ELECTRONICALLY FILED
Superior Court of California
County of Ventura
11/19/2025
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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF VENTURA

CINDY BRATT, individually and as successor-in-interest to decedent PIPPER BRATT; JOHN BRATT, individually and as successor-in-interest to decedent PIPPER BRATT;

Plaintiffs,

vs.

CASA PACIFICA CENTERS FOR CHILDREN AND FAMILIES, a California corporation; and DOES 1 through 100, inclusive,

Defendants.

Case No. 2025CUPP054394

COMPLAINT FOR DAMAGES AND DEMAND FOR JURY TRIAL

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I. INTRODUCTION

1. In January 2017, California rebranded most "group homes" as Short-Term Residential Therapeutic Programs ("STRTPs") to promise something better: round-the-clock care, real therapy, and vigilant supervision for the most vulnerable kids. Too often, the promises are broken the moment a child walks through the door.

2. Pipper Bratt was only fourteen. On March 10, 2025, after escalating psychiatric crises, she was removed from her parents, Plaintiffs Cindy and John Bratt. Within days she was self-harming and hospitalized on an involuntary psychiatric hold. By April 2025 she was placed into the STRTP system.

3. In early summer 2025, after yet another involuntary hold and near-constant runaways, officials said Pipper needed a "higher level of care." On August 5, 2025, she was sent to Casa Pacifica Centers for Children & Families in Camarillo, California—the very place that advertises specialized mental-health treatment, constant supervision, and an on-site clinic for youth who have exhausted community options.

4. From the start, Casa Pacifica did not keep Pipper safe. She walked away on day one. In August and September 2025, Casa Pacifica's own logs show near-daily AWOLs (absences without leave), drug exposure, property destruction, and self-injury. Police repeatedly had to bring her back.

5. In this same window, Pipper—along with at least two other Casa Pacifica girls—was preyed upon by an adult man, Benito Najera, who, prosecutors now allege supplied Pipper and the two other girls with drugs and alcohol before raping them. Najera is now charged with human trafficking of a minor, multiple counts of rape — including rape of an unconscious person, rape of an intoxicated person, and statutory rape — several counts of forcible oral copulation, one count of production of child pornography, and one count of possession of child pornography.

6. Even with that fresh trauma, Casa Pacifica did not change course. The facility treated AWOLs as routine, not as emergencies. By mid-September 2025, Casa Pacifica knew Pipper had just survived horrific exploitation and that she was running from campus over and over again.

7. California law required Casa Pacifica to act: individualize Pipper's AWOL-prevention plan as a commercially sexually exploited child (CSEC), increase supervision up to line-of-sight or 1:1,

coordinate closely with law enforcement and the placing agency, and document every search, action, and safeguard. Instead, Casa Pacifica returned to "business as usual." A facility built to protect children left this child unsupervised in the face of clear escalating self-harm behaviors.

8. On the night of September 19, 2025, Casa Pacifica again allowed Pipper to AWOL. This time, just seconds after she stepped into the roadway just outside the facility, a large SUV struck her. She held onto life for four days. However, on September 23, 2025, Pipper succumbed to her injuries and her parents made the impossible decision to remove life support.

9. Cindy and John Bratt lost their daughter because Casa Pacifica ignored repeated warnings and legal duties. This case seeks to hold Casa Pacifica accountable for choosing convenience over care, and routine over a child's life.

II. PARTIES

10. At all relevant times, Decedent Pipper Bratt was a resident of the County of Santa Barbara.

11. Plaintiff Cindy Bratt is a resident of the County of Santa Barbara and was at all relevant times the mother of Decedent Pipper Bratt. Cindy Bratt is one of the surviving heirs of decedent Pipper Bratt. Cindy Bratt is acting both individually, and as the successor-in-interest to the estate of Pipper Bratt. Cindy Bratt therefore proceeds both on an individual basis, and as successor-in-interest to the claims of Pipper Bratt.

12. Plaintiff John Bratt is a resident of the County of Santa Barbara and was at all relevant times the father of Decedent Pipper Bratt. John Bratt is one of the surviving heirs of decedent Pipper Bratt. John Bratt is acting both individually, and as the successor-in-interest to the estate of Pipper Bratt. John Bratt therefore proceeds both on an individual basis, and as successor-in-interest to the claims of Pipper Bratt.

13. Defendant Casa Pacifica Centers for Children & Families is a non-profit corporation and is an organization licensed by the State of California as a Short-Term Residential Therapeutic Program provider.

14. The true names and capacities, whether individual, corporate, associate, or otherwise, of defendants DOEs 1 to 100, inclusive, and each of them, are unknown to Plaintiffs, who thereby sue these defendants by such fictitious names, and will ask leave of this court to amend this complaint when the same shall have been ascertained. Plaintiffs are informed and believe, and upon that basis allege, that each defendant named herein as a DOE is responsible in some manner for the events and happenings referred to herein which proximately caused injury to Plaintiffs as hereinafter alleged.

15. Plaintiffs are informed and believe, and on that basis allege, that at all times mentioned herein the Defendants, and each of them, were the agents, joint venturers, servants, employees, assistants, and consultants of each other, and as such were acting within the course, scope, and authority of said agency, joint venture, and employment, and that each and every Defendant, when acting as a principal, was negligent and reckless in the selection, hiring, entrustment, and supervision of each and every other defendant as an agent, servant, employee, assistant, or consultant.

