INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FOWARD TO: TORT AND CONTRACT UNIT
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGMT.
PO BOX 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. CLAIMANT:

McFarlane	Ryan	C.
LAST NAME	**FIRST**	**MIDDLE**

[redacted]
DATE OF BIRTH

422 Northumberland Way
STREET ADDRESS

MAILING ADDRESS IF OTHER THAN STREET ADDRESS

Monmouth Junction	NJ	08852
CITY	**STATE**	**ZIP CODE**

[redacted]
SOCIAL SECURITY NUMBER

2. IF NOTICES AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, COMPLETE ITEM #2.

Law Offices of Gregory S. Shields, LLC
NAME

524 N. Providence Road
MAILING ADDRESS

Media	PA	19063
CITY	**STATE**	**ZIP CODE**

Suite 200

RELATIONSHIP TO CLAIMANT: ATTORNEY AT LAW ☒ **OR** _____
EXPLAIN RELATIONSHIP

THE OCCURRENCE OR ACCIDENT WHICH GAVE RISE TO THIS CLAIM:

3a.

02/08/2016	2:45 a.m
DATE	**TIME**

b. DESCRIBE THE LOCATION OR PLACE OF THE ACCIDENT OR OCCURENCE.

New Brunswick (East Brunswick)
MUNICIPALITY

Route 1 (South) near Houlihan's restaurant
EXACT LOCATION OF THE OCCURRENCE

c. DESCRIBE HOW THE ACCIDENT OR OCCURENCE HAPPENED: IF A DIAGRAM WILL ASSIST YOUR EXPLANATION, PLEASE USE THE REVERSE SIDE OF THIS FORM.

Mr. McFarlane was stopped for supposed violations by officers of the East Brunswick Police Department, asked to step out of his vehicle, detained in handcuffs and then thrown to the ground and had his head repeatedly thrust into the pavement until he lost consciousness.

d. STATE THE NAME AND ADDRESS OF THE STATE AGENCY OR AGENCIES THAT YOU CLAIM CAUSED YOUR DAMAGE.

East Brunswick Police Department (1 Civic Center Drive, East Brunswick, NJ 08816); Township of East Brunswick (1 Jean Walling Civic Center Drive, East Brunswick, NJ 08816); Middlesex County (75 Bayard Street, New Brunswick, NJ 08901); and the State of New Jersey (P.O. Box 620, Trenton, NJ 08625).

STATE THE NAMES OF STATE EMPLOYEES WHOM YOU CLAIM WERE AT FAULT, INCLUDING ANY INFORMATION THAT WILL ASSIST IN INDENTIFYING AND LOCATING THEM.

Patrolman Kye Jun (badge no. 222), Patrolman Christopher Williams (badge no. 244), Patrolman Kevin Bolch (badge no. 197), and Patrolman Dennis Chieffo (badge no. 213) of the East Brunswick Police Department.

e. STATE THE NEGLIGENCE OR WRONGFUL ACTS OF THE STATE AGENCY AND STATE EMPLOYEES WHICH CAUSED YOUR DAMAGES.

Detainment without reasonable suspicion, assault, and false imprisonment (false arrest).

f. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO THE ACCIDENT OR OCCURRENCE.

Besides the aforementioned patrolmen and Mr. McFarlane, it is unknown at present whether there are other witnesses.

g. STATE THE NAMES OF ALL POLICE OFFICERS AND POLICE DEPARTMENTS WHO INVESTIGATED THIS ACCIDENT.

Patrolman Kye Jun (badge no. 222), Patrolman Christopher Williams (badge no. 244), Patrolman Kevin Bolch (badge no. 197), Patrolman Dennis Chieffo (badge no. 213), Lt. Martin O'Neill (badge no. 164), and Sgt. Drew Walsh (badge no. 179) of the East Brunswick Police Department.

4a. CLAIM FOR DAMAGES (CHECK APPROPRIATE BLOCK):

☒ PERSONAL INJURY ☐ PROPERTY DAMAGE

☐ OTHER - EXPLAIN IN DETAIL

b. IF YOU CLAIM PERSONAL INJURY:

(1) DESCRIBE YOUR INJURIES RESULTING FROM THIS ACCIDENT OR OCCURRENCE.

Head injuries, including possible brain/neurological injuries, facial abrasions, left eye injury, and right ear injury. See attached medical records.

(2) DO YOU CLAIM PERMANENT DISABILITY RESULTING FROM THIS INJURY:

☒ YES ☐ NO

IF YES, DESCRIBE THE INJURIES BELIEVED TO BE PERMANENT.

Unknown at this time. Mr. McFarlane continues to treat and have symptoms from the incident.

