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MARC GOLICK and MAKENA GOLICK

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF NAPA

MARC GOLICK and MAKENA GOLICK by and through her guardian ad litem MARC GOLICK,

Plaintiffs,

v.

STATE OF CALIFORNIA, DEPARTMENT OF VETERANS AFFAIRS; NAPA COUNTY SHERIFF DEPARTMENT, COUNTY OF NAPA, STEVE LOMBARDI and DOES 1 through 50,

Defendants.

Case No: 19CV000350

FIRST AMENDED COMPLAINT FOR DAMAGES FOR WRONGFUL DEATH

JURY TRIAL DEMANDED

Plaintiffs Marc Golick and Marc Golick as the Guardian ad Litem for Makena Golick allege as follows:

PARTIES

1. Plaintiff Marc Golick is the surviving spouse of decedent Dr. Jennifer Golick. Marc and Jennifer Golick were married for 20 years. Marc is the father of Makena Golick, a minor, age 9, born on November 22, 2009. Makena is the daughter of Marc and Jennifer. Marc is the personal representative of the Estate of Jennifer Golick. Marc brings this action for himself and as Guardian ad Litem for Makena, in accord with the February 14, 2019 order of this Court.

2. Marc and Makena are suing for the wrongful death of their wife and mother, shot to death by Albert Cheung Wong ("Wong") on Friday, March 9, 2018 at The Pathway Home located at Madison Hall, Building G on the Veterans Home Campus of California, 100 California Drive, Yountville, California. The Veterans Home of California ("VHC"), is owned and operated by Defendant State of California by and through the California Department of Veterans Affairs.

3. Dr. Jennifer Golick was 42 at the time of her death. Dr. Golick was employed as the clinical director at Pathway Home for seven months prior to her death. Dr. Golick was licensed by the State of California since 2007 as a Marriage and Family Therapist.

4. Defendant State of California by and through the California Department of Veterans Affairs ("CalVet"), wrongfully sued as "STATE OF CALIFORNIA, DEPARTMENT OF VETERANS AFFAIRS," is, and at all times mentioned herein, was, a sovereign state of the United States of America and was the owner of CalVet property in Yountville. At all relevant times, Defendant CalVet was a public entity that owned, operated, managed, controlled, and supervised the Yountville campus, and all buildings, installations, roadways, grounds and premises associated with that property.

5. Defendant State of California by and through the California Department of Veterans Affairs is vicariously liable for the wrongful death of Dr. Golick by and through the acts and omissions of its employees and agents, DOES 1 through 24, in the course and scope of their employment pursuant to California Government Code section 815.2(a).

6. Defendant Napa County Sheriff Department organized in 1853 is, and was at all times herein, mentioned a public entity. Napa County was duly organized and formed in 1849 and was one of the original counties in the State of California.

7. Defendant Steve Lombardi was and all times mentioned a deputy sheriff employed by the Napa County Sheriff Department. Defendant Napa County Sheriff Department is vicariously liable for the wrongful death of Dr. Golick by and through the acts and omissions of its employees and agents in the course and scope of their employment, including the above-mentioned individual defendants, pursuant to California Government Code section 815.2(a).

8. Plaintiffs do not presently know the true names and capacities of the defendants sued herein under the fictitious names DOES 1-50, inclusive, and will seek to amend this complaint to allege their true names and capacities when ascertained. DOES 1-24 are employees and/or agents of defendant State of California; DOES 25-50 are employees and/or agents of defendant Napa County/Napa County Sheriff Department. Plaintiffs are informed and believe and thereon allege that each of these fictitiously named defendants is legally responsible for the events described herein and for plaintiffs' injuries and damages.

9. Plaintiffs are informed and believe that, at all times relevant herein, each of the defendants was acting as the agent, employee, alter ego or joint venture of the other, and was at all times or is otherwise vicariously liable to plaintiffs.

JURISDICTION AND VENUE

10. Venue in this action is proper in the County of Napa based upon the fact that the wrongful death of Jennifer Golick and injuries suffered by plaintiffs herein occurred within Napa County.

GOVERNMENT CLAIMS

11. On September 7, 2018, plaintiffs presented a written claim for damages to defendant State of California, Department of General Services by delivering a claim to the clerk for the injuries, disability, losses, and damages suffered and incurred by plaintiffs, all in compliance with the requirements of Government Code Section 905.

12. On or about September 12, 2018 and October 5, 2018, the State of California, Department of General Services ***twice*** rejected the claim in its entirety.

13. On September 7, 2018, plaintiffs presented to the County of Napa a written claim for damages by delivering a claim to the clerk for the injuries, disability, losses, and damages suffered and incurred by plaintiffs by, all in compliance with the requirements of Government Code Section 905.

14. On or about October 22, 2018, plaintiffs' claim against County of Napa was rejected by operation of law.

15. On January 18, 2019, plaintiffs presented an Application for Leave to Present Late Claim and a written amended claim for damages to defendant State of California, Department of General Services, all in compliance with the requirements of Government Code Section 905.

16. On February 7, 2019, the State of California, Department of General Services rejected the amended claim.

17. On January 18, 2019, plaintiffs presented to the County of Napa an Application for Leave to Present Late Claim and a written amended claim for damages by delivering a claim to the clerk for the injuries, disability, losses, and damages suffered and incurred by plaintiffs by, all in compliance with the requirements of Government Code Section 905.

18. On January 29, 2019, the County of Napa granted plaintiff's Application for Leave to Present a Late Claim and rejected plaintiff's amended claim.

19. On February 13, 2019, Plaintiff filed a Petition in this court for relief from the claim requirements as to the State Of California, Department Of Veterans Affairs.

20. In February 2019, the State Of California, Department Of Veterans Affairs through their attorneys stipulated to the relief sought in the petition.

GENERAL ALLEGATIONS

CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS

21. Defendant State of California by and through the California Department of Veterans Affairs owns, controls and maintains the CalVet home in Yountville, called the Veterans Home of California – Yountville ("VHC"). Founded in 1884, VHC is approximately 615 acres and is the largest veteran's home in the United States, offering residential accommodations with a wealth of recreational, social and therapeutic activities for independent living. Some 1,200 aged or disabled veterans of World War II, Korean War, Vietnam War, Desert Storm, and Operation Enduring Freedom/Operations Iraqi Freedom reside on the Yountville campus. VHC also houses the alternate seat of government for the governor's office and, is therefore, familiar with the need for increased security measures. The Yountville campus

has fourteen (14) residential buildings with a social worker and residential care unit leader provided by CalVet.

22. At all relevant times to this complaint, CalVet's agents and/or employees were acting within the course and scope of their employment or agency with the State of California, CalVet, and the wrongful acts described herein flow from the very exercise of their authority.

23. In or around 2004, CalVet, by and through CalVet administrators Bart Buechner and Marcella McCormack, created a program to help Iraq war veterans recover from severe injuries and post-traumatic stress disorder. This program became known as The Pathway Home program and was designed to treat veterans. In or around 2007, McCormack and Buechner said they hoped to launch the Pathway program in the summer of 2007. McCormack and Buechner said the program would be geared toward war-traumatized soldiers who have already received some medical treatment at military and VA hospitals. The goal was to provide the veterans with extra physical and mental therapy to transition back to civilian life. McCormack said The Pathway Home program would be staffed by "treatment teams" that consist of PTSD counselors, marriage and family therapists, nurses, doctors, dietitians and physical therapists. CalVet had Building G, the residential building to house the new veteran patients christened the Pathway Home, refurbished and renovated for its new purpose by the 578th and 579 engineering battalions of the Army National Guard. At some point prior to December 2007, CalVet entered into a cooperative agreement in which The Pathway Home would provide mental health services for veterans. Up to 40 veterans who suffered from PTSD and other symptoms and disorders were to reside at Pathway for treatment from 30 to 120 days and then return to their communities. A private grant of $5.6 million from the Tides Center was used to start the Pathway Home program at Madison Hall.

24. To effectuate CalVet's mission to treat Iraq war veterans with PTSD through the Pathway Home program it started, CalVet entered into a lease with The Pathway Home on or about January 1, 2008. The 2008 Lease was for Building G (13,693 square feet of building space) for the purpose of providing "a three year pilot program of mental health care treatment

for returning veterans of military conflicts in Iraq and Afghanistan. The program is designed to accommodate approximately 30-40 veterans at any one time." In exchange for the Pathway Home providing these mental health services for CalVet, CalVet waived the fair market rent of $7,942.00 per month. If, for any reason, the Pathway Home failed to operate this program, that failure would be a breach of the lease, requiring the Pathway Home to pay the fair market rent. Under the 2008 Lease, CalVet was required to maintain structural components of the premises and "maintain exterior locks to the Premises." Pathway could not make door lock changes without first obtaining CalVet's approval in writing. The lease also provided that Cal Vet could make temporary emergency repairs, which are Pathway's responsibility and charge back Pathway for these repairs. Pathway could not make repairs, changes, alterations or improvements to Building G until CalVet approved of them in writing. CalVet "shall, through the Veterans Home of California, Yountville Administrator, have the full power and right to determine and regulate the operations of the LESSEE [Pathway] insofar as they affect the operation, safety of consumers and the effective use of STATE-owned facilities at The Veterans Home of California, Yountville." Moreover, under the lease, "STATE shall provide security for any joint-use areas in, on, or about the Premises." Marcella McCormack signed this Lease on behalf of CalVet on December 28, 2007.

