

IN THE GRAND COURT OF THE CAYMAN ISLANDS



CAUSE NO. 474 OF 2004

BETWEEN  
AND  
AND  
AND

SHARON EBANKS  
THE CHRISSIE TOMLINSON  
MEMORIAL HOSPITAL  
DR. NICHOLAS CAPPELLO  
DR. AKIN OMITOWOJU

PLAINTIFF  
1<sup>st</sup> DEFENDANT  
2<sup>nd</sup> DEFENDANT  
3<sup>rd</sup> DEFENDANT

**WRIT OF SUMMONS**

TO: *The Chrissie Tomlinson Memorial Hospital  
Walkers Road  
George Town, Grand Cayman*

TO: *Dr. Nicholas Cappello  
SAAD Specialist Hospital  
Saudi Arabia*

TO: *Dr. Akin Omitowaju  
c/o Quin & Hampson  
Harbour Centre  
George Town, Grand Cayman*



**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 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 495G, George Town, Grand Cayman, the accompanying Acknowledgement of Service, stating therein whether you intend to contest these proceedings.

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

Issued this      day of                      2004

**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.

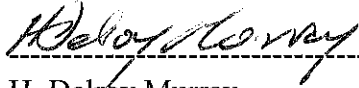
**ENDORSEMENT**

The Plaintiff claims damages and interest for personal injuries, loss and damage suffered by her and resulting from the negligence of the First Defendant, its employees or agents in and about the medical investigation and treatment of her condition by the Second and Third Defendants at The Chrissie Tomlinson Hospital between the 17<sup>th</sup> day of September 2002 and the 31<sup>st</sup> day of January 2003.

***AND THE PLAINTIFF CLAIMS:***

1. Damages
2. Interest
3. Costs

Dated this 30<sup>th</sup> day of November 2004



-----  
H. Delroy Murray  
Plaintiff's Attorney-at-Law

**IN THE GRAND COURT OF THE CAYMAN ISLANDS**

**CAUSE NO.**

**OF 2004**

**BETWEEN**

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**SHARON EBANKS**

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**MEMORIAL HOSPITAL**

**DR. NICHOLAS CAPPELLO**

**DR. AKIN OMITOWOJU**

**PLAINTIFF**

**1<sup>st</sup> DEFENDANT**

**2<sup>nd</sup> DEFENDANT**

**3<sup>rd</sup> DEFENDANT**

**STATEMENT OF CLAIM**

1. The Plaintiff was at all material times a resident of the Cayman Islands and a patient of the First Defendant and as such was at all material times owed a duty at common law by the Defendants to exercise reasonable skill and care in examining her and investigating and diagnosing her condition and in treating her.
2. The First Defendant is registered, inter alia, as a private Hospital providing medical services to the residents of the Cayman Islands.
3. The Second and Third Defendants were at all material times employees or servants and/or agents of the First Defendant and at all material times held themselves out or allowed themselves to be held out by the First Defendant as qualified medical practitioners and Board Certified Orthopaedist and Orthopaedic Specialists, respectively.
4. On the 17<sup>th</sup> day of September 2002 the Plaintiff fell at home and hurt her left foot.
5. The Plaintiff on the 17<sup>th</sup> day of September 2002 attended The Chrissie Tomlinson Memorial Hospital for treatment of her left leg and was seen there by the Second Defendant.
6. The Plaintiff described what had occurred to the Second Defendant who carried out a clinical examination of her left leg and then ordered that x-rays be taken of her left leg. The Second Defendant on receipt of the x-rays diagnosed that the Plaintiff had fractured her left ankle and informed her that surgery was required to repair the damage. The Plaintiff consented to having the surgery done and the same was performed by the Second Defendant who inserted a screw into her ankle.

