FORM 5A

Rule 5.02 (1)

IN THE SUPREME COURT OF VICTORIA
AT MELBOURNE
COMMON LAW DIVISION
~~MAJOR TORTS LIST~~ GROUP PROCEEDINGS LIST

Court No: S ECI 2020 03339

BETWEEN:

EFSTATHIA (EFFIE) FOTIADIS

Plaintiff

and

ST. BASIL'S HOMES FOR THE AGED IN VICTORIA
ACN 070 511 616

First Defendant

-and-

ARCHBISHOP MAKARIOS GRINIEZAKIS

Second Defendant

-and-

KONSTANTINOS (KON) KONTIS

Third Defendant

-and-

THE TRUSTEES OF THE GREEK ORTHODOX ARCHDIOCESE OF AUSTRALIA CONSOLIDATED TRUST

Fourth Defendants

AMENDED WRIT AND THIRD FURTHER AMENDED STATEMENT OF CLAIM PURSUANT TO THE ORDERS OF THE HON JOHN DIXON J MADE ON 21 FEBRUARY 2023

Date of Document: ~~20 August 2020~~ 24 February 2023
Filed on behalf of: The Plaintiff
Prepared by:
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Ref: 200449

TO THE DEFENDANTS

TAKE NOTICE that this proceeding has been brought against you by the plaintiff for the claim set out in this writ.

IF YOU INTEND TO DEFEND the proceeding, or if you have a claim against the plaintiff which you wish to have taken into account at the trial, **YOU MUST GIVE NOTICE** of your intention by filing an appearance within the proper time for appearance stated below.

YOU OR YOUR SOLICITOR may file the appearance. An appearance is filed by—

(a) filing a "Notice of Appearance" in the Prothonotary's office, 436 Lonsdale Street, Melbourne, or, where the writ has been filed in the office of a Deputy Prothonotary, in the office of that Deputy Prothonotary; and

(b) on the day you file the Notice, serving a copy, sealed by the Court, at the plaintiff's address for service, which is set out at the end of this writ.

IF YOU FAIL to file an appearance within the proper time, the plaintiff may **OBTAIN JUDGMENT AGAINST YOU** on the claim without further notice.

***THE PROPER TIME TO FILE AN APPEARANCE** is as follows—

(a) where you are served with the writ in Victoria, within 10 days after service;

(b) where you are served with the writ out of Victoria and in another part of Australia, within 21 days after service;

(c) where you are served with the writ in Papua New Guinea, within 28 days after service;

(d) where you are served with the writ in New Zealand under Part 2 of the Trans-Tasman Proceedings Act 2010 of the Commonwealth, within 30 working days (within the meaning of that Act) after service or, if a shorter or longer period has been fixed by the Court under section 13(1)(b) of that Act, the period so fixed;

(e) in any other case, within 42 days after service of the writ.

IF the plaintiff claims a debt only and you pay that debt, namely, $ and $ for legal costs to the plaintiff or the plaintiff's solicitor within the proper time for appearance, this

proceeding will come to an end. Notwithstanding the payment you may have the costs taxed by the Court.

FILED

Prothonotary

THIS WRIT is to be served within one year from the date it is filed or within such further period as the Court orders.

IN THE SUPREME COURT OF VICTORIA AT MELBOURNE
COMMON LAW DIVISION GROUP PROCEEDINGS LIST

S ECI 2020 03339

BETWEEN

EFSTATHIA (EFFIE) FOTIADIS

Plaintiff

-and-

ST. BASIL'S HOMES FOR THE AGED IN VICTORIA
ACN 070 511 616

First Defendant

-and-

ARCHBISHOP MAKARIOS GRINIEZAKIS

Second Defendant

-and-

KONSTANTINOS (KON) KONTIS

Third Defendant

-and-

THE TRUSTEES OF THE GREEK ORTHODOX ARCHDIOCESE OF AUSTRALIA CONSOLIDATED TRUST

Fourth Defendants

THIRD ~~SECOND~~ FURTHER AMENDED STATEMENT OF CLAIM –

PURSUANT TO THE ORDERS OF THE HON JOHN DIXON J MADE ON ~~16 DECEMBER 2021~~ ~~26 SEPTEMBER 2022~~ 21 FEBRUARY 2023

Date of Document: ~~14 August 2020~~ ~~12 May 2021~~ ~~07 February 2022~~ ~~26 September 2022~~ 24 February 2023

Filed on behalf of: The Plaintiff
Prepared by:
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~~PARTIES AND GROUP MEMBERS~~

~~1. The plaintiff is the daughter of the deceased, Dimitrios Fotiadis ("**the deceased**").~~

~~2. At all material times the defendant:~~

a. ~~is and was incorporated in the State of Victoria and is capable of being sued in the State of Victoria pursuant to the provisions of the Corporation Law;~~

b. ~~is accredited as an approved provider of aged care services pursuant to the provisions of the *Aged Care Quality and Safety Commission Act 2018* (Cth) ("**ACQSCA**");~~

c. ~~provided aged care services pursuant to the provisions of the *Aged Care Act 1997* (Cth) ("**ACA**");~~

d. provided residential accommodation and aged care services at its care facility located at 24-36 Lorne Street, Fawkner in the State of Victoria ("**St Basil's**");

3. This proceeding is commenced as a group proceeding pursuant to Part IVA of the *Supreme Court Act 1986* (Vic) by the plaintiff on his own behalf and on behalf of:

   a. all persons who at any point from February 2020 sustained mental or nervous shock in connection with a person with whom they had a close proximate relationship and who was or is a resident at St Basil's pursuant to a resident agreement for residential care and who was either killed, injured or put in danger by acts or omissions of the defendant;

   b. the legal personal representatives of the estates of any deceased persons who came within sub-paragraph (a) herein during the period;

   c. all residents at St Basil's pursuant to a resident agreement for residential care residents who at any point from February 2020 sustained injury, mental or nervous shock, loss and damage and/or were put in danger by acts or omissions of the defendant;

   d. all employees and/or contractors of the defendant who had worked at St Basil's who at any point from February 2020 sustained physical injury, mental or nervous shock in connection with their employment and/or work at St Basil's and/or were put in danger by acts or omissions of the defendant.

4. As at the commencement of this proceeding, there are seven or more persons who have claims against the defendant.

THE DECEASED

5. The deceased was born in Greece on 4 April 1941.

6. In or about 2014 the deceased, together with the support of the plaintiff and the deceased's immediate family members, entered into an agreement with the defendant entitled Resident Agreement for Residential Care ("the agreement").

PARTICULARS

A copy of the agreement is in the defendant's possession.

7. On entering into the agreement, the deceased took up full time residence at St Basil's.

8. Whilst a resident at St Basil's the deceased was dependent on the defendant for his care needs and the provision of a safe living environment.

9. In the course of his residence at St Basil's, the deceased, inter alia:

   a. was exposed to COVID-19 positive staff and residents;

   b. was exposed to an unsafe residential environment contaminated by St Basil's COVID-19 positive residents, staff and unauthorised visitors;

c. was not properly isolated or cared for in accordance with Commonwealth and State Government Care Facility guidelines and directions; and

d. was not provided with any or any adequate personal protective equipment ("**PPE**"); and

e. was made to and/or forced to live in an unhygienic personal care condition and a unhygienic residential environment.

10. On 25 July 2020 the deceased died from contracting COVID-19.

THE DEFENDANT

11. Pursuant to the terms and conditions of the agreement and its accreditation as a provider of aged care services under the ACQSCA, the defendant agreed to provide to the deceased aged care services and accommodation.

12. In requesting the defendant, and the defendant agreeing, to provide accommodation and aged care services under the terms and conditions of the agreement to the deceased, the defendant then entered a fiduciary relationship with the deceased.

PARTICULARS

(i) The relationship between defendant and deceased is a fiduciary relationship.

(ii) By reason of that relationship, the deceased reposed trust and confidence in the defendant in its capacity as the deceased's accommodation and aged care provider.

13. By reason of the relationship referred to in paragraph 12, the defendant was under duties, amongst other duties, to:

a. act in the deceased's best interests;

b. actively work to provide a safe and comfortable environment consistent with the Deceased's care needs;

c. actively work to provide a personal hygienic and living environment consistent with the Deceased's care needs

d. deliver accommodation and aged care services safely, competently, diligently and as well as reasonably practicable;

e. be responsible to the care needs of the deceased;

f. be compliant with all relevant legislation, regulations and professional standard guidelines;

g. disclose in a timely and proper manner all matters relevant the deceased's aged care and accommodation requirements, health, well-being and security to the plaintiff;

h. at all times provide adequate and properly trained staff to care for the deceased's health and well-being;

i. at all times ensure there is available all necessary inventory and equipment to provide for and ensure as reasonably practicable the health and well-being of the deceased;

j. at all times ensure it has in place and when necessary properly implement in a timely way an effective infection control program.

14. Further, or alternatively, the agreement contained a contractual term, requiring the defendant to use its best endeavours to protect the deceased's interests and to exercise reasonable care and skill in carrying out, by all proper means, its obligations and duties to the deceased under the terms and conditions of the agreement and in compliance with all relevant legislation, regulation and professional standard guidelines ("**the Implied Term**").

PARTICULARS

(i) The Implied Term was implied in the agreement.

(ii) The Implied Term was implied in law.

15. Further, or alternatively, the defendant, as an accredited aged care services and residential accommodation provider, it was under a duty of care to exercise a level of skill, care and diligence sufficient to prevent occurrence of the kind which occurred of matters referred to in paragraphs 9, 10 and 18 herein and which were within the scope of the risk of which the defendant was positively required to avoid and prevent from occurring ("**duty of care**").

CLAIM AGAINST THE DEFENDANT

16. In all the circumstances, the matters pleaded in paragraph 9 and 10 herein occurred by reason of the defendant's negligent actions, omissions and conduct.

17. Further, in addition to the matters referred to in paragraph 9 herein, the defendant:

a. was or ought to have been aware that at all relevant times prior to 25 July 2020 a COVID-19 pandemic has been declared in the State of Victoria;

b. was or ought to have been aware the State of Victoria considered it reasonably necessary to issue to the defendant Care Facilities Directions pursuant s.200 (1) (b) and (d) of the *Public Health and Wellbeing Act 2008* (Vic) ("**PHWA**") to protect public health and the health of the deceased;

c. was or ought to have been aware the State of Victoria considered it reasonably necessary to issue to the defendant on 13 April 2020 *Care Facilities Directions (No*

2) pursuant s.200 (1) (b) and (d) of the PHWA ("**CFD2**") to protect public health and the health of the deceased.

BREACHES

18. In breach of its duty of care and and/or in breach of the implied term, the defendant:

a. allowed or permitted staff and residents to:

i. not wear PPE;

ii. rove freely within St Basil's

when there was a risk of spreading contamination and contracting COVID-19 infection.

b. Permitted "visitors" and "excluded persons" as defined in CFD2 entry to St Basil's and thereby exposed the deceased to contracting COVID-19.

PARTICULARS

allowed staff from other aged care facilities entry to St Basil's without having self-isolated or provide an up to date vaccination against influenza;
permitting "excluded persons" entry to St Basil's;
permitting "excluded persons" entry to St Basil's without having been tested for COVID-19.

c. failed to act in the deceased's best interests;

d. failed to actively work to provide a safe and comfortable environment consistent with the Deceased's care needs;

e. failed to deliver accommodation and aged care services safely, competently, diligently and as best as reasonably practicable;

f. failed to responsibly and/or adequately care needs of the deceased;

g. failed to be compliant with all relevant legislation, regulations and professional standard guidelines;

h. failed to disclose to the deceased and/or the plaintiff in a timely and proper manner all matters relevant the deceased's aged care and accommodation requirements, health, well-being and security to the plaintiff;

i. failed to at all material times provide adequate and properly trained staff to care for the deceased's health and well-being;

j. failed to at all times ensure there is available all necessary inventory and equipment to provide for and ensure as reasonably practicable the health and well-being of the deceased;

k. failed to at all times ensure it had in place and implemented an effective infection control program;

l. exposing the deceased and/or causing her through the defendant's conduct to contract COVID-19;

m. causing and/or materially contributing to the deceased's death;

n. at all material times exposing or subjecting the deceased to the unnecessary risk of death.

o. at all material times failing to warn the deceased he should use adequate PPE whilst on St Basil's premises;

p. falling to advise or properly advise persons the deceased and/or the plaintiff that they should wear PPE;

q. failing to ensure its staff were properly informed of the dangers of COVID-19 and were instructed in safe working practices necessary to protect the deceased from contracting COVID-19;

r. failing in all the circumstances to employ adequate staff levels;

s. failing to instruct staff adequately or at all in relation to:

i. its COVID-19 infection control program; and

ii. The dangers of exposing the deceased, residents of St. Basil's, employees and/or contractors to COVID-19 and

iii. the dangers of exposure to COVID-19;

t. failing to have any or any adequate awareness of the dangers of exposing the deceased to COVID-19 in any form;

u. failing to keep abreast of the known literature and information relating to the dangers of COVID-19;

v. failing to heed the warnings given by State and Federal Governments as to the dangers of COVID-19.

w. failing to educate staff in regard to COVID-19;

x. failing to take any reasonable care for the safety and wellbeing of the deceased and the plaintiff.

y. concealing information from the plaintiff regarding the risks which it exposed the deceased to;

z. improperly concealing from and/or misrepresenting information to the plaintiff, and all relevant Government authorities concerning the severity of risks and dangers of COVID-19 contamination and spread at St Basil's.

19. As a result of the defendant's failures referred to in paragraphs 9 and 18 the deceased died after contracting COVID-19.

20. By reason of the defendant's failures referred to in paragraphs 9 and 18, the defendant breached its fiduciary duties to:

    a. act in the plaintiff's best interests;

    b. act in the deceased's best interests; and

    c. deliver aged care and accommodation services to a standard competently, diligently and to a standard consistent with the deceased's aged care needs.

21. Further, or alternatively, by reason of the defendant's failures referred to in paragraphs 9 and 18, the defendant:

    a. did not use its best endeavours to protect the deceased from contracting COVID-19 and preventing his death as a consequence thereof; and/or

    b. did not exercise reasonable care and skill in carrying out, by all proper means, its obligations and duties required of it as an accredited aged care service and accommodation provider which amounted to a breach of the Implied Term referred to in paragraph 14 above.

22. Further, or alternatively, by reason of the defendant's failures referred to in paragraph 9 and18, the defendant did not in all the circumstances use all reasonable skill, care and diligence in carrying out its obligations and duties to the deceased as an accredited aged care service and accommodation provider, which amounted to:

    a. a breach of the defendant's duty of care referred to in paragraph 15 above; and/or

    b. a breach of the implied term; and/or

    c. a breach of its obligations and duties pursuant to the provisions of the ACQSCA and ACA and the regulations and guidelines made thereunder; and/or

    d. a breach of a direction or requirement under paragraphs 5 and 8 of CFD2 and thereby committed an offence under s.203 of the PHWA.