25. Concurrent with the Lease, CalVet and Pathway entered into an Operating Agreement on or about January 1, 2008. Pursuant to the Operating Agreement, CalVet retained the full power and right to determine and regulate the operations of the Pathway program insofar as they affect the operation, safety of consumers and effective use of the Yountville campus.

The Operating Agreement set forth the Scope of Work as follows:

- "**Summary of Services:** The multi-component program will accommodate up to 30 to 40 veterans on an ongoing basis with program stays ranging from 30 to 90 days. Participants in the program will receive case managed individual and group treatment. Education and program activities will occur over the course of the day and evening that will address a broad range of transition issues and target specific

areas of dysfunction. Participants will benefit from the Home's extensive experience with veteran's issues and its social environment enhanced by intergenerational veteran camaraderie. Participants will have full access to the VHC-Y's existing facilities and services on the 500-acre campus.

- **DETAILS OF PROGRAM OPERATION: Program Participant Profile:** Participants shall be OIF [Operation Iraqi Freedom] or OEF [Operation Enduring Freedom] veterans who present with psychological injuries sustained in the way, resulting in difficulties transitioning to family, work or community life, that can be ameliorated through therapy and rehabilitation. In addition, Participants shall present with DSM-IV diagnostic criteria for post-traumatic stress disorder." The Operating Agreement detailed the program's treatment and activities. It also stated that Cal Vet was responsible for the following: program participants' meals at any food service provider on the VHC-Y campus; program participants to VHC-Y recreational facilities; monitoring the Program's quality assurance measures; landscaping, maintenance and utilities for leased areas; providing security for the greater VHC-Y facility and any joint-use area; preparation and maintenance of all Program leases and Operating Agreement documents and billing the United States Department of Veterans Affairs for per-diem reimbursements. Plaintiffs are informed and believe and thereupon allege that CalVet and Pathway entered into substantially similar Leases and Operating Agreements in 2011 (one year), 2012 (one year), 2013 through December 2017 (5 years) and 2018 through December 2022 (5 years).

26. The 2018 Lease was for Building G (13,693 square feet of building space) for the purpose of mental health care treatment for returning veterans of military conflicts in Iraq and Afghanistan. The program was designed to accommodate approximately 20-34 veterans at any one time. In exchange for the Pathway Home providing these mental health services for CalVet, CalVet waived the fair market rent of $14,144 per month. If, for any reason, the Pathway Home

failed to operate this program, that failure would be a breach of the lease, requiring the Pathway Home to pay the fair market rent. Under the 2018 Lease, CalVet was required to maintain structural components of the premises and "maintain exterior locks to the Premises." Pathway could not make door lock changes without first obtaining CalVet's approval in writing. The lease also provided that CalVet could make temporary emergency repairs, which are Pathway's responsibility, and charge back Pathway for these repairs. Pathway could not make repairs, changes, alterations or improvements to Building G until CalVet approved of them in writing. CalVet "shall, through the Veterans Home of California, Yountville Administrator, have the full power and right to determine and regulate the operations of the LESSEE [Pathway] insofar as they affect the operation, safety of consumers and the effective use of STATE-owned facilities at The Veterans Home of California, Yountville." Moreover, under the lease, "STATE shall provide security for any joint-use areas in, on, or about the Premises."

27. The leases and operating agreements between CalVet and Pathway was primarily intended to offer a direct mental health treatment services to veterans, which had not been offered prior to the formation of the Pathway Home program. The introduction of this program changed the profile of on-campus veterans to include veterans suffering from PTSD, Traumatic Brain Injury and other mental health symptoms. The in-kind rent for the Madison Building was in exchange for the mental health treatment services provided to eligible veterans by Pathway. Therefore, the purpose of the leases and operating agreements was to provide a direct service of mental health treatment for CalVet rather than a potential revenue generator for CalVet. This lease's primary purpose was to assist CalVet to meet its "mission-critical objectives of providing housing and care to eligible veterans. These agreements have less regard to revenue generation and community partnership than the pre-eminent goal of meeting the needs of California veterans." CalVet assessed its lease with Pathway by determining if (1) Pathway was delivering the direct services that are provided for in the agreement, (2) the agreement could be improved to more effectively provide that service, and (3) the service could be located in a better location on the VHC-Yountville campus.

28. The State of California was in a strategic public-private partner with Pathway, a California non-profit, providing both inpatient and outpatient mental health services to veterans who had recently served in Iraq, Iran and the Middle East, including former patient Wong. According to Pathway's Articles of Incorporation, "This corporation will carry out its purpose principally by providing treatment and social services to veterans, who suffer from post-traumatic stress disorder, traumatic brain injury, and other combat-related injuries." The causal medical link between combat and mental trauma, including anxiety disorders, PTSD and Traumatic Brain Injury is well documented. Veterans who suffer from these disorders are prone to emotional and physical outbursts and an inability to modulate their emotional responses. For this group of veterans, their pre-existing medical conditions can foreseeably result in violence, which too often includes death by gunfire of others, as has been increasingly and alarmingly common. At all relevant times, the State of California, CalVet was aware and had prior notice of the potential for violence, and specifically gun violence, from the population of veterans treated at Pathway for psychological disorders, including PTSD. Defendant State of California, and any and all officers, agents, servants and employees through whom said defendant acted, are collectively referred to herein as "State of California" or "CalVet."

29. Defendant CalVet owned and controlled the Veterans Home of California – Yountville, the largest Veterans Home in the nation. CalVet provided security for the Yountville campus. Pathway participants were entitled to use the entire Yountville campus, including the cafeteria and recreational areas.

30. Pathway entered into a lease agreement for a portion of the subject property with CalVet, specifically Madison Hall, Building G. Because of the partnership between Pathway and CalVet, CalVet leased the subject property to Pathway at no cost, as part of a compensation package from CalVet to Pathway in order to treat combat veterans. The 35,000 square foot building occupied by the Pathway was therefore subsidized by CalVet because Pathway was treating and educating returning veterans. As set forth on the Pathway website: "The SFVAHCS, in conjunction with the State of California campus at Yountville, have come together to support

the Pathway Home in their quest to help student Veterans successfully negotiate the strains of academic life as they transition from military service...With a significant amount of research and planning from a number of VA, UCSF and UCSD faculty and staff, we developed a model that the current TPH (The Pathway Home) staff has successfully implemented." Thus, CalVet partnered with the Pathway to provide these comprehensive services to veterans. Because of this partnership and by the terms of the leases and operating agreements, defendant CalVet had actual knowledge as to the use of the facility, the nature of the program to aid veterans and the general population of veterans treated at Pathway and their particular vulnerabilities, such as suffering from PTSD and other combat related mental and physical disabilities.

31. In or around 2010, the California Highway Patrol performed a vulnerability site assessment on the CalVet campus and found that there was no security at the front gate, few security cameras, inadequate fencing along the campus perimeter, inadequate panic buttons or alarms, and an inadequate staff of unarmed security officers on the grounds. The assessment reported that VHC, with over 1,000 residents, is home to almost half the population of Yountville. The CHP vulnerability assessment report provided these observations and recommendations to CalVet and Defendants DOES 1 through 24, who failed to take reasonable precautions to safeguard decedent and others in the face of actual knowledge of the lack of security, and the frequency of criminal conduct on the Yountville campus.

32. The Tug McGraw Foundation ("Tug McGraw") was established in 2003 to enhance the quality of life for kids and adults diagnosed with debilitating neurological brain conditions such as Traumatic Brain Injury and PTSD. Tug McGraw created a wellness program for residents at the Yountville Veterans Home. Tug McGraw leased the first floor of Madison Hall (Building G) and shared the building with Pathway for a period of time.

33. On or about December 16-17, 2010, Legacy Protection Services conducted a risk assessment at the facilities that housed the Tug McGraw Foundation (TMF) offices in Building G of the Yountville campus. TMF shared Building G with The Pathway Home at the time of the risk assessment. The Legacy Report, attached hereto as **Exhibit 1**, states that The Pathway Home

is "a live-in treatment program for returning war veterans experiencing traumatic stress related issues due to their deployment" and that these issues "include 'Post Traumatic Stress' (PTS) and 'Traumatic Brain Injuries' (TBI). The report states: "Perhaps the most pertinent core principle of threat assessment is the fact that persons with a history of violence are much more likely to act out violently in the future given a stimulus (or trigger). Past behavior is almost always the best predictor for future performance. Without question, our returning war veterans have been asked to perform some extremely violent acts in the furtherance of the war effort…One of the greatest challenges of TPH project is the de-programming of this very instinct that has been so ingrained, trained, and coveted by the military." The Legacy Report summarized: "The unfortunate reality is that TPH program houses and treats a population of individuals that present a disproportionately high risk of violence potential towards themselves and others." Based on its findings, Legacy issued the following recommendations to the TMF (1) relocation to another building that offers controlled access and no patients-in-residence services; (2) building modifications and the deployment of a receptionist to regulate ingress/egress of patients, visitors and TPH staff; (3) alarmed doors; (4) installation of an audible duress alarm that would alert the Napa County Sheriff to any developing emergency; (5) installation of telephone and internet access to monitor security cameras. Legacy also recommended the following physical changes to the premises: (1) electronic surveillance system to be enhanced by adding outside cameras, roof installed, for greater visibility of points of access, including the parking lot, the hallway, the loading bay and rear entrance to the facility, doors to the lower basement level, doors to the courtyard, exterior doors at the end of the residential wings; (2) lighting to be enhanced/installed at all points of entry and parking lot with an additional light placed on the power building; (3) install prying-protection shields on all exterior doors to prevent unauthorized access; (4) all exterior emergency exit doors should be alarmed and programmed to sound when opened; (5) a duress or panic alarm system connected directly to Napa County Sheriff; (6) updated floor plan to be provided to local Sonoma County Sheriff Watch Commander's office for reference in the event of an emergency call for services; (7) access to the boiler room/electrical room should be

secure and the exterior door adjoining the boiler room should remain locked at all times; (8) the nursing station should be modified to serve as a reception desk; (9) new wall/doorway should be constructed to provided further barrier/security to TMF offices; (10) move the monitoring station from the second floor to the first floor lobby area and next to the elevator. Plaintiffs are informed and believe and thereupon allege that this Legacy Report, and/or the substance of the report, was transmitted to CalVet during lease negotiations in or around December 2010. At some point after this risk assessment, in or around 2016/2017, Tug McGraw relocated to the Administration Building on the Yountville Campus and Pathway took over both floors of Madison Hall (Building G).

