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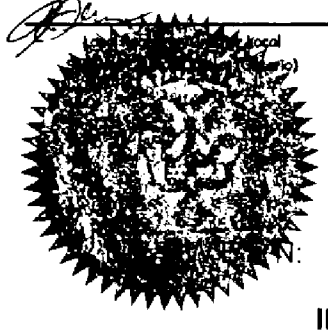

Court File No. CV-20-00001332-00CP

ONTARIO
SUPERIOR COURT OF JUSTICE

IRENE BOBYK, as litigation administrator for THE ESTATE OF ROSE BOBYK-SEMBAY, deceased, and, IRENE BOBYK, personally

Plaintiffs

and

OXFORD LIVING, LLC, OXFORD SC LUNDY NIAGARA INC, and OXFORD SC MASTER LP c.o.b. LUNDY MANOR RETIREMENT RESIDENCE

Defendants

Proceeding Under the *Class Proceedings Act, 1992*

AMENDED STATEMENT OF CLAIM

TO THE DEFENDANT(S)

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the plaintiff. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or an Ontario lawyer acting for you must prepare a statement of defence in Form 18A prescribed by the Rules of Civil Procedure, serve it on the plaintiff's lawyer or, where the plaintiff does not have a lawyer, serve it on the plaintiff, and file it, with proof of service, in this court office, WITHIN TWENTY DAYS after this statement of claim is served on you, if you are served in Ontario.

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your statement of defence is forty days. If you are served outside Canada and the United States of America, the period is sixty days.

Instead of serving and filing a statement of defence, you may serve and file a notice of intent to defend in Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your statement of defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five (5) years after the action was commenced unless otherwise ordered by the court.

Date 05-MAY-2020 Issued by "E-Filing"
Local Registrar

Address of court office: 491 Steeles Avenue East
Milton, ON L9T 1Y7

TO: **OXFORD LIVING, LLC**
5420 North Service Road
Suite 201
Burlington, ON L7L 6C7

OXFORD SC LUNDY NIAGARA INC.
19 Lesmill Road
Toronto, ON M3B 2T3

OXFORD SC MASTER LP
22 Adelaide Street West
Suite 3600
Toronto, ON M5H 4E3

LUNDY MANOR RETIREMENT RESIDENCE
7860 Lundy's Lane
Niagara Falls, ON L2H 1H1

CLAIM

1. The Plaintiffs claim as against the Defendants:

   (a) Compensatory damages for negligence, breach of contract and wrongful death in the amount $10,000,000.00;

   (b) Punitive and exemplary or aggravated damages in the amount of $10,000,000.00, or such other amount as may be proven at trial;

   (c) Cost of insured health services provided by the Ontario Health Insurance Plan ("OHIP") – the particulars of which will be provided prior to trial;

   (d) Prejudgment interest in accordance with section 128 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended;

   (e) Post-judgment interest in accordance with section 129 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended;

   (f) The costs of this proceeding, plus applicable tax; and,

   (g) Such further and other relief as to this Honourable Court may seem just.

THE PARTIES

2. The Plaintiff, Rose Bobyk-Sembay ("Rose"), is now the Estate of Rose Bobyk-Sembay as represented by its Litigation Administrator, Irene Bobyk. At all material times, Rose was a resident of the retirement home known as Lundy Manor

Retirement Residence, located at 7860 Lundy's Lane, in the City of Niagara Falls, in the Province of Ontario, until her death on April 9, 2020, at age 88.

3. The Plaintiff, Irene Bobyk, is an individual residing in the municipality of Fort Erie, in the Province of Ontario, and was the daughter of Rose.

4. The Defendants, Oxford Living, LLC, Oxford SC Lundy Niagara Inc., and Oxford SC Master LP, collectively c.o.b. Lundy Manor Retirement Residence ("Lundy Manor") are corporate entities and a partnership, carrying on business as a retirement home licenced by the Retirement Homes Regulatory Authority and located at the premises known as 7860 Lundy's Lane, in the City of Niagara Falls, in the Province of Ontario. At all material times, Lundy Manor was responsible for the acts and/or omissions of its staff, servants, employees and agents.

THE CLASS

5. The Plaintiffs bring this action pursuant to the *Class Proceedings Act* on behalf of the following class:

(a) All persons who contracted the coronavirus ("COVID-19") at Lundy Manor;

(b) All persons who contracted COVID-19 from one of the residents or from another cross-infected person;

(c) All residents of Lundy Manor who paid for such residency in the period of the pandemic caused by COVID-19, as staff shortages precluded the care contracted and paid for; and,

(d) All living children, grandchildren, siblings and spouses within the

meaning of section 61 of the *Family Law Act,* R.S.O. 1990, c.F-3, as amended, of the persons who contracted COVID-19 at Lundy Manor and Cross-Infected Persons ("the *Family Law Act* Claimants").

6. The Plaintiff, Irene Bobyk, is an appropriate representative of the proposed class. She will be able to adequately and fairly represent the interests of the proposed class and does not have an interest that conflicts with the interests of the proposed class.

THE EVENTS AND NEGLIGENCE OF LUNDY MANOR

7. In or about October 2019, the Defendants, Oxford Living, LLC, Oxford SC Lundy Niagara Inc. and Oxford SC Master LP purchased and assumed the operation of Lundy Manor, a retirement home for seniors who privately pay for their residence there.

8. In December 2019, the first cases of patients suffering from COVID-19 were reported in China.

9. COVID-19 is a viral infection that can cause mild to severe disease that may be fatal. Commonly observed symptoms include fever, cough, shortness of breath, sore throat, and breathing difficulties. In more severe cases, infection can cause pneumonia or severe acute respiratory syndrome, particularly in those individuals with other chronic underlying health conditions. Seniors are a particularly vulnerable group as they are more likely to have chronic underlying health conditions and/or a compromised immune system.

10. On January 23, 2020, a patient suffering from the first presumptive case of

COVID-19 in Canada was admitted to Sunnybrook Health Sciences Centre in Toronto.

11. By Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care Dated January 31, 2020, the Government of Ontario ("the Government") released guidance on the prevention and screening of COVID-19 specifically in long-term care homes. In this guidance, the Government noted the heightened vulnerability of residents in long-term care homes, stating:

> The resident community in LTCHs [Long-Term Care Homes] is likely to be older, frailer, and have chronic conditions which weaken their immune systems. Residents may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways. **Residents are also at risk because respiratory pathogens may be more easily transmitted in an institutional environment.** [emphasis added]

12. Furthermore, the Government provided the following general advice to long-term care homes to prevent an outbreak of COVID-19 in their facility:

- Have procedural masks, tissues and alcohol-based hand rub available to residents and staff;
- Review infection prevention and control and occupational health and safety policies and procedures;
- Post signage on building entrances informing persons to self-identify if they are experiencing fever and/or acute respiratory illness, and have a travel history to Hubei province (including Wuhan), China in the last 14 days since onset of illness or contact with a person who has the above travel history and is ill; and,
- Have ongoing surveillance programs in place throughput the year, including both passive and active surveillance to quickly detect respiratory infections.

13. By Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care dated February 11, 2020, the Government released updated guidance on the prevention and screening of COVID-19 in long-term homes.

14. By Memo dated March 9, 2020, the Government advised the long-term homes sector that "elderly individuals and those with underlying health conditions are at increased risk of severe outcomes [from COVID-19]." For the purposes of preventing an outbreak of COVD-19 in a long-term care home, it issued guidance to actively screen all visitors, residents, re-admissions and returning residents to long-term care homes. More fully, it advised:

- Posting signage and advising visitors who have travelled to affected areas or been exposed to a case of COVID-19 in the last 14 days to postpone their visit;
- Posting signage and advising all visitors who are ill to postpone their visit;
- Ensuring availability and accessibility of hand hygiene throughout the facility;
- Keeping staff and residents informed on COVID-19;
- Reminding staff to be monitoring themselves for illness and to stay at home when they are sick;
- Developing policies for managing staff who may have been exposed to a case of COVID-19;
- Assessing incoming residents for respiratory symptoms and potential exposures to COVID-19;
- Monitoring residents for new respiratory symptoms or fever;
- Quickly identifying and isolating any resident with acute respiratory illness or fever;
- Ensuring signage is clear and that personal protective equipment (gowns, gloves, masks and eye protection) for health care workers

are available and accessible for care for patients with acute respiratory illness;

- Helping visitors with personal protective equipment if they are visiting residents under precautions; and,
- Reporting any suspected COVID-19 illness in residents or staff to the local public health unit.

15. As a further precaution to prevent the spread of COVID-19 amongst a vulnerable group, long-term care home respiratory tests were to be automatically screened for COVID-19.

16. On March 11, 2020, the World Health Organization officially declared a pandemic in respect of the outbreak of COVID-19.

17. On March 12, 2020, Lundy Manor arranged for a girls basketball team to perform a demonstration for residents of the facility.

18. On March 17, 2020, the Government declared a state of emergency, issuing an order under the *Emergency Management and Civil Protection Act*. With this measure, the Government ordered the closure of all bars and restaurants as well as libraries, theatres, cinemas, schools and daycares and all public gatherings of more than 50 people.

19. These closures were premised on the practice of social distancing. COVID-19 spreads mainly among people within six feet of each other. Spread happens when an infected person coughs, sneezes, or talks, and droplets from their mouth or nose are launched into the air and land in the mouths or noses of people nearby. As well, spread may happen when a person touches a surface or object where such droplets have landed and then touch their own mouth, nose, or eyes.

20. On the same day, the Government enhanced its response to COVID-19 with up to $304 million in funding for 24/7 screening at long-term care homes as well as including building additional hospital capacity, supporting public health units with testing and screening, purchasing additional personal protective equipment for frontline workers and ventilators, and dedicated supports for rural, remote, Northern, and Indigenous communities.

21. March 18, 2020, upon the advice of the Chief Medical Officer of Health, the Government recommended that retirement homes only allow essential visitors.

22. On March 20, 2020, by an amendment to s.27(5) of Ont. Reg. 166/11 of the *Retirement Homes Act, 2010*, the Government required retirement homes to comply with the recommendations of the Chief Medical Office for long-term care homes in respect of COVID-19 and preventing the spread of it. To ensure the protection and safety of Ontario's seniors, retirement homes had to take all reasonable steps to follow: (i) any directive respecting COVID-19 issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the *Health Protection and Promotion Act*, and, (ii) any guidance, advice or recommendations respecting COVID-19 given to long-term care homes by the Chief Medical Officer of Health and made available on the Government's website respecting COVID-19. This regulation took immediate effect.

23. On March 20, 2020, the Government amended regulations to allow for increased flexibility in staffing at long-term care homes, making it easier for qualified staff to be hired and for homes to prioritize skills where they are needed most. These measures allowed for homes to quickly bring in more and new staff, to prevent potential staffing shortages, and to allow staff to spend more time on direct care to residents.

24. On March 22, 2020, the Chief Medical Officer of Health issued a directive

to long-term care homes to immediately implement further important measures. Firstly, the homes were to not permit residents to leave the home for short-stay absences to visit family and friends. Secondly, wherever possible, they were to limit the number of work locations that employees are working.

25. On March 23, 2020, the Government issued a temporary order for long-term care homes to support increased staffing flexibility, enabling homes to be able to prevent and, if necessary, alleviate an outbreak of COVID-19. Additionally, it suspended short-stays in long-term care homes and provided guidance to homes on how to use short-stay beds to maximize capacity for applicants waiting for admission to a long-stay bed in a long-term care.

26. On March 24, 2020, the Government amended regulations to allow for streamlined long-term care admissions, discharge and re-admissions process, freeing up much-needed capacity in hospitals and ensuring residents who leave their long-term care home during the COVID-19 pandemic are prioritized for re-admission, giving them peace of mind.

27. On March 25, 2020, the Government launched "Ontario's Action Plan: Responding to COVID-19", which was a $17 billion emergency relief package to provide relief to families and certainty to businesses. This package included $3.3 billion in additional resources for the health care system and specifically $243 million for long-term care.

28. By memo dated March 26, 2020, the executive director of Lundy Manor, Greg Fortier, advised that Lundy Manor intended to commence social distancing in respect of its dining room. At the time, Lundy Manor still served three meals on a daily basis to two sittings of 40 to 50 residents. Each table, which had dimensions of only three feet by three feet, sat four residents. Specifically, Greg Fortier notified that:

> We will be implementing social distancing to the best of our ability in the dining room. Our seating times will be staggered. There will be only 2 people per table, and we may have to use our craft room for additional seating. This has been discussed with and approved by Public Health. We will be in compliance.

29. Additionally, Greg Fortier advised that social distancing would also be implemented with social activities, stating:

> Activities are still being held but social distancing is implemented so we may not be able to have as many programs. We may have to run one program more than twice with the number of residents that we have that participate; we don't want to leave anyone out. ...

30. Lundy Manor never implemented, or failed to properly implement in a timely manner, social distancing in respect of the dining room and social activities.

31. On March 27, 2020, the Government issued a second temporary order for long-term care homes to provide further flexibility in redirecting their staffing and financial resources to essential tasks during the COVID-19 crisis.

32. On March 28, 2020, based on the best advice of Ontario's Chief Medical Officer of Health, the Government issued an emergency order immediately prohibiting organized public events and social gatherings of more than five people, under the *Emergency Management and Civil Protection Act.*

33. Despite the emergency order issued by the Government, on the same day, Lundy Manor hosted a pub night for the residents.

34. On the pub night, as reported in The Niagara Falls Review on April 5, 2020, Mary Timbers - who held a casual position as a receptionist at Lundy Manor – saw "there was a big problem with people sick, not isolating. ... Everyone (was) in the

dining room and still carrying on activities." As a result, she sent the following email to the executive director of Lundy Manor, Greg Fortier:

> I was wanting to help, but I'm not going to endanger myself or my family. In my opinion, Lundy Manor is a time bomb. I'm willing to work again once the situation is under control.

35. On March 29, 2020, as also reported in The Niagara Falls Review, Greg Fortier sent a reply email, advising that Lundy Manor was "aware of activities continuing and, effective Monday (March 30), we are changing the dining-room arrangement to get as close to social distancing as we can." He further noted that he "didn't feel the residents showed signs of COVID-19," before concluding that "there is a ton of misinformation and fear out there right now and that we appreciate everyone's concern for their health, but we work in the care industry and all have an obligation to assist our seniors through this pandemic."

36. On March 30, 2020, an outbreak of COVID-19 was declared at Lundy Manor.

37. After lunch on March 30, 2020, Lundy Manor confined residents to their rooms.

38. Prior to confining residents to their rooms, Lundy Manor failed to implement, or properly implement in a timely manner, the practice of social distancing.

39. For meals, Lundy Manor persisted in having 40 to 50 residents congregate in the lobby before breakfast, lunch and dinner. In the lobby, chairs had not been moved such that they were separated by a distance of six feet. While eating, four residents shared tables that had dimensions of only three feet by three feet. Each meal had two sittings.

40. Additionally, Lundy Manor continued to allow residents to participate in regular social activities. As well as other activities, it allowed groups of residents to continue playing cards on a nightly base and continued to host bingo games, with numerous individuals handling the same playing cards and bingo cards. A number of residents who played cards on a nightly basis contracted COVID-19 and have passed away from it.

41. By April 2, 2020, Niagara's acting medical officer of health reported that 13 confirmed cases of COVID-19 had been associated with Lundy Manor.

42. On April 4, 2020, during a press briefing as reported by The Canadian Press, Premier Doug Ford made the following remarks about the pub night at Lundy's Manor: "First thing out of my mouth was, 'you gotta be kidding me!' ... Most people are using common sense but, folks, c'mon. ... You can't have pub nights in a seniors' building when we're saying we need to put an iron ring around the seniors and long-term care. It just can't happen."

43. In early April 2020, on behalf of Lundy Manor, the mother of the executive director of Lundy Manor, Greg Fortier, posted a plea on social media for nurses to staff Lundy Manor as it had almost no registered nurses available.

44. Brave registered nurses responded this plea. However, such nurses did not have training specific to retirement homes but rather training related to emergency rooms and other areas, where treatment focuses on fewer patients. Lundy Manor failed to provide these nurses with any adequate training for providing care in a retirement home setting or any specific training for providing such care in an outbreak of COVID-19. At Lundy Manor, these nurses had to manage an excess of 80 residents. Many of whom required a variety of medical administrations and were exhibiting acute symptoms.

45. For lengthy periods, Lundy Manor expected a single nurse, lacking adequate training, to care for the entirety of its residents without providing any established or proper protocols. A single nurse had to administer routine medications to all residents, which are critical for those residents who require cardiac medication or similar essential medications. This administration process was significantly slowed by necessary disinfectant routines undertaken between entering each resident's room. This delay prevented such nurses from administering routine medications in a timely manner, putting the residents at risk. While doing so, this single nurse had to assess residents for COVID-19, including taking swabs. Finally, these nurses had to make the decision to call 911 and send the residents to the hospital due to respiratory distress.

46. Additionally, after the outbreak of COVID-19, Lundy Manor failed to establish and adhere to proper protocols for the prevention of contamination and the further spread of COVID-19. Amongst other failures, Lundy Manor's failures included:

- Advising staff to wear the same disposable gown to enter another resident's room, if the previous resident had not been tested for COVID-19 or did not exhibit symptoms of having contracted COVID-19, contaminating the gown and making it a potential source of infection;

- Permitting the designated cart, carrying unused masks and gloves for the staff, to have a garbage can that overflowed such that the garbage contacted the masks and gloves, contaminating them and making them a potential source of infection; and,

- Not providing staff with proper or adequate training for donning and doffing personal protective equipment, resulting in the contamination of the personal protective equipment and making it a potential source of infection.

47. By April 21, 2020, following the outbreak at Lundy Manor, 15 people had

died from contracting COVID-19 and 41 residents and 8 staff members had contracted COVID-19.

48. The particulars of the allegations of negligence, gross negligence, breach of contract and wrongful death against the Defendants, Oxford Living, LLC, Oxford SC Lundy Niagara Inc., and Oxford SC Master LP, include but are not limited to the following:

(a) They failed to ensure that the residents and staff of Lundy Manor were kept safe;

(b) They failed to comply with directives issued by the Chief Medical Officer of Health and orders issued by the Government of Ontario that related to preventing COVID-19 from infecting residents and staff of long-term care facilities, such as Lundy Manor;

(c) They failed to institute reasonable measures to prevent COVID-19 from infecting residents of Lundy Manor, such as undertaking proper screening of visitors and practicing social distancing;

(d) They failed to employ and properly train competent staff on proper, safe and adequate measures for preventing COVID-19 from infecting residents and staff of Lundy Manor;

(e) They failed to take proper care in the circumstances;

(f) They breached their duty as a caregiver and fiduciary to the residents and staff of Lundy Manor;

(g) They failed to meet the minimum standards of practice for preventing transmission of infectious diseases in the setting of a long-term care facility;

(h) They failed to warn the residents and staff of Lundy Manor of the potential exposure to COVID-19 in a timely fashion;

(i) They failed to adequately supervise the work of their employees and staff regarding compliance with directives issued by the Chief Medical Officer of Health and orders issued by the Government of Ontario that related to preventing COVID-19 from infecting residents of long-term care facilities, such as Lundy Manor;

(j) They failed to take all reasonable, necessary and protective measures to ensure that the residents and staff of Lundy Manor were safe while on the premises of Lundy Manor; and,

(k) Such further and other particulars which may become known to the Plaintiff or the residents or staff of Lundy Manor or their family members that will be proven at the trial of this action and are within the knowledge of the Defendant.

DAMAGES

49. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of contract and wrongful death. The full particulars of which the Plaintiffs undertake to provide to the Defendants prior to the trial of this action.

50. The Plaintiffs and the estates of the Plaintiffs claim for damages for pain and suffering arising from contracting COVID-19.

51. The *Family Law Act* Claimants claim for damages pursuant to s. 61 of the *Family Law Act*. The damages for these class members include pecuniary losses resulting from the injury or death of their family member, expenses incurred for the benefit of their family member, travel expenses incurred in visiting their family member during his or her treatment and recovery, funeral expenses, a reasonable allowance for loss of income and the value of nursing, housekeeping and other services rendered to their family member, an amount to compensate for the loss of guidance, care and companionship reasonably expected to be received from their family member had the aforesaid negligence and misconduct not occurred.

52. The Plaintiff states that the Defendants conducted their affairs leading to these subject occurrences in a high-handed and arrogant manner with a wanton

disregard for the safety and well-being of the Plaintiffs and, as such, they are entitled to aggravated damages.

53. The Defendants' conduct was reprehensible and departed to a marked degree from ordinary standards of decent behaviour. The Defendants' reckless disregard for the Plaintiffs is deserving of punishment and condemnation by means of an award of punitive damages.

54. The Defendants' actions were callous and arrogant and offend the ordinary community standards of moral and decent conduct. The actions, omissions or both of the Defendants involved such want of care as could only have resulted from actual conscious indifference to the rights, safety or welfare of the Plaintiffs.

THE PLAINTIFFS' INDIVIDUAL CIRCUMSTANCES

55. In 2016, the Plaintiff, Rose Bobyk-Sembay, became a resident of Lundy Manor, after her husband had passed away.

56. As a resident, the Plaintiff, Rose Bobyk-Sembay, was paying a monthly fee of approximately $2,800 to Lundy.

57. Irene regularly visited the Plaintiff, Rose Bobyk-Sembay, while she was a resident at Lundy Manor. Irene's son, Derek Stefanovich, also regularly visited the Plaintiff, Rose Bobyk-Sembay - on an almost daily basis.

58. Throughout March 2020, the Plaintiff, Rose Bobyk-Sembay, continued to socialize as permitted and encouraged by Lundy Manor, in violation of social

distancing practices, including eating three meals on a daily basis in the dining room and attending social activities.

59. During the week of March 23, 2020, the Plaintiff, Rose Bobyk-Sembay, began to exhibit symptoms of having contracted COVID-19, including having a fever and nasal excretions.

60. On April 4, 2020, the Plaintiff, Rose Bobyk-Sembay, was transported to St.. Catharine's General Hospital, where she learned that she tested positive for COVID-19.

61. On April 9, 2020, the Plaintiff, Rose Bobyk-Sembay, passed away due to contracting COVID-19.

62. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of contract and wrongful death. The full particulars of which the Plaintiffs undertake to provide to the Defendants prior to the trial of this action.

63. The Estate of the Plaintiff, Rose Bobyk-Sembay, claims for damages for pain and suffering arising from contracting COVID-19 .

64. The Plaintiff, Irene Bobyk, is entitled to damages pursuant to s. 61 of the *Family Law Act*, including include pecuniary losses resulting from the death of the Plaintiff, Rose Bobyk-Sembay, expenses incurred for her benefit, travel expenses incurred in visiting her during her treatment, funeral expenses, a reasonable allowance for loss of income and the value of nursing, housekeeping and other services rendered to them, an amount to compensate for the loss of guidance, care and companionship reasonably expected to be received from her had the aforesaid negligence and misconduct not occurred.

65. The Plaintiffs plead and rely upon the following statues, as amended:

a) Class Proceedings Act, 1992, S.O. 1992, c. 6

b) Courts of Justice Act, R.S.O. 1990, c. C.43;

c) Negligence Act, R.S.O. 1990, c. N.1.I; and

d) Retirement Homes Act, 2010, c. 11.

66. The Plaintiffs propose that this action be tried in the Town of Milton in the Province of Ontario.

Dated:

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Lawyers for the Plaintiffs

Bobyk et al.
Plaintiffs

-and-

Oxford Living LLC et al.
Defendants

Court File No. CV-20-00001332-00CP

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT
MILTON

AMENDED STATEMENT OF CLAIM

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