23. By reason of the matters aforesaid it was reasonably foreseeable to the defendant that the plaintiff, as a person of normal fortitude, would, in all the circumstances suffer a recognizable illness by reason of the defendant's breaches to the deceased referred to above and by reason thereof the plaintiff has suffered injuries, loss and damage.

PARTICULARS

Psychological reaction marked by depression and anxiety.
Nervous shock.

PARTICULARS OF LOSS AND DAMAGE

The plaintiff has incurred medical and like expenses details of which will be provided prior to the trial of this action

PARTICULARS

The plaintiff is aged 48, born in Melbourne, on 25 November 1971.
The plaintiff is unemployed.
The plaintiff's particulars of loss of earnings and loss of earnings capacity will be provided prior to trial.

24. Further and/or in the alternative, at all times material the defendant knew, that by reason of its conduct, it was putting the deceased at risk of death or serious injury and that nevertheless in wanton and contumelious disregard of the deceased and his health the defendant chose to knowingly continue to provide aged care services and accommodation in breach of Federal and State Government legislation, regulations, guidelines and directions. Further, in all the circumstances the defendant either knew or ought to have known that in doing so there was a reasonable likelihood the deceased would die or suffer serious injury. As a consequence of the above the plaintiff and each of the group members claim punitive damages against the defendant.

COMMON QUESTIONS

25. The questions of law or fact common to the claims of the plaintiff and each of the group members are:

a. Whether or not a duty of care was owed to the plaintiff and the group members and if so the content of that duty.
b. Whether or not the defendant committed the acts and/or engaged in the conduct alleged in the statement of claim.
c. Whether or not the defendant committed the wrongs alleged in the statement of claim.
d. Whether or not the plaintiff's and the group members' similar conditions were causally related to the defendant's claimed breaches.
e. Did the defendant breach its common law duty of care.
f. If the defendant breached its common law duty of care, was such breach a cause of the death of the deceased and any of the losses suffered by the plaintiff.
g. What are the principles for identifying and measuring losses suffered by the plaintiff and group members as a result of the conduct and actions of the defendant as alleged in the statement of claim.

~~THE PLAINTIFF CLAIMS:~~

~~1. Damages.~~

~~2. Punitive damages.~~

~~3. Interest pursuant to the *Penalty Interest Rates Act 1983* as amended.~~

~~4. Costs.~~

~~5. Such further or other relief or order or direction as the Court thinks fit or just and equitable.~~

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A PARTIES AND GROUP MEMBERS

A.1 Plaintiff

1 Dimitrios Fotiadis (**Mr Fotiadis**):

(a) was born in Greece on or about 4 April 1941;

(b) moved to Australia in the late-1960s and subsequently became an Australian citizen;

(c) in or about 2014, entered into an agreement with the First defendant for the provision of accommodation and residential care services (**Resident Agreement**) at the First defendant's aged care facility located at 24-36 Lorne St, Fawkner in the State of Victoria (**St Basil's**);

Particulars

The Resident Agreement in respect of Mr Fotiadis:

(i) is in writing to the effect alleged; and

(ii) was signed by a representative of Mr Fotiadis on his behalf.

(d) at material times from 2014, was:

(i) a Resident (defined below);

(ii) a 'care recipient' of 'residential care' services provided by the First defendant within the meaning of the *Aged Care Act 1997* (Cth) (**Aged Care Act**), including 'hotel services' and 'care and services' within the meaning of the *Quality of Care Principles 2014* (Cth) (**Residential Care Services**); and

(iii) a 'consumer' of 'services' within the meaning of:

(1) Schedule 2 to the *Competition and Consumer Act 2010* (Cth), being the Australian Consumer Law (**ACL**); and

(2) the *Quality of Care Principles 2014* (Cth) (**Quality of Care Principles**);

(e) died on or about 25 July 2020 as a result of having contracted the novel coronavirus disease 2019 (**COVID-19**).

2 The plaintiff, Efstathia (Effie) Fotiadis (**Ms Fotiadis**):

(a) is the legal personal representative of the estate of Mr Fotiadis; and

(b) was the child of Mr Fotiadis.

3 This proceeding is commenced as a group proceeding pursuant to Part 4A of the *Supreme Court Act 1986* (Vic) by Ms Fotiadis on her own behalf and on behalf of the Group Members (defined below), being:

(a) the Resident Sub-Group Members (defined below), in her capacity as the legal personal representative of Mr Fotiadis' estate;

(b) the Family Sub-Group Members (defined below), in her personal capacity; and

(c) the Representee Sub-Group Members (defined below), in her personal capacity.

A.2 First Defendant

4 At all material times, the First defendant:

(a) is and was a corporation incorporated according to law;

(b) is and 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; and

(c) supplied the Residential Care Services to the Resident Sub-Group Members in trade or commerce.

A.2A. Second Defendant

4A. At all material times since 9 May 2019, the Second Defendant is and was:

(a) The unanimously elected Archbishop of the Greek Orthodox Archdiocese of Australia ("**the Archdiocese**");

(b) By virtue of his position and responsibility as the Archbishop of the Archdiocese, the mind, will and embodiment of the Archdiocese;

(c) By virtue of his position and responsibility as the Archbishop of the Archdiocese, responsible for management and control of the Archdiocese including the functions, duties and activities performed by it;

(d) By virtue of his position and responsibility as the Archbishop of the Archdiocese, stood in the shoes of the Archdiocese as the owner and/or operator and/or an occupier of St Basil's;

(e) By virtue of his position and responsibility as the Archbishop of the Archdiocese, stood in the shoes of the Archdiocese as an occupier, at common law and/or pursuant to Part IIA, *Wrongs Act 1958* (Vic), of St Basil's;

(f) By virtue of his position and responsibility as the Archbishop of the Archdiocese, responsible for approving, endorsing and/or representing to the public a connection, affiliation and/or association with the First Defendant and St Basil's;

(g) By virtue of his position and responsibility as the Archbishop of the Archdiocese, responsible for ensuring, or representing, the Archdiocese was holding a supervisory or oversight responsibility over St Basil's;

Particulars

As per page 17 of the 'Independent Review of COVID-19 outbreaks at St Basil's Home for the Aged in Fawkner, Victoria and Heritage Care Epping Gardens in Epping, Victoria' by Professor Lyn Gilbert AO and Adjunct Professor Alan Lilly dated 30 November 2020 (**Independent Review**), it was determined that "*St Basil's is owned and operated by the Greek Orthodox Archdiocese of Australia, which is registered as the Approved Provider within the meaning of the Aged Care Act 1997*".

Moreover, various communications from St Basil's to Residents and Family were purportedly made on behalf of the Second Defendant and/or with his blessing including, but not limited to a letter from the Third Defendant dated 22 July 2020.

(h) By virtue of his position and responsibility as the Archbishop of the Archdiocese, responsible for requesting the Third Defendant, upon his enthroning as Archbishop of the Archdiocese in May 2019, to remain in the position of Chairman of St Basil's for a transitional period until an appropriate alternative structure was devised for St Basil's.

(i) By virtue of his position and responsibility as the Archbishop of the Archdiocese, possessing the capacity to exercise control over the activities at the Premises, or otherwise had the authority and power to ensure that the Plaintiffs would not be injured or damaged by reason of activities conducted at the Premises.

A.2B. Third Defendant

4B. At all material times, the Third Defendant is and was:

(a) The Chairman of St Basil's;

(b) Originally appointed to the position of Chairman of St Basil's by the now deceased former Archbishop Stylianos Harkianakis;

(c) Requested by the Second Defendant, upon the Second Defendant's enthroning as Archbishop of the Archdiocese in May 2019, to remain in the position of Chairman of St Basil's for a transitional period until an appropriate alternative structure was devised for St Basil's;

(d) Responsible for the overall care, control, supervision and management of St Basil's and the Residents forming part of the aged care facility thereat.

A.2C. Fourth Defendants

4C. At all material times, the Fourth Defendants:

(a) Were the owner and registered proprietor of the land on which St Basil's is located, being 24-36 Lorne St, Fawkner in the State of Victoria ("**the Premises**");

(b) Were an occupier, at common law and/or pursuant to Part IIA, *Wrongs Act 1958* (Vic), of the Premises;

(c) Had the capacity to exercise control over the activities at the Premises, or otherwise had the authority and power to ensure that the Plaintiffs would not be injured or damaged by reason of activities conducted at the Premises.

A.3 COVID-19 Period

5 On 8 July 2020, the First defendant was notified that a staff member of St Basil's had tested positive to COVID-19.

Particulars

Page 19 of the 'Independent Review of COVID-19 outbreaks at St Basil's Home for the Aged in Fawkner, Victoria and Heritage Care Epping Gardens in Epping, Victoria' by Professor Lyn Gilbert AO and Adjunct Professor Alan Lilly dated 30 November 2020 (**Independent Review**).

6 Between 8 July 2020 and 22 October 2020, 94 Residents and 94 staff members at St Basil's tested positive to COVID-19 (**COVID-19 Outbreak**).

7 Further, 45 Resident Sub-Group Members died as a result of having contracted COVID-19, including Mr Fotiadis.

Particulars

Independent Review, page 6.

Australian Government Department of Health, "COVID-19 outbreaks in Australian residential aged care facilities" dated 23 October 2020.

A.4 Group Members

8 The group members to whom this proceeding relates (**Group Members**):

(a) are Residents~~,~~ and Family ~~and legal personal representatives of the estates~~ who suffered loss or damage ~~in the COVID-19 Period~~ as a result of the First, Second, Third and/or Fourth defendant~~s~~'s~~'s~~ conduct in the COVID-19 Period as alleged in this Amended Statement of Claim;

(b) are the legal personal representatives of the estates of Residents who suffered loss or damage ~~in the COVID-19 Period~~ as a result of the First, Second, Third and/or Fourth defendant~~s~~'s~~'s~~ conduct in the COVID-19 Period as alleged in this Amended Statement of Claim;

(c) are not any of the persons mentioned in s 33E(2) of the *Supreme Court Act 1986* (Vic),

where:

(i) "**Residents**" mean persons who were resident at St Basil's at any time in the COVID-19 Period;

(ii) "**Family**" means partners, sons-in-law or daughters-in-law, siblings, children, grandchildren, cousins, nieces or nephews of a Resident;

(iii) "**loss or damage**" means any one or more of:

(1) personal injury or death, whether by contracting COVID-19 or otherwise;

(2) pain and suffering;

(3) mental or nervous shock;

(4) disappointment and distress;

(5) injured feelings;

(6) funeral expenses;

(7) medical and like expenses;

(8) other economic loss consequent on personal injury or death;

(iv) "**COVID-19 Period**" means the period 26 February 2020 to 22 October 2020.

9 As at the date of the commencement of this proceeding, there are seven or more Group Members.

10 The Group Members are each a member of one or more of the following sub-groups:

(a) a sub-group (**Resident Sub-Group Members**), comprising Residents or the legal personal representatives of their estates whose loss or damage was caused (directly and/or through its servants or agents including the Third Defendant) by the First defendant's:

(i) Breaches of Resident Duty (defined below);

(ii) Breaches of Contract (defined below); and/or

(iii) Breaches of Consumer Guarantees (defined below);

and/or caused by the Negligence (defined below) of the Second Defendant and/or Fourth Defendant;

(b) a sub-group (**Family Sub-Group Members**), comprising Family whose loss or damage was caused by the First defendant's Breaches of Family Duty (defined below) (including through its servants or agents including the Third Defendant), and/or the Negligence (defined below) of the Second Defendant and/or the Fourth Defendant;

(c) a sub-group (**Representee Sub-Group Members**), comprising Residents or Family to whom the Representations (defined below) were made prior to the COVID-19 Period.

11 At all material times, Resident Sub-Group Members were:

(a) 'care recipients' of Residential Care Services; and

(b) 'consumers' of 'services' within the meaning of:

(i) Schedule 2 to the *Competition and Consumer Act 2010* (Cth), being the ACL; and

(ii) the Quality of Care Principles.

12 The claims of the Group Members:

(a) arise out of the same, similar or related circumstances; and

(b) give rise to the common questions of law or fact identified in Section I below.

B STATUTORY AND REGULATORY CONTEXT

13 At all material times, the First defendant and its servants or agents including but not limited to the Third Defendant were ~~was~~ required to comply with:

(a) the Aged Care Act;

(b) the Quality of Care Principles 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 s 200(1) of the *Public Health and Wellbeing Act 2008* (Vic) from time to time (**Victorian Directions**).

14 Further, the First defendant and its servants or agents including but not limited to the Third Defendant, and the Second Defendant were ~~was~~ aware or ought to have been aware of the content of the following guidelines:

(a) Australian Guidelines for the Prevention and Control of Infection in Healthcare from May 2019 (**Infection Control Guidelines**);

(b) CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (**CDNA National Guidelines**) from 13 March 2020;

(c) guidelines published by the Commonwealth Department of Health (**Department**) regarding Social Distancing Measures (defined below); and

(d) guidance published by the Department regarding outbreak management, as pleaded in Section B.10 below.

B.1 Aged Care Act

15 At all material times, the following provisions of the Aged Care Act applied and were to the effect alleged:

(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(l);

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

(v) 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.

B.2 Quality of Care Principles

16 At all material times, the following provisions of the Quality of Care Principles applied and were to the effect alleged:

(a) further to paragraph 15(a)(i) above, s 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],

(Hotel Services);

(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],

(Care Services);

(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.

B.3 Aged Care Quality Standards

17 At all material times, the following provisions of the Aged Care Quality Standards, at Schedule 2 of the Quality of Care Principles, applied and were to the effect alleged:

(a) 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)];

(b) 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)];

(c) 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)];

(d) 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)];

(e) 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)];

(f) 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)];

(g) 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)]; and

(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)].

B.4 User Rights Principles

18 At all material times, the following provisions of the User Rights Principles applied and were to the effect alleged:

(a) further to paragraph 15(b)(i) above, 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].

B.5 Charter

19 At all material times, the following provisions of the Charter, at Schedule 1 of the User Rights Principles, applied and were to the effect alleged:

(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; and

(v) be listened to and understood.

B.6 Victorian Directions

20 At material times between 21 March 2020 and 11 October 2020, the Victorian Directions in Annexure A applied and were to the effect alleged.

21 The effect of the Victorian Directions listed in Annexure A was that, at material times between 21 March 2020 and 8 July 2020:

(a) only one person, or two persons together, could visit a resident of a residential aged care facility for up to 2 hours per day if for the purpose of providing care and support to that resident;

(b) notwithstanding subparagraph (a), a person could not visit if the person:

(i) had a temperature higher than 37.5 degrees or symptoms of acute respiratory infection;

(ii) did not have an up to date vaccination against influenza, if such a vaccination was available to the person;

(iii) was under the age of 16 and not providing end of life support to the resident;

(c) notwithstanding subparagraph (a) above, a person could visit a resident for longer than 2 hours if the person was providing end of life support to the resident.

