

BETWEEN :

ROBERT DOUGLAS JOSEPH
(Widower)
(as Personal Representative of the Estate of
TANYA EDITH JOSEPH, Deceased)

Plaintiff

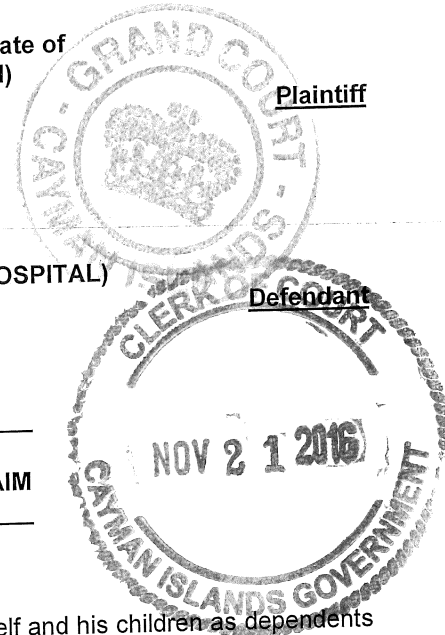
- and -

P.M.C. LTD
(t/a CHRISSIE TOMLINSON MEMORIAL HOSPITAL)

Defendant

AMENDED STATEMENT OF CLAIM

1. The Plaintiff brings this action to recover damages for himself and his children as dependents of his late wife Tanya Edith Joseph (hereinafter referred to as "the Deceased"), under the Torts (Reform) Law (1996 Revision) and for the benefit of his late wife's estate under the Estates Proceedings Law (1995 Revision).
2. At all material times the Deceased was, prior to her death on 25th September 2010, a private patient in the care of the Defendant's employees, servants or agents working at the Chrissie Tomlinson Memorial Hospital, Cayman Islands (hereinafter referred to as "the hospital").
3. It was an implied term of the contract between the Deceased and the Defendant that the Defendant's servants or agents would use reasonable care and skill in providing advice to the Deceased and/or in the treatment of the Deceased.
4. The Deceased had been born on 13th October 1978 and was therefore, at the time of her death on 25th September 2010, 31 years 11 months of age.



5. In or about October 2009 the Deceased developed epigastric pain and was seen by Dr C Charles, a gastroenterologist on 1st December 2009. She was noted to be *H.Pylori* positive (indicating the possibility of peptic ulceration) and was treated with triple therapy and mild analgesics. The pain resolved but then recurred and her liver function tests became abnormal. Dr Charles diagnosed gallstones (cholelithiasis) and recommended a laparoscopic cholecystectomy.
6. On 12th August 2010 Dr Charles prescribed the opioid analgesic pethidine (also known as meperidine) 100 mg three times daily if necessary to treat severe pain.
7. On 22nd September 2010 the Deceased was seen by Dr Murphy (consultant Gastroenterologist) and referred her to Dr Bromley (Surgeon) with a view to 'early operative intervention'.
8. On 23rd September 2010 the Deceased was seen by Dr Bromley who advised her that he could perform a procedure (laparoscopic cholecystectomy) to remove the gallstones, that the procedure was elective and that the procedure should be undertaken 'right away'. A laparoscopic cholecystectomy was scheduled to take place on 24th September 2010.
9. On Friday 24th September 2010 at approximately 7.00 am the Deceased was admitted to the hospital. She arrived on the ward at 7.30 am. It was noted that she was taking pethidine and had taken 250 mg on 23rd September 2010. She had no known drug allergies. The results of her pre-operative investigations were normal apart from an elevated concentration of the liver enzyme gamma-glutamyl transferase (attributable to her gallbladder disease).
10. The Deceased's treating surgeon Dr Bromley had several surgeries booked for this day. She had been told she would be the fourth person to be operated on by Dr Bromley on this day.
11. Dr Stephen Gay, anaesthetist, saw the Deceased after her admission to hospital. He noted she had no problems from previous anaesthesia and recorded a doctor had told her she

“didn’t need a lot to put her to sleep.” She had a past history of caesarean-section with spinal anaesthetic and a D&C gastroscopy, both performed under general anaesthetic without problems. Dr Gay noted that she was taking pethidine when necessary. He noted that there were no predictors of difficult tracheal intubation. Blood pressure and heart rate were normal. Her blood pressure was 131/88 and her heart rate was 76. Her chest was clear. He graded her as ASA 2 (a patient with mild systemic disease which does not interfere with normal activities of living, on the 5-point assessment scale devised by the American Society of Anaesthesiologists).