7. The Plaintiff was admitted to The Chrissie Tomlinson Memorial Hospital and remained there for two days under the care of the Second Defendant before being discharged with her left leg in a cast.
8. The Plaintiff remained with her left leg in cast for six (6) weeks, after which it was removed on the instructions of the Second Defendant who, after clinically examining her leg and without ordering a fresh set of x-rays, informed the Plaintiff that her ankle had healed and then prescribed a six week course of physiotherapy for the Plaintiff to assist in her regaining full usage of the said leg.
9. The Plaintiff attended the prescribed course of physiotherapy but found no improvement in her condition and noted that her leg remained swollen and unable to bear her full weight throughout this period.
10. On a date in either the month of December 2002 or January 2003 the Plaintiff attended on the First Defendant to consult with the Second Defendant, as she was not making any improvement in her condition. The Plaintiff was informed that the Second Defendant ceased being a member of the First Defendants staff on the date that he prescribed the course of physiotherapy treatment for her.
11. That the Plaintiff was then sent to see the Third Defendant to whom she described what had happened. The third Defendant carried out a brief clinical examination of the Plaintiff's leg. He then told her that she needed to work harder at physiotherapy and that it would take up to a year for her ankle to full heal and for her to regain full use of the same. He then prescribed another six weeks of physiotherapy for her, which she undertook.
12. That on the 31<sup>st</sup> day of January 2003 the Plaintiff having noted no improvement in her leg attended on the Cayman Orthopaedic Group offices. There Dr. Frank Smith, a registered specialist in Orthopaedic Surgery, saw her. The Plaintiff described the history of her injury and the treatment she had received up to then. After performing a clinical examination of her leg the doctor ordered a fresh set of x-rays of the leg. The x-rays disclosed that the screw inserted by the Second Defendant with the intention of fixing the medial malleolus had not actually penetrated the bone and had therefore failed to do its job. Dr. Smith informed the Plaintiff that she needed to have her ankle re-operated on as she was already showing signs of narrowing of the ankle and the talus was in fact impinging on the lateral margin of the tibia, which would lead to severe damage to the articulating surfaces.
13. That on the 27<sup>th</sup> day of February 2003 the Plaintiff's left ankle was successfully re-operated on by members of the Cayman Orthopaedic Group but she is still left with lingering medical problems in relation to the said

ankle. For the avoidance of doubt the Plaintiff makes no complaint about her treatment by and from the Cayman Orthopaedic Group.

14. The Plaintiff is now left in residual pain as she has not regained a full range of movement of her ankle and she is at risk of having the ankle replaced or an artificial joint surface fitted between the talus and the tibia or alternatively having an ankle fusion. She is also left with a significant chance of developing osteoarthritis in the left ankle. Further particulars of her ankle injury appear in the medical reports of Dr. Frank Smith dated 12<sup>th</sup> November 2003 and 3<sup>rd</sup> May 2004, and that of Dr. Pervez Ali dated 27<sup>th</sup> February 2003, copies of which are served with these Statements of Claim.
15. The combination of the Plaintiff's injuries as pleaded herein has had a severe effect upon her physically and financially. Further the Plaintiff has suffered loss and damage:

**Particulars of Special Damages**

(a)	Past Medical Expenses	CI\$39,307.21
(b)	Wages paid to Helper	CI\$ 2,761.00
(c)	Loss of Income	<u>CI\$41,289.47</u>
		CI\$83,357.68

16. A portion of the Plaintiff's Past Medical Expenses were paid by her medical insurance providers and the Plaintiff on behalf of the said providers seek reimbursement of the same from the Defendants.
17. The Plaintiff's injuries were caused by the negligence of the Second and Third Defendants for whom the First Defendant is vicariously liable and by the negligence of the First Defendant itself. Alternatively the Second and Third Defendants caused the same in their individual capacity.

**Particulars of Negligence**

- (a) The Second Defendant was negligent in:
- (ai) failing to pay or any adequate heed of the Plaintiff's complaint of pain in her ankle after the surgery and after he had removed the cast.
  - (aia) failing adequately to examine the Plaintiff.
  - (aiii) failing to have further x-rays taken of the Plaintiff's leg prior to referring her for physiotherapy treatment.
  - (aiv) failing to follow through on the diagnostic imaging examination of Dr. Asit Kumar Banerjee done on 16<sup>th</sup> October 2002 and realising the significance of the same.
  - (av) failing to diagnose that the that the screw inserted by him

with the intention of fixing the medial malleous had not actually penetrated the bone and had therefore failed to do its job.

