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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

J.M., an individual; K.G., an individual; R.S., an individual; K.M., an individual; A.O., an individual; S.P., an individual; R.P., an individual,

Plaintiffs,

vs.

COUNTY OF SANTA CLARA, a governmental entity, on its own behalf and on behalf of its departments, including but not limited to FAMILY AND CHILDREN'S SERVICES; KEN BORELLI, an individual; PATRICK CLYNE, an individual; and DOES 1 to 100 inclusive,

Defendants.

Case No. 26CV493431

COMPLAINT FOR DAMAGES AND DEMAND FOR JURY TRIAL

I. INTRODUCTION

1. This case exposes a profound institutional betrayal. For over a decade, Santa Clara County operated a child-protection system that actively shielded a predator instead of the vulnerable children it was sworn to protect. The County possessed every legal tool, mandate, and warning necessary to stop Defendant Patrick Clyne—a medical doctor and licensed foster parent—from preying on dependent youth. Instead, the County chose complicity.

2. This was not a tragedy of missed clues. It was a deliberate course of conduct directed at the highest levels of County government. The County weaponized its own authority to legitimize Clyne, treating him as an untouchable insider. When glaring red flags emerged, the County did not just look the other way. It actively suppressed the truth. County management directed investigators to stand down and granted Clyne institutional cover.

3. Clyne operated with the actual and apparent authority of Santa Clara County. The County licensed his home for foster placements. It allowed him to handle County-connected child-abuse investigations. It offered him as an expert witness in criminal trials. It relied on him as a pediatrician for children. It positioned him as a trusted medical authority whose words carried institutional weight with parents, children, and clinic personnel.

4. The County created a severe power disparity. It positioned Clyne as an unimpeachable adult in the lives of children who were already dependent on the County for placement, medical care, supervision, and protection. When those children entered his home or his examination room, they did not encounter a private stranger. They encountered a doctor who appeared to carry the County's blessing as a trusted individual.

5. The County knew enough to act. In 1996, it received a written Unusual Incident Report placing Clyne, a pediatrician and foster parent, in the middle of a foster child's genital fondling involving an electric massager. In January 2001, it received a neighbor complaint concerning neglect and lack of supervision of foster children inside Clyne's home. In November 2001, it received disclosures by four boys—Kyle, Max, Dean, and Jeffrey—describing sexual abuse at the hands of Clyne.

6. The County responded to those warnings through avoidance. It failed to conduct the investigation its own rules required. It failed to interview children. It notified Clyne of the

January 2001 complaint and gave him time, information, and institutional cover. Then, after the November 2001 disclosures, County management directed investigatory personnel to "stand down" and not look into Clyne's perversions.

7. That decision preserved Clyne's reputation and access to children. It permitted him to remain in roles that carried County legitimacy, including child-abuse medical functions and foster-care medical access. Parents and children continued to encounter him as a safe authority. Clyne used that authority and access to molest countless children. That manufactured trust became the bridge from the 2001 disclosures to the abuse of K.G., J.M., K.M., A.O., S.P., R.P., and R.S. in County-run medical centers over the next decade.

II. PARTIES

8. Plaintiff K.G. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

9. Plaintiff J.M. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

10. Plaintiff K.M. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

11. Plaintiff A.O. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

12. Plaintiff S.P. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

13. Plaintiff R.P. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

14. Plaintiff R.S. is an individual who, at all relevant times, was a minor child in Santa Clara County and was brought within the care, supervision, placement authority, medical referral system, child-welfare authority, or foster-care medical system of Defendant County of Santa Clara.

15. Plaintiffs use initials in this Complaint to protect privacy. This action concerns childhood sexual assault, foster-care status, dependency records, medical records, and trauma that should not be unnecessarily exposed in the public record.

16. At all relevant times, Defendant County of Santa Clara was a public entity in the State of California within the definition of Cal. Gov. Code § 811.2. At all relevant times, the County acted through its Social Services Agency, Department of Family and Children's Services, emergency response functions, licensing functions, Valley Medical Center, Santa Clara Valley Medical Center, Children's Shelter, County clinics, and foster-care medical programs.

17. Defendant Ken Borelli was employed by Defendant County of Santa Clara in its Department of Family and Children's Services, including in an Emergency Response managerial or supervisory capacity and Deputy Director of DFCS. Plaintiffs are informed and believe, and on that basis allege, that Borelli acted within the course and scope of his County employment when he supervised, directed, controlled, approved, or ratified County responses to child abuse and neglect referrals, foster family home licensing matters, emergency response investigations, and interagency child-protection decisions. Plaintiffs are informed and believe, and on that basis allege, that Borelli was a managing agent, supervisor, policymaker, or final decisionmaker for the County with respect to the operational response to child-abuse allegations involving Defendant Patrick Clyne. Borelli directed, approved, or ratified County conduct that preserved Clyne's access, protected his County-backed credibility, failed to warn foster parents and medical personnel, and allowed Clyne to remain in child-facing authority. At all relevant times, Borelli's acts and omissions were performed within the course and scope of his employment with the County.

18. Defendant Patrick Clyne was at all relevant times, a physician licensed to practice medicine in California, a pediatric medical provider, a licensed foster parent, and a County-connected child-facing medical authority. Plaintiffs are informed and believe, and on that basis allege, that Clyne resided, worked, practiced medicine, maintained foster-care involvement, and committed the acts alleged herein in Santa Clara County, California. At all relevant times, Clyne

also acted as a County employee, actual agent, ostensible agent, contractor, independent contractor, consultant, expert witness, SART provider, child-abuse medical provider, foster-care physician, or County-authorized medical provider. Plaintiffs allege these capacities in the alternative. Through those roles, Clyne obtained actual and apparent authority to conduct medical examinations of foster children, dependent youth, and vulnerable minors in County-connected medical settings, including County clinics, Valley Medical Center settings, the Children's Shelter clinic, and other County-connected child-serving medical environments. Plaintiffs are informed and believe, and on that basis allege, that Clyne used his County-created and County-ratified authority to gain access to Plaintiffs and to commit childhood sexual assault, sexual battery, battery, and other intentional torts during purported medical examinations. Clyne's conduct was not legitimate medical care, was not medically necessary, and was committed under the pretense of pediatric, foster-care, child-abuse, or County-connected medical authority.

19. The true names and capacities, whether individual, corporate, associate or otherwise, of defendants DOEs 1-100, inclusive, and each of them, are unknown to Plaintiff, who therefore 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. Plaintiff is informed and believes and upon that basis alleges 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 Plaintiff as hereinafter alleged.

20. Plaintiff is informed and believes and on that basis alleges 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

21. 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 Santa Clara.

22. Santa Clara County 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

A. The County Child-Welfare System When Clyne's Conduct Was Exposed

23. Between the late 1990s and 2011, Santa Clara County operated a child-welfare apparatus defined by severe systemic dysfunction and a deliberate abdication of mandatory protective duties. A 2001 Management Audit of the Department of Family and Children's Services revealed a catastrophic operational collapse at the agency's primary intake point. Of the more than 26,000 calls directed to the Child Abuse and Neglect Reporting Center during the reviewed period, social workers answered only 59 percent. The County systematically abandoned over 7,000 reports of abuse and neglect to voicemail or diversion. By failing to maintain the primary reporting mechanism utilized by mandated reporters and vulnerable youth, the County established a baseline practice of deliberate indifference to known dangers.

24. This operational collapse did not result from a lack of resources. During the exact same period that thousands of abuse calls went unanswered, the Department's budget surged by approximately 72 percent to nearly $175 million. The severe disparity between the influx of public funding and the failure of basic protective machinery demonstrates that the County's inaction stemmed from deliberate institutional mismanagement rather than financial scarcity.

25. The County maintained an equally dangerous environment at the centralized Children's Shelter. Despite expending an exorbitant $19,000 per child per month, the County consistently exposed traumatized wards to rampant violence, severe runaway risks, and commercial sexual exploitation. Rather than providing adequate staffing and trauma-informed care, the County relied on severe chemical restraints, including the administration of powerful antipsychotics like Thorazine, to suppress and control the dependent population.

26. The County's internal culture actively prioritized liability mitigation over child safety and transparency. Plaintiffs are informed and believe, and on that basis allege, that County officials deliberately altered or obscured official child-abuse records to conceal agency misconduct. Furthermore, the County affirmatively retaliated against and terminated whistleblowers who attempted to expose these dangerous practices, establishing an unwritten administrative mandate that protecting the institution superseded protecting its wards.