12. The Deceased had been scheduled to undergo the operation during the morning hours of 24th September 2010 but the operation was delayed by reason of a need to obtain approval from her insurance company and also because of a procedure or procedures ahead of her on the operating list.
13. During the early afternoon of 24th September 2010 an intravenous infusion was started. The fluid balance chart records no oral fluid input.
14. By 6.00 pm the Deceased had still not been taken for surgery. The last patient before her was taken in for surgery at or around 6.00 pm. The Deceased became concerned because she had not eaten all day, the surgery to be performed on her had been delayed because of complications with one of the earlier surgical cases and the doctors had been working all day. The Deceased and the Plaintiff discussed matters between themselves and agreed that if the surgery had not taken place by 8.00 pm, it would be too late for surgery to be commenced and the Plaintiff would pick the Deceased up and take her home.
15. At or around 8.30 pm the Plaintiff agreed with the Deceased on the telephone that he would pick her up. He told her to be ready and waiting.
16. At 9.00 pm the Deceased rang her nurse call bell on the ward, to inform the nurse that she did not want to proceed with the procedure that night. This message was relayed to Dr Bromley

and the nurse advised the Deceased to wait for Dr Bromley to talk to her after he finished his case in the operating room. The Defendant is put to proof as to what response was provided to the Deceased in respect of this desire not to proceed with the procedure that night and who provided that response.

17. When the Plaintiff arrived at the hospital, the Deceased told the Plaintiff that Dr Bromley wanted to talk to him. The Plaintiff then met Dr Bromley and immediately told him that he had concerns and told him that he did not think it was a good idea for the doctor to perform surgery on his wife at that time of the night for a number of reasons. The Plaintiff expressed his view that it was too late, he was concerned his wife had not eaten for 24 hours and he was also concerned the hospital may only operate with limited staff at night. The Plaintiff also informed Dr Bromley he was aware Dr Bromley had been in surgery all day and he was afraid Dr Bromley was tired. Dr Bromley replied by assuring the Plaintiff "we have adequate staff here." The Plaintiff asked Dr Bromley if he could schedule the surgery early the next day or later in the week but Dr Bromley said he could not and that he had to get the surgery done that night as he was leaving the Cayman Islands in a couple of days. Dr Bromley also told the Plaintiff that if he took the Deceased home, he would be forced to bring her back later in the night by reason of a deterioration in her condition.
18. The Plaintiff remained at the hospital with the Deceased until about 9.30 pm when he had to leave to take their 2 year old daughter Areini home.
19. At 10.15 pm the Deceased was transferred to the operating room.
20. At about 10.20 pm the sedative midazolam was administered in a dose of 5 mg intravenously, together with the short-acting opioid analgesic fentanyl 100 µg. Anaesthesia was induced at about 10.25 pm by administration of propofol 120 mg. The muscle relaxant rocuronium (Esmeron) was given in a dose of 50 mg and the trachea was intubated. Anaesthesia was maintained by inhalation of the volatile anaesthetic agent sevoflurane in a mixture of oxygen and air, supplemented by two doses of pethidine (80 mg at about 10.50 pm and 20 mg at

about 11.45 pm). The antibiotic cefepime was also administered in a dose of 1 g. Standard monitoring was employed and the recorded values of physiological variables are unremarkable.

21. At the end of the procedure, the operation sites were infiltrated with the local anaesthetic bupivacaine, and any residual effect of rocuronium was reversed by administration of neostigmine 2.5 mg at 11.55 pm, together with a glycopyrrolate (Robinul) 0.6 mg to antagonise the unwanted side-effects of neostigmine.
22. The surgery involving laparoscopic cholecystectomy was therefore commenced at 10.20 pm and had lasted until 12.10 am. The administration of anaesthesia was discontinued between 12.10 am and 12.15 am.
23. Dr Gay noted on the Deceased's Recovery Chart she was awake and stable at 12.35 am and that she was transferred to the ward only 5 minutes later at 12.40 am. Dr Gay gave instructions to the ward to commence "routine observations", that nasal oxygen should be given overnight, that a Bair Hugger (a warming blanket) should be used and that pethidine should be given as necessary and intravenous pethidine given 6-hourly.
24. No guidance/instruction was given by Dr Gay as to what he meant by "routine observations."
25. At 12.45 am on 25th September 2010 the Deceased returned to the ward from the operating room. A nurse recorded she was conscious but "drowsy ++" and that she was complaining of "pain ++". The operation site revealed 4 stab wounds and the lower left site was oozing a bit. A nurse recorded that the pulse rate was about 89 beats/minute and temperature 35 degrees C when the Deceased was re-admitted to the ward and that blood pressure was 119/78 mmHg. Saturations were 100%. These were the last formal observations of vital signs being taken until the Deceased was found in a collapsed state at 5.35 am, 4 hours and 50 minutes later.

