Court of Common Pleas of Philadelphia County
Trial Division

Civil Cover Sheet

For Prothonotary Use Only (Docket Number)	
APRIL 2018	001272
E-Filing Number: 1804022548	

PLAINT FF'S NAME XIANGUO KONG	DEFENDANT'S NAME TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
P	DEFENDANT'S ADDRESS 3451 WALNUT STREET ROOM 329 PHILADELPHIA PA 19104
PLAINT FF'S NAME ZHAO LIN	DEFENDANT'S NAME
P	DEFENDANT'S ADDRESS
PLAINT FF'S NAME	DEFENDANT'S NAME
PLAINT FF'S ADDRESS	DEFENDANT'S ADDRESS

TOTAL NUMBER OF PLAINT FFS	TOTAL NUMBER OF DEFENDANTS	COMMENCEMENT OF ACTION
2	1	☒ Complaint ☐ Petition Action ☐ Notice of Appeal ☐ Writ of Summons ☐ Transfer From Other Jurisdictions

AMOUNT IN CONTROVERSY	COURT PROGRAMS
☐ $50,000.00 or less ☒ More than $50,000.00	☐ Arbitration ☐ Mass Tort ☐ Commerce ☐ Settlement ☒ Jury ☐ Savings Action ☐ Minor Court Appeal ☐ Minors ☐ Non-Jury ☐ Petition ☐ Statutory Appeals ☐ W/D/Survival ☐ Other:

CASE TYPE AND CODE
20 - PERSONAL INJURY - OTHER

STATUTORY BASIS FOR CAUSE OF ACTION

RELATED PENDING CASES (LIST BY CASE CAPTION AND DOCKET NUMBER)	IS CASE SUBJECT TO COORDINATION ORDER?
FILED PRO PROTHY APR 10 2018 M. BRYANT	YES NO

TO THE PROTHONOTARY:

Kindly enter my appearance on behalf of Plaintiff/Petitioner/Appellant: XIANGUO KONG , ZHAO LIN

Papers may be served at the address set forth below.

NAME OF PLAINTIFF'S/PETITIONER'S/APPELLANT'S ATTORNEY CAROL N. SHEPHERD		ADDRESS 1845 WALNUT STREET 21ST FLOOR PHILADELPHIA PA 19103
PHONE NUMBER (215)567-8300	FAX NUMBER (215)567-8333	
SUPREME COURT IDENTIFICATION NO. 28650		E-MA L ADDRESS cshepherd@feldmanshepherd.com
SIGNATURE OF FILING ATTORNEY OR PARTY *CAROL SHEPHERD*		DATE SUBMITTED Tuesday, April 10, 2018, 11:15 am

FINAL COPY (Approved by the Prothonotary Clerk)

FELDMAN, SHEPHERD, WOHLGELERNTER,TANNER, WEINSTOCK & DODIG, LLP
By: Carol Nelson Shepherd, Esquire/Patricia M. Giordano, Esquire/Andrew K. Mitnick, Esquire
I.D. No.: 28650/45051/80667
1845 Walnut Street, 21st Floor
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ATTORNEYS FOR PLAINTIFFS

Filed and Attested by the
Office of Judicial Records
10 APR 2018 11:15 am
M. BRYANT

XIANGUO KONG and ZHAO LIN, Administrators of the Estate of AO KONG, Deceased and XIANGUO KONG and ZHAO LIN, Individually	COURT OF COMMON PLEAS PHILADELPHIA COUNTY
	APRIL TERM, 2018
	NO.:
v.	JURY TRIAL DEMANDED
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA 3451 Walnut Street, Room 329 Philadelphia, PA 19104	

NOTICE TO PLEAD

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defense or objections to the claim set forth against you.

You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP

LAWYER REFERENCE SERVICE
ONE READING CENTER
PHILADELPHIA, PA 19107
(215) 238-1701

AVISO

Le han demandado a usted en la corte. Si desea defendersecontra las quejas presentadas, es absolutamente necesario que usted responda dentro de 20 dias despues de ser servido con esta demanda y aviso. Para defendderse es necesario que usted, o su abogado, registre con la corte en forma escrita, el punto de vista de usted y cualquier objeccion contra las quejas en esta demanda.

Recuerde: Si usted no responde a esta demanda, se puede proseguir con el proceso sin su participation. Entonces, la corte puede, sin notificarlo decidir a favor del demandante y requerira que usted cumpla con todas las provisiones de esta demanda. Por razon de esa decision, es possible que usted pueda perder dinero, propiedad o otros derechos importantes.

"LLEVE ESTA DEMANDA A UN ABOGADO IMMEDIATAMENTE. SI NO TIENE ABOGADO O SI NO TIENE EL DINERO SUFICIENTE DE PAGAR TAL SERVICIO VAYA EN PERSONA I LLAME POR TELEPHONO A LA OFICINA CUYA DIRECCION SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CON SEGUIR ASISTENCIA LEGAL.

SERVICIO DE REFRENCIA LEGAL
ONE READING CENTER
1101 MARKET STREET
PHILADELPHIA, PA 19107
(215) 238-1701

COMPLAINT IN CIVIL ACTION

THE PARTIES

1. Plaintiffs Xianguo Kong and Zhao Lin, husband and wife, are adult residents of the Commonwealth of Pennsylvania residing at [redacted] [redacted].

2. Plaintiffs Xianguo Kong and Zhao Lin are the parents of Ao "Olivia" Kong, deceased. Olivia was born on March 7, 1995 and died on April 11, 2016.

3. Plaintiffs Xianguo Kong and Zhao Lin are the duly appointed Administrators of the Estate of Ao Kong, Deceased. (A copy of the Letters of Administration is attached as Exhibit "A.")

4. At all relevant times, Olivia Kong was a full-time undergraduate student at University of Pennsylvania, an Ivy League academic institution.

5. Defendant Trustees of the University of Pennsylvania is a corporation and/or legal entity organized and existing under the laws of the Commonwealth of Pennsylvania. At all relevant times, Trustees of the University of Pennsylvania maintained an office at 3451 Walnut Street, Room 329, Philadelphia, Pennsylvania 19104.

6. At all relevant times, Trustees of the University of Pennsylvania owned, operated, controlled and did business as the University of Pennsylvania, also known as "Penn." (From here forward, Trustees of the University of Pennsylvania will be referred to as "Trustees," "Penn" or "University.")

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7. At all relevant times, Penn formulated and enacted multiple programs and resources focused on helping its students manage academic stress and situational crises.[1] Among these programs and resources were the Counseling and Psychological Services, known and hereafter referred to as "CAPS," the Student Health Service and Academic Services, including services provided by its academic advisors.

8. Although CAPS provides free and confidential professional counseling, the confidentiality of the information shared by the student, whether in-person or over the phone, is waived in instances where the student is in imminent danger of serious harm.[2]

9. CAPS is set up so that students in crisis can walk into its offices during regular business hours and be seen immediately by a member of its clinical staff.[3] After hours, an on-call CAPS clinician is available by calling an emergency telephone number that connects students to an emergency operator at the Hospital of the University of Pennsylvania (HUP). When warranted, the on-call after-hours clinician has the option of referring a student in-crisis to HUP's Psychiatric Emergency and Evaluation Center (PEEC) or contacting Penn's on-campus police which, in urgent situations and in partnership with Penn's Medical Emergency Response Team, evaluates a student in-crisis to ensure the student's safety.[4] CAPS clinicians also have the

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[1]*See* February 2015 report of Penn's Task Force on Student Psychological Health and Welfare, found at *https://almanac.upenn.edu/archive/volumes/v61/pdf/task-force-psychological-health.pdf*.

[2]*See https://www.vpul.upenn.edu/caps/faq*.

[3]The information contained in this paragraph is found in the report of Penn's Task Force on Student Psychological Health and Welfare, the cite for which is found in n. 2, *supra*.

[4]Per the Task Force, Penn's Division of Public Safety, including its Police Department, "provides emergency communications for police, fire and medical emergency responders *24-hours-a-day, 7-days-a-week*" (emphasis added). The Task Force continued: "In addition, the Division is an active advisor to the student-run Medical Emergency Response Team (MERT). MERT members, who are certified emergency medical technicians and Penn Police Officers,

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option of working with Student Intervention Services (SIS)[5] to manage students in acute distress or referring students to those appropriate clinicians affiliated with the University of Pennsylvania Health System and/or the Hospital of the University of Pennsylvania.

10. Upon information and belief, either prior to or upon Olivia's arrival at Penn in the fall of 2013, Penn notified her of the services offered by CAPS, the Student Health Service and Academic Services, including those available through The Wharton School.

11. At all relevant times, Trustees acted by and through its employees, servants, agents, contractors, subcontractors and staff, including those physicians, social workers and other clinicians who provided treatment and care to students seeking services at CAPS and the Student Health Service as well as those faculty and academic advisors who provided students with advice and assistance regarding course load, withdrawal from classes and/or leaves of absence. At all relevant times, all of these employees, servants, agents, contractors, subcontractors, faculty and staff acted with actual, apparent and/or ostensible authority and within the course and scope of their employment or affiliation with Trustees and/or Penn. Among those physicians, social workers, clinicians, faculty and staff who provided services to Olivia during the relevant time are Amanda Swain, M.D., John Stein, M.D., Nicole Nardone, Ken Meehan, Lindy Black-Margida and Teran Tadal.

12. At all relevant times, Trustees by and through its executives, directors, program administrators, senior management and/or other administrators, employees, servants, agents,

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receive training from CAPS on recognizing signs of emotional distress and the campus resources available to support students in crisis."

