Filed in accordance with an order made by His Honour on 18 August 2023.

Form 3A (version 7)
UCPR 6.2

AMENDED STATEMENT OF CLAIM

COURT DETAILS	
Court	Supreme Court of New South Wales
Division	Common Law
List	Representative Proceedings
Registry	Sydney
Case number	2023/00124390
TITLE OF PROCEEDINGS	
First Plaintiff	**MARK FAHEY**
First Defendant	~~**ANGLICAN COMMUNITY SERVICES INVESTMENT HOLDINGS PTY LTD TRADING AS ANGLICARE SYDNEY**~~ ~~**(ACN: 662 330 154)**~~ **ANGLICAN COMMUNITY SERVICES TRADING AS ANGLICARE SYDNEY** **(ABN: 39 922 848 563)**
Second Defendant	**NEPEAN BLUE MOUNTAINS LOCAL HEALTH DISTRICT**
FILING DETAILS	
Filed for	**Mark Fahey,** Plaintiff
Legal representative	Simon Morrison Shine Lawyers Level 6, 299 Elizabeth St Sydney NSW 2000
Legal representative reference	~~ECL:~~6281675
Contact name and telephone	~~Emily Clarke (02) 8754 7265~~ Christopher Slan, 02 8754 7281
Contact email	~~eclarke@shine.com.au~~ cslan@shine.com.au
TYPE OF CLAIM	

Representative Proceedings - Personal Injury – Occupiers Liability - Professional Negligence – Medical Negligence - Nervous Shock

NOTATION

These proceedings are listed for an initial case conference at 9.00 am on being the Wednesday after the expiration of 42 days following the filing of the originating process

RELIEF CLAIMED

1 Damages.

2 Interest.

3 Costs.

4 Such further order(s) as the Court considers appropriate.

PLEADINGS AND PARTICULARS

The Plaintiff and Group Members rely upon the following facts and assertions:

REPRESENTATIVE PROCEEDINGS

1 These proceedings are commenced as a representative proceeding pursuant to Part 10 of the *Civil Procedure Act 2005* (NSW) on behalf of the Plaintiff and all Group Members.

PARTIES

The Plaintiff

2 At all material times, Mark Fahey (**Plaintiff**) was the son of Ann Fahey (**Plaintiff's Mother**), born 26 October 1943.

3 At all material times, the Plaintiff's Mother:

a. entered into an agreement with the First Defendant to be a permanent resident of the Anglicare Newmarch House aged care facility, located at 50 Manning Street, Kingswood, NSW, 2747 (**Newmarch House**) in or about 14 December 2017.

b. remained a permanent resident at Newmarch House until her death.

c. was a 'care recipient' of 'residential care' services (**Residential Care Services**) provided by the First Defendant within the meaning of the *Aged Care Act 1997* (Cth) (**Aged Care Act**).

d. was virtually admitted to the 'Hospital in the Home' (**HITH**) service provided by the First and/or Second Defendant.

e. was treated within the HITH and Virtual Aged Care Service (**VACS**) model of care provided by the Second Defendant.

f. died at the Nepean Hospital, on 2 May 2020, from corona virus disease 2019 (**COVID- 19**).

4 The Plaintiff suffered injury loss and damage as a result of the death of the Plaintiff's Mother.

The Defendants

5 At all material times, the First Defendant:

(a) was a corporation able to be sued in and by its said corporate name and style.

(b) was an 'approved provider' of aged care within the meaning of the Aged *Care Quality and Safety Commission Act 2018* (Cth) and the Aged Care Act.

(c) was responsible for the care, control and management of the aged care facility known as Newmarch House.

6 At all material times, the Second Defendant:

a. was a body corporate able to be sued in its said corporate name and style pursuant to s17 and Schedule 1 of the *Health Services Act* 1997 (NSW).

b. was responsible for implementing and providing medical services for the prevention, detection, control, management and treatment of COVID-19 infection including the provision of ~~provided~~ medical treatment to the residents of the Newmarch House through the HITH and VACS model of care (**Medical Care Services**).

Group Members

7 For the purpose of this Statement of Claim:

a. "**Residents**" mean persons who were resident at Newmarch House ~~at any time~~ during the period from March 2020 to ~~June~~ May 2020, and died between 18 April 2020 and 19 May 2020 as a consequence of contracting COVID-19.

b. "**Family**" means spouse or partner of a Resident, child or step-child of a Resident or any other person for whom a Resident had parental responsibility, brother, sister, half-brother or half-sister or step-brother or step-sister of a Resident.

8 The Group Members to whom these proceedings relate (**Group Members**) ~~were at all material times Family who suffered injury, loss or damage as a result of~~:

a. ~~The First Defendant's conduct in the provision of Residential Care Services during an outbreak of Covid-19 at the Newmarch House aged care facility between April 2020 to June 2020.~~

b. ~~The Second Defendant's provision of medical care and treatment services administered through the HITH and VACS care model between April 2020 and June 2020.~~

c. Are Family.

d. Suffered mental harm consisting of a recognised psychiatric illness within the meaning of s.31 of the *Civil Liability Act 2002* (NSW) (**CLA**) as a result of the death of a Resident.

e. Allege that such mental harm was caused by breach by the First and Second Defendants of a duty owed to the Group Members.

f. Allege that the First Defendant's breach of its duty of care to the Group Members occurred as a result of acts and omissions by the First Defendant, its servants or agents, in the provision of Residential Care Services to Residents at Newmarch House.

g. Allege that the Second Defendant's breach of its duty of care to the Group Members occurred as a result of acts and omissions by the Second Defendant, its servants or agents, in the provision of Medical Care Services to Residents at Newmarch House.

9 The group comprises 7 or more persons.

10 The claims of the Group Members arise out of the same, similar or related circumstances.

10A The commonality between the Group Members includes:

a. Each Group Member being a "*close member of the family*" of a Resident within the meaning of s.30 CLA.

b. Each Resident to whom the Group Member was related having received Residential Care Services from the First Defendant during an outbreak of COVID-19 at Newmarch House between April 2020 and May 2020.

c. Each Resident to whom the Group Member was related having received Medical Care Services from the Second Defendant during an outbreak of COVID-19 at Newmarch House between April 2020 and May 2020.

d. Each Resident to whom the Group Member was related having contracted COVID-19 and died between 18 April 2020 and 19 May 2020 as a result of acts or omissions of the First Defendant in the provision of Residential Care Services.

e. Each Resident to whom the Group Member was related having contracted COVID-19 and died between 18 April 2020 and 19 May 2020 as a result of acts or omissions of the Second Defendant in the provision of Medical Care Services.

10B Furthermore, commonality of damage exists between the Group Members, having regard to the fact that each Group Member has suffered pure mental harm in the form of a recognised psychiatric illness caused by:

a. The First Defendant's negligent provision of Residential Care Services to the Residents between April 2020 and May 2020.

b. The Second Defendant's negligent provision of Medical Care Services between April 2020 and May 2020.

c. The death of a Resident as a consequence of contracting COVID-19 between 18 April 2020 and 19 May 2020.

11 The claims of the Group Members give rise to substantial common questions of law and fact.

OUTBREAK OF COVID-19 AT NEWMARCH HOUSE

Overview

12 At all material times, Newmarch House had 97 Residents.

13 On 11 April 2020, the First Defendant was notified that a staff member of Newmarch House had tested positive to COVID-19.

14 On or around 12 April 2020, the First Defendant engaged the services of the Second Defendant to provide clinical advice in respect of infection prevention and control (**IPAC**) procedures and, subsequently, appropriate medical treatment for the Residents.

15 Between 11 April 2020 and 7 May 2020, 34 staff members of Newmarch House and 37 Residents tested positive to Covid-19 (**COVID-19 Outbreak**).

Particulars

a. By 12 April 2020, 2 staff members and 2 Residents had tested positive to Covid-19.

b. By 13 April 2020, 6 staff members and 4 Residents had tested positive to Covid-19.

c. By 14 April 2020, 10 staff members and 5 Residents had tested positive to Covid-19.

d. By 15 April 2020, 10 staff members and 20 Residents had tested positive to Covid-19.

e. By 17 April 2020, 12 staff members and 20 Residents had tested positive to Covid-19.

f. By 18 April 2020, 14 staff members and 27 Residents had tested positive to Covid-19.

g. By 19 April 2020, 14 staff members and 28 Residents had tested positive to Covid-19.

h. By 21 April 2020, 15 staff members and 29 Residents had tested positive to Covid-19.

i. By 22 April 2020, 16 staff members and 29 Residents had tested positive to Covid-19.

j. By 23 April 2020, 16 staff members and 31 Residents had tested positive to Covid-19.

k. By 24 April 2020, 19 staff members and 34 Residents had tested positive to Covid-19.

l. By 26 April 2020, 20 staff members and 34 Residents had tested positive to Covid-19.

m. By 27 April 2020, 21 staff members and 34 Residents had tested positive to Covid-19.

n. By 28 April 2020, 22 staff members and 34 Residents had tested positive to Covid-19.

o. By 30 April 2020, 26 staff members and 37 Residents had tested positive to Covid-19.

p. By 3 May 2020, 28 staff members and 37 Residents had tested positive to Covid-19.

q. By 4 May 2020, 29 staff members and 37 Residents had tested positive to Covid-19.

r. By 5 May 2020, 30 staff members and 37 Residents had tested positive to Covid-19.

s. By 6 May 2020, 31 staff members and 37 Residents had tested positive to Covid-19.

t. By 7 May 2020, 34 staff members and 37 Residents had tested positive to Covid-19.