(avi) holding himself out as a Board Certified Orthopaedist when in fact such Board Certification had been lifted by the Massachusetts Board of Registration in Medicine on the 27<sup>th</sup> September 2000 and by the Arkansas Medical Board in April 2000.

- (b) The Third Defendant was negligent in:
- (bi) failing adequately to examine the Plaintiff's left ankle
  - (bii) failing to diagnose that the that the screw inserted by the Second Defendant with the intention of fixing the medial malleous had not actually penetrated the bone and had therefore failed to do its job.
  - (biii) failing to have further x-rays taken of the Plaintiff's left ankle prior to referring her for further physiotherapy treatment.
  - (biv) examining the Plaintiff without the benefit of having her file and medical records present.
  - (bv) failing to avail himself of the findings of Dr. Asit Kumar Banerjee of the First Defendant's Diagnostic Imaging Department and the significance of the same.
- (c) The First Defendant was negligent in:
- (ci) failing to employ adequate medical staff.
  - (cii) employing the services of the Second Defendant and holding or causing him to be held out as a person possessing the necessary qualifications and Board Certifications to hold the post or office he held with the First Defendant.
  - (ciii) failing to carry out due diligence searches on the background and qualification of its staff and in particular the Second Defendant.
  - (civ) failing to act in a timely manner or at all on the report prepared by Dr. Asit Kumar Banerjee of the Department of Diagnostic Imaging at The Chrissie Tomlinson Memorial Hospital dated 3<sup>rd</sup> January 2003, which confirmed that there was a delayed or non-union of the fracture site in the Plaintiff's ankle.

18. The Plaintiff's case on causation is that had the true nature of her injuries been appreciated by the Second Defendant prior to his sending her for physiotherapy treatment in November 2002 and by the Third Defendant prior to his recommending a continuation of the said physiotherapy treatment after a clinical examination of the Plaintiff and without the benefit of the Plaintiff's

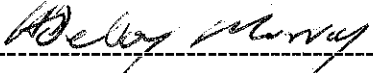
file and other diagnostic testing (i.e. further x-rays) she would have been given immediate treatment for the non-union of the fracture site with a good chance of the fibula uniting in a satisfactory position and a satisfactory fixation of the Plaintiff's ankle. The Plaintiff's fractured ankle would have been reduced with good prospects of achieving union and a full or almost full use of her ankle would have been achieved and the consequential further medical complications and future medical loss and costs avoided. Further and or in the alternative the injuries sustained by the Plaintiff was caused as stated herein by the failure of the Defendant to employ adequate qualified and certified medical staff, with particular reference to the Second Defendant.

19. The Plaintiff is entitled to and claims interest upon her losses pursuant to the Judicature Law.

AND THE PLAINTIFF CLAIMS:

- (a) Special Damages of C\$83,357.68 (which said damages are continuing)
- (b) General Damages
- (c) Interest on Damages as per the Judicature Law, as amended
- (d) Costs

Dated the 30<sup>th</sup> day of November 2004

  
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H. DELROY MURRAY  
Plaintiff's Attorney-at-Law

# The Cayman Orthopaedic Group Smith Road Plaza, Smith Road

Box 11698 Airport P.O., Grand Cayman, B.W.I. Phone: (345) 945-8380 Fax: (345) 945-8405, Email – sportmed@candw.ky

