

JANE DOE,)	
)	
)	
Plaintiff,)	
)	Case No.:
v.)	Division:
)	
KIDS TLC, INC.,)	JURY TRIAL DEMANDED
)	
Defendant.)	

PETITION FOR DAMAGES PURSUANT TO K.S.A. CHAPTER 60

Plaintiff Jane Doe, by counsel, files this *Petition for Damages Pursuant to K.S.A. Chapter 60* against Defendant Kids TLC, Inc. (“Kids TLC”), to recover damages and other relief resulting from the Defendant’s negligent and tortious conduct and violations of Jane Doe’s rights under Kansas Law and the United States Code.

This case concerns the repeated rape and sexual assault of Jane Doe (“Jane”), while she was a minor and under the direct care and supervision of Kids TLC’s Psychiatric Residential Treatment Facility (“Facility”).

This Court is now called upon to address the Defendant’s conduct that not only violates statutory mandates but betrays the very principles those laws were designed to safeguard: human dignity, and the right of every child, especially those with disabilities, to safety, care, and respect. In support of this *Petition for Damages*, Plaintiff respectfully states the following:

I. PARTIES

Plaintiff

1. Jane Doe was, at the relevant times, a fifteen-year-old minor child and resident of Kids TLC’s Psychiatric Residential Treatment Facility. Jane turned eighteen on March 6, 2025.
2. Kids TLC, Inc. is responsible for the Kids TLC Psychiatric Residential Treatment Facility.

3. Jane was, at all relevant times, entrusted to the care and supervision of Kids TLC.
4. Jane has multiple disabilities including Borderline Personality Disorder, Posttraumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, and Attention-Deficit/Hyperactivity Disorder.
5. Jane is a “qualified individual with a disability” under 42 U.S.C. 12101, et seq.
6. Jill and John Doe (“Mr. and Ms. Doe”) are the parents of Jane and were the parents and legal guardians of Jane at all relevant times.
7. Jane Doe is a resident of Johnson County, and she is currently residing in a foster home.

Defendant

8. Defendant Kids TLC is a 501(c)(3) nonprofit organization that operates a psychiatric residential treatment facility located at 480 S. Rogers Road, Olathe, Kansas 66062.
9. Kids TLC is a place of public accommodation and a recipient of federal funding.
10. Kids TLC is a “psychiatric residential treatment facility” as defined under Kan. Stat. Ann. § 39-2002(m). As such, Kids TLC is regulated by the secretary of the Kansas Department for Aging and Disability Services (“KDADS”). Kan. Stat. Ann. § 39-2001 et seq.
11. Erin Dugan (“Dugan”) was, at all relevant times, the President and CEO of the Facility. Her duties include oversight of the Facility’s operations and implementation of policies and practices that ensure residents of the Facility receive trauma-informed, evidence-based care. She is also responsible for ensuring that the Facility remains in compliance with KDADS regulations and that residents’ federal and state rights are not violated by the practices of the Facility and its employees. At all relevant times Dugan was acting within the scope and course of her employment with the Facility.
12. John Laffoon (“Laffoon”) was, at all relevant times, the Chief Clinical Program Officer of the Facility. His responsibilities include the design, oversight, integrity, and effectiveness of all

clinical and therapeutic services within the Facility. He is responsible for ensuring that the Facility's programs and policies provide adequate resident safety, including supervision protocols, safety assessments, risk-reduction strategies, and therapeutic crisis intervention practices. He is also entrusted with the duties of managing clinical staff and ensuring that clinical operations meet reasonable standards of care, comply with all applicable federal and state regulations, and align with the Facility's policies and practices. Additionally, Defendant Laffoon is responsible for ensuring that residents who experience a critical incident are provided prompt and appropriate care. At all relevant times Laffoon was acting within the scope and course of his employment with the Facility.