[5]Per the Task Force, Penn's Student Intervention Services or SIS "coordinates the University's response to individual students in need and provides support and assistance to groups of students affected by a crisis. The SIS staff and members of the SIS network team are trained in *crisis intervention* and management and are *available 24-hours-a-day, 7-days-a-week*" (emphasis added).

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contractors, subcontractors and/or staff were responsible for the establishment, oversight and operation of CAPS, the Student Health Service and/or the Academic Services and for the hiring, training, supervision and retention of those individuals providing services through CAPS, the Student Health Service and The Wharton School's Academic Services. Among these executives, directors, program administrators, senior management and/or other administrators, employees, servants, agents, contractors, subcontractors and/or staff were Amy Gutmann, Vincent Price, Rebecca Bushnell, Anthony Rostain, Joann Mitchell, Andrew Binns, Jody Foster, Charles Howard, Valerie Swain-Cade McCollum, Maureen Rush, Wendy White, Leah Popowich, Rob Nelson, William Alexander, Michal Saraf, Meeta Kumar, Jane Kotler, Scott Rameika, Lindy Black-Margida and Kendal Barbee.

13. At all relevant times, Trustees by and through its executives, directors, program administrators, senior management and other administrators, employees, servants, agents, contractors, subcontractors and/or other staff, including but not limited to those individuals identified in paragraphs 11 and 12, *supra*, oversaw those individuals providing services by and through CAPS, the Student Health Service and the Academic Services, including those available through The Wharton School. Additionally Trustees, by and through these or other executives, directors, program administrators, senior management and other administrators, employees, servants, agents, contractors, subcontractors and/or other staff, formulated and enacted policies governing the operation of CAPS, the Student Health Service and the Academic Services, including those available through The Wharton School.

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14. Although plaintiffs do not believe that this action falls within the purview of Pa.R.C.P. 1042.1 *et seq.*, they have obtained a written statement(s) from an appropriately licensed professional(s) and a Certificate of Merit as to Defendant Trustees is attached as Exhibit "B."

AO "OLIVIA" KONG

15. Olivia Kong was born in China and came to the United States when she was nine years old. She lived with her parents, also Chinese immigrants, and younger brother in Philadelphia.

16. From an early age, Olivia was an outstanding student. She attended Philadelphia's best public schools graduating from Central High School with honors in 2013.

17. Olivia's academic achievements also included National Honor Society, first place in multiple science fairs sponsored by the City of Philadelphia and multiple first place finishes in national math contests.

18. Olivia's achievements at Central High were not just limited to academics as she played on the varsity tennis team, was the Op-Ed/Layout Editor of the school newspaper, played in its orchestra and participated in the drama club. Committed to improving the lives of others, Olivia also volunteered with numerous community service organizations.

19. Because of her strong academic record, Olivia was accepted by early decision to Penn's Wharton School, Class of 2017. Because of her academic prowess, Olivia was awarded several academic grants and scholarships, including the prestigious Mayor's Scholarship, which is awarded each year to the City of Philadelphia's top 50 high school seniors.

20. With the exception of semesters abroad, Penn undergraduates are required to take a minimum of 4 course units a semester. Wharton undergraduates are required to get permission

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from their academic advisor to take more than 5.5 credit units (CUs) a semester. To maintain satisfactory progression, Wharton undergraduates are required to complete a minimum of 24 CUs by the end of junior year.

21. In her freshman year, Olivia earned 4 CUs her first semester and 5 CUs the second semester.

22. She earned 5 CUs in both the fall and spring semesters of her sophomore year.

23. Olivia studied abroad in Australia during the first semester of her junior year, earning the maximum 3 CUs available through that program.

24. Having earned only A's and B's, Olivia's cumulative grade point average heading into the spring semester of her junior year was an impressive 3.3. Because of her multiple accomplishments while at Penn, Olivia was offered a paid summer internship with Bank of America in its New York City office.

25. Despite having accumulated 22 of the 24 CUs needed to stay on track to graduate at the end of four years, Olivia's academic advisor, Lindy Black-Margida, encouraged her to take 6 CUs the second semester of her junior year. Aware that such a heavy course load could increase Olivia's academic stress, Ms. Black-Margida cautioned Olivia to "assess [her] workload at beginning of semester and keep track of [the] drop deadline."

26. In the spring of 2016, undergraduate students were permitted to drop a course without consequence up until the end of the fifth week of the semester, or by February 19th. Between the fifth and tenth weeks of the semester, ending March 25th, students were permitted to withdraw from a course only with the written permission of the course instructor. After the tenth week, withdrawals were permitted only under extraordinary circumstances and after consultation

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with a "specialized" academic advisor. Notably, none of Wharton's written or on-line materials identified by name the "specialized" academic advisor overseeing late withdrawals.

27. Approximately half-way through the semester, Olivia became ill. On March 4th she was seen by a nurse practitioner in the Student Health Service complaining of a sore throat, nasal congestion and pink eye. She also reported having a fever during the previous week. She was diagnosed with an upper respiratory infection and conjunctivitis for which she was given antibiotics and eye drops. Olivia was told to take fluids, get some rest and return as needed.

28. Less than a month later, on Wednesday, March 30, 2016, Olivia returned to the Student Health Center. She was seen initially by a nurse who recorded Olivia's complaints of a fever for three days, a sore throat and cough. Olivia also reported that she "tried to do work [but] is stressed that [she] can't do work" and was anxious. On examination, Olivia had a fever of 102.1°F and her pulse at 153 was significantly elevated.

29. Olivia was then seen by Amanda Swain, M.D. to whom Olivia repeated that she "felt very tired" and hadn't been getting enough sleep, with as little as three hours a night. Despite her documented references to Olivia's stress, anxiety, lack of sleep and inability to concentrate, Dr. Swain attributed Olivia's signs and symptoms to an upper respiratory infection and fever.

30. Dr. Swain merely instructed Olivia to get a good night sleep. Dr. Swain did not address Olivia's self-reported anxiety or academic stress nor did she refer Olivia to any of the other Penn programs or resources intended to assist students experiencing such stress.

31. By the early morning hours of April 7th, Olivia's physical and mental health had deteriorated dramatically and this time, instead of seeking help at the Student Health Service, she contacted CAPS. Tragically, over the course of the next few days, multiple CAPS clinicians

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intentionally disregarded, completely ignored and/or utterly failed to understand Olivia's repeated pleas for help and specific statements that she was feeling hopeless and considering suicide.

Thursday, April 7, 2016

32. Distraught, Olivia called CAPS sometime around 1:30 a.m. Dr. John Stein, a psychiatrist who was the on-call after-hours CAPS clinician, returned her call at 1:39 a.m.

33. In his note (written approximately 12 hours later at 2:23 p.m.), Dr. Stein recorded that Olivia was anxious and unable to sleep because of her anxiety. She reported being scared of failing a class and that she had suffered a panic attack about a week earlier (which, perhaps not coincidentally, would have occurred about the same time Olivia was seen by Dr. Swain in the Student Health Service). She conveyed a hatred of herself and that she had "***suicidal*** thoughts." Despite these statements, Dr. Stein incredibly described Olivia as having "no apparent derangements of her mental status" nor poor or impaired judgment.

34. Moreover, despite Olivia's seeking help at such an unusual hour, Dr. Stein merely discussed with her how CAPS could assist her during regular business hours with pursuing a late withdrawal. Seemingly aware of Wharton's requirement that a late withdrawal required a showing of exceptional circumstances, Dr. Stein nevertheless dismissed Olivia's concerns and fears as typical and run of the mill for undergraduates.

35. In need of urgent help, Olivia went to the CAPS office later that day where she was required to complete an intake form. Her responses were extremely concerning. After reporting that she was experiencing academic issues that were getting worse, Olivia affirmed that she was having *current* thoughts of ***suicide***.

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36. Upon information and belief, sometime between 10:40 a.m. and 2:30 p.m., Olivia met with Nicole Nardone, a licensed social worker, for approximately 40 minutes. It was not until 6:22 p.m., after she was further apprised of Olivia's fragile state, that Ms. Nardone documented her earlier interactions with Olivia.

37. Notably, although Olivia did not recall Dr. Stein by name, she reported to Ms. Nardone that he had told her that due to extenuating circumstances, CAPS could help her withdraw from a class without her having to speak with her advisor, who was out of the country and therefore unavailable to assist her. Olivia repeatedly stated to Ms. Nardone that she was scared about failing her classes. She was worried that if she couldn't get one of her classes dropped, things were going to get worse. She explained that she had been sick and that despite her requests for academic help, no one would help her. She was frustrated and ashamed and felt stupid for not knowing what to do and believed there was no one with whom she could speak about this problem.

38. Olivia told Ms. Nardone that she felt ***suicide*** was an easier option than catching up with her studies. She also said that she had been thinking of committing ***suicide*** for a few weeks; as most recent as the previous evening. Significantly, she also offered that she would use sleeping pills as the method to kill herself. Believing that Olivia did not have access to sleeping pills, Ms. Nardone concluded that Olivia had no actual intention or means to commit suicide.

39. Olivia also reported to Ms. Nardone that she had not slept for more than one hour a night for the last week and that she would shake when sleeping. She had no appetite and her nose was "bleeding massively." She described herself as "very depressed."