**Dr. Pervez Ali**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Foot & Ankle  
Surgery

**Dr. Parvez Ansari**  
MD, FRCS(C)  
Orthopaedic  
Surgeon, Paeds &  
& Spinal Surgery

**Dr. Edward English**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Foot & Ankle  
Surgery

**Dr. Robert Gordon**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Knee & Shoulder  
Surgery

**Dr. Steven Richie**  
MD, FRCS(C)  
Orthopaedic Surgeon

**Dr. Vir Sennik**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Knee, Hand &  
Upper Limb Surgery

**Dr. Frank Smith**  
MB, ChB FRCS(C)  
Orthopaedic Surgeon  
Reconstructive  
Surgery

**Dr. G (Bill) Viviani**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Paediatrics & Spinal  
Surgery

REF: 3832

February 27, 2003

## Operative Report

**Patient: Sharon Ebanks**

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**DOB: June 8<sup>th</sup>, 1954**

**Surgeon: Dr. Pervez Ali**

**Assistant: Dr. John Madden**

**Anesthetist: Dr. Vivek**

**Anesthetic Type: General Anaesthetic**

**Pre-Operative Diagnosis: Left ankle malunion.**

**Post-Operative Diagnosis: Same.**

**Procedure in details:**

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Repair of left ankle malunion, osteotomy medial malleolus, removal of previous fixation medial malleolus, excision of scar tissue at medial and lateral joint ankle, fibular osteotomy, fibular plating with eight-hole DCP with syndesmosis screw.

### Operation:

Ms. Sharon Ebanks was placed under general anesthetic in a supine position with a tourniquet placed and inflated on the left thigh. She also had an injection of Depo-Medrol and Marcaine into her right heel as per the patient request for treatment of plantar fasciitis. The left ankle was prepped and draped.

Antibiotics had been infused pre-tourniquet inflation. We made a long incision over the fibula exposing the soft tissues and being careful to avoid accessory nerve branches. We exposed the fibular malunion site and exposed the fibula down to the anterior joint

Operative Report  
Re: Sharon Ebanks

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distally and also went ahead with excision of all the abundant scar tissue in the syndesmosis region.

We carried out a fibular osteotomy with the small oscillating saw in an oblique fashion matching the previous malunion site. The fibula seemed to be malunited with shortening and lateral displacement. With the osteotomy carried out we were able to drag the fibula down to the appropriate length level and bring it into the syndesmosis into an anatomical position.

Through the syndesmosis excision area we identified that the lateral talus had an area of chondral calcinosis and loss of cartilage surface and we tried to debride this area. We applied an eight-hole DCP and held it in place with clamps in the lengthened reduced position. We then went ahead with exposure of the medial joint through the previous incision.

We opened the previous incision being careful to avoid any vascular or neurologic structures and exposed the medial tibia. The previous pin and screw were identified and were seen to be not placed within the medial malleolus fragment. The medial malleolus fragment was displaced medial to the fixation and had healed in this position. The previous fixation was removed and we carried out an osteotomy through the area of partial malunion.

We then placed the talus in the appropriate position as we could now see inside the ankle joint after excising the scar tissue that was present there and then held the ankle in a reduced position while placing the single K-wire through the main bone section of the medial malleolus fragment into the tibia. We then had a clinically anatomic reduction.

We carried out intra-operative x-rays identifying good position of the plate and the pin.

We therefore exchanged the medial pin for a 50 mm malleolar screw which compressed the fracture site nicely and then inserted our screws as for routine in the lengthened reduced position for the fibula, inserting as well, a syndesmosis screw with the syndesmosis screw and foot in 90 degrees of dorsiflexion.

A repeat intraoperative x-ray of a mortise view was carried out with the syndesmosis screw showing anatomic reduction.

We then irrigated all the surgical sites and carried out closure of both wounds with interrupted 2.0 Vicryl followed by 3.0 nylon interrupted sutures and applied a well-padded below-knee plaster of Paris splint.

The tourniquet was deflated at just over two hours and the patient was then extubated

**Operative Report**  
**Re: Sharon Ebanks**

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and taken to the recovery room in good condition with all counts correct and no complications.

