IN THE CIRCUIT COURT
FOR THE COUNTY OF NEWPORT NEWS, VIRGINIA

HALEY KEFFER,
Personal Representative and
Administratrix of the Estate of
Raven Nichole Keffer, Decedent,
Plaintiff

v.

UNIVERSAL HEALTH SERVICES, INC.,

And

KEYSTONE NEWPORT NEWS, LLC
d/b/a NEWPORT NEWS BEHAVIORAL
HEALTH CENTER,

And

JOHN AND/OR JANE DOES,
Doctors, Nurses, Nursing Assistants, and/or
Other Employees,
NEWPORT NEWS BEHAVIORAL
HEALTH CENTER,
Defendants.

Case No. CL19037722-11

COMPLAINT

COMES NOW the plaintiff, Haley Keffer, by counsel, and states as follows, upon information and belief:

1. This is an action about the tragic and utterly preventable death of a seventeen-year-old girl while she was in the care of a children's residential treatment facility. The decedent, Raven Nichole Keffer ("Raven" or "decedent"), died on June 29, 2018, from a preventable adrenal insufficiency while under the care and supervision of Newport News Behavioral Health Center.

2. Plaintiff Haley Keffer is a resident of Craig County, Virginia and is the decedent's half-sister (through their mother) and personal representative. Haley became qualified as the administratrix of the decedent's estate on August 6, 2019, in the Circuit Court of Giles County, Virginia. Please refer to *Exhibit A* for verification of Haley Keffer's qualification.

3. Defendant Universal Health Services, Inc. ("UHS") is a Fortune 500 hospital management company operating through its subsidiary health care providers and treatment centers, including Newport News Behavioral Health Center. UHS is incorporated in the state of Delaware and its corporate headquarters are located in King of Prussia, Pennsylvania.

4. Defendant Keystone Newport News, LLC, d/b/a Newport News Behavioral Health Center (NNBHC), is a limited liability company formed under the laws of the Commonwealth of Virginia (SEC CIK #0001513646). Keystone Newport News, LLC is a subsidiary of UHS.

5. Defendants John and/or Jane Does were doctors, nurses, nursing assistants, and/or other employees or agents of NNBHC who were on duty while Raven was under the care of the facility and at the time of Raven's death. These employees and/or agents willfully ignored Raven's obvious medical distress and pleas for help.

6. Raven Nichole Keffer was born on April 24, 2001. She was a vibrant, capable, and loving child, but her life was short and difficult. She grew up in Giles County, where drug and alcohol abuse, mental illness, neglect, and domestic violence were constants in her life. Her mother, who suffered from borderline schizophrenia or bipolar disorder, was addicted to opiates and her father was an alcoholic who was sometimes physically abusive to Raven and her mother. Raven's maternal grandmother, maternal grandfather, and paternal grandmother also had mental health challenges and abused alcohol, methamphetamines, and other drugs. As a young girl Raven was shuffled between the homes of her mother, father, and other relatives.

7. For most of her life Raven lived in close proximity to her half-sister, Haley. As young children, Raven and Haley saw each other daily and went to elementary school together. They briefly lived together with Raven's mother and aunt.

8. At times Raven lived with other relatives, including her maternal grandmother. Raven and her grandmother were very close, usually seeing each other or speaking daily up until the time of Raven's death.

9. In 2016, unable to provide a safe and stable home for Raven, her parents relinquished all parental rights. At the age of fifteen, Raven entered foster care in the custody of the Virginia Department of Social Services (DSS). Raven's grandmother sought custody of the child, but was not approved because of her own drug abuse. Even so, Raven, her

grandmother, and sister Haley spoke with each other frequently, and Haley visited her sister as often as she could.

10. Being surrounded by drug and alcohol abuse at home her entire life, it is no surprise that Raven eventually began using drugs and alcohol also. Tragically, at nine years old, she began drinking alcohol; by age 12 or 13 she was using methamphetamines, and she used cocaine and heroin by age 15. She was also diagnosed with several mental health disorders, including Major Depressive Disorder and Post-Traumatic Stress Disorder as a result of her exposure to domestic violence.