26. At some time following surgery the Plaintiff received a telephone call from the Deceased to inform him the surgery was complete but she was in excruciating pain. She sounded very groggy to the Plaintiff and stressed she was in serious pain. She said that she would call for a nurse because she wanted some medication to alleviate the pain.
27. It is recorded that pethidine 75 mg was given intramuscularly to the Deceased, in accordance with Dr Gay's prescription at 1.00 am. The pethidine log was not completed contemporaneously with its administration but instead only completed after the time of death.
28. The Plaintiff notes that the pathologist was later told that the Deceased had remained on the operating table for the next 25 minutes after the end of surgery, during which she was "out of anaesthesia as well as fully awake." This is disputed by the Plaintiff. On return to the ward, the Deceased was conscious but remained "drowsy ++".
29. At 2.00 am the nursing staff noted the Deceased was asleep. Her IV fluids were replenished at this time (dextrose saline 500 mls).
30. At 3.00 am the nursing staff noted the Deceased was asleep and "breathing spontaneously" and "snoring". The "nurse" who checked on the Deceased at 3.00 am was a Miss Evelyn who was not a registered and properly qualified nurse. There was only one registered and properly qualified registered nurse on duty at this time, RN Nurse Sharna, and the Plaintiff's case is that this nurse was dismissed as a result of disciplinary proceedings that took place as a result of the death complained of herein. The dismissal was directly linked to the incident involving the Deceased's death, this having been the evidence given by Dr Tomlinson to the Coroner at the inquest into the death of the Deceased and disclosure of relevant documentation relating to these disciplinary proceedings is awaited. Dr Tomlinson had conducted his own investigation into the death of the Deceased. The Plaintiff's case is there should at all material times have been two registered and properly qualified nurses on duty, to include the nurse who checked on the Deceased at 3.00 am.

30A. At all material times Mrs Julie Ann Dowie was the Director of Nursing at the hospital. She has been a registered UK nurse since 1985. She also gave evidence at the inquest into the death of the Deceased. She confirmed Miss Evelyn was not expected to function as a nurse as she was not legally registered to work in the Cayman Islands at that time. She confirmed at the inquest that good practice would require that a patient on pethidine be checked regularly and the Defendant has now admitted in the proceedings herein that checks of vital signs should have been carried out as follows: 1.00 am, 1.15 am, 1.30 am, 1.45 am, 2.15 am, 2.45 am, 3.45 am, 4.45 and 5.45 am. No such checks of vital signs were carried out and the Defendant has admitted by e-mail dated 21st December 2015 that this failure amounts to a breach of duty and that expenditure by the Plaintiff's legal advisers concerning "investigations into breach of primary duty of care" should now cease.

30B. The Plaintiff's case, in accordance with the evidence given by Mrs Dowie at the inquest, is that the snoring patient who had been administered pethidine should have been checked by gently shaking her for a response. This did not take place at 3.00 am or at any other time.

30C. Further pain medication, of an unrecorded type and amount but likely to have been pethidine, was administered at 3.00 am. Dr Bromley advised Gerald M Joseph, the Claimant's brother, that further pain medication had been administered at this time at a meeting at the hospital on the morning of Saturday 25th September 2010.

31. There was no further check made by the nursing staff until 5.35 am, 2 hours 35 minutes after the earlier check, when the nursing staff found the Deceased in a collapsed state. She was unresponsive with a small amount of bloody vomitus on her gown. The alarm was raised by a Nurse Assistant. The carotid pulse was noted to be very weak and there was no blood pressure shown on the machine recording the same. Dr Belafonte was called.

32. At or around 5.40 am Dr Belfonte was called and by 5.54 am Dr Belfonte was in attendance. By the time he arrived, cardiopulmonary resuscitation ("CPR") was in progress and a back board was in place. He assessed the Deceased and found her to be cold, unresponsive and

with no pulse on respiration. Her pupils were fixed and dilated. There was a lot of serosanguinous fluid in her mouth and nose. There was an immediate attempt to remove the fluid with suction and Dr Bromley and Dr Gay were called urgently. The trachea was intubated and copious amounts of fluid were aspirated from the trachea. ECG leads were attached and showed asystole. Adrenaline and sodium bicarbonate were given.

