IN THE GRAND COURT OF THE CAYMAN ISLANDS

CIVIL DIVISION

CAUSE NO. GD164 OF 2015

BETWEEN: ANDREA ALESEA CALDERON **PLAINTIFF**

AND: DR. VIR SENNIK **1st DEFENDANT**

AND: CAYMAN ORTHOPAEDIC GROUP LTD **2nd DEFENDANT**

WRIT OF SUMMONS

TO: **Dr. Vir Sennik**
c/o Mourant Ozannes, 94 Solaris Avenue, Camana Bay, PO Box 1348, Grand Cayman KY1-1108, Cayman Islands

Cayman Orthopaedic Group Ltd
(1) Unit 1, Smith Road Plaza, Smith Road, George Town, Cayman Islands
(2) Rurik Trust Company (International) Limited, 2nd Flr, Britcay House, 236 Eastern Avenue, PO Box 31496, Grand Cayman, Cayman Islands

THIS WRIT OF SUMMONS has been issued against you by the above-named Plaintiff in respect of the claim set out on the next page.

Within 14 days after the service of this Writ on you, counting the day of service, you must either satisfy the claim or return to the Court Office, P.O. Box 495 Grand Cayman KY1-1106, Cayman Islands, the accompanying Acknowledgment of Service stating therein whether you intend to contest these proceedings.

If you fail to satisfy the claim or to return the Acknowledgment within the time stated, or if you return the Acknowledgment without stating therein an intention to contest the proceedings, the Plaintiff may proceed with the action and judgment may be entered against you forthwith without further notice.

Issued this 25th day of September 2015

NOTE – This Writ may not be served later than 4 calendar months [*or, if leave is required to effect service out of the jurisdiction, 6 months]* beginning with the date of issue unless renewed by order of the Court.

IMPORTANT

Directions for Acknowledgement of Service are given with the accompanying form.

STATEMENT OF CLAIM

1. The Plaintiff is a Caymanian citizen born 22 April 1949. At all material times the Plaintiff was in the care of the first Defendant and second Defendant.

2. At all material times the first Defendant ("**Dr Sennik**") was a qualified medical practitioner employed by or acting as an agent of the second Defendant.

3. At all material times the second Defendant ("**COG**") was a non-resident Cayman Islands company operating as a specialist orthopaedic practice in the Cayman Islands.

4. On 17 September 2012 the Plaintiff was diagnosed with medial compartment osteoarthritis in the right knee. The Plaintiff was referred to COG for a Unicompartmental Arthroplasty ("**UKA**") on the right knee. COG assigned Dr Sennik to treat the Plaintiff.

5. On 27 September 2012 the Plaintiff underwent surgery (the "**Surgery**") performed by Dr Sennik which she believed to be for a UKA. However, and without further consulting the Plaintiff, Dr Sennik performed a total knee arthroplasty ("**TKR**") on the Plaintiff.

6. The Plaintiff was discharged from hospital on 2 October 2012 having been told that the Surgery and immediate post-recovery were satisfactory.

7. Following the Surgery the Plaintiff became concerned about her ability to move and flex her knee. During the course of an outpatient visit on 19 November 2012, although the prosthesis was found to be in a good position, x-rays revealed that there was a "wedge" of bone cement which had been used by Dr Sennik in the Surgery obstructing flexion.

8. On 21 November 2012 COG recommended arthroscopic exploration overseas to remove the remaining wedge of cement.

9. As a result, the Plaintiff underwent arthroscopic exploration and excision on 28 December 2012 in Jamaica (the "**Jamaican Surgery**") following which it was confirmed

that the wedge of cement had been impinging the joint and thereby affecting the Plaintiff's ability to move her knee and recover from the Surgery.

10. After the Jamaican Surgery the Plaintiff continued to experience pain and a slower than expected recovery. As a consequence in July 2013 the Plaintiff was referred to Dr Matthias Herzig at Chrissie Tomlinson Memorial Hospital. He diagnosed the Plaintiff with loosening and subsidence of the tibial component of the right knee.

11. On 13 August 2013 the Plaintiff underwent revision surgery for: a) the irritated but healed scar over the posterior-medial aspect of her right knee in addition to suspicions of a low grade infection; and b) a right knee arthroscopy (the "**August 2013 Surgery**").

12. On 19 October 2013, a further revision surgery was conducted in which the tibial component of the TKR was replaced with a smaller, stemmed tray (the "**Revision Surgery**"). Surgical notes state that the tibial tray was "completely loose." In his post-surgical report of 5 February 2014 Dr Herzig stated that the new prosthesis was intact; there was no loosening but there was some soft tissue swelling at the knee joint.

13. The Plaintiff started to experience a recurrence of painful symptoms in her right leg below the knee from December 2014 with radiographic signs of translucency and signs of increasing migration of the tibial implant component on the subsequent radiographic examinations of her right knee. She is now facing the prospect of a further revision surgery for the right knee.

14. The Plaintiff's subsequent surgical and hospital treatment: namely the Jamaican Surgery, the August Surgery and the Revision Surgery and the pain and suffering she underwent in relation thereto were caused by the negligence of the Defendants, their employees or agents prior to and in the course of the Surgery and subsequent treatment in the following ways.

PARTICULARS OF NEGLIGENCE

(a) The first Defendant failed to properly inform the Plaintiff that she might require a TKR and obtain her consent;

(b) The first Defendant failed to generate the necessary pre-operative radiographic assessment and peri- and postoperative clinical documentation with respect to:

(1) The procedure by which consent for the TKR was obtained,
(2) The patient's preoperative medical history,
(3) Why surgery was performed or the rationale behind the decision to perform a TKR rather than a UKA,
(4) How the tibial tray was implanted or the surgical technique deployed to do so,
(5) The methods used to remove bone cement and the period of time after which the joint was moved.

(c) in conducting the Surgery the first Defendant failed to:

(1) Take into account the particular characteristics of the Plaintiff,
(2) Ensure that the TKR was properly positioned or fitted,
(3) Properly or adequately irrigate,
(4) Properly or adequately apply bone cement.

(d) The first Defendant failed to properly or adequately examine the Plaintiff post-operatively and detect excess bone cement within her right knee;

(e) The first Defendant failed to ensure that the Plaintiff was properly rehabilitated by failing to recognise the cause of her decreased range of movement following surgery;

(f) The second Defendant failed to properly or adequately supervise the first Defendant in his treatment of the Plaintiff and failed to ensure that a sufficiently experienced and expert surgeon was available to treat the Plaintiff; and

(g) Both the first Defendant and second Defendant failed to treat the Plaintiff adequately or at all.

