dr Low that avascular necrosis was present. In view of their opinions, none of the other doctors provided useful evidence as to whether the need for the total hip replacement was related to the osteochondral fracture of the femoral head or avascular necrosis, or both.

[193] It is possible that, as Dr Low seems to be saying, Ms Gibson would have required the hip replacement due to increase in symptoms whether she had

suffered the minor hip fracture or not. On the other hand, he agreed that Ms Gibson would have experienced increased symptoms associated with the fracture. In addition, Dr Low agreed that her symptoms were such that as at 1 October 2020 the hip replacement was the “only option”.

[194] As a matter of legal, as opposed to medical or scientific causation, I think that it is more likely than not that in this scenario that there were two material contributions to the pain and consequent disability suffered by the plaintiff which led to the need for the hip replacement on 1 October 2020; the underlying avascular necrosis and the subchondral fracture to the femoral head which she suffered on 14 July 2020. The fracture therefore represented an aggravation or exacerbation of the plaintiff’s underlying condition.

[195] That being the case, and noting the views of Drs Journeaux and Kapur, there must have been a chance that the plaintiff would not have needed a hip replacement on 1 October 2020, had she not suffered the fracture. There was no direct evidence about the likelihood that Ms Gibson would have required a hip replacement in the future due to avascular necrosis had she not suffered the fracture. Although that could be inferred from Dr Low’s evidence I am reluctant to infer that a hip replacement was inevitable in view of Dr Low’s earlier opinion that the hip could have been managed conservatively, which is consistent with the views of Dr Journeaux and Dr Kapur. Therefore, I am not prepared to find that the plaintiff would have

required a hip replacement at some time between 1 October 2020 and the present whether she had suffered the fracture or not.

What was the effect of delay in treatment?

[196] The plaintiff also claims that because of the delay in treatment, that is the failure by the defendant to identify and treat the weakness (“complication”) after the procedure that she suffered injury. As I explained above, the relevant period in relation to any failure to identify or treat the condition was 14 to 17 July 2020. The following comments are therefore on the basis that the defendant should have identified a need for further investigations and/or treatment in that period, which I have not found.

[197] There is no evidence to support the plaintiff’s contentions that, but for the delay there would have been no need for the hip replacement. None of the doctors who gave evidence in the proceeding suggested that the delay was significant. Dr Low said that it was appropriate to investigate the reasons for the problem when the trochanteric bursa injection did not provide relief. He did not suggest that any delay was likely to further worsen the situation. This is consistent with his view, and the opinions of Dr Journeaux and Dr Kapur that conservative treatment could have been tried for a longer period.

[198] It was suggested in a letter from Dr Shahrokhi to the defendant that the delay may have played a role in the worsening of the condition. However, this was put as a possibility not a definite position and in any event

Dr Shahrokhi did not give evidence in the proceeding and it is not possible to draw any conclusions based upon that letter.

[199] Dr Kluver said that a timelier face to face clinical review should have been arranged but did not say what the outcome of a failure to do that was likely to have been so far as the plaintiff's injury was concerned. He did say that in the period from 15 July 2020 to 1 October 2020 Ms Gibson suffered significant pain and was mostly bedridden and that period would have been less likely had treatment been initiated earlier. He said that this *may* have contributed to her sensitisation to pain, deconditioning and psychological distress which in turn may have negatively impacted her prognosis. However this statement, with the exception of the psychological matters dealt with below, is too vague to be of assistance.

[200] Therefore, even if I had found that there should have been more timely attention to Ms Gibson's symptoms after the procedure I would not have found any causal connection between that failure and her injury.

When did the exacerbation cease?

[201] So far as the hip replacement is concerned, for the reasons set out above the subchondral fracture continues to be a material cause.

[202] However, I am not satisfied that Ms Gibson's present ongoing pain and disability is causally connected to the hip injury of 14 July 2020.