B.7 Infection Control Guidelines

22 In or around May 2019, the Infection Control Guidelines were published publicly and contained provisions to the following effect:

(a) with respect to hand hygiene [3.1.1]:

(i) routine hand hygiene should be performed: before touching a patient; before a procedure; after a procedure or body substance exposure risk; after touching a patient; after touching a patient's surroundings;

(ii) hand hygiene must also be performed before putting on gloves and after the removal of gloves;

(iii) alcohol-based hand rubs that contain between 60% and 80% v/v ethanol or

equivalent should be used for all routine hand hygiene practices;

(iv) soap and water should be used for hand hygiene when hands are visibly soiled;

(b) with respect to routine management of the physical environment [3.1.3]:

(i) it is good practice to routinely clean surfaces as follows: clean frequently touched surfaces with detergent solution at least daily, when visibly soiled and after every known contamination; and clean general surfaces and fittings when visibly soiled and immediately after spillage;

(c) with respect to contact precautions [3.2.2]:

(i) it is suggested that contact precautions, in addition to standard precautions, are implemented in the presence of known or suspected infectious agents that are spread by direct or indirect contact with the patient or the patient's environment;

(ii) it is suggested that appropriate hand hygiene be undertaken and personal protective equipment (**PPE**) worn to prevent contact transmission;

(d) with respect to droplet precautions [3.2.3]:

(i) it is suggested that droplet precautions, in addition to standard precautions, are implemented for patients known or suspected to be infected with agents transmitted by respiratory droplets that are generated by a patient when coughing, sneezing or talking;

(ii) it is suggested that a surgical mask should be worn when entering a patient-care environment to prevent droplet transmission;

(iii) it is good practice to place patients who require droplet precautions in a single-patient room;

(e) with respect to airborne precautions [3.2.4]:

(i) it is recommended that airborne precautions, in addition to standard precautions, are implemented in the presence of known or suspected infectious agents that are transmitted person-to-person by the airborne route;

(f) with respect to infection control strategies to contain an outbreak [3.4.2.1]:

(i) it is good practice to consider the use of early bay closures to control known

or suspected norovirus outbreaks rather than ward/unit closures;

(ii) rather than closing an entire ward or unit to manage an outbreak of norovirus in a healthcare facility, it may be more efficient to control an outbreak through cohorting symptomatic patients in bays. If taken, this approach needs to be implemented promptly and early (within three days of the first case becoming ill) in combination with adequate infection control strategies.

Particulars

The Infection Control Guidelines were produced by the National Health and Medical Research Council in collaboration with the Australian Commission on Safety and Quality in Healthcare and published on the Australian Commission on Safety and Quality in Healthcare's website.

B.8 CDNA National Guidelines

23 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;

(ii) 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 include 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],

Particulars

The CDNA National Guidelines were published on the Department's website on 13 March 2020. Thereafter, they were updated on 30 April 2020 and 14 July 2020. The updated versions, on which the plaintiff will also rely at trial, contain guidelines that were equivalent or no less onerous than the measures set out in Sections B.7 and B.8 above

(those measures set out in Sections B.7 and B.8 are hereafter defined as **Infection Control Measures**).

B.9 Department of Health Guidelines on social distancing

24 At all material times during the COVID-19 Period, the Department issued guidelines to the effect that all persons should (*inter alia*):

(a) keep 1.5 metres away from others wherever possible;

(b) avoid physical greetings such as handshaking, hugs and kisses;

(c) avoid large gatherings;

(d) stay home if they have any cold or flu symptoms;

(e) wear a surgical mask when they are in the same room as a sick person;

(f) when at work: stop shaking hands to greet others; avoid non-essential meetings and, if needed, hold meetings via video conferencing or phone calls; put off large meetings to a later date; hold essential meetings outside in the open air if possible; eat lunch at their desk or outside rather than in the lunch room; regularly clean and disinfect surfaces that many people touch; open windows or adjust air conditioning for more ventilation; limit food handling and sharing of food in the workplace; and avoid non-essential travel,

(together, Social Distancing Measures).

Particulars

The Social Distancing Measures were published to the Department's website and updated from time to time during the COVID-19 Period. Further particulars may be provided after discovery.

B.10 Department of Health Guidance on Outbreak Management

25 On or about 15 June 2020, guidance was issued by the Aged Care Quality and Safety Commission (**Commission**) which indicated that an approved provider must notify a case of COVID-19 by email to agedcareCOVIDcases@health.gov.au as well as to the local public health unit (**15 June Guidance**).

Particulars

Independent Review, page 22.

26 On or about 29 June 2020, the Department published guidelines entitled 'First 24 Hours – Managing COVID-19 in a Residential Aged Care Facility' (**First 24 Hours Guidance**), which provided that, *inter alia*, within 30 minutes of receiving a positive COVID-19 result:

(a) if the COVID-19 positive person is a staff member, they must immediately leave the premises and isolate at home as directed by the public health unit. They must stay in isolation until the public health unit clears them;

(b) if the COVID-19 positive case is a resident, they should be immediately isolated in a single room with an ensuite, if possible and may be transferred to hospital or other accommodation if clinically required;

(c) the provider should use PPE for any interactions with positive cases;

(d) the provider should sensitively inform the resident and their family of their diagnosis;

(e) the provider must immediately notify both the local public health unit and the Commonwealth Department of Health at agedcareCOVIDcases@health.gov.au of any cases of COVID-19 among residents and staff; and

(f) lockdown the residential aged care facility, including by evacuating non-essential people from the aged care facility, asking all residents to remain in their rooms, avoid resident transfers if possible, and reinforce standard precautions including hand hygiene, cough etiquette and staying 1.5 metres away from other people throughout the facility.

Particulars

24 Hours Guidance, pages 1 to 2.

27 The 24 Hours Guidance further provided that, within two to three hours of a positive COVID-19 result, the provider should:

(a) appoint staff to manage communications and take calls from families;

(b) develop a script or talking points to assist those taking the calls; and

(c) prepare a holding statement and update as appropriate.

Particulars

24 Hours Guidance, page 5.

28 The 24 Hours Guidance further provided that, within 12 to 24 hours of a positive COVID-19 result, the provider should ensure there is strong ongoing governance of "routine" primary health care, including maintaining nutrition, physical activity and preventing boredom, loneliness and unhappiness.

Particulars

24 Hours Guidance, page 9.

C EVENTS SURROUNDING COVID-19 OUTBREAK

C.1 COVID-19 and the Symptoms

29 COVID-19:

(a) is a highly infectious disease caused by the severe acute respiratory syndrome coronavirus 2 virus (SARS-CoV-2);

(b) causes death in some infected persons;

(c) is transmissible primarily through face-to-face contact and contact with surfaces with which an infected person has been in contact, through droplet and airborne transmission; and

(d) is infectious even while an infected person may be asymptomatic.

30 On 21 January 2020, COVID-19 was added as a "listed human disease" to the *Biosecurity (Listed Human Diseases) Determination 2016* (Cth), under s 42(1) of the *Biosecurity Act 2015* (Cth), by promulgation of the *Biosecurity (Listed Human Diseases) Amendment Determination 2020* (Cth).

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

32 On 29 January 2020, COVID-19 was added to the list of notifiable conditions in Schedules 3 and 4 of the *Public Health and Wellbeing Regulations 2019* (Vic), under ss 232 and 238 of the *Public Health and Wellbeing Act 2008* (Vic), by promulgation of the *Public Health and Wellbeing Amendment (Coronavirus) Regulations 2020* (Vic).

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

34 On or about 16 March 2020, the Department published an information sheet entitled 'Coronavirus (COVID-19) – Identifying the symptoms', which provided that (*inter alia*):

(a) fever and cough were common symptoms of COVID-19;

(b) sore throat, shortness of breath, fatigue, aches and pains, headaches and diarrhea were sometimes symptoms of COVID-19.

35 On or about 2 April 2020, the Department published an information sheet entitled 'Coronavirus (COVID-19): Outbreak Management' in relation to residential care facilities, which provided that (*inter alia*):

(a) an outbreak of COVID-19 in a residential care facility is likely to be worse than an outbreak of influenza. In the outbreak in the aged care facility in Washington state USA, two thirds of residents (80/120) were infected. Of these, 32 per cent died;

(b) it is possible that residents will not be able to be transferred to a hospital. For this reason, it is important to have advanced care plans in place ahead of outbreaks;

(c) the most common signs and symptoms of COVID-19 include fever (although fever may be absent in the elderly) and dry cough;

(d) other symptoms can include shortness of breath, coughing up thick mucus or phlegm and fatigue;

(e) older people may also have symptoms of increased confusion, worsening chronic conditions of the lungs and loss of appetite;

(f) less common symptoms include: sore throat; headache; myalgia/arthralgia (generalised muscle or joint pain); chills; nausea or vomiting; nasal congestion; diarrhoea; haemoptysis (coughing up blood); conjunctival congestion (red, swollen and watery eyes),

(the symptoms set out in paragraphs 34 and 35 above are hereafter defined as **Symptoms**).

C.2 The 26 February Notification

36 On 26 February 2020, the Chief Medical Officer of the Commonwealth, Professor Brendan Murphy, notified aged care providers, including the First defendant, that their existing obligations with respect to infection prevention and control applied to COVID-19 (**26 February Notification**).

Particulars

The 26 February Notification is in writing to the effect alleged and is contained in a letter to aged care providers, including the First defendant, dated 26 February 2020.

The existing obligations referred to are summarised in Sections B.1, B.2, B.3, B.4, B.5 and B.7 above.

37 The 26 February Notification stated, *inter alia*, that:

(a) "COVID-19 (formerly known as novel coronavirus) presents a challenge for all involved in providing care to vulnerable people, including the residential aged care sector. The COVID-19 situation is evolving, and as we move toward the 2020 influenza season, I note that there is a need for collaboration between the Commonwealth, the aged care sector, state and territory public health authorities, and the healthcare sector as part of our COVID-19 planning and preparedness activity";

(b) "…I would like to reiterate the importance of infection control and being prepared for health emergencies. Aged care homes often have frequent visitors and carers coming and going, and close physical contact between staff, residents and their families. Elderly residents are more at risk of infections generally, and are particularly vulnerable to serious illness if they do become infected";

(c) "In this context, and within the context of the Aged Care Quality Standards, your implementation of standard and transmission-based precautions to prevent and control infections is an important action. Indeed, aged care homes are expected to assess the risk of, and take steps to prevent, detect and control, the spread of infections. Infection management practices, such as isolating infectious individuals and applying standard precautions to prevent transmission, minimise the risk of infection spreading";

(d) "Homes should implement effective infection prevention and control programs that are in line with national guidelines. The [Infection Control Guidelines] set out the requirements for best practice infection control. Infection prevention and control programs will vary between aged care homes, depending on the nature of the care and services provided, the context and the risk";

(e) "As well as implementing an infection control program, there should be established protocols in place at aged care homes to manage any health emergencies that arise, including service-wide infection outbreaks or broader community epidemics. While the number of cases of COVID-19 is currently small in Australia, it is possible that this situation could change and services need to plan and be prepared for this"; and

(f) "Further information on the public health management of COVID-19 is available in the [CDNA National Guidelines]".

C.3 Further advice and Dorothy Henderson Lodge Outbreak

38 On or about 2 March 2020, Aged Care Quality and Safety Commissioner Janet Anderson (**Commissioner Anderson**) wrote to all aged care providers, including the First defendant, to provide "updated advice regarding COVID-19", stating that:

(a) "While the number of cases of COVID-19 is currently small in Australia, it is possible that this situation could change at any time, and providers of all services need to give a high priority to planning and being prepared for this scenario"; and

(b) "All aged care service providers should pay close attention to requirements under the Aged Care Quality Standards … at this critical time and be vigilant in maintaining the highest possible standards for minimisation of infection-related risks. Providers are urged to undertake a self-assessment against the Quality Standards taking into account the requirements under Standard 3 and Standard 8 and ensure that your services have in place arrangements for:

- assessment and management of risk associated with infectious outbreaks if infection is suspected or identified
- ensuring adequate care of the infected individual
- protection measures for consumers staff and for residential aged care services, visitors to the service
- notification advice to consumers, families, carers and relevant authorities".

Particulars

The document is in writing to the effect alleged and is contained in a letter to aged care providers, including the First defendant, from Commissioner Anderson dated 2 March 2020.

39 On or about 3 March 2020, aged care facility 'Dorothy Henderson Lodge' in northern Sydney, New South Wales, detected its first case of COVID-19; by 11 April 2020,

17 residents and five staff had contracted COVID-19 and six residents had died (**Dorothy Henderson Lodge Outbreak**).

40 On or about 17 March 2020, the Australian Health Protection Principal Committee published recommendations to residential aged care facilities, which stated that:

(a) "While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a significant health risk particularly for the elderly and individuals with co-morbidities or low immunity";

(b) "[Aged care facilities] must ensure that they are prepared to manage outbreaks of COVID-19";

(c) "[Facilities] should implement the following measures for restricting visits and visitors to reduce the risk of transmission to residents, including:

(i) Limiting visits to a short duration;

(ii) Limiting visits to a maximum of two visitors at one time per day. These may be immediate social supports (family members, close friends) or professional service or advocacy;

(iii) Visits should be conducted in a resident's room, outdoors, or in a specific [designated] area … rather than communal areas where the risk of transmission to residents is greater;

(iv) No large group visits or gatherings, including social activities or entertainment, should be permitted at this time";

(d) "Active screening for symptoms of COVID-19 in residents being admitted or re-admitted from other health facilities and community settings should be conducted"; and

(e) "Staff should be made aware of early signs and symptoms of COVID-19. Any staff with fever OR symptoms of acute respiratory infection (e.g. cough, sore throat, runny nose, shortness of breath) should be excluded from the workplace and tested for COVID-19 … Sick leave policies must enable employees to stay home, if they have symptoms of respiratory infection".

Particulars

The recommendations were published on the Department's website on 17 March 2020.

C.4 The First defendant's purported 'lock-down'

41 On or about 21 March 2020:

(a) 229 cases of COVID-19 were confirmed in the State of Victoria;

(b) the *Aged Care Facilities Directions* were issued under s 200(1)(b) and (d) of the *Public Health and Wellbeing Act 2008* (Vic), which had the effect of prohibiting people from visiting residential aged care facilities (with limited exceptions) from 6.00pm on 21 March 2020.

Particulars

The *Aged Care Facilities Directions* were issued on 21 March 2020, and published in Victoria Government Gazette No. S 142 on 22 March 2020.

42 In or about March 2020:

(a) following the issue of the Victorian Directions pleaded at paragraph 41(b), visitors were restricted, then excluded, from St Basil's;

(b) staff were permitted by the First defendant (and/or its servants or agents including but not limited to the Third Defendant) to go in and out of St Basil's without wearing PPE;

Particulars

Independent Review, page 32. Further particulars may be provided after discovery.