34. In or around September 2015, Pathway ran out of funding and went on hiatus, shutting down its operations. The Pathway lease remained in effect during this time. On or about November 17, 2016, CalVet hosted an Advisory Community Meeting at Grant Hall on the Yountville Campus. Pathway and Tug McGraw were in attendance at this public forum. Don Veverka, the Administrator of CalVet at the time, headed the forum. The purpose of the forum was to discuss how to keep the Pathway program going, given the recognized issues of the aggressive behavior of the veterans in the program. After this forum, Pathway started up again in or around September 2016.

35. Moreover, one to two years prior to the shooting, Napa County Sherriff Department performed a site assessment of the premises due to the fact that the Pathway program enrolled veterans with PTSD because an active shooting situation at the Yountville campus was foreseeable and the Napa County Sheriff Department needed to prepare for such an eventuality. Indeed, Napa County Sheriff Department deputies responded to calls for service at the Yountville campus about forty (40) times per month. Plaintiffs are informed and believe and thereupon allege that this assessment required that Napa County Sherriff Department be aware of the Pathway program's location and the building that housed the Pathway program in the event of an active shooter. This is significant as Deputy Lombardi, when responding to the incident, could not recall where Building G was located and could not find his map of the Yountville

campus in his patrol car. Plaintiffs are informed and believe and thereupon allege that the assessment was critical of security precautions at VHC, including a lack of adequate security checkpoints, video surveillance cameras and monitors, and personnel. The assessment specifically recommended that CalVet install security features including a security checkpoint, front gate, fencing, working locks, and intercoms. The Napa County Sheriff Department is the primary source of law enforcement for the Yountville campus. For these reasons, CalVet, Napa County Sheriff Department, and their employees and/or agents DOES 1 through 50, failed to take reasonable precautions to safeguard decedent and others in the face of actual knowledge of the lack of security and the frequency of criminal conduct on the Yountville campus.

36. Plaintiffs are informed and believe and thereupon allege that the Safety Officers employed by CalVet lacked adequate training, equipment and authority to address security issues on the VHC campus; and that CalVet had longstanding prior knowledge of these inadequacies, yet failed to take any steps to train the Safety Officers who were better and more specifically trained, equipped, and authorized to respond to the security needs of the veterans and their treating health care providers on the Yountville campus.

THE EVENTS OF FEBRUARY 2018

37. Approximately two weeks prior to the fatal shootings, on or about February 13, 2018, Wong, a 36-years-old Army combat veteran and former Pathway Home patient who had been treated at Pathway for psychological conditions following his military service in Afghanistan, was discharged from the Pathway program and cleared out his room. Wong was discharged at this meeting for making death threats to Pathway employees and bringing weapons onto the Yountville campus. Wong had specifically threatened to harm members of the clinical staff by coming onto the premises and shooting them with a gun.

38. Wong was officially discharged from The Pathway Home on or about February 20, 2018 and had expressed extreme anger and frustration toward the clinical staff. Plaintiffs are informed and believe and thereon allege that both the State of California, CalVet and Napa County Sheriff Department had actual knowledge of Wong's threats and that Wong had brought

weapons onto the Yountville campus and did not take any action to restrict Wong's access to either the Yountville campus or Building G at any time prior to the incident.

THE EVENTS OF MARCH 9, 2018

39. At or around approximately 10:00 a.m. on March 9, 2018, Wong arrived at the Veterans Home of California – Yountville campus in a rental car and parked along the northwest side of Madison Hall, Building G. Wong was armed with a .308 caliber semi-automatic rifle loaded with a 20-round magazine and a loaded 12-gauge double barrel shotgun, and carried three extra 20-round magazines for the rifle in a tactical belt around his waist. Wong also carried 12 shotgun shells in his tactical belt and wore earplugs and over-the-ear protection as well as eye protection. Wong did nothing to camouflage his weapons or appearance. Wong had unfettered access to the Yountville campus and to Madison Hall. Wong was able to enter the CalVet property and then Madison Hall without having to pass through a gate, security check, intercom, barrier, locked door and/or alarmed door and/or any other physical barrier or security check. Wong easily entered Madison Hall from a subterranean boiler room door and walked directly to the second floor "Group Room" where a going away party during a mandatory community meeting attended by 10-15 staff members and veterans was in progress. Wong entered the Group Room at or around 10:19 a.m. and immediately ordered the veterans in the room to leave and then granted permission to individual staff members one-by-one to exit the room. Left in the room with Wong were decedents Dr. Jennifer Golick, Dr. Jennifer K. Gonzales Shushereba and Pathway's Executive Director Christine Loeber.

40. Staff and veterans who were allowed to leave the Group Room called 911. At or around approximately 10:21 a.m., Napa County Sheriff Department deputies working in Yountville were dispatched to a report of "Active Shooter" in progress at the Pathway. The caller reported, "We have an active shooter." All available Napa County Sheriff deputies were dispatched to a report of "possible shooting…at the Veteran's Home." Deputy Steven Lombardi of Napa County Sheriff Department arrived as "primary on scene" and was the first officer to respond at approximately 10:26 a.m. On his way, Deputy Lombardi heard radio updates that the

suspect's name was Albert Wong, and Dispatch provided a physical description including that Wong was equipped with an assault rifle, a lot of ammunition, was prior military and a former Pathway resident, and was holding hostages.

41. Upon his arrival, Deputy Lombardi was given directions to the second floor Group Room by a Pathway employee who had been released by Wong and was told that Wong was holding the three women in the Group Room. Deputy Lombardi climbed the stairwell and arrived on the second floor; he was the sole law enforcement officer responding to the active shooter at Pathway. When Deputy Lombardi reached the Group Room at or around 10:31 a.m., he partially pushed open a closed metal door to the Group Room and saw Wong with a rifle through the partially opened door. Lombardi let go of the door, backed up and took up a position covering the doorway. At or around 10:32, Lombardi began firing through the closed door to the Group Room. Wong, who had moved to a position of cover, fired back at Lombardi from inside the Group Room. After this exchange of gunfire, Wong shot and killed the three victims and then killed himself. Lombardi held his position of cover until he was relieved by other Napa County Sheriff Department Deputies, including Sergeant Jon Thompson and Deputies William Branco and Erik Fisher who arrived six minutes after the shots were fired. There was no further engagement with Wong. A later investigation by the California Highway Patrol revealed that Wong killed the three decedents after Lombardi exchanged gunfire with Wong.

42. Deputy Lombardi fired a total of thirteen rounds from his .223 caliber rifle at Wong during the shooting sequence that lasted approximately ten seconds. Wong fired a total of twenty-two rounds from his .308 caliber rifle during the shooting sequence. The subsequent autopsies revealed that no shots fired by Deputy Lombardi struck Dr. Golick, Dr. Gonzales Shushereba, Executive Director Loeber or Wong.

43. The Napa County Sheriff Department then transitioned into a hostage/barricaded suspect protocol. At approximately 6:30 p.m., the FBI SWAT team entered to the Group Room and discovered the four deceased: Wong, Loeber, Shushereba and decedent Dr. Jennifer Golick.

FIRST CAUSE OF ACTION

PLAINTIFFS' FIRST AMENDED COMPLAINT FOR DAMAGES FOR WRONGFUL DEATH

AGAINST PUBLIC EMPLOYEES AND DOES 1 THROUGH 24 FOR NEGLIGENCE (GOVERNMENT CODE SECTION 815.2), AND STATE OF CALIFORNIA FOR VICARIOUS LIABILITY (GOVERNMENT CODE SECTION 820)

44. Plaintiffs reallege and incorporate by reference the allegations set forth in paragraphs 1 through 43 as though fully set forth herein.

45. At all times herein mentioned, a special relationship existed between decedent and CalVet and DOES 1 through 24, and each of them, both individually and as State of California, CalVet agents and employees. State of California expressly invited decedent onto the Yountville campus to perform her duties, which were beneficial to defendants. These services were individual and group therapy services defendant State of California, CalVet was obligated by law to provide, as mandated by the joint venture and/or partnership between CalVet and Pathway. Moreover, the subject leases and operating agreements created a special relationship between CalVet and Pathway's employees and CalVet had a duty to exercise reasonable care to secure joint use areas against foreseeable criminal acts. And, as set forth in the Lease, CalVet had a contractual obligation to provide security "for any joint-use areas in, on, or about the Premises." At all relevant times, CalVet was directly responsible for the management, control, direction and supervision of joint use areas in and around the Yountville campus and for all buildings and facilities located on its campus.