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40. Despite all of those warning signals, Ms. Nardone (after speaking with Ken Meehan, another more experienced CAPS clinician) did nothing more than advise Olivia that CAPS could not help her effectuate a late withdrawal. Instead, she advised Olivia that "if appropriate," CAPS could only provide her with "supporting documentation." She had Olivia leave a voicemail for her academic advisor and sign a form allowing CAPS to speak directly with Ms. Black-Margida.

41. Remarkably, Ms. Nardone did not refer Olivia to either a CAPS or private psychiatrist nor any of the other emergency services available for students in acute distress such as the Psychiatric Emergency and Evaluation Center (PEEC), the on-campus police, the Student Intervention Services, the University of Pennsylvania Health System or the Hospital of the University of Pennsylvania.

42. Instead, she merely offered Olivia an appointment later that day or the next day with the on-call CAPS clinician. Due to her conflicting academic schedule, Olivia was unable to accept those appointments. She did, however, schedule a follow-up appointment with another counselor four days later on Monday, April 11, 2016 at 3:00 p.m.

43. Later that afternoon, Olivia met with Teran Tadal, another Wharton academic advisor. Ms. Tadal documented her meeting with Olivia noting that Olivia had not felt well and had spoken with CAPS. After speaking with Ms. Tadal for approximately twenty minutes, Olivia filed a Petition for Late Withdrawal. Before Olivia left, Ms. Tadal encouraged her to stay in touch.

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44. In the Petition, which was submitted electronically at 3:47 p.m., Olivia requested permission for late withdrawal of an upper level course. As Olivia explained, she was "struggling with the class and it is causing me to become depressed. I have not been able to sleep for the past week and have had no appetite or desire to talk to anyone." She further explained that she still had five other classes and that if she could concentrate only on those classes, she would be "in a better mental health condition." She concluded her Petition by noting that she "*has* thoughts of ***suicide*** and am seeing a CAPS advisor about my problems but I would like to have more time to catch up with my other classes because I have also had multiple fevers this semester and am just behind on classes overall."

45. After Olivia left her office, Ms. Tadal called CAPS and spoke with Ken Meehan. In a note written at 6:22 p.m., Mr. Meehan indicated that Ms. Tadal had called him to express her concerns for Olivia. She told Mr. Meehan that Olivia mentioned to her that she had "***suicidal*** ideation in the past," and she wanted to make sure that CAPS had that information.

46. After speaking with Ms. Tadal, Mr. Meehan consulted Ms. Nardone and asked her to send Olivia an email "reminding her of CAPS walk-in service should she need support prior to her scheduled appointment [on April 11]."

47. As instructed, at 6:20 p.m., Ms. Nardone sent Olivia a perfunctory email. After stating that "[i]t was a pleasure speaking with you today," she reminded Olivia of her April 11th appointment. She then mentioned that should Olivia become "distressed" prior to her appointment, she had the option to either walk-in to or call CAPS during regular business hours or contact the on-call clinician after-hours. Alternatively, she indicated that Olivia could call 1-800-SUICIDE twenty-four hours a day. She closed with a gratuitous final reminder that Olivia should "feel free to reach out with questions or concerns."

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Friday, April 8, 2016

48. The next morning, at approximately 8:30 a.m., Olivia contacted the Student Health Service and requested copies of the records from her last two visits (March 4th and March 30th) to support her request for a late withdrawal.

Saturday, April 9, 2016

49. Olivia's shame and frustration continued throughout the weekend. During the afternoon of Saturday, April 9th, Olivia informed a friend that she "had been trying to see a doctor but it's not working." She also reported to this friend that she was "stressed at school" and "thinking about suicide."

50. Concerned with Olivia's wellbeing, her friend contacted a graduate assistant named Kevin who, in turn, contacted the on-call after-hours CAPS clinician, who happened to be Dr. Stein, to report Olivia's texts.

51. According to Dr. Stein's notes, he received a call from a graduate assistant named Kevin who told him that a student had come to him concerned about Olivia. That student's concerns were based on the text messages referenced above in paragraph 49, including the text that Olivia was "thinking about ***suicide.***" According to his note, Dr. Stein called Olivia's friend, who reportedly told Dr. Stein that the friend suggested that Olivia speak with her course instructor.

52. Sometime between 5:30 p.m. and 7:00 p.m., Dr. Stein left a voicemail advising Olivia that he had gotten a call from the "RA" as a result of someone expressing concerns about her well-being. After reminding her of the CAPS emergency telephone number, Dr. Stein asked Olivia to return his call.

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53. Olivia returned Dr. Stein's call, and they spoke for an hour beginning at 8:15 p.m. In his note dictated *after* he learned of Olivia's death, Dr. Stein recorded that Olivia was "still having some [thoughts] about ***suicide***." She told him that she felt hopeless about her situation and that Wharton was putting up roadblocks to her withdrawing from a class as evidenced, in part, by the fact that two of her academic advisors were out of the country and therefore of no help to her in making an informed decision about her options, including a possible leave of absence. Olivia told Dr. Stein that she thought CAPS would facilitate her dropping a class but Ms. Nardone had been of no help in that regard. After telling him that "people aren't listening to me," Olivia said that she planned to return to campus the next day [Sunday] and ***kill herself***!

54. Olivia also told Dr. Stein that she had gone home Friday night and her mother held her while she cried. She still wasn't able to sleep and although her parents had given her an Ambien, a sleeping pill, it didn't help as all she could do was anxiously ruminate about her situation.

55. During the course of their conversation, Olivia asked Dr. Stein for information about an inpatient psychiatric admission, a clear indication of her measure of distress and her willingness to do whatever was necessary to obtain help. He told her that was an option "if no other plan can work." In response to Olivia's questions about the expense of getting help at the emergency department, Dr. Stein callously remarked that "the cost of [an emergency room] is likely less than [the] cost of funeral arrangements"!

56. Dr. Stein then reiterated that Olivia's options included taking a leave of absence or dropping a class, and he encouraged her to speak with her parents about her concerns. He also told her that he would contact Kendal Barbee, another Wharton advisor, and ask her to assist

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Olivia with her situation. Finally, he reminded Olivia that she had the options of calling CAPS or 9-1-1.

57. Dr. Stein's exculpatory note concludes with his opinion that despite occasional periods when she sounded "sleepy and distracted," Olivia did not sound "psychotic." He believed that she would return to Penn on Monday to follow-up on the process of taking a leave of absence. In addition to his meaningless responses, Dr. Stein did absolutely nothing to keep her safe, especially given her stated plan to return to campus on Sunday to "kill herself."

58. At 9:45 p.m., Dr. Stein emailed Ms. Barbee with a copy to Olivia. He advised Ms. Barbee that he had spoken with Olivia that evening while he was on-call for CAPS. Expressly noting that he did not expect Ms. Barbee to receive the email until Monday morning, April 11th, he advised her that Olivia had been "stressed about her academic situation for many days" and "getting little sleep." He informed Ms. Barbee that Olivia had been having "significant thoughts which are quite worrisome to me as a clinician." He advised Ms. Barbee that Olivia seemed worse that night "due to a lack of sleep, overthinking and stress." After mentioning that Olivia had an appointment on Monday afternoon with the CAPS on-call clinician, he advised Ms. Barbee that he had told Olivia that if she did not think she could emotionally make it until Monday, then she should call the CAPS on-call clinician, 9-1-1 or "get herself to the ER." He concluded his email by asking Ms. Barbee to prioritize Olivia's case due to her being "quite frazzled."

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59. Notably, at no time that evening did Dr. Stein contact Olivia's parents to apprise them of their daughter's precarious and fragile condition or her stated suicide plan. Further, he failed to refer her to any of Penn's other programs or resources established to assist Penn students in acute distress or to any of its affiliated medical facilities, including the Hospital of the University of Pennsylvania, Penn Presbyterian or Pennsylvania Hospital.

60. Later that evening, one of Olivia's friends received a text from her that concerned him. He called her and found her unwell. She was stuttering and her voice was frail. She did not seem to know the day or time. She said her mind wasn't straight and she hadn't been able to sleep. She agreed to meet him the next morning.

Sunday, April 10, 2016

61. As planned, he and Olivia met at approximately 9:30 a.m. the following morning. He thought Olivia looked defeated and emotionally emaciated as well as ashen, tired and listless. They spoke about the difficulty she was having with school and her fear of failing. She told him that she never received a reply back from the two tutors she had contacted previously for help with the class she was trying to drop. She also told him that she was scared of the impact her failing and/or taking a leave of absence would have on her summer internship with Bank of America as well as her financial aid, and she was afraid that Penn would not let her return if she failed. They departed with him suggesting that she get some sleep.

62. At some other point that day, Olivia expressed to another friend that she was having a difficult time getting an appointment with a CAPS counselor and that she didn't see the point in "going on."

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63. Sometime that same day, Dr. Stein allegedly called Olivia to "check in with her given [his] concerns about her from yesterday." Supposedly, Olivia didn't answer and he left a voicemail suggesting that she call the CAPS emergency number to speak with (another) on-call clinician.

64. In yet another exculpatory note written *after* her death, Dr. Stein explained that at the time he left Olivia that voicemail, it was his assessment "that she was capable of reaching out should she need to as she had done a few days previously." He ended the note by expressing his erroneous conclusion "that further intervention by me at the time was [not] indicated or appropriate."

<u>Monday, April 11, 2016</u>

65. At or shortly after about midnight, concerned with her welfare but sadly unaware of her expressed intention to commit suicide, Olivia's parents visited her at school to check on her and give her a hug. That was the last time they saw her alive. Had they known that Olivia was suicidal, they would have brought her home and taken immediate action to ensure that she received the help she so desperately needed.