(c) the First defendant received a complaint from Resident Chris Vaggos that staff were not wearing appropriate PPE and could bring COVID-19 into the St Basil's facility;

(d) the First defendant (and/or its servants or agents including but not limited to the Third Defendant) did not act on the complaint pleaded in the preceding subparagraph.

C.5 Continued advice and Newmarch House Outbreak

43 On or about 26 March 2020, the Department published an information sheet entitled 'Coronavirus disease (COVID-19): Environmental cleaning and disinfection principles for health and residential care facilities', which provided that (*inter alia*):

(a) coronaviruses can survive on surfaces for many hours but are readily inactivated by cleaning and disinfection;

(b) cleaning staff should wear impermeable disposable gloves and a surgical mask plus eye protection or a face shield while cleaning;

(c) if there is visible contamination with respiratory secretions or other body fluid, the cleaners should wear a full length disposable gown in addition to the surgical mask, eye protection and gloves;

(d) in communal areas such as staff dining rooms, cafes, retail outlets, staff meeting rooms and patient transport vehicles, the risk of transmission of COVID-19 in these settings can be minimised through a good standard of general hygiene, including: promoting cough etiquette and respiratory hygiene; routine cleaning of frequently touched hard surfaces with detergent/disinfectant solution/wipe; providing adequate alcohol-based hand rub for staff and consumers to use; and training staff on use of alcohol-based hand rub;

(e) in non-patient areas and well residents' rooms and communal areas in aged care facilities, routine cleaning should be performed of frequently touched surfaces with detergent/disinfectant solution/wipe at least daily or when visibly dirty;

(f) in patient areas, staff should clean and disinfect frequently touched surfaces with detergent and disinfectant wipe/solution between each episode of patient care (according to normal infection prevention and control practice), and take care to clean/disinfect surfaces in areas that patients have directly been in contact with or have been exposed to respiratory droplets;

(g) in rooms of aged care residents who are ill, staff should clean and disinfect frequently touched surfaces with detergent and disinfectant wipe/solution at least daily; clean and disinfect equipment after each use; clean and disinfect surfaces that have been in direct contact with or exposed to respiratory droplets.

Particulars

The information sheet is in writing to the effect alleged and was published on the Department's website on 26 March 2020.

44 Between 11 April and 15 June 2020, aged care facility 'Newmarch House' in western Sydney, New South Wales, experienced an outbreak of COVID-19 in which 37 residents and 34 staff members tested positive for COVID-19, and 19 residents died (**Newmarch House Outbreak**).

C.6 IPC Training

45 Between March and June 2020, the First defendant provided infection prevention and

control (**IPC**) training to its staff at monthly intervals that was:

(a) conducted by external doctors whose IPC expertise was unknown;

(b) based upon a guideline from 2013 entitled 'Prevention and Control of Infection in Residential and Community Aged Care' which was out of date and had little specific relevance to prevention and control of COVID-19,

(**IPC Training**).

Particulars

Independent Review, pages 18 to 19. Further particulars may be provided after discovery.

C.7 Conditions preceding COVID-19 Outbreak

46 In or about April 2020, the First defendant produced a document entitled 'Infection Control – Pandemic and Outbreak Management' which:

(a) purported to be an outbreak management plan;

(b) was not an adequate outbreak management plan; and

(c) was not kept up to date with the most recent advice from the Commission or the Department,

(**Purported Plan**).

Particulars

That the Purported Plan was inadequate was determined to be the case by the authors of the Independent Review at page 18. The plaintiff cannot presently give further particulars of the inadequacy of the Purported Plan, which is in the possession of the First defendant. The plaintiff will require discovery and production of the Purported Plan, after which further particulars may be provided.

47 At material times between May 2020 and July 2020:

(a) visitors were not told to limit the time of their visits;

Particulars

By way of example, one Family member visited his Resident spouse at St Basil's in or around late June 2020, was not told by the First defendant to limit the time of his visit and stayed for between 3 to 4 hours. Further particulars may be provided after discovery.

(b) hand sanitiser was not made available to visitors or made readily available throughout the facility;

Particulars

The matter alleged in subparagraph (b) is to be inferred from the matters in Independent Review, page 19. Further, by way of example, there was no hand sanitiser available for visitors, or throughout the St Basil's facility, in or around late May 2020. Further particulars may be provided after discovery.

(c) use of masks and other PPE by staff and Residents was not enforced by the First defendant;

(d) adequate PPE was not provided by the First defendant to its staff;

(e) Social Distancing Measures were not enforced by the First defendant;

Particulars

By way of example, staff were dancing in close proximity on a date between 29 June and 9 July 2020 that the plaintiff cannot presently better particularise. Staff also often crowded into communal areas without PPE or Social Distancing: Independent Review, page 26. Further particulars may be provided after discovery.

(f) there was no or little signage relating to IPC at St Basil's;

(g) waste bins were not emptied at least twice daily;

(h) PPE donning and doffing stations were not separated;

Particulars

The matters alleged in subparagraphs (f) to (h) are to be inferred from the matters in Independent Review, pages 19 to 20.

(i) Residents with Symptoms were not treated or tested for COVID-19;

Particulars

The matter alleged in subparagraph (i) is to be inferred from the fact that some Residents, including Apostolis Barbousas, were taken to Northern Hospital for reasons unrelated to COVID-19 whereupon doctors noticed they had Symptoms and tested them for COVID-19, after which they received a positive COVID-19 result.

(j) Residents and staff members were not regularly tested for COVID-19;

Particulars

The matter alleged in subparagraph (j) is to be inferred from the fact that there had been significant transmission of COVID-19 within the facility before the First Test on 15 July 2020 (defined below).

(k) no outbreak management committee was formed by the First defendant;

Particulars

Independent Review, page 18.

(l) Residents were often left in soiled clothing for prolonged periods of time;

(m) Residents were not given adequate or sufficient food;

Particulars

By way of example:

(i) when some Residents asked for food, staff members would not give it to them and would send them back to their room;

(ii) on a date which the plaintiff cannot presently better particularise, the First defendant provided meatballs to Residents which were so tough that some Residents could not chew them. When a Resident asked for a softer item to eat, he was told to 'take it or leave it'.

(n) hygiene of living areas was often not maintained; and

(o) complaints were made by Family Sub-Group Members but the First defendant (and/or its servants or agents including but not limited to the Third Defendant) did not act upon them.

Particulars

By way of example, in or about May 2020, the Family of Resident Boro Petkovic complained about the quality of care he received, including that he had a rash to which the First defendant took no action, and that he had bruising on his hands and wrists. Abuse of Mr Petkovic by the First defendant's staff was also reported to human services and the police. Further particulars may be provided after discovery.

C.8 COVID-19 Outbreak

48 On 3 July 2020, it was reported that:

(a) two healthcare workers at Northern Hospital in Epping had tested positive to COVID-19;

(b) 66 new cases were detected the previous day, making it the 17th consecutive day of double-digit case growth in Victoria, with a continuing number of new cases associated with transmission in households and families.

Particulars

Victorian Department of Health and Human Services (**DHHS**), Media Release entitled 'Coronavirus update for Victoria – 03 July 2020' dated 3 July 2020.

49 By reason of the matters pleaded in paragraph 48(a), by 3 July 2020, COVID-19 had been detected in the area local to St Basil's.

50 On or about 8 July 2020, a staff member at St Basil's received a positive COVID-19 result.

Particulars

Independent Review, page 19. Further particulars may be provided after discovery.

51 On or about 9 July 2020, the First defendant reported a case of COVID-19 in a staff member to the Victorian local public health unit.

Particulars

Independent Review, page 19. Further particulars may be provided after discovery.

52 The First defendant failed to notify the COVID-19 case to the Department and did not email agedcareCOVIDcases@health.gov.au, as required by the 15 June Guidance and the 24 Hours Guidance.

Particulars

Independent Review, page 22. Further particulars may be provided after discovery.

53 Later on 9 July 2020, daily PPE training for staff began at St Basil's, after the COVID-19 Outbreak had commenced.

Particulars

Independent Review, page 19. Further particulars may be provided after discovery.

54 As at 11 July 2020:

(a) visitors continued to be allowed to enter the premises at St Basil's without wearing masks; and

(b) the First defendant was not enforcing PPE usage by staff.

Particulars

Independent Review, page 33. Further particulars may be provided after discovery.

55 On or about 12 July 2020, the First defendant notified Family of the commencement of the COVID-19 Outbreak by email.

Particulars

Independent Review, page 33. The email attached a letter from Vicky Kos, Facility Manager, dated 10 July 2020.

56 On or about 14 July 2020, the DHHS notified the Department of the commencement of the COVID-19 Outbreak at St Basil's.

Particulars

Independent Review, page 19. Further particulars may be provided after discovery.

57 On or about 15 July 2020:

(a) Residents and staff were tested for COVID-19 (**First Test**); and

(b) a DHHS squad of IPC Outreach Nurses visited St Basil's to assess its IPC practices and observed a need for improved access to hand sanitiser and PPE, leadership to ensure their correct use and IPC education at each staff handover; and recommended separation of PPE donning and doffing stations, replacement of vinyl with nitrile gloves, emptying of waste bins twice daily and additional signage.

Particulars

Independent Review, pages 19 to 20. Further particulars may be provided after discovery.

58 On or about 16 July 2020, Family member Violet Warszawski telephoned Manager Vicky Kos in which:

(a) Ms Warszawski said words to the effect that she had heard on the news that there were five active cases at St Basil's and she wanted confirmation of the same;

(b) Ms Kos replied with words to the effect that she was aware of the announcement, but that it was false information and she had requested rectification of the error and there should be an announcement on the news, hopefully that day, to confirm that St Basil's was clear of COVID-19.

59 On the same day, 16 July 2020, the DHHS announced that five cases of COVID-19 were linked to St Basil's.

Particulars

DHHS website entitled "Coronavirus update for Victoria – 16 July 2020" dated 16 July 2020.

60 The results of the First Test were that 18 Residents and 15 staff tested positive to COVID-19.

Particulars

Independent Review, page 20. Further particulars may be provided after discovery.

61 Over the course of the next few days, the First defendant declined follow-up offers of assistance.

Particulars

Independent Review, page 20. Further particulars may be provided after discovery.

62 As at 18 July 2020:

(a) St Basil's did not have adequate supplies of PPE and its use of PPE was inconsistent; and

(b) COVID-19 positive residents were not confined to one section of the St Basil's facility.

Particulars

Independent Review, page 20. Further particulars may be provided after discovery.

63 After a second round of testing on 19 July 2020, a total of 47 Residents and 18 staff tested positive to COVID-19 (**Second Test**).

Particulars

Independent Review, page 20. Further particulars may be provided after discovery.

64 On or about 21 July 2020, the Victorian Chief Health Officer wrote to the First defendant and stated that:

(a) he was writing to provide advice and direction from the DHHS in relation to the "significant outbreak of COVID-19" at St Basil's;

(b) as was the fact, the ongoing outbreak represented a significant and serious threat to public health, including the health and lives of residents and staff of St Basil's;

(c) given the significant and extensive transmission of infection to date, the high case fatality rate of COVID-19 and the ease with which it can spread within the residential aged care facility and the community, it was essential that further immediate actions were taken to safeguard the health and wellbeing of residents, and the health – under occupational health and safety obligations – of staff;

(d) as was the fact, the number of resident and staff cases indicated that there had been significant transmission within the facility; and

(e) all staff of St Basil's were designated as close contacts of positive cases and had to be quarantined at home.

65 On or about 21 July 2020, Resident Sub-Group Members who had tested positive to COVID-19 began being cohorted in "COVID wings".

Particulars

Letter from the Manager, Ms Kos dated 21 July 2020.

66 Between 8 and 21 July 2020, the First defendant:

(a) failed to provide basic primary care to many Resident Sub-Group Members;

Particulars

By way of example, on or about 19 July 2020, Resident Maria Vasilakis was positioned in her bed incorrectly, such that the top half of her body was leaning over the right side of her bed; there was no equipment to monitor her oxygen intake or vital organs; and she did not have access to a drip to provide her with liquid in her dehydrated state. A further example is that on or about 10 July 2020, Resident Boro Petkovic was reported to have lost 2.9kg while at St Basil's, prior to contracting COVID-19. Further particulars may be provided after discovery.

(b) did not prevent Residents from wandering about the hallways of St Basil's and into rooms of Resident Sub-Group Members who had tested positive to COVID-19;

Particulars

By way of example, the matter pleaded in subparagraph (b) was observed on or about 21 July 2020 by Family member Spiros Vasilakis. Further details may be provided after discovery.

(c) was not ensuring that doors to the rooms of Resident Sub-Group Members who had tested positive to COVID-19 were closed;

Particulars

By way of example, the matter pleaded in subparagraph (c) was observed on or about 19 July 2020 in relation to the room of Resident Maria Vasilakis. Further details may be provided after discovery.

(d) was not enforcing Social Distancing Measures or PPE usage by staff;

Particulars

By way of example, on or about 8 July 2020, staff were not wearing PPE or masks. A further example is that, on or about 10 July 2020, a staff member passed a bouquet of flowers from a Family member to a

Resident without maintaining 1.5 metres from the Resident and without wearing a mask or gloves. Further particulars may be provided after discovery.

(e) was not ensuring that PPE was stored in sealable tubs outside the hallways, and instead was storing the boxes open in residents' rooms where they could be contaminated;

Particulars

The matter pleaded in paragraph (e) continued even after a nurse from the Northern Hospital had communicated this instruction to the Manager, Ms Kos. Further particulars may be provided after discovery.

(f) routinely did not answer calls from Family Sub-Group Members;

Particulars

By way of example, Family member Ivan Rukavina called the First defendant several times over the course of a few days, which went unanswered, following which he reported that his mother was 'missing'. He later discovered that she was in hospital, days before she passed away. A further example is Family member Vaia Govas who called the First defendant several times between 24 and 26 July 2020 which went unanswered, and became distressed to learn in media reports of inadequate care provided to Resident Sub-Group Members and a lack of Infection Control Measures being implemented at St Basil's. Further details may be provided after discovery.

(g) did not promptly tell Family Sub-Group Members of Residents' positive COVID-19 test result;

Particulars

By way of example, the plaintiff was only told by the First defendant that Mr Fotiadis had tested positive to COVID-19 approximately three weeks after his positive test result. A further example is that the First defendant telephoned Family member Ivan Rukavina to tell him his mother had tested positive to COVID-19 four days after receiving her positive test results. Further, many Family members only learned their Resident had COVID-19 when they were telephoned by the hospital to which the Resident had been transferred. Further particulars may be provided after discovery.

(h) did not promptly communicate changes in Residents' mental or physical condition to Family Sub-Group Members;

Particulars

By way of example, the plaintiff was told on multiple occasions by

the First defendant that Mr Fotiadis was "fine" up until his death in connection with COVID-19. Further particulars may be provided after discovery.

(i) often gave incorrect information to Family Sub-Group Members about their Residents' location and condition.