27. Plaintiffs are further informed and believe, and on that basis allege, that County child-welfare managers during this time directed, approved, or tolerated the artificial inflation of caseload numbers to illicitly draw down hundreds of millions of dollars in federal funding. This overarching environment of financial manipulation, record alteration, and severe operational neglect created the exact conditions necessary for a predator to operate undetected.

28. Within an agency paralyzed by public criticism and liability exposure, County management viewed Patrick Clyne not as a risk requiring stringent oversight, but as an indispensable institutional asset whose utility shielded him from necessary scrutiny.

B. Clyne's Authority Was Given By The County

29. At all relevant times, Defendant County affirmatively placed, endorsed, and retained Clyne in multiple overlapping positions of authority over dependent youth. The County licensed his foster home, employed or contracted with him as a pediatrician for foster children, assigned him to child-abuse-related medical evaluations, appointed him to the County Child Death Review Team, and utilized him as a trusted expert witness in sensitive child abuse and sexual exploitation criminal matters. Through these specific, concurrent delegations of power, Clyne operated with the actual and apparent agency of Santa Clara County.

30. By continuously elevating Clyne within its child-welfare and medical infrastructure, the County affirmatively represented to parents, social workers, and children that Clyne was a safe and vetted medical authority. Parents and the minor Plaintiffs reasonably relied on the County's endorsement when complying with Clyne's directives, including his instructions to undress and submit to intimate physical examinations.

31. The County knew or reasonably should have known that concurrently vesting a single individual with the custodial control of a foster parent and the clinical authority of a County pediatrician created a severe and foreseeable risk of exploitation. This convergence of roles granted Clyne isolated access to traumatized youth and the institutional credibility to demand unquestioned compliance from families.

32. Rather than imposing the strict supervision and immediate restrictions required by law following early reports of sexual misconduct, the County ratified Clyne's authority. By continuing to employ, refer, and present Clyne as a safe provider after receiving actual and

constructive notice of his abuses, the County affirmatively placed Plaintiffs in a position where a known predator could invoke County rules and reputation to compel their submission.

C. The County Deliberately Breached Strict, Non-Discretionary Statutory and Regulatory Mandates

33. Santa Clara County's protective obligations were strictly defined by mandatory statutory and regulatory enactments, including Title 22 of the California Code of Regulations, the CDSS Community Care Licensing Division Evaluator Manual, and a binding Memorandum of Understanding (MOU) executed between the California Department of Social Services and the County. Under California Health and Safety Code section 1511, the State is authorized to delegate its licensing functions to local counties.

34. Pursuant to this explicit statutory authority, Santa Clara County executed the MOU and formally assumed the State's non-delegable duty to implement and enforce California's strict licensing standards within its jurisdiction. In accepting this delegated authority, the County expressly agreed that its internal local policies could never supersede, diminish, or conflict with these mandatory State directives.

35. These regulatory frameworks imposed an absolute, non-discretionary mandate upon the County to conduct immediate and exhaustive complaint investigations of misconduct. Upon receipt of any information raising reasonable questions concerning child safety, the County was legally required to execute an independent on-site evaluation within 10 calendar days. To prevent institutional blind spots, the enactments mandated that investigators conduct direct interviews of victims, suspects, and witnesses. Furthermore, to guarantee supervisory accountability, the County was compelled to maintain highly detailed complaint logs meticulously tracking the intake, investigative timeline, and ultimate resolution of every allegation.

36. The governing manuals explicitly stripped the County of any discretion to passively delay child-safety interventions. The Evaluator Manual categorized allegations of inappropriate sexual touching and exploitation as critical emergencies requiring urgent, independent, evidence-based licensing evaluations. Parallel mandates within the Child Welfare Services Manuals compelled trained social workers to conduct immediate face-to-face emergency response assessments to determine the ongoing risk to any child residing in the targeted household, utilizing required monthly contacts to monitor safety and create reliable opportunities for victim disclosure.

37. Together, these written enactments established the exact standard of care required of Santa Clara County throughout Patrick Clyne's tenure as a foster parent and County pediatrician.

D. The 1996 Unusual Incident Report Is The First Known Instance Of Documented Notice of Sexual Misconduct By Clyne

38. In February 1996, the County received an Unusual Incident Report detailing an encounter with Max, a dependent minor placed in Clyne's licensed foster home. In this official record, Clyne explicitly admitted to handling the young boy's genitals following an incident involving an electric muscle massager. This submission did not constitute an ambiguous rumor or an anonymous grievance. It was an incontrovertible written admission of a County-licensed foster parent and pediatrician documenting intimate, highly inappropriate sexual contact with a dependent ward in a private setting.

39. Upon receipt of this document, the County was strictly bound by its mandatory enactments to execute an immediate, comprehensive child-safety intervention. The explicit nature of the report—detailing severe boundary violations, sexualized proximity, and textbook grooming behavior—required County licensing personnel to immediately enter the residence, conduct private interviews with Max, Kyle R., and all other residing minors, and suspend Clyne's access to dependent youth pending a thorough fitness assessment.

40. Instead of initiating these non-discretionary protective measures, the County deliberately buried the warning. The County outright failed to investigate, failed to dispatch field investigators to secure the premises, and failed to conduct the required private child interviews.

41. This deliberate indifference in 1996 establishes the baseline for the County's liability. Years before the explosive 2001 disclosures, and more than a decade before the Plaintiffs were subjected to Clyne's perversions, Santa Clara County already possessed direct, documentary evidence connecting its trusted insider to the sexualized exploitation of a foster child. By choosing institutional deference over mandatory investigation, the County affirmatively signaled to Clyne that his authority rendered him immune from oversight.

E. The County Systematically Ignored Early Warning Signs Within Clyne's Foster Home

42. Upon placing dependent minors, including Jeff W., Kyle R. and Max B., into Patrick Clyne's licensed foster home, the County assumed strict, non-delegable duties to conduct regular face-to-face contacts and independent safety evaluations. These field visits offered a mechanism designed to detect exploitation and assess the ongoing fitness of County-affiliated caregivers, such as Clyne.

43. Despite the explicit grooming indicators documented in the 1996 Unusual Incident Report concerning Max, County social workers conducted only two face-to-face visits with Kyle R. during the entirety of 1996—when the law required monthly contact. Rather than utilizing these exceedingly rare contacts to independently investigate the highly sexualized environment described in Clyne's own written admission, the County instead used this period to facilitate Clyne's formal adoption of Kyle.

44. Once the adoption was facilitated, the County utilized the new legal status as a bureaucratic shield to unlawfully terminate its oversight, never conducting another child-welfare safety check on Kyle R. again. Concurrently, the County systematically breached its mandatory contact obligations regarding other dependent wards who remained placed in the residence, allowing severe gaps and missed field visits to accumulate over multi-year periods.

45. By deliberately failing to execute these required visits, County personnel abdicated their legal duty to privately interview the minors and independently assess the household dynamics. This conscious, multi-year abdication of mandated oversight effectively blinded the agency to an active predator operating within its own ranks. By leaving the boys entirely unmonitored for years, the County insulated Clyne from early administrative detection, thereby preserving the institutional reputation he would later rely upon to access and abuse Plaintiffs.

46. In January 2001, the County received a formal complaint from a neighbor alleging severe neglect and lack of supervision involving Kyle R. at Clyne's residence. Under the County's mandatory protocols, this report required investigators to immediately enter the home, conduct private interviews with all residing children and issue a formal licensing determination regarding Clyne's ongoing fitness as a caregiver. Instead of executing this mandatory field investigation, the County utilized Kyle R.'s recent adoption by Clyne to dismiss the inquiry entirely.

47. The County deliberately ignored the continued presence of another vulnerable foster child in the home and completely disregarded the 1996 warning already residing in Clyne's file. Rather than conducting an independent safety assessment to evaluate a County-affiliated doctor, the County affirmatively notified Clyne of the complaint, providing a suspected predator with the opportunity to conceal his misconduct. By choosing institutional avoidance over mandatory investigation, the County granted Clyne yet another administrative free pass, allowing him to maintain the County credentials he subsequently utilized to access Plaintiffs in clinical settings.

F. The November 2001 Disclosures Constituted Absolute Actual Notice of Clyne's Predatory Conduct

48. In November 2001, the truth about Clyne's perversions became clear through the courageous disclosures by multiple children. Kyle R. disclosed sexual abuse by Clyne. Max B. disclosed abuse by Clyne. The child of Clyne's neighbor, a boy named Dean, described molestation in Clyne's home. Clyne's very first foster child, Jeffrey W., disclosed abuse by Clyne.