11. Despite these significant challenges, Raven eventually completed a high school equivalency program and received her GED at age 16. As a teenager, she was also steadily employed, working 20 to 30 hours per week at various restaurant and convenience store jobs. Her social workers described her as resourceful and skilled in independent living skills including cooking and maintaining a savings account. A counselor described her as honest, open, helpful, and pleasant, while Raven described herself as motherly and caring of others. In fact, Raven confided in her sister Haley that she wanted to go to college to become a counselor so she could help others going through difficult times.

12. Through DSS, Raven participated in several pediatric substance abuse and therapy programs in pursuit of her goal of independent living. In July 2017, Raven completed

one such substance abuse program and was placed within a therapeutic foster home through First Home Care.

13. Unfortunately, after a few months at First Home Care, Raven relapsed. On February 1, 2018, she was evaluated at Bon Secours Memorial Regional Hospital in Mechanicsville, Virginia for body pain, tremors, and blurry vision. The emergency room physician diagnosed her with anxiety and adverse drug effects. Some of Raven's laboratory results were abnormal and she was advised to seek follow-up care with a primary care physician.

14. On February 2, 2018, Raven saw Valerie Bowman, M.D., a pediatrician. When Dr. Bowman's testing revealed Raven had low serum potassium and elevated thyroid-stimulating hormone, she referred Raven to an endocrinologist.

15. On March 9, 2018, Raven was evaluated by Elna Kochummen, M.D., a pediatric endocrinologist. At that time, testing showed normal thyroid-stimulating hormone and potassium levels. Dr. Kochummen advised Raven to return in six months for additional testing.

16. On May 22, 2018 and again on May 25, 2018 – one day after her seventeenth birthday – Raven was seen at St. Mary's Hospital in Richmond, Virginia for abdominal pain, nausea, vomiting, shortness of breath, and an elevated heart rate. She admitted to having used opioids.

17. Acknowledging her drug abuse and wanting to be free of addiction, Raven entered a substance abuse treatment program at Phoenix House in Arlington, Virginia. Her treatment plan included the use of Suboxone (buprenorphine and naloxone), a prescription medication for the treatment of opioid dependence. On June 1, 2018, after her first dose of Suboxone, Raven was taken to the emergency room of Virginia Hospital Center in Arlington, Virginia for shortness of breath, nausea, vomiting and dizziness. She had low blood pressure and low sodium levels and was diagnosed with dehydration.

18. On June 5, 2018, Raven returned to the emergency room reporting shortness of breath, elevated heart rate, and abdominal pain. She was again diagnosed with dehydration, atypical chest pain, and tachycardia. Thereafter, treatment with Suboxone was discontinued because of Raven's apparent adverse reactions to the medication.

19. On June 13, 2018, Raven was evaluated at Inova Fairfax Children's Hospital in Arlington, Virginia for vomiting, heart palpitations, dizziness, dehydration, lightheadedness, chest pain, shortness of breath, and weight loss. After extensive evaluation, she was diagnosed with gallstones. Because her sodium and thyroid levels were abnormal, the attending pediatric endocrinologist advised Raven to have follow-up testing in one month.

20. On June 20, 2018, Raven returned to the emergency room for increased heart rate and vomiting. She was again diagnosed with postural tachycardia and dehydration and instructed to increase her intake of fluids and salt.

21. During this period, Raven continued to live at the Phoenix House and apparently received regular medical monitoring. However, Raven's social workers believed Phoenix House was not well suited to care for her many medical complications and, therefore, they sought other housing arrangements where she could receive more comprehensive care.

22. On June 21, 2018, a representative of DSS contacted Newport News Behavioral Health Center regarding possible admission of Raven for more comprehensive treatment of her medical conditions and symptoms, substance abuse, and mental health. During this preadmission screening conversation, DSS advised NNBHC that Raven had gallstones, needed her thyroid rechecked in one month, and had been treated at an emergency department several times within the past few months for increased heart rate, substance abuse complications, difficulty breathing, vomiting, and dehydration.