III. JURISDICTION & VENUE

16. The Court has jurisdiction over this action by virtue of the fact that this proceeding is based on activity conducted in the State of California, and in the County of Ventura.

17. County of Ventura is where some, or all, of the Defendants reside and therefore, venue is properly in this judicial district pursuant to California Code of Civil Procedure § 395.

IV. GENERAL ALLEGATIONS

— Casa Pacifica and Its Legal Obligations as a Licensed STRTP

18. California converted most "group homes" into Short-Term Residential Therapeutic Programs beginning January 1, 2017, under the Continuum of Care Reform (AB 403 and follow-up legislation). STRTPs serve youths who have significant behavioral and mental-health needs—often after repeated failed family or lower-level placements—who require 24-hour supervision alongside access to specialty mental-health services.

19. By design, STRTPs provide integrated, specialized, and intensive care and supervision together with 24-hour, non-medical residential care and on-site therapeutic services to children, youth, and non-minor dependents who need a higher level of care than a family setting can provide. STRTPs are intended to be short-term and treatment-focused, not long-term placements.

20. In day-to-day practice, STRTP operations are expected to be team-driven and child-centered. California requires use of the Child and Family Team ("CFT") to plan services, drive placement and step-down decisions, and respond to crises.

21. Casa Pacifica operates an STRTP on its 25-acre campus at 1722 South Lewis Road, Camarillo, Ventura County. Its own materials describe the STRTP as a treatment-focused, 24-hour program serving female, transgender, and nonbinary youth ages 12–17 in a primarily female setting, integrating clinical services and intensive supervision in a structured environment. Casa Pacifica promotes itself as empowering youths, having access to an on-site clinic for psychiatric care and medication administration, and administering services geared to discharge to a less-restrictive family setting.

22. As a licensed STRTP, Casa Pacifica is subject the California Department of Social Services ("CDSS") STRTP Licensing Standards. These legal mandates require, amongst other things:

- **Child and Family Team integration and needs & services planning.** The STRTP Licensing Standards require a written plan showing "procedures for collaborating with the child and family team" and ensuring consistency with the child's case plan and CFT recommendations. Staff must offer the CFT the opportunity to participate in the needs-and-services plan and obtain written approvals before implementation.
- **Staffing, training, and supervision ratios.** STRTPs must "employ the number of direct care staff necessary" to meet the ratios and provide adequate care and supervision, including during off-site activities and in vehicles. The standards specify 1:4 staff-to-youth from 7 a.m.–10 p.m. and 1:6 awake staff-to-youth from 10 p.m.–7 a.m., with no fewer than two direct-care staff on premises whenever children are present. New direct-care staff cannot be left alone with youth until they complete mandatory training.
- **Runaway/AWOL prevention and response.** The standards require an emergency intervention plan, including early interventions to prevent runaways, steps staff must take to locate a child, staff training in de-escalation, and procedures for involving law enforcement and notifying the child's authorized representative.
- **Mental Health Program Approval and services.** STRTPs must demonstrate the ability to meet children's mental health needs and, absent current mental-health program approval, cannot provide specialty mental-health services directly.
- **Mandated Reporting.** The Child Abuse and Neglect Reporting Act (CANRA) requires mandated reporters, including STRTP staff, to submit child abuse and neglect reports to the county child welfare office upon receiving information that would cause reasonable suspicion that a child has been the victim of abuse, neglect, or sexual exploitation.

23. However, recent California provider and policy reports describe an acute workforce crisis in youth behavioral health, impacting STRTPs', like Casa Pacifica, ability to recruit, train, and retain qualified direct-care staff and clinicians. These conditions predictably degrade supervision, training compliance, and clinical continuity.

— Pipper Bratt's Removal, Acute Mental-Health History, and STRTP Placement

24. On March 10, 2025, Pipper Bratt was removed from her parents, Plaintiffs Cindy Bratt and John Bratt, following a series of escalating psychiatric and behavioral episodes. Within days after she was detained, Pipper exhibited dangerous self-harm behaviors, leading to an involuntary psychiatric hold by April 2025. That month, Pipper was moved from traditional foster care to an STRTP.

25. On April 4, 2025, Pipper was placed into an STRTP in Santa Maria. By the summer of 2025, after another involuntary psychiatric hold and near frequent AWOL events, it was determined that Pipper needed a higher level of residential therapeutic care. As a result, she was placed at Casa Pacifica on August 5, 2025.

26. After Pipper is placed at the facility, Casa Pacifica staff documented an immediate AWOL the day of placement. Pipper left at 4:28 p.m. and was returned by law enforcement at 5:44 p.m. Throughout August and September 2025, Casa Pacifica documented near daily AWOLs, property destruction, and self-harm, including:

- August 7: pulling the fire alarm; AWOL from 3:54 p.m. to 5:08 p.m. (returned by law enforcement).
- August 9: self-inflicted cuts with a broken eyeliner pencil.
- August 10-12: AWOL at night; found under the influence of marijuana and suspected laced cigarette; hospital clearance in the early morning hours.
- August 16-23: repeated AWOLs, including law enforcement returns and statements about wanting to "do drugs."
- August 19–21: Casa Pacifica recorded additional AWOLs, damage to facility property, and continued marijuana use upon return.
- August 24–28: Casa Pacifica documented further AWOLs, with multiple police contacts and late-night retrievals by law enforcement.
- August 29: Records show that law enforcement interviewed Pipper at 9:59 p.m., having been victimized and exploited by an adult male;
- August 31: Casa Pacifica reported Pipper's AWOL to a Walmart in Camarillo, her detention in handcuffs by police, and her admission that she ingested "random pills" found on the floor.
- September 2–3: Casa Pacifica recorded an assault on a peer and two more AWOLs requiring police retrieval.