33. Dr Bromley was called at home at 6.10 am and attended at the hospital at 6.55 am. Dr Gay also attended. After 1 hour of CPR, CPR was discontinued at 6.45 am and the Deceased was pronounced dead at 6.45 am. She had sustained and died from a cardiac arrest.
34. At post mortem examination, no obvious cause of death was identified. There was no pneumothorax, no significant blood loss at the surgical site, no injuries to blood vessels, bile duct or intestines, no laryngeal oedema and no evidence of pulmonary embolism. The results of toxicology investigations revealed that the concentrations of a number of drugs which the Deceased had received were within expected ranges but that the blood concentration of pethidine was high (2.6 µg/ml) and that the concentration of pethidine in gastric fluid was 6.2 µg/ml. The blood concentration of pethidine in the sample of blood taken at post mortem of 2.6 µg/ml was more than twice that which would have been expected on average. The concentrations of norpethidine were 0.24 and 0.40 µg/ml in blood and gastric fluid respectively. At post mortem, the Deceased's oral cavity showed whitish froth and both lungs appeared edematous with haemorrhagic areas. Cerebral edema and superficial gastric erosions were noted. It was considered by the pathologist Dr Shravana K Jyoti that the cause of death appeared to be pethidine toxicity and that "complication of polydrug toxicity in therapeutic levels administered for treatment procedure is considered contributing factor."
35. The Plaintiff's case is that snoring is a sign of partial upper airway obstruction and the most likely reason for the cardiac arrest suffered is that the Deceased had developed total upper airway obstruction at some time after 3.00 am leading to hypotension and bradycardia, then cardiac arrest initially in pulseless activity, progressing to asystole that remained undetected and untreated. The observation that large amounts of fluid had to be aspirated from the

Deceased's airway is consistent with the presence of acute fulminant pulmonary oedema which had occurred after the Deceased had developed severe or total upper airway obstruction. This can happen in deeply sedated patients.

36. The Deceased suffered an asystolic cardiac arrest caused by profound hypoxaemia resulting either from central respiratory depression caused by a high blood concentration of pethidine or from upper airway obstruction as a result of deep sedation caused by a high blood concentration of pethidine, the residual effects of other sedative agents and the time of day. Hypoxaemia is a reduced arterial oxygen saturation.

37. The aforesaid death of the Deceased was caused or contributed to by the negligence and/or breach of contract of the Defendant, its servants or agents. In advising and treating the Deceased as detailed above, the Defendant, its servants or agents were negligent and/or in breach of contract in the following respects:

DETAILED ALLEGATIONS OF NEGLIGENCE AND/OR

BREACH OF CONTRACT

The Defendant, its servants or agents were negligent and/or in breach of contract by:

- (a) Failing to give any or any adequate warning to the Deceased of the possibility that an elective operation performed late at night on 24th September 2010 might lead to severe complications for which she would need a greater level of nursing supervision than was likely to be available in the early hours of 25th September 2010. Had the Deceased been advised of these risks of complications, she would not have proceeded to have an elective operation performed late at night but instead opted for surgery during day-time hours as had originally been envisaged;
- (b) Causing, permitting or suffering the Deceased to undergo the aforesaid elective operation late at night on 24th September 2010 without any or any adequate supervised

nursing care being in existence in the event that the Deceased developed severe or total upper airway obstruction;

- (c) By Dr Bromley and/or other servants or agents of the Defendant advising and/or persuading the Deceased to proceed to undergo an elective operation late at night and at a time when there would be insufficient time afforded to the Deceased to ensure she had made a full and proper recovery from the operation before transfer back to the ward;
- (d) By Dr Gay advising the nursing staff just to carry out "routine observations" without providing any greater detail about the nature and level of observations that were required and failing to make any or any adequate attempt at explaining to the nursing staff what he meant by "routine observations";
- (e) Causing, permitting or suffering the Deceased to develop respiratory complications by reason of polydrug toxicity and/or failing to maintain and implement any or any adequate system to check for the signs of the development of such toxicity;
- (f) Failing to have any or any adequate regard to the Deceased's pre-operative chronic oral administration of pethidine when advising her on the merits of proceeding to an elective operation late at night and/or when devising and implementing her post surgery nursing treatment;
- (g) Failing to devise and/or institute any or any adequate post-operative nursing care plan in respect of the Deceased's post-operative nursing care. There should have been an individual or an adapted core care plan to include, *inter alia*, observation of vital signs, breathing, prevention of complications of bed rest, elimination and sleep;
- (h) Failing to provide any or any adequate nursing care to the Deceased. If the nursing staff had carried out regular post-operative observations on the Deceased, as they should have done, any deterioration in her vital signs would have been observed much

earlier and appropriate action could and would have been taken that would on the balance of probabilities have saved the Deceased's life;