49. These were not isolated claims disconnected from one another. The disclosures described a coherent pattern of nighttime access, genital touching, and an adult using foster-care authority to molest children who depended on him.

50. The County's own Emergency Response Referral identified Patrick Clyne as the alleged perpetrator. It identified sexual abuse as the category. It described genital fondling. It placed the abuse inside Clyne's residence. It recorded that Kyle R. reported Clyne came into his bedroom and fondled his penis while Kyle R. pretended to sleep.

51. The referral was routed to County licensing investigator Steven Katz and his supervisor. It also moved through emergency response and law-enforcement channels. The County therefore had formal notice through the very systems designed to protect children from abuse.

52. At that point, the County did not need a conviction to act. It did not need an indictment to protect children. It did not need proof beyond a reasonable doubt to suspend placements, restrict access, warn medical personnel, require chaperones, audit prior examinations, or open an independent licensing investigation. The County's written, mandatory duties were already fixed. The MOU required complaint investigation, on-site response, interviews, documentation, complaint logs, and supervisory review. The Evaluator Manual required the

County to treat reasonable child-safety concerns as complaints. The Child Welfare Services framework required assessment of whether children in the household remained at risk.

53. The County instead chose to abdicate the duties and made the decision at the highest level to **not respond** to the November 2001 disclosures. Steven Katz testified that the Clyne investigation was taken **out of his hands**, as follows:

> Q. And then the licensing unit, your investigation is to determine if there has been any violation of the personal rights of a foster child in a licensed foster family home; that's the ultimate goal of that investigation, right?
>
> A. Yes.

> Q. So in terms of a traditional complaint investigation where you are going through the handbook requirements, you are making contact with the children, you are interviewing them in a quiet, private environment, the whole list of criteria to do a complaint investigation, did that happen in this case with this November 2001 referral?
>
> A. No.

> Q. BY MR. VESPERMANN: Yeah. How do you feel about that? Does it feel like an investigation wasn't conducted for reasons that were removed from whether children are being abused or neglected by him?
>
> A. The investigation was out of my hands.

> Q. All right. It shouldn't have been out of your hands. It should have been in your hands and you should have conducted a complaint investigation. That's what the protocol, that's what the handbook, that's what all your training dictated; that's an accurate statement; right, sir?

A. Normal circumstances. These were abnormal circumstances. I was directed to hold off.

Q. In your approximate 200 to 250 complaint investigations that you conducted, is this the only instance where you were told to hold off?

A. Yes.

54. Mr. Katz identified Defendant Ken Borelli as the County manager who dictated that stand-down. Borelli was not a bystander. He was the Emergency Response program manager within the child-protection hierarchy responsible for responding to abuse and neglect allegations. Defendant Borelli later was promoted to the Deputy Director of the County of Santa Clara's Department of Family and Children's Services.

55. Katz's testimony exposed the preferential nature of the decision. In approximately 200 to 250 complaint investigations, this was the only time he was told to hold off. The difference was Clyne. Katz described Clyne as a trusted expert witness for the County who had been entrusted with delicate and sensitive investigations on behalf of the agency:

Q. And that's because someone in emergency response, a program manager, had told you to stand down?

A. The program manager certainly contacted the director of the agency. I have no record of that. A program manager wouldn't have the authority, and certainly not in an instance like this when we are dealing with an alleged perpetrator who is and has been a trusted expert witness for the county.

Q. What do you know about that, about Patrick Clyne being involved in expert work for the county?

A. I know that that's -- I know that they entrusted him to do delicate and sensitive investigations on behalf of the agency.

17	Q. Who in the county hierarchy dictated that to
18	you?
19	A. Ken Borelli.

56. The County did not stand down for an ordinary accused foster parent. It carved out an exception to protect a trusted expert witness and County insider. The exception does not appear in the MOU, Title 22, the Evaluator Manual, or the Child Welfare Services Manuals. It was an institutional decision to protect a useful employee from the consequences of mandatory child-protection rules.

57. The stand-down order constitutes explicit proof of a custom, practice, and policy of deliberate indifference. High-level County executives made a calculated decision that preserving the reputation and utility of their staff pediatrician superseded their constitutional and statutory obligations to protect dependent minors. By deliberately terminating an active abuse investigation to shield a County asset, the agency's top policymakers affirmatively ratified Clyne's conduct and laid the groundwork for his continued access to Plaintiffs.

G. The County's Affirmative Ratification and Continued Endorsement of Clyne Proximately Caused Plaintiffs' Abuse

58. Between 2001 and 2011, the County affirmatively retained Clyne in County-connected, child-facing medical positions. By deliberately concealing the multiple 2001 sexual abuse disclosures and suppressing any independent administrative action, the County manufactured a highly dangerous illusion of safety. Foster parents reasonably relied upon the County's institutional endorsement when transporting dependent minors to Valley Medical Center clinics and the Children's Shelter, entirely unaware that the County was harboring an accused, unvetted serial abuser.

59. Plaintiffs K.G., J.M., K.M., A.O., S.P., R.P., and R.S. suffered severe abuse as a direct and proximate result of this manufactured trust. Rather than functioning as a safeguard, the County's system actively supplied Clyne with a continuous stream of vulnerable patients, granting him the institutional credibility necessary to compel submission.

60. Operating under the pretext of County-mandated pediatric care, Clyne subjected Plaintiffs to severe sexual exploitation devoid of any legitimate medical necessity.

61. K.G., then approximately eight years old, was instructed to remove her clothing and assume a frog-like squatting posture before Clyne penetrated her vagina and anus with his fingers. Clyne utilized his apparent medical authority to compel K.G. into highly vulnerable physical positions, a pattern of exploitation she reported had occurred during previous examinations.

62. Similarly, Clyne instructed K.M., then approximately ten years old, to expose her genitalia, forcibly spread her legs, and made highly inappropriate vocalizations while fixating on her vagina.

63. S.P., then approximately eight years old, was likewise instructed to assume a frog-like posture and subjected to digital vaginal penetration.

64. J.M., who was examined by Clyne beginning at approximately age eight, was directed to lie supine with her legs raised while Clyne massaged her breasts and digitally penetrated her vagina.

65. R.P. was subjected to severe, ongoing sexual exploitation by Clyne from the time he was a newborn until he was approximately two years old. Operating entirely under the guise of routine pediatric care, Clyne subjected R.P. to medically unnecessary and highly invasive genital contact during clinical examinations.

66. R.S. was similarly subjected to assault, molestation, and penetration during purported medical examinations, enduring dozens of instances of abuse throughout his childhood.

67. The severe exploitation of Plaintiff A.O. provides explicit evidentiary proof of both the causal nexus and the County's entrenched custom of administrative cover-up. On July 29, 2009, AO's foster mother, Dayna Lansaw, transported the nine or ten-year-old minor to Clyne at the Children's Shelter clinic in direct reliance on his elevated, County-manufactured reputation as an outstanding physician. Lansaw had been specifically referred to Clyne by another foster parent who described him as "an outstanding doctor."

68. During the clinical encounter, Lansaw advised Clyne that A.O. had been the victim of childhood sex abuse in her family home leading to her coming into foster care. In reaction,

Clyne falsely invoked the County's administrative authority, explicitly advising Lansaw that Santa Clara County required or mandated vaginal examinations for all female foster children by law. When Lansaw questioned this directive—specifically noting that A.O. "was not a new child in the system" and had "been in the system for many years"—Clyne wielded his agency as a County-connected physician, repeatedly insisting "that it was required by the County of Santa Clara."

69. Clyne then executed a highly inappropriate, unchaperoned genital examination during which A.O. exhibited profound visible distress, initially giggling and moving around on the examination table, then "hysterically laughing" in a manner Lansaw testified she had "never heard her laugh that hard before" and "never heard her laugh that hard afterwards." In the immediate aftermath, in the car following the appointment, when Lansaw asked A.O. why she was laughing, the child stated "because it tickled" and "because he was really tickling me."

70. Recognizing the absence of legitimate medical protocol, Lansaw immediately initiated a series of urgent reports to County-affiliated personnel. That same day, Lansaw contacted the County District Attorney's office, where she encountered an assistant district attorney who was "so rude" and dismissive, telling her he "can't do anything" and that she needed "to go to the police," refusing to take action despite her explicit disclosure that "Dr. Clyne molested my foster daughter. He's molesting children over there and you need to follow up on it."