15. By reason of the Defendants' aforesaid negligence, the Plaintiff suffered personal injury, loss, damage and expense.

PARTICULARS OF INJURY

The Plaintiff suffered the following injuries as a result of the Surgery:

(a) The presence of a loose bone cement fragment which caused decreased range of movement and resulted in the requirement for the Jamaican Surgery;

(b) Cellulitis caused by the Jamaican Surgery which required the August 2013 Surgery procedure to resolve;

(c) Mechanical loosening of the replacement parts which resulted in the Revision Surgery to replace those same parts; and

(d) Pain and suffering related to the above injuries and surgeries.

Medical reports concerning the personal injuries described above are attached.

PARTICULARS OF MEDICAL REPORTS

Report of Dr Matthias Herzig, MD, PhD, dated 31 August 2015.

PARTICULARS OF SPECIAL DAMAGES

See attached schedule of past and future expenses and losses.

16. Further, the Plaintiff claims interest upon such damages as may be awarded under the provisions of section 34 of the Judicature Law (2013 Revision).

AND THE PLAINTIFF CLAIMS:

(a) General Damages;
(b) Special Damages;
(c) Pre-judgment interest in accordance with section 34 of the Judicature Law (2013 Revision);
(d) Post-judgment interest in accordance with section 34 of the Judicature Law (2013 Revision);
(e) Further and/or other relief; and
(f) Costs.

DATED THIS 25th day of September 2015

Priestleys.

PRIESTLEYS

TO: The Clerk of the Court

AND TO: The Defendants

This Writ of Summons is issued by Priestleys Attorneys-at-Law for the Plaintiff herein whose address for service is Second Floor, Caribbean Plaza, 878 West Bay Road, P.O. Box 30310, Grand Cayman, KY1-1202

DIRECTIONS FOR ACKNOWLEDGEMENT OF SERVICE OF WRIT OF SUMMONS

1. The accompanying form of *Acknowledgement of Service* should be completed by an Attorney acting on behalf of the Defendant or by the Defendant if acting in person.

   After completion it must be delivered or sent by post to the Law Courts, PO Box 495, George Town, Grand Cayman.

2. A Defendant who states in his Acknowledgement of Service that he intends to contest the proceedings *must also serve a defence* on the Attorney for the Plaintiff (or on the Plaintiff if acting in person).

   If a Statement of Claim is endorsed on the Writ (i.e. the words "Statement of Claim" appear on the top of page 2). The defence must be served within fourteen (14) days after the time for acknowledging service of the Writ, unless in the meantime a summons for judgment is served on the Defendant.

   If the Statement of Claim is not endorsed on the Writ, the defence need not be served until fourteen (14) days after a Statement of Claim has been served on the Defendant.

   If the Defendant fails to serve his defence within the appropriate time, the Plaintiff may enter judgment against him without further notice.

3. A *Stay of Execution* against the Defendant's goods may be applied for where the Defendant is unable to pay the money for which any judgment is entered. If a Defendant to an action for a debt or liquidated demand (i.e. a fixed sum) who does not intend to contest the proceedings states, in answer to question 3 in the Acknowledgment of Service, that he intends to apply for a stay, execution will be stayed for fourteen (14) days after his Acknowledgement, but he must, within that time, *issue a Summons* for a stay of execution, supported by an affidavit of his means. The affidavit should state any offer which the Defendant desires to make for payment of the money by installments or otherwise.

Notes for Guidance

1. Each Defendant (if there are more than one) is required to complete an Acknowledgement of Service and return it to the Courts Office.

2. For the purpose of calculating the period of fourteen (14) days for acknowledging service, a Writ served on the Defendant personally is treated as having been served on the day it was delivered to him.

3. Where the Defendant is sued in a name different from his own, the form must be completed by him with the addition in paragraph 1 of the words "sued as (*the name stated on the Writ of Summons*)".

4. Where the Defendant is a FIRM and an Attorney is not instructed, the form must be completed by a PARTNER by name, with the addition in paragraph 1 of the description "Partner in the firm of (.....)" after is name.

5. Where the Defendant is sued as an individual TRADING IN A NAME OTHER THAN HIS OWN, the form must be completed by him with the addition in paragraph 1 of the description "trading as (.....)" after his name.

6. Where the Defendant is a LIMITED COMPANY the form must be completed by an Attorney or by someone authorized to act on behalf of the Company, but the Company can take no further steps in the proceedings without an Attorney acting on its behalf.

7. Where the Defendant is a MINOR or a MENTAL HEALTH PATIENT, the form must be completed by an Attorney acting for a guardian *ad litem*.

8. A Defendant acting in person may obtain help in completing the form at the Courts Office.

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CIVIL DIVISION

CAUSE NO. OF 2015

BETWEEN: ANDREA ALESEA CALDERON **PLAINTIFF**

AND: DR. VIR SENNIK **1st DEFENDANT**

AND: CAYMAN ORTHOPAEDIC GROUP LTD **2nd DEFENDANT**

ACKNOWLEDGMENT OF SERVICE OF WRIT OF SUMMONS

If you intend to instruct an Attorney to act for you, give him this form IMMEDIATELY.

Important

Read the accompanying directions and notes for guidance carefully before completing this form. If any information required is omitted or given wrongly, THIS FORM MAY HAVE TO BE RETURNED.

Delay may result in judgment being entered against a Defendant whereby he may have to pay the costs of applying to set it aside.

---

1. State the full name of the Defendant by whom or on whose behalf the service of the Writ is being acknowledged.

2. State whether the Defendant intends to contest the proceedings *(tick appropriate box)*

   Yes [ ] No [ ]

3. If the claim against the Defendant is for a debt or liquidated demand, AND he does not intend to contest the proceedings, state if the Defendant intends to apply for a stay of execution against any judgment entered by the Plaintiff *(tick box)*

   Yes [ ] No [ ]

Service of the Writ is acknowledged accordingly

(Signed) _____

Address for service:

Please see overleaf…..

Notes on address for service

Attorney: where the Defendant is represented by an Attorney, state the Attorney's place of business in the Cayman Islands. A Defendant may not act by a foreign Attorney.

Defendant in person: where the Defendant is acting in person, he must give his post office box number and physical address of his residence or, if he does not reside in the Cayman Islands, he must give an address in Grand Cayman where communications for him should be sent. In the case of a limited company, "residence" means its registered or principal office.

Endorsement by Plaintiff's Attorney (or by Plaintiff if suing in person) of his name, address and reference, if any, in the box below.