Dr Shahrokhi's reports to Dr Savage indicate that Ms Gibson progressed

well after the hip replacement and was walking unaided with significantly improved pain. On 16 February 2021 Dr Shahrokhi reported to Dr Savage that Ms Gibson had suffered a twisting injury to her hip at home which increased pain in the area. Dr Shahrokhi expected that her symptoms would settle with rest, physiotherapy, use of a stick and analgesia. An ultrasound on 22 February 2021 did not show any issues with the hip replacement. A letter from Dr Savage to Ms Gibson's new general practitioner noted that Ms Gibson had relief following the hip replacement but exacerbated her hip and lower back pain while preparing for her move to Brisbane. On 22 June 2021, eight months after the hip replacement, Dr Shahrokhi reported to Dr Savage that Ms Gibson's pain and discomfort resulting from her (subsequent) twisting injury had "settled down with physiotherapy". He said that an MRI had demonstrated "some evidence" of trochanteric bursitis. He said that she was progressing reasonably well with some ongoing issues with her lower back and hip and required some maintenance therapy with physiotherapy.

[203] Dr Journeaux noted in his report of 26 May 2021 that the hip replacement was successful and "resolved her symptoms" but another injury to the hip had occurred, three months before he reviewed her, when Ms Gibson was "bending down and getting up and twisting in some way". Dr Journeaux noted that this pain was "chronic outer hip pain" and that she was to have an MRI investigation at a hospital in Queensland to investigate it. Dr Journeaux did not specifically comment on this further except to say that she was not

stable due to ongoing pain related to “recalcitrant trochanteric bursitis” for which she requires further treatment. He did not explain whether or in what way how that was related to the original injury or the hip replacement.

[204] Dr Kluver assessed the plaintiff to have a full range of motion of the hip but noted that she walked with a limp and that she had lost enjoyment of activities such as bushwalking. He assessed her as having a lower extremity impairment of 25 percent and a whole person impairment of 10 percent.¹³

[205] Ms Gibson has reported ongoing pain and loss of physical function since the hip replacement. In his report of 6 November 2024 Dr Kapur said that such a poor outcome from a hip replacement was unusual. Dr Kapur did not think that an uncomplicated hip replacement would leave a person unstable and at risk of falls. He said that hip replacement is generally a very successful operation with good, usually complete, reduction in pain and major improvement in function. In the absence of any specific complication, such as dislocation or infection, Dr Kapur thought that the ongoing problems Ms Gibson reported were of “uncertain aetiology”.

[206] Added to the very complicated picture are the ongoing problems which Ms Gibson has had with her shoulder, neck and lower back pain. There is no doubt that back pain has been a problem for her for some time. Ms Gibson said in her affidavit that issues with her back were one of the reasons she was attending the ASH pain clinic in 2020. In 2023 she underwent a spinal

¹³ In accordance with the *American Medical Association Guides to the Assessment of Permanent Impairment* (6th edition), in accordance with s 26 of the *Personal Injuries (Liabilities and Damages) Act 2003* (NT).

fusion in Queensland. Ms Gibson said that was to “buy her some time”. In 2023 she also had a right shoulder reconstruction. Ms Gibson said in her evidence that her shoulder and low back pain was related to her hip problems, but there is no medical evidence to that effect.

[207] A period of rehabilitation after the hip replacement would have been required. Based upon Dr Shahrokhi’s letter it seems that Ms Gibson was still requiring physiotherapy eight months after the operation and may have done so for a period after that. There is no evidence as to exactly what was required or for how long after Dr Shahrokhi’s last report. In view of the evidence of Dr Kapur and the reports of the treating doctors from the time, I am not satisfied that the plaintiff’s ongoing pain is related to the hip replacement. It is much more likely to be related to Ms Gibson’s many other issues, notably her back problems. However, doing the best I can on the evidence, had there been a breach of duty of care involved in the femoral head fracture, I would have found that a period of 12 months rehabilitation after the hip replacement would have been reasonable.

Mental injury

[208] I have found that the defendant did not breach its duty of care to Ms Gibson in any of the ways pleaded. It follows that Ms Gibson’s claim for consequential mental injury cannot succeed. However, had I found breach, I would have found that Ms Gibson was more likely than not to have suffered

a short term exacerbation of her pre-existing mental health symptoms as a result of the injury to her hip and its sequelae.