27. During this time period, Pipper, along with two other Casa Pacifica youths, were preyed upon by Benito Najera. Najera supplied Pipper and the two other girls with drugs and alcohol before sexually assaulting them. Najera is now charged with human trafficking of a minor, multiple counts of rape — including rape of an unconscious person, rape of an intoxicated person, and statutory rape — several counts of forcible oral copulation, one count of production of child pornography, and one count of possession of child pornography.

28. Under California law, after her rape and AWOL events, Casa Pacifica was required to: (i) individualize Pipper's AWOL prevention plan given her CSEC status and AWOL history; (ii) increase supervision, up to line-of-sight / 1:1; (iii) coordinate with law enforcement and the placing agency; and (iv) document all actions, searches, and notices. Despite Casa Pacifica's knowledge of Pipper's recent survival of rape and dangerous AWOL behaviors, Casa did none of the above and reverted to business as usual.

29. On or about September 19, 2025, Casa Pacifica left Pipper unsupervised and allowed her to AWOL once again. As she entered the roadway immediately outside the Casa Pacifica facility, she was struck by a large SUV. After four days, on September 23, 2025, Pipper was taken off of life support with her mother and father, Plaintiffs Cindy and John Bratt, at her side.

— Casa Pacifica's Historical Safety and Supervision Failures

30. Supervision concerns at Casa Pacifica go back decades. In 1996-1997 a Ventura Grand Jury was assembled after reports that a toddler was sexually abused by another child on campus. Investigative findings revealed hundreds of instances of AWOL-events, physical assaults, and self-harm behaviors. The report also found a critical episode where one staff member was left to supervise approximately 12 children and noted line-of-sight problems throughout the campus. The Grand Jury's findings demonstrate long-standing supervision and AWOL-management challenges at Casa's campus.

31. In 2009, CDSS received a complaint that a staff member at Casa Pacifica was having sex with a minor resident. The man, hired in 2008, was supposed to be working exclusively with boys, but kept showing up in the girls' cottage. Casa Pacifica reprimanded the man but decided to keep him on the staff. In early 2009, it was reported that man had been having sex with another girl on the

campus. State records showed the worker had impregnated an under-age child eight years earlier in 2001—a fact which was inexcusably missed during background check.

32. In a 2017 investigative series, the San Francisco Chronicle reported that Casa Pacifica's campus accounted for 107 arrests, citations, and detainments in 2015–2016, noting law-enforcement contacts are "not unusual" at the facility.

33. In 2018, a Thousand Oaks man was arrested for sexually assaulting five teens, three from Casa Pacifica. His crimes dated back to July 2015 with victims between 14 and 17 years old. It was known to Casa Pacifica's CEO at the time, Steve Elson, that predators would use alcohol and drugs to entice girls at Casa Pacifica to run away and later sexually assault them. Nonetheless, Casa Pacifica maintained the policy of being an "unlocked campus," such that residents can easily walk away from the campus on Lewis Road with no attempt from Casa Pacifica to prevent them from leaving.

34. In April 2018, the Camarillo Police Department and Ventura County Sheriff's Office enacted its "Casa Pacifica Runaway Reporting Procedures" in response to the high volume of runaways from the Casa Pacifica campus. The procedure describes that Casa Pacifica has its own policy for handling runaways through "a hands-off approach," with the primary response to report the incident to the Sheriff's office. Because of this hands-off policy, local law enforcement confirms "there are a large number of calls for service at Casa Pacifica involving runaways."

— Casa Pacifica's Special Relationship with Pipper and Reckless Disregard for her Safety

35. By accepting Pipper for 24-hour care in its licensed Short-Term Residential Therapeutic Program, Casa Pacifica entered into a custodial, special relationship with Pipper that created affirmative, non-delegable duties to protect her from foreseeable harm, to supervise her constantly at a level matched to her risks, to individualize and implement an AWOL prevention plan, to coordinate with the placing agency and law enforcement, and to escalate staffing (including line-of-sight or 1:1) when clinically or behaviorally indicated.

36. Casa Pacifica had superior control over the physical environment, staffing, and security of its campus. Pipper, a 14-year-old with known acute needs, had no similar ability to protect herself. These duties flowed from Casa Pacifica's status as a licensed STRTP, its written promises to provide

intensive, specialized supervision and therapeutic services, its acceptance of public funds for Pipper's care, and its undertaking to deliver a safe, structured program.

37. Casa Pacifica markets and represents that it provides intensive treatment, enhanced supervision, and on-site clinical care for youths who have exhausted lower levels of care. Those promises were material to the placement decision. Yet, once Pipper arrived, Casa Pacifica failed to deliver the safeguards it advertised: it allowed immediate and repeated AWOLs; it did not implement an individualized AWOL prevention plan responsive to her history; it did not increase staffing to line-of-sight or 1:1 supervision after serious safety incidents; it did not create or enforce campus controls designed to interrupt predictable flights from care; and it treated a cascade of escalating events as routine.