66. After a restless night, Olivia walked to the SEPTA Station at 40th and Market Streets. Beginning at approximately 6:45 a.m., a SEPTA surveillance camera captured Olivia pacing back and forth and back and forth along the train platform. She is alone and in her pajamas. She is tugging at her hair and staring at her hands. After two trains pass, Olivia flops onto the platform bench. After a third train comes and goes, she gets up and begins walking along the platform's yellow textured caution strip toward the tunnel; with each step, she moves closer and closer to the platform's edge. Near the mouth of the tunnel, she crouches down and then sits with her legs dangling off the platform. Within seconds, she jumps onto the train tracks and begins walking along the tracks into the dark tunnel.

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67. According to the train conductor, as the train entered the tunnel, he saw someone laying on the tracks. As the train entered the tunnel, Olivia looked up and made eye contact with him. Although he applied the emergency brake, he was unable to prevent the train from hitting her.

68. At 6:59 a.m., within seconds of entering the station, the train stops. The conductor peers out the window and then the train's front door. He takes the train out of service and the passengers exit. He jumps onto the tracks to investigate.

69. The conductor contacted his superiors, and SEPTA notified the police and medical examiner, to report what had happened.

70. About ninety minutes later, Olivia's crumpled and broken body was removed from the tracks. Her body was transported to the medical examiner's office where an autopsy found that she died from blunt force trauma.

71. At some point later that morning or early afternoon, Penn was notified of Olivia's suicide. Initially, Amy Gutmann, the University's President, sent an email announcing the "death" of a Penn student. The email did not identify Olivia by name, nor did it identify the cause of death.

72. Several minutes later, at 2:34 p.m., Lori Rosenkopf, Vice Dean of the Undergraduate Division of The Wharton School, sent an email to Wharton's undergraduates advising them that "Ao 'Olivia' Kong . . . died this morning in an *accident* at the 40th Street Septa station" (emphasis added). In that same email, Dean Rosenkopf "encouraged students needing information and support to seek assistance" from, *inter alia*, CAPS, Wharton's academic advisors and the Student Health Service.

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73. No one from Penn notified Olivia's parents of the manner of her death. On the contrary, Penn representatives told the parents that Olivia's cause of death was "an accident." It was not until several hours later, at 3:45 p.m., that they were notified by someone from the medical examiner's office of the cause and manner of her death.

74. Outraged by Penn's use of "accident" as a euphemism for Olivia's suicide, several students demanded that the University reissue its notice of Olivia's death to identify it as a suicide.

75. Olivia was the *10th Penn student to commit suicide in 3 years*, well above the national average. Since Olivia's suicide, another four Penn students have committed suicide, also well above the national average.

CAPS

76. Over many years, Penn touted its commitment to student wellbeing and its "wide-range of services to support and address the mental and physical health needs of students."[6]

77. As noted, among those services was CAPS which, in its "Managing Stress"[7] brochure, identified stress as the biggest threat to college students' *academic* performance.

78. In that same brochure, CAPS identifies the multiple ways in which stress manifests itself, including feelings of anxiety, fear, self-criticism, repetitive and excessive thoughts, insomnia and loss of appetite, all of which Olivia experienced within the last few weeks of her life and which she reported to the Student Health Service, Dr. Stein, Nicole Nardone, Teran Tadal, and through another student, a graduate assistant.

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[6] *See* *https://provost.upenn.edu/policies/pennbook/2013/02/15/involuntary-leave-of-absence*.

[7] A current version of this brochure is available on-line at *https://www.vpul.upenn.edu/caps/files/managingstress.pdf*.

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79. The brochure also identifies two types of stress. The first of these is academic stress, which arises out of work overload, and the second is internal stress, which results from "unreasonably" high standards, dwelling on the negative, worry and comparison with others.

80. The brochure also warns students that "bad" stress decreases one's ability to perform and can be a "threat" to one's health and wellbeing leading to feelings of hopelessness, a feeling Olivia communicated to the multiple Penn representatives from whom she sought help.

81. The brochure also encourages students to pursue professional help if they feel stressed or anxious, are having academic problems or otherwise not enjoying school, having troubling thoughts of harming themselves, or if they are having difficulty sleeping or eating, all of which Olivia expressed during her communications with the multiple Penn representatives from whom she sought help.

TASK FORCE

82. In February of 2014, shortly after two undergraduates committed suicide within three weeks of each other, Penn convened a Task Force on "Student Psychological Health and Welfare," the purported purpose of which was to "examine the challenges confronting students that can affect their psychological health and wellbeing, review and assess the efficacy of Penn resources for helping students manage psychological problems, stress, or situational crises; and make recommendations related to programs, policies, and practices designed to improve the quality and safety of student life."[8]

83. At the time the Task Force was formed, President Gutmann issued a statement in which, after acknowledging the "increasing need for psychological support services and

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[8]*See* the report of the Task Force on Student Psychological Health and Welfare, found at *https://almanac.upenn.edu/archive/volumes/v61/n23/pdf/task-force-psychological-health.pdf*, *citing* *http://www.upenn.edu/pennnews/news/penn-forms-new-task-force-student-psychological-health-and-welfare*.

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programs" and Penn's "assiduous" efforts "to ensure the wellbeing of our students," she recognized that the time had come for Penn "to review our work and to ensure that we have in place the best practices in outreach, education, intervention, and treatment."[9]

84. Among those assigned to the Task Force were Dr. Anthony Rostain, Professor of Psychiatry and Pediatrics and Director of Education for the Department of Psychiatry at the Perelman School of Medicine,[10] Jody Foster, Clinical Associate Professor of Psychiatry, Perelman School of Medicine and Chair of the Department of Psychiatry at Pennsylvania Hospital[11] and Maureen Rush, Vice President for Public Safety and Superintendent of Penn Police.

85. Notably absent from the Task Force were students from Penn's four undergraduate schools, including Wharton. Equally troubling is the complete absence of any Wharton undergraduate from either of the two Task Force's "working groups."[12] Similarly, there is no evidence that John Stein, Nicole Nardone, Ken Meehan, Lindy Black-Margida, Teran Tadal or any other Wharton academic advisor was part of either of the working groups.

86. In its report issued a year later in February, 2015, and more than a year before Olivia's suicide, the Task Force acknowledged that the transition from high school to college "can be very stressful" and that such "stressors are compounded when the student's resilience and other life skills have not developed to allow them to recover from setbacks and challenges in ways that allow for growth rather than distress."

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[9] *See* *http://www.upenn.edu/pennnews/news/penn-forms-new-task-force-student-psychological-health-and-welfare*.

[10] Perelman School of Medicine is the medical school of the University of Pennsylvania.

[11] Pennsylvania Hospital is a hospital affiliated with the University of Pennsylvania Health System.

[12] The working groups were the Education and Outreach Working Group and the Intervention and Treatment Working Group.

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87. The Task Force also acknowledged that "Penn has a highly competitive academic and extracurricular culture that some students perceive to demand perfection. Such perceptions may lead to pressures to succeed both academically and socially that may be unrealistic and lead to feelings of being overwhelmed. Some experience depression or other forms of distress often evidenced by changes in behavior."

88. In response to these known pressures, Penn had "created a comprehensive set of offices and programs for fostering the psychological health and welfare of its students, extending from preventative care to responses to crises."

89. Shockingly, however, the Task Force placed the responsibility for its students' health and wellbeing not on the professionals associated with those offices and programs but on the students themselves.

90. Nevertheless, the Task Force admitted that the University was responsible for ensuring its students' safety, health and wellbeing when "during times of stress or distress," it becomes "challenging [for the student] to maintain one's perspective and to make sound decisions about whether and to whom to turn for help."

91. According to the Task Force, Penn met that responsibility by developing "a strong and committed network of individuals and offices that can either provide direct assistance or ensure that students are appropriately referred." Among these programs were CAPS, the Student Health Service and Academic Services.

92. The Task Force was particularly impressed with CAPS, recognizing it as being "at the forefront of the University's efforts to provide professional mental health services to all Penn students" and highlighting its "crucial role" in responding to students in crisis.

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93. Notwithstanding the existence of those programs and resources, the Task Force did recognize that there were challenges to dealing with students who perceive "only one pathway to success which demands a near-perfect academic record," leaving them vulnerable to setbacks that "can lead to distress which, in turn, can manifest as demoralization, alienation, or conditions like anxiety or depression [which] [i]f left untreated [may] lead to serious impairment."

94. Equating anxiety and depression with "mental illness," the Task Force recognized that these conditions "can lead to suicide, with devastating consequences for families, friends, and entire communities." As such, the Task Force "believe[d] that the University and all members of [Penn's] community *must do all we can to reduce the risk of suicide*, even if the complete elimination of that risk is not possible" (emphasis added).

95. Paradoxically, after acknowledging that neither its faculty nor staff "always know how to respond or where to turn for support when they observe a student in need of help," the Task Force promised that CAPS would strive to "meet the highest professional standards and [employ] the best practices consistent with nationally established criteria" to ensure student wellbeing.

96. Then, after again lauding Penn's existing resources and programs (none of which prevented three additional student suicides committed during the year between the formation of the Task Force and the publication of its report), the Task Force concluded that the problem did not lie with those programs and resources but in persuading students to use them.[13]

[13]The ultimate irony being that Olivia not only sought help from <u>all</u> of the resources available to her, but she also specifically communicated her suicidal thoughts and plans, all to no avail.

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97. Despite the inference that the University's success in reducing or preventing student suicide should be measured by the use of those programs and resources, the Task Force tacitly recognized that its success actually depended on Penn's ability to reduce the risk of student suicide.