Dr. Pervez Ali, M.D., F.R.C.S. (C)

PA/ad

cc: Cayman Islands Health Services  
Medical Records  
P.O. Box 915  
George Town

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**Dr. Bernard Rerri**  
MD, FRCS(C)  
Orthopaedic Surgeon  
Spinal Surgery

**Dr. F. Smith**

**REF: 3832**

November 12<sup>th</sup> 2003

Mr H Delroy Murray  
Samson Murray Jackson  
Attorneys-At-Law & Notary Public  
PO Box 10067  
APO  
Grand Cayman

Dear Mr Murray:

**RE: Sharon Kathryn Ebanks**  
**DOB: June 8<sup>th</sup> 1954**

## **INTRODUCTION:**

I am a duly licensed medical practitioner registered with the General Medical Council of Great Britain and the Royal College of Surgeons and Physicians in Ontario Canada and the Royal College of Physicians and Surgeons. I am a registered specialist in Orthopaedic surgery. I was entered into the general medical registry in Great Britain in 1970 and the Royal College of Surgeons in Canada as an Orthopaedic Surgeon in Canada in 1977. I am an associate Professor of Surgery in McMaster University in Hamilton, Ontario Canada.

Sharon Ebanks first came under the care of the Cayman Orthopaedic Group on January 31<sup>st</sup> 2003.

## **HISTORY:**

She gave a history that on the 17<sup>th</sup> September 2002 she sustained an injury to her foot when putting out garbage. She slipped in water left by recent rain, landing very forcibly on her left ankle. She was seen at the Chrissie Tomlinson Hospital, admitted and had surgery carried out by Dr Nicholas Capello.

She was kept in hospital for two days and then sent home and placed in a cast for six weeks. The cast was then renewed and she was started on physiotherapy in November. She noticed severe stiffness and pain in her ankle and she had numerous physiotherapy visits and was told her that she needed to work harder and that it would take her a year to get better.

She did not see herself making an improvement at all and so came to this practice for reassessment. At

at time, she complained of two issues, tightness of her right ankle and pain in the foot which proved to be a plantar fasciitis and a contracture of the tendoachilles. The left ankle was very stiff and swollen.

**EXAMINATION:**

On examination the left ankle indeed was extremely stiff and was displaced.

**X-RAYS:**

The x-rays show that the fibular fracture on the left ankle had healed and the medial malleolus was also united but was displaced and the talus was markedly displaced in relation to the distal tibia. She had new x-rays which confirmed this as the previous films were quite old and I pointed out to Mrs Ebanks that she needed to have this re-operated on as she was already showing signs of narrowing of the ankle joint and the talus was, in fact, impinging on the lateral margin on the tibia. This was clearly going to lead to severe damage to the articulating surfaces.

**TREATMENT:**

As I was about to return to Canada, I arranged for Dr Pervez Ali to take over her care. He is an experienced foot and ankle surgeon. He saw Mrs Ebanks and concurred with the opinion that this needed to be re-operated on and she was having significant problems. He found that she had lost 50% of her dorsi flexion and plantar flexion and about 25% of her subtalar motion. She did have an intact neurovascular supply except there was a minimal amount of numbness over the dorsum of the foot.

On February 27<sup>th</sup> 2003 she was taken to the operating room. The old fracture site was exposed and the fractures site of the fibular exposed. This was displaced and united in that position. An osteotomy had to be carried out with that bone. The medial malleolar fracture had united and had to be osteotomized and it was noticeable that the screw and wire that had been used to fix the medial malleolus had actually missed the medial malleolus that was imbedded in the tibia.

Dr Ali carried out the osteotomy and cleared out a lot of debris in the ankle and then relocated the talus into it's own proper position, fixed the medial malleolus with a screw and then put a syndesmosis screw across the between the fibula and tibia to secure the detachment between the ligaments at the distal end of the tibia and fibula. He also fixed the osteotomy of the fibula with a plate.

**CURRENT STATUS:**

These fracture sites have gone on to heal fully on the fibula and the cortical margin of the medial malleolus. The ankle is also in an anatomical position now and Mrs Ebanks is much more comfortable and there is no need for analgesic medication further. She is full weight bearing. She still lacks some motion in the ankle and that is improving and she is working hard at that. She has also managed to loose fifteen pounds since we first saw her and is continuing to work on that.