16 On 23 April 2020, the Aged Care Quality and Safety Commission (**ACQSC**), which exercised regulatory authority over the First Defendant, administered a direction to the First Defendant requiring it to appoint Baptiste Care to assist manage the COVID-19 Outbreak.

17 On 6 May 2020, ACQSC issued a notice on the First Defendant directing it to appoint an external manager to Newmarch House.

18 Between 18 April 2020 and 19 May 2020, 19 Residents died of COVID-19.

Particulars

a. Raymond Jennings on 18 April 2020.

b. Ronald Farrell on 19 April 2020.

c. Edith Brownlee on 21 April 2020.

d. Maria James on 23 April 2020.

e. Margaret Brocklehurst on 24 April 2020.

f. Keith Smith on 25 April 2020.

g. Leone Corrigan on 27 April 2020.

h. Barry Jehan on 28 April 2020.

i. Shirley Yates on 27 April 2020.

j. Blanche Billinghurst on 28 April 2020.

k. David Gee on 28 April 2020.

l. Catherine Adam on 28 April 2020.

m. Victor Stone on 30 April 2020.

n. Ann Fahey on 2 May 2020.

o. Marko Vidakovich on 4 May 2020.

p. Olive Grego on 5 May 2020.

q. Fay Rendoth on 8 May 2020.

r. Margaret Sullivan on 11 May 2020.

s. Alice Bacon on 19 May 2020.

Preparedness for COVID -19 Outbreak

19 At all material times, the First Defendant was responsible for the care and/or control and/or management of 23 aged care facilities, including Newmarch House.

20 The first positive case of COVID-19 was detected in Australia on 25 January 2020.

21 On 30 January 2020, COVID-19 was declared by the World Health Organisation to be a 'Public Health Emergency of International Concern'.

22 Sometime in March 2020, the First Defendant encouraged, but did not mandate, its' staff members to perform re-fresher training on infection control practices.

23 Sometime in March 2020, the First Defendant created a 'Surge Workforce' from internal staff to provide cover for the anticipated unavailability of staff due to the COVID-19 outbreak.

Particulars

a. By 1 April 2020, there were 30 members in the Surge Workforce team.

b. By 20 April 2020, there were 40 members in the Surge Workforce team.

24 On 23 March 2020, the First Defendant placed Newmarch House into a 'lockdown', and prevented anyone other than staff members, contractors and healthcare workers to enter and/or visit Newmarch House.

25 On 24 March 2020, the First Defendant responded to a questionnaire issued by the ACQSC and rated its' readiness for a COVID-19 outbreak to be 'best practice'.

Decision to Keep Residents at Newmarch House

26 On or around 11 April 2020, the First Defendant determined that all Residents were close contacts of persons infected with Covid-19 and directed that they could not leave Newmarch House.

27 On or around 14 April 2020, the ACQSC advocated to the need for 'cohorting' of Residents.

Particulars

a. The term 'cohorting' included options such as:

   i. The COVID-19 positive Residents be removed from Newmarch House.

   ii. The COVID-19 negative Residents be removed from Newmarch House.

   iii. The COVID-19 positive Residents be zoned within Newmarch House with other COVID-19 positive Residents.

iv. The COVID-19 negative Residents be zoned within Newmarch House with other COVID-19 negative Residents.

28 The Second Defendant opposed the recommendation to cohort Residents and insisted the Residents remain at Newmarch House.

Particulars

a. Dr Branley, head of the Infectious Diseases department within the Second Defendant, opposed the recommendations made by ACQSC regarding cohorting.

29 The First Defendant was party to the Second Defendant's opposition to cohorting Residents.

30 None of the 19 Residents who contracted COVID-19 were transported to hospital on account of being COVID-19 positive.

31 On 22 April 2020, a request was made from Family on behalf of Resident Barry Jehan to a representative of the First Defendant.

32 The request was to transfer Barry Jehan from Newmarch House if Mr Jehan remained COVID-19 negative.

33 The First Defendant declined this request on the alleged basis of Government Guidance and legally binding Public Health Orders.

Particulars

a. Email from Mr Goodhew of the First Defendant to John Van Put on behalf of Mr Jehan, dated 19 April 2020.

34 The First Defendant's representations in respect of the transfer request pleaded above were incorrect.

35 On 22 April 2020, the family of Mr Jehan sought clarification from the Second Defendant regarding the representations made by the First Defendant in respect of the transfer request pleaded above.

36 The Second Defendant confirmed the First Defendant's incorrect position.

Particulars

a. Email from Sarah Allen on behalf of Second Defendant to Gavin Taylor on behalf of Mr Jehan, dated 22 April 2020.

37 Effective cohorting of Residents did not occur until 1 May 2020, after an external infection control specialist was appointed to Newmarch House.

Staffing Shortages

38 The First Defendant experienced severe staff shortages throughout the COVID -19 Outbreak at Newmarch House.

Particulars

a. By 13 April 2020, 32 staff members of the First Defendant were unavailable to work.

b. By 15 April 2020, 40 staff members of the First Defendant (approximately 37%) were unavailable to work.

c. By 18 April 2020, approximately 94 of the First Defendant's staff members who were designated to work at Newmarch House were unavailable to work (approximately 87%).

39 On 13 April 2020, the First Defendant engaged "Mable", an online recruitment platform, to procure further staff.

40 Staff sourced by the First Defendant from Mable commenced working at Newmarch House on 16 April 2020.

41 Many of the staff sourced from Mable were not appropriately skilled or qualified and some had not worked in aged care before.

42 Despite the additional workers sourced through Mable, the First Defendant continued to experience severe staff shortages.

Particulars

a. At approximately 9pm on 16 April 2020, there was only 1 Registered Nurse and 1 care staff attending upon 20 Residents who had tested positive to COVID-19.

b. At some stage on 20 April 2020, the staffing shortage was so severe that every available staff member, including the management staff and cleaners, were working in the kitchen and serveries of Newmarch House.

c. At some stage on 20 April 2020, there was only 1 enrolled nurse and 3 registered nurses on duty. Two of these registered nurses were working their first ever shift.

d. At some stage on 20 April 2020, there was only 1 registered nurse attending to 28 Residents who had tested positive to COVID-19.

43 The Commonwealth Government offered to supply the First Defendant with clinical staff known as the 'Emergency Response Team' from Aspen Medical on 14, 15 and 17 April 2020.

44 The First Defendant declined to accept the Commonwealth Government's offers to supply staff from Aspen Medical, as pleaded above, until 20 April 2020.

45 The number of staff and healthcare agency workers did not materially improve until Baptist Care were appointed to assist the First Defendant at the instigation of ACQSC.

Standard of Residential Care Services

46 The standard of Residential Care Services provided by the First Defendant during the COVID-19 Outbreak was grossly inadequate and incompetent:

Particulars

a. The First Defendant and its staff ceased:
    i. Showering the Residents.
    ii. Assisting the Residents with toileting.
    iii. Providing laundry services.
    iv. Responding to call button requests from Residents.
    v. Administering medications on time, or at all.
    vi. Provision of timely and adequate meals and/or assistance to ingest same.
    vii. Provision of water and fluids and/or assistance to ingest same.
    viii. Caring for Residents who had suffered falls, pain and other acute incidents.
    ix. Emptying bins.
    x. Cleaning floors.
    xi. Changing bed linen and making the Residents' beds
b. On 17 April 2020:
    i. There were delays in breakfast being served.
    ii. Some Residents were not fed at all.
    iii. One Resident was not provided his insulin medication.

iv. The Residents' call buttons were going off, without any staff members responding.

c. On 18 April 2020, Resident Ron Farrell:

i. Could not breath properly because his oxygen mask was not working.

ii. Could not elicit assistance from the First Defendant's staff members due to call button continually not being answered.

iii. Was not served with his meals on time, or at all.

d. On 18 April 2020, Resident Ann Fahey:

i. Did not receive her lunchtime medication until 10pm.

e. Resident Ann Fahey reported:

i. She was not being showered.

ii. Was receiving bread only for lunch, as opposed to appropriate meals.

f. On 19 April 2020, Resident Keith Smith was on two occasions found to be kneeling down with a wet incontinence pad, incontinent of faeces and urine and was helped back into bed.

g. Several Residents developed pressure sores as a result of the lack of routine care.

h. Several residents were not provided with fluids, or not enough fluids.

i. Resident Fay Rendoth was given bottled water but could not open the lids.

ii. Resident ~~Mary~~ Alice Bacon was given bottled water but could not open the lids.

Communication with Residents and Family

47 During the Covid Outbreak ~~Period~~, the communication between the staff members of the First Defendant and Family was inadequate:

Particulars

a. Family called the Newmarch House premises regularly for updates on the condition of the Residents and the level of care the Residents were receiving without response, or alternatively, a timely response.

b. Contact was made by the First Defendant's staff members to incorrect Family, including one instance involving the death of a Resident.

48 The First Defendant caused broadcast communications to be conveyed to Family which were designed to reassure Family about the standard of Residential Care Services and medical care being received by the Residents and the First Defendant's adherence to COVID-19 protocols, but failed to convey the true position.

Particulars

a. Letter sent by First Defendant to Family on 22 April 2022.

b. Webinar conveyed to Family, at the direction of the First Defendant, on 23 April 2022.

49 The First Defendant's failure to provide adequate and/or accurate updates to Family was a source of ongoing distress and anguish for Family:

Particulars

a. Open letter from Family members to the First Defendant, dated 28 April 2020.

50 Communication between Family and the First Defendant did not improve until the Family Support Program was established on 30 April 2020 following the appointment of an independent advisor at the instigation of ASQSC.

51 The Second Defendant's level of communication with Residents and Family regarding the Residents' medical care needs was inadequate and/or inaccurate and a source of ongoing distress and anguish for Family.