[209] Ms Gibson had a significant pre-existing psychiatric condition, Bipolar Disorder Type 1. That condition was longstanding and serious. However, the contemporaneous treating records indicate that, before the incident of 14 July 2020, her mental health was relatively stable, albeit with chronic vulnerability and regular fluctuations associated with chronic pain and life stressors.

[210] After the hip injury, Dr Blomeley's records document a deterioration in Ms Gibson's psychiatric symptoms. On 5 August 2020, he recorded that poorly controlled hip pain was contributing to her symptoms and increased the frequency of psychiatric review because of concern about increased suicidal thinking. Although he did not consider that she was then suffering a major mood episode, the record demonstrates an increase in psychiatric risk and need for monitoring after the hip injury. On 17 September 2020, following the diagnosis of avascular necrosis and advice that hip replacement was required, Dr Blomeley recorded acute episodic anxiety and distress. On 8 October 2020, after the hip replacement, he described Ms Gibson as overwhelmed, acutely stressed and emotionally dysregulated, and altered her medication to manage those symptoms.

[211] There was some improvement by mid-October and early November 2020.

Dr Blomeley recorded on 14 October 2020 that Ms Gibson was "almost at

her baseline mental state”, but that was after additional medication and increased psychiatric support. On 3 November 2020, he recorded that she remained largely stable and had returned to teaching music, but she continued to report trauma-like symptoms associated with ASH. Later records continued to link her psychiatric symptoms to pain, reduced function, frustration, litigation stress and perceived lack of support, arising from the hip injury and its consequences. However, it seems that from late 2020 or early 2021 Ms Gibson’s psychiatric reviews returned to their monthly schedule.

[212] Dr Elzahaby, who took over as Ms Gibson’s treating psychiatrist on the retirement of Dr Blomeley in about February 2022 also recorded symptoms consistent with ongoing psychiatric vulnerability in the context of chronic pain and psychosocial stressors. Dr Elzahaby recorded mood swings and fleeting suicidal ideation, although without plan, and assessed Ms Gibson as at low risk of self-harm but at moderate risk of relapse of bipolar disorder.

[213] Dr O’Hare, consultant psychiatrist, reviewed Ms Gibson for this proceeding. She produced a report and gave oral evidence. Dr O’Hare considered that the July 2020 hip injury, its orthopaedic consequences, the need for hip replacement and ongoing pain caused an aggravation of Ms Gibson’s pre-existing Bipolar Disorder Type 1 and complex Post-Traumatic Stress Disorder, together with a superimposed adjustment disorder with mixed anxiety and depressed mood. She explained that the injury and its sequelae caused deterioration in mood, anxiety, sleep and general functioning,

required increased olanzapine and more frequent psychiatric review, and contributed to loss of employment, relocation and grief associated with functional decline. She also explained that Ms Gibson's pre-existing psychiatric conditions reduced her resilience and tolerance of pain and predisposed her to low mood, anxiety, suicidality, insomnia and feelings of hopelessness and worthlessness when confronted with the hip injury, pain and perceived failures in care.

[214] In cross-examination, Dr O'Hare accepted that parts of her report depended on Ms Gibson's self-report and on the assumptions contained in the letter of instruction. Those matters indicate a need for caution in accepting the full breadth of Dr O'Hare's opinion, particularly insofar as it concerned Ms Gibson's functional capacity and activities of daily living. Dr O'Hare also accepted in cross-examination that if Ms Gibson had pre-existing difficulties with activities such as gardening, domestic tasks or other activities of daily living, that would qualify any opinion that those impairments were caused by the post-incident psychiatric exacerbation. She also accepted that she had not seen some potentially relevant pre-incident material, including pre-incident reports or assessments by Dr Blomeley concerning Ms Gibson's functional impairment, and that such material might have been relevant to her opinion.

[215] In cross-examination, Dr O'Hare maintained an important distinction between Ms Gibson's previous pain conditions and the hip-related pain after July 2020. She accepted that Ms Gibson had other pain, including cervical

pain associated with violin playing, but described the hip pain as a new pain source resulting from the July 2020 injury. That distinction is consistent with Dr Blomeley's records, which specifically identify poorly controlled hip pain, the diagnosis of avascular necrosis, impending hip replacement, and later hip and back pain as factors associated with increased distress, suicidal thinking and anxiety after 14 July 2020.