Particulars

By way of example, Family member Nicholas Barboussas was told by a representative of the First defendant that his father was isolating in his room when his father was in fact at the Northern Hospital. Further details may be provided after discovery.

67 On or about 26 July 2020, the Commission notified the First defendant, by way of a 'Notice to Agree' under s 63U(2) of the *Aged Care Quality and Safety Commission Act 2018* (Cth), of the First defendant's non-compliance with the following Aged Care Quality Standards:

(a) ongoing assessment and planning with consumers (Standard 2);

(b) personal care and clinical care (Standard 3);

(c) feedback and complaints (Standard 6); and

(d) organisational governance (Standard 8),

(**Notice to Agree**).

Particulars

The Notice to Agree is in writing and is published on the Commission's website.

68 In response to the Notice to Agree, on or about 26 July 2020, the First defendant accepted the matters set out in the Notice to Agree and agreed to conditions set out in that Notice.

Particulars

Greek Orthodox Archdiocese of Australia Press Office, Media Release dated 27 July 2020. Further particulars may be provided after discovery.

69 On or about 23 October 2020, the COVID-19 Outbreak at St Basil's was declared 'resolved'.

Particulars

Australian Government Department of Health, "COVID-19 outbreaks in Australian residential aged care facilities" dated 23 October 2020, page 16.

70 As pleaded in paragraphs 6 and 7 above, by the end of the COVID-19 Outbreak, 94 Residents and 94 staff members had tested positive to COVID-19 and 45 Residents had

died.

C.9 Mr Fotiadis

71 Mr Fotiadis tested positive for COVID-19 in approximately early July 2020.

Particulars

Further particulars may be provided after discovery.

72 Approximately three weeks later, Ms Fotiadis was told by the First defendant:

(a) that Mr Fotiadis had tested positive for COVID-19;

(b) words to the effect that "your father is fine".

73 As pleaded in paragraph 1(e) above, Mr Fotiadis died shortly afterwards, on 25 July 2020, in connection with COVID-19.

D BREACH OF CONTRACT CLAIM

D.1 Resident Agreement

74 At material times before the COVID-19 Period, Mr Fotiadis and the other Resident Sub-Group Members entered into a Resident Agreement with the First defendant.

Particulars

The plaintiff refers to and repeats the matters in paragraph 1(c) above.

75 The Resident Agreement took at least one of two forms:

(a) a standard form contract entitled "Resident and Accommodation Agreement" issued in or about December 2014 (**2014 Resident Agreement**); and

Particulars

The 2014 Resident Agreement is in writing. Some Resident Sub-Group Members signed the 2014 Resident Agreement and some may not have.

In respect of any Resident Sub-Group Members who did not sign the 2014 Resident Agreement, their acceptance is implied by the fact that:

(i) they were given a copy of the 2014 Resident Agreement by the First defendant;

(ii) they paid the relevant fees and deposits, and moved into accommodation at St Basil's, in accordance with the 2014 Resident Agreement; and

(iii) the First defendant thereafter supplied them with accommodation and Residential Care Services in accordance with the 2014 Resident Agreement.

(b) a standard form contract entitled "Resident and Accommodation Agreement" issued in or about June 2019 (**2019 Resident Agreement**).

Particulars

The 2019 Resident Agreement is in writing. Some Resident Sub-Group Members signed the 2019 Resident Agreement and some may not have.

In respect of any Resident Sub-Group Members who did not sign the 2019 Resident Agreement, their acceptance is implied by the fact that:

(i) they were given a copy of the 2019 Resident Agreement by the First defendant;

(ii) they paid the relevant fees and deposits, and moved into accommodation at St Basil's, in accordance with the 2019 Resident Agreement; and

(iii) the First defendant thereafter supplied them with accommodation and Residential Care Services in accordance with the 2019 Resident Agreement.

Group Members reserve the right to contend that there were other forms of the Resident Agreement following discovery.

76 There were terms of each Resident Agreement that:

(a) the First defendant would provide the Resident Sub-Group Member with residential care and services at St Basil's as assessed for the Resident's needs;

Particulars

2014 Resident Agreement, clause A1.1.

2019 Resident Agreement, clause B1.

(b) the accommodation services provided to the Resident Sub-Group Member would include the Hotel Services and Care Services specified in the Quality of Care Principles that the Resident was assessed as requiring;

Particulars

2014 Resident Agreement, clause A2 and Annexure F.

2019 Resident Agreement, clause B1, Part G, Part J (60).

The plaintiff refers to and repeats the matters in paragraph 16(a) above.

(c) the First defendant would observe and act in accordance with the Charter, including the following rights of the Resident Sub-Group Member:

(i) in respect of the 2014 Resident Agreement, the right to: full and effective use

of his or her personal, civil, legal and consumer rights; quality care appropriate to his or her needs; be treated with dignity and respect, and to live without exploitation, abuse or neglect; and to live in a safe, secure and home-like environment;

(ii) in respect of the 2019 Resident Agreement, the right to: safe and high quality care and services; be treated with dignity and respect; live without abuse and neglect.

Particulars

2014 Resident Agreement, clause C6 and Annexure E.

2019 Resident Agreement, Part A and clause D4(1).

(d) any complaints would be handled fairly and promptly in accordance with the First defendant's complaints procedure which was that the First defendant would:

(i) review and investigate all complaints whether made verbally or in writing;

(ii) review its policies, practices and procedures in light of the complaint where appropriate; and

(iii) respond to all complaints within a reasonable timeframe having regard to the nature of the complaint.

Particulars

2014 Resident Agreement, clause C15.1.

2019 Resident Agreement, clause D14(1).

77 There was an implied term of each Resident Agreement that the First defendant would exercise proper or reasonable care or skill in the discharge of its duties under the Resident Agreement, including in the provision of the Residential Care Services to the Resident Sub-Group Member.

Particulars

The term is implied by law.

78 The purpose of the Resident Agreement was to supply Residents with peace of mind and the experience of being cared for in a safe, secure and home-like environment.

Particulars

The purpose is to be inferred from the provisions of the Aged Care Act, Aged Care Quality Standards and the Charter. Further, the plaintiff refers to and repeats the particulars to paragraph 82 below.

D.2 Breaches of contract

79 In breach of the Resident Agreements:

(a) the Hotel Services provided did not comply with the Quality of Care Principles, in that as from May 2020:

(i) by reason of the matter set out in paragraph 47(n) above, the First defendant failed to ensure that St Basil's and the furniture, equipment and fittings therein, were adequately cleaned, contrary to item 1.6 of the table at Schedule 1, Part 1 of the Quality of Care Principles (**Table**);

(ii) by reason of the matter set out in paragraph 47(m) above, the First defendant failed to ensure that meals of adequate quality and quantity were provided to each Resident Sub-Group Member, contrary to item 1.10(a) of the Table;

(b) the Care Services provided did not comply with the Quality of Care Principles, in that:

(i) as from May 2020, by reason of the matter set out in paragraph 47(l) above, the First defendant failed to ensure that Resident Sub-Group Members' personal hygiene was maintained, contrary to item 2.1 of the Table; and

(ii) as from 8 July 2020, by reason of the matter set out in paragraph 66(a) above, the First defendant failed to provide basic primary care to many Resident Sub-Group Members;

(c) the First defendant did not act in accordance with Residents' rights under the Charter in that:

(i) as from May 2020, by reason of the matters set out in paragraphs 47 and 66 above, Resident Sub-Group Members did not receive quality care appropriate to their needs;

(ii) as from March 2020, by reason of the matters set out in paragraphs 42, 45 to 47, 52 to 54, 60 to 63, 66 and 68 above, Resident Sub-Group Members were not able to live in a safe, secure and home-like environment;

(iii) by reason of the matters set out in paragraphs 42, 45 to 47, 52 to 54, 60 to 63, 66 and 68 above, Resident Sub-Group Members were not provided with safe and high quality care and services;

(iv) by reason of the matters set out in paragraphs 47 and 66(a) above, were not

able to live at St Basil's without neglect;

(d) by reason of the matter set out in paragraphs 42(c)-(d) and 47(o) above, as from May 2020, the First defendant did not handle complaints made by Residents or their Families promptly and/or within a reasonable timeframe; and

(e) by reason of the matters set out in subparagraphs (a) to (d) above, the First defendant did not exercise proper or reasonable care or skill in the provision of the Residential Care Services,

(**Breaches of Contract**).

D.3 Loss and damage

80 As a result of the Breaches of Contract, Mr Fotiadis and the other Resident Sub-Group Members suffered loss and damage.

Particulars

The plaintiff contends, in support of her personal claim as the legal personal representative of Mr Fotiadis' estate, that Mr Fotiadis suffered the following loss and damage as a result of the Breaches of Contract:

(i) disappointment and distress prior to his death;

(ii) death; and

(iii) funeral expenses.

Other Resident Sub-Group Members suffered the following loss and damage as a result of the Breaches of Contract:

(iv) disappointment and distress;

(v) personal injury or death;

(vi) pain and suffering;

(vii) nervous shock; and/or

(viii) economic loss, including funeral expenses.

Particulars of the losses and damage suffered by individual Resident Sub-Group Members will be supplied after the determination of common issues in the plaintiff's case.

E CONSUMER GUARANTEE CLAIMS

E.1 Care and Skill Guarantee under s 60 ACL

81 In supplying the Residential Care Services to Mr Fotiadis and the other Resident Sub-Group Members, the First defendant guaranteed Mr Fotiadis and the other Resident Sub-Group Members that the Residential Care Services would be rendered with due care and skill (**Care and Skill Guarantee**).

Particulars

The guarantee arose in law pursuant to s 60 of the ACL.

82 In contravention of the Care and Skill Guarantee, the First defendant failed to exercise due care in supplying the Residential Care Services, in that:

(a) by reason of the matters set out in paragraphs 42, 45 to 47, 52 to 54, 60 to 63, 66 and 68 above, the First defendant failed to implement adequate Infection Control Measures during the COVID-19 Period; and

(b) by reason of the matters set out in paragraph 79 above, the Residential Care Services provided by the First defendant did not comply with:

(i) the Quality of Care Principles; or

(ii) Residents' rights under the Charter,

such that it was unlikely that Mr Fotiadis and the other Resident Sub-Group Members would be able to experience peace of mind or being cared for in a safe, secure and home-like environment.

E.2 Purpose Guarantee and Result Guarantee under s 61 ACL

83 Further and alternatively, Mr Fotiadis and the other Resident Sub-Group Members made known to the First defendant that the particular purpose for the acquisition of Residential Care Services from it, as a supplier, was to bring them peace of mind and supply them with the experience of being cared for in a safe, secure and home-like environment.

Particulars

In the case of Mr Fotiadis and the other Resident Sub-Group Members, the particular purpose was impliedly made known by them to the First defendant by: the nature of the relationship between Mr Fotiadis and the other Resident Sub-Group Members and the First defendant (the supply of Residential Care Services to each and every one of them), the purpose of the transactions that Mr Fotiadis and the other Resident Sub-Group Members entered into with the First defendant, and the obligations of the First defendant under the Aged Care Act and related instruments.

Group Members reserve the right to contend that the particular purpose was also made expressly known to the First defendant; however, this would be the subject of individual enquiry and may be subject of further particulars after determination of the common issues.

84 Further and alternatively, Mr Fotiadis and the other Resident Sub-Group Members made known to the First defendant that the desired result that they wished to achieve from the

acquisition of services from the First defendant was peace of mind and the experience of being cared for in a safe, secure and home-like environment.

Particulars

In the case of Mr Fotiadis and the other Resident Sub-Group Members, the desired result was impliedly made known by the plaintiff and each of group members by: the nature of the relationship between Mr Fotiadis and the other Resident Sub-Group Members and the First defendant (the supply of Residential Care Services to each and every one of them), the purpose of the transactions that Mr Fotiadis and the other Resident Sub-Group Members entered into with the First defendant, and the obligations of the First defendant under the Aged Care Act and subsidiary instruments.

Group Members reserve the right to contend that the desired result was also made expressly known to the First defendant; however, this would be the subject of individual enquiry and may be subject of further particulars after determination of the common issues.

85 In the premises, in supplying the Residential Care Services, the First defendant further guaranteed to Mr Fotiadis and the other Resident Sub-Group Members that:

(a) the Services supplied would be reasonably fit for that purpose (**Purpose Guarantee**);

Particulars

The guarantee arose in law pursuant to s 61(1) of the ACL.

(b) the Services might reasonably be expected to achieve that result (**Result Guarantee**).

Particulars

The guarantee arose in law pursuant to s 61(2) of the ACL.

86 By reason of the matters alleged in Sections C.4 and C.6 to C.9 above, in contravention of the Purpose Guarantee, the Residential Care Services provided by the First defendant were not reasonably fit for the particular purpose for which they were acquired, in that:

(a) during the COVID-19 Period, the Resident Sub-Group Members were not enjoying peace of mind or the experience of being cared for in a safe, secure and home-like environment; and

(b) despite that circumstance, the First defendant failed to improve its quality of care, implement the Infection Control Measures and/or request assistance prior to 21 July 2020.

87 By reason of the matters alleged in Sections C.4 and C.6 to C.9 above, in contravention of the Result Guarantee, the Residential Care Services provided by the First defendant were

not of such nature and quality as reasonably might be expected to achieve the result the subject of the Result Guarantee, in that:

(a) during the COVID-19 Period, the Resident Sub-Group Members were not enjoying peace of mind or the experience of being cared for in a safe, secure and home-like environment; and

(b) despite that circumstance, the First defendant failed to improve its quality of care, implement the Infection Control Measures and/or request assistance prior to 21 July 2020.

88 The contraventions pleaded at paragraphs 82, 86 and 87 above are hereafter defined as **Breaches of Consumer Guarantees**.

E.3 Sections 267(3) and 268 ACL

89 The Residential Care Services supplied to Mr Fotiadis and the other Resident Sub-Group Members:

(a) would not have been acquired by a reasonable consumer fully acquainted with the nature and extent of the failure to comply with the Care and Skill Guarantee, the Purpose Guarantee and/or the Result Guarantee;

(b) were substantially unfit for the purpose for which services of the same kind were commonly supplied and could not, easily and within a reasonable time, be remedied so as to make them fit for such purpose;

(c) were unfit for the particular purpose they were acquired by Mr Fotiadis and the other Resident Sub-Group Members, which was made known to the First defendant, and could not easily and within a reasonable time, be remedied so as to make them fit for such purpose; and/or

(d) were not of such a nature, quality, state or condition that might reasonably be expected to achieve the result desired by Mr Fotiadis and the other Resident Sub-Group Members, that was made known to the First defendant and could not easily and within a reasonable time, be remedied to achieve such a result.

90 In the premises, the Breaches of Consumer Guarantees could not or cannot be remedied, or were a 'major failure' within the meaning of ss 267(3) and 268 of the ACL.

E.4 Loss and damage

91 Mr Fotiadis and the other Resident Sub-Group Members suffered loss or damage because of

the said contraventions of the Care and Skill Guarantee, Purpose Guarantee and/or Result Guarantee.