Particulars

a. Family and Residents were not appropriately informed about the differences between the HITH and VACS model of care compared to the level of care which would be received in hospital.

b. Family input in respect of the Residents' Advanced Care Plans were not accurately recorded or considered.

c. Consent was not appropriately obtained from Residents or Family in respect of end-of-life procedures and/or the prescription of crisis medications and/or medical treatment.

Infection Prevention and Control

52 The First Defendant did not appoint or engage a specialist infection control expert to have a consistent presence at Newmarch House to implement and supervise appropriate infection prevention and control (**IPAC**) procedures during the COVID-19 Outbreak, until 1 May 2020.

Particulars

a. On 19 April 2020, the Quality and Compliance Manager of the First Defendant, proposed that the First Defendant seek to engage a full-time infection and control specialist. The First Defendant did not implement this proposal.

53 The First and/or Second Defendants did not implement daily testing to screen Residents for COVID-19 at Newmarch House.

Particulars

a. Polymerase chain reaction (**PCR**) testing did not occur at Newmarch House until 14 April 2020.

b. The second round of PCR testing did not occur at Newmarch House until 17 April 2020.

c. The third round of PCR testing did not occur until 23 April 2020.

d. The fourth round of PCR testing did not occur until 29 April 2020.

54 The First and/or Second Defendants did not cause daily PCR testing for the staff members and/or third-party contractors and/or clinical agency workers to ensure they were not COVID-19 positive until 4 May 2020.

55 The First and/or Second Defendants permitted staff members and/or third-party contractors and/or healthcare agency workers to travel between COVID-19 positive and COVID-19 negative ~~r~~Residents.

56 The First and/or Second Defendants did not ensure Residents adhered to isolation protocols by remaining in their rooms and/or in stay isolated from others during the COVID-19 Outbreak.

Particulars

a. First Defendant's meeting notes dated 16 April 2020.

b. On 20 April 2020, Resident Barry Jehan was videoed sitting in the lounge room of Newmarch House and not wearing a PPE mask.

c. Resident Alice Bacon continued her morning routine of making a cup of tea in the communal area of Newmach House until 24 April 2020.

d. Resident Victor Stone continued to leave his room after testing positive to COVID-19 on multiple occasions.

e. Residents of the Wentworth Heights wing of Newmarch House, in particular, did not adhere to the direction to isolate in their rooms.

57 The First and/or Second Defendants did not cohort the Residents of Newmarch House.

Particulars

a. The COVID-19 positive Residents were not transferred to hospital and/or removed from Newmarch House.

b. The COVID-19 negative Residents were not removed from Newmarch House.

c. The COVID-19 Positive and COVID-19 negative Residents were not segregated and separately grouped within Newmarch House.

58 The First and/or Second Defendants did not implement and/or supervise a standardised protocol regarding the use of PPE equipment in Newmarch House for all staff and healthcare agency workers to adhere to.

59 The First and Second Defendants did not issue appropriate PPE, namely N95 masks to staff and/or ~~r~~Residents.

Testing for COVID-19

60 The Second Defendant was responsible for conducting PCR testing of all Residents, agency workers and third-party contractors of Newmarch House and reporting the results thereafter.

61 The Second Defendant did not ensure that all Residents were tested on the same day at any one time.

62 The Second Defendant did not ensure the results of the COVID-19 tests were ~~administered~~ processed and communicated within 24 hours.

Particulars

a. 8 Residents who were tested on 26 and 27 April 2020 had not received their test results by 29 April 2020.

63 The Second Defendant did not address the results of the COVID-19 tests to an identified person or medical practitioner.

Particulars

a. Results were presented generically to Newmarch House.

Leadership and Coordination

64 Throughout the COVID-19 Period, there was an obligation on the First Defendant to provide clear leadership and adequate management and to administer a reasonably effective emergency response to the COVID-19 Outbreak.

Particulars

a. Need to liaise clearly with government authorities and healthcare agencies with accurate information regarding the COVID-19 status of Residents and workers.

b. Need to streamline infection control procedures amongst the various health agency workers to facilitate a consistent and controlled clinical environment.

c. Need for established a streamlined reporting structure for all staff members and healthcare agency workers.

d. Need for a clear chain of command.

e. Need to make executive decisions regarding the health of Residents and staff members.

65 Throughout the COVID-19 Period, there was a lack of clear leadership and adequate management shown by the First Defendant.

Particulars

a. There was no consistent executive presence at Newmarch House until approximately 24 April 2020.

b. An incident controller with clinical knowledge was not appointed.

c. The First Defendant's staff members were unable to provide ACQSC with relevant information regarding:

   i. Where the COVID-19 positive Residents were located within Newmarch House.

   ii. Who was the facility manager of Newmarch House.

   iii. Who was responsible for managing the response to the COVID-19 Outbreak.

   iv. The management structure of the First Defendant.

d. As of 24 April 2020, the Residential Care Manager of Newmarch House, was unable to inform Baptiste Care:

   i. How many Residents had tested positive to COVID-19.

ii. Where the Residents who had tested positive to COVID-19 were located within Newmarch House.

e. The executive board members of the First Defendant did not adequately support the Residential Care Manager of Newmarch House during the COVID-19 Period.

f. There was no clear chain of command and/or hierarchy.

g. The various healthcare agencies were unsure as to who to report non-compliance with IPAC to, nor who to approach to field enquiries or ventilate concerns.

h. The various healthcare agencies were left to apply their own rules and procedures regarding IPAC until 1 May 2020.

Hospital in the Home / VASC Care Model

66 The First and/or Second Defendant's determined the Residents who tested positive to COVID-19 be 'virtually' admitted to a service known as 'Hospital in the Home' (**HITH**), as opposed to being physically admitted into the care of a hospital.

67 The First and/or Second Defendant was responsible for the care and/or control and management of the HITH service.

68 The Second Defendant was responsible for the care, control and management of a service known as the Virtual Aged Care Service (**VACS**), a multidisciplinary team, which provided services in conjunction with the HITH program to Newmarch House during the COVID-19 Period.

69 Prior to the COVID-19 Period, the HITH service had not been involved in treating COVID-19 patients from an aged care facility.

70 The First and/or Second Defendant did not appoint a lead clinician under the HITH and VACS model of care.

71 VACS representatives commenced attending Newmarch House from 14 April 2020.

72 The HITH program was governed by the following guideline and policy:

a. NSW Health's Adult and Paediatrician Hospital in the Home Guideline 2018 (**HITH Guideline**)

b. NBMLHD Nepean Hospital in the Home Policy 2017 (**HITH Policy**).

73 The HITH Guideline prescribed, among other things, that:

a. A patient must receive daily clinical care or clinical review from a member of the multidisciplinary team.

b. To be suitable for HITH treatment, a patient must be competent in managing their condition and know when to escalate their care or have a live in carer who takes this responsibility.

c. A patient may not be eligible if they are medically unstable, require complex care that exceeds the capacity of the HITH service, are cognitively impaired or physically incapacitated with no live in carer to take responsibility.

d. It was a principle of the HITH Guideline that:

    i. HITH is acute/sub-acute care that requires the equivalent skilled staff and knowledge as those working in acute hospital environments.

    ii. 24-hour escalation processes be in place.

    iii. Participation in HITH requires consent and active involvement from patients and their carers who are to be informed of the clinical progress and changes in their clinical management.

    iv. Patients and their careers are to receive a written plan and instructions on how to escalate their care.

    v. Escalation processes ought to be in place, even for patients who cannot be contacted.

e. A written agreement should set out the roles and responsibilities of the facility (Newmarch House).

f. HITH is to give training and support to the facility staff, if the staff are to assist in the clinical care and management of acutely unwell patients.

g. A medical review will determine whether a patient can be treated within the HITH program or be transferred to a hospital for further treatment and assessment.

h. HITH service should have systems and processes in place to quickly recognise, respond to and escalate care for a deteriorating patient.

i. Staff of the facility are to be trained and competent in recognising and responding to signs of deterioration in adults and older people.

j. Vital signs of patients are to be recorded on a standardised observation chart, such as a Standard Adult General Observation (**SAGO**) Chart.

74 The HITH Policy was mandatory, and it stipulated, among other things, that:

a. In respect of admission criteria:

   i. There be a primary carer who is willing and competent to provide care in the home environment where required.

   ii. The patient must consent to receiving HITH treatment in the home.

b. In respect of exclusion criteria:

   i. Patients who decline the HITH service.

   ii. Patients that are at risk of non-compliance with the treatment regime.

c. All patients are to receive daily nursing contact.

d. Patients' care is to be escalated based on the Clinical Emergency Response System, as indicated on the SAGO charts.

e. Relevant consultants are to be contacted if a patient deteriorates.

75 The HITH Guideline and HITH Policy were breached in relation to the care provided to the Residents.

Particulars

a. There was no written agreement between HITH and the First Defendant and Residents and Family.

b. None of the staff members of Newmarch House were trained by HITH prior to the implementation of the HITH service.

c. Many Residents required complex care, were cognitively impaired and/or became medically unstable.

d. There were insufficient care staff at times.

e. Residents did not receive daily care or clinical review from the HITH team.

f. The Residents did not receive any regular reviews until the VACS team who only commenced regular telehealth consultations on 28 April 2020.

g. Many Residents showed signs of clinical deterioration, without escalation in care needs.

h. Vital signs were not recorded on SAGO charts. Rather, the vital signs were recorded in individual progress notes and charts, making it difficult to identify clinical deterioration.

i. There was no escalation process in place or being followed.

j. The HITH consultants were not contacted when deterioration in Resident's condition occurred.

k. Family of the Residents were unaware the Residents had been admitted to HITH and/or had no material understanding of HITH.

l. Consent from the Residents and Family was not obtained.

m. Newmarch House was not a safe clinical environment.