46. Plaintiffs allege that the lease between CalVet and Pathway was primarily intended to offer a direct mental health treatment and educational services to veterans. The in-kind rent for the Madison Building was in exchange for the mental health treatment services and education provided to eligible veterans by Pathway. Accordingly, decedent's services procured additional revenue for defendant State of California. Decedent's presence on the Yountville campus supplemented defendant State of California's budget and satisfied certain duties defendant State of California owed its veterans.

47. Having invited decedent onto the campus property, having undertaken to provide unarmed public safety officers in light to the prior threats of violence and incidents, and having

induced decedent to rely and depend upon this protection, a special relationship existed between decedent and defendants to which defendants, DOES 1 through 24, were obligated to take reasonable protective measures to ensure decedent's safety against violent attacks and otherwise protect her from foreseeable criminal conduct and/or to warn her as to the nature and frequency of prior incidents or attacks or threats. The special relationship between decedent and defendants imposed upon them an affirmative duty to use reasonable care to protect decedent by, among other things, supplying her with a reasonably safe place to provide her contracted services and providing adequate security. Defendants assumed responsibilities toward decedent to protect her from unreasonable risks of harm, to warn her and to protect her.

48. Defendants CalVet and DOES 1 through 24, and each of them, breached the duty that emanated from their special relationship with decedent, as set forth below.

49. At all relevant times, State of California by and through its employees DOES 1 through 24 knew that the veterans' population at the Yountville campus included veterans with impulse control issues, physical aggression and potential violence and access to weapons. Moreover, defendants actually knew that Wong made prior threats of violence and Wong's weapons were confiscated prior to the fatal shooting.

50. By reason of their knowledge and the actual dangers of post-combat veterans suffering from PTSD and other behavioral disorders, a special relationship also existed between defendants and the veterans receiving treatment at the Yountville Campus. This placed upon defendant State of California agents and employees an affirmative duty to exercise reasonable care so as to provide the personnel and safeguards required to prevent these veterans from creating an unreasonable risk of bodily harm to others.

51. CalVet failed to take any steps to provide adequate security for the Yountville campus or control access onto the campus. The entry to the campus has a building which plaintiffs are informed and believe and thereupon allege had been used as a security checkpoint staffed by CalVet Safety Officers to stop incoming vehicles and assess security risks. However, this security checkpoint was not in use on the day of the incident and Wong, in combat attire,

easily accessed the Yountville campus and Madison Hall. The placement of the Safety Officers at the checkpoint would have a discouraging effect on troubled veterans seeking to do harm and, if violence erupted, professionals who were equipped and trained to deal with such violence would have been able to deal with the situation. CalVet's employees negligently failed to task its Safety Officers with staffing a security checkpoint to conduct security clearances for incoming persons and vehicles and/or failed to adequately train its Safety Officers to do so or respond to the foreseeable risk of an active shooter. CalVet's employees also negligently failed to provide adequate security cameras and monitoring and failed to maintain the door locks and limit access entry points to Madison Hall, which it was required to do under the Lease agreements.

52. CalVet by and through its employees knew or should have known that the primary focus of the Pathway program was to provide physiological counseling and treatment to recently returning veterans who had PTSD and/or Traumatic Brian Injury and that these veterans had access to weapons and were professionally trained in the use of such weapons, and by the very nature of their mental injuries were susceptible to rage and violence. CalVet's employees should have recognized that by concentrating these veterans in Madison Hall without imposing minimal security practices and devices increased and encouraged the foreseeable risk of violence to other veterans and their treating health care providers on campus, including death by an armed gunman.

53. Government Code section 845 is inapplicable here. That section provides, "Neither a public entity nor a public employee is liable for failure to establish a police department or otherwise to provide police protection service, or, if police protection service is provided, for failure to provide sufficient police protection service." First, this immunity does not apply as here, as it is the negligence of the existing security force known as "Safety Officers" that gives rise to the claim. Second, cases have found an exception to this immunity based upon a special relationship and the voluntary assumption by the public entity of a duty toward the injured party. "Even though there is initially no liability on the part of the government for its acts or omissions, once it undertakes a duty on behalf of a member of the public, and thereby induces

that individual's reliance, it is then held to the same standard of care as a private person or organization." *Hartzler v. City of San Jose* (1975) 46 Cal.App.3d 6, 12; see also, *Antique Arts Corp. v. City of Torrance* (1974) 39 Cal.App.3d 588, 593.

54. Government Code section 820.2 is inapplicable here. That section provides, "a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, where or not such discretion be abused." California cases hold that immunity exists if the injury results from the public employee's discretion to undertake an activity, liability if it results from his negligence in performing it after he has made the discretionary decision to do so. *Roseville Community Hospital v. State* (1977) 74 Cal.App.3d 583. Immunity is restricted to basic policy decisions that have been expressly committed to coordinate branches of government and as to which judicial interference would be "unseemly." *Barner v. Leeds* (2000) 24 Cal.4th 676, 685. There is no basis for immunizing lower-level decisions that merely implement a basic policy that has already been formulated. *Id.* CalVet had made the decision to employ Safety Officers to protect the Yountville campus and the negligence alleged here relates to the operational negligence of the security force in carrying out their duties under the law and pursuant to the Lease Agreements.

55. At all times herein, Defendant CalVet and DOES 1 through 24, and each of them, did, in the course and scope of their public employment, breach their above-described duties by, among other things, the following:

- Placing decedent in danger of violence while she provided therapy to veterans;
- Failing to warn or protect decedent when Wong came onto the Yountville Campus on March 9, 2018;
- Negligently failing to take minimal precautions such as a security checkpoint, a front gate, fencing, working locks and intercoms, among others, to secure the premises, even after the 2010 site vulnerability assessment had flagged these security failures and the Napa County Sheriff's Department's site assessment that recognized the foreseeability of an active shooter on the Yountville campus and

the December 2010 Legacy Report also flagged security failures. Indeed, defendant CalVet and DOES 1 through 24 also knew of the death threats made by Wong and that Wong brought weapons onto the Yountville campus but took no action to warn and/or protect decedent from Wong's deadly violence.

- Negligently providing security by and through CalVet's public Safety Officers' acts and/or omissions prior to the shooting and on the day of the shooting and failing to properly train said Safety Offices; and
- Negligently failing to fulfill its obligations under the Lease.

56. The conduct of defendant CalVet and DOES 1 through 24 as herein alleged created unreasonable risks of harm that were foreseeable, and the harm to decedent as herein alleged almost certainly would have been prevented had defendants exercised ordinary care and met their legal obligations.

57. The negligence and other wrongful conduct of said defendants, as herein described, was a legal cause of and substantial factor in the wrongful death of decedent as alleged herein.

58. By reason of the foregoing and the death of the decedent, the plaintiffs have been deprived of a loving mother and wife and have sustained pecuniary loss resulting from the loss of the society, comfort, attention, services, and financial support of the decedent. As a further proximate result of the dangerous condition of the defendant's property, and the death of the decedent, the plaintiffs have incurred funeral and burial expenses.

59. Defendant State of California, CalVet is vicariously liable for the wrongful death of decedent by and through the acts and omissions of its employees and agents in the course and scope of their employment, including the above-mentioned individual defendants, pursuant to California Government Code section 815.2(a).

60. The individual defendants CalVet and DOES 1 through 24, and each of them, are personally liable for their wrongful conduct as alleged herein, pursuant to California Government Code section 820(a).

Plaintiffs pray for judgment as hereinafter stated.

SECOND CAUSE OF ACTION

AGAINST DEFENDANT STATE OF CALIFORNIA AND DOES 1 THROUGH 24 FOR DANGEROUS CONDITION OF PUBLIC PROPERTY

61. Plaintiffs reallege and incorporate by reference the allegations set forth in paragraphs 1 through 60 as though fully set forth herein.

62. Defendant State of California, CalVet, is and at all times herein mentioned was, a public entity that owned, maintained, and controlled the real property located at 100 California Drive, Veterans Home of California, Yountville, California. CalVet leased Building G Madison Hall to Pathway and entered into a strategic public-private partnership and/or joint venture with Pathway to provide mental health services to veterans. Defendant State of California, CalVet, knew that Pathway served as a residential and outpatient treatment program focused on treating and educating veterans suffering from PTSD, mild Traumatic Brain Injuries and other post-deployment mental health issues and exhibited symptoms of anger, stress, mood swings, depression and anxiety.

63. Defendant State of California, CalVet, was directly responsible for the management, control and supervision of Yountville campus and all buildings on its campus and for the safety and security of tenants, residents, employees and others working at, visiting, or residing at Pathway. Having invited decedent, and other mental health providers and veterans onto the campus property, having undertaken to provide security at the campus and having induced decedent and other mental health providers and veterans to depend on this protection, defendant had a special relationship with the decedent pursuant to which the defendant was obliged to take reasonable protective measures to ensure the decedent's safety against violent attacks and otherwise protect the decedent from foreseeable criminal conduct and/or to warn the decedent. At all relevant times, defendant State of California, CalVet, failed to implement or require any safeguards to protect Yountville campus and Pathway visitors, residents, staff or

personnel from the foreseeable risk of shooting by a veteran suffering from PTSD or other mental illness.

64. On March 9, 2018 and prior thereto, defendants breached their duty of care to the decedent by carelessly, negligently, and improperly owning, managing, maintaining, supervising, controlling and securing the property so as to maintain the property in such a way so as to increase the risk of criminal activity or in such a way as to create a reasonable foreseeable risk of criminal conduct resulting in the type of injury hereinabove alleged when the decedent used the property with due care.