13. Devin Burgin ("Burgin") was, at all relevant times, the Director of Operations of the Facility. In that role, he was responsible for overseeing the day-to-day operations at the Facility. This includes managing the Facility's employees, ensuring the Facility policies are upheld, maintaining compliance with KDADS regulations, and implementing all reasonable measures to ensure residents' safety and preventing violations of residents' state and federal rights. He is also responsible for overseeing the development of critical incident policies, providing direction to staff during critical incidents, and managing the investigation of critical incidents. At all relevant times Burgin was acting within the scope and course of his employment with the Facility.
14. Lucinda Whitney ("Whitney") was, at all relevant times, an Advanced Practice Registered Nurse ("APRN") at the relevant unit of this Facility. In this role, she was responsible for delivering comprehensive psychiatric and medical care to residents, including conducting psychiatric evaluations, monitoring residents' clinical stability, and developing and managing residents' care plans. The APRN is expected to collaborate closely with therapists, case managers, psychiatrists, and other Facility staff to ensure that each resident's treatment plan is

appropriate, individualized, and responsive to emerging risks or changes in condition. The APRN must perform ongoing assessments, document clinical findings, and intervene promptly when residents exhibit signs of deterioration, heightened vulnerability, or behavioral instability. The APRN is also responsible for ensuring that care is delivered in accordance with accepted professional standards, state scope-of-practice requirements, facility policies, and all applicable federal and state regulations. Additionally, the APRN is entrusted with participating in critical-incident reviews, providing follow-up care to affected residents, and contributing clinical judgment to decisions related to supervision, safety planning, and risk management. At all relevant times Whitney was acting within the scope and course of her employment with the Facility.

II. JURISDICTION AND VENUE

15. This Court maintains general original jurisdiction over this matter pursuant to K.S.A. § 20-301 and Article 3 § 6 of the Kansas Constitution.
16. This Court maintains proper subject matter jurisdiction over this action because the events giving rise to Plaintiff's injuries occurred in Kansas and because Plaintiff resides in Kansas.
17. The Court maintains both general and specific personal jurisdiction over Defendant, pursuant to K.S.A. § 60-308(b)(1), because Plaintiff's causes of action arise from Defendant's transacting of business in the State of Kansas (subsection A), because Defendant committed tortious acts in the State of Kansas as described in this Petition (subsection B), because Defendant uses, owns, or possesses real estate in the State of Kansas (subsection C), because Defendant entered into a contract with a Kansas resident to be performed in Kansas (subsection E), because Defendant caused injury to Plaintiff here (subsection G) and because Defendant is a citizen, resident and/or domiciled in Kansas.

18. The exercise of personal jurisdiction over Defendant in Johnson County, Kansas is constitutional and comports with due process and all traditional notions of fair play and substantial justice in that Defendant: (1) engaged in business in Kansas; (2) availed itself of the benefits of Kansas law; and (3) injured Plaintiff, in whole or in part, in Kansas.
19. Upon information and belief, proper venue rests in this Court pursuant to K.S.A. §§ 60-603(1)-(4) and additional ways to be determined.

III. ALLEGATIONS COMMON TO ALL COUNTS

20. Jane Doe was at all relevant times a fifteen-year-old minor child.
21. Jane was admitted to the Facility in March 2022, because she was unable to safely reside in her family home with her parents and younger siblings as she required a high level of supervision and clinical care to manage her multiple conditions including Posttraumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Attention-Deficit/Hyperactivity Disorder, and suspected Borderline Personality Disorder.
22. Due to her disabilities, Jane faces a combination of emotional, cognitive, and interpersonal vulnerabilities that significantly increases her susceptibility to sexual victimization. Her conditions impair judgment, heighten fear responses, reduce ability to identify unsafe situations, and hinder her capacity to assert boundaries or seek help promptly. Jane's trauma-related symptoms also often lead to dissociation or compliance in the face of perceived threats, while her mood and attention-regulation impairments make it difficult for her to accurately interpret others' intentions or exit escalating situations.
23. These vulnerabilities create an elevated risk profile that warrants heightened supervision, structured support, and vigilant safety protocols to provide Jane with reasonable protection from sexual assault or exploitation.