76 The VACS and HITH teams combined to create two key documents entitled:

a. 'Flow of RCF Patient Positive for SARS CoV2 (**Flow Chart**).

b. VACS COVID-19 Step Up Plan (**Step Up Plan**)

77 In accordance with the Flow Chart:

a. Daily phone calls by HITH nurses and VACS were to be made to check well-being and observations.

b. The VACS team were to ensure that advanced care plans were made for all COIVD-19 positive Residents and to liaise with facility GP's and family.

c. HITH and VACS were to inform the palliative care team of the Residents condition when appropriate.

d. An escalation plan was to be put in place, which ultimately reverted to the Advanced Care Plan of each ~~r~~Resident.

e. If active treatment was required, communication was to be made with VACS and the Infectious Disease department of the Second Defendant.

f. If deemed appropriate, the patient was to be transferred to Nepean Hospital.

78 The terms of the Flow chart were breached because:

a. Phone calls did not occur.

b. The Palliative care team did not get involved until 28 April 2020.

c. None of the Residents were transferred to Nepean Hospital for treatment and care of COVID-19 related symptoms.

79 The Step-Up Plan was approved by the Second Defendant in late March 2020 and mandated that referrals to VACS would be triaged to either telehealth consultations or face-to face consultations, with the latter to be arranged within 24 hours.

80 In accordance with the Set-Up plan:

a. The service was to liaise with the palliative care team to provide support and patient management during the end-of-life stages of Residents.

b. VACS team were to provide intravenous (**IV**) fluids and antibiotics (as opposed to the HITH team) and to assist the Newmarch House staff members.

c. The VACS team were supposed to be equipped with IV fluids, IV cannulas, blood collecting equipment, swabbing equipment.

81 The terms of the Step-Up Plan were breached because:

a. VACS telehealth consultations did not commence until 24 April 2020.

b. Face to face consultations from VACS were extremely rare and did not occur at all until after 17 April 2020.

c. Some of the Residents who tested positive to COVID-19 and subsequently passed away did not receive a single face-to-face consultation from a VACS clinician or medical staff at any time.

d. Intravenous fluids were never administered by VACS.

e. The VACS team were not fully equipped with IV fluids, IV cannulas, blood collecting equipment, swabbing equipment.

f. Many of the Residents met the exclusion criteria as a result of being hemodynamically unstable at times.

g. The palliative Care team was not involved until 24 April 2020.

82 Newmarch House was not a hospital and was not equipped to provide adequate Residential Care for Residents with COVID-19 Symptoms, nor was equipped to effectively manage Infection Control procedures.

Particulars

a. Newmarch House was not staffed with an appropriate number of health care workers to adequately assess the clinical condition of the Residents.

b. The Newmarch House health care workers were not appropriately skilled and/or clinically trained to implement and/or effectively operate with the HITH and VACS model of care.

c. The lack of communication from the Newmarch House staff severely compromised the ability of the HITH team to monitor the condition of the Residents.

d. The HITH and VACS teams did not have a clear understanding of or about the care being provided by the Newmarch House care workers.

e. Communication between the Newmarch House staff workers and VACS/ HITH was limited and/or compromised.

f. The recording of the Residents observations was not appropriately structured or recorded.

g. SAGO Charts were not used.

h. The VACS and HITH teams were not able to communicate with Family regarding the frequency or level of care being provided to the Residents.

i. Newmarch House did not have isolation rooms for Covid-19 infected ~~r~~Residents.

j. Newmarch House did not have negative pressure rooms to aid infection control.

k. The poor quality of and state of the clinical observations compromised the Second Defendant's ability to understand the progression of the Resident's illness and/or treat the Resident.

l. There was no escalation of the Resident's needs once the observations fell outside the normal ranges.

m. There was confusion regarding reporting lines.

83 VACS relied on remote review of clinical records until 24 April 2020 when telehealth consultation were held.

84 The Telehealth consultations were focussed on discussions around not transferring Residents to hospital and/or anticipatory medications and were not focussed on appropriate treatment or management of COVID-19 symptoms.

85 The COVID-19 ward of the closest Hospital to Newmarch House, Nepean Hospital, did not reach capacity at any stage during the COVID-19 period.

86 Morphine and midazolam (**crisis/end of life medications**) were prescribed to all of Residents who passed away during the COVID-19 Period.

87 The Second Defendant was responsible for prescribing the crisis medications.

88 The crisis medications were prescribed in response to a Resident contracting COVID-19 and in the absence of a thorough review and/or clinical indication that it would be appropriate.

89 There was inadequate consultation with Residents and/or Family regarding the prescription of crisis medications.

90 There was an emphasis on palliative care, as opposed to active treatment of the COVID-19 symptoms.

91 Most Residents had Advanced Care Plans prior to the COVID-19 Period, which were revised after the outbreak of COVID-19 at the direction of the Second Defendant.

92 Residents and Family members were not appropriately consulted as to their attitudes to resuscitation, intubation, ionotropic medication, hospital transfer and antibiotic use.

93 Residents and Family members were incorrectly advised that, apart from intubation, ventilation, CPR and life support, all other types of medical care and management could be administered at Newmarch House through the HITH and VACS care model.

94 Residents and Family were not adequately informed of the differences between the HITH/ VACS model of care by comparison to hospital admission.

95 The Second Defendant, in particular, emphasised the alleged benefits of Residents staying at Newmarch House under the HITH and VACS model of care.

96 Advanced Care plans were too general and not specific to the Resident's needs.

97 Newmarch House was in an inferior position for the provision of care and treatment to Residents compared to that of a hospital, having regard in particular to:

a. The number and quality of the nursing staff required .

b. The level of observation required .

c. The availability of specialised medical equipment.

d. The availability of doctors in the event of deterioration.

e. The fact that hospitals are designed for infection control (flooring of Newmarch house soft and not suitable to infection control).

f. The fact that Newmarch House staff were not trained, apart from the registered nurses.

g. The fact that assistance was required with meals.

h. Requirements for administration of medication.

i. Requirements for observation of vital signs.

j. The need for detection of deterioration and the availability of medical staff ~~available~~ to assess and manage the Resident.

k. The fact that , unlike a hospital, Newmarch House had no immediate access to pathology testing or imaging services.

l. The need for access to adequate and appropriate medications.

m. The fact that at Newmarch House there was no linen or laundry service available to clean sheets and clean clothes for the ~~r~~Residents.

n. The fact that at Newmarch House oxygen was used at a low flow rate with low flow nasal prongs, rather than high flow nasal prongs and appropriate masks that were available in a hospital.

o. The need for adequate staff to ensure appropriate equipment, such as oxygen tanks were being refilled and/or replaced.

p. The facility to isolate Residents, which was available in a hospital.

q. The fact that it was inappropriate for assessments to be conducted virtually and/or by telehealth given the age of the Residents and their comorbidities and the serious of COVID-19 virus.

r. The fact that a hospital would not prescribe crisis or end of life medications without review from palliative health care professionals and appropriate consent obtained.

STATUTORY AND REGULATORY CONTEXT

98 At all material times, the First Defendant was required to comply with:

(a) The Aged Care Act.

(b) The Quality-of-Care Principals made under s 96-1 of the Aged Care Act, including the Aged Care Quality Standards in Schedule 2.

(c) The *User Rights Principles 2014* (Cth) made under s 96-1 of the Aged Care Act (**User Rights Principles**), including the Charter of Aged Care Rights in Schedule 1 (**Charter**); and

(d) Directions made pursuant to s7 *Public Health Act 2010* (NSW) (**NSW Directions**).

Aged Care Act

99 At all material times, the following provisions of the Aged Care Act applied and had the following effect:

(a) Section 54-1(1) provided that the responsibilities of an approved provider in relation to the quality of residential aged care are:

(i) To provide such care and services as are specified in the Quality-of-Care Principles in respect of aged care of the type in question.

(ii) To maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.

(iii) To provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles for the purposes of paragraph 56-1(m), 56-2(k) or 56-3(1).

(iv) To comply with the Aged Care Quality Standards made under section 54-2.

(v) To observe such other responsibilities as are specified in the Quality-of-Care Principles.

(b) Section 56-1 provided that the responsibilities of an approved provider in relation to a care recipient are, *inter alia*:

(i) Not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles [s 56-1(m)].

(ii) Such other responsibilities as are specified in the User Rights Principles [s 56-1(n)].

(c) Section 9-1(1), read with s 63-1(1)(c), provided that an approved provider must notify the Aged Care Quality and Safety Commissioner of a change of circumstances that materially affects the approved provider's suitability to be a provider of aged care within 28 days after the change occurs.

Quality of Care Principles

100 At all material times, the following provisions of the Quality-of-Care Principles Act 2014 applied and had the following effect:

(a) Section 7 provided that an approved provider of a residential care service must provide the care or service specified in Schedule 1 to any care recipient who needs it, in a way that complies with the Aged Care Quality Standards, including (*inter alia*):

(i) the following hotel services:

1. Cleanliness and tidiness of the entire residential care service, only excluding a care recipient's personal area if the care recipient chooses and is able to maintain this himself or herself [item 1.6 of the table at Schedule 1, Part 1].
2. Meals of adequate variety, quality and quantity for each care recipient, served each day at times generally acceptable to both care recipients and management, and generally consisting of 3 meals per day plus morning tea, afternoon tea and supper [item 1.10(a) of the table at Schedule 1, Part 1].
3. Special dietary requirements, having regard to either medical need or religious or cultural observance [item 1.10(b) of the table at Schedule 1, Part 1].
4. At least one responsible person is continuously on call and in reasonable proximity to render emergency assistance [item 1.12 of the table at Schedule 1, Part 1].