98. To meet this goal, the Task Force recommended earlier and more consistent communication and education about the importance of mental health and wellbeing to its students' success; making information about the University's available resources for student mental health and wellness more easily accessible; educating and training faculty and staff "about fostering mental health and responding to students who need help"; and optimizing CAPS resources to meet the needs of students seeking its services. [14]

99. At a minimum, the Task Force's report establishes that as of February, 2015, more than a year before Olivia's suicide, Penn was clearly aware that the highly competitive academic stresses it placed upon its students not only increased their risk of developing depression and anxiety but decreased their ability to maintain proper perspective and make sound decisions about their safety, health and wellbeing thereby increasing their risk of committing suicide.

100. The suicides of two additional students in the year or so between the issuance of the Task Force's report and Olivia suicide establishes the University's complete and utter failure to eradicate the worsening epidemic of Penn student suicides.

101. As for Olivia, instead of protecting her from the harms caused by her overwhelming academic stress by referring her to or collaborating with the multiple mental health services and programs available to Penn's students, including its Behavioral Health

[14] Again, all of the then existing resources following the Task Force failed Olivia.

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Service, the PEEC or any of the other services offered by or through the University of Pennsylvania Health System and/or HUP, the persons from whom she sought help, including Dr. Amanda Swain, Dr. John Stein, Nicole Nardone, Ken Meehan and Teran Tadal, were either completely unaware of those resources, thus calling into question the University's commitment to disseminating that information, completely disregarded those resources or completely misunderstood the seriousness of and potential effects of Olivia's anxiety and suicidal ideation thereby calling into question their competency and qualifications. Regardless, the failure of those persons from whom Olivia sought help to ensure her ability to maintain proper perspective and make sound decisions about her safety, physical and mental health and wellbeing left her feeling that her only option was suicide.

102. The pervasiveness of Penn's inability to effectuate any meaningful changes to the manner in which its employees, servants and agents assisted students in-crisis or to reduce the risks associated with that distress is further exemplified by a statement made by Professor Arthur Dunham, Associate Chair of Biology, just two days after Olivia's suicide (and more than a year after the issuance of the Task Force report) that he "took no personal responsibility for any [student] suicides." In addition, Professor Dunham's statement infers that the Task Force's findings and recommendations were ignored by the very people responsible for ensuring the students' wellbeing.

103. Not surprisingly, after Olivia's suicide, Penn faced criticism from many students and faculty who believed it incapable of effectively responding to the issue of student suicide.

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104. To combat that perception, Penn reconvened the Task Force after Olivia's suicide.

105. However, when the reconvened Task Force's work was completed, sometime around September of 2016, it failed to release a report because, remarkably, it concluded that existing mental health initiatives were adequately addressing the issue.

106. Shortly thereafter, on October 31, 2016, yet another Penn student committed suicide. Since then there have been at least three additional student suicides.

107. The only reasonable inferences to be drawn from these ongoing student suicides are that Penn does not care about the safety, health and wellbeing of its students and/or is unwilling to take appropriate measures to preventing such tragedies. Given Penn's $12 billion endowment, there were (and are) sufficient resources to address its continued failure to ensure the safety of its students, but for inexplicable reasons, it has failed (and continues) to do so.

108. Regardless of the reasons, so long as Penn refuses to adequately address the academic and personal stresses underlying these suicides and take appropriate measures to protect its students from the harms associated with those stresses, it willfully and recklessly exposes its students to an extraordinarily high risk of suicide.

109. Similarly, Penn's abject failure to hire competent and qualified professionals to assist its students in managing their stress and/or enact and implement policies designed to ensure the safety, physical and mental wellbeing of its students, constitutes a reckless disregard and callous indifference to the safety, health and wellbeing of its students.

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COUNT I
NEGLIGENCE, GROSS AND CORPORATE NEGLIGENCE

PLAINTIFFS XIANGUO KONG AND ZHAO LIN, ADMINISTRATORS OF THE ESTATE OF AO KONG, DECEASED AND XIANGUO KONG AND ZHAO LIN, INDIVIDUALLY V. DEFENDANT TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

110. The averments of the preceding paragraphs are incorporated herein by reference as though fully set forth at length.

111. As evidenced by Olivia Kong's availing herself of Penn's Student Health Service, CAPS and Wharton's Academic Services, she was obviously aware of the "multiple programs and resources" designed to assist her regain her physical and mental health.

112. Despite availing herself of these services and the failure of Penn to provide any meaningful help, support and safety net, Olivia became increasing despondent over her academic situation resulting in worsening anxiety, insomnia and anorexia.

113. On no less than ***nine*** occasions Olivia either told Penn's employees, servants and agents or it was otherwise communicated to Penn that she was suicidal. Among these communications are:

a. the April 7th telephone call between Olivia and Dr. Stein;

b. the CAPS Intake form completed by Olivia on April 7th;

c. Olivia's April 7th consultation with Nicole Nardone;

d. Olivia's Petition for Late Withdrawal completed on April 7th;

e. Olivia's April 7th meeting with Teran Tadal;

f. the April 7th telephone call from Ms. Tadal to Ken Meehan;

g. the April 9th telephone call from the Graduate Assistant to Dr. Stein;

h. the April 9th telephone call from Dr. Stein to Olivia's friend; and

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i. the April 9th telephone call between Olivia and Dr. Stein.

114. Additionally, Olivia told nearly all of the Penn professionals from whom she sought help that she was anxious, stressed, depressed, scared and finally, hopeless.

115. Short of wearing a neon sign that she planned to commit suicide, Olivia was all but begging Penn for help. Appallingly, Penn didn't just fail her, it killed her.

116. Beginning as early as March 30th and continuing through the early morning hours of April 11, 2016, each and every Penn physician, mental health professional and academic advisor from whom Olivia sought help had a duty to ensure her safety and wellbeing and protect her from harm.

117. Beginning on April 7th and continuing until her death, the Penn professionals from whom she sought help knew or should have known that because of her overwhelming academic stress, Olivia was becoming more and more anxious, depressed and physically ill, all of which rendered her incapable of maintaining proper perspective or making sound decisions regarding her own health, safety and wellbeing.

118. Moreover, beginning on April 7th and continuing until her death, the Penn professionals from whom Olivia sought help affirmatively *knew* that she was suicidal and yet failed to take adequate and proper precautions or preventative measures to protect her from harm.

119. The failure of these multiple professionals, all of whom were employed by or affiliated with Penn and working on its behalf, to take adequate and proper precautions or preventative measures to adequately treat Olivia and protect her from harm during a period when they knew her articulated suicidal thoughts and plans or in the exercise of due care should have known that she was suicidal and that she was incapable of maintaining proper perspective and

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making sound decisions regarding her health, safety and wellbeing was the proximate cause of her suicide.

120. The general, gross and corporate negligence of Defendant Trustees of the University of Pennsylvania as it pertained to its students, including Olivia Kong, in the spring semester of 2016 consisted of one or more of the following acts or omissions:

a. failing to provide outreach and support programs regarding student psychological wellbeing that complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

b. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

c. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong were aware of and complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

d. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong were aware of the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

e. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

f. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong were aware of and understood fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

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g. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong were aware of and understood fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

h. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the steps necessary to fully assess and treat students in-crisis, including those suffering academic stress;

i. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong were aware of, understood and took the necessary steps to fully assess and treat students in-crisis, including those suffering academic stress;

j. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong were aware of, understood and took the necessary steps to fully assess and treat students in-crisis, including those suffering academic stress;

k. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the steps necessary to assess and treat students with suicidal ideation;

l. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong were aware of, understood and took the necessary steps to fully assess and treat students with suicidal ideation;

m. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong were aware of, understood and took the necessary steps to fully assess and treat students with suicidal ideation;

n. failing to hire, retain and ensure that the persons providing services through CAPS, including those providing such services to Olivia Kong were aware of and complied with CAPS confidentiality policies, including its policy waiving confidentiality when a student was in imminent danger of causing serious harm, including suicide, to herself;

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o. failing to hire, retain and ensure that the persons overseeing, supervising and administering the CAPS program, including those overseeing, supervising and administering the CAPS program were aware of CAPS confidentiality policies, including its policy waiving confidentiality when a student was in imminent danger of causing serious harm, including suicide, to herself;

p. failing to hire, retain and ensure that the persons providing the services offered by the University in its outreach and support programs regarding student psychological wellbeing, including those providing such services to Olivia Kong were aware of all of the programs and resources available to students in-crisis, including those programs and resources identified by the Task Force;

q. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University in its outreach and support programs regarding student psychological wellbeing, including those overseeing, supervising and administering such were aware of all of the programs and resources available to students in-crisis, including those programs and resources identified by the Task Force;

r. failing to make information about all of the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, easily accessible to the persons providing those services and to its students;

s. failing to ensure that information about all of the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, was easily accessible to the persons providing those services and to its students;

t. failing to ensure that the persons appointed to the Task Force were qualified to review the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, were qualified to determine if those programs and resources complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

u. failing to appoint undergraduate students and/or ensure that undergraduate students, including those in The Wharton School, were appointed to the Task Force;

v. failing to assign undergraduate students and/or ensure that undergraduate students from The Wharton School were assigned to each of the Task Force's working groups;