Particulars

The plaintiff contends, in support of her personal claim as the legal personal representative of Mr Fotiadis' estate, that Mr Fotiadis suffered the following loss and damage as a result of the Care and Skill Guarantee, Purpose Guarantee and/or Result Guarantee:

(i) disappointment and distress prior to his death, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth);

(ii) death; and

(iii) funeral expenses.

Other Resident Sub-Group Members suffered the following loss and damage as a result of the First defendant's contravention of the Care and Skill Guarantee, Purpose Guarantee and/or Result Guarantee:

(iv) disappointment and distress, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth);

(v) personal injury or death;

(vi) pain and suffering;

(vii) nervous shock; and/or

(viii) economic loss, including funeral expenses.

Particulars of the losses and damage suffered by individual Resident Sub-Group Members will be supplied after the determination of common issues in the plaintiff's case.

F NEGLIGENCE CLAIM – RESIDENTS

F.1 Foreseeability of risks of harm

92 At all material times:

(a) there was a risk that a failure by the First defendant and/or the Third Defendant as the Chairman of St Basil's to ensure the exercise of reasonable care and skill in the provision of the Residential Care Services during the COVID-19 Period would cause the Resident Sub-Group Members to suffer loss or damage arising from neglect, infection, disease, dehydration, choking, failure to be given the correct medication or any at all, or any other failure by the First defendant to provide the Residential Care Services with reasonable care or at all (**Care Risk of Harm**); and

(b) there was a risk that a failure by the First defendant and/or the Third Defendant as the Chairman of St Basil's to ensure the exercise of reasonable care and skill in the implementation of Infection Control Measures during the COVID-19 Period would

lead to Resident Sub-Group Members becoming infected with, and dying of causes relating to, COVID-19 (**Infection Risk of Harm**).

93 Each of the Care Risk of Harm and the Infection Risk of Harm:

(a) was not remote or insignificant; and

(b) was reasonably foreseeable by the First defendant and/or the Third Defendant as the Chairman of St Basil's.

Particulars

The plaintiff refers to and repeats the matters in Sections B and C above.

F.2 Resident Duty of Care

94 At all relevant times, the First defendant and/or the Third Defendant as the Chairman of St Basil's each had a direct and non-delegable duty:

(a) to take reasonable care in the provision of the Residential Care Services to Resident Sub-Group Members and in the implementation of Infection Control Measures; and

(b) to ensure that reasonable care was taken by any third party engaged by or on behalf of the First defendant to provide Residential Care Services and implement Infection Control Measures,

to avoid or minimise each of the Care Risk of Harm and the Infection Risk of Harm (**Resident Duty of Care**).

94A. Further and alternatively to paragraph 94 as it relates to the Third Defendant, the Third Defendant owed a common law duty to the Resident Sub-Group Members, and such duty required him to take reasonable care for the safety of the Residents in the wake of the COVID-19 pandemic.

95 The Resident Duty of Care, or alternatively the duty of care owed by the Third Defendant in paragraph 94A herein above, required that, during the COVID-19 Period, the First defendant and/or the Third Defendant as the Chairman of St Basil's:

(a) with respect to the provision of Residential Care Services:

(i) provide safe and effective personal care and/or clinical care to Resident Sub-Group Members that was best practice, tailored to their needs and optimised their health and well-being;

(ii) effectively manage high-impact or high-prevalence risks associated with the care of each consumer, including the Care Risk of Harm and the Infection Risk of Harm;

(iii) ensure that deterioration or change in a Resident Sub-Group Members' mental and/or physical health was recognised and responded to in a timely manner;

(iv) ensure that St Basil's, and any furniture, fittings and equipment, was safe, clean, well-maintained and comfortable;

(v) ensure that Resident Sub-Group Members' personal hygiene was maintained;

(vi) provide sufficient and appropriate meals to Resident Sub-Group Members;

(vii) respond to complaints in a timely manner;

(b) provide up-to-date and regular IPC training to staff;

(c) minimise infection-related risks through implementing the Infection Control Measures to prevent and control infection, including by:

(i) limiting visitors to St Basil's in accordance with the applicable Victorian Directions;

(ii) implementing the Social Distancing Measures;

(iii) cleaning frequently touched surfaces with detergent solution at least daily, and cleaning visibly soiled surfaces immediately after contaminated;

(iv) providing staff with sufficient masks (and PPE where appropriate), and ensuring they were worn when in close contact with a Resident;

(v) constantly monitoring Residents and staff for Symptoms with a high level of vigilance, and having a low threshold for investigation;

(vi) restricting Residents with Symptoms in their room, or cohorting them in a designated bay or ward, and if they must leave, ensuring they wear a mask;

(vii) ensuring any Resident or staff member with Symptoms is promptly tested for COVID-19;

(viii) regularly testing Residents for COVID-19;

(d) with respect to managing an outbreak of COVID-19:

(i) within the first 30 minutes of receiving a positive COVID-19 result, isolating the person, ensuring PPE is used to interact with them, sensitively informing their Family (if the positive person is a Resident), and locking down the

facility in accordance with the measures pleaded at paragraph 26 above;

(ii) within the first 30 minutes, notifying both the local public health unit and the Department of the COVID-19 result, in accordance with the measures pleaded at paragraphs 25 and 26 above;

(iii) within two to three hours, appointing staff to manage communications and take calls from Families and update holding statements as appropriate, in accordance with the measures pleaded at paragraph 27 above; and

(iv) within 12 to 24 hours, ensuring that primary health care is being maintained, in accordance with the measures pleaded at paragraph 28 above.

F.3 Breaches of Resident Duty

96 Further, by reason of the matters pleaded in Sections A.3, B and C, and in circumstances where:

(a) COVID-19 had been detected in Victoria from 25 January 2020;

(b) two prior COVID-19 outbreaks in aged care homes in Sydney had led to significant loss of life;

(c) COVID-19 had been detected in the area local to St Basil's from 3 July 2020;

(d) aged care providers had the obligations set out in Sections B.1 to B.6 above; and

(e) guidelines and advice had been published as set out in Sections B.7 to B.10, C.3 and C.5 above,

a reasonably prudent approved aged care provider and/or a reasonably prudent Chairman of St Basil's in the position of the Third Defendant would have ensured that:

(i) the measures pleaded in subparagraphs 95(a) to 95(c) were taken, and were taken in a reasonable time after the 26 February Notification; and

(ii) the measures pleaded in subparagraph 95(d) were taken, and were taken in the time specified in that subparagraph.

97 In breach of the Resident Duty of Care:

(a) the First defendant and/or the Third Defendant as the Chairman of St Basil's did not exercise reasonable care and skill in the provision of the Residential Care Services during the COVID-19 Period or ensure that reasonable care and skill was taken, in that (**Care Breaches**):

(i) by reason of the matters set out in paragraphs 42, 45 to 47, 52 to 54, 60 to 63, 66 and 68 above, the quality of personal care of Resident Sub-Group Members was inadequate and in breach of Standard 3 of the Aged Care Quality Standards;

(ii) by reason of the matters set out in paragraphs 42, 45 to 47, 52 to 54, 60 to 63, 66 and 68 above, the First defendant and/or the Third Defendant as the Chairman of St Basil's failed to adequately or at all manage high- impact or high-prevalence risks, including the Care Risk of Harm and the Infection Risk of Harm, and was in breach of Standard 3 of the Aged Care Quality Standards;

(iii) by reason of the matters set out in paragraphs 47(i), 47(l), 60, 63, 64(d), 66(a) and 68 above, deterioration or change in Resident Sub-Group Members' mental and/or physical health was not responded to in a timely manner;

(iv) by reason of the matter set out in paragraph 47(l) above, Resident Sub-Group Members' personal hygiene was not maintained;

(v) by reason of the matter set out in paragraph 47(m) above, Resident Sub-Group Members were not adequately nourished;

(vi) by reason of the matters set out in paragraphs 42(c)-(d) and 47(o) above, the First defendant and/or the Third Defendant as the Chairman of St Basil's did not respond to complaints in a timely manner or in some cases at all;

(b) with respect to training (**Training Breaches**):

(i) by reason of the matters set out in paragraph 45 above, the IPC Training was deficient by reason of it being only once a month and the content being based on out-dated material from 2013; and

(ii) by reason of the matters set out in paragraph 53 above, daily PPE training for staff only began after the commencement of the COVID-19 Outbreak;

(c) the First defendant and/or the Third Defendant as the Chairman of St Basil's did not take reasonable steps to ensure the exercise of reasonable care and skill in the provision of the Infection Control Measures during the COVID-19 Period or ensure that reasonable care and skill was taken, in that (**Infection Breaches**):

(i) by reason of the matter set out in paragraph 47(a), the First defendant and/or the Third Defendant as the Chairman of St Basil's did not limit the time for

which visitors stayed at St Basil's, contrary to the Victorian Directions;

(ii) by reason of the matters set out in paragraph 47(e), Social Distancing Measures were not implemented or enforced at St Basil's;

(iii) by reason of the matters set out in paragraphs 47(c), 47(d), 47(h), 54, 62(a) and 66(e) above, masks and PPE were not appropriately used or stored at St Basil's;

(iv) by reason of the matters set out in paragraphs 47(i), 47(j), 60 and 63 above, Residents and staff were not vigilantly monitored for Symptoms, and instead Residents with Symptoms:

(1) were left untreated;

(2) were not promptly tested for COVID-19; and

(3) were not isolated promptly or in some cases at all;

(v) by reason of the matter set out in paragraph 47(j) above, Residents were not regularly tested for COVID-19; and

(vi) by reason of the matters set out in paragraphs 46 and 47(k) above, the First defendant and/or the Third Defendant as the Chairman of St Basil's did not adequately plan for an outbreak of COVID-19;

(d) the First defendant and/or the Third Defendant as the Chairman of St Basil's did not exercise reasonable care and skill in the management of the COVID-19 Outbreak or ensure that reasonable care and skill was taken in that (**Outbreak Management Breaches**):

(i) by reason of the matters set out in paragraphs 62(b) and 66(c) above, within 30 minutes of receiving positive COVID-19 tests of Residents, those Residents were not isolated;

(ii) by reason of the matters set out in paragraphs 66(f) to 66(i) above, the First defendant and/or the Third Defendant as the Chairman of St Basil's did not inform Family of COVID-19 positive Residents within 30 minutes of receiving the positive COVID-19 test results;

(iii) by reason of the matters set out in paragraph 66 above, the First defendant and/or the Third Defendant as the Chairman of St Basil's did not lock St Basil's down on or after 8 July 2020 in accordance with the measures

pleaded at paragraph 26 above;

(iv) by reason of the matters set out in paragraphs 52 and 56 above, the First defendant and/or the Third Defendant as the Chairman of St Basil's failed to notify the Department of the first positive COVID-19 test result on 8 July 2020 either within the first 30 minutes or at all;

(v) by reason of the matter set out in paragraph 66(f) above, the First defendant and/or the Third Defendant as the Chairman of St Basil's failed to appoint staff to manage telephone calls from Families within days of 8 July 2020;

(vi) by reason of the matter set out in paragraph 61 above, the First defendant and/or the Third Defendant as the Chairman of St Basil's failed to accept offers of assistance at the height of the COVID-19 Outbreak in mid-July; and

(vii) by reason of the matter set out in paragraph 66(a) above, the First defendant and/or the Third Defendant as the Chairman of St Basil's failed to ensure that primary health care of Residents was being maintained during the COVID-19 Outbreak,

(the Care Breaches, Training Breaches, Infection Breaches and Outbreak Management Breaches are hereafter defined as the **Breaches of Resident Duty**).

98 By reason of the Breaches of Resident Duty:

(a) COVID-19 was not promptly detected in staff and Residents at St Basil's;

(b) COVID-19 was able to spread quickly to all areas of the St Basil's facility; and

(c) Resident Sub-Group Members were neglected by the First defendant's failure and/or the Third Defendant's failure as the Chairman of St Basil's to provide the Residential Care Services with reasonable care or at all,

giving rise to the materialisation of the Care Risk of Harm and the Infection Risk of Harm.

99 But for the Breaches of Resident Duty:

(a) those Resident Sub-Group Members who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(b) alternatively to (a), some of those Residents who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(c) Resident Sub-Group Members would not have been infected with COVID-19 at St Basil's;

(d) alternatively to (c), the number of Resident Sub-Group Members infected with COVID-19 at St Basil's would have been limited and quickly contained;

(e) those Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury;

(f) alternatively to (e), some of the Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury.

F.4 Loss and damage

100 In the premises, the Breaches of Resident Duty, or one or more of them, caused loss or damage to Mr Fotiadis and the other Resident Sub-Group Members.

Particulars

The plaintiff contends, in support of her personal claim as the legal personal representative of Mr Fotiadis' estate, that Mr Fotiadis suffered death as a result of the Breaches of Resident Duty, and that his estate incurred funeral expenses by way of consequence.

Other Resident Sub-Group Members suffered the following loss and damage as a result of the Breaches of Resident Duty:

(i) personal injury or death;

(ii) pain and suffering;

(iii) nervous shock; and/or

(iv) economic loss, including funeral expenses.

Particulars of the losses and damage suffered by individual Resident Sub-Group Members will be supplied after the determination of common issues in the plaintiff's case.

F.5 Resident and Family Duty of Care - Second Defendant

100A. At all material times during the COVID-19 Period:

(a) It was reasonably foreseeable that, if care was not taken by the Second Defendant in supervision and/or oversight of the operations at St Basil's, and/or with St Basil's response to the COVID-19 pandemic, the Resident Sub-Group Members might suffer loss or damage;

(b) It was reasonably foreseeable that, if care was not taken by the Second Defendant to ensure that Infection Control Measures were implemented, adequately or at all, at St Basil's, the Resident Sub-Group Members might become infected with, and die from causes relating to, COVID-19;

(c) The Second Defendant had the capacity to exercise control, authority and power

over;

(i) the activities and Care Services conducted at the Premises

(ii) the Residents, their safety and their care at St Basil's;

(iii) the decision of whether or not to implement Infection Control Measures at St Basil's;

(iv) the entry of non-Residents, including Family, onto the premises of St Basil's;

(v) communications to Family about events taking place at St Basil's;

(vi) the decision of whether or not to respond to complaints received from Family;

(d) The Second Defendant knew or ought to have known that Family had deep emotional and interpersonal attachments to their Residents, by virtue of their close relationship with the Residents;

(e) The Second Defendant knew or ought to have known that, by approving, endorsing and/or representing to the public that there existed a connection, affiliation and/or association with St Basil's, it would likely cause Residents and Family to have trust and confidence in St Basil's as a reputable and safe aged care facility, and said Residents and Family were vulnerable to failings in the level of care afforded by St Basil's;

(f) The Second Defendant represented to the public including Residents and Family that he and the Archdiocese had assumed responsibility for ensuring Infection Control Measures were properly implemented at St Basil's.