(ii) the following care and services:

1. Personal assistance, including individual attention, individual supervision, and physical assistance, with the following: bathing, showering, personal hygiene and grooming; maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management; eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary); dressing, undressing, and using dressing aids; moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids [item 2.1 in the table at Schedule 1, Part 2].
2. Emotional support to, and supervision of, care recipients [item 2.3 in the table at Schedule 1, Part 2].
3. Treatments and procedures that are carried out according to the instructions of a health professional or a person responsible for assessing a care recipient's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, subject to requirements of

State or Territory law (includes bandages, dressings, swabs and saline) [item 2.4 in the table at Schedule 1, Part 2].

4. Individual attention and support to care recipients with cognitive impairment (for example, dementia and behavioural disorders) [item 2.9 in the table at Schedule 1, Part 2].

(b) Section 18 provided, *inter alia*, that the Aged Care Quality Standards applied to residential care, and that the Standards applied equally for the benefit of each care recipient being provided with residential care through an aged care service, irrespective of the care recipient's financial status, applicable fees and charges, amount of subsidy payable, agreements entered into, or any other matter.

Aged Care Quality Standards

101 At all material times, the following provisions of the Aged Care Quality Standards, at Schedule 2 of the Quality-of-Care Principles Act, applied and had the following effect:

(i) Standard 1 required approved providers to demonstrate that (*inter alia*):

(i) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued [clause 1(3)(a)].

(ii) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice [clause 1(3)(e)].

(ii) Standard 2 required approved providers to demonstrate that (*inter alia*):

(i) Assessment and planning, including consideration of risks to the consumer's health and well-being, informs the delivery of safe and effective care and services [clause 2(3)(a)].

(ii) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer [clause 2(3)(e)].

(iii) Standard 3 required approved providers to demonstrate (*inter alia*):

(i) That each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; and is tailored to their needs; and optimises their health and well-being [clause 3(3)(a)].

(ii) Effective management of high-impact or high-prevalence risks associated with the care of each consumer [clause 3(3)(b)].

(iii) That deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner [clause 3(3)(d)].

(iv) Minimisation of infection-related risks through implementing standard and transmission-based precautions to prevent and control infection [clause 3(3)(g)(i)].

(iv) Standard 4 required approved providers to demonstrate (*inter alia*):

(i) That each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, well-being and quality of life [clause 4(3)(a)].

(ii) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared [clause 4(3)(d)].

(v) Standard 5 required approved providers to demonstrate (*inter alia*):

(i) The service environment is safe, clean, well maintained and comfortable [clause 5(3)(b)(i)].

(ii) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer [clause 5(3)(c)].

(vi) Standard 6 required providers to demonstrate that, *inter alia*, appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong [clause 6(3)(c)].

(vii) Standard 8 required providers to demonstrate (*inter alia*):

(i) Effective organisation wide governance systems relating to the following information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints [clause 8(3)(c)].

(ii) Effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers; and identifying and responding to abuse and neglect of consumers [clause 8(3)(d)].

User Rights Principles

102 At all material times, the following provisions of the User Rights Principles 2014 applied and had the following effect:

(a) Sections 9 and 9A of the User Rights Principles provided that, for the purposes of paragraph 56-1(m) of the Aged Care Act:

(i) The rights of a care recipient who is being provided with, or is to be provided with, residential care include the rights mentioned in the Charter [section 9].

(ii) An approved provider of residential care must not act in a way which is inconsistent with the legal and consumer rights of a care recipient [section 9A].

Charter

103 At all material times, the following provisions of the Charter, at Schedule 1 of the User Rights Principles 2014, applied and had the following effect:

(a) Clause 2 provided that care recipients who are provided with residential care have the right to (*inter alia*):

i. Safe and high-quality care and services.

ii. Be treated with dignity and respect.

iii. Live without abuse and neglect.

iv. Be informed about their care and services in a way they understand.

v. Be listened to and understood.

NSW Government Directions

104 At all material times, the following NSW Directions applied and had the following effect:

105 *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020*:

a. Persons not permitted to enter aged care facilities if they have been outside of Australia in previous fourteen (14) days.

b. Persons not permitted to enter aged care facilities if they have been in contact with someone who was positive for COVID-19.

c. Persons not permitted to enter aged care facilities if they have a temperature higher than 37.5 degrees centigrade.

d. Persons not permitted to enter aged care facilities if they do not have an up-to-date influenza vaccine.

e. Persons under sixteen (16) years of age not permitted to enter aged care facilities, with the exception of end-of-life care.

f. The operator of the aged care facility must take all reasonable steps to ensure that a person in the category of those listed in points a - e does not enter the facility.

106 *Public Health (COVID-19 Spitting and Coughing) Order 2020*:

a. Persons must not intentionally spit at or cough on a public official in a way that would reasonably be likely to cause fear about the spread of COVID-19.

107 *Public Health (COVID-19 Restrictions on Gathering and Movement) Order 2020*:

a. Persons may not, without reasonable excuse, leave their place of residence. Reasonable excuses include medical or caring reasons.

b. Persons may not, without reasonable excuse, participate in a gathering of a public place with more than two (2) persons. Reasonable excuses are listed under point 107.

c. Reasonable excuses include:

i. Providing assistance to a vulnerable person;

ii. Providing emergency assistance;

iii. A gathering at a hospital or other medical or health service facility that is necessary for the normal business of the facility;

iv. a gathering at a disability or aged care facility that is necessary for the normal business of the facility.

APPLICABLE GUIDLINES

108 Further, the First and/or Second Defendant was aware, or ought to have been aware, of the content of the following guidelines:

(a) The CEC Guidelines entitled *Infection Prevention and Control COVID-19 (Sars-Cov-2) Residential and Aged Care Facilities* issued by the NSW Health Clinical Excellence Commission on 12 March 2020 (**CEC Guidelines**).

(b) The CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

(**CDNA National Guidelines**) issued by the Communicable Diseases Network Australia on ~~from~~ 13 March 2020, and updated on 30 April 2020.

(c) The WHO Interim guidelines entitled *Infection Prevention and Control Guidance for Long Term Care Facilities in the Context of COVID-19* issued by the World Health Organisation on 21 March 2019 (**WHO Guidelines**).

(d) The Interim Guidelines for the Clinical Management of COVID-19 issued by the Australian Society for Infectious Diseases Limited (**ASID Guidelines**) from 20 March 2020.

(e) The Living Guidelines for treatment of people with corona virus from the Australian National COVID-19 Clinical Evidence Taskforce (**Living Guidelines**) from April 2020.

CDNA National Guidelines

109 On or about 13 March 2020, the CDNA National Guidelines were published publicly on the Department's website and contained provisions to the following effect:

(a) Clause 1.3.1 provided that all residential care facilities (*inter alia*):

i. Should have in-house (or access to) infection control expertise, and outbreak management plans in place.

1. Are required to: detect and notify outbreaks to state health departments; self-manage outbreaks in accordance with the CDNA National Guidelines, the Infection Control Guidelines and the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* (2020); confirm and declare an outbreak; provide advice on infection control measures and use of PPE; and confirm and declare when an outbreak is over.

(b) With respect to preparation, clause 3.1 provided that facilities (*inter alia*):

(i) Should prepare an "outbreak management plan" which includes the prevention strategies outlined in the CDNA National Guidelines [3.1.1].

(ii) Must identify a dedicated staff member to plan, co-ordinate and manage logistics in an outbreak setting as well as communicate and liaise with the state/territory health department [3.1.1].

(iii) Should inform and support staff to exclude themselves from work when they have any kind of respiratory illness and to notify the facility if they were confirmed to have COVID-19. The principle underlying staff and

visitors staying away from the facility if they are unwell should be reinforced by placing signage at all entry points to the facility [3.1.2].

(iv) Should have a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work. The workforce management plan should be able to cover a 20 to 30% staff absentee rate [3.1.3].

(v) Are responsible for ensuring their staff are adequately trained and competent in all aspects of outbreak management prior to an outbreak. Staff should know the signs and symptoms of COVID-19 in order to identify and respond quickly to a potential outbreak [3.1.4].

(vi) Should ensure that they hold adequate stock levels of all consumable materials required during an outbreak, including: PPE (gloves, gowns, masks, eyewear); hand hygiene products (alcohol-based hand rub, liquid soap, hand towel); diagnostic materials (swabs); cleaning supplies (detergent and disinfectant products) [3.1.5].

(vii) Should have an effective policy in place to obtain additional stock from suppliers as needed. In order to effectively monitor stock levels, facilities should: undertake regular stocktake (counting stock); and use an outbreak kit/box [3.1.5].

(c) With respect to prevention, clause 3.2 provided that facilities (*inter alia*):

(i) Are expected to use risk assessments to ensure the risks of a COVID-19 outbreak are as low as possible, which can involve examining the facility's service environment, equipment, workforce training, systems, processes or practices that affect any aspect of how they deliver personal and clinical care.

(ii) Should instruct all staff to self-screen for symptoms of COVID-19. Staff must not come to work if symptomatic and must report their symptoms to the facility. Sick leave policies must enable employees to stay home if they have symptoms of respiratory infection [3.2.1].

(iii) Must instruct visitors not to enter the facility if they have symptoms of COVID-19 [3.2.1].

(iv) Must monitor residents and employees for fever or acute respiratory symptoms [3.2.1 and 3.2.3].

(v) Must restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, facilities should have them wear a facemask (if tolerated) [3.2.1].