23. Having been apprised of Raven's medical history and recent symptoms, NNBHC admitted her on June 22, 2018. Many of her admission forms were incompletely filled out by NNBHC staff or unsigned by Raven.

24. Upon admission, Raven's blood pressure was taken and found to be low. It appears no steps were taken to address her low blood pressure or determine the underlying cause.

25. On June 25, 2018, Raven advised staff at NNBHC that she had been nauseous for three days and was vomiting. Her blood pressure was measured and found to be low. Raven

was given Emetrol, an over-the-counter nausea medication, and ginger ale. There is no indication that any other action was taken to address or try to determine the cause of her symptoms.

26. The following day, on June 26, 2018, Raven again complained of nausea, recent weight loss, and generally feeling very unwell. The nursing staff again provided her with anti-nausea medication. Again, it appears they did not conduct or order any additional testing to try to diagnose the cause of Raven's continued symptoms.

27. On June 27, 2018, Raven continued to experience nausea, fatigue, and weakness. She pleaded to be taken to the hospital.

28. Instead of taking Raven to the hospital, providing her with additional treatment, or further investigating her symptoms, NNBHC nursing staff ignored Raven's complaints and encouraged other staff members to do the same. Moreover, Raven was placed on a restrictive "binge and purge" protocol on June 28, 2018, usually used on patients believed to be intentionally inducing vomiting.

29. On June 29, 2018, Raven again reported to NNBHC nursing staff that she was experiencing weakness, lightheadedness, nausea, and abdominal pain. She had low blood pressure, developed chest pain, and had difficulty walking. She deteriorated quickly throughout the day, reporting blurry vision, leg numbness, and extreme weakness. A resident reported to staff that Raven was vomiting blood. In the presence of a resident

and an employee of NNBHC, Raven became incontinent, urinating on herself but unable to stand or walk to change out of her soiled clothing. She continued to request to go to the hospital.

30. As Raven became more and more desperately ill, NNBHC staff did not offer any assistance or call for medical help. Instead, video footage displays staff members walking by a collapsing Raven as she was supported by another minor resident. Rather than offer even minimal intervention or assistance, NNBHC staff ignored Raven and the increasingly frantic calls by other residents to help her. Eventually, another resident – a 15-year-old girl – called 911 and pleaded with the emergency responders to send help.

31. Around this time – after several days of observing Raven's serious medical complaints, and after many hours of her increasingly alarming symptoms – NNBHC staff requested an outside medical consultation. Before the consultation occurred, however, Raven became unresponsive. She was lethargic, gasping for air, had dilated pupils, and was pale and cold to the touch. Finally, NNBHC staff called 911.

32. Sadly, Raven entered cardiac arrest during transportation to Mary Immaculate Hospital. Upon arrival at the hospital, she was intubated and in critical condition with blood in her stomach and a possible brain injury. According to NNBHC's own Nursing Daily Progress Notes, the doctor treating Raven stated that she was "dehydrated and malnourished." Raven entered cardiac arrest again and chest compressions were

performed, but they were not able to revive her. Raven passed away at 10:33 p.m. with no family or friends by her side. She was just just 17 years and one month old.

33. Raven's autopsy report listed her cause of death as complications of lymphocytic adrenalitis or adrenal crisis. She had no illegal substances in her system at the time of her death. The medical examiner stated in her case notes that Raven's death was preventable, had she had been treated in time.

34. The symptoms Raven reported and exhibited for several days, and which were documented in her numerous visits to physicians and emergency rooms, were consistent with adrenal insufficiency and adrenal crisis. Adrenal insufficiency is normally treated with synthetic hormones such as hydrocortisone, prednisone, or aldosterone. In an adrenal crisis, a simple injection of a corticosteroid can be life-saving. However, if left untreated, the symptoms lead to death, as they did in young Raven's case.