PRIESTLEYS
ATTORNEYS-AT-LAW
SECOND FLOOR, CARIBBEAN PLAZA
878 West Bay Road
PO BOX 30310
GEORGE TOWN, GRAND CAYMAN
CAYMAN ISLANDS, KY1-1202

Endorsement by Defendant's Attorney (or by Defendant if suing in person) of his name, address and reference, if any, in the box below.

Dr.med. Matthias Herzig, MD, PhD

Consultant Orthopaedic and Trauma Surgeon, General Surgeon

P.O.Box 273, 91 Middle Rd, Georgetown, Grand Cayman KY1 – 1104, CAYMAN ISLANDS
phone 1 (345) 949 - 6066 ext 211 / email dr.m.herzig@gmail.com

MEDICAL REPORT

Reference number:	**N/A**
Claimant's Name:	**Ms CALDERON, Andrea Alesea**
Address:	**167 Midnight Road** **General Delivery Savannah PO** **Grand Cayman KY1-1500** **CAYMAN ISLANDS** **Tel 1(345) 929 5600** **Email andreamartinez_655@hotmail.com**
Date of Birth:	**22nd of April 1949**
Subject of report:	**Orthopaedic surgical treatment for osteoarthritis of the right knee**
Date of Examination:	**4th of July 2015**
Place of Examination:	**CTMH / Georgetown, Grand Cayman**
Date of Report:	**31st of August 2015**
Solicitors name and address:	**Priestleys, Attorneys-at-Law** **Second Floor, Caribbean Plaza** **878 Westbay Road** **George Town** **P.O. Box 30310** **Grand Cayman KY1-1202** **Cayman Islands** **Email nick.hoffman@palawcayman.com**
Solicitor's reference:	**3028-1908**

Contents

Page

1. Introduction and background 3
   1.1. Instructional party 3
   1.2. About the expert 3
   1.3. Circumstances of Examination 4
2. Medical History and Physical Examination 4
2.1. General and Medical History 4
   2.2. Medical examination 7
   2.3. Neck Examination 7
   2.4. Examination of the Back 8
   2.5. Examination of Upper Limbs 8
   2.6. Examination of Lower Limbs 8
3. Issues to address 9
   3.1. Diagnosis of >>severe osteoarthritis<<. 9
   3.2. TKA - appropriate remedial action? 11
   3.3. Surgeon's expertise in TKA - surgery 11
   3.4. Standard of procedure. 11
   3.5. Ms Andrea Calderon's condition. 14
   3.6. Precautions to avoid excess bone cement. 14
   3.7. Level of Standard of Care 15
   3.8. Primary positioning of TKA and detection of bone cement wedge on post-operative imaging. 15
   3.9. Causation. 15
   3.10. Infection after removal of bone cement. 16
   3.11. Role of arthroscopic surgery in the infection of the knee 16
   3.12. Contribution of infection to endoprothetic component loosening and bone resorption. 17
   3.13. Origin of bone cement debris as described in follow-up reports 17
   3.14. Contribution of "intervening" events to loss and damage caused 17
   3.15. Contribution of patient's compliance to loss and damage caused by primary surgery. 18
4. Declaration 19
   4.1. Compliance 19
   4.2. Confirmation of Truth 19
   4.3. Confirmation of Completeness 19
   4.4. Confirmation of Independency 19
5. Glossary 20

1. Introduction and background

1.1. Instructional party

I prepared this medical report on the instructions of Priestleys, Attorneys-at-Law in Grand Cayman. For the preparation of this medical report I interviewed and examined the Claimant on 4th of July 2015 in my rooms at the Chrissie Tomlinson Memorial Hospital in Grand Cayman.

1.2. About the expert

I am a Senior Consultant Orthopaedic Surgeon with experience in Trauma and Orthopaedics. I have been actively involved in Trauma and Orthopaedic Surgery, non-surgical Orthopaedic activities and Rehabilitation for Orthopaedic and Trauma patients since 1991. I am registered as Specialist in Trauma and Orthopaedics and as Specialist in General Surgery with the GMC in the United Kingdom of Great Britain, Specialist Registration number 4494728. I am registered with the Medical and Dentil Council of the Cayman Islands as Medical Doctor Orthopaedic and Trauma Surgeon with the Registration No. MDC/PL/MED/225. I have been trained in Joint Arthroplasty under care of Professor Hartmut Kiefer, Lukas Krankenhaus, Buende, Germany for three years. The Trauma and Orthopaedic Department at this institution is a German Reference Centre for Joint Arthroplasty.

I declare that I have not been actively involved in the care of Ms Andrea Calderon until the 21st of November 2012. Ms Andrea Calderon was seen and examined by myself for the first time on the 21st of November 2012 and subsequently on the 6th and 7th of December 2012. At this time she was provided with an opinion on the status of her right knee with regards to the TKA surgery performed on her right knee on the 27th of September 2012 and a recommendation for further treatment was given. Thereafter I did not see the patient until the 22nd of July 2013 upon referral by Dr Sekhar, Orthopaedic Surgeon at the Cayman Islands Health Service Authority Hospital in Grand Cayman (CIHSA). Ms Andrea Calderon has been under my care for her right knee problems ever since.

1.3. Circumstances of Examination

I have seen this 66 year old normally fit and healthy woman who lives currently on her own in a rented apartment in Grand Cayman. The Claimant underwent a total knee arthroplasty surgery (TKA) for painful osteoarthritis of the right knee on the 27th of September 2012 under care of Dr. Vir Sennik, MD, FRCSC, Orthopaedic Surgeon, Knee, Hand & Upper Limb Surgery at the CIHSA Hospital in George Town, Grand Cayman, Cayman Islands. According to the operative report at this time the following procedure was carried out: >>TKA right -LCS Femur med, Tibia 2.5, Insert 12.5 Patelloplasty without Replacement<<.

2. Medical History and Physical Examination

2.1. General and Medical History

Ms Andrea Calderon tells me that she is a retired former legal secretary who worked also as a full-time chef and catering service owner, a sales representative, a real estate agent, and a property manager. She tells me that she is now unable to carry out any of these activities and is currently unemployed, that she lives currently on her own in a rented accommodation, that she used to live in her own house which is now for foreclosure as she has difficulties to pay the mortgage. She tells me that her only current income is a stipend from the Cayman Islands Government.