71. Lansaw also reported the unchaperoned molestation to AO's assigned County social worker, Monica Jessup, providing "every single detail" of the abuse. Jessup assured Lansaw that she "would report it." However, nearly two years later, on June 8, 2011, when A.O. was relocated to a new foster home, Lansaw confronted Jessup again during the placement interview. When explicitly asked whether she had ever reported Dr. Clyne, Jessup admitted she had not, stating "because he's a very well respected doctor" and offering various justifications. This explicit prioritization of a physician's institutional reputation over a dependent minor's physical safety constituted deliberate suppression of mandatory reporting duties.

72. The handling of A.O.'s abuse explicitly demonstrates the County's continuous, active suppression of sexual misconduct allegations to protect a valued insider. The County not only manufactured the illusory reputation that granted Clyne unchallenged access to A.O.'s body, but County personnel actively weaponized that exact same reputation to suppress the foster

mother's direct disclosure, seamlessly perpetuating the exact culture of deliberate indifference established during the 2001 stand-down order.

H. Later Regulatory Action Confirmed What The County Should Have Done Years Earlier

73. The County eventually separated itself from Clyne in March 2011, 15 years after the first report of sexual misconduct and 10 years after Kyle, Max, Jeff, and Dean's disclosures, and only after his usefulness as an expert and institutional asset had been compromised by investigations and credibility concerns. The timing confirms the County's priorities. The County did not meaningfully remove him when children needed protection. It acted when his value to the institution was damaged.

74. When the County ultimately severed ties with Clyne following the 2009 through 2011 wave of clinical abuse disclosures, it did so silently. By concealing the corroborated findings of sexual misconduct and facilitating a quiet administrative departure, the County actively preserved Clyne's unblemished medical license and his public status as a physician in good standing.

75. This served as the direct and proximate cause of Clyne's continued access to unsuspecting children in the private sector. Armed with the professional credentials effectively safeguarded by the County's institutional cover-up, Clyne seamlessly transitioned his pediatric practice to private medical facilities, including the Pediatric Medical Group of Watsonville. Operating under the identical guise of legitimate pediatric care that the County had authorized and normalized for over fifteen years, Clyne predictably continued to subject new cohorts of minors to severe medicalized sexual abuse.

76. In July 2014, CDSS initiated an exclusion action against Clyne from ever being a foster parent again. CDSS alleged that he had been licensed to operate a foster family home beginning in or about December 1994, surrendered his foster-family-home license in or about March 2007, and after surrender still had regular, unsupervised contact with children residing in licensed community-care facilities through at least 2011.

77. CDSS further alleged that Clyne violated a child's personal rights and engaged in conduct inimical to the health, morals, welfare, or safety of children. CDSS sought to prohibit Clyne from employment in, presence in, and contact with clients of licensed or certified facilities.

78. In 2021, a formal Accusation filed by the Medical Board of California explicitly details the devastating consequences of the County's cover-up. State regulators found, amongst other alarming conduct, that in his private practice Clyne instructed a nine-year-old female patient to completely remove her pants and underwear, falsely claiming he needed to insert his fingers into her vagina to medically examine her stomach. Clyne likewise ordered an eight-year-old male patient to completely disrobe before using his bare hands to physically spread the child's buttocks apart. State investigators further documented that Clyne routinely conducted unchaperoned, bare-handed examinations of the genitalia of multiple adolescent patients.

79. In 2025, the Medical Board of California adopted a stipulated surrender of Clyne's physician's and surgeon's certificate, effective June 13, 2025. That later action confirms the conclusion the County should have reached years earlier: Clyne should never have been given access to children.

FIRST CAUSE OF ACTION

Childhood Sexual Assault & Sexual Battery

FOR A FIRST CAUSE OF ACTION AGAINST DEFENDANTS PATRICK CLYNE, COUNTY OF SANTA CLARA, KEN BORELLI, AND DOES 1-100 FOR CHILDHOOD SEXUAL ASSAULT AND SEXUAL BATTERY, PLAINTIFFS ALLEGE:

80. Plaintiffs incorporate by reference each preceding paragraph as though fully set forth in this cause of action.

81. At all relevant times, Plaintiffs were minors. Defendant Patrick Clyne was an adult physician whose County-created authority placed him in positions of power over dependent youth, foster children, and vulnerable minors brought into County-connected medical systems.

82. Defendant Clyne sexually abused Plaintiffs during purported medical examinations. He used the language, setting, procedures, examination positions, and authority of pediatric medicine to require children to remove clothing, expose their bodies, and submit to harmful and offensive sexual contact. That contact included sexualized touching of intimate body parts, genital contact, breast contact, vaginal contact, anal contact, digital penetration, and other sexualized acts committed under the pretense of medical care.

83. Defendant Clyne's conduct constituted childhood sexual assault, sexual battery, battery, and intentional tortious conduct under California law, including Civil Code section 1708.5 and Code of Civil Procedure section 340.1.

84. The County and Defendant Borelli are liable for Defendant Clyne's intentional torts under Government Code sections 815.2 and 815.4. Plaintiffs allege that Clyne acted as a County employee, actual agent, ostensible agent, independent contractor, County-authorized medical provider, or County-ratified medical authority when he obtained access to Plaintiffs and performed the purported examinations during which the sexual batteries occurred.

85. The County and Defendant Borelli employed, used, retained, presented, or relied upon Defendant Clyne as a pediatric medical authority, including inside systems serving foster children and dependent youth. He performed child-facing medical work connected to County clinics, foster-care medical programs, child-abuse evaluations, and sensitive County investigations. The County also allowed him to remain associated with child-abuse and foster-care medical work after repeated notice that he posed a sexual-abuse risk to children.

86. Through those acts and omissions, the County and Defendant Borelli affirmatively placed Defendant Clyne in a position where foster parents, social workers, clinic personnel, and children reasonably believed he acted with County authority. A foster parent who brought a child to Defendant Clyne did not encounter an unknown private doctor. The County gave him public legitimacy and allowed that legitimacy to remain in force after warnings that required immediate restriction.

87. Defendant Clyne's sexual batteries were committed through that County-conferred authority. He obtained access to Plaintiffs as the physician foster parents were led to trust, as the doctor connected to County clinics and child-welfare systems, and as the adult who could represent intimate examinations as required by foster-care rules or County-connected medical practice.

88. Defendant Clyne's conduct occurred while he was performing, purporting to perform, or invoking County-connected medical functions. The batteries were accomplished by means of the examination room, the foster-care medical referral structure, the County's endorsement of Defendant Clyne's authority, and the power disparity the County created between Defendant Clyne and children dependent on public systems for care, placement, and protection.

89. The County is further liable under ostensible-agency principles. By its conduct, the County caused Plaintiffs and their caregivers reasonably to believe that Clyne was authorized to act on the County's behalf in providing medical care to foster children and dependent youth. Plaintiffs and their caregivers relied on that appearance of authority when they submitted to, permitted, or did not resist Clyne's purported examinations.

90. The County is further liable under ratification principles. By 1996, the County had written notice of an Unusual Incident Report involving a foster child's swollen genitals and inappropriate touching by Defendant Clyne. By January 2001, the County had received a report raising concerns about neglect and lack of supervision in Clyne's home. By November 2001, the County had disclosures by Kyle R., Max, Dean, and Jeffrey W. of sexual abuse perpetrated by Defendant Clyne that required immediate protective action.

91. Those facts gave County supervisors, managers, licensing personnel, child-welfare officials, medical administrators, and policymakers, including Defendant Borelli, actual or constructive knowledge that Clyne posed a serious sexual-abuse risk to children.

92. The County and Defendant Borelli had authority to investigate him, restrict him, remove him from child-facing roles, warn foster parents, alert County medical personnel, impose examination safeguards, and prevent further access to vulnerable minors.

93. County managing agents and supervisors, including Defendant Borelli, did not respond as child-protection law required. They failed to conduct an independent administrative investigation required by law. They directed the County officials legally mandated to conduct that investigation to stand down. They failed to discipline or restrict Defendant Clyne. They failed to warn foster parents and County medical personnel. They failed to remove Defendant Clyne from child-facing authority.