24. The Facility was additionally on notice that Jane was vulnerable to sexual assault or exploitation based on an incident that occurred on or about April 16, 2022. Jane was found exposing her chest to another resident who was in a room across the hall. Because of this, Jane was placed in the Facility's "saferoom." This unsafe behavior that Jane exhibited should have placed the Facility and its staff on heightened alert that she was at an increased risk of sexual exploitation and assault.
25. The explicit purpose of the Facility's saferoom, according to its own policies, is to provide a greater level of supervision for a resident when there is an immediate threat to the resident's individual safety. According to the Facility's own policies, a resident is never to be left alone in the saferoom but is to be supervised by staff at all times while in the saferoom.
26. On the evening of April 16, 2022, Jane was raped by a male resident, because the Facility failed to provide her with a reasonable and appropriate level of supervision, especially in light of her increased vulnerability and clear need for heightened supervision.
27. On April 16, 2022, at approximately 8:00 p.m., a staff member unlocked the bathroom door for a teenage male resident ("Male Resident 1"). Male Resident 1 went inside the bathroom. Shortly after that, the staff member unlocked Jane's bathroom door which was next to Male Resident 1's bathroom door. Jane went into her bathroom, and then the staff member walked away. No other staff member came to supervise Male Resident 1 and Jane despite the fact that they were in an isolated location of the residential unit at the end of the hall near the saferoom.
28. After the staff member walked away, Male Resident 1 left his bathroom and entered Jane's bathroom at 8:15 p.m. He then exited Jane's bathroom at 8:23 p.m. This was captured on the Facility's surveillance camera footage.
29. When Male Resident 1 entered Jane's bathroom, he shoved her further into the bathroom, took his pants off, and forcibly put his penis in her mouth. He then forcibly penetrated her

vagina with his penis.

30. According to the Facility's own protocols and KDADS regulations, the lack of supervision that caused this horrific event should never have occurred. Staff are to maintain sight or sound observation of residents at all times. Additionally, the regulations specify that if a resident is in the restroom being supervised by sound only, then safety shall be verified verbally or by sight every five minutes.
31. The Facility failed to maintain an appropriate level of supervision of Jane and Male Resident 1 when the staff member walked away sometime before 8:15 p.m. while Jane and Male Resident 1 were left completely alone until sometime after 8:23 p.m.
32. The location where Jane and Male Resident 1 were left unattended is a particularly isolated location as the two bathrooms they were in were located at the end of a small hallway in a corner that is away from the main halls. This location is not within sight or sound of other areas in the Facility. Because of this, when the staff member walked away, the staff member knew that Jane and Male Resident 1 were being left completely unsupervised.
33. Male Resident 1 has a criminal history including at least six battery charges from at least six different incidents.
34. The Facility's failure to supervise Jane and Male Resident 1, despite knowing Jane's heightened vulnerability and her recent safety incident, as well as Male Resident 1's extensive history of criminal battery charges, was inexcusable and demonstrated the Facility's utter disregard for Jane's safety.
35. The next day, on April 17, 2022, at 3:30 p.m., Jane reported to the Facility that she had been raped in the bathroom the night before by Male Resident 1.
36. The Facility was disorganized and apathetic in its response to this critical incident.
37. The Facility did not contact the police immediately but waited over an hour until 4:45 p.m.

38. Burgin explicitly instructed Facility staff not to contact Jane's parents, Mr. and Ms. Doe.
39. Because Facility staff failed to contact Jane's parents to inform them that Jane had been raped, Mr. and Ms. Doe, did not find out about this critical incident until 6:00 p.m. when the Olathe Police Department contacted Ms. Doe to obtain her consent for Jane to undergo a forensic examination at Children's Mercy Hospital.
40. Learning that their daughter had been raped while under the care of the Facility, which was charged with ensuring her safety, was deeply distressing in and of itself for Mr. and Ms. Doe. However, the fact that they learned of this incident through a third party, hours after the report was made, greatly compounded the parents' distress.
41. The Facility failed to follow the KDADS regulations which require any incident of suspected sexual assault of a resident to be reported to the parent or legal guardian of the resident.
42. The Facility also compounded the distress that Jane experienced as a result of this traumatic incident when it assigned a male staff member to take her to the hospital and sit with her not only in the waiting room but also in the hospital room.
43. Mr. and Ms. Doe spoke with Burgin on April 18, 2022, two days after her daughter was raped. She asked to be immediately sent a copy of the safety plan that would be put in place for Jane. Defendant Burgin informed her that a safety plan had not yet been developed, and he also told her that it probably would not be done until the end of the week. This extremely callused response to an urgent safety concern was appalling and distressing to Ms. Doe especially because Jane was under the direct care of the Facility and Ms. Doe was unable to independently ensure her daughter's safety.
44. Mr. and Ms. Doe also spoke with Dugan after the incident. Dugan informed Ms. Doe that there was "no excuse" for what happened to Jane. She also stated that the Facility does not have a protocol for alleged rape. She stated that the Facility was inexperienced in this area

and that when Jane reported what happened that “it was chaos, and no one knew what to do.”