Ms Andrea Calderon tells me that her current complaint is as follows: There is very minor right knee pain when at rest; she rates the painful symptoms at a level of 0-1 on the VAS. She tells me that she usually walks with one crutch. She tells me that when standing or walking she is in most severe pain which she rates at a level of 7-9 on the VAS. She tells me that she experiences pain in her right leg below knee reaching down the whole shin bone and into the right ankle. She tells me that as a result of the severe pain it is very difficult for her to ambulate and as a result her social life and her ability to work are significantly affected. She tells me that she is taking anti-inflammatory and anti-pain medication regularly (Ibuprofen daily 400mg by mouth every day).

Ms Andrea Calderon tells me that she has a previous history of Deep Venous Thrombosis and Pulmonary Embolism in February 2000 for which she received treatment with anti-coagulants for 6 subsequent years. She has a history of a left distal radius fracture for which she received ORIF (open reduction and internal fixation) with plate and screws under care of Dr Alejandro Badia, Upper Limb Specialist, Miami, Florida, USA, in March 2011. In the past she underwent a hysterectomy and bilateral ovariectomy in January 2001 and that she gave birth to a son via Caesarean Section in March 1975. She sustained a vertebral fracture

probably after a fall in February 2010 for which she received conservative treatment. She was diagnosed with Osteoporosis based on QCT (quantitative computer tomography) bone mineral densitometry in April 2014. She is known for allergy towards Voltaren (diclofenac). She was first diagnosed with bilateral osteoarthritis of the knees in 2008 at CIHSA specialist clinic.

Ms Andrea Calderon was seen by Dr Sekhar at CIHSA on the 28th of August 2012 at the Specialist Clinic for her right knee pain and referred to Dr. Frank Smith, Orthopaedic Surgeon, Cayman Orthopaedic Group (COG), for a right knee UKA = unicompartmental knee arthroplasty the same day. The referral was approved the next day by Dr Gerald Smith, CMO at CIHSA.

Ms Andrea Calderon tells me that she subsequently was informed by COG, most likely over the phone, that Dr F. Smith's earliest availability for surgery would have been on the 15th of October 2012 to which she agreed.

Ms Andrea Calderon tells me that she then received further information from COG telling her that due to cancellation an opening for earlier surgery had become available with Dr Sennik on the 27th of September 2012 to which she agreed.

She was seen by Dr Sennik on the 17th of September 2012 for the following complaints: >> Lots of problems with her right knee, with frequent limping, reduced walking distance, difficulties to sleep at night, constant right knee pain<<. She was diagnosed with medial compartment osteoarthritis in the right knee and later on listed for a TKA right knee, consented for a TKA right knee by Dr Sennik on the 27th of September 2012 and received a TKA right knee under care of Dr Sennik on the 27th of September 2012.

Ms Andrea Calderon had first post-operative right knee X-rays (anterior-posterior and lateral views) on the 29th of September 2012. X-rays were reported on as: >> TKR right knee. Satisfactory appearance.<< Dr. E J Bogle-Taylor.

Ms Andrea Calderon received post-operative care including physiotherapy treatment at the physiotherapy department at the CIHSA Hospital. She was discharged home on the 2nd of October 2012. Her post-operative course was complicated by stiffness, restricted active and passive range of motion of her right knee. She continued to have physiotherapy treatment as an out-patient at CIHSA.

A second post-operative X-ray of the right knee (AP and lateral views) on the 19th of November 2012 was reported on as follows: >> TKR with good alignment. There is a 19.27mm x 16.51mm x 16.30mm triangular wedge of cement present posteriorly in the medial compartment of the knee (Dr E.J. Bogle-Taylor, Radiologist).

Ms Andrea Calderon was seen thereafter on numerous occasions by several Orthopaedic Surgeons and it was eventually suggested to her that the removal of the remaining bone cement should be done overseas.

Subsequently she was referred by Dr Sekhar on the 21st of November 2012 for the removal of the remaining bone cement to overseas.

Ms Andrea Calderon underwent removal of a significantly sized lump of bone cement from the posterior medial knee cavity under care of Dr. Mansingh, UWI, Kingston, Jamaica, on the 28th of December 2012. Physiotherapy was resumed on the 15th of January 2013. The post-operative course was complicated by exacerbation of pain worsening around end of January 2013.

Ms Andrea Calderon was diagnosed with cellulitis over the incision site right posterior-medial knee by Dr Sekhar on the 8th of February and given a course of antibiotic treatment with Cefuroxime 500mg p.o. twice daily.

Ms Andrea Calderon continued to be seen for clinical follow-ups by Dr Sekhar in the specialist clinic at CIHSA. A ultra-sound examination of the right knee was carried out on the 3rd of July 2013. This was reported on as follows: >> 6ml of anechoic fluid seen in suprapatellar recess, some larger calcific densities less than 1.10cm were seen in the soft tissue in the posterior lateral compartment, possibly bone fragments as seen on x-rays<<.

Ms Andrea Calderon was then referred to Dr Herzig by Dr Sekhar for further treatment on the 18th of July 2013. Ms Andrea Calderon was seen by Dr Herzig on the 22nd of July 2013. She was diagnosed with loosening and subsidence of the tibial component of the right knee TKA. On the 13th of August 2013 she underwent a) open revision surgery for the irritated but healed scar over the posterior-medial aspect of her right knee which was suspicious for low grade infection and b) a right knee arthroscopy. Both surgical interventions were carried out by Dr Herzig. To investigate for the suspicion of a low grade infection surgery included harvesting of synovial specimen and bacterial swab samples from the right knee. The relevant microbiological testing with breeding of samples for over 2 weeks did not reveal bacterial

growth. The relevant histology reports reported proliferative synovium with mild chronic inflammation, benign. Ms Andrea Calderon underwent then a partial revision TKA for her right knee on the 19th of October 2013 under care of Dr Herzig. Intra-operatively the tibial component was found to be loose with significant subsidence. The post-operative course was then uneventful for about 14 months after the surgery.

Ms Andrea Calderon started to experience a recurrence of painful symptoms in her right leg below knee from December 2014 with radiographic signs of translucency and signs of increasing migration of the tibial implant component on the subsequent radiographic examinations of her right knee. She is now facing the requirement for a further revision surgery for the right knee.

2.2. Medical examination

1 Weight: 180 lbs / pounds
2 Height: 4ft 11 in
3 General Examination: Unremarkable
4 Neurological Assessment: Unremarkable

2.3. Neck Examination

The Claimant holds head and neck in a decent forward position. There is no evidence of any neurological impairment. There are no tender areas over the cervical spinous processes and there are no tender areas in the cervical paraspinal muscles especially not in the segments between C4/5 and C7/T1. The range of movement of the neck in all directions is slightly restricted. The Claimant does not complain about pain at the endpoint of any movement of the cervical spine.