94. The County and Defendant Borelli's ratification was affirmative. It did not merely miss a warning. It preserved Defendant Clyne's County-backed authority after material facts made that authority dangerous to vulnerable children. It allowed him to remain in positions where children and caregivers would continue to encounter him as a safe County-connected doctor. It withheld from the foster-care community and County medical system the information necessary to protect children from him.

95. Alternatively, to the extent any battery was unauthorized when committed, the County later ratified Clyne's conduct and continued authority after learning material facts. The County accepted the benefit of Clyne's continued usefulness as a pediatric expert, foster-care medical provider, child-abuse physician, and trusted County insider while refusing to impose the restrictions necessary to protect children from the risk he presented.

96. The County's ratification relates back to the intentional torts committed through Clyne's County-created authority. In the alternative, the County is liable for the acts and omissions of its own supervisors, managers, policymakers, licensing personnel, child-welfare officials, and medical administrators who, while acting within the course and scope of their public employment, adopted, approved, concealed, minimized, or knowingly failed to correct Clyne's sexual misconduct and continued access to children.

97. As a direct and legal result of Defendant Clyne's intentional torts, and as a direct and legal result of the County's vicarious liability, actual-agency liability, ostensible-agency liability, enterprise-risk liability, respondeat superior liability, independent-contractor liability, and ratification, Plaintiffs suffered physical injury, emotional distress, humiliation, fear, anxiety, depression, post-traumatic stress, dissociation, loss of trust, sexual dysfunction, relationship impairment, medical expenses, therapy expenses, lost earnings, lost earning capacity, and other damages according to proof.

98. Plaintiffs seek punitive and exemplary damages only against Defendant Clyne and any non-public-entity Defendant against whom such damages are legally available.

99. Plaintiffs do not seek punitive damages, exemplary damages, or punitive-equivalent statutory enhanced damages against the County to the extent barred by Government Code section 818.

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SECOND CAUSE OF ACTION

Negligent Hiring, Supervision, or Retention (Gov. Code §§ 815.2 and 820)

FOR A SECOND CAUSE OF ACTION AGAINST DEFENDANTS COUNTY OF SANTA CLARA, KEN BORELLI, AND DOES 1-100 FOR NEGLIGENT HIRING, SUPERVISION, OR RETENTION OF EMPLOYEE AND AGENTS, PURSUANT TO GOVERNMENT CODE SECTIONS 815.2 AND 820, PLAINTIFFS ALLEGE:

100. Plaintiffs incorporate by reference each preceding paragraph as though fully set forth in this cause of action.

101. Plaintiffs bring this cause of action against Defendant County of Santa Clara and Ken Borelli under Government Code sections 815.2 and 820. The County and Defendant Borelli are liable for injuries proximately caused by negligent acts and omissions of County employees, supervisors, managers, licensing personnel, evaluators, medical administrators, and other public employees acting within the course and scope of their public employment.

102. This cause of action is pleaded in addition to, and independent of, Plaintiffs' claim for failure to perform mandatory duties under Government Code section 815.6. Plaintiffs plead the statutes, regulations, MOU, Title 22 standards, Evaluator Manual provisions, and County licensing materials both as sources of mandatory duties and as standards of care governing the work County employees were hired, trained, supervised, and retained to perform.

103. The liability alleged here arises from operational negligence by County employees who failed to perform child-protection, licensing-investigation, evaluator, supervisory, training, referral, warning, documentation, and risk-management functions after the County received notice that Clyne posed a foreseeable danger to children.

104. Amongst other duties, at all relevant times, the County was a public entity charged with delegated licensing responsibilities for foster family homes located in Santa Clara County. The County acted as the licensing agency for the Clyne Foster Family Home. The County certified, monitored, evaluated, and regulated the Clyne Foster Family Home through employees and agents who were required to comply with California law, Title 22, the California Community Care Facilities Act, the CDSS Memorandum of Understanding, the CCLD Evaluator Manual, and applicable County licensing policies.

105. Pursuant to the County's delegated licensing authority, the County and its employees were required to implement, enforce, and comply with State laws, regulations, standards, and policies governing foster family home licensing. The County was required to keep the Evaluator Manual current for licensing staff. The County was not permitted to adopt local practices that conflicted with or superseded CCLD policy, the Evaluator Manual, or written State protocol directives.

106. The County's licensing and evaluator responsibilities were not abstract oversight functions. They were concrete child-safety duties. County employees were required to process foster-family-home applications, evaluate applicant qualifications, ensure completion of required health screening and foster-parent training, conduct periodic evaluations, perform annual on-site visits, respond to incident reports, investigate complaints, document investigative work, maintain complaint logs, make case assessments when a licensee was noncompliant, and pursue administrative remedies when licensing action was required.

107. The County's complaint-investigation duties were especially important. Once the County received information raising reasonable questions about care, supervision, personal rights, facility conditions, or possible licensing violations in a foster family home, County licensing personnel were required to treat that information as a complaint or otherwise initiate the proper licensing response. The duty attached to the facility, the licensee, the allegation, and the risk to children.

108. County employees were required to make the required on-site complaint visit within the applicable time frame unless a lawful exception applied. They were required to perform an actual investigation. They were required to interview victims, suspects, and witnesses whenever necessary to determine whether licensing violations occurred. They were required to maintain a complaint log identifying the facility, the allegations, the date received, the assigned investigator, the date the site visit was due, the date the site visit occurred, the resolution of each allegation, and supervisory review.

109. When complaints alleged abuse, sexual abuse, inappropriate sexual touching, fondling, exploitation, penetration, genital contact, lack of supervision, or conduct creating a health-and-safety risk to children, County employees were required to respond.

110. The County, including Defendant Borelli, owed Plaintiffs duties of reasonable care through its employees' performance of these licensing and evaluator functions. Those duties included reasonable hiring, training, retention, supervision, and discipline of the employees assigned to licensing, complaint investigation, abuse response, documentation, supervisory review, interagency referral, and child-facing medical-risk communication.

111. The County, including Defendant Borelli, further owed Plaintiffs duties of reasonable care in the manner its employees retained, supervised, entrusted, referred to, and continued to endorse Clyne as a County-connected physician, foster parent, child-abuse medical authority, expert witness, and trusted doctor for foster children. The County knew that those overlapping roles created an extraordinary power disparity. The same adult could control a foster home, invoke medical authority, speak as a County-trusted expert, and obtain intimate access to children who depended on County systems for safety.

112. County employees, including Defendant Borelli, also failed to maintain a reasonable system for supervising their own licensing personnel. A competent licensing system would have required supervisors to ensure that incident reports and complaints involving Clyne were logged, investigated, reviewed, cross-reported where required, and evaluated for cumulative risk. The County instead permitted a fragmented system in which warnings entered the file without producing child-safety action.

113. In 1996, the County received an Unusual Incident Report concerning the Clyne Foster Family Home. The report described a foster child's swollen genitals, an electric massager, and Clyne's involvement with the child's penis. County employees knew, or should have known, that a pediatrician and foster parent reporting his own involvement with a child's genitals inside a licensed foster home required immediate licensing scrutiny.

114. Reasonable licensing employees would have opened a documented licensing investigation, entered the home, interviewed the child, interviewed Kyle R., interviewed other children who may have been at risk, contacted relevant witnesses, assessed whether personal rights had been violated, evaluated whether grooming or boundary violations were occurring, and referred the matter for supervisory and administrative action.

115. County employees failed to perform that work. They failed to properly investigate the 1996 report. They failed to create or preserve adequate complaint documentation. They failed to meaningfully interview the children in the home. They failed to restrict Clyne's access. They failed to escalate the matter as a serious licensing concern. They failed to treat the report as notice that Clyne's foster-care license and County-connected child-facing roles required immediate review.

116. The County's own hiring, supervision, and retention failures made that breach possible. The employees assigned to license, evaluate, investigate, and supervise the Clyne Foster Family Home were not properly trained, supervised, corrected, or retained to perform their duties when a trusted adult presented as a medical authority. The County allowed employees to treat Clyne's professional status as a reason for deference rather than as a reason for heightened scrutiny.

117. By November 2001, the County had received disclosures by Kyle R., Max, Dean, and Jeffrey W. Those disclosures identified sexual abuse, genital touching, nighttime access, sleeping vulnerability, and abuse connected to Clyne and the Clyne Foster Family Home. At that point, any reasonably trained licensing employee, supervisor, or manager would have recognized that the County faced a severe child-safety pattern involving a County-certified foster parent and County-connected pediatric authority.

