

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

R. BARTLEY HALLORAN,	)	No.
ADMINISTRATOR OF THE ESTATE	)	
OF TIMOTHY PERRY,	)	
	)	COMPLAINT FOR DAMAGES
Plaintiff,	)	
	)	
	)	
vs.	)	
	)	DEMAND FOR JURY TRIAL
JOHN J. ARMSTRONG;	)	
CONNECTICUT DEPARTMENT OF	)	
CORRECTION; UNIVERSITY OF	)	April 11, 2001
CONNECTICUT HEALTH CENTER;	)	
HARTFORD CORRECTIONAL CENTER;	)	
GERALDO TORRES; ANDRE	)	
CHOUINARD; WILLIAM SCOTT;	)	
STEVEN SANELLI; JIMMY	)	
GUERRERO; JEFFREY HOWES;	)	
MAURELLIS POWELL; DENNIS	)	
CAMP; RAYMOND BRODEUR; MOISES	)	
PADILLA; CHRISTOPHER ST. JOHN;	)	
ANNE MARIE STOREY; RONALD	)	
HENSLEY, M.D.; CONNECTICUT	)	
DEPARTMENT OF MENTAL HEALTH	)	
AND ADDICTION SERVICES;	)	
CEDARCREST REGIONAL HOSPITAL;	)	
WHITING FORENSIC DIVISION;	)	
DENISE RIBBLE, R.N.; JOSEPH	)	
MORE, M.D.; ASHA QUSBA, M.D.;	)	
ALI FARD, M.D.; and	)	
STEPHEN BRZEZINSKI,	)	
	)	
	)	
Defendants.	)	

### JURISDICTION

1. This case is brought pursuant to 42 U.S.C. § 1983. Jurisdiction is based upon 28 U.S.C. §§ 1331 and 1343. Jurisdiction over the state law claims is conferred by 28 U.S.C. § 1367.

### VENUE

2. Venue is based upon 28 U.S.C. §§ 1391 (b)(1) and (2). All of the Defendants reside in the District of Connecticut, and all of the events or omissions giving rise to the claims herein arose in the District of Connecticut.

### INTRODUCTION

3. This Complaint for Damages concerns the failure of the Connecticut Department of Correction and the Connecticut Department of Mental Health and Addiction Services (DMHAS) to care properly for persons with mental illness. It specifically concerns the brutal death of a mentally ill man at the hands of the correctional officers and medical workers charged with his supervision and care.

4. On April 12, 1999, at approximately 10:30 p.m., 21 year old Timothy Perry was found dead, strapped to a bed in a cell on the mental health unit of the Hartford Correctional Center, a facility of the Connecticut Department of Correction.

5. For many years, and at the time of his death, Timothy suffered from severe psychiatric disorders.

6. For much of his young life, Timothy was a patient at state facilities for the mentally ill, and from January 26 to March 31, 1999, he was admitted for care, supervision and treatment to Cedarcrest Regional Hospital, a DMHAS facility.

7. Twelve days before his death, however, DMHAS psychiatrists and other employees, rather than properly treat Timothy's mental illness, had him arrested and transferred to prison where they knew he would receive inadequate psychiatric supervision and care, and where they knew he would be at risk of serious injury and death.

8. Several hours before he was discovered dead, Hartford Correctional Center guards used excessive force against Timothy, rendered him unconscious, comatose, dying or dead while restraining and subduing him, and deliberately failed to summon or provide obvious and urgently needed medical care for him.

9. The guards then strapped Timothy down to a "four-point restraint" bed, and a nurse employed at the Hartford Correctional Center injected Timothy with powerful sedatives while also failing to summon or provide obvious and urgently needed medical care for him.

10. Approximately two hours later, Timothy was found dead.

11. This Complaint seeks redress from the persons and entities responsible for Timothy's anguish, injuries and death.

#### PARTIES

12. Plaintiff R. BARTLEY HALLORAN is the Administrator of the Estate of Timothy Perry.

13. Defendant JOHN J. ARMSTRONG is, and was at all relevant times, the Commissioner of the CONNECTICUT DEPARTMENT OF CORRECTION. As such, he was responsible for the administration of this State's correctional system, the care and custody of persons incarcerated by the DEPARTMENT, and the hiring, supervision, training, discipline and control of persons working for the DEPARTMENT.

14. Defendant CONNECTICUT DEPARTMENT OF CORRECTION, acting through its agents, representatives and employees, was responsible for the care, custody and treatment of Timothy Perry at all relevant times mentioned herein.