38. Casa Pacifica knew predators target its campus and residents, including by luring youths off campus with drugs and alcohol. This was not a novel threat. Casa Pacifica had years of notice through prior incidents, public reporting, and coordination with local law enforcement concerning high volumes of runaways and victimization of Casa Pacifica youths. Against that backdrop, Casa Pacifica also knew in late August 2025 that Pipper had recently been abducted, drugged, and sexually abused by an adult male. This combination—longstanding institutional knowledge plus fresh, case-specific trauma—required an immediate safety reset, individualized planning, and heightened, sustained supervision. Casa Pacifica did not provide it.

39. Once Casa Pacifica documented Pipper's first-day AWOL and then near-daily AWOLs, drug exposure, and exploitation, basic professional care required escalation: constant or line-of-sight observation, staffing adjustments to meet heightened acuity, targeted milieu changes, campus security measures tailored to the resident's flight pattern, and coordinated law-enforcement engagement focused on prevention, not just recovery. Casa Pacifica's records reflect none of that. Instead, Casa Pacifica adhered to a hands-off, "open campus" approach ill-suited to Pipper's risks and in conflict with its duty to provide "intensive" care and supervision.

40. California requires a child- and family-centered team process to drive placement, step-down, crisis response, and safety planning for youth like Pipper. Given Pipper's AWOL pattern, self-harm, drug exposure, and confirmed exploitation, Casa Pacifica was required to convene and

meaningfully use that team to re-tool supervision, update the AWOL plan, and coordinate with the placing agency and law enforcement. Any such teaming that occurred was perfunctory and non-responsive. Critically, when Pipper's exploitation came to light in late August 2025, Casa Pacifica did not immediately escalate staffing and supervision or implement a written, individualized prevention plan tied to those events.

41. Casa Pacifica's leadership, including its STRTP Program Director and on-site campus management, made business-driven choices that subordinated safety to occupancy and program optics: limiting the use of 1:1 staffing because it strains budgets and staffing ratios; avoiding short-term closures or census holds that would permit retraining or security retrofits; and discouraging physical campus controls that could be perceived as inconsistent with an "empowering" environment. Those choices were made despite known, repeated AWOLs, law-enforcement returns, and fresh evidence that Pipper had been targeted by an adult predator.

42. Casa Pacifica's Lewis Road campus abuts public streets and open access points. Casa Pacifica knew, long before August–September 2025, that this configuration facilitates quick exits to high-speed traffic area. Reasonable care required situational controls—staffing at egress points, alert protocols when at-risk youth approach exits, and immediate staff interventions. Casa Pacifica did not implement or enforce such controls for Pipper.

43. By the end of August 2025, Pipper's file reflected: multiple AWOLs; drug ingestion (including "random pills" off a store floor); police detentions; self-harm; and exploitation by an adult male. Each event independently demanded escalation; together, they demanded an all-hands reset. Casa Pacifica's response was a return to business as usual—no 1:1 supervision, no effective perimeter control, no individualized AWOL plan matched to a recently exploited minor, and no sustained law-enforcement-backed prevention strategy.

44. Casa Pacifica's campus sits immediately adjacent to public roadways. When Casa Pacifica permits a high-risk youth to leave unsupervised, harm from motor-vehicle impact is a known and foreseeable result. Casa Pacifica's leadership had actual knowledge that Pipper's repeated AWOLs ended in street-level police contact and that she had recently been recovered in altered states. Allowing

her to leave unsupervised on September 19, 2025, to cross or enter the roadway outside the facility, was a direct violation of Casa Pacifica's duty of care and a substantial factor in causing her death.

45. Casa Pacifica's executive leadership (including its Chief Executive Officer), STRTP Program Director(s), and campus administrators were repeatedly advised of (a) the chronic volume of AWOLs from the STRTP campus; (b) the dangers of a "hands-off" approach to AWOL prevention; (c) the specific pattern of Pipper's AWOLs, self-harm, drug exposure, and recent exploitation; and (d) staff pleas for more supervision and security. Instead of correcting course, these managing agents ratified the status quo, refused to staff 1:1 coverage, and declined to implement effective perimeter controls. Their decisions were corporate policy and practice decisions, not isolated line-level errors.

46. As a licensed STRTP, Casa Pacifica was required to demonstrate the ability to meet residents' mental-health needs; maintain sufficient direct-care staff to provide adequate care and supervision; implement emergency-intervention and AWOL-prevention procedures; and collaborate through the Child and Family Team to ensure services aligned with the case plan. Casa Pacifica's leadership knowingly disregarded these obligations: it accepted Pipper for "intensive" care while operating an environment that predictably permitted AWOLs; it failed to tailor a written AWOL prevention plan to her CSEC-level risks; it refused to escalate supervision after exploitation; and it failed to document and implement corrective actions.

47. The events here are consistent with prior episodes at Casa Pacifica involving supervision gaps, runaway volume, and the targeting of Casa Pacifica youths by adult offenders. Those prior events put Casa Pacifica on notice that leaving at-risk residents unsupervised or lightly supervised on an "open" campus invites precisely the harms that befell Pipper. Despite that notice, Casa Pacifica continued operating with inadequate staffing, porous campus controls, and a culture that normalized AWOLs as unavoidable rather than preventable.