45. As Mr. and Ms. Doe continued to ask Dugan more questions about the incident, Dugan quickly became defensive and retaliatory toward Ms. Doe who was just trying to understand what had happened to her daughter. She told Ms. Doe that she was asking too many questions and stated: “I am going to handle you very differently if you’re going after us as an agency.” She even told Ms. Doe that information would be withheld from her if she did not “play nice.”
46. Mr. and Ms. Doe continued to speak with other Facility staff and many of them told her the same thing: that the Facility was not prepared to deal with the situation that happened with Jane and that the Facility had failed in its responsibilities to Jane.
47. The Facility did eventually put a safety plan in place for Jane, but it immediately proved to be ineffective. Jane encountered Male Resident 1 at the Facility despite the fact that they were supposed to be kept completely separate. This visual encounter re-traumatized Jane and caused her to suffer severe emotional distress.
48. Nearly a month later, on May 10, 2022, Laffoon informed Ms. Doe that the Facility had completed its “investigation.” He then informed her of some convenient and new findings from this investigation. He told her that Jane told a Facility nurse on April 20, 2022, that she had actually had consensual sex with Male Resident 1 on April 16, 2022, and that later that night, Male Resident 1 told her that he regretted it. Jane was upset by this and so she reported a rape the next day.
49. This account is inconsistent, because the incident on April 16, 2022, occurred between 8:15 p.m. and 8:23 p.m., and based on the Facility’s protocols, all residents are required to be in their rooms by 8:30 p.m., so there would have been no opportunity for this alleged conversation to have taken place later that night. Additionally, there is no camera footage of the Jane and Male Resident 1 interacting to corroborate this account.

50. Additionally, the nurse's note referenced by Laffoon was dated April 23, 2022, three days after Jane allegedly gave this account to the nurse. Laffoon stated that he directed the nurse to make this note.
51. The KDADS regulations require that clinical records "must be created at the time the service is provided."
52. Unfortunately, the Facility's failures to Jane and her family did not stop at a single isolated incident.
53. Prior to and following April 2022, multiple licensed psychiatric medical providers employed by the Facility raised repeated concerns to executive leadership regarding unsafe supervision practices, including residents being left unsupervised in bathrooms, hallways, and other isolated areas where sexual contact between residents had previously occurred.
54. These medical providers reported that sexual contact between residents, including sexual activity occurring in Facility bathrooms during shift changes, was a known and recurring problem, and that Facility leadership failed to implement or enforce policies designed to prevent such conduct, instead dismissing these incidents as normal adolescent behavior.
55. Medical providers further reported that Facility leadership routinely refused to authorize medically indicated safety measures, including one-to-one supervision, even when such measures were ordered to protect residents with known vulnerabilities or elevated risk of sexual exploitation.
56. Facility leadership also discouraged staff from documenting safety concerns in writing, instructed employees not to create discoverable records, and directed staff to minimize or omit references to serious incidents in clinical documentation.

57. When medical providers escalated concerns regarding patient safety, supervision failures, and regulatory noncompliance, Facility leadership responded with intimidation, retaliation, and efforts to suppress or discredit those concerns rather than implementing corrective action.
58. These systemic failures and practices were known to, condoned by, or carried out under the direction of senior Facility administrators, including those responsible for clinical oversight, operations, and regulatory compliance.
59. The conditions described above mirror the precise circumstances under which Jane Doe was sexually assaulted, including being left unsupervised in bathrooms adjacent to male residents, the absence of sight-and-sound supervision, and the failure to implement or enforce effective safety planning despite Jane's known vulnerabilities.
60. The Facility's failure to correct these known and ongoing safety deficiencies rendered Jane's sexual assault foreseeable and preventable and demonstrates that the harm she suffered was not the result of an isolated lapse, but rather the predictable consequence of the Facility's longstanding practices and deliberate indifference to resident safety.
61. On August 20, 2022, just a few months after Jane was raped while under the Facility's care, the Facility again failed to supervise Jane resulting her in her being the victim of another sexual assault.
62. On August 20, 2022, a resident reported that another male resident ("Male Resident 2") was rubbing Jane between the legs during a Facility movie night activity.
63. One component of Jane's safety plan from the rape that occurred a few months earlier was that a medical order had been written for a six-foot ban from peers. The fact that a male resident was permitted to be close enough to Jane to touch her in this way shows that the safety plan was not being followed by the Facility.
64. Based on information and belief, the Facility failed to file a timely report with the Department