I assessed her on the 4<sup>th</sup> August 2003 and found her measurements as below:

The left ankle had dorsi flexion 5° to the right and 10° to the left. The ankle had 30° of plantar flexion on right and 65°. The ankles both had 10° of eversion and 80° of inversion.

The malleolar girth of the ankle on the left was 28.5 centimetres on the right and 27 centimetres indicating that there is still some significant soft tissue swelling at this side.

**Medical Legal Report**  
**Re: Sharon K EBANKS**

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The calf girth at a measured distance was 40.5 centimetres and 41.5 on the right indicating wasting of the calf muscles which one would indicate.

The striking feature is, however, the she does not have any pain now. The x-rays as stated show that the fibula has solidly united in a good position and the medial malleolus has united peripherally but the deep part of it still has a defect and that will probably take up to a year to unite. The hardware of course is still retained within the ankle and will remain there until we are comfortable with its removal. It may not be necessary to remove it until she has symptoms from the hardware.

**SUMMARY:**

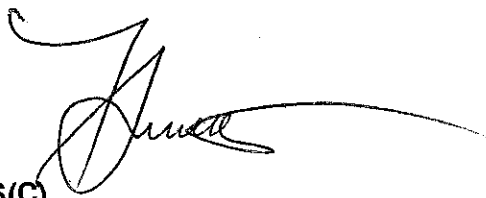
She is taking Glucosamine 500mg tid for which there is some scientific evidence of protection of the articular cartilage. She also takes one Aspirin a day and a cardio protective agent and she takes blood pressure pills. No other medication is required.

I pointed out to Mrs Ebanks that she is at risk of developing osteoarthritis in this ankle even though she has it now anatomically reduced. The joint space between the distal tibia and the talus is somewhat thinned out and once that process has started unless Glucosamine has a miraculous effect on her, she will have gradual progress of osteoarthritis. She will have gradual progress of osteoarthritis. She will probably take ten to fifteen years depending on whether or not she develops a condition called Chondrolysis where the cartilage literally falls apart. She will probably never regain a full range of motion in her ankle, although it is significantly better than when we first met her.

**ROGNOSIS:**

I found that the long term effects cannot be fully appreciated at this time and she should be further assed in about six months when we may be able to have more accurate information with regard to the rate of degeneration of this joint. For the time being, however, she is pain free and that is highly satisfactory.

Yours sincerely



**F C Smith MB ChB FRCS(C)**

FCS:fc

# The Cayman Orthopaedic Group

## Smith Road Plaza, Smith Road

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Spinal Surgery

**Ref: 3832**

**May 3rd, 2004.**

**Mr. H. Delroy Murray**  
**Samson-Murray-Jackson**  
**Attorneys-At-Law & Notary Public**  
**P.O. Box 10067**  
**APO**

**Dear Mr. Murray:**

**Re: Sharon EBANKS**

**Sharon Ebanks was seen with regard to her ankle for follow-up following the original treatment and then assumption of her care by our group, the Cayman Orthopaedic Group, once she came to us for help.**

**The fractures have gone on to unite and are satisfactory now but there has been significant narrowing of the ankle joint space. She is almost bone on bone in the joint so it has established osteoarthritis secondary to the injury. She feels comfortable and is able to walk with her ankle quite well. She does have some sensation of limitation of function compared with the other side but this is well within functional range. However, given the x-ray changes and history she is inevitably going to develop osteoarthritis of this ankle and will require further intervention. Her range of motion is unchanged from my report to you of November 12<sup>th</sup>, 2003.**

**Your question concerning the previous treating surgeons, I am not able to comment on the involvement of Dr. Ahmatowuju as Sharon has not mentioned his intervention or capacity to me. However, the surgeon, Dr. Capello did carry out surgical intervention and as I reported in my letter to you of November the 12<sup>th</sup>, 2003, the screw that he had used with the intention of fixing the medial malleolus did not actually penetrate bone and therefore failed to do its job. Also, with the failure of fixation the ankle had displaced. Uneven pressure was then placed on the talus, or ankle bone, in relation to the tibia, or shin bone, and this led to rapid wear of the joint surface.**