The Claimant's head and neck shows the following active range of movement (ROM): The Claimant bends forward to reach the chest and breast bone with the chin to a 2 finger distance and reclinates to 70 degrees (normal ROM: 0 to ½ finger distance between chin and breast bone in bending ability forward to 80 to 85 degrees ability bending backwards). Head and neck rotation in anteclination and in reclination is 80 degrees to the right and 80 degrees to the left (normal ROM: 80 to 85 degrees to either side). Lateral bending of the Claimant's head and neck to the right is 35 degrees and is 35 degrees to the left (normal ROM: 30 to 35 degrees to either side).

2.4. Examination of the Back

The Claimant stands with a normal posture. The Claimant holds chest and back decent upright position. The Claimant bends forward to reach the floor in a distance of 40 cm between fingertips and floor with minor difficulties and regains normal posture with minor difficulties (norm 0 - 15cm). The Claimant bends forward to about 70 degrees (normal 90 degrees) and reclinates to maximally 10 degrees (normal 30 degrees) with minor painful restriction. The Claimant rotates the trunk ~ 25 degrees to the right and ~25 degrees to the left (normal ROM: 35 degrees to either side). The Claimant bends laterally 20 degrees to the right and 20 to the left (normal 45 degrees to either side). On palpation the lumbar paravertebral muscles are unremarkable. There is no obvious tenderness on palpation of the lower lumbar spine and sacrum. There is no tenderness over the sacroiliac joints. The straight leg rise test (SLR) is negative on the right and on the left. The deep tendon reflexes for quadriceps tendons are equally normally responsive on the right and on the left. The deep tendon reflexes for Achilles tendons are normally responsive on the right and on the left. No obvious muscular deficit is noted. No vascular deficit is noted in the legs and in the feet. The Claimant denies the presence of any Cauda Equina Syndrome symptoms, such as altered sensation in the crotch area, change of bladder and bowel habits.

2.5. Examination of Upper Limbs

NAD. Unremarkable scar over distal radial volar aspect of left distal forearm.

2.6. Examination of Lower Limbs

Mrs Andrea Calderon walks with a limp and uses the support of a crutch on the left side. There are several scars over the right knee: All scars are without sign of infection or inflammation. I note 1 anterior scar over the right knee of 18cm of length, 1 scar of 5 cm length over the posterior medial aspect right knee.

There is soft tissue swelling over the right knee but no obvious signs of acute inflammation or infection are noted. Skin is overall intact. Regular, norm-frequent peripheral pulses can be felt over dorsal pedal and posterior tibial arteries. There is normal capillary reflux in both feet. On palpation no evidence of joint effusion is observed but tenderness over the medial shin. The right knee is stable with a mild gapping of the medial compartment under valgus stress in 15 degrees of flexion but with firm endpoint of the medial collateral ligament. The active and passive range of motion of the right knee is restricted. The active and passive range of motion of the left knee is unrestricted. Both hip joints and ankle joints present without obvious restriction in active and passive range of motion. There is no tenderness over the right or left calf. For result of measurement of girth/circumferences and ROM right and left lower leg see table below:

Level of measurements:	Right leg [cm]	Left leg [cm]
20 cm above knee joint line	63	62
At knee joint line	45	41.5
20cm below knee joint line	30	31
Active and Passive Range of Motion (ROM) acc. to neutral-zero-method	Right knee [degree]	Left knee [degree]
Extension/flexion **active**	0-0-95	5-0-135
Extension/flexion **passive**	0/0/140	5/0/130

3. Issues to address

I have been asked to address the following issues:

3.1. Diagnosis of >>severe osteoarthritis<<.

Does the expert witness concur with the diagnosis of >>severe osteoarthritis of both patello-femoral joints<< with cartilage loss and osteophytes in the medial compartments of both knees, more marked on the right?

X- rays of both knees obtained 12th of MAY 2008 show bilateral osteoarthritis of the knees mainly affecting both medial compartments, more so on the right side, with close to complete loss of radiographic joint space of the medial compartment on the AP views, however, without osteophyte formation. At this time lateral views do not show significant osteoarthritic changes in the lateral compartments and do not significant osteoarthritic changes in the patellofemoral compartments. Patella skyline or Merchant's views were not obtained.

X- rays of both knees obtained on 23rd of November 2011 show bilateral osteoarthritis of the knees mainly affecting both medial compartments, more so on the right side, with close to complete loss of radiographic joint space of the medial compartment on the AP views and with subtle osteophyte formation over the medial joint line of the right knee, tibial console. Some progress of the osteoarthritic changes are seen, however, not so in the patellofemoral compartments. Again, patella skyline or Merchant's views were not obtained.

X- rays of both knees obtained on 28th of August 2012 show bilateral osteoarthritis of the knees mainly affecting both medial compartments, more so on the right side, with close to complete loss of radiographic joint space of the medial compartments on the AP views and with further growth of osteophytes over the medial joint line area in the right knee (tibial console). In addition there is evidence of osteophyte formation over the medial joint line aspect left knee (tibial console). The osteoarthritic changes in both patello-femoral joint compartments and both lateral compartments remain fairly minor.

In my opinion the presented series of X-rays right and left knee anterior-posterior and lateral views from 2008, 2011 and 2012 show development of medially accentuated osteoarthritis of the knee with very minor development of osteoarthritic changes in the lateral and patello-femoral compartments. There are no obvious and convincing radiographic findings representing significant osteoarthritic changes in the lateral and patello-femoral compartments of both knees on the X-rays from the 28th of August 2012.

I concur with the diagnosis of bilateral advanced to severe medial compartment osteoarthitis of the knees. Using the Kellgren and Lawrence classification (grading 0-4) I would attribute maximum grade 1 to patello-femoral and lateral knee compartments and grade 3 to the medial compartments.

For adequate pre-operative evaluation of the patello-femoral joint compartment of the knee a patella skyline view or a Merchant's view X-ray is helpful and recommended. Such pre-operative images were not obtained. However, my impression from lateral X-rays of both knees in August 2012 is that of patello-femoral ostearthritis grade maximum 1 acc. to Kellgren and Lawrene. Dr Sennik's theatre notes support this impression when he notes the following: >> Patella everted and seen good cartilage coverage so not replace <<.

I do not concur with the diagnosis of >>severe osteoarthritis of both patello-femoral joints<<. I do concur the diagnosis of >>cartilage loss and osteophytes in the medial compartments of both knees, more marked in the right knee <<.