[216] The central question is not whether Ms Gibson had pre-existing psychiatric illness, pre-existing pain, or some pre-existing functional limitation. She clearly did. Nor is the question whether every aspect of her later psychiatric and functional presentation was caused by the hip injury. It was not. The question is whether the hip injury and its consequences materially exacerbated her pre-existing psychiatric symptoms. On that issue, Dr O'Hare's opinion that there was an exacerbation of symptoms is to an extent supported by the contemporaneous reports of the treating doctors.

[217] Dr Hundertmark, consultant psychiatrist, also provided a report and gave evidence in this proceeding. Dr Hundertmark said that Ms Gibson had a severe, lifelong bipolar affective disorder, chronic suicidal thinking and a chronic pain state before 14 July 2020. He opined that bipolar disorder is constitutionally based, characterised by relapses and remissions, and requires ongoing treatment. Dr Hundertmark noted that Ms Gibson's chronic pain state had existed for many years before the incident. On that basis, he concluded that it was difficult to demonstrate any exacerbation or aggravation after the incident because, both before and after 14 July 2020,

Ms Gibson suffered from bipolar disorder, suicidal thinking and chronic pain. He further considered that it was not possible to diagnose an adjustment disorder against the background of severe bipolar disorder and chronic pain due to the significant disparity in severity of the two conditions, and that there was no manifestly worse psychiatric outcome attributable to the index incident.

[218] In cross-examination, Dr Hundertmark did not accept that Dr Blomeley's references to remission or stable mood meant that Ms Gibson was psychiatrically well. He pointed to her continuing treatment, medication, opioid use, chronic pain, prior depressive symptoms and psychosocial stressors. I accept that Ms Gibson was not free of psychiatric illness before 14 July 2020. However, the contemporaneous records of Dr Blomeley still show that, after the incident, Ms Gibson experienced increased, although episodic, suicidal thinking, distress, pain-related sleep disturbance, anger, and frustration. As a result, her psychiatric reviews were increased from monthly to fortnightly for a period of approximately six months.

[219] Dr Hundertmark also accepted that the symptoms recorded by Dr Blomeley in October 2020 — hypervigilance, agitation, anxiety, distress and vivid recollections associated with ASH — were new symptoms, although he did not accept that they were properly characterised as symptoms of Post Traumatic Stress Disorder (PTSD). I accept Dr Hundertmark's caution about characterising those symptoms as PTSD. The issue here, however, is not whether Ms Gibson developed PTSD. The significance of the evidence is

that new anxiety and trauma-like symptoms were recorded by her treating psychiatrist after the incident of 14 July 2020 and in connection with it.

[220] I also take into account Dr Hundertmark's criticism of Dr O'Hare's diagnosis of adjustment disorder. He said that the Diagnostic and Statistical Manual of Mental Disorders (DSM) criterion was that an adjustment disorder should not be diagnosed where the disturbance is merely an exacerbation of a pre-existing mental disorder. That evidence provides a reason to approach Dr O'Hare's separate diagnosis of adjustment disorder with caution. However, it does not undermine the more limited conclusion that Ms Gibson suffered a short-term exacerbation of pre-existing psychiatric symptoms as documented by Dr Blomeley.

[221] Dr Hundertmark's evidence that Ms Gibson's presentation was influenced by her perception of events is also important. The psychiatric consequence should not be understood as arising from physical pain alone. It arose from the combination of increased hip pain, impaired function, uncertainty about the cause of that pain, the diagnosis of avascular necrosis, the need for surgery, distress associated with seeking medical assistance, and Ms Gibson's perception that she had been treated poorly because of her bipolar disorder. Those matters are all reflected, to varying degrees, in the treating records.

[222] I do not accept Dr Hundertmark's opinion that there was no relevant worsening or psychiatric symptoms. In my view, that opinion gives

insufficient weight to the contemporaneous records of the treating psychiatrist, Dr Blomeley, which document a clear temporal association between the hip injury, uncontrolled hip pain, diagnosis of avascular necrosis, need for hip replacement and increased symptoms of suicidal thinking, anxiety, distress and emotional dysregulation.

