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SB#029031996

FILED

APR 11 2014

CAMILLE M. KENNY
J.S.C.

EDWARD DEMAREST,

Plaintiff,

vs.

UNION COUNTY DEPARTMENT OF
CORRECTIONS, NURSE PHYLLIS, et als.

Defendants.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - CIVIL PART
UNION COUNTY

DOCKET NO: **UNN-L-0975-14**

CIVIL ACTION

ORDER GRANTING LEAVE TO FILE A
TORT CLAIMS ACT NOTICE OUT OF TIME
PURSUANT TO N.J.S.A 59:8-9

THIS MATTER having been opened to the Court by Motion of Stephen Zullo, Esq., attorney for the Plaintiff, for an Order seeking permission to File a Notice of Claim Out of Time against the County of Union and County of Union, Department of Corrections, pursuant to N.J.S.A. 59:8-9; and the Court having considered the moving papers, and any opposition thereto; and for good cause having been shown:

IT IS on this 11th day of April, 2014;

ORDERED that the Plaintiff may File a Notice of Claim Out of Time against the County of Union, State of New Jersey and Department of Corrections of Union County, State of New Jersey pursuant to N.J.S.A. 59:8-9; and it is further

ORDERED that a copy of this Order shall be served upon counsel for the Defendants, in accordance with the Rules of Court, within 7 days of the date hereof. *Plaintiff has demonstrated extraordinary circumstances, which Defendants do not challenge.*

HON. CAMILLE M. KENNY, J.S.C.

Opposed - *only as to constitutional claims*
 Unopposed

NOTICE OF CLAIM

1. Claimant:

Edward Demarest

Last First Middle

[REDACTED]

Address

10/10/67

Date of Birth

[REDACTED]
Social Security Number

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please complete this section.

STEPHEN M. ZULLO, ESQ.

Street Address

40 W. HIGH ST.

Name

SOMERVILLE, NJ 08876

Address

City

State

Zip Code

800-709-1131

Area Code/Telephone Number

ATTORNEY

Relationship

3. Accident:

A. The occurrence or accident which gave rise to this claim:

5/10/13-5/24/13

B. Describe location or place of the accident or occurrence:

Union County Jail, 15 Elizabethtown Plaza, Elizabeth, New Jersey.

C. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

The claimant suffered when he presented to the Jail medical facility with symptoms of a stroke and was not provided treatment for several hours. He may also have had a heart valve infection which was not diagnosed upon entry to the facility and thereafter. violations of its civil rights, including but not limited to, violations of Article 1 Paragraphs 1, 6, 18, 20, and Article 4 Paragraph 4 of the New Jersey Constitution; violations of Amendment XIV, V, I and Article IV §2 of the U.S. Constitution; infliction of emotional distress; medical malpractice by doctors and nurses in said facility; actions of a government entity

depriving the claimant of a civil right under color of law (notice of action under 42 U.S.C. 1983). See, 3F.

D. State the name and address of the Local Unit that caused your damage.

The Union County Department of Corrections and/or Union County.

E. State the name of the Local Units employees whom you claim were at fault, including any information that will assist in identifying them.

All doctors and nurses at the facility during the relevant time period.

F. State in detail each and every negligent or wrongful act of the Local Unit and the Local Unit's employees which caused your damage.

Failure to treat and diagnose a heart valve condition and stroke. Failure to provide a proper exam and diagnose an illness.

G. State the name and address of all witnesses to the accident or occurrence.

Claimant; and guards.

H. If vehicle accident, state the names, address, age and relationship to insured of all passengers in your vehicle.

N/A.

I. State the names of all police officers and police departments who investigated the accident.

N/A.

4. A. **Claim for Damages:** (Check appropriate box)

Bodily Injury Property Damage Other

If other, explain: The defendant was deprived of Civil Rights, and injured due to lack of medical care.

B. i. If you claim bodily injury - describe your injuries from this accident or occurrence.

Worsened outcome due to delay in treatment.

ii. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be

permanent.

[REDACTED]

iii. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, please list:

Trinitas MC, St Michaels MC

Name of Hospital, Doctor or Facility

5. The amount of claim. \$3,000,000.00

6. Have you made a claim against anyone else for any losses or expenses claimed in this notice?

Yes No

I hereby certify that the foregoing statements made by me are true, that the . I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

3/18/2014

Date

Edward Domagala

Claimant or person filing on behalf of claimant