Literature reference:

Kellgren, J. H.; Lawrence, J. S. (1957). "Radiological assessment of osteo-arthrosis". *Annals of the rheumatic diseases* **16** (4): 494–502. PMC 1006995. PMID 13498604.

Braun HJ, Gold GE, Diagnosis of osteoarthritis: Imaging, Bone (2011), doi:10.1016/j.bone.2011.11.019

3.2. TKA - appropriate remedial action?

Does the expert witness concur with the following: Was the TKA procedure as opposed to the originally proposed UKA for the right knee the appropriate remedial action in the circumstances?

In view of the patient's age, grade of osteoarthritis (medial compartment OA grade 3, lateral compartment OA max grade 1, patello-femoral compartment OA max grade 1) of the right knee, the lack of ligament instability, the lack of flexion contracture, the absence of gross mal-alignment one could have considered Mrs Calderon a suitable candidate for a Unicondylar Knee Arthroplasty (UKA). However, the following problems have to be considered with UKA: early implant component loosening, bone fracture and requirement for conversion to Total Knee Arthroplasty (TKA) due to development of symptomatic osteoarthritis in the lateral and patello-femoral compartments. As a result many knee joint arthroplasty surgeons favor a TKA over a UKA even in absence of advanced to severe OA in the lateral and patellofemoral compartments.
I concur that the TKA procedure as opposed to the originally proposed UKA for the right knee can be considered the appropriate remedial action in the circumstances.

Literature reference:
Stein Hakon Lastad Lygre, MSc, PhD, et al. Pain and Function in Patients After Primary Unicompartmental and Total Knee Arthroplasty. In the Journal of Bone and Joint Surgery. December 15, 2010.Vol 92-A. No. 18. Pp. 2890-2897.

3.3. Surgeon's expertise in TKA - surgery.

Does Dr Sennik have the appropriate expertise to conduct this surgery (TKA)?

The expert witness has to assume that Dr Sennik as a Canadian Board Certified Orthopaedic Surgeon has undergone adequate training to perform TKR. However, the following issues are beyond my current knowledge: What is the objective outcome of patients who undergo TKR or UKA under his care? Is his operative technique current? I do not possess valid information to answer these questions.

3.4. Standard of procedure.

Does Dr Sennik appear to have followed standard procedure?

In have reviewed Dr Scenic's letters, clinical and operative notes regarding the treatment of Ms Andrea Calderon.

1) There is a letter to the Department of Immigration, dated 27th of September 2012 pointing out that Ms Andrea Calderon is scheduled for right total knee arthroplasty on 27th of September 2012, the requirement for three months of rehabilitation and requirement for assistance with activities of daily living for that period.

2) There is a Operative Report from the 27th of September 2012, 13:22h.

3) There is an Inpatient Physician Report from the 29th of September 2012, 11:17h.

4) There is a letter to Dr K. Sekhar at CIHSA dated 17th of September 2012.

5) There is a letter to Dr K. Sekhar at CIHSA dated 24th of September 2012.

By reviewing these notes I have made the following observations:

There is no further entry or documentation by the Surgeon, Dr Sennik, as to Ms Andrea Calderon's further outcome of her right knee surgery, such as notes on results on clinical follow-ups during the expected 3 months rehabilitation period (as per 1).

The X-rays obtained from Ms Andrea Calderon's both knee joints in 2008, 2011 and 2012 are not entirely referred to in his preoperative letters (4,5).

A complete radiographic preoperative status (this would be the following: standing full-length anteroposterior radiograph from hip to ankle in case of angular deformity (a valgus deformity was noted by Dr Sennik in his pre-operative letter), standing anteroposterior of knees on large cassette (14" x 17"), standing extension lateral on large cassette, flexion lateral (90-100 degrees) on large cassette, Merchant's view) and a complete radiographic post-operative status (AP, lateral and Merchant's view radiographs) was not ordered.

Literature reference: MILLER M, Review of Orthopaedics, Fifth Edition, 2008, ISBN 978-1-4160-4093-4.

Dr Sennik note's do not contain any reference to the post-operative x-rays by Dr Sennik (3).

The Operative Report from the 27th of September 2012, 13:22h, compiled by Dr Sennik, is rather short.

In the report there is no reference to the patient's preoperative medical history. There is no reference to the consent procedure. There is no explanation as to why surgery was per-

formed and what the rational was for the decision for a TKR rather than for a UKA. Neither the use of a Tourniquet, the level of pressure used or duration of pressure is mentioned. No estimate of blood loss is recorded. There is no record as to what distal femoral cut ankle (Valgus cut angle) was chosen (in view of the rather small height of the patient) and what degree of femoral rotation was chosen. There is no reference as to how the tibial tray was implanted, i.e. what degree of rotation was chosen with regards to the tibial tubercle. It is also not recorded what type of lavage was used prior to the implantation of the tibial tray. Over all a comprehensive description of surgical technique is not available. A precise description of removal of remnant cement prior to final reduction is not available. Following reduction there is no record of the time period elapsed before the joint was passively moved. There is no report on the position of the joint when wound closure was performed. Suture material used is not specified.

These findings are in contrast to the current recommendations of the British Association for Surgery of the Knee which outlines the following recommendations:

>> 10.6 A record of the operation should be made immediately following surgery and should include:
10.6.1 Name of operating surgeon, assistant and the name of consultant responsible.
10.6.2 The diagnosis and procedure performed.
10.6.3 Details of the incision and any additional procedures to achieve satsifactory exposure.
10.6.4 Description of the findings.
10.6.5 Details of all soft tissue release procedures.
10.6.6 Details of significant tissue excision, transposition, or augmentation.
10.6.7 Details of serial numbers of prostheses and other implanted material.
10.6.8 Details of bone grafting.
10.6.9 Details of component alignment and rotation.
10.6.10 Post surgery flexion range.
10.6.11 Tourniquet time.
10.6.12 Details of sutures used.
10.6.13 An accurate description of any difficulties or complications encountered and how these were overcome.
10.6.14 Immediate post-operative instructions.
10.6.15 The surgeons signature and the date of the operation. <<.

In my opinion, it appears that Dr Sennik has not followed standard procedure when it comes to preoperative radiographic assessment and to peri- and postoperative clinical documentation.

3.5. **Ms Andrea Calderon's condition.**

Was there anything in Ms Andrea Calderon's condition about which he (Dr Sennik) should have been particularly aware of?