of Children and Families as required by the KDADS regulations, as the report was not filed until August 23, 2022

65. When Ms. Doe spoke to Facility staff about this second incident, she asked if the camera footage had been reviewed, and staff responded that it had not because footage was only reviewed if something “super intense” happened. According to this Facility employee, a reported sexual assault was not “intense” enough to warrant even a cursory investigation.
66. After this incident with Male Resident 2, the Facility failed to amend Jane’s safety plan or put in place any measures to keep her separated from Male Resident 2.
67. The next day, on August 22, 2022, Ms. Doe received a call from the Facility at 3:30 a.m. notifying her that Jane had again been taken to Children’s Mercy Hospital. When Ms. Doe asked why she was being taken to the hospital, the staff member responded that she did not know. This was highly distressing to Ms. Doe who had no idea what had happened to her daughter and why she would need to be hospitalized.
68. Eventually, the staff member was able to inform Ms. Doe that there had been an incident in a Facility bathroom with Jane and Male Resident 2.
69. At approximately 1:00 a.m., a staff member had let Jane into the bathroom and then walked away to go on break. Immediately after that another staff member let Male Resident 2 into the adjacent bathroom and also walked away.
70. After the incident, Jane was found huddled in the corner of the bathroom “acting strangely.”
71. Jane was taken to Children’s Mercy Hospital where she screened positive for suicide risk. She was transferred to Marillac Psychiatric Hospital.
72. Mr. and Ms. Doe did not receive any further information or updates from the Facility until twelve hours later when they received an email from Whitney at 3:30 p.m. requesting a phone call to discuss the incident. On the phone, Whitney immediately placed the blame on Jane,

stating that “[Jane] did it again.” She called Jane a “predator” and opined that Jane had “set it up.”

73. Prior to the events giving rise to Plaintiff’s claims, Defendant Kids TLC, Inc. had notice of serious supervision failures involving foster children placed under its care, including incidents in which minor children were left unsupervised in bathrooms and other isolated areas.

74. In one such incident occurring on or about January 25, 2021, two minor foster children placed through Kids TLC were left alone in a bathroom for an extended period of time while under the supervision of Kids TLC-licensed foster parents. During this period of unsupervised access, sexual contact occurred between the minors, resulting in severe and permanent injury to one of the children.

75. At the time of that incident, Kids TLC and its agents were aware of behavioral warnings and supervision concerns involving the minors and had previously instructed that the children were to remain separated.

76. A Kansas district court subsequently entered judgment arising from that incident. This court found that the foster parents licensed and supervised by Kids TLC failed to exercise reasonable care in supervising the children placed in their custody.

77. As a result of this prior incident, Kids TLC was on notice that inadequate supervision of minors, particularly in bathrooms and other isolated locations, posed a foreseeable risk of sexual harm to children placed under its care, yet failed to implement or enforce sufficient corrective supervision measures.