48. Had Casa Pacifica fulfilled even the most basic aspects of its special-relationship duties—individualized AWOL prevention, line-of-sight or 1:1 observation following exploitation, effective campus controls at egress points, and real-time coordination with law enforcement and the placing agency—Pipper would not have been permitted to leave unsupervised on September 19, 2025,

would not have been exposed to roadway traffic, and would be alive today. Pipper's death was not an accident of fate; it was the product of institutional choices.

49. Plaintiffs allege that Casa Pacifica's officers, directors, and managing agents acted with malice and oppression as defined by Civil Code § 3294 in that they consciously disregarded Pipper's safety and the safety of other similarly situated youths, persisted in an "open campus"/hands-off model despite years of notice of serious harm, rejected available supervision and security measures after learning Pipper had recently been exploited, and ratified staff decisions that returned her to ordinary supervision and routine programming. These were not good-faith misjudgments at the margins; they were intentional, institutional choices that elevated operational convenience and program optics over the safety of a child in Casa Pacifica's care.

50. Plaintiffs allege that Casa Pacifica's officers, directors, and managing agents expressly approved of, authorized, and/or ratified the conduct described herein, including the decision to maintain ordinary staffing and supervision levels for Pipper after her exploitation and during a period of daily AWOL activity, the decision to continue operating without effective egress controls, and the decision to treat repeated AWOLs and law-enforcement returns as routine. Casa Pacifica is therefore liable for punitive damages under Civil Code § 3294(b).

51. Casa Pacifica accepted public reimbursement to provide what the law contemplates as the highest level of residential therapeutic care available outside of locked psychiatric hospitalization. Having accepted that public trust and the funds attached to it, Casa Pacifica owed a heightened duty to meet the safety and supervision needs of a 14-year-old with a known AWOL pattern and fresh trauma. Casa Pacifica failed that duty at every turn.

52. Casa Pacifica made promises to the Bratt family, to the placing agency, and to the public: a safe, supervised, therapeutic environment capable of meeting the needs of high-acuity youth. Faced with daily evidence that those promises were not being kept for Pipper, Casa Pacifica's leadership chose to continue a model that normalized AWOLs and minimized risk. Those choices—made with full knowledge of the danger—caused Pipper's death and justify an award of punitive damages to deter repetition of this conduct.

FIRST CAUSE OF ACTION

Negligence/Negligence *Per Se*

FOR A FIRST CAUSE OF ACTION AGAINST DEFENDANTS CASA PACIFICA CENTERS FOR CHILDREN AND FAMILIES AND DOES 1-100 FOR NEGLIGENCE, PLAINTIFFS ALLEGE:

53. Plaintiffs refer to each and every one of the above paragraphs, and incorporate those paragraphs as though set forth in full in this cause of action.

54. At all relevant times, Defendants Casa Pacifica Centers for Children and Families and DOEs 1-100 owned, occupied, controlled, and operated the Short-Term Residential Therapeutic Programs on its 25-acre campus at 1722 South Lewis Road, Camarillo, Ventura County, where Decedent Pipper Bratt was placed.

55. Defendant Casa Pacifica had a special relationship with Pipper such that Casa Pacifica owed Pipper an affirmative duty to protect and supervise her, and to exercise reasonable care to keep the premises in a condition that was reasonably safe for foster children and to comply with mandatory STRTP laws and regulations. This duty included, without limitation, the duty to ensure Pipper's basic safety and protective needs were met.

56. Defendant Casa Pacifica further assumed a duty to protect and to exercise reasonable care to protect and supervise Pipper, and to keep the premises in a condition that was reasonably safe when they admitted Pipper into their STRTP campus in exchange for public funds.

57. Defendant Casa Pacifica breached these duties by, among other things:

- **Failure to supervise and protect in light of known, escalating risk.** Casa Pacifica had actual, documented notice—beginning the day of admission—that Pipper was continually leaving campus, using or being exposed to drugs, self-harming, and was at heightened risk of sexual exploitation. Yet Casa Pacifica failed to institute one-to-one or line-of-sight supervision, failed to control egress to a known hazardous roadway immediately adjacent to campus, and repeatedly permitted her to depart the facility, including during evening hours, without effective intervention.

- **Pattern and practice of normalizing AWOLs.** Casa Pacifica documented a string of AWOLs between August 5 and September 3, 2025 and multiple late-night law-enforcement returns. Rather than escalating protective measures, Casa Pacifica's records show routine documentation and return to status quo, despite Pipper's disclosures of drug ingestion and the known presence of predatory adults in the vicinity.
- **Failure to promptly convene and implement effective team-based planning at or before placement.** Although Pipper was admitted to Casa Pacifica on August 5, the first CFT meeting did not occur until September 4, after weeks of repeated AWOLs and the contemporaneous Qualified Individual assessment shows incomplete information-gathering and perfunctory team engagement. Casa Pacifica failed to push for, convene with, and act on team-based planning commensurate with the risks.
- **Licensing and programmatic failures**. Casa Pacifica failed to operate its STRTP according to its plan of operation and program statement, and failed to provide specialized and intensive care and supervision calibrated to an obviously high-risk child, in violation of the STRTP Licensing Standards and related statutes and regulations, the very rules designed to prevent harms from runaway episodes, community victimization, and unsafe egress.
- **Premises-safety failures.** Casa Pacifica failed to maintain reasonable barriers, staffing of exits, line-of-sight monitoring posts, and traffic-safety controls at the campus edge where dependent children routinely move on and off the property, creating a foreseeable risk of impact with vehicles on the immediately adjacent roadway.