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w. failing to appoint appropriate professionals and/or ensure that appropriate professionals from CAPS and Academic Services, including academic advisors from The Wharton School, were appointed to the Task Force;

x. failing to ensure that the outreach and support programs and resources identified by the Task Force complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

y. failing to require and/or ensure that the findings and conclusions of the Task Force complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

z. failing to ensure before April, 2016 that the entire Penn community, including but not limited to those persons and professionals providing mental health services through the University and those overseeing, supervising and/or administering such services, including the outreach and support programs and resources identified by the Task Force, were fully aware of and complied with the findings, recommendations and conclusions of the Task Force;

aa. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure that the findings, recommendations and conclusions of the Task Force were implemented and followed;

bb. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure the safety of its students;

cc. failing to provide and/or dedicate before April, 2016 sufficient resources to reduce the risk of or prevent student suicides;

dd. failing to provide and/or dedicate before April, 2016 sufficient resource April, 2016 to ensure that the most current professional standards, nationally established criteria and/or best practices regarding student psychological wellbeing, including those addressing academic stress and the risk of suicide, were formulated, implemented and enforced;

ee. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure that only the most qualified professionals were hired to evaluate and treat student's in-crisis;

ff. failing to formulate, implement and enforce clear, streamlined and uniform policies, rules and guidelines before April, 2016 regarding withdrawing from a class beyond the tenth week of the semester;

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gg. failing to formulate, implement and enforce clear, streamlined and uniform policies, rules and guidelines before April, 2016 regarding students taking leaves of absence;

hh. failing to have an effective system in place in the spring semester of 2016 to reduce a student's course load when it became unmanageable;

ii. failing to have in the spring semester of 2016 an effective system for addressing student distress caused by an unmanageable course load; and

jj. failing to ensure in the spring semester of 2016 that students seeking tutoring services were provided with those services.

121. The general, gross and corporate negligence of Defendant Trustees of the University of Pennsylvania as it pertained to Olivia Kong in the spring semester of 2016 further consists of one or more of the following acts or omissions:

a. failing to recognize timely that the academic pressures that Olivia was experiencing during the spring semester of 2016 caused her substantial mental and physical distress such that she was unable to maintain proper perspective and make sound decisions regarding her safety, health and wellbeing;

b. failing to take appropriate action in compliance with the most current professional standards, nationally established criteria and/or best practices to assist Olivia during a time of intense stress and crisis to restore her proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

c. failing to take timely and appropriate action in compliance with the most current professional standards, nationally established criteria and/or best practices to either reduce Olivia's risk of suicide or prevent her from committing suicide, including but not limited to prescribing medication; providing appropriate psychotherapy; referring her to other clinicians who were more competent to treat her stress and suicidal ideation; collaborating with other clinicians who were more competent to treat her stress and suicidal ideation; consulting with other University programs, services and clinicians involved in assessing and treating students in-crisis; referring her to other facilities that were more capable to treat her stress and suicidal ideation; taking action to have her admitted (either voluntarily or involuntarily) to an appropriate facility to treat her stress and suicidal ideation; notifying the police of her precarious state of mind and intention to commit suicide; and/or arranging for someone to stay with her until she could obtain the appropriate help she needed;

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d. failing to follow CAPS policy of waiving the confidentiality protections of information shared by Olivia given the knowledge that she was in imminent danger of harming herself;

e. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

f. as to Dr. John Stein:

1. providing Olivia with false information and false hope regarding his ability and the ability of other CAPS clinicians to assist her with and/or expedite her ability to withdraw from a class beyond the 10th week of the semester;

2. failing to recognize timely that the academic pressures that Olivia was experiencing caused her substantial mental and physical distress such that she was unable to maintain proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

3. disregarding and ignoring Olivia's multiple communications of a specific suicide plan;

4. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

5. failing to conduct an in-person assessment of Olivia;

6. failing to develop an appropriate treatment plan to address Olivia's distress and suicidal ideation;

7. failing to prescribe Olivia appropriate medication;

8. failing to provide Olivia appropriate psychotherapy;

9. failing to refer Olivia to other clinicians who were more competent to treat her stress and suicidal ideation;

10. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

11. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

12. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable of evaluating and treating treat her stress and suicidal ideation;

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13. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

14. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide;

15. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed; and

16. failing to fully, timely and accurately document his interactions and communications with Olivia and other persons concerning Olivia's psychological wellbeing.

g. as to Nicole Nardone:

1. providing Olivia with false hope regarding her ability and the ability of other CAPS clinicians to assist her with and/or expedite her ability to withdraw from a class beyond the 10th week of the semester;

2. failing to recognize timely that the academic pressures that Olivia was experiencing caused her substantial mental and physical distress such that she was unable to maintain proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

3. disregarding and ignoring Olivia's multiple communications of a specific suicide plan;

4. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

5. failing to develop an appropriate treatment plan to address Olivia's distress and suicidal ideation;

6. failing to provide Olivia with appropriate psychotherapy;

7. failing to refer Olivia to other clinicians who were more competent to treat her stress and suicidal ideation;

8. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

9. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

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10. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable of evaluating and treating her stress and suicidal ideation;

11. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

12. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide;

13. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed; and

14. failing to timely and accurately document her interactions and communications with Olivia and other persons concerning Olivia's psychological wellbeing.

h. as to Ken Meehan:

1. failing to recognize timely that the academic pressures that Olivia was experiencing caused her substantial mental and physical distress such that she was unable to maintain proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

2. disregarding and ignoring Olivia's multiple communications of her intention to commit suicide;

3. failing to notify Olivia's parents or ensure that Olivia's parents were notified of Olivia's suicidal ideation and/or imminent risk of self-harm;

4. failing to develop an appropriate treatment plan and/or ensure that an appropriate treatment plan was developed to address Olivia's distress and suicidal ideation;

5. failing to provide or ensure that Olivia received appropriate psychotherapy;

6. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

7. failing to refer her to clinicians who were more competent than he, Dr. Stein, Ms. Nardone and the other CAPS mental health clinicians to evaluate and treat her stress and suicidal ideation;

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8. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

9. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable to treat her stress and suicidal ideation;

10. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

11. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide; and

12. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed.

i. as to Teran Tadal:

1. failing to recognize timely that the academic pressures that Olivia was experiencing caused her substantial mental and physical distress such that she was unable to maintain proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

2. failing to take appropriate action to relieve Olivia's severe academic stresses caused by her maintaining an excessive course load;

3. failing to expedite a decision on Olivia's petition for late withdrawal;

4. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self harm;

5. failing to refer Olivia to clinicians other than those affiliated with CAPS to ensure that she received the appropriate treatment for her suicidal ideation;

6. failing to collaborate with or refer Olivia to University programs, services and clinicians (other than CAPS) involved in assessing and treating students in-crisis; and

7. failing to refer Olivia to a facility capable of handling her suicidal ideation.

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j. as to Lindy Black-Margida and the other Wharton academic advisors:

1. failing to provide Olivia with accurate and complete information about her ability to withdraw from a class beyond the 10th week of the semester;

2. failing to take action prior to the 10th week of the semester to ensure that Olivia was capable of handling an extra-heavy course load;

3. failing to assess the effect of Olivia's taking an extra-heavy course load on her ability to maintain proper perspective and make sound decisions regarding her safety, health and wellbeing;

4. failing to ensure that in their absence, appropriate arrangements were made to assist students suffering academic stress, including Olivia, who sought their assistance; and

5. failing to notify Olivia of those persons who in their absence could assist Olivia with expediting the withdrawal from a class beyond the 10th week of the semester.

122. To the extent that these acts and omissions were committed and/or omitted by employees, servants and agents, including those identified in paragraphs 11 and 12, *supra*, of Trustees of the University of Pennsylvania and/or Penn, Defendant Trustees of the University of Pennsylvania by virtue of the doctrines of vicarious liability and/or *respondeat superior* is responsible for these acts and omissions.

WHEREFORE, Plaintiffs Xianguo Kong and Zhao Lin, as Administrators of the Estate of Ao Kong, Deceased, and Individually demand judgment in in favor of the Estate of Ao Kong, Deceased and in their favor and against Defendant Trustees of the University of Pennsylvania in an amount in excess of the jurisdictional limits for arbitration together with delay damages and/or costs of suit.

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COUNT II
WANTON AND WILLFUL MISCONDUCT AND RECKLESS DISREGARD

PLAINTIFFS XIANGUO KONG AND ZHAO LIN,
ADMINISTRATORS OF THE ESTATE OF AO KONG,
DECEASED AND XIANGUO KONG AND ZHAO LIN, INDIVIDUALLY
V. DEFENDANT, TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

123. The averments of the preceding paragraphs are incorporated herein by reference as though fully set forth at length.

124. As evidenced by Olivia Kong's availing herself of Penn's Student Health Service, CAPS and its Academic Services, she was obviously aware of the 'multiple programs and resources' designed to assist her regain her physical and mental health.

125. Despite availing herself of these services and the failure of Penn to provide any meaningful help, support and safety net, Olivia became increasing despondent over her academic situation resulting in worsening anxiety, insomnia and anorexia.

126. On no less than ***nine*** occasions Olivia either told Penn's employees, servants and agents or it was otherwise communicated to Penn that she was suicidal. Among these communications are:

a. the April 7th telephone call between Olivia and Dr. Stein;

b. the CAPS Intake form completed by Olivia on April 7th;

c. Olivia's April 7th consultation with Nicole Nardone;

d. Olivia's Petition for Late Withdrawal completed on April 7th;

e. Olivia's April 7th meeting with Teran Tadal;

f. the April 7th telephone call from Ms. Tadal to Ken Meehan;

g. the April 9th telephone call from the Graduate Assistant to Dr. Stein;

h. the April 9th telephone call from Dr. Stein to Olivia's friend; and

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i. the April 9th telephone call between Olivia and Dr. Stein.