100B. By reason of the matters pleaded in paragraph 100A herein above, the Second Defendant owed a common law duty to the Resident Sub-Group Members and Family, such duty required it to take reasonable care for the safety, mental and physical wellbeing of the Residents, the Resident Sub-Group Members, and Family in the wake of the COVID-19 pandemic.

F.6 Breaches of Resident and Family Duty – Second Defendant

100C. The Second Defendant was negligent and/or breached its duty of care owed to the Residents, the Resident Sub-Group Members and Family.

Particulars

(a) Failing to take reasonable steps to ensure the measures pleaded in subparagraphs 95(a) to 95(c) herein above were adopted at St Basil's, or alternatively were adopted within a reasonable time after the 26 February Notification;

(b) Failing to take reasonable steps to ensure the measures pleaded in subparagraph 95(d) were adopted at St Basil's, or alternatively were adopted within the time specified in that subparagraph;

(c) Failing to take reasonable steps to ensure that the quality of personal care provided at St Basil's to Residents was adequate and in compliance with Standard 3 of the Aged Care Quality Standards;

(d) Failing to take reasonable steps to ensure all high-impact or high-prevalence

risks including the Care Risk of Harm and Infection Risk of Harm were being adequately and effectively managed at St Basil's;

(e) Failing to take reasonable steps to ensure any deterioration or change in Resident Sub-Group Members' mental and/or physical health at St Basil's as a result of the COVID-19 Pandemic was addressed and/or responded to in a timely manner;

(f) Failing to take reasonable steps to ensure the personal hygiene of Resident Sub-Group Members at St Basil's was being maintained;

(g) Failing to take reasonable steps to ensure adequate nourishment of Resident Sub-Group Members at St Basil's;

(h) Failing to take reasonable steps to ensure any and all complaints, concerns and issues relating to the St Basil's management and response to the COVID-19 Pandemic were being addressed and/or responded to, adequately, at all and/or in a timely manner;

(i) Failing to take reasonable steps to ensure a high standard of IPC Training at St Basil's was implemented and maintained;

(j) Failing to take reasonable steps to ensure a high standard of PPE training at St Basil's was implemented and maintained;

(k) Failing to take reasonable steps to ensure Infection Control Measures were being implemented and maintained including, but not limited to;

(i) measures relating to limits on visiting hours at St Basil's;

(ii) Social Distancing Measures;

(iii) Requirements to use and store masks and PPE at St Basil's;

(iv) Testing, monitoring and policies for Residents and Staff experiencing COVID-19 or symptoms suggestive of COVID-19;

(l) Failing to take reasonable steps to ensure St Basil's had a clear, implemented and maintained outbreak response policy which addressed one or more of the following;

(i) A policy which resulted in Residents being isolated within 30 minutes of receiving positive COVID-19 test results;

(ii) A policy which resulted in Family being notified in a timely manner that a Resident had received a positive COVID-19 test result;

(iii) A policy which resulted in locking St Basil's down on or after 8 July 2020 in accordance with paragraph 26 herein above;

(iv) A policy which would have resulted in notifying the Department of the first positive COVID-19 test result on 8 July 2020, either within the first 30 minutes or at all;

iv) A policy which would have required the allocation of staff to manage telephone calls from Families within days of 8 July 2020;

100D. But for the negligence and/or breaches of duty referred to in paragraph 100C herein above:

(a) those Resident Sub-Group Members who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(b) alternatively to (a), some of those Residents who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(c) Resident Sub-Group Members would not have been infected with COVID-19 at St Basil's;

(d) alternatively to (c), the number of Resident Sub-Group Members infected with COVID-19 at St Basil's would have been limited and quickly contained;

(e) those Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury;

(f) alternatively to (e), some of the Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury;

(g) Residents would have been properly cared for and protected from COVID-19 and neglect, and Family Sub-Group Members would have been given accurate and timely information regarding their Residents' mental and physical condition, and regarding the conditions at St Basil's, and, as a result, would not have been shocked or surprised to learn that their Resident had died, suffered injury or was in hospital, with the consequence that Family Sub-Group Members would not have been exposed to such distressing circumstances as to be likely to cause psychiatric harm.

100E. The Second Defendant's Negligence and/or Breach of Duty referred to in paragraph 100C herein above was a cause of loss or damage to Mr Fotiadis and the other Resident Sub-Group Members, and to Ms Fotiadis and the other Family Sub-Group Members.

Particulars

The particulars to paragraph 100 herein above and paragraph 111 herein below are hereby referred to and repeated.

F.7 Resident and Family Duty of Care – Fourth Defendants

100F. The Fourth Defendants owed a duty of care pursuant to Part IIA, *Wrongs Act 1958* (Vic), to take reasonable care to see that the Residents at St Basil's would not be injured or damaged by reason of the state of the Premises, or things done or omitted to be done in respect of the state of the Premises.

100G. The duty of care referred to in paragraph 100E herein above:

(a) Required the Fourth Defendants to take reasonable care with regard to the activities, circumstances and attributes of St Basil's including its management and responses to the COVID-19 Pandemic;

(b) Required the Fourth Defendants to take reasonable care to ensure the Residents, the Resident Sub-Group Members and Family did not suffer reasonably foreseeable injury or damage arising from activities, circumstances and attributes of St Basil's including its management and responses to the COVID-19 Pandemic.

F.8 Breaches of Resident and Family Duty – Fourth Defendants

100H. The Fourth Defendants were negligent and/or breached their duty of care owed to the Residents, the Resident Sub-Group Members and Family.

Particulars

The particulars to paragraph 100C herein above are hereby referred to and repeated.

100I. But for the negligence and/or breaches of duty referred to in paragraph 100H herein above:

(a) those Resident Sub-Group Members who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(b) alternatively to (a), some of those Resident Sub-Group Members who died, would not have died in connection with neglect or COVID-19 during the COVID-19 Period;

(c) Resident Sub-Group Members would not have been infected with COVID-19 at St Basil's;

(d) alternatively to (c), the number of Resident Sub-Group Members infected with COVID-19 at St Basil's would have been limited and quickly contained;

(e) those Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury;

(f) alternatively to (e), some of the Resident Sub-Group Members who suffered injury by reason of the Care Breaches, would not have suffered that injury.

(g) Resident Sub-Group Members would have been properly cared for and protected from COVID-19 and neglect, and Family Sub-Group Members would have been given accurate and timely information regarding their Residents' mental and physical condition, and regarding the conditions at St Basil's, and, as a result, would not have been shocked or surprised to learn that their Resident had died, suffered injury or was in hospital, with the consequence that Family Sub-Group Members would not have been exposed to such distressing circumstances as to be likely to cause psychiatric harm.

100J. The Fourth Defendants' Negligence and/or Breaches of Duty referred to in paragraph 100H herein above was a cause of loss or damage to Mr Fotiadis and the other Resident Sub-Group Members, and to Ms Fotiadis and the other Family Sub-Group Members.

Particulars

The particulars to paragraph 100 herein above and paragraph 111 herein below are hereby referred to and repeated.

G NEGLIGENCE CLAIM – FAMILY

G.1 Foreseeability of risks of harm

101 At all material times, there was a risk that exposing Family to distressing circumstances arising from the death of or injury to their Residents at St Basil's by the First defendant's

conduct, would cause loss or damage to the Family of those Residents (**Family Risk of Harm**).

102 The Family Risk of Harm:

(a) was not remote or insignificant; and

(b) was reasonably foreseeable by the First defendant.

Particulars

The plaintiff refers to and repeats the matters in Sections B and C above.

G.2 Salient features

103 By reason of the matters pleaded in Sections A to D above, at material times during the COVID-19 Period:

(a) the First defendant exercised control over:

(i) the Residents, their safety and their care at St Basil's;

(ii) the decision of whether or not to implement Infection Control Measures at St Basil's;

(iii) the entry of non-Residents, including Family, onto the premises of St Basil's;

(iv) communications to Family about events taking place at St Basil's;

(v) the decision of whether or not to respond to complaints received from Family;

(b) the First defendant knew or ought to have known that Family had deep emotional and interpersonal attachments to their Residents, by virtue of their close relationship with the Residents;

(c) once their Resident was admitted to the First defendant's care:

(i) Family were vulnerable to the Family Risk of Harm, arising from any failure to provide the Residential Care Services with reasonable care and skill and/or to protect the relevant Resident from the Care Risk of Harm and the Infection Risk of Harm;

(ii) Family were further vulnerable to the Family Risk of Harm arising from the risk of their Resident becoming infected with COVID-19 at St Basil's;

(iii) Family were reliant on the First defendant to provide care to their Resident

and keep them safe;

(iv) Family were reliant on the First defendant to communicate changes in their Resident's condition to them; and

(v) Family were reliant on the First defendant to promptly, regularly and accurately inform them of the conditions at St Basil's and any changes in those conditions;

(d) the First defendant knew or ought to have known that if the Care Risk of Harm and/or Infection Risk of Harm eventuated in respect of a Resident, their Family would suffer associated harm;

(e) the liability alleged herein is determinate in that it is limited to liability for harm suffered by Family of persons who were Residents during the COVID-19 Period.

G.3 Family Duty of Care

104 In the premises, the First defendant owed a duty to each of the Family Sub-Group Members to take reasonable care to avoid the materialisation of the Family Risk of Harm (**Family Duty of Care**).

105 Alternatively to paragraph 104, the Family Duty of Care was owed to those Family Sub-Group Members who were partners, siblings, children or grand-children of Resident Sub-Group Members.

106 The Family Duty of Care required the First defendant to:

(a) respond to complaints received from Family Sub-Group Members in a timely manner;

(b) promptly communicate changes in Residents' mental and/or physical condition to the relevant Family Sub-Group Members;

(c) promptly, regularly and accurately inform Family Sub-Group Members of the conditions at St Basil's regarding health and safety and any changes in those conditions;

(d) take reasonable care to ensure that its system of care at St Basil's did not cause or materially contribute to the death or injury of Residents; and

(e) otherwise take reasonable care to avoid exposing Family Sub-Group Members to circumstances that might result in them suffering psychiatric harm.

G.4 Breaches of Family Duty

107 By reason of the matters pleaded in Sections A.3, B and C, and in circumstances where:

(a) COVID-19 had been detected in Victoria from 25 January 2020;

(b) two prior COVID-19 outbreaks in aged care homes in Sydney had led to significant loss of life; and

(c) COVID-19 had been detected in the area local to St Basil's from 3 July 2020,

a reasonably prudent approved aged care provider would have ensured that:

(i) complaints by Family regarding infection control and the quality of care provided to Residents were responded to in a timely manner;

(ii) changes in Residents' mental and/or physical condition were promptly communicated to Family;

(iii) Family were promptly, regularly and accurately informed of the conditions at the aged care facility regarding health and safety and any changes in those conditions; and

(iv) its system of care did not cause or materially contribute to the death or injury of Residents.

108 In the circumstances of the matters pleaded in Section C above, in breach of the Family Duty of Care:

(a) the First defendant ignored complaints by Family Sub-Group Members regarding infection control and quality of care during the COVID-19 Period;

(b) Family Sub-Group Members were not promptly notified of their Residents' positive COVID-19 test results or other deterioration of their Residents' mental and/or physical condition;

(c) Family Sub-Group Members were not promptly, regularly and accurately informed of the conditions at St Basil's regarding health and safety during the COVID-19 Period prior to 10 July 2021 and, after 10 July 2021, were unable to promptly contact the First defendant to obtain information specific to their Resident;

(d) by reason of the matters set out in paragraphs 58, 59 and 66(i) above, Family Sub-Group Members were at times given misinformation by the First defendant;

(e) the First defendant's system of care caused and/or materially contributed to the death or injury of Residents, as pleaded in Sections D, E and F herein,

(**Breaches of Family Duty**).

109 By reason of the Breaches of Family Duty, Family Sub-Group Members were exposed to distressing circumstances likely to cause psychiatric harm in that they:

(a) saw the conditions of care quality and infection control at St Basil's prior to the COVID-19 Outbreak and complained to management, but did not observe improvements;

(b) heard rumours of the escalating deterioration of conditions regarding health and safety at St Basil's and frequently called the First defendant but could not obtain prompt information regarding their Resident and their mental or physical condition;

(c) were at times given misinformation by the First defendant about the conditions at St Basil's and/or their Resident's health or location; and

(d) observed their Residents suffering death or injury during the COVID-19 Period.

110 But for the Breaches of Family Duty:

(a) the First defendant would have improved its quality of care and implementation of the Infection Control Measures by listening and responding to complaints by Family Sub-Group Members;

(b) Residents would have been properly cared for and protected from COVID-19 and neglect such that:

(i) those Resident Sub-Group Members who died, or some of them, would not have died in connection with COVID-19 or neglect during the COVID-19 Period;

(ii) Resident Sub-Group Members would not have been infected with COVID-19, or any infections would have been limited and quickly contained;

(iii) those Resident Sub-Group Members who suffered injury by reason of the Care Breaches, or some of them, would not have suffered that injury;

(c) Family Sub-Group Members would have been given accurate and timely information regarding their Residents' mental and physical condition, and regarding the conditions at St Basil's, and, as a result, would not have been shocked or surprised

to learn that their Resident had died, suffered injury or was in hospital,

with the consequence that Family Sub-Group Members would not have been exposed to such distressing circumstances as to be likely to cause psychiatric harm.

G.5 Loss and damage

111 The Breaches of Family Duty, or one or more of them, caused loss or damage to Ms Fotiadis and the other Family Sub-Group Members.

Particulars

The plaintiff contends, in support of her personal claim, that she suffered the following loss and damage as a result of the Breaches of Family Duty:

(i) psychological reaction marked by depression and anxiety;

(ii) mental or nervous shock; and

(iii) medical and like expenses, details of which will be provided prior to trial.

Other Family Sub-Group Members suffered the following loss and damage as a result of the Breaches of Family Duty:

(iv) personal injury;

(v) pain and suffering;

(vi) nervous shock; and/or

(vii) economic loss.

Particulars of the losses and damage suffered by individual Family Sub-Group Members will be supplied after the determination of common issues in the plaintiff's case.

H MISLEADING OR DECEPTIVE CONDUCT

112 Prior to admitting Mr Fotiadis to St Basil's, Ms Fotiadis was told by a representative of the First defendant that Mr Fotiadis' aged care needs, health and safety would be taken care of.

113 Similarly, prior to admitting other Residents to St Basil's, the other Representee Sub-Group Members were told by representatives of the First defendant that their Residents' aged care needs, health and safety would be taken care of.

114 By reason of the matters alleged in paragraphs 112 and 113, the First defendant represented to the Representee Sub-Group Members, including Ms Fotiadis, that the Residential Care Services provided at St Basil's were and would be adequate, on an ongoing basis, to meet the Residents' needs (**the Ongoing Care Representations**).

Particulars

The representation is to be implied from the fact that the statements alleged in paragraphs 112 and 113 were made.