58. The preceding statutes, regulations, and directives were designed to protect a class of persons that includes Decedent, and to prevent the type of harm that occurred here.

59. Casa Pacifica's acts and omissions were a substantial factor in causing the injuries that led to Pipper's death. Had Casa Pacifica complied with its licensing duties, STRTP core-service obligations, and basic standards of care, Pipper would not have been permitted to leave unsupervised into traffic on September 19, 2025.

60. These statutory and regulatory violations were a substantial factor in causing Pipper's deaths and Plaintiffs' damages. No adequate excuse exists for these violations.

61. As a direct result of the acts and omissions of Defendant Casa Pacifica, Pipper Bratt incurred general damages prior to her death, and was severely harmed, endured pain, suffering, disability, impairment, disfigurement, inconvenience, loss of enjoyment of life, scarring, and other non-economic damages.

62. Plaintiffs Cindy Bratt and John Bratt are the personal representative or successors in interest and authorized to bring a survival action on behalf of the Pipper Bratt's Estate pursuant to Code of Civil Procedure § 377.30, *et seq*.

63. Plaintiffs Cindy Bratt and John Bratt, as the personal representatives or a successors in interest to Pipper Bratt, are entitled to recover Pipper Bratt's pre-death economic and non-economic damages against Defendant Casa Pacifica.

64. Further, as set forth in greater detail in Paragraphs 35-52, *supra*, Casa Pacifica, through its managing agents and supervisors, acted with oppression and malice by adopting and enforcing a pattern and practice of normalizing AWOLs and minimizing known exploitation risks, despite actual knowledge that:

- Prior events put Casa Pacifica on notice that leaving at risk residents unsupervised or lightly supervised on an "open" campus invites precisely the harms that befell Pipper. Despite that notice, Casa Pacifica continued operating with inadequate staffing, porous campus controls, and a culture that normalized AWOLs as unavoidable rather than preventable;
- Pipper had a recent history of involuntary psychiatric holds and suicidal ideation;
- In Casa Pacifica's own records, she was repeatedly leaving campus, being returned by law enforcement at all hours, ingesting unknown pills, and reporting drug use;
- Law enforcement interviewed Pipper on August 29, 2025, consistent with her disclosure as a victim of a predatory adult male, and Casa Pacifica had information that other girls from its program were also targeted; and

- Despite this notice, Casa Pacifica failed to implement heightened supervision or protective measures and allowed Pipper to again leave the campus on September 19, 2025, with fatal consequences.

65. Casa Pacifica's conduct was despicable in that it consciously disregarded Pipper's safety and the foreseeable risk of traffic death immediately outside its campus, warranting an award of exemplary damages to punish and deter.

SECOND CAUSE OF ACTION

Negligent Hiring, Supervision, or Retention

FOR A SECOND CAUSE OF ACTION AGAINST DEFENDANTS CASA PACIFICA CENTERS FOR CHILDREN AND FAMILIES AND DOES 1-100 FOR NEGLIGENT HIRING, SUPERVISION, OR RETENTION OF EMPLOYEE AND AGENTS, PLAINTIFFS ALLEGE:

66. Plaintiffs refer to each and every one of the above paragraphs, and incorporate those paragraphs as though set forth in full in this cause of action.

67. At all relevant times, Defendants Casa Pacifica Centers for Children and Families and DOEs 1-100 owed Pipper, and foreseeably her parents, a duty to use reasonable care in the recruitment, backgrounding, assignment, training, supervision, evaluation, and retention of its employees, agents, and managing staff responsible for resident care, safety, and program operations. That duty includes: (a) performing meaningful pre-hire screening and reference checks; (b) ensuring employees are competent and adequately trained before being left alone with residents; (c) maintaining staffing levels and direct-care ratios sufficient to meet the needs of higher-risk youth; (d) providing ongoing training and oversight in runaway prevention, CSEC-responsive safety planning, suicide/self-harm risk management, emergency intervention, and perimeter safety; and (e) removing, reassigning, or augmenting staff when performance, conduct, or program acuity shows a risk to resident safety.

68. Casa Pacifica breached these duties. By way of non-exhaustive example, Casa Pacifica:

- Hired and retained direct-care and supervisory staff who lacked the training, temperament, or experience to provide the intensive supervision and safety planning that Casa Pacifica advertises and that Pipper's risks required;

- Understaffed the unit(s) where Pipper resided and failed to assign line-of-sight or one-to-one supervision despite repeated AWOLs, self-harm, drug exposure, and known recent victimization;
- Failed to train staff in individualized AWOL-prevention and CSEC-responsive protocols, including how to escalate observation levels, stage staff at egress points, and coordinate prevention-focused engagement with law enforcement and the placing agency;
- Failed to supervise and evaluate personnel after key events (including the drugging and rape by Benito Najera and the August 31, 2025 ingestion of pills off a Walmart floor) and failed to discipline or remove personnel when performance issues jeopardized safety;
- Tolerated and ratified a culture that normalized repeated AWOLs as routine and relied on law enforcement to retrieve residents rather than preventing foreseeable departures to the public roadway and community; and
- Ignored or minimized internal incident trends, staff warnings, and obvious risk indicators—thereby leaving Pipper without the heightened supervision and tailored safeguards that reasonable care demanded.

69. Casa Pacifica knew or should have known of the unfitness, incompetence, or insufficient preparation of its employees and supervisors based on (a) its own daily incident and AWOL logs; (b) repeated law-enforcement contacts and returns; (c) direct notice that Pipper had recently been targeted and abused by an adult in the community; (d) the frequency with which staff reported losing visual contact as Pipper exited toward Lewis Road; and (e) the facility's well-documented history of runaway volume and supervision challenges. Despite that knowledge, Casa Pacifica failed to retrain, reassign, augment, or replace personnel and failed to implement the supervision model and perimeter practices necessary to keep Pipper safe.

70. As a direct and proximate result of Casa Pacifica's negligent hiring, supervision, and retention, Pipper was repeatedly left without adequate supervision, permitted to leave the campus

unsafely, and ultimately entered the public roadway immediately outside the facility on or about September 19, 2025, where she was struck by a vehicle and sustained fatal injuries.

71. As a direct result of the acts and omissions of Defendant Casa Pacifica, Pipper Bratt incurred general damages prior to her death, and was severely harmed, endured pain, suffering, disability, impairment, disfigurement, inconvenience, loss of enjoyment of life, scarring, and other non-economic damages.

72. Plaintiffs Cindy Bratt and John Bratt are the personal representative or successors in interest and authorized to bring a survival action on behalf of the Pipper Bratt's Estate pursuant to Code of Civil Procedure § 377.30, *et seq*.

73. Plaintiffs Cindy Bratt and John Bratt, as the personal representatives or a successors in interest to Pipper Bratt, are entitled to recover Pipper Bratt's pre-death economic and non-economic damages against Defendant Casa Pacifica.

74. Further, as set forth in greater detail in Paragraphs 35-52, *supra*, Casa Pacifica, through its managing agents and supervisors, acted with oppression and malice by adopting and enforcing a pattern and practice of normalizing AWOLs and minimizing known exploitation risks, despite actual knowledge that:

- Prior events put Casa Pacifica on notice that leaving at risk residents unsupervised or lightly supervised on an "open" campus invites precisely the harms that befell Pipper. Despite that notice, Casa Pacifica continued operating with inadequate staffing, porous campus controls, and a culture that normalized AWOLs as unavoidable rather than preventable;
- Pipper had a recent history of involuntary psychiatric holds and suicidal ideation;
- In Casa Pacifica's own records, she was repeatedly leaving campus, being returned by law enforcement at all hours, ingesting unknown pills, and reporting drug use;
- Law enforcement interviewed Pipper on August 29, 2025, consistent with her disclosure as a victim of a predatory adult male, and Casa Pacifica had information that other girls from its program were also targeted; and

- Despite this notice, Casa Pacifica failed to implement heightened supervision or protective measures and allowed Pipper to again leave the campus on September 19, 2025, with fatal consequences.

75. Casa Pacifica's conduct was despicable in that it consciously disregarded Pipper's safety and the foreseeable risk of traffic death immediately outside its campus, warranting an award of exemplary damages to punish and deter.

THIRD CAUSE OF ACTION

Premises Liability

FOR A THIRD CAUSE OF ACTION AGAINST DEFENDANTS CASA PACIFICA CENTERS FOR CHILDREN AND FAMILIES AND DOES 1-100 FOR PREMISES LIABILITY, PLAINTIFFS ALLEGE:

76. Plaintiffs refer to each and every one of the above paragraphs, and incorporate those paragraphs as though set forth in full in this cause of action.

77. At all relevant times, Casa Pacifica owned, occupied, controlled, and/or maintained the real property located at 1722 South Lewis Road, Camarillo, California, including all structures, cottages, driveways, walkways, gates, and egress points leading to the public roadway.

78. Casa Pacifica owed Pipper a duty to use reasonable care to keep the premises in a reasonably safe condition and to protect residents from foreseeable harm arising from conditions on, or connected with, the property—particularly where Casa Pacifica knew that residents with significant behavioral and mental-health needs routinely traverse egress points that lead directly to an active roadway.

79. Casa Pacifica breached this duty by creating, allowing, and/or failing to correct a dangerous condition and by failing to implement reasonable protective measures. By way of non-exhaustive example, Casa Pacifica:

- Maintained open exit points and a campus layout that allowed a direct, rapid path from cottages to the Lewis Road corridor without appropriate staffing, interception points, or line-of-sight coverage;

- Failed to stage personnel at doors, gates, driveways, and other thresholds to interrupt foreseeable departures by high-risk residents and to escort them safely back to care;
- Failed to adopt and enforce perimeter practices (consistent with licensing) that would reasonably reduce unsafe exits to the roadway, such as observation posts at egress points, controlled movement during higher-risk periods, real-time alerting when a high-risk youth approaches an exit, and immediate staff interventions at thresholds;
- Failed to adjust the physical environment (e.g., signage, visual barriers, cueing, or other reasonable environmental design measures) to reflect the known risk that AWOL-prone residents could move unimpeded into the roadway; and
- Failed to warn or otherwise protect Pipper from the specific hazard of vehicular traffic immediately outside the campus once Casa Pacifica elected to operate an "open" perimeter and knew she was repeatedly exiting that area.

80. Casa Pacifica had actual and constructive notice of the dangerous condition and of the need for protective measures based on (a) its own incident and AWOL records showing residents, including Pipper, leaving the campus and moving toward or into the roadway; (b) frequent law-enforcement calls for runaway returns from the vicinity; (c) direct knowledge that Pipper had recently been targeted and harmed in the community after departing campus; and (d) the physical configuration of the property, which placed youthful residents at the edge of an active street.

81. Casa Pacifica's failure to use reasonable care in the management, maintenance, and operation of the premises was a substantial factor in causing Pipper to access the roadway on or about September 19, 2025, resulting in the collision and her fatal injuries.

82. As a direct result of the acts and omissions of Defendant Casa Pacifica, Pipper Bratt incurred general damages prior to her death, and was severely harmed, endured pain, suffering, disability, impairment, disfigurement, inconvenience, loss of enjoyment of life, scarring, and other non-economic damages.

83. Plaintiffs Cindy Bratt and John Bratt are the personal representative or successors in interest and authorized to bring a survival action on behalf of the Pipper Bratt's Estate pursuant to Code of Civil Procedure § 377.30, *et seq*.

84. Plaintiffs Cindy Bratt and John Bratt, as the personal representatives or a successors in interest to Pipper Bratt, are entitled to recover Pipper Bratt's pre-death economic and non-economic damages against Defendant Casa Pacifica.

85. Further, as set forth in greater detail in Paragraphs 35-52, *supra*, Casa Pacifica, through its managing agents and supervisors, acted with oppression and malice by adopting and enforcing a pattern and practice of normalizing AWOLs and minimizing known exploitation risks, despite actual knowledge that:

- Prior events put Casa Pacifica on notice that leaving at risk residents unsupervised or lightly supervised on an "open" campus invites precisely the harms that befell Pipper. Despite that notice, Casa Pacifica continued operating with inadequate staffing, porous campus controls, and a culture that normalized AWOLs as unavoidable rather than preventable;
- Pipper had a recent history of involuntary psychiatric holds and suicidal ideation;
- In Casa Pacifica's own records, she was repeatedly leaving campus, being returned by law enforcement at all hours, ingesting unknown pills, and reporting drug use;
- Law enforcement interviewed Pipper on August 29, 2025, consistent with her disclosure as a victim of a predatory adult male, and Casa Pacifica had information that other girls from its program were also targeted; and
- Despite this notice, Casa Pacifica failed to implement heightened supervision or protective measures and allowed Pipper to again leave the campus on September 19, 2025, with fatal consequences.

86. Casa Pacifica's conduct was despicable in that it consciously disregarded Pipper's safety and the foreseeable risk of traffic death immediately outside its campus, warranting an award of exemplary damages to punish and deter.

FOURTH CAUSE OF ACTION

Wrongful Death (Cal. Code Civ. Proc. § 377.60)

FOR A FOURTH CAUSE OF ACTION AGAINST DEFENDANTS CASA PACIFICA CENTERS FOR CHILDREN AND FAMILIES AND DOES 1-100 FOR WRONGFUL DEATH, PLAINTIFFS ALLEGE:

87. Plaintiffs refer to each and every one of the above paragraphs, and incorporate those paragraphs as though set forth in full in this cause of action.

88. Plaintiffs Cindy Bratt and John Bratt are the adoptive parents and statutory heirs of Decedent Pipper Bratt and bring this cause of action pursuant to Cal. Code Civ. Proc. § 377.60.

89. Defendants owed Decedent a duty of reasonable care to meet her protective and safety needs, to supervise her, and keep the premises in a reasonably safe condition for foster children and to comply with applicable laws and standards.

90. Defendants breached their duties as set forth herein.

91. As a direct and proximate result of Defendant Casa Pacifica's negligence, Decedent Pipper Bratt was permitted to leave the Casa Pacifica campus unsupervised on September 19, 2025 and was immediately exposed to roadway traffic, resulting in fatal injuries.

92. As a direct and proximate result, Plaintiffs Cindy Bratt and John Bratt suffered the wrongful death of their child, including economic damages (loss of financial support, loss of the value of household services, funeral and burial expenses) and non-economic damages for the loss of love, companionship, comfort, care, assistance, protection, affection, society, and moral support.

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PRAYER FOR DAMAGES

Wherefore, Plaintiffs Cindy Bratt and John Bratt pray for judgment against Defendants as follows:

1. For an award of compensatory, general, and special damages, including both survival damages and wrongful death damages, all in an amount to be proven at the time of trial;
2. For punitive damages, according to proof; and
3. For prejudgment interest and pre-trial interest, according to proof;
4. For costs of suit incurred herein, according to proof;
5. For damages for Plaintiff's other losses, according to proof; and
6. For such other and further relief as the Court may deem just and proper.

Dated: November 19, 2025

PANISH | SHEA | RAVIPUDI LLP

By: _____

Wyatt A. Vespermann
Attorneys for Plaintiff

DEMAND FOR JURY TRIAL

Plaintiffs request a jury trial on all causes of action as to all Defendants.

Dated: November 19, 2025

PANISH | SHEA | RAVIPUDI LLP

By: _____

Wyatt A. Vespermann
Attorneys for Plaintiff