65. The defendants further breached its duty of care in that defendants had actual knowledge of the existence of the condition and knew or should have known of its dangerous character a sufficient time prior to March 9, 2018 to have taken measures to protect against the dangerous condition and that a population of veterans suffering from PTSD and other mental health issues and who had combat experience could experience an episode resulting in gun violence to others. Specifically, defendant State of California, CalVet had actual knowledge that Wong was ejected from Pathway's outpatient program for making threats of violence and carrying a weapon onto the premises. Defendant State of California created a substantial risk of injury and dangerous condition on the subject property. "Condition of property" has been defined to include all public property that may be substantially dangerous to reasonably foreseeable users who sustain injury as a result of a combination of a condition of the property – either a physical defect or the absence of adequate safety features – and negligent or criminal conduct by others on the property. Defendant State of California, CalVet was responsible for the creating a dangerous condition in the following ways:

- No front gate and/or front mechanical security gate at the entrance of the Veterans Home of California, Yountville campus;
- Inadequate fencing along the perimeter of the Yountville campus;
- Lack of security cameras on the subject property;
- Lack of physical access control systems;

- Lack of silent alarm distress signals and mechanisms;
- Excessive number of entry doors to Madison Hall, Building G, for the population of veterans treated by Pathway for mental illness and PTSD;
- Doors and door locks were in a defective condition, both in design and operation; the doors and door locks were not properly maintained and did not prevent Wong from entry;
- The subterranean boiler room door that Wong entered was hidden from sight, not blocked off from entry and did not have a breached door alarm;
- The video door intercom entry system was defective in design and operation; the system was not in working order nor did the system alert anyone of Wong's entrance into the facility;
- There were inadequate security measures by CalVet, which had actual knowledge that post-9/11 veterans exhibit symptoms of anger, stress, mood swings, PTSD, depression, anxiety and other post-deployment combat issues and who were potentially violent and had military weapon training. These post-9/11 veterans congregated at Madison Hall, building G, for treatment on a regular basis. Veterans returning from active duty want to retain weapons for protection and recreation. Wong had been ejected from the Pathway program two weeks earlier for making threats and carrying a weapon onto the premises. With actual knowledge of these facts, defendants failed to place security barriers and failed to take appropriate security measures or other install physical barriers and failed to warn of the foreseeable risk of a veteran with a weapon from entering the building.

66. The defendants had actual knowledge of the existence of the condition and knew or should have known of its dangerous character a sufficient time prior to March 9, 2018 to have taken measures to protect against the dangerous condition. DOES 1 through 24, acting within the course and scope of their employment with defendant Cal Vet, negligently and carelessly created

this dangerous condition and failed to warn of the dangerous condition. This negligence caused a dangerous condition that created a substantial risk of the type of injury as herein alleged when the property was used with due care in a manner in which it was reasonably foreseeable that it would be used. On March 9, 2018, the decedent Jennifer Golick was shot and killed by Wong, a veteran with mental health issues and access to semi-automatic weapons. Wong, in combat attire, was able to gain easy access to the campus and entered Madison Hall, Building G fully armed without anyone noticing. As a proximate result of the dangerous condition of the property—including but not limited to lack of a physical barrier, no perimeter fencing, the hidden subterranean boiler room door, door lock and/or security camera failures, or any other mechanical security measure—nothing was in place to stop Wong along the way.

67. By reason of the foregoing and the death of the decedent, the plaintiffs have been deprived of a loving mother and wife and have sustained pecuniary loss resulting from the loss of the society, comfort, attention, services, and financial support of the decedent. As a further proximate result of the dangerous condition of the defendant's property, and the death of the decedent, the plaintiffs have incurred funeral and burial expenses.

68. Plaintiffs pray for judgment as hereinafter stated.

THIRD CAUSE OF ACTION

AGAINST PUBLIC EMPLOYEE DEPUTY STEVEN LOMBARDI AND DOES 25 THROUGH 50 FOR NEGLIGENCE (GOVERNMENT CODE SECTION 815.2), NAPA COUNTY SHERIFF DEPARTMENT/NAPA COUNTY FOR VICARIOUS LIABILITY

69. Plaintiffs incorporate paragraphs 1 through 43 as if fully set forth herein. At all times herein mentioned, a special relationship existed between decedent and defendant Deputy Steven Lombardi and DOES 25 through 50, and each of them, both individually and as agents and employees of defendant Napa County/Napa County Sheriff Department.

70. Defendant Steven Lombardi of Napa County Sheriff Department and DOES 25 through 50 knew that Pathway served as a residential and outpatient treatment program focused on treating veterans suffering from PTSD, mild Traumatic Brain Injuries and other post-

deployment mental health issues and exhibited symptoms of anger, stress, mood swings, depression and anxiety; and also knew that Wong had been ejected from the premises for making threats of violence and carrying weapons onto the premises. Defendant Steven Lombardi had also been trained how to respond to an active shooter on the Yountville campus and knew that Napa County Sheriff Department was the response unit for the Yountville campus. As such, defendants Steven Lombardi of Napa County Sheriff Department and DOES 25 through 50 had the power to prevent, remedy, warn or guard against the fatal shooting.

71. The special relationship between decedent and defendants and each of their DOES imposed upon them an affirmative duty to use reasonable care to protect decedent by, among other things, providing decedent a reasonably safe place to work, to warn and to protect her prior to the shooting and on the day of the shooting when defendants Steven Lombardi and DOES 25 through 50 responded to the call of an active shooter.

72. Plaintiff is informed and believes and thereupon alleges that in or around January 2018, two months prior to the shooting, the FBI trained Napa County Sheriff's Department in the best tactics to handle an active shooter. Sergeant John Hallman from Napa County Sheriff's Department stated, "If we think that we're above and beyond a major incident happening so we don't have to train to be prepared, then we're not doing what the public pays us to do to be ready and to take care of them." Moreover, prior to the shooting, Napa County Sherriff Department performed a site assessment of the premises for the purpose of assessing and responding to potential threats due to the fact that the Pathway program enrolled veterans with PTSD because an active shooting situation at the Yountville campus was foreseeable. Indeed, Napa County Sheriff Department deputies responded to calls for service at the Yountville campus approximately forty (40) times per month. The Napa County Sheriff Department is the primary source of law enforcement for the Yountville campus. In addition, the California Highway Patrol performed a vulnerability site assessment in 2010 and found that there was no security at the front gate, few security cameras, inadequate fencing along the campus perimeter; inadequate panic buttons or alarms; and an inadequate staff of unarmed security officers on the grounds. The

CHP vulnerability assessment report provided these observations and recommendations. Defendants Lombardi and DOES 25 through 50 failed to take reasonable precautions to safeguard decedent and others in the face of actual knowledge of the lack of security and the frequency of criminal conduct on the Yountville campus, and the known risk of an active shooter.

73. At all relevant times, defendants Lombardi and DOES 25 through 50 knew of the needs of the population of veterans on the Yountville campus and the capacity for physical aggression and violence, along with military weapons training. Moreover, defendants Steven Lombardi of Napa County Sheriff Department and DOES 25 through 50 actually knew of Wong's propensity for violence, Wong's threats of violence and that Wong brought weapons onto the Yountville campus prior to the fatal shooting. Defendants breached their duties owed to decedent by, among other things:

- Failing to warn others of Wong's ejection from the premises for making threats and carrying weapons onto the premises;
- Failing to assess and report the hostage situation to the dispatcher;
- Failing to wait for backup, including the negotiation team;
- Failing to contain, stabilize or de-escalate the situation;
- Failing to wait for all resources to be in place;
- Impulsively engaging in an exchange of gunfire, shooting through a closed door and escalating the situation;
- Failing to shoot and kill Wong upon opening the door to the Group Room;
- Failing to follow police training and protocol.

74. When Lombardi appeared on the scene, he knew he was responding to an "active shooter" and that he was the only law enforcement officer on the scene. Lombardi stated and represented that he was capable of reacting and responding to this call and knew how to engage and stop the threat; yet, at the same time, Lombardi considered whether to stop by his office to

get something for his guns. Once on the scene, Lombardi learned from released hostages that Wong held the three women in the Group Room. Lombardi was informed of Wong's location and that no shots had been fired yet. Instead of either waiting for backup and hostage negotiators so as not to inflame the situation or, alternatively, going into the Group Room and engaging Wong (Lombardi knew or should have known that "to engage" means to confront the active shooter and eliminate the threat to others), Lombardi failed to engage when he slightly pushed open the Group Room door (which closed on its own) and he did not enter the Group Room and confront Wong at that time. By doing this, Lombardi inserted himself into the situation and caused a desperate Wong to react more violently; Lombardi induced decedent's reliance on Lombardi's promise, expressed and implied, that he would provide her with protection. By so acting, Lombardi assumed a duty, changed the status quo and enhanced and increased the risk. Next, Lombardi recklessly fired shots through the solid door with no windows, with no view of the target, which only served to further agitate and provoke Wong, increasing the peril and altering the risk to decedents. Wong then shot the women and himself. All of these representations and affirmative acts to render service created a special relationship between Lombardi and decedent Dr. Jennifer Golick. A breach of the duty of care may arise from an affirmative act that places a person in peril or increases the risk of harm, or from an omission or failure to act (e.g., the failure to warn in an appropriate case). See *Williams v. State* (1983) 34 Cal.3d 18, 24. .