COUNT I – DEATH BY WRONGFUL ACT

35. The wrongful and willfully, grossly, and wantonly negligent acts of the defendants were the proximate cause of the tragic and avoidable death of Raven Nichole Keffer.

36. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) investigated Raven's death and identified at least thirteen areas of noncompliance by

NNHBC with Virginia law governing children's residential facilities. These violations directly led to Raven's death.

37. The violations identified by DBHDS include violations of the following sections of Title 12 of the Virginia Administrative Code governing children's residential facilities:

a) 35-46-640, requiring the admission of only those children whose needs are compatible with the services provided by the facility;

b) 35-46-70, requiring the facility to provide care "consistent with basic human dignity" and consistent with "sound therapeutic practice" and requiring the development and implementation of policies and procedures to address emergencies;

c) 35-46-700, requiring the development and implementation of an emergency admissions policy, to include information demonstrating that the child meets the facility's admission criteria;

d) 35-46-710, regarding policies and procedures to ensure the facility's ability to meet the needs of the prospective resident, including the child's physical health needs;

e) 35-46-800, requiring a structured program of care designed to meet the physical and emotional needs of the resident and to provide protection, guidance, and supervision of the child;

f) 35-46-810, requiring the facility to develop and implement policies to promptly provide medical services for health problems identified at admission; to promptly provide emergency care when necessary; and to ensure, in an emergency, readily accessible information about the resident's medical history;

g) 35-46-840, requiring documentation of follow-up medical care recommended by a physician or as indicated by the needs of the child and of the child's health complaints and injuries; and

h) 35-46-920, prohibiting the facility to deprive the resident of "appropriate services and treatment."

38. These documented, multiple, and egregious violations of applicable law by the defendants directly resulted in Raven's untimely death. Absent these willful violations of the defendants' duties to Raven, her adrenal insufficiency would have been diagnosed and treated, and the adrenal crisis that killed her would have been entirely prevented or treated in a timely manner.

39. Even absent these regulations governing their duties to Raven, the defendants UHS and NNBHC were grossly, willfully, and wantonly negligent in developing and implementing policies and procedures to ensure, among other things, the hiring, proper training, and supervision of competent medical personnel, the provision of routine medical monitoring

and care to adequately assess potentially serious medical problems, and the prompt provision of emergency medical care. These failures in hiring, training, supervision, and the development and implementation of appropriate policies and procedures directly led to Raven's completely preventable death.

40. Likewise, the defendants Jane and/or John Does (doctors, nurses, nursing assistants, and/or other employees or agents of NNBHC) were grossly, willfully, and wantonly negligent in their absolute failure to provide even the most basic medical assistance to Raven as she reported multiple serious symptoms over several days, pleaded for help, and deteriorated into adrenal crisis. Their failure to provide any medical assistance whatsoever until the very last moments of Raven's life, when she had become unresponsive, evince a conscious disregard for Raven's safety and directly caused her untimely death.

COUNT II – BREACH OF CONTRACT

41. Upon information and belief, there existed an express or implied contract between UHS and NNHBC, on one hand, and the Commonwealth of Virginia's Department of Social Services, on the other hand. Raven Keffer was a third-party beneficiary of this contract. UHS and NNHBC had a contractual duty to provide adequate medical care to Raven, a minor within their care and supervision. UHS and NNHBC breached this contractual duty, to the detriment of Raven and her beneficiaries.

CLAIM FOR RELIEF

The decedent is survived by certain beneficiaries who have sustained financial and pecuniary loss as a result of the death of the decedent and have suffered mental anguish and emotional loss and such other damages as are recoverable under the Virginia Wrongful Death Act as set forth in Virginia Code Section 8.01-50 *et. seq*. The plaintiff herein claims damages against the defendants, jointly and severally, in the amount of Twenty Million Dollars ($20,000,000.00) in compensatory damages and Three Hundred Fifty Thousand ($350,000.000) in punitive damages, with regards to:

(1) Sorrow, mental anguish, solace, loss of society and companionship of the decedent suffered by the beneficiaries;

(2) Funeral and cremation expenses;

(3) Compensation for the reasonably expected loss of income of the decedent;

(4) Compensation for the reasonably expected loss of the services, protection, care, and assistance provided by the decedent;

(5) Punitive damages for the defendants' willful and wanton conduct and recklessness evincing a conscious disregard for the safety of others;

(6) Her costs expended in this action; and

(7) Other such other damages as seem fair and just.