- (i) Failing to make any or any adequate response to the "drowsy ++" condition of the Deceased noted on her arrival back to the ward;
- (j) Failing to devise and/or institute a system for the scoring of physiological measurements to identify deteriorating patients such as MEWS (Modified Early Warning Score) or NEWS (National Early Warning Score) scores or similar to enable prompt interventions to take place;
- (k) Failing to provide adequate post-operation monitoring charts to include a system for physiological measurements and/or to enable nursing staff to record basic observations of, *inter alia*, oxygen saturation levels and/or pain levels and/or wound sites;
- (l) Causing, permitting or suffering the Deceased to be transferred back to the ward too quickly after the operation and in a condition noted to be "drowsy ++" before she had properly recovered from the effects of anaesthesia and the medications provided to her;
- (m) In so far as it may be proved the Deceased was fully awake following surgery and then in a "drowsy ++" condition very shortly thereafter by 12.45 am on 25th September 2010, failing to make any or any adequate investigations into the cause of this marked drowsiness and/or to monitor and treat the Deceased appropriately and with reasonable care thereafter;
- (n) Failing to observe the Deceased regularly in the post-operation period and/or to monitor her adequately or at all including a failing to adequately monitor vital signs including heart rate, blood pressure, respiratory rate, oxygen saturation levels and urine output. The nurses caring for the Deceased were in breach of their Code of Ethics and in breach of duty by failing to carry out regular formal observations and checks of all vital signs on the Deceased, quarter hourly for the first hour (as she had not gone into

recovery), then half hourly for the next hour and then hourly for the next four hours;

- (nn) Causing, permitting or suffering the Deceased to be checked in a very cursory and brief manner at 3.00 am without the taking and recording of vital signs, by an unqualified and not legally registered nurse. A proper check of the apparently snoring Deceased should have included a gentle shaking of the Deceased for a response but no such check took place;
- (o) Without prejudice to the generality of the preceding allegation, failing to observe/monitor the Deceased at all between 3.00 am and 5.35 am;
- (p) By Dr Belafonte, failing to order Naloxone IV 400-2000 mcg to be given at the time he was first informed of the Deceased's collapse and/or by other servants failing to recognise timeously or at all the earlier need for the prescription of Naloxone;
- (q) In the premises failing to advise the Deceased and/or to treat and/or nurse the Deceased with reasonable care and competence and in accordance with the standard of a reasonable body of anaesthetists and/or surgeons and/or a reasonable body of nursing staff;
- (r) In the circumstances, failing to exercise any or any adequate care in treating the Deceased and exposed the Deceased to an unnecessary risk of injury. The Deceased died from the combined paralytic and respiratory depressive effects of Propofol, Rocuronium, Meperidine (Pethidine) and Sevoflurane. This combination of drugs should be administered only under the direct supervision of anaesthesia professionals and monitored by anaesthesia physicians and nurses. The Deceased received an additional 75 milligrams of pethidine intramuscularly at 1.00 am without a clearly recorded indication and a patient under the influence of the drug combination she had received, which was identified in post-mortem blood, should have been under continuous medical monitoring of their airway and respiratory status until the drugs were detoxified or eliminated from her body. The outcome could have been prevented with proper post-anaesthesia care, as Dr Bruce Hyma, MD, Chief Medical Examiner,

advised Ms Cheryl M Richards, Director of Public Prosecutions, by letter dated 6th September 2012.

38. As a result the Deceased suffered injury and she and her Estate and her dependents have suffered loss and damage. Prior to the surgery on 24th September 2008, the Deceased was healthy and had a normal life expectancy. As a result of the matters complained of herein and in the circumstances described hereinbefore, the Deceased died.

DETAILS OF CONSEQUENTIAL LOSS AND DAMAGE

These are set out below in a Preliminary Schedule of Special Damages.