IV. CLAIMS FOR RELIEF

COUNT I: NEGLIGENT CARE AND SUPERVISION/NEGLIGENCE PER SE

78. Plaintiffs allege all other paragraphs as if fully stated herein.

79. The Facility owed a duty of care to Jane. The Facility was at all relevant times standing *in loco parentis* for Mr. and Ms. Doe, and as such, the Facility was responsible for ensuring Jane's health, safety and welfare. This duty includes providing services necessary to maintain her physical safety and mental health and to reasonably prevent foreseeable harm.
80. The Facility breached this duty when it failed to supervise Jane by leaving her unattended in an isolated hallway in a bathroom adjacent to an older male resident who had an extensive criminal history of battery charges.
81. According to the KDADS regulations and the Facility's own policies, Facility staff are to be within sight or sound supervision of residents at all times. Additionally, the regulations specify that if a resident is in the restroom being supervised by sound only, then safety shall be verified verbally or by sight every five minutes.
82. The Facility failed to provide any form of supervision when staff members walked away after letting Jane and Male Resident 1 into their adjacent bathrooms.
83. The Facility knew that Jane was a highly vulnerable resident based on her multiple diagnoses and her recent safety issue which caused her to be placed in the saferoom.
84. The express purpose of the saferoom is to provide residents with a heightened level of supervision. According to the Facility's own policies and protocols, residents who are assigned to the saferoom require a higher level of supervision and are not to be left alone.
85. The Facility further failed in its duties to Jane when it failed to provide her with appropriate psychological and medical treatment after she was raped and sent to her to the hospital with a male staff member. This greatly exacerbated Jane's emotional injuries.
86. The Facility failed to have policies in place that would have prevented Jane from multiple instances of rape and sexual assault. The Facility, by its own admission, had no policies or

procedures in place for responding to and investigating reports of rape or sexual assault among residents.

87. The Facility further failed in its duties to Jane when it failed to implement an effective safety plan.
88. The Facility's failure to implement an effective safety plan caused her to be retraumatized by her attacker just days after she was forcibly raped by him.
89. The Facility's failure to implement an effective safety plan caused Jane to be sexually assaulted and raped again just months later by another perpetrator after she was again left unsupervised.
90. As a result of the Facility's actions and inactions, Jane suffered damages.

WHEREFORE, Plaintiff respectfully requests that the Court grant judgment in her favor and against Defendant, for damages in excess of \$75,000, for post judgment interest at the statutory rate, for taxable court costs, and for such further relief the Court finds fair and reasonable under the circumstances.

COUNT II: NEGLIGENT HIRING/SUPERVISION/TRAINING/RETENTION AS TO THE FACILITY

91. Plaintiff alleges all other paragraphs as if fully stated herein.
92. The Facility knew or should have known that the employees who mishandled these multiple instances of rape and sexual assault (including but not limited to Dugan, Burgin, Laffoon, and Whitney) were incompetent or unfit for their positions.
93. The Facility's handling of Jane Doe's reports of sexual assault was consistent with its broader institutional pattern of minimizing serious safety incidents, discouraging reporting, manipulating clinical documentation, and retaliating against those who raised concerns, including licensed medical professionals charged with safeguarding resident welfare.
94. The Facility failed to provide adequate oversight and review of its employees in the performance of their job duties.

95. The Facility failed to control its employees with propensities that foreseeably posed risk of harm to residents.

96. The Facility's failure to provide oversight and control of its employees allowed them to take actions which directly caused harm to Jane. These actions include but are not limited to the following:

- a. When Dugan threatened to withhold information from Mr. and Ms. Doe, indicating her intent to cover up the incident;
- b. When Burgin explicitly instructed other employees to not contact Mr. and Ms. Doe about the reported rape indicating his intent to cover up the incident and prevent Jane from getting the help she needed;
- c. When Laffoon directed a Facility nurse to improperly record a clinical note days later, raising serious concerns with the integrity and truthfulness of this clinical note; and,
- d. When Whitney placed the blame of multiple rapes on Jane, the victim, indicating her intent to retaliate against Jane and dismiss her claims which were supported by evidence.

97. The Facility failed to provide adequate training for its employees, evidenced by the employees' disorganized response to multiple critical incidents, Mr. and Ms. Doe's difficulty in obtaining clear information about multiple critical incidents involving their daughter, and the employees' failure to develop or implement an adequate safety plan to protect Jane.

98. As a result of the Facility's actions and inactions, Jane suffered damages.

WHEREFORE, Plaintiff respectfully requests that the Court grant judgment in her favor and against Defendant, for damages in excess of \$75,000, for pre and post judgment interest at the

statutory rate, for taxable court costs, and for such further relief the Court finds fair and reasonable under the circumstances.