A TRIAL BY JURY IS DEMANDED.

Respectfully Submitted,
Haley Keffer

By: _____
Of Counsel

D. Stephen Haga, Jr. (VSB# 19125)
THE HAGA LAW FIRM, PLC
27 Scattergood Drive, NW
Christiansburg, VA 24073
Phone: (540) 382-6321
Fax: (540) 381-2884
Attorney for Plaintiff

CERTIFICATE OF MAILING

I, D. Stephen Haga, Jr., hereby certify that on this 15th day of November 2019, the foregoing Complaint was mailed, postage prepaid, via USPS to:

Keystone Newport News, LLC d/b/a Newport News Behavioral Health Center
c/o Corporation Service Company, Registered Agent
100 Shockoe Slip, Floor 2
Richmond, VA 23219

A. William Charters
Goodman Allen Donnelly
150 Boush Street, Suite 900
Norfolk, VA 23510

Chris Forrest
Pro Assurance Insurance
7200 Glen Forest Drive, Suite 310
Richmond, VA 23226

D. Stephen Haga, Jr.

Exhibit "A"

VIRGINIA: IN THE CIRCUIT COURT OF GILES COUNTY Amended

COURT FILE NO. CWF1800142

IN RE: RAVEN NICHOLE KEFFER , Deceased

QUALIFICATION OF ADMINISTRATOR

It appearing that RAVEN NICHOLE KEFFER , resided at 211 MAIN ST APT 109 NARROWS VA 24124 , in Giles County, Virginia, within the jurisdiction of this Court, and died intestate on June 29, 2018, on motion of HALEY KEFFER, it is ORDERED that HALEY KEFFER is hereby appointed Administrator of the estate of RAVEN NICHOLE KEFFER , deceased.

HALEY KEFFER then appeared, made oath as the law directs, and acknowledged a bond as Administrator in the penalty of $10,000.00. The bond, being payable and conditioned according to law, is ORDERED to be recorded.

Certificate is GRANTED HALEY KEFFER for obtaining letter of administration upon the personal estate of RAVEN NICHOLE KEFFER , in due form.

The statement of responsibilities required by Section 64.2-507, Code of Virginia was given to the Administrator. The written notice of probate referred to in Section 64.2-508, Code of Virginia, are not required in this estate pursuant to Section 64.2-508 (B).

_____, Clerk
August 6, 2019

A True Copy Teste: 8/6, 2019
Sherry E. Gautier
CIRCUIT COURT OF GILES COUNTY
CLERK/DEPUTY CLERK

CERTIFICATE/LETTER OF QUALIFICATION Court File No. **CWF1800142**

COMMONWEALTH OF VIRGINIA

VA. CODE §§ 6.2-893, 6.2-1171, 6.2-1365, 6.2-1367, 64.2-2011, 64.2-506, 64.2-607

Giles County Circuit Court

I, the duly qualified clerk of this Court, **CERTIFY** that on **August 6, 2019**

DATE

HALEY KEFFER,

NAME(S) OF PERSON(S) QUALIFYING

duly qualified in this court, under applicable provisions of law, as **Administrator** of the estate of

RAVEN NICHOLE KEFFER

☒ DECEASED ☐ MINOR ☐ INCAPACITATED

The powers of the fiduciary named above continue in full force and effect.

$10,000.00 bond has been posted.

Given under my hand and the seal of this Court on

August 6, 2019
DATE

Sherry E Gautier, Clerk

by _____, Clerk

FORM CC-1625 MASTER 10/12