(3) FOR EACH HOSPITAL, DOCTOR OR OTHER PRACTITIONER RENDERING TREATMENT, EXAMINATION OR DIAGNOSTIC SERVICES, STATE:

NAME OF HOSPITAL, DOCTOR OR OTHER FACILITY	ADDRESS	DATES OF TREATMENT OR SERVICE	AMOUNT OF CHARGE TO DATE	AMT. PAID OR PAYABLE BY OTHER SOURCE SUCH AS INSURANCE
Robert Wood Johnson University Hospital ER	1 Robert Wood Johnson Place New Brunswick, NJ 08901	02/08/2016	TBD	TBD
Princeton HealthCare Family Medicine (PCP)	401 Ridge Road, Ste 6 Dayton, NJ 08810	02/09/2016-present	TBD	TBD
Executive Eye Assocaites	1 Executive Drive Monmouth Junction, NJ 08852	TBD	TBD	TBD
Sall Myers Medical Associates	57 Livingston Ave New Brunswick, NJ 08901	03/28/16-present	TBD	TBD

(4) IF YOU CLAIM LOSS OF WAGE OR INCOME AS A RESULT OF THE INJURY STATE:

Headquarters II Barbershop
NAME OF EMPLOYER

3790 US-1, Monmouth Junction, NJ 08852
ADDRESS OF EMPLOYER

Barber
YOUR OCCUPATION

September of 2015
DATE YOU BECAME EMPLOYED

varies (average of $16.00/hour)
RATE OF PAY

02/08/16-02/16/16
DATE OF ABSENCE FROM WORK

$896-$1120
TOTAL LOSS WAGES TO DATE

Not applicable.
IF STILL OUT, EXPECTED DATE OF RETURN

NOTE: IF YOUR CLAIMED LOSS OF INCOME ARISES FROM SELF-EMPLOYMENT OR OTHER THAN WAGE, ATTACH A CALCULATION SHOWING THE BASIS OF YOUR CALCULATION OF LOST INCOME.

(5) SET FORTH ANY AND ALL OTHER LOSSES OR DAMAGE CLAIMED BY YOU.

$125 for the fee paid by Mr. McFarlane to release his vehicle from the impound lot; bail paid/owed (amount to be provided).

C. IF YOU CLAIM PROPERTY DAMAGE:

(1) DESCRIBE THE PROPERTY DAMAGED.

Not applicable.

(2) THE PRESENT LOCATION AND TIME WHEN THE PROPERTY MAY BE INSPECTED.

Not applicable.

(3) DATE PROPERTY ACQUIRED. Not applicable.

(4) COST OF PROPERTY $ Not applicable.

(5) VALUE OF PROPERTY AT TIME OF ACCIDENT: $ Not applicable.

(6) DESCRIPTION OF DAMAGE.

Not applicable.

(7) HAS THE DAMAGE BEEN REPAIRED? Not applicable. **IF SO, BY WHOM, WHEN AND COST OF REPAIRS.**

Not applicable.

(8) ATTACH EACH ESTIMATE OF REPAIR COSTS TO THIS FORM.

(9) SET FORTH IN DETAIL THE LOSS CLAIMED BY YOU FOR PROPERTY DAMAGE.

Not applicable.

d. SET FORTH IN DETAIL ALL OTHER ITEMS OF LOSS OR DAMAGES CLAIMED BY YOU AND THE METHOD BY WHICH YOU MADE THE CALCULATION.

None at present.

5. **THE AMOUNT OF THE CLAIM.** $1,000,000.00

6. **HAVE YOU MADE A CLAIM AGAINST ANYONE ELSE FOR ANY OF THE LOSSES OR EXPENSES CLAIMED IN THIS NOTICE?**

No.

IF YES, SET FORTH THE NAME AND ADDRESS OF ALL PERSONS AND INSURANCE COMPANIES AGAINST WHOM YOU HAVE MADE SUCH CLAIMS:

Not applicable.

7. **ARE ANY OF THE LOSSES OR EXPENSES CLAIMED HEREIN COVERED BY ANY POLICY OF INSURANCE?**

Yes. Mr. McFarlane's medical insurance (see below); East Brunswick PD insurance (unknown at present)

FOR EACH SUCH POLICY, STATE THE NAME AND ADDRESS OF THE INSURANCE COMPANY, POLICY NUMBER AND BENEFITS PAID OR PAYABLE

Aetna US Healthcare; 151 Farmington Avenue, Hartford, CT 06156; policy number and benefits paid to be provided.

8. **HAVE YOU RECEIVED OR AGREED TO RECEIVE ANY MONEY FROM ANYONE FOR THE DAMAGES CLAIMED HEREIN?**

☐ YES ☒ NO

IF YES, SET FORTH THE DETAIL OF SUCH AGREEMENT.

Not applicable.

9. **THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE:**

(1) **COPIES OF ITEMIZED BILLS FOR EACH MEDICAL EXPENSE AND OTHER LOSSES AND EXPENSES CLAIMED.**

(2) **FULL COPIES OF ALL APPRAISALS AND ESTIMATES OF PROPERTY DAMAGE CLAIMED BY YOU.**

(3) **COPIES OF ALL WRITTEN REPORTS OF ALL EXPERT WITNESSES AND TREATING PHYSICIANS.**

(4) **A LETTER FROM YOUR EMPLOYER VERIFYING YOUR LOST WAGES. IF SELF-EMPLOYED, A STATEMENT SHOWING THE CALCULATION OF YOUR CLAIMED LOST INCOME.**

See documented attached. To be supplemented as additional documents become available.

I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. THAT THE ATTACHED STATEMENTS, BILLS, REPORTS AND DOCUMENTS ARE THE ONLY ONES KNOWN TO ME TO BE IN EXISTENCE AT THIS TIME. I AM AWARE THAT IF ANY STATEMENT MADE HEREIN IS WILLFULLY FALSE OR FRAUDULENT, THAT I AM SUBJECT TO PUNISHMENT PROVIDED BY LAW.

4/6/16
DATE

Greg S.
Gregory S. Shields
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT