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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

MICHELE BRYANT, an individual; and the ESTATE OF KENDRA CZEKAJ, by and through her successor-in-interest MICHELE BRYANT,

Plaintiffs,

v.

SACRAMENTO COUNTY DEPARTMENT OF CHILD, FAMILY AND ADULT SERVICES; CHILDREN'S RECEIVING HOME OF SACRAMENTO; MICHELLE CALLEJAS; NKIRU EMILIA EZEDINACHI; CAREWIN VINUYA CZEKAJ; and DOES 1 through 50, inclusive,

Defendants.

CASE NO.:

**PLAINTIFFS' COMPLAINT FOR WRONGFUL DEATH AND SURVIVAL ACTION**

1. **Negligence**
2. **Dangerous Condition of Public Property (Cal. Gov. Code § 835)**
3. **Intentional Infliction of Emotional Distress**
4. **Negligent Infliction of Emotional Distress**
5. **Failure to Discharge a Mandatory Duty (Cal. Gov. Code § 815.6)**
6. **Wrongful Death**
7. **Automobile Negligence**

**DEMAND FOR JURY TRIAL**

## INTRODUCTION

1. This case involves the tragic and untimely death of a twelve-year-old girl while in the care of the Children's Receiving Home of Sacramento ("CRH"). CRH is the main emergency shelter for children who are removed from their homes by the County of Sacramento ("the County") as a result of neglect or abuse. Under a contract with the County, CRH is intended to serve as a temporary shelter for these children until they can be placed with a family member or in a foster care home. At any given time, CRH houses more than 100 children ranging in age up to 18 years old.

2. Unfortunately, CRH has a long history of chronic understaffing and failing to comply with numerous state regulations designed to protect the children it shelters. Over and over again, CRH has been cited for failing to supervise the children in its care. In fact, over the past five years there have been thousands of reports of children going missing from its facility. These children often leave in small groups, sometimes in the dead of night, and are left unsupervised roaming the streets for hours at a time.

3. To make matters worse, CRH is located in one of the most crime-infested neighborhoods in the Sacramento region and is in close proximity to the I-80 freeway and the busy intersection of Auburn Boulevard and Watt Avenue. As a result, there have been numerous incidents where children leaving the facility have been struck by vehicles or targeted by sex traffickers, drug dealers, and other criminals who roam the streets surrounding the facility.

4. The problems at CRH and its inability to protect the children in its custody have been widely known to the County of Sacramento for many years. Despite this, the County continued to place vulnerable children at CRH whom it had removed from their homes or for whom it had otherwise failed to find an appropriate placement. The County also failed to find alternative locations for its emergency shelter beds in a less dangerous area of the County.

5. On the night of January 15, 2020, the predictable outcome of CRH's deficiencies and the County's failures came to a terrible fruition. On this date, twelve-year-old Kendra Czekaj was spending her eleventh day at CRH. Just prior to her stay at CRH, Kendra had been

hospitalized because of her acute mental health needs and instead of allowing her to stay with her mom, the County placed Kendra at the CRH shelter. As she had done virtually every other day during her stay, Kendra left CRH with a group of other children. CRH staff failed to deter Kendra from leaving, failed to supervise the group after they left, and failed to take reasonable steps to ensure the children's safety once they left the CRH campus. Once again, these children were free to wander the streets. Approximately two hours later, Kendra met a second group of residents who had separately left CRH. One of the children from the second group, who was displaying signs of distress, led the newly formed group across the six-lane I-80 freeway, which is located directly behind CRH. Although the other children made it across, Kendra was not as lucky. Kendra was struck by a vehicle at highway speed and pronounced dead at the scene.

6. Kendra has been described in court documents as mature, witty, and quick to engage. Her friends remember her as heart-warming, an amazing person who always had a smile on her face. She was bright, enrolled in honors classes, and her favorite thing about school was art class. Kendra was a smart, talented, and kind twelve-year-old, who died while in the care of CRH.

## PARTIES

7. Plaintiff THE ESTATE OF KENDRA CZEKAJ, by and through her successor-in-interest, MICHELE BRYANT, was at all times material hereto a resident of Sacramento County.

8. Plaintiff MICHELE BRYANT is the mother and successor-in-interest to KENDRA CZEKAJ. She will comply with Welfare & Institutions Code Section 15657.3(d) by filing a successor-in-interest affidavit pursuant to Code of Civil Procedure Section 377.32. At all times relevant to this action, MICHELE BRYANT was and is a resident of Sacramento County.

9. Defendant CHILDREN'S RECEIVING HOME OF SACRAMENTO ("CRH") is a nonprofit 501(c)(3) corporation organized and existing under the laws of the State of California with a principal place of business in Sacramento County. Among its programs, CRH runs a Temporary Shelter Care Facility licensed by the state to provide twenty-four-hour emergency shelter and care for abused and neglected children on behalf of the County of Sacramento.

10. Upon information and belief, CRH's license has been issued to CRH "on behalf of" Sacramento County.

11. Defendant SACRAMENTO COUNTY DEPARTMENT OF CHILD, FAMILY AND ADULT SERVICES ("DCFAS") is a local governmental entity, duly authorized and formed under the laws of the State of California. Sacramento County DCFAS has "sole responsibility for the operation of the child welfare services program" within Sacramento County. Cal. Welf. & Inst. Code § 16500. The Sacramento County Child Protective Services ("CPS") Division of DCFAS is responsible for investigating reports of abuse or neglect, providing foster care services, providing case management services, and providing adoption services. The Sacramento County CPS Division of DCFAS is also responsible for selecting children's foster care placements, monitoring foster children's well-being, and ensuring the implementation of their case plans. Cal. Welf. & Inst. Code § 16501(a).

12. Defendant MICHELE CALLEJAS is the Director of the Sacramento County DCFAS (together with DCFAS, "the County Defendants"). In this role, she is responsible for administering child welfare services in Sacramento County and ensuring the safety and well-being of foster youth under court supervision pursuant to California Welfare and Institutions Code Section 300. Defendant Callejas is sued in her official capacity.

13. Defendant NKIRU EMILIA EZEDINACHI is a resident of Sacramento County. Defendant EZEDINACHI was driving the vehicle that struck KENDRA CZEKAJ on January 15, 2020.

14. Nominal Defendant CAREWIN VINUYA CZEKAJ is Kendra's biological father. He is currently incarcerated in the State of California after pleading guilty to sexual crimes committed against Kendra.

15. Plaintiffs are informed and believe, and thereon allege, that at all times mentioned herein, all Defendants named herein, including DOES 1 through 50, inclusive and each of them, were agents, servants, employees, successors in interest, and/or joint venturers of their co-Defendants, and were acting within the course, scope, and authority of said agency, employment, and/or venture.

## FACTS

A. Children's Receiving Home of Sacramento

16. Shelters such as CRH are intended to be a safe haven for endangered children. By law, temporary shelters are required to provide children with appropriate housing, direct care, and supervision. They are also required to provide children in their care with numerous services, including "trauma-informed services and interventions" and "crisis intervention services." Cal. Welf. Inst. Code § 11462.022(e).

17. Despite these requirements, for years CRH has utterly failed the children in its care and has been one of the worst performing temporary shelters in the state. Over the last five years, there have been more than 300 incidents at the facility that required intervention by state regulators. In fact, a recent analysis by the *Sacramento Bee* showed that CRH was visited by regulators twenty times more often than the state average for group homes and was cited eighteen times more often for posing an immediate risk to a child's health, safety, or personal rights.[1] Complaints have included chronic understaffing, failing to supervise children, drug use by staff with residents, and employees having sex with residents.

18. One of the most pervasive problems with CRH involves its failure to keep children safe from the surrounding neighborhood where its facility is located. Under state law, CRH cannot lock its residents within its facility. To discourage children from leaving or to ensure their safety if they do, CRH must employ sufficient staff that is adequately trained. Additionally, youth shelters should offer sufficient educational and recreational activities at their facilities to serve as a disincentive to children leaving in the first instance, as well as mental health resources and crisis intervention services for those children in distressed emotional states.

19. However, as a result of chronic understaffing, poor training, and the failure to implement services and incentives for children to remain at the facility, children leaving CRH has been a daily occurrence. In fact, over the past five years, CRH has reported thousands of

[1] Michael Finch II & Molly Sullivan, Runaways, prostitution and a girl's death. How Sacramento's largest group home failed its kids, The Sacramento Bee, August 29, 2020, 05:00 AM, updated September 09, 2020, 04:51 PM, https://www.sacbee.com/news/local/article245239195.html.

children leaving its facility and has become the leading source of missing persons reports for the entire State of California. In light of CRH's location, the failure to adequately supervise children in its care invites tragedy.

20. Specifically, CRH is located near the corner of Auburn Boulevard and Watt Avenue and backs up directly against the intersection of the I-80 and Business 80 freeways. This area has one of the highest crime rates in the Sacramento region and is known for sex trafficking, gang activity, and the drug trade.

21. CRH's location, coupled with the huge number of children leaving its facility, creates an extremely dangerous situation. There have been numerous reports of children being lured into the sex trade, being offered drugs, or becoming victims of violent crime. Also, CRH's location next to a busy intersection and freeway creates additional dangers for children, especially children who have already experienced significant trauma. There have been several instances where unsupervised residents of the facility have ventured onto the nearby freeway or been struck by vehicles on surrounding roads.

22. The problems with CRH and, specifically, the dangers caused by its location have been known to the County of Sacramento for many years. In 2017, the Sacramento County Grand Jury investigated CRH and issued a report of its findings. In the report, the Grand Jury specifically noted that one of the main problems with CRH was its location.

> "[The CRH facility] is in a high crime neighborhood. The 2017 Sacramento Police Department Crime Analysis Unit reported 3,149 missing persons within a two-mile radius. The location is in close proximity to motels, bars and adult shops, increasing the potential for children to be exposed to sex trafficking by predators in the area. The location puts CPSU staff and traumatized youths in undue danger."[2]

23. The Grand Jury also noted how CRH's location is of particular concern when one considers that children in the facility are essentially able to leave the facility whenever they choose:

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[2] Sacramento Grand Jury, Sacramento County Grand Jury Report 2017-2018, 5 (2017-2018), https://www.saccourt.ca.gov/grand-jury/docs/reports/17-18/report-1-foster-children.pdf.

"One of the challenges of placing youth in an appropriate environment is having their cooperation as they can legally refuse placement for any reason. Children (12 and older) who have been in/out of the foster care system may repeatedly refuse placement and/or leave the premises at any time. . . . CRH staff have limited ability to intervene. Although they have security guards at the CPSU, it remains a highly vulnerable and questionable area to accept and shelter traumatized children."[3]

24. Despite knowledge of the problems with CRH, CRH's inability to care for its residents, and its incredibly dangerous location, the County continued to contract with CRH every year without making any effort to remedy the risk specifically associated with the facility. In so doing, the County knowingly placed countless children, like Kendra, in harm's way.

B. The Duties and Responsibilities of the County and CRH

25. California law provides that the administration of public social services, including child welfare services, within a local area is a county function and responsibility. Cal. Welf. & Inst. Code §§ 10800, 16500, 16501(a).

26. In Sacramento County, the DCFAS administers child welfare services. Cal. Welf. & Inst. Code §§ 16500, 16501(c). The Sacramento County CPS Division of DCFAS is responsible for investigating reports of abuse or neglect, providing foster care services, providing case management services, and providing adoption services. The Sacramento County CPS Division of DCFAS is also responsible for selecting children's foster care placements, monitoring foster children's well-being, and ensuring the implementation of their case plans. Cal. Welf. & Inst. Code 16501(a).

27. Foster children entering Sacramento's foster care system are assigned a social worker who is responsible for providing these services. *See* Cal. Dep't of Soc. Servs., Manual of Policies and Procedures ("MPP") §§ 31-000-31-530. Sacramento County DCFAS must complete a comprehensive case plan for each foster child within sixty days of their removal from their parents' home. Cal. Welf. & Inst. Code § 16501.1(e). The case plan "ensures that the child receives protection and safe and proper care and case management," "that services are provided

[3] *Id.*

to the child and parents or other caretakers," that "reasonable services [are] offered or provided to make it possible for [the] child to return to a safe home environment" (absent a court determination to the contrary), and that the needs of the child are addressed while in care. Cal. Welf. & Inst. Code § 16501.1(a)(2), (5). The case plan must include a "plan which will ensure that the child will receive medical . . . care which places attention on preventive health service," and that "[a]rrangements" are "made for necessary treatment." MPP §§ 31-206.36, 31-206.362. The case plan must also include a description of the type of placement being used and "the reasons for that placement decision." Cal. Welf. & Inst. Code § 16501.1(d)(1).

28. Sacramento County DCFAS may only place children in community care facilities that are licensed by the California Department of Social Services ("CDSS"). Cal. Health & Safety Code § 1536.1(b). "Prior to detaining the child in the temporary shelter care facility, the child welfare agency shall make reasonable efforts, consistent with current law, to place the child with a relative, tribal member, nonrelative extended family member, or in a licensed, certified, approved or tribally approved foster family home[,] approved resource family," or short term residential therapeutic program. Cal. Welf. & Inst. Code § 11462.022(b); Cal. Dep't of Soc. Servs., Temporary Shelter Care Facility Interim Licensing Standards (2017) ("TSCF ILS"), art. VI, § 84668.05(b)(1). Before accepting a child to the facility, a temporary shelter care facility is required to collaborate with the county placing agency to ensure that these reasonable efforts were made. TSCF ILS, art. VI, § 84668.05(b)(1).

29. Sacramento County DCFAS may place "a child who is the subject of a petition under Section 300 and who is 6 to 12 years of age, inclusive," in a temporary shelter care facility "only when the court finds that placement is necessary to secure a complete and adequate evaluation, including placement planning and transition time." Cal. Welf. & Inst. Code § 319.3. Sacramento County DCFAS may also place a child "in a temporary shelter care facility only for the duration necessary to enable the county placing agency to perform the required assessments and to appropriately place the child." Cal. Welf. & Inst. Code § 11462.022(c). "Commencing when a child is admitted into a temporary shelter care facility, and continuing until the child's discharge from the facility, the county welfare agency shall continuously strive to identify and

place the child in an appropriate licensed or approved home or facility." Cal. Welf. & Inst. Code § 11462.022(d).

30. "In no case shall the detention or placement in a temporary shelter care facility exceed 10 calendar days." Cal. Welf. & Inst. Code § 11462.022(f)(1); *see also* Cal. Welf. & Inst. Code § 319.3 (stating that, for a child 6 to 12 years of age, inclusive, the "placement period in a temporary shelter care facility shall not exceed 10 days"). "For any stay that exceeds 10 calendar days, the child welfare agency shall submit a written report to the department, within 24 hours of an overstay, that shall include a description of the reasons and circumstances for the child's overstay, and shall be signed by the county child welfare agency director or his or her designee." Cal. Welf. & Inst. Code § 11462.022(f)(1).

31. Pursuant to California law, counties can subcontract the operation of temporary shelters to third parties. Specifically, California Health and Safety Code Section 1530.8(c)(1) defines a "temporary shelter care facility" as a facility that "is owned and operated by the county or on behalf of a county by a private, nonprofit agency." Additionally, California Health and Safety Code Section 1530.8(d)(1) provides that the state may issue licenses for temporary shelters "to a county operating a licensed group home, or to an agency on behalf of a county."

32. At all times mentioned in this Complaint, the County of Sacramento had an ongoing contract with CRH to operate a temporary shelter on its behalf. Also, Plaintiffs are informed and believe that the state license to operate CRH was issued to CRH on behalf of the County of Sacramento.

33. Sacramento County DCFAS has an ongoing duty to monitor the well-being of children that it has placed in its temporary shelter care facilities. When putting a child into a placement, the social worker is required to "[m]onitor the child's physical and emotional condition, and take necessary actions to safeguard the child's growth and development," and to "[e]nsure that the child receives medical . . . care which places attention on preventive health." MPP §§ 31-405.22, 31-405.24; *see also* MPP §§ 31-310.12, 31-205.1 (the social worker must document the child's "need, if known, for any health/medical care"). At least once per calendar month, the social worker must privately visit with each child that the county welfare department

has placed in a group home or temporary shelter care facility to assess the child's safety and well-being, among other things. Cal. Welf. & Inst. Code §§ 16501.1(g)(4), 16516.5; MPP §§ 31-320.5, 31-320.61, 31-320.613. The social worker also must make contact with the child's doctors and nurses. MPP § 31-335.1.

34. California law also imposes specific duties upon counties that operate temporary shelters or entities operating shelters on the counties' behalf. Specifically, a county is only permitted to operate a temporary shelter care facility pursuant to licenses issued by CDSS and in compliance with the governing statutes and CDSS's regulations and rules. Cal. Health & Safety Code § 1508; Cal. Code Regs. tit. 22, § 80000(b); TSCF ILS, art. I, § 84600(a).

35. Under those statutes, regulations, and rules, CRH (acting on behalf of the County of Sacramento) is responsible for ensuring that each child placed in its care "is accorded [their] personal rights," including by providing them with appropriate housing, direct care and supervision, and meeting other basic needs. Cal. Code Regs. tit. 22, § 84072(d); *see, e.g.*, Cal. Code Regs. tit. 22, §§ 84065.2(b), 84067(c); *see also* Cal. Welf. & Inst. Code § 16001.9(a); Cal. Health & Safety Code § 1530.8. CRH must provide youth with numerous services, including "trauma-informed services and interventions" and "crisis intervention services." Cal. Welf. & Inst. Code § 11462.022(e)(3)-(4). CRH also must provide "medical, developmental, behavioral, and mental health" screenings and assessments, and "[r]eferrals to and coordination with service providers who can meet the medical, developmental, behavioral, or mental health needs of the child identified upon admission." Cal. Welf. & Inst. Code § 11462.022(d), (e)(1), (e)(6). In addition, CRH must "ensure each child's attendance at an educational program in accordance with state law." Cal. Code Regs. tit. 22, § 84078(d).

36. The County and CRH are also required to provide appropriate supervision for all children in their care. Cal. Welf. & Inst. Code § 11462.022(f)(2) ("Temporary shelters shall staff as necessary to adequately supervise children to ensure an appropriate environment for all children present."); *see also* Cal. Code Regs. tit. 22, § 80065(a) ("Facility personnel shall be competent to provide the services necessary to meet individual client needs and shall, at all times, be employed in numbers necessary to meet such needs."). Also, the County and CRH are

required to provide "[c]are and supervision provided by trauma-informed trained and qualified staff." Cal. Welf. & Inst. Code § 11462.022(e)(5). CRH must also inform a child's authorized representative by the next business day if a child has had an unusual absence from the facility. TSCF ILS, art. VI, § 84661(d)(1). If a child is identified to be at risk of, or has been, commercially sexually exploited, CRH must make this report to the authorized representative "as soon as is reasonably possible and in no case longer than 24 hours." TSCF ILS, art. VI, § 84661(d)(1)(A).

37. CRH is required to "develop and maintain a written runaway plan that describes how the facility will respond to . . . Runaway child(ren) [and] Child(ren) outside of the facility property without permission, but within view of the facility personnel." Cal. Code Regs. tit. 22, § 84322.2(a). "The runaway plan must be appropriate for the age, size, emotional, behavioral and developmental level of the child(ren)." Cal. Code Regs. tit. 22, § 84322.2(b). The runaway plan must include, among other things, a "continuum of interventions," a "staff training plan, to include non-physical interventions, strategies to de-escalate a situation," and a "plan to notify the child's authorized representative." Cal. Code Regs. tit. 22, § 84322.2(c). The facility must provide the runaway plan to each child and their authorized representative at the time of admission and discuss the plan with them. Cal. Code Regs. tit. 22, § 84322.2. If a "child has a history of running away from placement," "[t]he facility social work personnel and the child's authorized representative must develop an individualized plan for that particular child." Cal. Code Regs. tit. 22, § 84322.2(e)(1).

38. Further, the County and CRH must supervise, evaluate, and train all of CRH's childcare staff before they may supervise children and, on an ongoing basis, ensure that they have the "appropriate skills necessary to supervise the children in care." Cal. Code Regs. tit. 22, §§ 84065(h)-(i). The initial training must include training on the facility's policies and procedures, including on the responsibilities of childcare workers. Cal. Code Regs. tit. 22, § 84065(i)(3). CRH must also ensure all staff receive "training on the specialized needs of children in transition." TSCF ILS, art.VI, § 84665.3(b).

39. Finally, the County and CRH must "monitor and ensure the adequacy and quality

of care, supervision, and services provided by the facility, as informed by" various "indicators," including "the number of children absent without leave from the temporary shelter care facility," and "[a]ny other indicators that specialized or intensive needs of the children served by the temporary shelter care facility are not being met." TSCF ILS, art. III, § 84622(b)(7).

C. The County and CRH Failed to Adequately House and Supervise Kendra.

40. On March 4, 2019, Kendra reported to the Sacramento Police Department that she was being sexually abused by her father. Kendra and her siblings were removed from the home of their father and stepmother and placed into protective custody by the Citrus Heights Police Department. Later that evening, Kendra was transported to CRH and subsequently placed in a foster home.

41. On May 1, 2019, Kendra was moved from the foster home and placed with her mother, Plaintiff Michele Bryant. Michele repeatedly requested that the County provide additional mental health services for Kendra to help her deal with the psychological damage caused by her father's sexual abuse. Months passed before Kendra was eventually provided therapy. Michele's requests for family therapy to assist with rebuilding Kendra's connection with her and sense of safety were never granted.

42. In August, Kendra was involuntary hospitalized due to severe depression and threats of self-harm. During this hospitalization, she was prescribed various medications to address her trauma and depression.

43. Following the hospitalization, the County refused to return Kendra to Michele, alleging that she needed to "stabilize" prior to returning home. Far from providing Kendra with the stable placement and intensive mental health services she needed to heal from years of abuse, the County bounced Kendra from one placement to the next, failed to provide family therapy, and repeatedly failed to ensure she was enrolled in school. The County allowed continued interaction between Defendant Czekaj and Kendra by and through Defendant Czekaj's wife, despite her repeated mental abuse of Kendra. Throughout this time, Plaintiff Michele Bryant stayed in close contact with Kendra and repeatedly expressed her desire for Kendra to return to her home.

44. In late December, following months of instability and isolation from peers and any sense of normalcy, Kendra was again involuntarily hospitalized with a depressive episode stemming from PTSD and suicidal ideations. Once she was cleared for discharge a few days later, Michele picked her up and was allowed an overnight visit. Michele was told, however, that Kendra would need to return to CRH the next day.

45. On January 5, 2020, the County placed Kendra back at CRH. Michele was again told that Kendra could not return home because she needed to "stabilize" first. The County was also allegedly evaluating other placements to help Kendra deal with her ongoing trauma and depression. Upon information and belief, the County did not obtain court authorization to place Kendra at CRH.

46. Although CRH and the County had a duty to adequately supervise and house Kendra, during her eleven-day stay at CRH, she was essentially left unsupervised. Upon information and belief, CRH did not employ sufficient staff or train its staff to properly supervise the children in its care. From January 7, 2020, through January 14, 2020, Kendra went missing from the CRH facility on fifteen separate occasions and was left unsupervised for hours at a time. For example, on January 13, 2020, Kendra went missing from 1:03 a.m. to 4:58 a.m. Later that same day, she was gone from 9:47 p.m. to 1:45 a.m. On January 14, 2020, Kendra returned to the facility and reported that during her time away she had been lured into the car of an unknown male who had offered her marijuana in exchange for sex. Kendra later reported that this same male offered to serve as her "pimp." Not once during this time period was Michele advised that Kendra had gone missing or that she had been approached by a suspected human trafficker. Upon information and belief, CRH did not comply with its runaway plan and did not develop an individualized runaway plan for Kendra.

47. In addition to the lack of supervision, Kendra's needs were ignored while she was at CRH. She did not attend any educational program during her time at CRH; she was not taken to a scheduled interview with a new school; she was not taken to an appointment for a program to support her mental health needs; she was not transported to her court hearing on January 10; she was not visited by her case worker; and, she was not assessed for more intensive mental

health supports.

48. To make matters worse, during Kendra's stay at CRH, she had stopped taking her anti-depressant medication, which she had been prescribed during her hospitalization just days prior. There is no indication in CRH's records that anything was done to encourage her to take her medication or to inform her mother that she had stopped.

49. On the night of January 15, 2020, at 8:15 p.m., Kendra again left the CRH facility with a group of children. Although CRH employees followed the group for a short distance, they soon lost track of them and returned to CRH without locating the children. Approximately two hours later, Kendra's group met up with another group of children who had recently left the facility. One of the children from the newly formed group, who was distressed and in crisis, led the new group of children across the six-lane I-80 freeway that is located directly behind the CRH facility. Kendra, seemingly in an effort to help the distressed child, followed the group and was struck by a vehicle on the I-80 freeway at approximately 9:47 p.m. Kendra died shortly thereafter.

50. At no time on January 15, 2020, did CRH advise Michele that Kendra had gone missing or been involved in an accident. Michele did not find out about the incident until 1:00 a.m. the following morning when she heard someone knocking at her door. By the time Michele was able to get to the door, the person knocking had left. On the door was a yellow Post-it note from the Sacramento County Coroner's office advising Michele that her twelve-year-old daughter was dead. To this day, no one at CRH has called Michele to tell her what happened to Kendra, to explain why Kendra had been left free to roam the surrounding area, or to offer any condolences whatsoever for the loss of her twelve-year-old daughter.

51. On June 4, 2021, the Court granted Plaintiffs' request for relief to file a government tort claim and Plaintiffs were deemed to have complied with Government Code Section 945.4.

**FIRST CAUSE OF ACTION**
**(Wrongful Death and Survival Action Sounding in Negligence by all Plaintiffs as Against All Defendants and Does 1 through 50, Inclusive)**

52. Plaintiffs incorporate by reference paragraphs 1 through 51 as though alleged

fully in this cause of action, and further allege as follows:

53. At all times mentioned herein the County Defendants had statutory duties to provide Kendra adequate housing, supervision, protection, and care. Among other obligations, the County Defendants owed a duty to ensure that their temporary shelters were safe and sufficiently staffed with trained and qualified employees, including employees trained in trauma-informed practices; provided adequate supervision and mental health services to children; afforded residents recreational, social, and education programs; provided trauma-informed services and interventions and crisis intervention services; performed medical, developmental, behavioral, and mental health screenings and assessments; and coordinated services for children to meet their medical, developmental, behavioral, or mental health needs. The County Defendants also owed duties to obtain court approval prior to placing a young child at a temporary shelter, to only keep a child in such a facility for the time necessary to assess their needs and appropriately place them, to continuously strive to find an appropriate placement for the child, and to find a placement within ten calendar days. *See, e.g.*, Cal Welf. & Inst. Code § 11462.022(d), (e)(5), (e)(9), (f)(3); Cal. Code Regs. tit. 22, § 84065(h)-(i).

54. The foregoing regulations and statutes were enacted specifically to protect children like Kendra.

55. The County Defendants subcontracted these non-delegable duties to CRH, which operated the shelter where Kendra was placed "on behalf of" the County Defendants. In making such a delegation, the County Defendants and CRH are required to "monitor and ensure the adequacy and quality of care, supervision, and services provided by the facility, as informed by" various "indicators," including "the number of children absent without leave from the temporary shelter care facility," and "[a]ny other indicators that specialized or intensive needs of the children served by the temporary shelter care facility are not being met." TSCF ILS, art. III, § 84622(b)(7).

56. CRH owes further duties, and is directly responsible, to provide appropriate care, supervision, and services for children in its care. Among other things, CRH must maintain a runaway plan that sets forth how the facility will respond to children leaving its grounds,

including the continuum of interventions and de-escalation strategies that will be utilized, and must develop an individual runaway plan for children with a history of running away from placements. Cal. Code Regs. tit. 22, § 84322.2(a).

57. In addition, the County caseworker was required to visit with Kendra at least once a month, including having a private discussion with her. 42 U.S.C. § 622(b)(17); Cal. Welf. & Inst. Code §§ 16501.1(g)(4), 16516.5; MPP §§ 31-320.61, 31-320.613.

58. As described herein, the County Defendants and CRH breached their duty of care by failing to provide Kendra with adequate supervision, housing, protection, or care. Specifically, the County Defendants and CRH failed to provide adequate housing by locating their shelter in one of the most dangerous neighborhoods in the Sacramento region, which is located directly next to a major freeway and intersection. They did this despite having knowledge that children in their care often go missing and are then subjected to abuse, trafficking, and injury when they leave. The County Defendants and CRH also breached their duty of care by failing to adequately staff the facility with properly trauma-informed trained and qualified employees who could supervise the children in their care and discourage them from leaving the facility, by failing to provide trauma-informed services and interventions and crisis intervention services, and by failing to properly maintain and implement a facility-wide and individual runaway plans. The County Defendants and CRH also breached their duty of care to screen and assess Kendra's behavioral and mental health needs and to provide referrals to and coordination of services to meet these needs. The County Defendants further breached their duty of care by failing to obtain Court authorization before placing Kendra at CRH, by leaving Kendra at CRH in excess of ten days, by failing to ensure that a caseworker visited her at least once a month, and by failing to continuously strive to locate an appropriate placement for Kendra.

59. As a legal, direct, and proximate result of the Defendants' negligence and reckless conduct, Kendra suffered pre-death physical injuries, mental anguish, terror, anxiety, unconsciousness, and ultimately death. This paragraph pertains to the survival action damages of Plaintiff The Estate of Kendra Czekaj, by and through its successor in interest, Michele

Bryant, pursuant to California Code of Civil Procedure Sections 377.30 and 377.34. These code sections provide that damages recoverable under the survival action include the loss or damage that the decedent sustained or incurred before death, including penalties or punitive or exemplary damages that the decedent would have been entitled to recover had the decedent lived.

60. As a legal, direct, and proximate result of the conduct of Defendants as described herein, Plaintiff Michele Bryant has sustained damages resulting from the loss of love, affection, society, service, relationship, comfort, care, support, right of support, expectations of future support and counseling, companionship, solace and mental support, training, and guidance, as well as other benefits and assistance of Kendra, all to her general damages in a sum in excess of the jurisdictional limits of this Court, which will be stated according to proof, pursuant to Section 425.10 of the Code of Civil Procedure.

61. As a legal, direct, and proximate result of the conduct of Defendants as described herein, Plaintiffs have incurred property, medical, funeral, and burial expenses, all in relation to the death of Kendra, which will be stated according to proof, pursuant to Section 425.10 of the California Code of Civil Procedure.

62. As a legal, direct, and proximate result of the conduct of Defendants as described herein, Plaintiffs were compelled to, and did, employ the services of hospitals, physicians, surgeons, nurses, and the like, which will be stated according to proof, pursuant to Section 425.10 of the Code of Civil Procedure.

63. As a legal, direct, and proximate result of the conduct of Defendants as described herein, Kendra suffered lost earnings and property damages, which will be stated according to proof, pursuant to Section 425.10 of the Code of Civil Procedure.

64. Plaintiffs are informed and believe and thereon allege that CRH engaged in the conduct described in this complaint with a conscious disregard of the dangers such misconduct would and did create for the rights and safety of the public, including Kendra. Plaintiffs are further informed and believe and thereon allege, that for a substantial period of time prior to the incidents described in this complaint, CRH acted with malice in that it engaged in despicable conduct in conscious disregard of the rights, safety, and welfare of decedent Kendra and

Plaintiffs, including for the reasons set forth in paragraphs 65-69.

65. The County Defendants and CRH were fully aware and on notice that the CRH facility was located in one of the most dangerous neighborhoods in the Sacramento region.

66. The County Defendants and CRH were fully aware and on notice that the CRH facility was located directly next to a dangerous freeway and that children who left the facility could be injured by passing vehicles.

67. The County Defendants and CRH were fully aware and on notice that CRH did not maintain a sufficient number of properly trained staff to adequately supervise children in its care and, as a result, children would often leave the facility and be subject to the dangers of the surrounding neighborhood.

68. The County Defendants and CRH were fully aware and on notice that CRH did not provide adequate mental health support and crisis intervention services or offer a sufficient number of appropriate activities to discourage children in its care from leaving its shelter.

69. Despite knowing that the CRH shelter was located in an unsafe area and that it did not have sufficiently trained staff to supervise the children in its care, the County Defendants and CRH knowingly and recklessly continued to operate the CRH shelter and took no action to prevent Kendra and others from being injured.

70. CRH had prior knowledge of the dangers and risks that its misconduct would and did create, including causing innocent children serious injury or death. This misconduct, in knowingly or recklessly creating said substantial risk and high probability of injury or death, was oppressive, despicable, highly reprehensible, and done in the conscious disregard for the rights and safety of the public, including Plaintiffs. These acts and omissions were authorized and/or ratified by managerial employees of CRH and were carried out with the consent of their officers, directors, and/or managing agents. As such, the imposition of punitive damages against CRH and Does 1-50 is appropriate.

**SECOND CAUSE OF ACTION**
**(Premise Liability Against All Defendants and Does 1 through 50, Inclusive)**

71. Plaintiffs incorporate by reference paragraphs 1 through 70 as though alleged

fully in this cause of action, and further allege as follows:

72. At all times mentioned herein the County of Sacramento owned, controlled, or maintained the CRH facility by and through the delegation of its duties under California Welfare and Institutions Code Sections 11462.022(d), 11462.022(e)(5), 11462.022(e)(9), 11462.022 (f)(3) and California Code of Regulations tit. 22, Sections 84065(h)-(i).

73. On or before January 15, 2020, the CRH campus was maintained in a dangerous condition such that it created a reasonably foreseeable risk of injury to the children, including Kendra, who were housed at the facility.

74. The County Defendants and CRH were fully aware and on notice that the CRH facility was located in one of the most dangerous neighborhoods in the Sacramento region.

75. The County Defendants and CRH were fully aware and on notice that the CRH facility was located directly next to a dangerous freeway and that children who left the facility could be injured by passing vehicles.

76. The County Defendants and CRH were fully aware and on notice that CRH did not maintain a sufficient number of properly trained staff to adequately supervise children in its care and, as a result, children would often leave the facility and be subject to the dangers of the surrounding neighborhood.

77. The County Defendants and CRH were fully aware and on notice of the dangerous conditions on or before July 2017, which provided sufficient time to have protected Kendra against the dangerous conditions.

78. The County Defendants and CRH's continued use of the CRH facility despite knowledge of the risks was a substantial factor in causing Kendra's death.

79. As a direct and proximate cause of the County Defendants' and CRH's negligent maintenance and failure to take reasonable steps to protect against those dangers, Kendra was killed by a reasonably foreseeable risk.

## THIRD CAUSE OF ACTION
**(Survival Action Sounding in Intentional Infliction of Severe Emotional Distress, by the Estate of Kendra Czekaj as Against All Defendants and Does 1 through 50, Inclusive)**

80. Plaintiffs incorporate by reference paragraphs 1 through 79 as though alleged fully in this cause of action, and further allege as follows:

81. At all times mentioned herein the County Defendants owed statutory duties to provide Kendra adequate housing, supervision, protection, and care. Among other obligations, the County Defendants had a duty to ensure that their temporary shelters were safe and sufficiently staffed with trained and qualified employees, including in trauma-informed practices; provided adequate supervision and mental health services to children; afforded residents recreational, social, and education programs; provided trauma-informed services and interventions and crisis intervention services; performed medical, developmental, behavioral, and mental health screenings and assessments; and coordinated services for children to meet their medical, developmental, behavioral, or mental health needs. The County Defendants also had duties to obtain court approval prior to placing a young child at a temporary shelter, to only keep a child in such a facility for the time necessary to assess their needs and appropriately place them, to continuously strive to find an appropriate placement for the child, and to find a placement within ten calendar days. *See, e.g.*, Cal. Welf. & Inst. Code § 11462.022(d), (e)(5), (e)(9), (f)(3); Cal. Code Regs. tit. 22, § 84065(h)-(i).

82. The foregoing regulations and statutes were enacted specifically to protect children like Kendra.

83. The County Defendants subcontracted these non-delegable duties to CRH, which operated its shelter "on behalf of" the County Defendants. In making such a delegation, the County Defendants and CRH are required to "monitor and ensure the adequacy and quality of care, supervision, and services provided by the facility, as informed by" various "indicators," including "the number of children absent without leave from the temporary shelter care facility," and "[a]ny other indicators that specialized or intensive needs of the children served by the temporary shelter care facility are not being met." TSCF ILS, art. III, § 84622(b)(7).

84. CRH owes further duties, and is directly responsible, to provide appropriate care,

supervision, and services for children in its care. Among other things, CRH must maintain a runaway plan that sets forth how the facility will respond to children leaving its grounds, including the continuum of interventions and de-escalation strategies that will be utilized, and must develop an individual runaway plan for children with a history of running away from placements. Cal. Code Regs. tit. 22, § 84322.2(a).

85. As described herein, during her stay at the shelter, the County Defendants and CRH knowingly and intentionally failed to provide Kendra with adequate supervision, housing, or support services. Specifically, despite knowing that Kendra was a twelve-year-old victim of sexual abuse and was suffering from various psychological issues caused by years of trauma and placement instability, the County Defendants and CRH failed to provide her with adequate mental health and crisis intervention services, failed to ensure that she took her prescribed medication, allowed her to freely leave their facility at all hours of the day and night without any supervision, and allowed her to be exposed to sexual abuse. The County Defendants failed to obtain Court authorization before placing Kendra at CRH, left Kendra at CRH in excess of ten days, and did not continuously strive to locate an appropriate placement for Kendra while they left her at CRH.

86. Defendants' complete and utter failure to properly care for some of the most vulnerable children in our society, including Kendra, was extreme and outrageous and was beyond the bounds of that conduct tolerated in a decent society.

87. Defendants engaged in the conduct alleged herein with the intent to cause Kendra extreme emotional distress, or at a minimum, with reckless disregard as to whether the conduct would cause extreme emotional distress.

88. As a direct, legal, and proximate result of Defendants' negligence and reckless conduct, Kendra suffered pre-death severe emotional distress, physical injuries, mental anguish, terror, anxiety, unconsciousness, and ultimately death.

89. This cause of action is pursued on behalf of The Estate of Kendra Czekaj, by and through its successor in interest, Michele Bryant, pursuant to California Code of Civil Procedure Sections 377.30 and 377.34, which provide that damages recoverable under the survival action

include the loss or damage that the decedent sustained or incurred before death, including penalties or punitive or exemplary damages that the decedent would have been entitled to recover had the decedent lived.

90. Plaintiffs are informed and believe and thereon allege that CRH engaged in the conduct described herein with a conscious disregard of the dangers such misconduct would and did create for the rights and safety of the public, including Kendra. Plaintiffs are further informed and believe and thereon allege, that for a substantial period of time prior to the incidents described in this complaint, CRH acted with malice in that it engaged in despicable conduct in conscious disregard of the rights, safety, and welfare of decedent Kendra and Plaintiffs including for the reasons set forth in paragraphs 91-94.

91. The County Defendants and CRH were fully aware and on notice that the CRH facility was located in one of the most dangerous neighborhoods in the Sacramento region.

92. The County Defendants and CRH were fully aware and on notice that the CRH facility was located directly next to a dangerous freeway and that children who left the facility could be injured by passing vehicles.

93. The County Defendants and CRH were fully aware and on notice that CRH did not maintain a sufficient number of properly trained staff to adequately supervise children in its care and, as a result, children would often leave the facility and be subject to the dangers of the surrounding neighborhood.

94. The County Defendants and CRH were fully aware and on notice that CRH did not provide adequate mental health support and crisis intervention services or offer a sufficient number of appropriate activities to discourage children in its care from leaving its shelter.

95. Despite knowing that the CRH shelter was located in an unsafe area and that it did not have sufficiently trained staff to supervise the children in its care, CRH and the County Defendants knowingly and recklessly continued to operate its shelter and took no action to prevent Kendra and others from being injured.

96. CRH had prior knowledge of the dangers and risks that its misconduct would and did create, including causing innocent children serious injury or death. This misconduct, in

knowingly or recklessly creating said substantial risk and high probability of injury or death, was oppressive, despicable, highly reprehensible, and done in the conscious disregard for the rights and safety of the public, including Plaintiffs. These acts and omissions were authorized and/or ratified by managerial employees of CRH and were carried out with the consent of their officers, directors, and/or managing agents. As such, the imposition of punitive damages against CRH and Does 1-50 is appropriate.

## FOURTH CAUSE OF ACTION
**(Survival Action Sounding in Negligent Infliction of Severe Emotional Distress, by the Estate of Kendra Czekaj as Against All Defendants and Does 1 through 50, Inclusive)**

97. Plaintiffs incorporate by reference paragraphs 1 through 96 as though alleged fully in this cause of action, and further allege as follows:

98. At all times mentioned herein the County Defendants owed statutory duties to provide Kendra adequate housing, supervision, protection, and care. Among other obligations, the County Defendants had a duty to ensure that their temporary shelters were safe and sufficiently staffed with trained and qualified employees, including in trauma-informed practices; provided adequate supervision and mental health services to children; afforded residents recreational, social, and education programs; provided trauma-informed services and interventions and crisis intervention services; performed medical, developmental, behavioral, and mental health screenings and assessments; and coordinated services for children to meet their medical, developmental, behavioral, or mental health needs. The County Defendants also had duties to obtain court approval prior to placing a young child at a temporary shelter, to only keep a child in such a facility for the time necessary to assess their needs and appropriately place them, to continuously strive to find an appropriate placement for the child, and to find a placement within ten calendar days. *See, e.g.*, Cal. Welf. & Inst. Code § 11462.022(d), (e)(5), (e)(9), (f)(3); Cal. Code Regs. tit. 22, § 84065(h)-(i).

99. The foregoing regulations and statutes were enacted specifically to protect children like Kendra.

100. The County Defendants subcontracted these non-delegable duties to CRH, which operated the shelter where Kendra was placed "on behalf of" the County Defendants.

101. At all times mentioned herein, it was foreseeable and probable that Kendra would suffer severe emotional distress if CRH and the County Defendants breached these duties.

102. As described herein, during her stay at CRH, the County Defendants and CRH breached the duties owed to Kendra by failing to provide her with adequate supervision, housing, or support services. Specifically, despite knowing that Kendra was a twelve-year-old victim of abuse and was suffering from various psychological issues caused by years of trauma and placement instability, the County Defendants and CRH failed to provide her with adequate mental health and crisis intervention services, failed to ensure that she took her prescribed medication, allowed her to freely leave the facility in the middle of the night without any supervision, and allowed her to be exposed to sexual abuse. The County Defendants failed to obtain Court authorization before placing Kendra at CRH, left Kendra at CRH in excess of ten days, and did not continuously strive to locate an appropriate placement for Kendra while they left her at CRH.

103. As a direct, legal, and proximate result of Defendants' negligence and reckless conduct, Kendra suffered pre-death severe emotional distress, physical injuries, mental anguish, terror, anxiety, unconsciousness, and ultimately death.

104. This cause of action is pursued on behalf of The Estate of Kendra Czekaj, by and through its successor in interest, Michele Bryant, pursuant to Code of Civil Procedure Sections 377.30 and 377.34. These code sections provide that damages recoverable under the survival action include the loss or damage that the decedent sustained or incurred before death, including penalties or punitive or exemplary damages that the decedent would have been entitled to recover had the decedent lived.

105. Plaintiffs are informed and believe and thereon allege that CRH engaged in the conduct described herein with a conscious disregard of the dangers such misconduct would and did create for the rights and safety of the public, including Kendra. Plaintiffs are further informed and believe and thereon allege, that for a substantial period of time prior to the incidents described in this complaint, CRH acted with malice in that it engaged in despicable conduct in conscious disregard of the rights, safety, and welfare of decedent Kendra and

Plaintiffs including for the reasons set forth in paragraphs 106-109.

106. The County Defendants and CRH were fully aware and on notice that the CRH facility was located in one of the most dangerous neighborhoods in the Sacramento region.

107. The County Defendants and CRH were fully aware and on notice that the CRH facility was located directly next to a dangerous freeway and that children who left the facility could be injured by passing vehicles.

108. The County Defendants and CRH were fully aware and on notice that CRH did not maintain a sufficient number of properly trained staff to adequately supervise children in its care and, as a result, children would often leave the facility and be subject to the dangers of the surrounding neighborhood.

109. The County Defendants and CRH were fully aware and on notice that CRH did not provide adequate mental health support and crisis intervention services or offer a sufficient number of appropriate activities to discourage children in its care from leaving its shelter.

110. Despite knowing that the CRH shelter was located in an unsafe area and that CRH did not have sufficiently trained staff to supervise the children in its care, CRH and the County Defendants knowingly and recklessly continued to operate its shelter and took no action to prevent Kendra and others from being injured.

111. CRH had prior knowledge of the dangers and risks that its misconduct would and did create, including causing innocent children serious injury or death. This misconduct, in knowingly or recklessly creating said substantial risk and high probability of injury or death, was oppressive, despicable, highly reprehensible, and done in the conscious disregard for the rights and safety of the public, including Plaintiffs. These acts and omissions were authorized and/or ratified by managerial employees of CRH and were carried out with the consent of their officers, directors, and/or managing agents. As such, the imposition of punitive damages against CRH and Does 1-50 is appropriate.

**FIFTH CAUSE OF ACTION**
**(Survival Action Based on Negligent Hiring, Training, and Supervision, by the Estate of Kendra Czekaj as Against All Defendants and Does 1 through 50, Inclusive)**

112. Plaintiffs hereby incorporate by reference paragraphs 1 through 111 as though

alleged fully in this cause of action, and further allege as follows:

113. Due to the unique status and access afforded CRH's employees and staff over its minor residents, the County Defendants and CRH owed a duty of care in the selection of such employees and agents and thereafter to properly train, monitor, supervise, and control such employees and agents to protect its minor residents from an unreasonable risk of harm. *See, e.g.*, Cal. Welf. & Inst. Code § 11462.022(f)(2) ("Temporary shelters shall staff as necessary to adequately supervise children to ensure an appropriate environment for all children present."); Cal. Code Regs. tit. 22, § 80065(a) ("Facility personnel shall be competent to provide the services necessary to meet individual client needs and shall, at all times, be employed in numbers necessary to meet such needs."). The County Defendants and CRH were required to supervise, evaluate, and train all of CRH's childcare staff before they could supervise children and, on an ongoing basis, to ensure that they had the "appropriate skills necessary to supervise the children in care." Cal. Code Regs. tit. 22, § 84065(i)(3). The initial training had to include training on the facility's policies and procedures, including on the responsibilities of childcare workers. *Id.* CRH also was required to ensure all staff received "training on the specialized needs of children in transition." TSCF ILS, art. VI, § 84665.3(b). CRH's written runaway plan also had to include a "staff training plan, to include non-physical interventions, [and] strategies to de-escalate a situation." Cal. Code Regs. tit. 22, § 84322.2(c)(4). The County Defendants and CRH further owed a duty to its residents to create policies and procedures to protect its residents and to ensure that such policies and procedures were fully and consistently followed.

114. Upon information and belief, the County Defendants and CRH knew, or in an exercise of reasonable caution, should have known that, among other things, staff were neither sufficient in quantity, training, and/or supervision to care for Kendra without presenting an unreasonable risk of harm to her, and that their policies and procedures designed to protect children from harm were insufficient or inconsistently followed, exposing Kendra to the harm alleged herein.

115. The County Defendants and CRH negligently failed to properly train, regulate, control, or supervise their employees and agents in the proper exercise of their tasks in a

residential facility for vulnerable and at-risk children.

116. As a legal, direct, and proximate result of the conduct of the County Defendants and CRH, Kendra suffered pre-death severe emotional distress, physical injuries, mental anguish, terror, anxiety, unconsciousness, and ultimately death.

117. As a legal, direct, and proximate result of the conduct of the County Defendants and CRH as described herein, Plaintiffs have incurred property, medical, funeral, and burial expenses, all in relation to the death of Kendra, which will be stated according to proof, pursuant to Section 425.10 of the California Code of Civil Procedure.

118. As a legal, direct, and proximate result of the conduct of the County Defendants and CRH as described herein, Plaintiffs were compelled to, and did, employee the services of hospitals, physicians, surgeons, nurses, and the like, which will be stated according to proof, pursuant to Section 425.10 of the California Code of Civil Procedure.

119. As a legal, direct, and proximate result of the conduct of the County Defendants and CRH as described herein, Kendra suffered lost earnings and property damages, which will be stated according to proof, pursuant to Section 425.10 of the California Code of Civil Procedure.

## SIXTH CAUSE OF ACTION

**(Survival Action Based on Failure to Discharge a Mandatory Duty (Cal. Gov. Code § 815.6), by the Estate of Kendra Czekaj as Against the County Defendants)**

120. Plaintiffs hereby incorporate by reference paragraphs 1 through 119 as though alleged fully in this cause of action, and further allege as follows:

121. Government Code Section 815.6 provides for liability against a public entity when:

122. The public entity violates a mandatory duty imposed by an enactment;

123. The enactment is designed to protect against the kind of injury complained of by the plaintiffs;

124. The plaintiffs are in the class of persons protected by the enactment;

125. The violation proximately caused the injury; and

126. The public entity did not exercise reasonable diligence in discharging its duty

established by the enactment.

127. An enactment includes a federal or state constitutional provision, statute, charter provision, ordinance, or properly adopted regulation.

128. County Defendants owed a mandatory duty not to place a child who is the subject of a petition under Section 300 and who is six to twelve years of age, inclusive, in a temporary shelter care facility without a court finding that such a placement is necessary to secure a complete and adequate evaluation of the child. Cal. Welf. & Inst. Code § 319.3. Further, the County Defendants owed a mandatory duty to ensure that children of this age were not placed in such a facility for more than ten calendar days. *Id.* The County Defendants also owed a mandatory duty, "[c]ommencing when a child is admitted into a temporary shelter care facility, and continuing until the child's discharge from the facility," to "continuously strive to identify and place the child in an appropriate licensed or approved home or facility." Cal. Welf. & Inst. Code § 11462.022(d). In addition, the County caseworker was required to visit with Kendra at least once a month, including having a private discussion with her. 42 U.S.C. § 622(b)(17); Cal. Welf. & Inst. Code §§ 16501.1(g)(4), 16516.5; MPP §§ 31-320.61, 31-320.613.

129. Kendra, as a twelve-year-old dependent child who was the subject of a Section 300 petition, was within the class of persons these enactments were meant to protect. Temporary shelter care facilities have limited services and do not provide the least restrictive family setting promoting normal childhood experiences that is suited to meet a child's individual needs. They are intended for short-term placements only. These enactments were meant to ensure that a child of this age is not unnecessarily held in a facility that does not meet their unique needs or does not provide them with sufficient care and supervision for longer than necessary, and that the placing agency is continuously trying to locate a more appropriate placement for the child. In addition, the caseworker visit requirement is critical for ensuring the safety of children placed in out-of-home care, including to monitor the child's emotional and physical well-being.

130. Upon information and belief, County Defendants did not exercise reasonable diligence in exercising their mandatory duty to ensure that Kendra was only placed in CRH pursuant to a Judge's authorization to meet a specific need and for no more than ten calendar

days, and did not continuously try to identify and place her in an appropriate licensed or approved home or facility. Further, the County Defendants did not perform their mandatory duty to have a monthly caseworker visit with Kendra.

131. As a legal, direct, and proximate result of County Defendants' violation of their mandatory duties, Kendra was left for an extended period of time in a placement that did not meet her individual needs and that did not provide her with proper care, protection, and supervision, ultimately causing her death.

## SEVENTH CAUSE OF ACTION
**(Wrongful Death and Survival Action Sounding in Negligence by all Plaintiffs as Against Defendant Ezedinachi)**

132. Plaintiffs allege and incorporate herein by reference, as though fully set forth herein, each and every allegation set forth in paragraphs 1 through 51 of this Complaint.

133. Plaintiffs are informed and believe and, based thereon, allege that Defendant Ezedinachi owed Kendra a duty of care to operate, drive, and maintain the vehicle involved in this collision in a reasonably safe manner.

134. On the night of January 15, 2020, at 9:47 p.m., Defendant Ezedinachi struck Kendra as she crossed the six-lane I-80 freeway that is located directly behind the CRH facility. Kendra died shortly thereafter.

135. Plaintiffs are informed and believe and, based thereon, allege that Defendant Ezedinachi breached the duty of care as set forth above.

136. Plaintiffs are informed and believe and, based thereon, allege that as a direct and proximate result of Defendant Ezedinachi's breach of the duty of care, Plaintiffs have suffered and will continue to suffer, without limitation, physical, emotional, psychological, and financial harms.

137. Plaintiffs are informed and believe and, based thereon, allege that Defendant Ezedinachi's breach of the duty of care was a substantial factor, as set forth above, in causing Plaintiffs' harms.

138. Defendant Ezedinachi's negligence was a substantial factor in causing Plaintiffs'

harms.

139. As a proximate result of the negligence of Defendant Ezedinachi, Kendra was hurt and injured, and subsequently succumbed to those injuries.

140. As further proximate result of the said negligence of Defendant Ezedinachi, Kendra's life was cut short.

**WHEREFORE,** Plaintiffs pray for judgment and damages as follows:

1. For general damages according to proof;
2. For special damages according to proof;
3. For funeral and burial expenses according to proof;
4. For loss of earnings and property according to proof;
5. For punitive damages against CRH by the Estate of Kendra Czekaj, by and through its successor-in-interest Michele Bryant, pursuant to Code of Civil Procedure Sections 377.30 and 377.34 according to proof;
6. For prejudgment interest, fees, and costs of suit against all Defendants; and
7. For such other and further relief as the Court deems just and proper.

**JURY DEMAND**

Plaintiffs demand a trial by jury on all issues so triable.

Dated: July 2, 2021

**KERSHAW, COOK & TALLEY, PC**

By: _____
Jeffrey M. Schaff

**NATIONAL CENTER FOR YOUTH LAW**

By: _____
Leecia Welch

*Counsel for Plaintiffs*

VERIFICATION OF COMPLAINT

The undersigned hereby asserts as follows:

I am the Plaintiff in above captioned proceeding. I have read the above complaint and know the content thereof. The same is true to my own knowledge, except those matters which are stated therein on information and belief, and as to those matters, I believe them to be true.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on July 1st, 2021 at Sacramento California.

Michele Bryant