[223] I therefore prefer Dr O'Hare's opinion to that of Dr Hundertmark insofar as Dr O'Hare identifies a clinically significant deterioration in Ms Gibson's psychiatric symptoms after the hip injury, because that opinion better accords with the contemporaneous records. However, having regard to Dr Hundertmark's opinion as to the relationship between an Adjustment Disorder and the pre-existing conditions, I find that Ms Gibson suffered an exacerbation of her symptoms, it is unlikely that she suffered a separate adjustment disorder. On the balance of probabilities, taking into account the evidence of Dr O'Hare and Dr Hundertmark and the contemporaneous records of Dr Blomeley, the hip injury and its sequelae caused an exacerbation of anxiety, distress, suicidal thinking, low mood, sleep disturbance and trauma-like symptoms.

[224] That exacerbation was real, but it did not account for the whole of Ms Gibson's psychiatric presentation. the exacerbation occurred against the background of Bipolar Disorder Type 1 and complex PTSD together with chronic pain, functional limitations and psychosocial stressors which were all present before July 2020. The extent of the exacerbation should therefore be assessed cautiously and should not be treated as accounting for all of

Ms Gibson's later psychiatric or functional presentation. In my view the contemporaneous records of Dr Blomeley show that exacerbation of symptoms likely subsided back to baseline level after about six months. Based on that evidence and the opinion of Dr Hundertmark, I reject Dr O'Hare's opinion that an adjustment disorder (if it occurred at all) persisted after that time.

[225] I therefore find that Ms Gibson was more likely than not to have suffered an exacerbation of her pre-existing mental health symptoms as a result of the injury to her hip for about six months from 14 July 2020. However, while the exacerbation of Ms Gibson's symptoms required the frequency of her psychiatric reviews to be increased for about six months, I accept the evidence of Dr Handertmark that it did not fundamentally change her capacity for employment or her ability to engage in activities of daily living on an ongoing basis.

Quantum

[226] The plaintiff submitted a detailed case in relation to past and future economic loss based upon planned expansion of her music teaching and therapy business. Those claims depended upon a lot of contingencies and assumptions as to future capacity and success of the business generally. In view of my conclusions on liability it is not necessary to determine those claims in detail. However, in case it should be relevant in future I set out the following findings relevant to quantum.

[227] In April 2021 Ms Gibson relocated to Queensland and, since August 2021, she and her former husband have shared a home there where they care for their disabled adult son.

[228] Prior to 14 July 2020 Ms Gibson was self-employed as a violin teacher and was planning to build a business as a music teacher and therapist in Alice Springs. She had built a studio in her back yard for that purpose. Ms Gibson says that she was unable to continue with this work after 14 July 2020 and by the time she moved to Queensland her business was significantly depleted. Attempts to return to work in Queensland have been largely unsuccessful. Ms Gibson also says that she has a reduced ability to perform ordinary household tasks and has a reduced ability to engage in activities of daily living such as exercise and driving long distances.

[229] As to the plaintiff's ability to teach violin, very late in the proceedings the defendant sought to introduce evidence about some advertising for music students which Ms Gibson had done on Facebook. The introduction of that evidence was opposed by the plaintiff and I decline to accept it. The plaintiff was not cross examined on the material. Although she was cross-examined on the topic generally, there remains in my view a risk of unfairness. Further, the material could not take the evidence forward in any significant way and is therefore of little weight such that the risk of unfairness is much greater than its probative value.

[230] If I had found in favour of Ms Gibson I would have allowed the following amounts by way of damages:

- (a) Whole person impairment assessed by Dr Kluver at 10 percent of the statutory lump sum pursuant to the *Personal Injuries (Liabilities and Damages) Act 2003* (NT). The defendant argued that the assessment should be reduced on the basis of the pre-existing condition as in *Kent v Darwin City Council*.¹⁴ Prior to his accident, the plaintiff in *Kent* had significant pre-existing problems with his hip assessed as a 25 percent impairment of the lower extremity. In this case, there was no previous assessment. There were as I have explained above two material causes leading to the hip replacement. Therefore I would have allowed this amount in the current sum of \$30,396.¹⁵
- (b) As to past loss of earnings the plaintiff concedes that the long history of problems associated with her neck and her psychiatric problems have affected her ability to work. She points to the fact that she is a very resilient person and that she had returned to work in various capacities after previous operations on her neck, particularly in 2018. The plaintiff was capable of working part-time in 2019 and she earned \$14,676.95 in the six months from July to December 2019. She earned \$13,317.60 in the period from January to July 2020. During this time

14 [2018] NTSC 3, [97] – [101].