127. Additionally, Olivia told nearly all of the Penn professionals from whom she sought help knew that she was anxious, stressed, depressed, scared and finally, hopeless.

128. Beginning as early as March 30th and continuing through the early morning hours of April 11, 2016, each and every Penn physician, mental health professional and academic advisor from whom Olivia sought help had a duty to ensure her safety and wellbeing and protect her from harm.

129. Beginning on April 7th and continuing until her death, the Penn professionals from whom she sought help knew that because of her overwhelming academic stresses, Olivia was increasingly anxious, depressed and physically ill, all of which rendered her incapable of maintaining proper perspective or making sound decisions regarding her own health, safety and wellbeing.

130. As a result of Olivia's articulating to these Penn professionals her suicidal thoughts and plans, which they knew or should have known affected her ability to make sound decisions regarding her own health, safety and wellbeing, they knew or should have known that without their help and assistance there was a high degree of probability that Olivia would commit suicide.

131. The failure of these multiple professionals, all of whom were employed by or affiliated with Penn and working on its behalf, to take adequate and proper precautions or preventative measures to protect Olivia her from harm during this was the proximate cause of her suicide.

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132. The wanton and willful misconduct of Defendant Trustees of the University of Pennsylvania and/or its reckless disregard for Olivia's health, safety and wellbeing during the spring semester of 2016 consists of one or more of the following acts or omissions:

a. failing to provide outreach and support programs regarding student psychological wellbeing that complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

b. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

c. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong, were aware of and complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

d. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong, were aware of the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

e. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

f. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong, were aware of and understood fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

g. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong, were aware of and understood fully the warning signs of suicide in students in-crisis, including those suffering from academic stress;

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h. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the steps necessary to fully assess and treat students in-crisis, including those suffering academic stress;

i. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong, were aware of, understood and took the necessary steps to fully assess and treat students in-crisis, including those suffering academic stress;

j. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong, were aware of, understood and took the necessary steps to fully assess and treat students in-crisis, including those suffering academic stress;

k. failing to formulate, implement and enforce policies, practices and guidelines regarding student psychological wellbeing that addressed fully the steps necessary to assess and treat students with suicidal ideation;

l. failing to hire, retain and ensure that the persons providing the services offered by the University regarding student psychological wellbeing, including those providing such services to Olivia Kong, were aware of, understood and took the necessary steps to fully assess and treat students with suicidal ideation;

m. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University regarding student psychological wellbeing, including those overseeing, supervising and administering the services provided to Olivia Kong, were aware of, understood and took the necessary steps to fully assess and treat students with suicidal ideation;

n. failing to hire, retain and ensure that the persons providing services through CAPS, including those providing such services to Olivia Kong, were aware of and complied with CAPS confidentiality policies, including its policy waiving confidentiality when a student was in imminent danger of causing serious harm, including suicide, to herself;

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o. failing to hire, retain and ensure that the persons overseeing, supervising and administering the CAPS program, including those overseeing, supervising and administering the CAPS program, were aware of CAPS confidentiality policies, including its policy waiving confidentiality when a student was in imminent danger of causing serious harm, including suicide, to herself;

p. failing to hire, retain and ensure that the persons providing the services offered by the University in its outreach and support programs regarding student psychological wellbeing, including those providing such services to Olivia Kong, were aware of all of the programs and resources available to students in-crisis, including those programs and resources identified by the Task Force;

q. failing to hire, retain and ensure that the persons overseeing, supervising and administering the services offered by the University in its outreach and support programs regarding student psychological wellbeing, including those overseeing, supervising and administering such services provided to Olivia Kong, were aware of all of the programs and resources available to students in-crisis, including those programs and resources identified by the Task Force;

r. failing to make information about all of the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, easily accessible to the persons providing those services and to its students;

s. failing to ensure that information about all of the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, was easily accessible to the persons providing those services and to its students;

t. failing to ensure that the persons appointed to the Task Force were qualified to review the University's mental health resources, including the outreach and support programs and resources identified by the Task Force, were qualified to determine if those programs and resources complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

u. failing to appoint undergraduate students and/or ensure that undergraduate students, including those in The Wharton School, were appointed to the Task Force;

v. failing to assign undergraduate students and/or ensure that undergraduate students from The Wharton School were assigned to each of the Task Force's working groups;

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w. failing to appoint appropriate professionals and/or ensure that appropriate professionals from CAPS and Academic Services, including academic advisors from The Wharton School, were appointed to the Task Force;

x. failing to ensure that the outreach and support programs and resources identified by the Task Force complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

y. failing to require and/or ensure that the findings and conclusions of the Task Force complied with the most current professional standards, nationally established criteria and/or best practices to reduce academic stress and the risk of suicide;

z. failing to ensure before April, 2016 that the entire Penn community, including but not limited to those persons and professionals providing mental health services through the University and those overseeing, supervising and/or administering such services, including the outreach and support programs and resources identified by the Task Force, were fully aware of and complied with the findings, recommendations and conclusions of the Task Force;

aa. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure that the findings, recommendations and conclusions of the Task Force were implemented and followed;

bb. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure the safety of its students;

cc. failing to provide and/or dedicate before April, 2016 sufficient resources to reduce the risk of or prevent student suicides;

dd. failing to provide and/or dedicate before April, 2016 sufficient resource April, 2016 to ensure that the most current professional standards, nationally established criteria and/or best practices regarding student psychological wellbeing, including those addressing academic stress and the risk of suicide, were formulated, implemented and enforced;

ee. failing to provide and/or dedicate before April, 2016 sufficient resources to ensure that only the most qualified professionals were hired to evaluate and treat student's in-crisis;

ff. failing to formulate, implement and enforce clear, streamlined and uniform policies, rules and guidelines before April, 2016 regarding withdrawing from a class beyond the tenth week of the semester;

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gg. failing to formulate, implement and enforce clear, streamlined and uniform policies, rules and guidelines before April, 2016 regarding students taking leaves of absence;

hh. failing to have an effective system in place in the spring semester of 2016 to reduce a student's course load when it became unmanageable;

ii. failing to have in the spring semester of 2016 an effective system for addressing student distress caused by an unmanageable course load; and

jj. failing to ensure in the spring semester of 2016 that students seeking tutoring services were provided with those services.

133. The wanton and willful misconduct of Defendant Trustees of the University of Pennsylvania and/or its reckless disregard for Olivia's health, safety and wellbeing during the spring semester of 2016 further consists of one or more of the following acts or omissions:

a. failing to take appropriate action in compliance with the most current professional standards, nationally established criteria and/or best practices to assist Olivia during a time of intense stress and crisis to restore her proper perspective and make sound decisions regarding her physical and mental health and wellbeing;

b. failing to take timely and appropriate action in compliance with the most current professional standards, nationally established criteria and/or best practices to either reduce Olivia's risk of suicide or prevent her from committing suicide, including but not limited to prescribing medication; providing appropriate psychotherapy; referring her to other clinicians who were more competent to treat her stress and suicidal ideation; collaborating with other clinicians who were more competent to treat her stress and suicidal ideation; consulting with other University programs, services and clinicians involved in assessing and treating students in-crisis; referring her to other facilities that were more capable to treat her stress and suicidal ideation; taking action to have her admitted (either voluntarily or involuntarily) to an appropriate facility to treat her stress and suicidal ideation; notifying the police of her precarious state of mind and intention to commit suicide; and/ or arranging for someone to stay with her until she could obtain the appropriate help she needed;

c. failing to follow CAPS policy of waiving the confidentiality protections of information shared by Olivia given the knowledge that she was in imminent danger of harming herself;

d. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

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e. as to Dr. John Stein:

1. providing Olivia with false information and false hope regarding his ability and the ability of other CAPS clinicians to assist her with and/or expedite her ability to withdraw from a class beyond the 10th week of the semester;

2. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

3. failing to conduct an in-person assessment of Olivia;

4. failing to develop an appropriate treatment plan to address Olivia's distress and suicidal ideation;

5. failing to prescribe Olivia appropriate medication;

6. failing to provide Olivia appropriate psychotherapy;

7. failing to refer Olivia to other clinicians who were more competent to treat her stress and suicidal ideation;

8. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

9. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

10. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable of evaluating and treating treat her stress and suicidal ideation;

11. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

12. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide;

13. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed; and

14. failing to fully, timely and accurately document his interactions and communications with Olivia and other persons concerning Olivia's psychological wellbeing.