115 The Ongoing Care Representations were never qualified nor withdrawn and were continuing representations.

116 Further, by letters sent to Relatives, resident representatives and visitors to St Basil's dated 10 July 2020, 15 July 2020 and 17 July 2020, the First defendant represented to Representee Sub- Group Members that:

(a) it was doing everything possible to overcome what was a difficult situation (in the case of the 10 July 2020 letter); and

(b) it had taken all possible measures to contain the outbreak of COVID-19 at St Basil's (in the case of the 15 July 2020 letter and the 17 July 2020 letter),

(**the All Possible Measures Representations**).

117 Each of the Ongoing Care Representations and the All Possible Measures Representations (together, the **Representations**) were made in trade or commerce.

118 In reliance on one or more of the Representations, Ms Fotiadis and the other Representee Sub-Group Members decided to:

(a) admit their Resident to St Basil's (in the case of Family);

(b) agree to be admitted to St Basil's (in the case of Residents);

(c) refrain from withdrawing the Resident from St Basil's.

119 In the premises, the First defendant engaged in misleading or deceptive conduct in contravention of s 18 of the ACL (**the s 18 Contraventions**) by reason of the First defendant:

(a) failing to withdraw, correct or qualify the Ongoing Care Representations by May 2020 or at any time thereafter;

Particulars

The failure to withdraw, correct or qualify the Ongoing Care Representations was misleading or deceptive because, as from May 2020 and on a continuing basis thereafter, the Residential Care Services provided were not adequate to meet the Residents' needs having regard to the matters alleged in paragraphs 42, 45 to 47, 54, 61, 66 and 68 above.

(b) making the All Possible Measures Representations.

Particulars

The All Possible Measures Representations were untrue at the time that they were made. The First defendant had not taken all possible measures to overcome the situation as at 10 July 2020 and nor had it

taken all possible measures to contain the COVID-19 Outbreak as at 15 or 17 July 2020. The plaintiff relies on the matters set out in paragraphs 52, 54, 57(b), 61, 63, 64(c), 64(d), 66 and 68 above.

120 Because of the s 18 Contraventions, Ms Fotiadis and the other Representee Sub-Group Members suffered loss and damage.

Particulars

The plaintiff contends, in support of her personal claim, that she suffered the following loss and damage because of the s 18 Contraventions:

(i) psychological reaction marked by depression and anxiety;

(ii) mental or nervous shock;

(iii) medical and like expenses, details of which will be provided prior to trial;

(iv) disappointment and distress, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth); and

(v) injured feelings, or disappointment, anger and mental stress, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth).

Other Representee Sub-Group Members suffered the following loss and damage because of the s 18 Contraventions:

(vi) personal injury;

(vii) pain and suffering;

(viii) nervous shock;

(ix) economic loss;

(x) disappointment and distress, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth); and

(xi) injured feelings, or disappointment, anger and mental stress, not being personal injury within the meaning of s 4 of the *Competition and Consumer Act 2010* (Cth).

Particulars of the losses and damage suffered by individual Representee Sub-Group Members will be supplied after the determination of common issues in the plaintiff's case.

I COMMON ISSUES OF FACT AND LAW

~~121 The questions of law or fact common to the claims of the Group Members are:~~

~~(a) whether the events surrounding the COVID-19 Outbreak pleaded in Sections A.3 and C took place;~~

~~(b) whether the defendant had the obligations, responsibilities and/or duties pleaded in Sections B and D.1;~~

(c) whether the defendant owed the Resident Duty of Care and/or the Family Duty of Care;

~~(d) whether the acts and omissions of the defendant in Sections A, C to H occurred and, if so, whether the defendant was:~~

~~(i) in breach of contract;~~

~~(ii) in contravention of s 60 and/or 61 of the ACL;~~

~~(iii) negligent or otherwise in breach of the Resident Duty of Care and/or the Family Duty of Care; and/or~~

~~(iv) in contravention of s 18 of the ACL;~~

(e) ~~whether the plaintiff and the Group Members suffered loss by reason of the defendant's Breaches of Contract, Breaches of Consumer Guarantees, Breaches of Resident Duty, Breaches of Family Duty and/or s 18 Contraventions as alleged.~~

121 The questions of law or fact common to the claims of the Group Members are:

(a) in respect of common questions of fact:

(i) was the First defendant an approved provider of aged care services within the meaning of the Aged Care Act and *Aged Care Quality and Safety Commission Act 2018* (Cth)?

(ii) did the First defendant provide Residential Care Services to the Residents between 8 July 2020 and 22 October 2020?

(iii) if so, what Residential Care Services did the First defendant provide?

(iv) in providing the Residential Care Services, was the First defendant subject to the Aged Care Act, Quality of Care Principles (including the Aged Care Quality Standards) and the User Rights Principles (including the Charter) (together, the **Aged Care legislation**)?

(v) were the Residential Care Services provided under a written Resident Agreement?

(vi) what standard of Residential Care Services was the First defendant required to provide?

(vii) how did the Aged Care legislation, as supplemented by the directions issued

under s 200(1) of the *Public Health and Wellbeing Act 2008* (Vic), affect or inform the standard of aged care the First defendant was required to provide?

(viii) did the standard of Residential Care Services the First defendant was required to provide to avoid the Care Risk of Harm differ from the standard of Residential Care Services the First defendant was required to provide to avoid the Infection Risk of Harm?

(b) in respect of the negligence claim regarding Residents:

(i) did the First defendant and/or the Third Defendant as the Chairman of St Basil's owe to Resident Sub-Group Members the Resident Duty of Care in respect of the Care Risk of Harm – being a duty to take care in the provision of the Residential Care Services to avoid them, and each of them, suffering loss and damage through materialisation of the Care Risk of Harm?

(ii) did the First defendant and/or the Third Defendant as the Chairman of St Basil's owe to Resident Sub-Group Members the Resident Duty of Care in respect of the Infection Risk of Harm – being a duty to take care in the provision of the Residential Care Services to avoid them, and each of them, suffering loss and damage through materialisation of the Infection Risk of Harm?

(iii) did the First defendant and/or the Third Defendant as the Chairman of St Basil's provide the Residential Care Services with reasonable care between 8 July 2020 and 22 October 2020?

(iv) if the answer to (i) or (ii) is 'yes', was the Resident Duty of Care breached by any one or more of—

(1) the Care Breaches;

(2) the Training Breaches;

(3) the Infection Breaches; or

(4) the Outbreak Management Breaches?

(v) did any failure by the First defendant and/or the Third Defendant as the Chairman of St Basil's to provide the Residential Care Services with reasonable care cause the Resident Sub-Group Members loss and damage?;

(vi) Did the Second Defendant, as Archbishop of the Archdiocese, owe a duty of care to the Resident Sub-Group Members, such duty required it to take reasonable care for the safety, mental and physical wellbeing of the Residents and the Resident Sub-Group Members in the wake of the COVID-19 pandemic?

(vii) If yes to (vi), was that duty of care breached by the Second Defendant which was a cause of injury, loss and/or damage to the Resident Sub-Group Members?

(viii) Did the Fourth Defendants owe a duty of care as alleged to the Resident Sub-Group Members as an occupier of the Premises on which St Basil's was located?

(ix) If yes to (viii), was that duty of care breached by the Fourth Defendants which was a cause of injury, loss and/or damage to the Resident Sub-Group Members?

(c) in respect of the negligence claim regarding Family:

(i) did the First defendant and/or the Third Defendant as the Chairman of St Basil's owe to Family Sub-Group Members the Family Duty of Care – being a duty to take care in the provision of the Residential Care Services to avoid them, and each of them, suffering loss and damage through materialisation of the Family Risk of Harm?

(ii) if the answer to (i) is 'yes', was the Family Duty of Care breached by any one or more of—

(1) the Care Breaches;

(2) the Training Breaches;

(3) the Infection Breaches; or

(4) the Outbreak Management Breaches?

(iii) did any failure by the First defendant and/or the Third Defendant as the Chairman of St Basil's to provide the Residential Care Services with reasonable care cause the Family Sub-Group Members loss and damage?

(iv) Did the Second Defendant, as Archbishop of the Archdiocese, owe a duty of care to Family, such duty required it to take reasonable care for the safety, physical and mental wellbeing of the Family in the wake of the COVID-19 pandemic?

(v) If yes to (vi), was that duty of care breached by the Second Defendant which was a cause of injury, loss and/or damage to Family?

(vi) Did the Fourth Defendants owe a duty of care as alleged to Family as an occupier of the Premises on which St Basil's was located?

(vii) If yes to (vi), was that duty of care breached by the Fourth Defendants which was a cause of injury, loss and/or damage to Family?

(d) in respect of the breach of contract claim:

(i) did the First defendant breach any of the Resident Agreements, and if so, how?

(ii) did any breaches of contract by the First defendant cause the Resident Sub-Group Members loss and damage?

(e) in respect of the consumer guarantee claims:

(i) was the provision of Residential Care Services by the First defendant a supply in trade or commerce governed by the *Australian Consumer Law*?

(ii) did the First defendant owe to the Resident Sub-Group Members any or all of the Care and Skill Guarantee, the Purpose Guarantee or the Result Guarantee (**the Consumer Guarantees**)?

(iii) did the First defendant fail to comply with any of the Consumer Guarantees, and if so, how?

(iv) if the answer to (iii) is yes, could any such failures be remedied or were they a major failure within the meaning of ss 267(3) and 268 of the *Australian Consumer Law*?

(v) did the Resident Sub-Group members suffer loss or damage because of any failure of the First defendant to comply with any of the Consumer Guarantees?

(f) in respect of the misleading or deceptive conduct claim:

(i) did the First defendant make in trade or commerce any, and if so what, representations generally to prospective or existing Residents and/or Family

relating to the Residential Care Services provided or to be provided at St Basil's?

(ii) in making, or in failing to qualify, withdraw or correct, any of the

representations referred to at (i) above, did the First defendant engage in misleading or deceptive conduct in contravention of s 18 of the *Australian Consumer Law*?

(iii) did the Representee Sub-Group members suffer loss and damage because of any contraventions of s 18 of the *Australian Consumer Law*?

J MATTERS RELATING TO EXEMPLARY DAMAGES

122 At all material times after the 26 February Notification, the First defendant knew or ought to have known it was obliged to plan for a COVID-19 outbreak in its aged care facilities, including by implementing Infection Control Measures at St Basil's.

123 At all material times after the Dorothy Henderson Lodge Outbreak and the Newmarch House Outbreak, the First defendant knew or ought to have known that if COVID-19 entered one of its aged care facilities and Infection Control Measures were not adequately implemented, it could lead to a significant loss of life.

124 At all material times after 15 June 2020, the First defendant knew or ought to have known it must notify the Department of a positive COVID-19 case within 30 minutes of receiving the relevant test result.

125 At all material times, the First defendant knew or ought to have known that:

(a) if it did not promptly, regularly and accurately communicate information regarding Residents' health and location to their Family during the COVID-19 Outbreak, Family would suffer distress and would be at risk of psychiatric harm; and

(b) if it did not provide the requisite level of care and infection control pleaded herein, vulnerable people under its care would die.

126 Despite the knowledge pleaded in paragraphs 122 to 125 above:

(a) the First defendant did not implement any or any adequate Infection Control Measures at St Basil's;

(b) the First defendant did not notify the Department of its positive COVID-19 cases either within 30 minutes or at all;

(c) the First defendant refused assistance when it was offered prior to 21 July 2020; and

(d) the First defendant ignored calls from Family during the COVID-19 Outbreak.

127 In the premises, the First defendant's acts and omissions pleaded herein were in contumelious disregard of:

(a) the Resident Sub-Group Members' rights under the Charter; and

(b) the Family Sub-Group Members' interest in seeing the Residents' rights under the Charter upheld.

AND THE PLAINTIFF CLAIMS ON HER OWN BEHALF AND ON BEHALF OF GROUP MEMBERS:

A. Damages.

B. Damages pursuant to s 236 of the ACL.

C. Damages pursuant to s 267(3) of the ACL.

D. Damages pursuant to s 267(4) of the ACL.

E. Personal injury damages pursuant to Part VIB of the ACL.

F. A declaration that the First defendant has engaged in misleading or deceptive conduct.

G. Exemplary damages.

H. Interest.

I. Costs.

~~J. B. RICHARDS QC~~

~~A. T. BROADFOOT~~

~~D. C. DEALEHR~~

~~B.HUTCHINS~~

~~S. C. B. BRENKER~~

D WILLIAMS KC

P A CZARNOTA

Carbone Lawyers

CARBONE LAWYERS
Solicitors for the plaintiff

ANNEXURE A

Victorian Directions relating to visits

No	Description	In force
1.	*Aged Care Facilities Directions*, Special Gazette No. S 142, 22 March 2020	21 March 2020 to 7 April 2020
2.	*Care Facilities Directions*, Special Gazette No. S 191, 8 April 2020	8 April 2020 to 13 April 2020
3.	*Care Facilities Directions (No 2)*, Special Gazette No. S 194, 14 April 2020	14 April 2020 to 11 May 2020
4.	*Care Facilities Directions (No 3)*, Special Gazette No. S 231, 12 May 2020	11 May 2020 to 31 May 2020
5.	*Care Facilities Directions (No 4)*, Special Gazette No. S 267, 1 June 2020	31 May 2020 to 21 June 2020
6.	*Care Facilities Directions (No 5),* Special Gazette No. S 297, 22 June 2020	21 June 2020 to 1 July 2020
7.	*Care Facilities Directions (No 6),* Special Gazette No. S 339, 2 July 2020	1 July 2020 to 19 July 2020
8.	*Care Facilities Directions (No 7),* Special Gazette No. S 361, 20 July 2020	19 July 2020 to 22 August 2020
9.	*Care Facilities Directions (No 8),* Special Gazette No. S 367, 23 July 2020	22 July 2020 to 3 August 2020
10.	Care Facilities *Directions (No 9),* Special Gazette No. S 387, 4 August 2020	3 August 2020 to 16 August 2020
11.	*Care Facilities Directions (No 10)*, Special Gazette No. S 417, 17 August 2020	16 August 2020 to 13 September 2020
12.	*Care Facilities Directions (No 11*), Special Gazette No. S 464, 14 September 2020	13 September 2020 to 27 September 2020
13.	*Care Facilities Directions (No 12)*, Special Gazette No. S 492, 28 September 2020	27 September 2020 to 11 October 2020

1. Place of trial – Melbourne.

2. Mode of trial – Judge alone.

3. This writ was filed for the plaintiff by Carbone Lawyers of 302 King Street, Melbourne VIC 3000.

4. The address of the plaintiff is ~~Unit 1, 84A Maribyrnong Road, Moonee Ponds VIC 3039~~ Unit 2, 1 Hendry Street, Sunshine West VIC 3020.

5. The address for service of the plaintiff is care of Carbone Lawyers, 302 King Street, Melbourne VIC 3000.

6. The email address for service of the plaintiff is tony.carbone@carbonelawyers.com.au

7. The address of the First defendant is 24-36 Lorne Street, Fawkner VIC 3060.