The medical history of Ms Andrea Calderon contains information about a previous vertebral fracture and a previous distal radius fracture. In view of her gender (female), age and post-menopausal status there should have been a concern for osteoporosis. This is not reflected it the clinical documentation. The medical history of Ms Andrea Calderon contains information about hysterectomy and bilateral ovariectomy in January 2001, a possible cause for development of osteoporosis.

Ms Calderon is a rather short female individual, her height was recorded a 4ft 11inches on the pre-operative elective surgery anaesthetic assessment sheet. This would stipulate more comprehensive pre-operative radiographic assessment in order to allow for better pre-operative planning and implant templating.

3.6. Precautions to avoid excess bone cement.

What, if any, precautions would the expert witness expect to be taken to ensure that excess cement was removed in light of the fact that whilst the knee was "irrigated" prior to cement being inserted there is no mention of the joint being cleaned/irrigated afterwards to remove excess cement.

It is the expert witness' opinion that one would routinely remove any excess of bone cement around the tibial implant component after positioning the tibial component and prior to the final reduction. This is to reduce the risk of excess bone cement causing mechanical problems and soft tissue irritation. Other options to ensure that no excess cement is left around the implant components prior to closure of wounds are staged cementation in cases where both, the femoral and the tibial component are cemented or a different sequel of operative steps, such as performing a reduction with a trial insert after cementation and then a re-dislocation of the joint, a re-inspection for remnant excess cement prior to wound closure after the final reduction with the definite polyethylene insert in place.

3.7. Level of Standard of Care

In the view of the expert witness, did the standard of care fall below what could reasonably be expected of a surgeon performing a TKA and if so in what way(s)?

In my opinion the standard of care fell below what one would optimally expect by a surgeon performing a TKA due to the following:

The clinical documentation is incomplete. The refers to operative notes and post-operative notes. The sequel of available pre-operative radiographic assessment is not reflected on in the preoperative notes. A comprehensive preoperative radiographic assessment was not ordered. Surgery was not documented according to best practice recommendations. The post-operative follow-up notes by the knee surgeon are incomplete. There are no medical records by the surgeon reflecting on the early post-operative radiographs (as of the 29th of September 2012). It remains unclear whether the surgeon did examine personally the post-operatively obtained radiographs from the 29th of September 2012. Ideally, the post-operative radiographs would have entailed a Merchant's view radiograph.

3.8. Primary positioning of TKA and detection of bone cement wedge on post-operative imaging.

The expert witness is being asked to review Dr Sekhar's notes and provide his opinion on whether he concurs with the view that the prosthesis was in good position and also whether the x-rays do reveal a "wedge" of cement

In my opinion there is radiographic evidence of excess bone cement (a single bone cement lump posteromedial to the protheses; and several rather small bone cement pieces posterior to the femoral component posterior condyle) on the radiographs obtained on the 29th of September 2012 as well as on the radiographs obtained on the 19th of November 2012. As to the position of the prosthesis, in my opinion, postoperative radiographs show the tibial component in a suboptimal varus position and there is suspicion of incomplete cement underneath the lateral part of the tibial component. As there is no Merchant's view available, the femoral rotation of the femoral component of the implant and the position of the patella in relation to the femoral implant component can not be commented on.

3.9. Causation.

The expert witness is being asked whether he concurs that the "wedge" of cement was causative of Ms Andrea Calderon's failure to improve her range of movement.

In my opinion it is highly likely that the remnant "wedge of cement " contributed significantly to Ms Andrea Calderon's failure to improve the range of movement of her right knee after surgery. It is evident from the clinical notes from Dr Mansingh that the surgical removal of the bone cement lump contributed to an improved range of motion of Ms Andrea Calderon's right knee.

3.10. Infection after removal of bone cement.

The expert witness is being asked to review the notes on arthroscopic surgery and removal of wedge of bone cement via additional small excision of bone fragment and post-operative report (surgery performed under care of Dr Mansingh, UWI, Kingston, Jamaica), and Dr Sekhar's notes regarding cellulitis and whether this was the same infection he (the expert witness) diagnosed in July 2013

I my opinion one can assume a relationship between the cellulitis as described by Dr Sekhar on the 8th of February 2013 >>Induration and redness at the medial port of rt knee, site of surgery done in Jamaica<< and the surgical removal of a bone cement lump under car of Dr Mansingh. It is unclear whether peri-operative antibiotic prophylaxis was used as there are no detailed clinical notes available to me and as antibiotic treatment is not mentioned in Dr Mansingh's report. It is however unclear whether an infection occurred during surgery or during the post-operative phase as a secondary postoperative wound infection. One has to take into consideration that the patient received treatment for the removal of the bone cement lump abroad which involved travelling.
It is important to understand that the expert witness did not diagnosed an infection in July 2013. At this time there was a suspicion for a low-grade infection in the knee, however, multiple samples were processed and observed for over 2 weeks and no bacterial growth was observed.

3.11. Role of arthroscopic surgery in the infection of the knee.

The expert witness is being asked to provide his opinion on whether the infection noted by Dr Sekhar was most likely to be caused by the arthroscopic surgery (as performed under care of Dr Mansingh, UWI, Kingston, Jamaica).

In my opinion it remains unclear whether an infection occurred during surgery or as a secondary postoperative wound infection. It appears plausible that an infection occurred either at the time of surgery or during the post-operative course. One has to take into consideration that the patient received treatment for the removal of the bone cement lump abroad which involved travelling.

3.12. Contribution of infection to endoprothetic component loosening and bone resorption.

The expert witness is being asked to provide his opinion on whether in light of the notes the infection would have caused the mechanical loosening of the tibial tray and per-prosthetic bone resorption or /and aseptic loosening.

As the infection was not in the knee but rather affecting the soft tissue envelope around the knee, in my opinion, the infection did not contribute to the mechanical loosening of the tibial component.

3.13. Origin of bone cement debris as described in follow-up reports.

The expert witness is being asked to provide his opinion on whether further cement debris in the knee as described in the report on X-rays of the right knee (report dated 30th of MARCH 2013, and compiled by Dr Marlene Craigie) can be attributed to the original TKA.

Yes, in my opinion further cement debris can be attributed to the primary TKA. In my opinion this debris is already visible on the first post-operative knee radiographs from the 29th of September 2012.

3.14. Contribution of "intervening" events to loss and damage caused.

The expert witness is being asked to provide his opinion on whether it can be proven that none of the "intervening" events between the original surgery on the 27th of September 2012 and Ms Andrea Calderon's present condition, including the arthroscopic exploration and excision surgery, have either (i) been the operative or only cause of the damage and loss to Ms Andrea Calderon that the expert witness identifies (the "loss and damage"); namely the need for a replacement prosthetic or (ii) significantly contributed to that loss and damage; and if (ii) to what extent.