COUNT III: NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS AS TO THE FACILITY

99. Plaintiff alleges all other paragraphs as if fully stated herein.

100. The Defendant acted willfully, wantonly, and with reckless disregard to Jane's well-being when it attempted to cover up and dismiss Jane's multiple reports of sexual assault and rape at the Facility by failing to notify Mr. and Ms. Doe, directing after-the-fact clinical notes to discredit Jane's reports, placing the blame on Jane, failing to report the incident to the appropriate agencies, and failing to implement an effective safety plan for Jane.

101. The coordination among multiple Facility employees and administrators as well as the fact that they only attempted to discredit Jane's report after Mr. and Ms. Doe began investigating the Facility's inadequate response demonstrates that the Facility and its employees were not only negligent, but that they acted in a willful and calculated manner to avoid their own liability with reckless indifference to Jane's well-being.

102. These reckless and intentional acts by the Defendant caused Jane to suffer severe emotional harm to the point that she screened positive for suicide risk after the she was raped a second time under the Facility's care.

103. As a result of the Facility's actions and inactions, Jane suffered damages.

WHEREFORE, Plaintiff respectfully requests that the Court grant judgment in their favor and against Defendant, for damages in excess of \$75,000, for pre and post judgment interest at the statutory rate, for taxable court costs, and for such further relief the Court finds fair and reasonable under the circumstances.

COUNT IV: DISABILITY DISCRIMINATION AS TO THE FACILITY

104. Plaintiff alleges all other paragraphs as if fully stated herein.

105. Title III of the ADA applies to the Facility because the Facility is a place of public accommodation pursuant to 42 U.S.C. § 12181(7)(F).

106. Title III of the ADA prohibits places of public accommodation from discriminating against individuals with disabilities. This prohibited discrimination includes treating disabled individuals differently than other individuals and failing to make reasonable modifications of policies, practices, and procedures to allow disabled individuals to have equal access to the entity's programs and services. 42 U.S.C. § 12182 (2)(A).

107. Section 504 of the Rehabilitation Act prohibits programs or activities that receive federal funding from discriminating against disabled individuals. 29 U.S.C. § 794(a).

108. The Facility receives federal funding.

109. The Facility discriminated against Jane because of her disabilities when it failed to provide her the same services and benefits as non-disabled students. The Facility failed to keep her safe from dangerous situations and perpetrators even though it was aware that her disabilities caused her to be highly susceptible to sexual abuse and rape. On the other hand, the Facility does implement safety measures to protect non-disabled students from foreseeable physical harm.

110. The Facility discriminated against Jane when it failed to follow its own policies for supervision because of her disabilities. Other residents who were placed in the saferoom were provided constant supervision.

111. The Facility failed to make reasonable modifications to its policies, practices, and procedures when it failed to implement an effective safety plan for Jane, which caused her to be re-traumatized and suffer multiple instances of rape and sexual assault at the Facility.

112. The Facility discriminated against Jane when it allowed its employee, Whitney, to blame the repeated instances of rape on Jane due to her multiple disabilities.

113. The Facility failed to provide the same degree of care to Jane as it did for non-disabled students when it failed to provide her with adequate protection because of the nature of her specific disabilities.

114. The Facility failed to provide the same degree of care to Jane as it did for non-disabled students when it failed to provide her with timely medical and psychological treatment and failed to notify Mr. and Ms. Doe timely or accurately of the rape that occurred. If a non-disabled student had been physically injured in an accident at the Facility, the non-disabled student would have been provided medical treatment, and the parents would have been contacted immediately.

115. As a result of the Facility's actions and inactions, Jane suffered damages.

WHEREFORE, Plaintiff respectfully requests that the Court grant judgment in her favor and against Defendant, for damages in excess of \$75,000, for pre and post judgment interest at the statutory rate, for taxable court costs, and for such further relief the Court finds fair and reasonable under the circumstances.

JURY TRIAL REQUESTED

Plaintiff hereby requests a trial by jury on all claims in this matter.

Pursuant to Local Rule 3.7, the undersigned hereby certifies that no portion of this Petition for Damages was drafted/prepared using Generative A.I.

Dated: March 5, 2026.

Respectfully submitted,

/s/ Kara Trouslot Stubbs

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