(vi) Must implement non-pharmaceutical measures, which include: hand hygiene and cough and sneeze etiquette; use of appropriate PPE; environmental cleaning measures; isolation and cohorting; and social distancing [3.2.1].

(vii) Should advise all regular visitors to be vigilant with hygiene measures including social distancing, and to monitor for symptoms of COVID-19, specifically fever and acute respiratory illness. They should be instructed to stay away when unwell, for their own and residents' protection, and to observe any self-quarantine requirements [3.2.2].

(viii) Notify any possible COVID-19 illness in residents and employees to the relevant jurisdictional public health authority [3.2.3];

(d) With respect to identifying COVID-19, clause 4 provided that facilities (*inter alia*):

(i) Should establish systems to monitor staff and residents for COVID-19 with a high level of vigilance and have a low threshold for investigation [4.1];

(ii) Identification of a resident or staff member with acute respiratory illness should be followed by prompt testing for a causative agent and, while confirmation of SARS-CoV-2 infection is pending, immediate and appropriate infection control management of the person with acute respiratory illness may prevent further spread of the disease [4.1].

(e) With respect to COVID-19 case and outbreak management, clause 5 provided that facilities (*inter alia*):

(i) Should immediately isolate residents (**cohort**) with suspected or confirmed COVID-19 and minimise interaction with other residents [5.1].

(ii) Should immediately exclude from the facility any member of staff who develops symptoms of respiratory illness and instruct them to remain away whilst a diagnosis is sought [5.2].

(iii) With a suspected or confirmed COVID-19 outbreak, must use standard precautions including performing hand hygiene before and after every episode of resident contact, the use of PPE (including gloves, gown, appropriate mask and eye protection)

depending on the anticipated exposure, good respiratory hygiene/cough etiquette and regular cleaning of the environment and equipment [5.4.2].

DUTY OF CARE AND NEGLIGENCE

The First Defendant's Negligence

110 At all material times, the First Defendant by its servants and agents owed a non-delegable duty of care to each of the Residents, ~~to the Plaintiff and to the Family~~ to ~~take~~ ensure reasonable care was taken when providing Residential Care Services to avoid foreseeable risks of harm~~,~~ to the Residents. ~~including mental harm, associated with the provision of residential and aged care services at Newmarch House.~~

110A Alternatively, the First Defendant, by its servants or agents, owed each of the Residents a general duty of care when providing Residential Care Services to avoid foreseeable risks of harm to the Residents.

110B The scope of the duty of care owed by the First Defendant to the Residents extended to the taking of care to avoid Residents dying as a consequence of contracting COVID - 19.

110C At all material times, the First Defendant owed the Plaintiff and Family a duty of care to take reasonable care to avoid foreseeable risks of harm, including pure mental harm, caused as a result of harm being suffered by Residents whilst receiving Residential Care at Newmarch House.

110D The scope of the duty of care owed by the First Defendant to the Plaintiff and Family extended to the taking of reasonable care to avoid the death of Residents as a consequence of contracting COVID-19.

111 The duty of care owed by the First Defendant to the Plaintiff and the Family arose, inter alia, out of the following factors:

a. the Residents were elderly and vulnerable,

b. the Residents had been entrusted to the care and control of the First Defendant,

c. the First Defendant had been relied upon by the Family to ensure the safety and wellbeing of the Residents and thereby had a proximity of relationship with the Residents, the Plaintiff and the Family,

d. the relationship between the Residents and their families was such that the Plaintiff and the Family were vulnerable to pure mental harm in the event that a Resident ~~their family members~~ died whilst in the care of the First Defendant

e. ~~it was reasonably foreseeable that the Plaintiff and the Family would suffer mental harm if their family members died whilst in the care of the First Defendant.~~

f. the Family were *"close family members"* of the Residents, as that term is defined in s30(5) CLA.

g. it was reasonably foreseeable that a close family member of a Resident of normal fortitude would suffer a recognised psychiatric illness in circumstances where the Residents died as a consequence of contracting COVID-19 whilst in the care of the First Defendant.

112 At all material times there was a risk of harm (the risk of harm) that:

a. failure to exercise reasonable care and skill in the provision of ~~residential and aged care services~~ Residential Care Services at Newmarch House could cause the ~~r~~Residents to suffer injury or death, and

b. failure to exercise reasonable care and skill in the prevention, detection, control, management and treatment of COVID-19 infection could result in ~~r~~Residents becoming infected with, and dying from, COVID-19.

c. the Plaintiff and the Family could suffer pure mental harm as a result of ~~the death of~~ Residents dying as a consequence of contracting COVID – 19 whilst at Newmarch House.

113 The risk of harm to the Plaintiff and Family was foreseeable by the First Defendant, being:

a. a risk of harm that a person of normal fortitude might suffer in the circumstances, and

b. a risk of which the First Defendant either knew or ought to have known.

114 The risk of harm was not insignificant.

115 The First Defendant was negligent and failed to take precautions against the risk of harm that a reasonable person in the defendant's position would have taken in the circumstances.

Particulars of Negligence and Failure to take Reasonable Precautions

A reasonable person in the position of the First Defendant and/or in the position of the First Defendant's employees and/or agents and/or contractors would have taken the following precautions against the risk of harm:

1. Ensured that there was an adequate number of members in the Surge Workforce.
2. Mandated re-fresher training for all staff members involved in providing Residential Care Services at Newmarch House.
3. Ensured the effective cohort of the Residents into zones of COVID-19 positive and COVID-19 negative.
4. Transferred COVID-19 positive Residents to hospital.
5. Removed the COVID-19 negative Residents from Newmarch House.
6. Providing correct information to Family regarding government guidance, public health orders and potential fines.
7. Accepted the offers from the Commonwealth Government to supply clinical healthcare agency workers from Aspen Medical ~~until~~ prior to 20 April 2020.
8. Provided basic care needs to Residents, inclusive of showering, toileting, laundry, responding to call button requests, administering medications on time, or at all, provision of timely and adequate meals and/or assistance to ingest same, provision of water and fluids and/or assistance to ingest same, care for Residents who had suffered falls, pain and other acute incidents, emptying bins, cleaning floors, and changing bed linen.
9. Provided reasonably regular updates to Family regarding the Residential Care Services being provided to the Residents during the COVID-19 Outbreak.
10. Provided reasonably regular updates to Family regarding the level of medical care being received by the Residents.
11. Maintained a registry of emergency contacts to ensure the correct Family members were notified of incidents and important updates.
12. Appointed a specialist infection control expert.
13. Transferred the COVID-19 positive ~~r~~Residents to hospital immediately.
14. Used adequate and precautionary PPE, namely N95 respirators.

15. Ensured there was an adequate number of staff members to implement and oversee effective IPAC.
16. Ensured staff members and healthcare agency workers were adequately trained in the appropriate use of PPE.
17. Ensured the effective cohorting of Residents, or cohorting them at all.
18. Ensured staff members and healthcare agency workers did not transfer between COVID-19 positive and COVID-19 negative Residents.
19. Ensured Residents complied with isolation protocols.
20. Tested ventilation within Newmarch House and/or mitigating areas of poor ventilation.
21. Recognised that Newmarch House was not designed for effective IPAC during an outbreak of an infectious disease.
22. Adequately explained to Family the differences between HITH and hospital admission.
23. ~~Transferred COVID-19 positive residents to hospital immediately.~~
24. Recognised that a hospital is far greater equipped than an aged care facility to provide a higher standard of medical care.
25. Recognised that Newmarch House is an aged care facility, not a not a health care facility.
26. Not treated the Residents in the HITH and VACS model of care, which was inadequate.
27. Ensured adequate numbers of staff and/or healthcare agency workers to provide appropriate treatment.
28. Ensured the staff members of the First Defendant were adequately trained to provide appropriate treatment to the Residents who were infected by COVID-19.
29. Used high flow oxygen.
30. Assisted Residents to use oxygen therapy equipment.
31. Used IV fluids.
32. Obtained appropriate consent from the Residents and Family in the context of treating the Residents in the HITH and VACS care model.
33. Not misinformed Family about HITH's ability to care for COVID-19 positive Residents.

34. Adhered to Family requests for Residents to be transferred to hospital if needed.

35. Recognised and adhered to the admission and exclusion criteria for HITH, namely: ~~r~~Residents who required complex care and that Newmarch House was not a safe environment to administer the HITH program for the Residents, the skill and capacity of the treatment providers, and ~~their~~ level of communication to, and informed consent from, the Residents' carers.

36. Not actively encouraged Residents and Family to utilise 'not-for resuscitation' orders.

37. ~~Not used crisis medications (morphine and midazolam) as a blanket response to COVID-19 infection when it was inappropriate to do so.~~

38. ~~Not Prescribed Ventolin (an Asthma medication) to non-asthmatic Residents~~.

39. Adequately recorded clinical data, vital signs and SAGO charts.

40. Provided adequate communication between Family and healthcare treatment providers.

41. Not excluded regular treatment providers, such as GP's, from providing care to the Residents.

42. ~~Taken reasonable care in the provision of residential care services to Residents~~.

43. Ensured ~~residential care services~~ appropriate Residential Care Services were provided to Residents.

44. Taken reasonable care to ensure that adequate measures were taken to prevent and/or minimise and/or control and/or treat infection of COVID-19.

45. Ensured adequate preparation was undertaken to manage an outbreak of Covid-19 at Newmarch House.

46. Implemented cohorting and/or a similar practice to reduce the risk and/or severity of an outbreak of COVID-19 at Newmarch House.

47. Ensured that reasonable care was taken by employees and/or healthcare agency workers, including those representing the Second Defendant, to provide ~~residential care services~~ Residential Care Services and/or implement measures to prevent, minimise, control and treat infection of COVID-19.