It is the expert's opinion that the remnant bone cement lump was a main contributing factor in the patient's difficulties to achieve a satisfying range of motion in her right knee. Therapeutical attempts to improve the range of motion after the primary surgery in absence of recognition of the bone cement lump may have contributed to the failure of the implant by hinging. However, equally implant component positioning, cementing technique and bone quality (osteoporosis) may have played a contributing part as well.

In my opinion it can be ruled out that the arthroscopic exploration and removal of the bone cement lump via an 8cm incision has been the operative or only cause of the damage and loss to Ms Andrea Calderon, i.e. lack of achievement of expected active and passive range of motion after primary TKA and subsidence and aseptic tibial implant component loosening requiring revision surgery.

3.15. Contribution of patient's compliance to loss and damage caused by primary surgery.

The expert witness is being asked to provide his opinion on whether Ms Andrea Calderon' s apparent failure to fully cooperate with instructions and exercises with regard to physiotherapy between October and November 2012 had any effect on the loss and damage caused by the original surgery that you identify.

It is the expert's opinion that Ms Andrea Calderon's level of compliance with instructions and exercises with regard to physiotherapy between October and November 2012 is insignificant and irrelevant to the loss and damage caused by the original surgery.

4. Declaration

4.1. Compliance

I understand that my overriding duty is to the Court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with this duty.

4.2. Confirmation of Truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I confirm that I am aware of the requirements of CPR Part 35 and PD35, the protocol for the instruction of experts to give evidence in civil claims (supplementing PD 35 para 13.5) and the PD on pre-action conduct and confirm that I have complied with them.

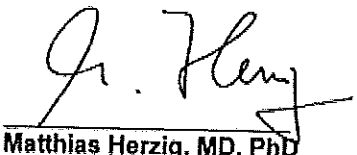
4.3. Confirmation of Completeness

I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All the matters on which I have expressed an opinion lie within my field of expertise.

4.4. Confirmation of Independency

I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

Signature:



Matthias Herzig, MD, PhD
Consultant Trauma and Orthopaedic Surgeon

5. Glossary

GP	General Practioner
DNA	did not attend
NIL	nothing relevant
ROM	range of movement
OTC	over the counter
NSAID	Non Steroidal Anti Inflammatory Drug
Vertebral body	the basic bony structural element of the spine
Dorsal spinous process	the bony part at the back side of a vertebral body
Cervical spine	the neck part of the spine
Cervical paraspinal muscles	muscles in the back of the neck stretching out alongside the dorsal spinous processes on either side
Costo-transverse joint	joint between rib and spine
Thoracic spine	upper back
Lumbar spine	lower back
Patellofemoral joint	joint between kneecap and thigh bone
CIHSA	Cayman Islands Health Service Authority (aka Georgetown Hospital)

PRELIMINARY SCHEDULE OF LOSS

All figures expressed in Cayman Island dollars unless otherwise stated.

I. GENERAL DAMAGES

1) Pain, Suffering and Loss of amenity	**$55,000** (Based upon English settlements and an exchange rate of 1 GBP to 1.25KYD)[1]
2) Loss of future earnings and Handicap on the Labour Market	**$50,000**[2]
3) Interest and Costs	To be assessed

II. PAST LOSSES AND EXPENSES

1) Loss of Earnings

Our client had three principle forms of income: Property Management; Catering and Interior Design. Set out below are her losses between the date of the Surgery to the present day and they are based upon her earnings in each area between March 2009 to November 2012:

(a) March 2009 - April 2010	$25,800.00
(b) May 2010 - February 2011	$13,920.00
(c) March 2011 - November 2012	$21,000
Total	$60,720
Lost Earnings between November 2012 and present day (34 months)	**$51,612**

2) Medical Expenses

(a) Consultations on 21.11.12, 4.4.14, 25.1.15 and 29.4.15 refused for payment by CINICO:	$731.79

[1] Benn v Doncaster NHS (2012); Blake v James Owen (2011); and Mason v South Devon NHS Trust (2013)

[2] Following *Blamire v South Cumbria Health Authority* we propose a global sum made up in the following way because of the nature of our client's previous earning capacity and the difficulty in assessing her future earning capacity this is the appropriate method of assessment: CI$25,000 for loss of congenial employment; CI$2,000 for future medical expenses and miscellaneous items; CI$10,000 for loss on account of acceleration of knee replacement surgery; a CI$10,000 *Smith v Manchester* award.

(b) Imaging costs incurred on 16.10.13; 4.6.14 and 21.8.14 refused for payment by CINICO: $536.25

(c) Prescription charges: $175.72

$1443.76

3) **Travel Costs**

(a) To and from medical consultations; after release from hospital; from airport on 3.1.13 following medical visit to Jamaica in December 2012: $50.00

(b) Visa costs for medical visit to Jamaica in December 2012: $166.27

(c) Additional personal spending occasioned by Medical visit to Jamaica in December 2012: $101.97

(d) Costs occurred by family members for hospital visits following additional surgeries $100.00

(e) Additional private vehicle expenses occasioned by inability to walk greater distances, including general wear and gasoline: $1500.00

$1918.24

4) **Care and Assistance**

(a) Additional costs not covered by insurance for February 2013: $94.00

(b) Home care for April 2013 inc. immigration Expenses: $1345.00

$1439.00

5) **Decorating, DIY and Gardening**

(a) Painting and hanging of drapery rods in January 2014: $288.00

(b) Immigration costs for employment of gardener From July 2014: $270.00

(c) Wages for gardener from July 2014 – August 2015: $3,790.00

	$4,348.00
6) **Aids and Equipment**	
(a) Costs associated with using disabled designated parking including license application for period July 2013 onwards:	$108.40
(b) Rental of disabled shopping cart:	$8.40
	$116.80
7) **Miscellaneous**	
(a) Advertisement in Cayman Compass seeking Boarder due to cashflow difficulties:	$10.00
(b) Photocopying and other administrative costs Incurred in pursuing claim:	$75.00
	$85.00

TOTALS

I	GENERAL DAMAGES	**$105,000**[3]
II	PAST LOSSES AND EXPENSES	**$60,962**
		$165,962

The Claimant reserves the right to serve an updated schedule of past and future losses and expenses and is not bound in any way by this document.

Dated this 8th day of September 2015

Priestleys

PRIESTLEYS
Attorneys for the Plaintiff

[3]Including the *Blamire* Award but excluding interest and costs