75. The conduct of defendants as alleged herein created unreasonable risks of harm that were foreseeable, and the harm to decedent almost certainly would have been prevented had defendants exercised ordinary care and met their legal obligations.

76. The negligence and other wrongful conduct of said defendants, as herein described, was a legal cause of, and a substantial factor in, the death of decedent.

77. The immunity under Government Code section 845 does not apply to ordinary police negligence in carrying out investigative, protective, or traffic safety responsibilities, as distinguished from a failure to provide police service. *McCorkle v. City of Los Angeles* (1969) 70

Cal.2d 252 (construing Gov't Code section 820.2); *Mann v. State* (1977) 70 Cal.App.3rd 773 (construing Gov't Code sections 820.2 and 845). When, as here, a special relationship is found to exist and the facts warrant, the rationale for not applying the immunity under Government Code section 845 is that section 845 immunity applies to basic policy decisions of law enforcement officials in deploying law enforcement resources, and that the immunity, like the discretionary immunity of Government Code section 820.2, does not apply to ordinary police negligence in carrying out investigative, protective, or traffic safety responsibilities. *Mann v. State* (1977) 70 Cal.App.3d 773.

78. Government Code section 820.2 is inapplicable here. That section provides, "a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, where or not such discretion be abused." California cases hold that immunity exists if the injury results from the public employee's discretion to undertake an activity, liability if it results from his negligence in performing it after he has made the discretionary decision to do so. *Roseville Community Hospital v. State* (1977) 74 Cal.App.3d 583. Immunity is restricted to basic policy decisions that have been expressly committed to coordinate branches of government and as to which judicial interference would be "unseemly." *Barner v. Leeds* (2000) 24 Cal.4th 676, 685. There is no basis for immunizing lower-level decisions that merely implement a basic policy that has already been formulated. *Id.* Here, Lombardi's negligent conduct is not an immunized discretionary act.

79. By reason of the foregoing and the death of the decedent, the plaintiffs have been deprived of a loving mother and wife and have sustained pecuniary loss resulting from the loss of the society, comfort, attention, services, and financial support of the decedent. As a further proximate result of the dangerous condition of the defendant's property, and the death of the decedent, the plaintiffs have incurred funeral and burial expenses.

80. Defendant Napa County/Napa County Sheriff Department are vicariously liable for the death of decedent and the injuries to plaintiffs by the acts and omissions of its employees

and agents in the course and scope of their employment, including the above-mentioned individual defendants, pursuant to California Government Code Section 815.2(a).

81. Defendants Steven Lombardi of Napa County Sheriff Department/Napa County and DOES 25 through 50, and each of them, are personally liable for their wrongful conduct as alleged herein, pursuant to California Government Code section 820(a).

WHEREFORE, plaintiffs pray for judgment against the defendants, and each of them, as follows:

1. For general damages according to proof;

2. For funeral and burial expenses according to proof;

3. For costs of suit herein incurred; and

4. For such other and further relief as the court may deem proper.

Date: June 26, 2019

FOREMAN & BRASSO

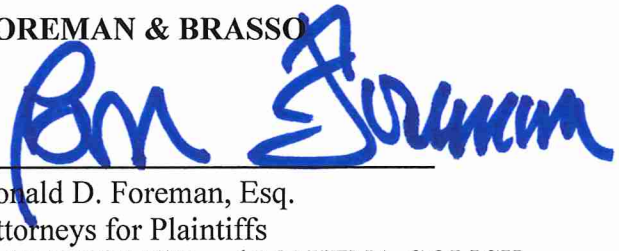

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EXHIBIT 1

Legacy Protection Services

606 East First Street
Los Angeles, CA 90012
(310) 948-1336

Overview

On December 16-17, 2010, *Legacy Protection Services* (*LPS*) conducted a risk assessment at the facilities that house the *Tug McGraw Foundation* (*TMF*) offices in Yountville, California. The *TMF* is presently collocated in the same facility as *The Pathway Home (TPH)*, a live-in treatment program for returning war veterans experiencing traumatic stress related issues due to their deployment.

These issues include 'Post Traumatic Stress' (PTS) and 'Traumatic Brain Injuries' (TBI). Presently there are 22 patients enrolled in *TPH* program experiencing varying degrees of stress / trauma related impairment. The patients have unrestricted access to all areas within the *TPH* building and surrounding grounds, to include the staff offices of the *TMF* and the employee parking lot.

The facility itself is a free standing building leased to *TPH* by the State of California. Formally designed and used as a medical ward, the structure is located on a renovated military base / complex with numerous similar structures that house other unrelated California Department of Veterans Affairs (CDVA) programs.

The compound is non-gated, non-secured with no formal check-in or check-out procedures. A minimally staffed security office is located at the main entrance onto the base but displays no requirement to stop allowing full access to members of the public.

TPH building itself is located several hundred yards from the main entrance and is accessible via a two lane road that dissects the base. Shared parking is available to *TPH* and *TMF* staff, clients and visitors at an open, unsecured community lot located approximately 50 yards north of *TPH* building.

Presently, the base Post Exchange (PX) and Canteen are located within *TPH* facility, allowing unrestricted access to the interior of the building by patrons and others unrelated to the programs offered by *TPH* or *TMF*.

Methodology

For the purposes of this report, the *LPS* evaluators viewed the overall risk assessment for the *TMF* as involving two distinct areas of concern: external risk factors and internal risk factors. Comments and observations made to the TMF Director by the evaluators during their visit, and since, are now part of the recommendations outlined in this report.

External Risk Factors

External risk factors are threats posed to *TMF* staff, patients and visitors from persons unrelated to the program or facility. Outside members of the public, as well as clients from other nearby CDVA programs would be included in this group.

External threats are generally difficult to predict since those targeted are usually not privy to observable behaviors or warning signs that could serve as precursors to violence. Violent acts from external sources may be opportunistic and can be the result of attempted burglaries, robberies, or predatory sexual behavior. Given the nature and location of *TPH* program, drug theft, trafficking, and substance abuse can contribute to the risks posed from external sources.

Strategies which serve to "harden the target" should be implemented in order to mitigate threats presented from external sources. These strategies include physical changes to *TPH / TMF* building, many already enumerated in our December 27th report (Attached). Protocols should be established to identify and limit access to individuals not associated with *TPH* program seeking to enter the facility. Suggested remedies discussed later in this report.

Internal Risk Factors

Internal risk factors are threats posed to *TMF* staff, patients, and visitors from persons related to *TPH* or *TMF* programs or facility. These threats may be posed by staff members, visitors, vendors, and former or current patients.

In general, internal threats can be more identifiable as these relate to a known individual or group whose risk factors and behaviors are more readily observable. With an emphasis on *TPH* patients, deterioration in behavior or increased aggression is often discernable in an individual's mannerisms and communications.

Early recognition of these changes in behavior can afford an opportunity for early intervention to interrupt a progression to violence. The key to early recognition is open communication and interaction between staff from *TPH* and the *TMF*. Suggestions to improve and formalize increased communications addressed later in this report.

Equally important to the mitigation of internal threats is the accessibility of *TMF* staff to occupants of *TPH* facility. Presently anyone within the facility has unrestricted access to *TMF* offices and personnel.

During *LPS* site visit, meetings with *TMF* staff were repeatedly interrupted by *TPH* patients wanting to speak with *TMF* executives. Although this accessibility provides for an open and caring atmosphere for patients, it also presents tremendous security risks for *TMF* staff.

Risk Assessment

The risk assessment process is multi-faceted and involves the evaluation of the potential victim's vulnerability as well as in-depth research on the person or group that may present a credible threat of violence. History of prior violent acts, criminal activity, mental health issues, access and familiarity with weapons, mobility and relationship, either real or perceived to the victim, are key considerations.

Stabilizing and de-stabilizing factors such as the living environment, existence of a personal support system, financial stability, as well as recent trauma or personal loss are also factors to be weighed.

These factors will vary among individuals within a given group. For the purposes of this assessment, the evaluators will focus on the general dynamics of *TPH*'s patient population as they present the most identifiable risk factors.

Perhaps the most pertinent core principle of threat assessment is the fact that *persons with a history of violence are much more likely to act out violently in the future* given a stimulus (or trigger). Past behavior is almost always the best predictor for future performance. Without question, our returning war veterans have been asked to perform some extremely violent acts in the furtherance of the war effort.

Many have been in repeated close combat situations that required them to react instantly to a perceived threat and to overcome that threat with greater force or violence. Their lives have depended on this reaction to become instinctive. The fact that these individuals are alive today is a testament to their ability to react instinctively and violently to adversity. One of the greatest challenges of *TPH* project is the de-programming of this very instinct that has been so ingrained, trained, and coveted by the military.

The nature of *TPH* treatment program and the dynamics of the live-in patient population present risk enhancers not usually associated with other work environments:

PTSD: The Department of Veterans Affairs lists symptoms of post-deployment related PTSD which includes:

- *Flashbacks* – reliving the traumatic incident. Triggers can vary widely depending upon the personal experience of the patient.
- *Sudden Anger / irritability.*

- *Drinking / drug dependency* – This diminishes inhibitions and affects decision making.
- *Relationship problems.*
- *Violence.*

TBI: According to the Department of Veterans Affairs, severe TBI manifests itself in varying degrees of cognitive and perceptual thought impairments. These impairments can greatly affect how an individual perceives the world and the actions of people around them.

The implications of the aforementioned symptoms in the workplace are significant. As these symptoms manifest themselves in daily interactions with staff, they can be particularly concerning given the fact that *TPH* population is almost entirely comprised of male patients while the *TMF* staff is predominantly female.

Assaults in the Workplace

According to the Bureau of Labor Statistics, since 1993 public and private businesses in the U.S. have averaged 1.5 million incidents of workplace related assaults each year. Of those, an average of 1,000 resulted in homicide and over 51,000 resulted in rape or other sexual assaults.

Nationally, homicides were the second leading cause of death for women in the workplace following traffic related deaths. Aside from retail service providers, such as taxi drivers and convenience store clerks, health care providers - nurses, emergency care providers - were among the largest groups experiencing work related violence.

Mental health practitioners and social workers interacting with the mentally ill were 3 times more likely to be victims of assault than their medical counterparts. The staff from *TPH* and *TMF* would fall within this category.

Obsessive Behavior / Stalking

Research conducted in 1993 by Michael A. Zona, M.D.; Kaushal Sharma, M.D.; and Lieutenant John Lane, LAPD, identified four distinct stalker typologies while evaluating 74 stalking subjects over a 3 year period.

In their published *Comparative Study of Erotomanic and Obsessional Subjects in a Forensic Sample*, Zona et al. identified a "Love Obsessional" stalker profile which describes subjects obsessed in their love and have the delusional belief that their victim reciprocally loves them.

The love obsessional stalker typically experiences thought impairments and frequently misperceives friendliness, compassion, availability or a simple smile as a sign of a victim's affection. J. Reid Meloy, Ph.D. and Kris Mohandie, Ph.D. reinforced this research in 2006 in their *Relationship Context (RECON) Typology* study.

The RECON research disclosed that these cases tend to be long-term in nature and can become aggravated if the delusion is challenged. Considering how closely these symptoms overlap with

those experienced by subjects experiencing PTSD and severe TBI, the threat posed by the interactions between *TPH* patients and *TMF* staff increases significantly.

During the December 2010 site visit, *LPS* evaluators were met by a patient who made a number of references to his girlfriend and his plans with her after leaving the program. It was later disclosed by *TMF* staff that this "girlfriend" was a person he had been chatting with for just a week on a social networking website and had actually never met her.

This could be an example of a developing love obsessional delusion. Fortunately, the woman has some degree of security due to the anonymity of the internet. The same would not be true if the delusion were to involve a *TMF* staff member. In discussions with both *TPH* and *TMF* staff it was learned that poor relationship choices are among the most common issues facing *TPH* patients.

Suicide

Eighteen U.S. veterans commit suicide each day. Statistics released in April 2010, cite an average of 950 suicide attempts each month from veterans receiving some form of treatment from the Department of Veterans Affairs. Of those attempts, 7% were completed and 11% of those who failed attempted suicide again within the next 9 months. In 2009, over 1860 Iraq and Afghan war veterans attempted suicide.

It is reasonable to assume that the vast majority of these suicide attempts were performed by individuals with stress related illnesses due to their deployment, the same population of those enrolled in *TPH* program. (Note: A patient of *TPH* attempted suicide at the CDVA facility. Three weeks later that patient was delivering mail and packages to *TMF* staff, as observed by *LPS* evaluators during the site visit).

While being suicidal does not necessarily equate to homicidal, individuals who feel they have no options in life can be particularly dangerous to those around them. Studies show that someone with ambiguous feelings about their own life is less likely to be concerned about the safety of others.

Recent research on the phenomenon of *'Suicide by Cop'* shows that individuals will often engage in threatening, assaultive, and at times combative behavior in order to force law enforcement personnel to take lethal action. These acts sometimes involve hostages and innocent bystanders being at the wrong place when the victim elected to act out. (Note: Nationally it is estimated that 3 out of every 10 police shootings have indications of *'Suicide by Cop.'* The number jumps to 8 out of 10 when military veterans are involved.

The fact that *TMF* personnel are in constant contact with *TPH* patients throughout the workday and during social functions, the odds of being in "the wrong place at the wrong time" greatly increases.

Recommendations

The unfortunate reality is that *TPH* program houses and treats a population of individuals that present a disproportionately high risk of violence potential towards themselves and others. Through no fault of their own, these veterans have been traumatized by atrocities that have damaged their coping skills to the point that intensive rehabilitation is required in order to assimilate back into mainstream society.

During the *LPS* and *TPH/TMF* staff interviews, Dr. Fred Gusman acknowledged that not all *TPH* patients respond favorably to the program; some are expelled before completion while others have relapsed after graduation. These patients were all housed at *TPH* facility alongside *TMF* staff. To ignore these risk factors would be irresponsible to the *TMF* and *TPH* staff, patients and visitors.

In considering the nature of the leased property and the limited ability of staff to make major modifications due to funding and the lease approval process, *LPS* evaluators make the following recommendations to the *TMF* in order of preference.

Relocation

Option 1: Housing the *TMF* at *TPH* presents a number of external and internal risks to staff. The building is designed to be a fully accessible medical facility rather than a secure administrative environment.

Due to the aforementioned risk factors and the extreme potential for a negative incident at *TPH*, *LPS* recommends that the *TMF* offices be relocated to an alternate building within the base complex that offers controlled access and no patients-in-residence services, such as the Community Center presently under construction.

The proximity of the Community Center to *TPH* facility is conducive to the daily interaction and working relationship of the respective *TMF* and *TPH* staffs. Prior to moving in, a site assessment should be performed to ensure that security and safety measures are addressed.

Public access to the PX and Canteen require their doors remain unlocked during normal work hours. It is important to note that anyone entering either store has full access to *TPH* building's power supply source, offices, dorms, and recreation rooms.

There is a plan under review to relocate the Canteen and PX but the time frame for the move is uncertain. Though physical improvements can enhance security by hardening the target, the cost to properly secure the building would be prohibitive and the restriction of access would be counter-productive to the treatment of *TPH* patients.

Internally, the risks posed by *TPH* clients can only be modestly mitigated by building modifications and the deployment of a receptionist to regulate ingress/egress of patients, visitors and *TPH* staff into the *TMF* office area. In spite of these needed improvements, the

configuration of the building and the otherwise unrestricted access afforded to patients and visitors will still allow for frequent and perhaps unwanted interaction with potentially problematic individuals.

Option 2: Recognizing that relocation may not take place in the immediate future, *LPS* evaluators strongly suggest the temporary relocation of the *TMF* offices to the first floor, north wing/hallway of the *TPH* facility. Our rationale for this recommendation is simple: it is a much easier area to secure than the present office locations.

The hallway has access to *TPH* facility from the entrance at the south hallway with a single point of exit at the north end of the hall that can be locked and secured to prevent access to outsiders and allow egress from the interior of the building. This door, leading directly to the facility parking lot, should be alarmed at all times.

A nursing station, currently unoccupied, sits at the south end of the hallway. A reception area can be readily established and manned by a single security agent or receptionist. Their duties would include regulating the flow of visitors into the *TMF* office area while also monitoring all doors and general traffic.

The recommended physical changes outlined in *LPS*'s December 27th report included the installation of an audible duress alarm to be installed at this location that would also alert the Napa County Sheriff to any developing emergency. Additional equipment to be installed includes a telephone and internet access to monitor security cameras.

It should be noted that absent *armed* security, these recommendations offer a deterrent to opportunistic violence but would only serve to temporarily delay someone determined and prepared to act out violently upon a specific target.

Boundaries

TPH patients regularly "appear" unannounced at the offices of *TMF* requesting to speak with staff members. In fact, one staff member commented that the patients were "extremely quiet" in their approach, seemingly to not alert anyone to their presence. *TMF* staff members found this to be unnerving.

It is recommended that *TMF* and *TPH* staff meet with the patients to establish "boundaries" and protocols to control access to *TMF* staff. This should include visiting hours, the need to set appointments, and prohibitions of unannounced visits.

Briefings

As a means of facilitating communication between *TMF* and *TPH* staff members, it is recommended that regular monthly briefings be scheduled to address topical issues involving the facility, patients /clients, upcoming events, personnel issues, etc.

The benefits derived from these meetings include improved communication serving to enhance and streamline operations, identify needed resources, reduce waste, eliminate the duplication of similar tasks, and identify external hazards. The greatest benefit would be the sharing of information and personal observations regarding *TPH* patients.

A single observation made in passing can reveal developing problematic behavior that can be addressed in treatment. Further, serious at-risk behavior can be identified in the early stages, affording the opportunity for early intervention to derail the progression to potential violence. Conversely, improvements in behavior and positive interactions can be communicated to the treating staff to validate their treatment plan for the individual.

LPS recommends that these meetings occur on specific, pre-scheduled days and times each month, e.g., 1:00 p.m. every first Wednesday of the month. Scheduling these meetings mid-week will eliminate cancellations due to extended holiday weekends.

Threat Management Team

Once a potential credible threat of violence is identified, a threat management team should be activated to identify the threatening behavior, the individual's personal dynamics, potential target(s), and a management plan to address the threat -- short and long term.

The team should consist of representatives from *TPH, TMF*, and other components such as human resources, employee assistance program, legal counsel, and an executive officer from each organization authorized to establish policy. External consultants such as psychologists, threat assessment experts, and local law enforcement should be included as the situation dictates.

The goal of the team is to have a comprehensive, multi-disciplinary approach to effectively manage threatening behavior. The various team members should view the individualized dynamics of each case from their own perspectives.

A management plan can be developed that best addresses the overall safety in the workplace, the impact on involved and uninvolved parties, legal options, potential civil consequences of any actions taken *or* not taken, the well-being of the individual being evaluated (within reason), and most importantly the safety of the potential targeted victims and those around them.