48. Provided safe and/or effective care and/or medical treatment to Residents tailored to their needs and that optimised their health and well-being.

49. Taken all measures available to reduce the risk of ~~r~~Residents contracting Covid-19 infection.

50. Complied with the Aged Care Act and/or the Quality of Care Principals made under s 96-1 of the Aged Care Act, including the Aged Care Quality Standards in Schedule 2 and/or the *User Rights Principles 2014* (Cth) made under s 96-1 of the Aged Care Act (User Rights Principles), including the Charter of Aged Care Rights in Schedule 1 (Charter); and/or directions made pursuant to s7 *Public Health Act 2010* (NSW) (NSW Directions).

51. Complied with the CEC Guidelines and/or the CDNA National Guidelines and/or the WHO Guidelines and/or the ASID Guidelines and/or the Living Guidelines.

52. Ensured that deterioration and/or change in a Resident's mental and/or physical health was recognised and that they were then provided adequate medical treatment.

53. Adequately and/or accurately communicated with Family as to the Outbreak and the measures taken to manage the Outbreak.

54. Exercised reasonable care and skill in treating the Residents.

55. Ensured ~~r~~Residents were treated to a standard that would be accepted by widespread peer professional opinion as competent professional medical practice.

56. ~~Taken adequate steps to minimise the spread of Covid-19.~~

57. Provided ~~r~~Residents infected with Covid 19 the best chance to survive by ensuring they were provided with the adequate and/or competent medical treatment and advice.

58. ~~Ensured there were not staff shortages during the Outbreak~~.

59. ~~Ensured adequate communication with Residents and/or Family.~~

60. Ensured there was adequate testing for COVID-19.

61. Not implemented HITH in respect to each Resident but assessed each Resident individually to ensure whether HITH would provide them with the best medical outcome.

62. Ensured entrants to Newmarch House were tested and cleared of COVID-19 before they entered the facility.

63. Ensured all entrants to Newmarch House were provided with adequate PPE and that they used PPE on the premises.

64. ~~Sought the consent of residents and/or their family to HITH individually before implementing HITH~~.

65. Responded to complaints by Family in a timely manner.

66. Promptly communicated changes in the mental and/or physical condition of Residents to Family.

67. Taken reasonable care to ensure that the system of care at Newmarch House did not cause or materially contribute to the death or injury of Residents.

68. Promptly and regularly informed Family of the conditions at Newmarch House regarding safety and health and any changes in those conditions.

69. Such further precautions disclosed from the outcome of ongoing and pending investigations and inquiries.

70. Ensured clear leadership and management to administer an effective emergency response to the COVID-19 Outbreak.

71. Liaised clearly with government authorities and healthcare agencies with accurate information regarding the COVID-19 status of Residents and workers.

72. Streamlined IPAC amongst the health agency workers.

73. Established a clear chain of command, with a streamlined reporting structure for all staff members and healthcare agency workers to report to thereunder.

74. Maintained a consistent executive presence at Newmarch House.

75. Ensured the Residential Care manager of Newmarch House was adequately supported.

116 Additionally, the Plaintiff relies upon the matters pleaded above under the headings 'Statutory and Regulatory Context' and "Applicable Guidelines" as informing the duty of care owed by the First Defendant to the Residents, including the Plaintiff's Mother, and detailing further reasonable precautions that ought to have been taken.

The Second Defendant's Negligence

117 At all material times the Second Defendant by its servants or agents owed a ~~non-delegable~~ duty of care to each of the Residents~~, to the Plaintiff and to the Family~~ to take reasonable care to avoid foreseeable risks of harm~~, including mental harm, in the provision of treatment and services~~ when providing Medical Care Services to ~~Newmarch House and its residents~~ the Residents of Newmarch House.

117A The scope of the duty of care owed by the Second Defendant to the Residents extended to the taking of reasonable care to avoid Residents dying as a consequence of contracting Covid – 19.

117B At all material times, the Second Defendant owed the Plaintiff and Family a duty of care to take reasonable care to avoid foreseeable risks of harm, including pure mental harm, caused as a result of harm being suffered by Residents as a result of the provision of Medical Care Services to the Residents.

117C The scope of the duty of care owed by the Second Defendant to the Plaintiff and the Family extended to the taking of reasonable care to avoid the death of Residents as a consequence of contracting Covid-19.

118 The duty of care owed by the Second Defendant to the Plaintiff and the Family arose, inter alia, out of the following factors:

a. the ~~r~~Residents were elderly and vulnerable,

b. the Medical Care ~~s~~Services provided by the Second Defendant impacted directly on the health, safety and wellbeing of the Residents.

c. the Second Defendant thereby had a proximity of relationship with the Residents, the Plaintiff and the Family,

d. the relationship between the Residents and their families was such that the Plaintiff and the Family were vulnerable to pure mental harm in the event that a Resident ~~their family members~~ died whilst at Newmarch House as a result of COVID-19 infection.

~~e. it was reasonably foreseeable that the Plaintiff and the Family would suffer mental harm if their family members died as a result of COVID-19 infection.~~

f. the Family were close family members of the Residents, as that term is defined in s30(5) CLA.

g. the Family relied upon and entrusted the Second Defendant to provide a professional level of Medical Care Services to the Residents.

h. it was reasonably foreseeable that a close family member of a Resident of reasonable fortitude would suffer a recognised psychiatric illness in circumstances where the Residents died as a consequence of contracting COVID – 19 whilst in the care of the Second Defendant.

119 At all material times there was a risk of harm (the risk of harm) that:

a. failure to exercise reasonable care and skill in the provision of ~~treatment and services~~ Medical Care Services at Newmarch House could cause the ~~r~~Residents to suffer injury or death, and

b. failure to exercise reasonable care and skill in the prevention, detection, control, management and treatment of COVID-19 infection could result in ~~r~~Residents becoming infected with, and dying from, COVID-19.

c. the Plaintiff and the Family could suffer pure mental harm as a result of the ~~death of residents~~ Residents dying as a consequence of contracting COVID-19 whilst at Newmarch House.

120 The risk of harm to the Plaintiff and Family was foreseeable by the Second Defendant, being:

a. a risk of harm that a person of normal fortitude might suffer in the circumstances, and

b. a risk of which the Second Defendant either knew or ought to have known.

121 The risk of harm was not insignificant.

122 The Second Defendant was negligent and failed to take precautions against the risk of harm that a reasonable person in the defendant's position would have taken in the circumstances.

Particulars of Negligence and Failure to take Reasonable Precautions

A reasonable person in the position of the Second Defendant and/or in the position of the Second Defendant's employees and/or agents and/or contractors would have taken the following precautions against the risk of harm:

1. Not threatening to issue a public health order if attempts were made to move COVID-19 negative Residents from Newmarch House and threatened fines and imprisonment.
2. Adequately explaining the differences between the HITH and VACS model of care by comparison to standard of medical care which would be received during hospital admission.
3. Obtaining Residents and Family consent in respect of end of life procedures and the prescription of crisis medications.
4. Provided reasonable surveillance and management of IACP and professional medical treatment measures at Newmarch House.
5. Ensured Residents were afforded and/or provided adequate medical treatment.
6. Not imposed HITH on each Resident.

7. Ensured safe and/or effective care and/or medical treatment was provided to Residents, which was tailored to their needs and that optimised their health and well-being.
8. Ensured ~~r~~Residents were treated to a standard that would be accepted by widespread peer professional opinion as competent professional medical practice.
9. ~~Ensured cohorting was implemented to reduce the risk of COVID-19 spreading.~~
10. Taken reasonable care to ensure that the system of care at Newmarch House did not cause or materially contribute to the death or injury of Residents.
11. Ensured the effective cohort of the Residents into zones of COVID-19 positive and COVID-19 negative.
12. ~~Transferred COVID-19 positive Residents to hospital.~~
13. Transferred the COVID-19 positive ~~r~~Residents to hospital immediately.
14. Recognised that Newmarch House was not designed for effective IPAC during an outbreak of an infectious disease.
15. ~~Adequately explained to Family the differences between HITH and hospital admission.~~
16. Recognised that a hospital is far greater equipped than an aged care facility to provide a higher standard of medical care.
17. Recognised that Newmarch House is an aged care facility, not a not a health care facility.
18. Not treated the Residents in the HITH and VACS model of care, which was inadequate.
19. Ensured adequate numbers of staff and/or healthcare agency workers to provide appropriate treatment.
20. Ensured the staff members of the First Defendant were adequately trained to provide appropriate treatment to the Residents who were infected by COVID-19.
21. Used high flow oxygen.
22. Used IV fluids.

23. Obtained appropriate consent from the Residents and Family in respect of the Medical Care Services associated with the HITH and VACS care model.

24. Not misinformed Family about HITH's ability to care for COVID-19 positive Residents.

25. Adhered to Family requests for Residents to be transferred to hospital if needed.

26. Recognised and adhered to the admission and exclusion criteria for HITH, namely: ~~r~~Residents who required complex care and that Newmarch House was not a safe environment to administer the HITH program for the Residents, the skill and capacity of the treatment providers, and the~~ir~~ level of communication to, and informed consent from, the Residents' carers.

27. Not actively encouraged Residents and Family to utilise 'not-for resuscitation' orders.

28. Not used crisis medications (morphine and midazolam) as a blanket response to COVID-19 infection when it was inappropriate to do so.

29. Not Prescribed Ventolin (an Asthma medication) to non-asthmatic Residents.

30. Adequately recorded clinical data, vital signs and SAGO charts.

31. ~~Implemented cohorting and/or a similar practice to reduce the risk and/or severity of an outbreak of COVID-19 at Newmarch House~~.