118. County employees had authority and duty to conduct an independent licensing investigation regardless of whether law enforcement also investigated. They had authority and duty to restrict Clyne's foster-care access, warn foster parents, alert County medical personnel, audit prior child-facing examinations, review all prior incident reports, seek administrative remedies, and communicate the risk across the County systems that continued to treat Clyne as safe.

119. County employees did the opposite. County management, including Defendant Borelli, directed or allowed the licensing investigation to stand down. Licensing personnel were told to wait for law enforcement and the grand jury. The County thereby abandoned its own child-safety standards in favor of a criminal process that could not determine whether Clyne's foster-care license, medical access, and County-connected authority remained safe.

120. The County's failure to train and supervise its employees was a substantial factor in that stand-down. Competent training would have made clear that a law-enforcement investigation does not extinguish licensing duties. Competent supervision would have required written justification for any delayed site visit, continuous monitoring of the licensing investigation, timely follow-up, independent evidence gathering, supervisory review, and administrative action.

121. The County retained employees and supervisors, including Defendant Borelli, who proved unfit or incompetent to perform the work for which they were hired. Their unfitness and incompetence included failure to understand delegated licensing duties, failure to follow complaint procedures, failure to investigate sexual-abuse warnings, failure to document required action, failure to resist improper stand-down orders, failure to protect children when the alleged perpetrator was a trusted insider, and failure to communicate known risk to County-connected medical systems.

122. The County knew, or in the exercise of reasonable care should have known, that these employees and supervisors were unfit or incompetent, or had become unfit or incompetent, to perform their child-protection and licensing functions. The County had notice from unanswered hotline failures, documentation failures, shelter failures, licensing irregularities, prior complaints, incident reports, and the County's own handling of Clyne that its child-welfare and licensing systems required correction.

123. The County also knew, or should have known, that negligent licensing and evaluator practices created a particular risk of sexual abuse to foster children and dependent youth. Foster children are uniquely dependent on adults selected, certified, licensed, supervised, referred, and endorsed by the County. When the County permits a trusted adult to remain in child-facing authority after genital-contact warnings and sexual-abuse disclosures, the danger is not speculative. It is foreseeable.

124. The County's negligent hiring, supervision, retention, training, entrustment, referral, and failure to protect extended beyond the foster home. County employees allowed Clyne to remain publicly associated with foster-care medical authority, County clinics, child-abuse work, SART functions, and the County's trusted medical network. Foster parents and children continued to encounter him as a County-approved doctor for dependent youth.

125. The County's negligence therefore created the bridge between the early foster-home warnings and the later medicalized abuse of K.G., J.M., K.M., A.O., S.P., R.P., and R.S. Had County employees performed the required licensing and evaluator work in 1996, January 2001, November 2001, or thereafter, Clyne would have been restricted, investigated, reported, warned against, removed from child-facing authority, or otherwise prevented from using County-created trust to access Plaintiffs during purported medical examinations.

126. The County's negligence was not limited to one employee or one document. It reflected a failure to maintain a functioning system for supervising licensing workers, enforcing evaluator duties, following up on incident reports, conducting abuse investigations, preserving complaint records, escalating dangerous patterns, and preventing favored insiders from receiving exceptions to child-safety rules.

127. At all relevant times, the County's negligent employees and supervisors, including Defendant Borelli, were acting within the course and scope of their public employment. Their negligent acts and omissions would, apart from Government Code section 815.2, have given rise to causes of action against them under Government Code section 820.

128. As a direct and legal result of the County and Defendant Borelli's negligent hiring, supervision, retention, training, entrustment, referral, and failure to protect, Plaintiffs suffered childhood sexual assault, sexual battery, physical injury, emotional distress, humiliation, fear, anxiety, depression, post-traumatic stress, dissociation, loss of trust, sexual dysfunction, relationship impairment, medical expenses, therapy expenses, lost earnings, lost earning capacity, and other damages according to proof.

129. The County and Defendant Borelli's negligence was a substantial factor in causing Plaintiffs' harm. Plaintiffs therefore seek compensatory damages against Defendant County of Santa Clara and Defendant Borelli according to proof.

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THIRD CAUSE OF ACTION

Failure To Perform Mandatory Duty (Gov. Code § 815.6)

FOR A THIRD CAUSE OF ACTION AGAINST DEFENDANT THE COUNTY OF SANTA CLARA AND DOES 1-100 FOR PUBLIC ENTITY LIABILITY FOR FAILURE TO PERFORM A MANDATORY DUTY, PLAINTIFFS ALLEGE:

130. Plaintiffs incorporate by reference each preceding paragraph as though fully set forth in this cause of action.

131. Plaintiffs bring this cause of action pursuant to Government Code section 815.6. At all relevant times, Defendant County of Santa Clara was under mandatory duties imposed by enactments designed to protect children from sexual abuse, physical abuse, neglect, unsafe County-endorsed child-facing employees/agents, inadequate complaint investigations, failures to document abuse concerns, failures to cross-report abuse concerns, failures to preserve licensing evidence, and failures to initiate administrative protection when a licensed foster parent posed a danger to children.

132. This cause of action is focused on the County's licensing, evaluator, complaint-investigation, reporting, cross-reporting, documentation, supervisory-review, and administrative-remedy duties. Plaintiffs do not rely in this cause of action on general foster-care case-management duties alone. The mandatory duties alleged here arise from the County's delegated foster family home licensing authority and from the County's required performance of licensing and evaluator functions after receiving information that Clyne posed a danger to children.

133. At all relevant times, the County acted as the licensing agency for the Clyne Foster Family Home. Pursuant to Health and Safety Code section 1511, the California Department of Social Services delegated specified foster family home licensing responsibilities to the County. In exercising that delegated authority, the County was required to conform to the California Community Care Facilities Act, Health and Safety Code section 1500 et seq., Title 22 foster family home regulations, CDSS rules, CDSS regulations, CDSS standards, the CDSS Memorandum of Understanding, and the CCLD Evaluator Manual.

134. The County's duties were mandatory. The County was required to implement, enforce, and comply with California state laws, rules, regulations, standards, and policies

pertaining to licensing. The County was required to keep the Evaluator Manual current and available to licensing staff. The County was prohibited from implementing local policies or practices that conflicted with or superseded the Evaluator Manual or written CCLD policy and protocol directives.

135. The County was required to process applications for licensure, conduct on-site licensing visits, conduct periodic evaluations, perform annual on-site visits, conduct complaint investigations, maintain complaint logs, perform case assessments when complaints were substantiated or when a licensee was otherwise noncompliant, and initiate the appropriate legal and administrative remedies when licensing action was required.

136. When the County received a complaint concerning Defendant Clyne, it was required to conduct a complaint investigation as specified in the Evaluator Manual. Except as otherwise allowed by the Evaluator Manual, the County was required to make an on-site facility visit within ten calendar days in response to any complaint.

137. The County's complaint investigations were required to include interviews of victims, suspects, and witnesses whenever necessary to determine whether licensing violations had occurred. That duty applied regardless of whatever decision the County placement office made. It also applied regardless of whether law enforcement, prosecutors, or a grand jury were also involved.

138. The County was required to maintain a complaint log for each complaint. The log was required to identify the facility, the complaint allegations, the date the complaint was received, the assigned investigator, the date any referral to a County investigation unit occurred, the date the mandatory ten-day site visit was due, the date the site visit was made, the resolution of each complaint allegation, whether further investigation was required, and the date the complaint investigation was reviewed and approved by the County licensing supervisor.

139. The County was required to treat complaint information broadly. Under the Evaluator Manual, a complaint included any allegation that a licensing law or regulation was being violated. If the information raised reasonable questions about the care of children or the condition of a facility that could possibly involve a licensing violation, the County was required to record the information as a complaint and follow complaint procedures.

140. The County was required to conduct licensing investigations in a manner sufficient to resolve each allegation. The County was required to plan the investigation, identify the extent of the problem, identify the laws and regulations potentially violated, notify a Local Unit Manager of allegations that, if true, would endanger the health or safety of children, conduct the required site visit, gather evidence, document communications, document findings, and make a finding for each complaint allegation.

141. The County was required to document complaint findings through the required licensing forms and records. Findings had to be supported by evidence and classified under the required categories. A complaint could be substantiated, inconclusive, unfounded, or remain subject to further investigation. The County was not permitted to collapse different allegations into one generic disposition when the facts required separate determinations.