Case management options can vary widely depending on the nature of the threatening behavior. Options may include but are not limited to: counseling, increased treatment/therapy, expulsion from the program, termination of employment, civil restraining orders, and in extreme cases, arrest. Sometimes taking no action initially is the best option. By watching and monitoring for escalation or de-escalation in aberrant behavior, a more informed management plan can be developed. The decision to monitor should be made by a consensus of the team rather than by an individual member operating alone.

Due to the fluid nature of threatening behavior it may not be always practical to convene an in-person team meeting. In cases where it is necessary to act quickly to preserve safety in the

workplace, conference calls involving team members unable to personally attend the meeting should be utilized. In furtherance of this recommendation, team members should be identified as soon as possible and a contact roster developed and made available to all involved. Overtures should be made to the Napa County Sheriff to identify a point of contact for consultation and possible inclusion on the team.

Policy on Workplace Violence

A concise workplace violence policy should be drafted and distributed to all managers, employees, and patients. This document would outline expected behavior in the workplace, detailing consequences for engaging in threatening acts or words. These "performance contracts" are to be signed by the receiving party thereby acknowledging the terms, conditions of the agreement and the document kept in the respective personnel file.

The policy should be viewed as a tool for management rather than a shield against violence. A signed contract will not prevent an individual from acting out violently if determined to do so. However, in cases where aberrant behavior is observed, the contract provides legal justification to take administrative actions while limiting exposure to civil liability. Administrative disciplinary actions may vary from counseling up to and including termination.

Since the *TMF* and *TPH* are separate but closely related entities working within the same environment, separate policies will be necessary. These policies should mirror one another with similar language and provisions to avoid conflicts within the shared environment. Once drafted, these policies should be reviewed by legal counsel prior to dissemination.

LPS consultants are available to assist in the drafting of these policies.

Emergency Response Plan

While the hope is that the aforementioned recommendations will help prevent a violent event at the *TMF/TPH* facility, the reality is that it may not. Due to the nature of the clientele and the incidence of PTS and TBI within that population, the potential for a violent incident or emergency remains high.

This point is best illustrated by the recent attempted suicide of one of the patients, and the collapsing of a patron to the Canteen without anyone able to administer CPR. Lastly, *TPH* and *TMF* regularly host fund-raising events attended by celebrities and high profile individuals.

It is imperative that TMF work with professionals and stakeholders to develop an *Emergency Response Plan*. Discussions held by *LPS* evaluators with *TMF* staff and Dr. Gusman included extending an invitation to the Napa County Sheriff's Department to become an active participant in planning, and training, for emergencies at *TBH*.

LPS consultants are available to assist in the drafting of these policies.

Conclusions

The purpose of this report is to inform and enlighten rather than frighten. The Tug McGraw Foundation and The Pathway Home are engaged in the noble work of helping our returning war heroes. The grim reality is that this work does not come without risks. The implementation of the recommendations made in this report can greatly minimize the risks.

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[i] Rick Wall, Jeff Dunn, and Tony Perez.

Legacy Protection Services

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RECOMMENDED PHYSICAL CHANGES
TO THE PATHWAYS HOME/TUG MCGRAW FACILITY
LOCATED IN YOUNTVILLE, CALIFORNIA

On December 16-17, 2010, Legacy Protection Services (LPS) conducted a site assessment of the facilities that house the Tug McGraw Foundation (TMF) offices. Based on this site visit as well as interviews of staff from The Pathway Home and TMF, LPS is completing an assessment of safety issues facing the staff of TMF.

Recognizing that TMF is housed at The Pathway Home facility, many of the recommendations involving physical modifications to the facility will necessitate the cooperation and assistance of The Pathway Home. Dr. Fred Gusman, Executive Director of The Pathway Home, indicated that since the facility is leased from the State of California, changes to the physical structure may need the approval of the State and be incorporated into the lease agreement. Dr. Gusman indicated that the new lease agreement is currently being negotiated and any suggested changes to the physical plant should be forwarded to TMF as soon as possible for inclusion.

LPS has prepared the following list of recommendations to enhance security for personnel of TMF, as well as improving the overall security to the facility that houses The Pathway Home. The following recommendations, numbered for ease of reference, are made to the TMF with the aim to establish or enhance measures that safeguard the security and safety of patients and staff at the facility.

The primary focus of these recommendations is to ensure that:

- Patients and staff are safe and secure within the current work/residence/treatment environment;
- Patients and clients are safe and secure from possible threats by intruders.
- Risk of injury or death to TMF staff is minimized or eliminated.

Recommendations

1. Electronic surveillance system (closed circuit television) to be enhanced [and integrated] by adding outside cameras - roof-installed - for greater visibility of points of access into the facility, to include windows. These cameras should be IP cameras that can be monitored by interested staff members, remotely, to be viewed from home or smart cellular phones. Specific locations to be monitored by the cameras include, but are not limited to:

    a. The TMF staff parking lot, to be located at the three parking spaces at the south part of the parking lot approaching the loading bay.

    b. The hallway outside the TMF offices (specifically the hallway that houses rooms 4114-4118 inclusive).

    c. The loading bay and rear entrance to the facility.

    d. Doors to the lower level (basement level). There is one door on the south side of the facility and one on the north, neither of which is currently in a position to be monitored by on-duty staff.

    e. Doors to the courtyard (currently there are four doors to the courtyard, two from each ground floor wing, and the main entrance which a double sliding door on the first floor.).

    f. Exterior doors at the end of the residential wings (two on the first floor, and two on the second floor).

2. Lighting to be enhanced/installed at all points of entry into the facility. Lighting should be significantly enhanced in the staff shared parking lot with an additional light placed on the "power building" directly north of the facility. This light should illuminate the two doors (upstairs and downstairs) on the north side of the facility and directly east of the shared staff parking lot.

3. Install prying-prevention shields on all exterior doors to prevent unauthorized access.

4. All exterior, emergency exit doors, especially those directly outside the TMF offices should be alarmed and programmed to sound when opened.

5. A duress or "panic alarm" system should be installed in each TMF office and conference room that can be activated by TMF staff in the event of an emergency. This alarm can be monitored by on-site security; however, it is recommended that this alarm be connected directly to the Napa County Sheriff to facilitate an emergency response if needed.

6. The facility's floor plans must be updated as soon as possible and should indicate the specific locations of executive / staff offices. The plan should then be provided to the local Sonoma County Sheriff Watch Commander's office for reference in the event of an emergency call for services.

Note: It should be noted that at the time of the site visit and as of the completion of this report, no actual floor plans were available to Legacy Protection Services staff.

7. Access to the boiler room /electrical room should be secure and access authorized by the on-duty facility monitor. The exterior door adjoining the boiler room to the facility basement should remain locked at all times, thereby restricting unauthorized access into the facility as well as limiting guest or patient access to the power source.

8. The "nursing station" or desk space outside the TMF offices (across from room 4114) should be modified to serve as a reception desk for TMF offices. This should include telephone, duress alarm, and internet capabilities (to monitor IP cameras).

9. A new wall/doorway should be constructed to provide further barrier/security to TMF offices. This doorway should be constructed at the hallway space directly outside room 4114 and across from the aforementioned "nursing station" (Item 8).

10. Relocation of Camera Monitoring station – Dr. Gusman indicated that in the next few months, the "Canteen" and "PX" currently located at the facility will be moved to another location. Currently, the monitoring station is located on the second floor, outside the Pathway Home staff offices. It is recommended that once the canteen and PX are removed, the monitoring station be relocated to the first floor in the lobby area and next to the elevator. This would provide the monitoring station personnel the ability to actually have "line of sight" view of all five courtyard doors, both doors to the residential wings located on the first floor, the door to the east side (next to the current "Canteen,") as well as the stairs that lead to the residential/offices on the second floor and the stairs to the basement (lower level).

As mentioned above, these recommendations are only to the physical plant that houses The Pathway Home and the TMF offices. A more detailed assessment and risk analysis will be provided to TMF staff at a later date. These recommendations are forwarded at this time to facilitate their inclusion in the lease agreement Dr. Gusman is negotiating on behalf of The Pathway Home.

Thank you!

Tony Perez

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF NAPA

MARC GOLICK and MAKENA GOLICK by and through her guardian ad litem MARC GOLICK, Plaintiffs, v. STATE OF CALIFORNIA, DEPARTMENT OF VETERANS AFFAIRS; NAPA COUNTY SHERIFF DEPARTMENT, COUNTY OF NAPA, STEVE LOMBARDI and DOES 1 through 50, Defendants.	Case No. 19-CV-000350 **PROOF OF SERVICE**

PROOF OF SERVICE

I am a resident of the United States, over 18 years of age, and not a party to the within entitled action; I am employed at and my business address is 930 Montgomery Street, Suite 600, San Francisco, California. On this date I served the following document(s):

- **FIRST AMENDED COMPLAINT FOR DAMAGES FOR WRONGFUL DEATH**

___ by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid in the United States mail at San Francisco addressed as shown below.

___ by facsimile to the facsimile number(s) shown below.

___ by causing a true copy thereof to be hand delivered.

___ by causing a true copy thereof enclosed in a sealed envelope to be delivered by FEDEX at the address shown below.

XXX by causing a true copy to be electronically e-mailed to the email address shown below.

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

Executed at San Francisco, California on June 27, 2019.

Polly Meno

SERVICE LIST

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