32. ~~Provided safe and/or effective care and/or medical treatment to Residents tailored to their needs and that optimised their health and well-being.~~

33. Ensured that deterioration and/or change in a Resident's mental and/or physical health was recognised and that the~~y~~ Residents were then provided adequate medical treatment.

34. Exercised reasonable care and skill in treating the Residents.

35. ~~Ensured Residents were treated to a standard that would be accepted by widespread peer professional opinion as competent professional medical practice.~~

36. Not implemented HITH in respect to each Resident but assessed each Resident individually to ensure ~~whether~~ the HITH would provide them with the best medical outcome.

37. ~~Sought the consent of residents and/or their family to HITH individually before implementing HITH~~.

38. Promptly communicated changes in the mental and/or physical condition of Residents to Family.

39. Taken reasonable care to ensure that the system of care at Newmarch House did not cause or materially contribute to the death or injury of Residents.

40. ~~Such further precautions disclosed from the outcome of ongoing and pending investigations and inquiries.~~

41. Ensured that testing for COVID-19 occurred on all Residents on the same day.

42. Ensured that the testing results for COVID-19 were processed and communicated within 24 hours.

43. Addressed the testing results for COVID-19 to an identified person or medical practitioner, as opposed to presenting same generically.

44. Appointed a lead clinician to lead the HITH and VACS model of care.

45. Ensured that the terms of HITH Guideline, HITH Policy, Flow Chart and Step Up Plan were adhered to when implementing the HITH and VACS care model.

46. Complied with the CEC Guidelines and/or the CDNA National Guidelines and/or the WHO Guidelines and/or the ASID Guidelines and/or the Living Guidelines

THE PLAINTIFF'S CLAIM

Negligence, Loss and Damage

123 The Plaintiff suffered injury, loss and damage as a result of the death of the Plaintiff's Mother on 2 May 2020 caused by COVID-19.

124 The Plaintiff's injury loss and damage was caused by the negligence of the First and Second Defendants, the circumstances and particulars of which are set out in the preceding paragraphs of this Statement of Claim.

125 Details of the Plaintiff's injury, loss and damage are as particularised in the Statement of Particulars filed in accordance with the Uniform Civil Procedure Rules.

Causation

126 The First Defendant's failure to ensure adequate numbers of staff and healthcare agency workers caused or contributed to:

a. The prevention of/failure to undertake daily swabbing and/or PCR testing of all Residents.

b. Significant failure to provide appropriate Residential Care to the Residents.

c. Significant breaches in Infection Control measures being implemented and overseen.

127 The decision by the First and/or Second Defendants not to transfer COVID-19 positive Residents to hospital caused or contributed to:

a. The spread of COVID-19 infection among the Residents, staff and healthcare agency workers.

b. The infection of Residents with COVID-19 in circumstances where such infection was preventable, at least in in some cases.

128 The decision by the First and/or Second Defendant's to utilise the HITH and VACS services caused or contributed to:

a. The spread of COVID-19 among the Residents, staff and healthcare agency workers.

b. The failure to effectively manage and treat COVID-19 infection

c. the premature death to some Residents of COVID-19.

129 The First and Second Defendant's decision to decline cohorting caused or contributed to increased infection of COVID-19 among Residents, staff and healthcare agency workers.

130 The Second Defendant's negligent administering of crisis medications instead of active COVID-19 treatments caused or contributed to the death of Residents who may have otherwise survived.

131 The First Defendant's negligent provision of Residential Care Services caused:

a. Deterioration in the physical and mental condition of the Residents.

b. Distress and psychological damage to Family.

c. Input in respect of the Residents' Advanced Care Plans not being accurately recorded.

d. Consent not being appropriately obtained from Residents or Family in respect of end-of-life procedures and the prescription of crisis medications.

132 The First and/or Second Defendant's delay in:

a. providing test results for the COVID-19 caused uninfected staff members, Residents and clinical agency workers to become infected with COVID-19.

b. providing COVID-19 test results caused or contributed towards the opportunity for new infection of COVID-19 to occur.

c. Implementing cohorting resulted in more Residents being infected.

132A The First Defendant's lack of leadership and coordination caused or contributed to:

a. there being chaos at Newmarch House during the COVID-19 Outbreak.

b. there being no streamlined IPAC for the Newmarch House workers or the healthcare agency workers.

c. there being no clear chain of command to report compliance issues with regarding IPAC.

d. The spread of infection of COVID-19.

132B The First and Second Defendant's lack of communication and consultation with the Residents and Family caused or contributed to:

a. there being angst and frustration among the Family who were prevented from seeing and caring for the Residents themselves.

b. inappropriate consent being obtained in respect of the Medical Care Services provided by the Second Defendant.

133 The negligence of the First and/or Second Defendant was a necessary condition of the occurrence of the Plaintiff's injury, loss and damage.

134 It is appropriate for the liability of the First and/or Second Defendant to extend to the Plaintiff's injury, loss and damage.

Accordingly, the Plaintiff claims:

a. Damages;

b. Interest; and

c. Costs.

THE GROUP MEMBER'S CLAIM

135 The Group Members seek damages in negligence from the First and Second Defendants in respect of injury, loss and damage caused by the death of Residents at Newmarch House between 18 April 2020 and 19 May 2020 and in support thereof rely upon the matters pleaded herein.

Common Questions of Law and Fact

136 The questions of law or facts common to the claims of the Group Members are:

a. The nature and scope of the duty of care owed by the defendants.

b. The risk of harm.

c. Breach of duty.

d. Causation of loss.

e. The factual circumstances prevailing in the period from April 2020 to June 2020.

f. The conduct, roles and responsibilities of the defendants.

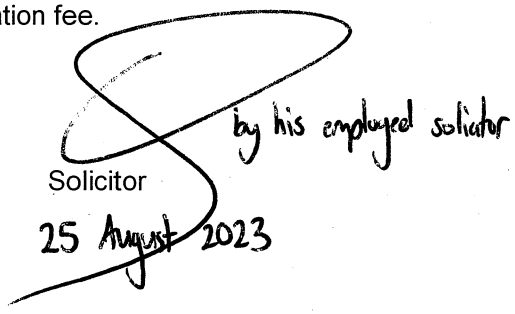
g. The application of statutory and regulatory provisions.

h. The expert and technical evidence in relation to the conduct of the defendants, the pathophysiology of COVID-19 and the proper protocols to detect, prevent, contain, manage and treat the disease.

SIGNATURE OF LEGAL REPRESENTATIVE

I certify under clause 4 of Schedule 2 to the *Legal Profession Uniform Law Application Act 2014* that there are reasonable grounds for believing on the basis of provable facts and a reasonably arguable view of the law that the claim for damages in these proceedings has reasonable prospects of success.

I have advised the plaintiff that court fees may be payable during these proceedings. These fees may include a hearing allocation fee.

Signature 

Capacity Solicitor

Date of signature 25 August 2023

NOTICE TO DEFENDANT

If you do not file a defence within 28 days of being served with this statement of claim:

- **You will be in default in these proceedings.**
- **The court may enter judgment against you without any further notice to you.**

The judgment may be for the relief claimed in the statement of claim and for the plaintiff's costs of bringing these proceedings. The court may provide third parties with details of any default judgment entered against you.

HOW TO RESPOND

Please read this statement of claim very carefully. If you have any trouble understanding it or require assistance on how to respond to the claim you should get legal advice as soon as possible.

You can get further information about what you need to do to respond to the claim from:

- A legal practitioner.
- LawAccess NSW on 1300 888 529 or at www.lawaccess.nsw.gov.au.
- The court registry for limited procedural information.

You can respond in one of the following ways:

1 **If you intend to dispute the claim or part of the claim,** by filing a defence and/or making a cross-claim.

2 **If money is claimed, and you believe you owe the money claimed,** by:

- Paying the plaintiff all of the money and interest claimed. If you file a notice of payment under UCPR 6.17 further proceedings against you will be stayed unless the court otherwise orders.
- Filing an acknowledgement of the claim.
- Applying to the court for further time to pay the claim.

3 **If money is claimed, and you believe you owe part of the money claimed**, by:

- Paying the plaintiff that part of the money that is claimed.
- Filing a defence in relation to the part that you do not believe is owed.

Court forms are available on the UCPR website at www.ucprforms.nsw.gov.au or at any NSW court registry.

REGISTRY ADDRESS	
Street address	Level 5, Law Courts Building, 184 Phillip Street, Sydney NSW 2000.
Postal address	Supreme Court of NSW, GPO Box 3, Sydney NSW 2001.
Telephone	1300 679 272

FURTHER DETAILS ABOUT PLAINTIFF

First Plaintiff

Name	Mark Fahey
Address	97 Newham Drive Cambridge Gardens NSW 2747

Legal representative for plaintiffs

Name	**Simon Morrison**
Practising certificate number	00004608
Firm	Shine Lawyers
Contact Solicitor	~~Emily Clarke~~ Christopher Slan
Address	Level 6, 299 Elizabeth Street Sydney NSW 2000
Telephone	02 8754 7200
Fax	02 9267 5650
Email	sydney@shine.com.au
Electronic service address	sydney@shine.com.au

DETAILS ABOUT DEFENDANTS

Defendant

Name	~~Anglican Community Services Investment Holdings Pty Ltd trading as Anglicare Sydney~~ ANGLICAN COMMUNITY SERVICES TRADING AS ANGLICARE SYDNEY (ABN: 39 922 848 563)
Address	Level 2, 62 Norwest Blvd Norwest, NSW 2153
Name	Nepean Blue Mountains Local Health District
Address	Nepean Blue Mountains LHD C/- Nepean Hospital, Derby Street Penrith NSW 2750