15 20,400 monetary units in accordance with the table in s 27(3)(c) of the *Personal Injuries (Liabilities and Damages) Act 2003*. The value of a monetary unit as defined in the *Monetary Units Act 2018* (NT) at the time of this decision is \$1.49.

she was teaching strings and working 7.6 hours per week at a school. Her weekly earnings were \$499.90 per week. Between July 2020 and November 2022, the plaintiff earned about \$189.89 per week. During this time the plaintiff voluntarily relocated to Queensland. Also, the plaintiff has since 2020 suffered from other unrelated problems, including with her neck and back which have prevented her from working. As a result, as the plaintiff's counsel concedes, her earnings are difficult to determine. I do not think that the plaintiff's income would have been considerably greater after mid 2020 had she not suffered the injury, although I would accept that she suffered some loss of earning capacity. In my view an allowance of about \$15,600 for past economic loss, being \$300 per week for 12 months, would adequately compensate her for past loss.

- (c) The plaintiff claims past medical and out of pocket expenses at \$58,665.80 in accordance with the schedule she filed in the proceeding. Of the matters claimed in that schedule I would allow in full the hospital expenses for the hip surgery in October 2020 in the sum of \$21,514.37 on the basis of the exacerbation. I would not allow the amounts claimed for attendance at the Axxon Pain Medicine Centre in 2022. I am not satisfied that those claims are related to this incident.
- (d) As explained above, I would have allowed a longer period of rehabilitation than might otherwise have been the case for the physical rehabilitation (Dr Shahrokhi's letters suggest he originally thought

six months) due to Ms Gibson's underlying problems which, in my view, caused a more prolonged recovery period than would have been the case for a person without her co-morbidities. I do not however accept that there is an ongoing need for rehabilitation or medical expenses relating to the left hip. On that basis I would allow the claims for medical expenses for general practitioner and Dr Shahrokhi appointments relating to the hip from July 2020 until the end of June 2021. Based on the plaintiff's schedule of past medical expenses I calculate an amount of \$3,344.35.

- (e) As to costs for attendance upon her psychiatrist. It is clear that Ms Gibson required the services of a psychiatrist on a monthly basis before the injury. She appears to have returned to a monthly or bi-monthly schedule by the end of 2020 a period of about six months. I would therefore allow half of the amount claimed which would be \$1,083.
- (f) As to radiology costs, I would not allow any amount after the rehabilitation period of the hip referred to above. On my calculations that makes the amount allowed for those amounts \$2,138. I would allow the amount of medication claimed at \$31.98. I would allow the amount for aids in September and October 2020 in the sum of \$3,897.
- (g) I would allow the claim for costs associated with the travel to Adelaide for the hip surgery in October 2020 in the sum of \$8,991.15.

[231] I would not have allowed any amount for home modifications or other future aids set out in Mr Mangipudi's report because none of those matters are, in my view, related to ongoing exacerbation of her hip pain in 2020.

[232] I would not have allowed any amount for future loss of earnings. In my view Ms Gibson was significantly incapacitated for work both before and after the procedure, due to unrelated issues with her neck, back and underlying psychiatric condition. She was not earning any significant income from either employment or self-employment at the time. Although she may have had high hopes for her music studio, in my view the evidence shows that it was unrealistic to think that that would have developed into a thriving business.

[233] Dr Savage and Dr Bromeley had both independently assessed Ms Gibson's capacity for work as very low prior to 14 July 2020. On 4 March 2020 Dr Savage wrote to the National Disability Insurance Agency (NDIA). This was her second letter in support of Ms Gibson's application for support. In this letter Dr Savage said that the impact of Ms Gibson's conditions affected her activities of daily living and also impacted her socially and financially. She said that Ms Gibson had difficulty washing, cleaning and lifting shopping bags and that pain management medications also affected her ability to function. Dr Savage said that Ms Gibson was unable to work full time and that her social isolation was exacerbating her depression.