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f. as to Nicole Nardone:

1. providing Olivia with false hope regarding her ability and the ability of other CAPS clinicians to assist her with and/or expedite her ability to withdraw from a class beyond the 10th week of the semester;

2. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self-harm;

3. failing to develop an appropriate treatment plan to address Olivia's distress and suicidal ideation;

4. failing to provide Olivia with appropriate psychotherapy;

5. failing to refer Olivia to other clinicians who were more competent to treat her stress and suicidal ideation;

6. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

7. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

8. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable of evaluating and treating her stress and suicidal ideation;

9. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

10. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide;

11. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed; and

12. failing to timely and accurately document her interactions and communications with Olivia and other persons concerning Olivia's psychological wellbeing.

g. as to Ken Meehan:

1. failing to notify Olivia's parents or ensure that Olivia's parents were notified of Olivia's suicidal ideation and/or imminent risk of self-harm;

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2. failing to develop an appropriate treatment plan and/or ensure that an appropriate treatment plan was developed to address Olivia's distress and suicidal ideation;

3. failing to provide or ensure that Olivia received appropriate psychotherapy;

4. failing to collaborate with other clinicians who were more competent to treat Olivia's stress and suicidal ideation;

5. failing to refer her to clinicians who were more competent than he, Dr. Stein, Ms. Nardone and the other CAPS mental health clinicians to evaluate and treat her stress and suicidal ideation;

6. failing to collaborate with or refer Olivia to other University programs, services and clinicians involved in assessing and treating students in-crisis;

7. failing to refer Olivia to other facilities, including a local hospital emergency department, that were more capable to treat her stress and suicidal ideation;

8. failing to take action to have Olivia taken to the emergency department and/or admitted (either voluntarily or involuntarily) to a facility capable of treating her stress and suicidal ideation;

9. failing to notify the police of Olivia's precarious state of mind and intention to commit suicide; and

10. failing to arrange to have someone stay with Olivia until she obtained the appropriate help she so desperately needed.

h. as to Teran Tadal:

1. failing to take appropriate action to relieve Olivia's severe academic stresses caused by her maintaining an excessive course load;

2. failing to expedite a decision on Olivia's petition for late withdrawal;

3. failing to notify Olivia's parents that she was expressing suicidal ideation and/or was at imminent risk of self harm;

4. failing to refer Olivia to clinicians other than those affiliated with CAPS to ensure that she received the appropriate treatment for her suicidal ideation;

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5. failing to collaborate with or refer Olivia to University programs, services and clinicians (other than CAPS) involved in assessing and treating students in-crisis; and

6. failing to refer Olivia to a facility capable of handling her suicidal ideation.

134. To the extent that the above-referenced wanton and willful misconduct and reckless disregard for Olivia's safety, health and wellbeing was committed and/or omitted by the employees, servants and agents, including those identified in paragraphs 11 and 12, *supra*, of Trustees of the University of Pennsylvania, Penn and/or Defendant Trustees of the University of Pennsylvania by virtue of the doctrines of vicarious liability and/or *respondeat superior* is responsible for this misconduct.

COUNT III
WRONGFUL DEATH

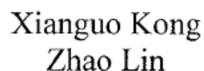
PLAINTIFFS XIANGUO KONG AND ZHAO LIN, ADMINISTRATORS OF THE ESTATE OF AO KONG, DECEASED AND XIANGUO KONG AND ZHAO LIN, INDIVIDUALLY V. DEFENDANT, TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

135. The averments of the preceding paragraphs are incorporated herein by reference as though fully set forth at length.

136. Plaintiffs bring this action as the personal representatives and wrongful death beneficiaries of the Estate of Ao Kong, Deceased, pursuant to the Pennsylvania Wrongful Death Act, 42 Pa.C.S.A. §8301.

137. The persons entitled by law to recover damages under the Pennsylvania Wrongful Death Act for the death of Ao "Olivia" Kong are:

Xianguo Kong
Zhao Lin



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138. Notice has been given to the wrongful death beneficiaries by virtue of their being the personal representatives of the Estate of Ao Kong, Deceased as well as their being parties to this action.

139. Plaintiffs claim all wrongful death damages recoverable under the Wrongful Death Act including medical expenses, death related expenses, past lost contributions, future loss of contributions and the loss of decedent's care, comfort, society, guidance and tutelage.

WHEREFORE, Plaintiffs Xianguo Kong and Zhao Lin as Administrators of the Estate of Ao Kong, Deceased and Individually demand judgment in favor of the Estate of Ao Kong, Deceased and in their favor and against Defendant Trustees of the University of Pennsylvania in an amount in excess of the jurisdictional limits for arbitration together with delay damages and/or costs of suit.

COUNT IV
SURVIVAL ACTION

PLAINTIFFS XIANGUO KONG AND
ZHAO LIN, ADMINISTRATORS OF THE
ESTATE OF AO KONG, DECEASED V. DEFENDANT,
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

140. The averments of the preceding paragraphs are incorporated herein by reference as though fully set forth at length.

141. Plaintiffs in their capacity as the personal representatives of the Estate of Ao Kong, Deceased, bring this action pursuant to the Pennsylvania Survival Act, 42 Pa.C.S.A. §8302, and claim on behalf of the Estate of Ao Kong all damages recoverable thereunder including but not limited to Ao Kong's pain, suffering and fright, past lost earnings and future loss of earnings.

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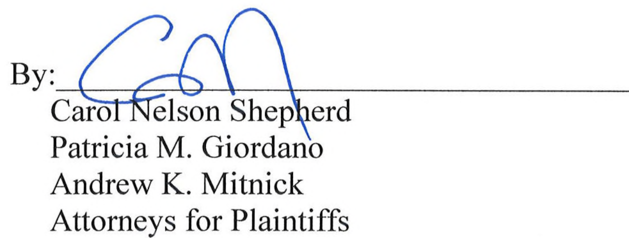
WHEREFORE, Plaintiffs Xianguo Kong and Zhao Lin as Administrators of the Estate of Ao Kong, Deceased demand judgment in favor the Estate of Ao Kong, Deceased, and against Defendant Trustees of the University of Pennsylvania in an amount in excess of the jurisdictional limits for arbitration together with delay damages and/or costs of suit.

FELDMAN, SHEPHERD, WOHLGELERNTER,
TANNER, WEINSTOCK & DODIG, LLP



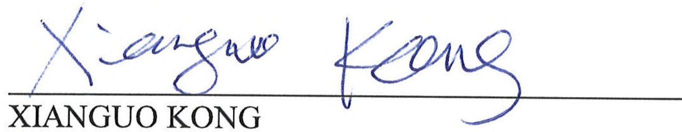
By:______________________________
Carol Nelson Shepherd
Patricia M. Giordano
Andrew K. Mitnick
Attorneys for Plaintiffs

Dated: 4/10/18

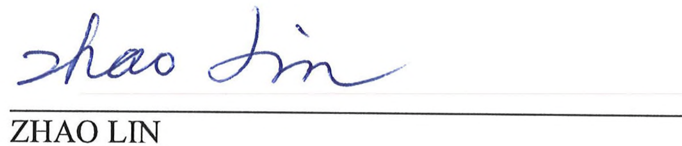
Case ID: 180401272

VERIFICATION

We, Xianguo Kong and Zhao Lin, Administrators of the Estate of Ao Kong, Deceased, plaintiffs in the foregoing pleading, state that the facts set forth are true and correct to the best of our knowledge, information and belief; and that this statement is made subject to the penalties of 18 Pa.C.S. §4904, which relates to unsworn falsification to authorities.



XIANGUO KONG



ZHAO LIN

EXHIBIT "A"

Case ID: 180401272

Office of the Register of Wills of Philadelphia County, Pennsylvania

File #: A1607-2016

Commonwealth of Pennsylvania
County of Philadelphia } ss.

I, **RONALD R. DONATUCCI, ESQUIRE**, Register for the Probate of Wills and Granting Letters of Administration in and for the County of Philadelphia, in the Commonwealth of Pennsylvania

DO HEREBY CERTIFY AND MAKE KNOWN That on the **26th** day of **April**

in the year of our Lord **2016** **LETTERS OF ADMINISTRATION**

on the Estate of **AO KONG**

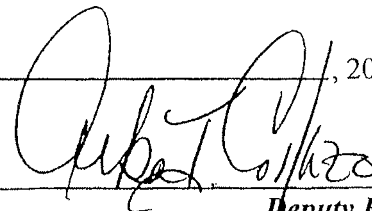
MEDICAL RECORDS

Deceased, were granted unto **XIANGUO KONG and ZHAO LIN**

having first been qualified well and truly to administer the same. And I further certify that no revocation of said Letters appears of record.

Date of death **4/11/2016**

Given under my hand and seal of office, this **27th** day of **April**, 20**16**



Deputy Register

NOT VALID WITHOUT ORIGINAL SIGNATURE AND IMPRESSED SEAL

10-14 (Rev. 3/08)

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EXHIBIT "B"

Case ID: 180401272

FELDMAN SHEPHERD WOHLGELERNTER TANNER WEINSTOCK & DODIG, LLP
By: Carol Nelson Shepherd, Esq./Andrew K. Mitnick, Esq.
Identification No.: 28650/80667
21st Floor
1845 Walnut Street
Philadelphia, PA 19103
(215) 567-8300

Attorneys for Plaintiffs

XIANGUO KONG and ZHAO LIN, Administrators of the ESTATE OF AO KONG, Deceased and XIANGUO KONG and ZHAO LIN, Individually Plaintiffs	COURT OF COMMON PLEAS PHILADELPHIA COUNTY APRIL TERM, 2018 No.
v.	Jury Trial Demanded
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA 3451 Walnut Street, Room 329 Philadelphia, PA 19104 Defendant	

Certificate of Merit as to Defendant The Trustees of the University of Pennsylvania

I, CAROL NELSON SHEPHERD, certify that:

☑ an appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by this defendant in the treatment, practice or work that is the subject of the Complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm;

AND

☑ the claim that this defendant deviated from an acceptable professional standard is based solely on allegations that other licensed professionals for whom this defendant is responsible deviated from an acceptable professional standard and an appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by the other licensed professionals in the treatment, practice or work that is the subject of the Complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm;

OR

☑ expert testimony of an appropriate licensed professional is unnecessary for prosecution of the claim against this defendant.

Carol Nelson Shepherd

Date: 4/10/18

Case ID: 180401272