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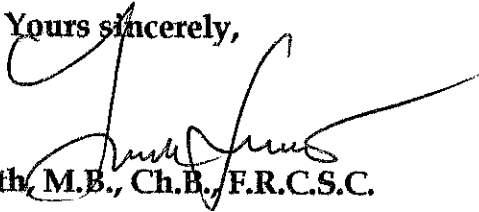
The fibula went on to unite but in an unsatisfactory position and had to be osteotomized, cut and put into a new position to be able to correct the alignment.

There is an incidence of osteoarthritic degeneration of the ankle after this type of fracture if it is fixed in a pristine fashion but it is certainly quite unusual and certainly one does not expect to see such rapid degeneration in the joint surface as has occurred in this case. If the fracture had been fixed anatomically in the first instance. I have to state that there is a 50% chance that the rapid degeneration and need for re-operation on this ankle was directly as a result of malposition of the first attempted internal fixation.

The future options for Mrs. Ebanks are, when the ankle becomes painful, to have an ankle replacement or artificial joint surface fitted between the talus and the tibia. This is a very skilled procedure and there are very few expert practitioner's of this particular procedure.

The second option is to perform an ankle fusion whereby the talus is fixed to the tibia obliterating all movement at that level but resolving the issue of pain. This does reduce the ability to walk on uneven surfaces and will certainly compromise the type of foot wear that she will be able to accommodate. The benefit of a fusion over an arthroplasty is that once the fusion is accomplished no further surgery is usually needed whereas with an artificial ankle joint there is still significant chance that it would deteriorate over the passage of time and will require revision. This is especially important in Mrs. Ebanks case as she is still a very young woman.

Yours sincerely,



F.C. Smith, M.B., Ch.B., F.R.C.S.C.

FCS\*sgb

Acknowledgment of service of writ of summons (O.12, r.3)

DIRECTIONS FOR ACKNOWLEDGMENT OF SERVICE  
OF WRIT OF SUMMONS

1. The accompanying form of *Acknowledgment 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, P.O. Box 495G, George Town, Grand Cayman.

2. A Defendant who states in his Acknowledgment 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 indorsed on the Writ (i.e. the words "Statement of Claim" appear on the top of page 2), the Defence must be served within 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 indorsed on the Writ, the Defence need not be served until 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 14 days after his Acknowledgment, 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 instalments or otherwise.

*See over for notes for guidance*

*Please complete overleaf*

## Notes for Guidance

1. Each Defendant (if there are more than one) is required to complete an Acknowledgment of Service and return it to the Courts Office.
2. For the purpose of calculating the period of 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 his 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 authorised to act on behalf of the Company, but the Company can take no further step in the proceedings without an Attorney acting on its behalf.
7. Where the Defendant is a **MINOR** or a **MENTAL 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.

BETWEEN  
AND  
  
AND  
AND

SHARON EBANKS  
THE CHRISSIE TOMLINSON  
MEMORIAL HOSPITAL  
DR. NICHOLAS CAPPELLO  
DR. AKIN OMITOWOJU

PLAINTIFF  
  
1<sup>st</sup> DEFENDANT  
2<sup>nd</sup> DEFENDANT  
3<sup>rd</sup> DEFENDANT

**ACKNOWLEDGEMENT 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 judgement being entered against a Defendant whereby he May have to pay the costs of applying to set it aside.**

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

2. State whether the Defendant intends to contest the proceedings (tick the 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 judgement entered by the Plaintiff (tick box).

yes

Service of the Writ is acknowledged accordingly

(Signed).....

[Attorney] for

[Defendant in person]

Address for service:

*Please complete 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 number and the 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 office.

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

H. Delroy Murray  
Associated Advocates Chambers  
Financial Integrated Services Bldg.  
196 Shedden Road  
PO Box 10067APO  
Grand Cayman, Cayman Islands

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