[234] In his letter to the NDIA of 14 April 2020 Dr Blomeley said that it was his professional opinion that Ms Gibson had a permanent psychiatric disability which substantially reduced her ability to function across multiple domains including communication, social interaction, learning, mobility, self-care and self-management. He also said that the disability affected her capacity for economic participation. His opinion was that Ms Gibson was significantly socially disabled by her condition with difficulties doing daily jobs, making decisions and handling problems.

[235] Ms Gibson's evidence was that both Dr Savage and Dr Blomeley were advocating for her and in that capacity exaggerating her disability when they wrote letters assessing her as having little or no capacity for work because they wanted to support her claim for funding from the National Disability Insurance Scheme. She said that she had remonstrated with both of them at the time about the content of these letters. While I accept that it is part of the role of a treating doctor to advocate for their patient where that is appropriate, I do not consider that either Dr Savage or Dr Blomeley would have lied to the NDIA. In my view, contrary to the plaintiff's evidence, the assessments of Dr Savage and Dr Blomeley are consistent with their other letters and notes during the relevant period. Ms Gibson may well not have agreed with the doctors' opinions, and may well have expressed this at the time, however I accept that they were telling the truth in accordance with their respective opinions, and that they were in a good position as treating doctors to make an objective assessment of Ms Gibson's abilities.

[236] I also take into account that those opinions were not altogether new assessments. In late 2018 Ms Gibson's capacity for employment was independently assessed by Centrelink. The assessment considered Ms Gibson's psychiatric condition and her physical health limitations which at that point were associated with the degenerative condition in her upper spine. The assessment noted that further surgery in 2018 was expected to improve the outlook, however there was no suggestion that the condition was curable.

[237] I accept Ms Gibson's evidence that the thoracic outlet syndrome surgery did give her some relief. I also accept that her capacity for work improved in 2019 and going into 2020 a result, as is shown in her earnings in that period. However, Ms Gibson had ongoing problems with her neck and shoulders. The 2018 Centrelink assessment found that she had a baseline work capacity of zero to seven hours per week which was expected to increase to eight to fourteen hours per week within two years. Although Ms Gibson says the assessment was inaccurate because her capacity was significantly increased after the operations, with hindsight it appears to have been fairly accurate because Ms Gibson was working around the higher expected level, on average, in the first part of 2020, although her hours fluctuated from week to week.

[238] In my view, the doctors' opinions, and the Centrelink job capacity assessment, are borne out by what actually occurred so far as Ms Gibson's attempts to work and limited earnings were concerned before 14 July 2020.

To some extent the assessment of the occupational therapist Mr Mangipudi prepared for this proceeding, is also consistent with what both Dr Bromeley and Dr Savage said although his report is of little assistance overall as he does not separate the matters relating to the hip replacement with other unrelated issues relating to Ms Gibson's neck and lower back which also cause significant functional impairment. I accept that Ms Gibson wanted to work more and may have felt that she could, however the evidence shows that she did not have the capacity for more than limited part-time work at any point. In view of her age, her significant comorbidity, and that any exacerbation resulting from the injury and total hip replacement would in my view have ceased a maximum of 12 months after the event, I am of the view that Ms Gibson is not entitled to any amount for future loss of earning capacity or future medical or rehabilitation costs.

[239] Therefore, the total amount I would have assessed for quantum, had the plaintiff established that the defendant was negligent, was:

Non pecuniary loss	\$30,396
Past loss of earnings	\$15,600
Past medical and associated costs	\$40,999.85
TOTAL:	\$86,995.85

Interest would have been added to the amounts for past losses in accordance with s 30 of the *Personal Injuries (Liabilities and Damages) Act 2003*.

Orders

[240] The claim is dismissed.

[241] In the usual course, costs on a standard basis to be taxed in default of agreement, should be awarded to the defendant. If either party wishes to seek a different order they should apply within 14 days.