- (a) Funeral expenses: CI\$29,373.00

PARTICULARS OF LOSS OF DEPENDENCY

- (a) The dependents upon whose behalf the action is brought are:
- i) The Plaintiff whose date of birth is 7th July 1971;
 - ii) The Deceased's daughter Areini Joseph whose date of birth is 19th June 2008;
 - iii) The Deceased's mother Edith Jane Cook Jones whose date of birth is 30th April 1958;
 - iv) The Deceased's grandmother Edith Jones Ebanks whose date of birth is 24th March 1932.
- (b) The Plaintiff first met the Deceased in the Cayman Islands in 2000 and they started dating shortly thereafter. The Deceased moved to the Cayman Islands from Honduras having been born there. After a lengthy and unbroken relationship, they moved in together in 2003 and were married in 2009.

- (c) From about 2000 to 2007 the Deceased had worked at Hurleys Supermarket in the Cayman Islands as a front end manager and earned approximately CI\$4,000 per month. She stopped working at Hurleys Supermarket because the Plaintiff and she agreed that she should look after Areini whilst she was of pre-school years. The Deceased cared for Areini for about 1.5 years.
- (d) In early 2010 the Deceased and the Plaintiff agreed that the Deceased should return to work. They both agreed they did not wish the Deceased to return to shift work and the Deceased decided that she wanted to move into banking as a field of work. The Deceased obtained a job almost immediately as a bank teller at Scotia Bank. She was paid a monthly salary of CI\$2,500. At this time, the entry level for a bank teller at the Bank was usually CI\$1,500 but she had impressed her prospective employers so much at interview they had decided to offer her a starting salary of CI\$2,500. The Deceased successfully completed her 6 month probation period and out of the 6 months she spent on probation, she had received the "employee of the month" award on 4 occasions. She advanced her career prospects in banking by obtaining some Certificates. She also received a pension from the Bank.
- (e) It was the Deceased's settled intention to advance her career in the banking industry by securing further qualifications and consequently higher earnings. In 2010 she enrolled with the University College of the Cayman Islands to start courses in Banking and Accounting. She had been told she would not be a bank teller for long and would be promoted within the Bank.
- (f) But for her premature death, the Deceased would have secured this promotion. There has therefore been a loss of financial dependency to include dependency on earnings, fringe benefits and pension.
- (g) The Deceased would also send money back to members of her family in Honduras.

She would send between CI\$200 to CI\$300 per week to her mother for the benefit of her family. The family members living in Honduras who were dependent on these payments were her mother and grandmother.

(h) There has also been a loss of services dependency. The Plaintiff has lost the services of his wife and Areini has lost the services of a loving and doting mother. In due course the Plaintiff will seek to rely upon a nursing care expert to assist in the valuation of the claim for the loss of a mother's services.

39. As a result of the Deceased's death, the Plaintiff, who was the Deceased's husband, has suffered bereavement and there has been loss of expectation of life to be compensated with an award under the Estates Proceedings Law (1995 Revision).

40. Further the Plaintiff claims interest upon such damages as may be awarded to him pursuant to the provisions of section 34 of the Judicature Law (2013 Revision).

DETAILS OF THE CLAIM FOR INTEREST

Interest is claimed upon each and every item of consequential loss incurred to date from the date such loss occurred to be assessed pursuant to section 34 of the Judicature Law (2013 Revision) on the amounts found due, for such period and at such rates as the Court deems fit. This is on the basis that the Plaintiff and the dependents have suffered loss and incurred expenses which the Plaintiff will not recover from the Defendant until judgment in this matter is satisfied. Interest is claimed upon general damages at the rate of 2% per annum from the date of service of the Writ of Summons herein until the date of judgment.

AND the Plaintiff claims:

- (a) Damages for the estate of the Deceased pursuant to the Estates Proceedings Law (1995 Revision);
- (b) Damages for the loss of expectation of life under the Estates Proceedings Law (1995

Revision);

- (c) Damages for the dependents of the Deceased pursuant to the Torts (Reform) Law (1996 Revision);
- (d) Interest thereon pursuant to section 34 of the Judicature Law (2013 Revision) on the amount found to be due, for such periods and at such rates as the Court deems fit.

COLIN MENDOZA

Dated this day of July 2014

Stuarts Walker Hersant

Attorneys-at-Law for the Plaintiff

Amended this 21 day of November 2016



Stuarts Walker Hersant Humphries

Attorneys-at-Law for the Plaintiff

THIS STATEMENT OF CLAIM was served by Stuarts Walker Hersant, Attorneys-at Law for the Plaintiffs, whose address for service is that of its said Attorneys, namely 1 Cayman Financial Centre, 36A Dr. Roy's Drive, P.O. Box 2510, Grand Cayman KY1-1104, Cayman Islands.