142. The County was required to follow the abuse-complaint procedures in the Evaluator Manual when allegations involved sexual abuse, inappropriate sexual touching, fondling, exploitation, penetration, genital contact, assault, battery, or other abuse posing a potential health and safety risk to children. These procedures required careful evidence gathering, interviews, documentation, evaluation of medical evidence, evaluation of victim disclosures, evaluation of corroborating evidence, supervisory involvement, and proper findings.

143. The County was further required to comply with the Child Abuse and Neglect Reporting Act. When County employees, mandated reporters, licensing personnel, social workers, medical personnel, or other County agents had knowledge of or reasonably suspected child abuse or neglect in their professional capacity or within the scope of employment, they were required to make the reports required by Penal Code section 11166.

144. The County was required to comply with Penal Code section 11166.1 and related cross-reporting provisions. When an agency received a report of abuse alleged to have occurred in a facility licensed to care for children by CDSS, the agency was required to notify the licensing office with jurisdiction over the facility within twenty-four hours and send the licensing agency a copy of its investigation and other pertinent materials.

145. The County was also required to comply with Division 31 cross-reporting regulations, including Division 31 Regulations sections 31-501.1 and 31-501.2, to the extent

applicable. Those provisions required cross-reporting to law enforcement and to the licensing agency when the County received information concerning abuse or neglect.

146. These enactments and mandatory standards were designed to protect foster children, dependent children, children receiving care or supervision through licensed community care facilities, and children later exposed to adults whose access and legitimacy depended on County licensing, County investigation, County reporting, and County administrative action.

147. Plaintiffs were members of the class these mandatory duties were designed to protect. Plaintiffs were minors who were dependent on County child-welfare, foster-care, licensing, medical, or County-connected systems for safety, supervision, medical care, placement, protection, or referral. Plaintiffs suffered the precise type of injury these duties were designed to prevent: childhood sexual assault, sexual battery, sexual abuse, harmful intimate touching, exploitation of foster-care vulnerability, and abuse committed through County-created medical and licensing authority.

148. The County breached these mandatory duties by directing or allowing its licensing investigation to stand down. The County failed to conduct an independent investigation. It failed to interview the required witnesses. It failed to gather and evaluate all available evidence. It failed to make a proper administrative finding based on licensing law. It failed to initiate appropriate legal and administrative remedies.

149. The County further breached its mandatory duties by failing to perform the legal and administrative remedy process required by the MOU and licensing standards. When complaints were substantiated, when the licensee chronically failed to meet licensing requirements, or when the licensee was otherwise found to be noncompliant, the County was required to conduct a case assessment and initiate the appropriate course of action.

150. The County further breached its mandatory duties by failing to protect children from Clyne after the County had notice that he posed a risk. The required administrative action would have included meaningful investigation, findings, documentation, restriction, warning, referral, licensing action, administrative remedy submissions, exclusion consideration, and communication to the County systems that continued to treat Clyne as safe.

151. Had the County discharged its mandatory duties, Clyne's access to children would have been restricted, investigated, disclosed, reported, administratively acted upon, or terminated. Foster parents would have been warned. County medical personnel would have been alerted. Prior examinations would have been audited. The foster-care community would not have continued to encounter Clyne as a safe County-connected physician.

152. The County's failure to discharge its mandatory duties was a substantial factor in causing Plaintiffs' harm. The failure preserved Clyne's foster-care and medical legitimacy. It allowed him to remain cloaked in County-created trust. It allowed children and caregivers to enter purported medical examinations without knowledge of the prior warnings. It allowed Clyne to exploit the same institutional credibility that the mandatory licensing system was designed to test, restrict, and remove when danger appeared.

153. Plaintiffs K.G., J.M., K.M., A.O., S.P., R.P., and R.S. were harmed as a legal and proximate result of the County's mandatory-duty violations. They were sexually abused, sexually battered, molested, exposed to harmful intimate touching, or subjected to sexualized conduct by Clyne in circumstances made possible by the County's failure to perform the mandatory licensing and evaluator duties alleged herein.

154. As a legal, direct, and proximate result of the County's failures to perform mandatory duties, Plaintiffs suffered childhood sexual assault, sexual battery, physical injury, emotional distress, humiliation, fear, anxiety, depression, post-traumatic stress, dissociation, loss of trust, loss of safety, sexual dysfunction, relationship impairment, medical expenses, therapy expenses, lost earnings, lost earning capacity, and other damages according to proof.

155. Plaintiffs seek compensatory damages against Defendant County of Santa Clara according to proof. Plaintiffs do not seek punitive damages, exemplary damages, or punitive-equivalent statutory enhanced damages against the County to the extent barred by Government Code section 818.

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FOURTH CAUSE OF ACTION

Negligence/Negligence *Per Se* (Gov. Code §§ 815.2 & 820)

FOR A FOURTH CAUSE OF ACTION AGAINST DEFENDANTS COUNTY OF SANTA CLARA, KEN BORELLI, AND DOES 1-100 FOR NEGLIGENCE, PURSUANT GOVERNMENT CODE SECTIONS 815.2 & 820, PLAINTIFFS ALLEGE:

156. Plaintiffs incorporate by reference each preceding paragraph as though fully set forth in this cause of action.

157. Plaintiffs bring this cause of action pursuant to Government Code sections 815.2 and 820, and Evidence Code section 669.

158. Plaintiffs do not assert independent direct liability against Defendant County of Santa Clara in this cause of action. Plaintiffs assert vicarious liability against the County for the negligent acts and omissions of County employees, supervisors, managers, licensing personnel, evaluators, emergency-response personnel, social workers, medical administrators, mandated reporters, clinic personnel, and other public employees and agents acting within the course and scope of their public employment.

159. Government Code section 820 provides that a public employee is liable for injury caused by his or her act or omission to the same extent as a private person. Government Code section 815.2 makes the County liable for injury proximately caused by the acts or omissions of its employees committed within the scope of public employment when those acts or omissions would give rise to employee liability.

160. Evidence Code section 669 establishes a presumption that a person failed to exercise due care when the person violated a statute, ordinance, or regulation, the violation proximately caused injury, the injury resulted from an occurrence of the nature the enactment was designed to prevent, and the injured person was within the class of persons the enactment was designed to protect.

161. At all relevant times, County employees and agents, including Defendant Borelli, owed Plaintiffs duties of reasonable care. Those duties arose from the County's delegated foster care licensing responsibilities, complaint-investigation functions, evaluator duties, child-abuse reporting responsibilities, cross-reporting duties, medical-risk communication functions, child-

facing referral practices, and operational control over County-connected systems through which Clyne obtained access to children.

162. Plaintiffs allege that County employees and agents, including Defendant Borelli, carelessly, negligently, grossly negligently, and recklessly failed to discharge those duties in a reasonable manner. Their failures placed foster children, dependent youth, and vulnerable minors at grave risk of sexual abuse by a County-endorsed physician whose danger was known or reasonably knowable years before Plaintiffs were abused.

163. The statutes, regulations, and written directives alleged in this cause of action supplied the standard of care for County employees and agents. Those enactments were designed to protect children from sexual abuse, neglect, unsafe licensees, deficient complaint investigations, undisclosed licensing dangers, failures to report abuse, failures to cross-report abuse, failures to document abuse concerns, failures to preserve licensing evidence, and failures to take administrative action when a licensee or County-connected adult posed a danger to children.

164. Pursuant to Health and Safety Code section 1511 and the California Community Care Facilities Act, Health and Safety Code section 1500 et seq., the County assumed delegated licensing responsibilities for foster family homes within Santa Clara County. In exercising those responsibilities, County employees and agents were required to conform their conduct to California law, CDSS regulations, Title 22 foster family home regulations, CDSS standards, the CDSS Memorandum of Understanding, and the CCLD Evaluator Manual.

165. Title 22, Division 6, Chapter 7.5 supplied mandatory and negligence-based standards of care governing licensee compliance subject to applicable laws and regulations, authorized licensing agency inspection and evaluation, required appropriate care and supervision, required unusual incident reporting, required protection of children's personal rights, required safe health-related services, and required the licensing agency to respond when a licensee failed to comply.

166. The CDSS Memorandum of Understanding supplied additional standards of care for County licensing employees and evaluators. Under that MOU, the County was required to implement, enforce, and comply with state laws, rules, regulations, standards, and policies governing foster care licensing. The County was required to keep the Evaluator Manual current for

licensing staff. The County was not permitted to implement local practices that conflicted with or superseded CCLD policy, the Evaluator Manual, or written protocol directives.

167. The MOU also required the County to conduct complaint investigations as specified in the Evaluator Manual. Except where the Evaluator Manual allowed otherwise, County employees were required to make an on-site visit within ten calendar days in response to any complaint. County employees were required to interview victims, suspects, and witnesses whenever necessary to determine whether licensing violations had occurred. That duty existed regardless of whatever decision the County placement office made.

168. The Evaluator Manual supplied the operational standard of care for receiving, recording, analyzing, researching, investigating, documenting, and resolving complaints alleging violations of licensing laws and regulations.

169. Under Evaluator Manual section 3-2010 and related provisions, County employees were required to treat information as a complaint when it raised reasonable questions about the care of children or the condition of a facility that could possibly involve a licensing violation.

170. Under Evaluator Manual section 3-2011 and related provisions, reports generated by a facility concerning special incidents, injury, use of restraints, death, or other critical events required special inquiry, evaluation, and follow-up when they indicated problems with the facility. County employees were required to evaluate the event and determine whether further licensing action was required.

171. Under Evaluator Manual sections 3-2100 through 3-2400 and related provisions, County employees were required to accept complaints, record complaints, establish controls, plan investigations, prioritize and evaluate allegations, conduct site visits, document investigations, perform exit interviews, clear complaints only after an adequate investigation, and make findings supported by evidence.

172. Under Evaluator Manual sections 3-2600 through 3-2650 and related abuse-complaint provisions, County employees were required to treat allegations of sexual abuse, penetration, inappropriate sexual touching, fondling, exploitation, assault, battery, lack of care, lack of supervision, drug use, and alcohol provided to minors as serious licensing matters. These

allegations required heightened evaluator care, appropriate referral, interviews, evidence gathering, supervisory involvement, and findings under the correct administrative standard.

173. County employees and agents also owed duties under the Child Abuse and Neglect Reporting Act, including Penal Code section 11166 and related provisions. When County employees had knowledge of or reasonably suspected child abuse or neglect in their professional capacity or within the scope of employment, they were required to report that abuse as the law required.

174. County employees and agents further owed cross-reporting duties under Penal Code sections 11166.1 and 11166.2 and related Division 31 provisions, including sections 31-501.1 and 31-501.2 to the extent applicable. When the County received information concerning abuse or neglect in a licensed foster family home or a County-connected child-serving setting, employees were required to make appropriate cross-reports to law enforcement, licensing authorities, and other agencies responsible for child protection.

175. County employees and agents violated these standards of care in 1996. The County received an Unusual Incident Report concerning the Clyne Foster Family Home. The report described a foster child's swollen genitals, an electric massager, and Clyne's involvement with the child's penis. A reasonable evaluator would have treated that report as a serious licensing and child-safety warning requiring immediate inquiry, interviews, documentation, supervisory review, and protective restrictions.

176. County employees failed to act reasonably after the 1996 report. They failed to conduct and document a sufficient licensing inquiry. They failed to privately interview the child involved. They failed to interview Kyle R. They failed to interview other children in the home or otherwise at risk. They failed to evaluate whether Clyne had violated personal rights, care-and-supervision requirements, health-and-safety requirements, and child-abuse reporting duties. They failed to impose restrictions or initiate administrative action.

177. County employees and agents again violated these standards of care in November 2001. The County received disclosures by Kyle R., Max, Dean, and Jeffrey W. identifying sexual abuse by Clyne. The County's own Emergency Response Referral identified Patrick Clyne as the

alleged perpetrator, identified sexual abuse as the category, described genital fondling, and routed notice to licensing personnel and a supervisor.

178. County employees failed to respond reasonably to the November 2001 disclosures. They failed to conduct an adequate independent licensing investigation. They failed to perform the necessary interviews. They failed to evaluate the evidence under the administrative standard. They failed to make proper findings. They failed to initiate legal or administrative remedies. They failed to restrict Clyne's child-facing access. They failed to warn foster parents and County medical personnel.

179. County managers and supervisors, including Defendant Borelli, further breached the standard of care by directing or permitting licensing personnel to stand down.

180. County employees and agents, including Defendant Borelli, continued to breach the standard of care after 2001. They allowed Clyne to remain publicly associated with County-connected child-facing authority. They failed to communicate the risk to foster parents, County clinics, child-welfare personnel, SART personnel, child-abuse medical systems, and other County-connected actors whose decisions affected whether children would be brought to Clyne for intimate examinations.

181. County employees and agents breached the standard of care when later reports surfaced involving K.G., J.M., K.M., A.O., S.P., R.P., and R.S., and other children examined by Clyne. County employees continued to minimize, fragment, or misclassify complaints involving Clyne. They treated him as a non-caretaker or information-only subject despite the County-created authority through which he obtained access to foster children and vulnerable minors.

182. Plaintiffs allege that these statutory and regulatory violations establish negligence per se under Evidence Code section 669. County employees and agents violated statutes, regulations, and written directives designed to protect children from the precise risks at issue. Those violations were substantial factors in causing Plaintiffs' injuries.

183. Plaintiffs were members of the class these enactments were designed to protect. Plaintiffs were minors, foster children, dependent youth, vulnerable patients, or children brought into County-connected systems of medical care and child protection. They were entitled to the

protection of reasonable licensing, evaluator, reporting, cross-reporting, documentation, warning, restriction, and administrative action.

184. Plaintiffs suffered the precise type of harm these enactments were designed to prevent. They were sexually abused, sexually battered, molested, subjected to harmful intimate touching, exposed to unauthorized genital examinations, or otherwise injured by a County-endorsed adult whose access should have been interrupted by competent performance of the governing duties.

185. Plaintiffs further allege ordinary negligence independent of negligence per se. Even if any statute, regulation, manual provision, MOU provision, or written directive is found not to support a negligence per se presumption, the same facts establish that County employees and agents failed to act as reasonably careful child-protection, licensing, evaluator, medical, and reporting personnel would have acted under the circumstances.

186. The negligence of County employees and agents, including Defendant Borelli, was a substantial factor in causing Plaintiffs' harm. Had County employees acted reasonably in response to reports of Clyne's perversion, Clyne would have been restricted, investigated, warned against, removed from child-facing authority, administratively acted upon, or otherwise prevented from using County-created credibility to access Plaintiffs.

187. At all relevant times, the negligent County employees and agents, including Defendant Borelli, were acting within the course and scope of their public employment. Their acts and omissions would, apart from Government Code section 815.2, have given rise to claims against them under Government Code section 820.

188. As a legal, direct, and proximate result of the negligence, gross negligence, recklessness, and negligence per se of County employees and agents, including Defendant Borelli, Plaintiffs suffered childhood sexual assault, sexual battery, physical injury, emotional distress, humiliation, fear, anxiety, depression, post-traumatic stress, dissociation, loss of trust, loss of safety, sexual dysfunction, relationship impairment, medical expenses, therapy expenses, lost earnings, lost earning capacity, and other damages according to proof.

189. Plaintiffs seek compensatory damages against Defendant County of Santa Clara under Government Code section 815.2 for the acts and omissions of its employees and agents, including Defendant Borelli, and against Does 1 through 100 under Government Code section

820, according to proof. Plaintiffs do not seek punitive damages, exemplary damages, or punitive-equivalent statutory enhanced damages against the County to the extent barred by Government Code section 818.

PRAYER FOR DAMAGES

WHEREFORE, Plaintiffs K.G., J.M., K.M., A.O., S.P., R.P., and R.S. pray for judgment against all Defendants as follows:

1. For general damages (also known as non-economic damages), including but not limited to, past and future physical, mental and emotional pain and suffering and disfigurement according to proof;

2. For special damages (also known as economic damages), including but not limited to, past and future medical expenses, past and future professional expenses, past and future loss of wages and wage earning capacity, past and future medical and rehabilitative expenses, and incidental expenses according to proof;

3. For statutory enhanced damages and treble damages to the extent permitted by law;

4. For punitive and exemplary damages against Defendant Patrick Clyne, and all non-public-entity Defendants against whom punitive damages are legally available;

5. For prejudgment interest and pre-trial interest, according to proof;

6. For costs of suit incurred herein, according to proof;

7. For damages for Plaintiffs' other losses, according to proof;

8. For all statutorily allowed damages; and

9. For such other and further relief as the Court may deem just and proper.

Dated: May 7, 2026

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: May 7, 2026

PANISH | SHEA | RAVIPUDI LLP

By: _____

Wyatt A. Vespermann
Attorneys for Plaintiffs