15. Defendant UNIVERSITY OF CONNECTICUT HEALTH CENTER is and was at all relevant times responsible for providing medical, mental health and psychiatric care, services and supervision to persons in the custody of the CONNECTICUT DEPARTMENT OF CORRECTION, including Timothy Perry.

16. Defendant HARTFORD CORRECTIONAL CENTER is the CONNECTICUT DEPARTMENT OF CORRECTION facility where Timothy Perry was incarcerated from March 31, 1999 until his death on April 12, 1999.

17. Defendant Captain GERALDO TORRES was at all relevant times a shift commander at the HARTFORD CORRECTIONAL CENTER. He was the shift commander on duty at the time of Timothy Perry's death, and he was specifically responsible for supervising the CORRECTIONAL OFFICER DEFENDANTS on April 12, 1999.

18. Defendants ANDRE CHOUINARD and WILLIAM SCOTT were Lieutenant Correctional Officers assigned on April 12, 1999 to the HARTFORD CORRECTIONAL CENTER. Defendants STEVEN SANELLI, JIMMY GUERRERO, JEFFREY HOWES, MAURELLIS POWELL, DENNIS CAMP, RAYMOND BRODEUR, and MOISES PADILLA were Correctional Officers assigned on April 12, 1999 to the HARTFORD CORRECTIONAL CENTER. Defendant CHRISTOPHER ST. JOHN was a Correctional Officer Cadet assigned on April 12, 1999 to the HARTFORD CORRECTIONAL CENTER. The Defendants in this paragraph are collectively referred to as the "CORRECTIONAL OFFICER DEFENDANTS."

19. Defendant ANN MARIE STOREY was at all relevant times a nurse employed by the UNIVERSITY OF CONNECTICUT HEALTH CENTER, and assigned to the HARTFORD CORRECTIONAL

CENTER. She was responsible for providing medical care to Timothy Perry on April 12, 1999.

20. Defendant RONALD HENSLEY, M.D., was at all relevant times a physician employed at the CONNECTICUT DEPARTMENT OF CORRECTION. He was responsible for providing medical care to persons with mental illness in the custody of the CONNECTICUT DEPARTMENT OF CORRECTION, and he was specifically responsible for providing medical care to Timothy Perry on April 12, 1999.

21. Defendant CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES, acting through its agents, representatives and employees, was responsible for the care, custody and treatment of Timothy Perry at all relevant times mentioned herein.

22. Defendant CEDARCREST REGIONAL HOSPITAL is a facility of the CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

23. Defendant WHITING FORENSIC DIVISION OF CONNECTICUT VALLEY HOSPITAL is a division of the CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

24. Defendant DENISE RIBBLE, R.N., was at all relevant times the assistant director of WHITING FORENSIC DIVISION, and was specifically responsible for denying and

preventing Timothy Perry's transfer to WHITING and for authorizing, permitting and not objecting to Timothy's transfer to prison.

25. Defendant JOSEPH MORE, M.D., was at all relevant times a physician employed at WHITING FORENSIC DIVISION, and was specifically responsible for denying and preventing Timothy Perry's transfer to WHITING and for authorizing, permitting and not objecting to Timothy's transfer to prison.

26. Defendant ASHA QUSBA, M.D., was at all relevant times a physician employed at CEDARCREST REGIONAL HOSPITAL. She was responsible for providing medical and psychiatric care to persons with mental illness at CEDARCREST, and was specifically responsible for caring for Timothy Perry during the period January 26 to March 31, 1999. She was also specifically responsible for authorizing, requesting and not objecting to Timothy's transfer from CEDARCREST to prison.

27. Defendant ALI FARD, M.D., was at all relevant times a physician employed at CEDARCREST REGIONAL HOSPITAL. He was responsible for providing medical care to patients at CEDARCREST, and was specifically responsible for caring for Timothy Perry during the period January 26 to March 31, 1999. Defendant FARD was also specifically responsible for

authorizing, requesting and not objecting to Timothy's transfer from CEDARCREST to prison.

28. Defendant STEPHEN BRZEZINSKI was at all relevant times a social worker employed at CEDARCREST REGIONAL HOSPITAL. He was responsible for providing care to patients at CEDARCREST, and was specifically responsible for caring for Timothy Perry during the period January 26 to March 31, 1999. Defendant BRZEZINSKI was also specifically responsible for authorizing, requesting and not objecting to Timothy's transfer from CEDARCREST to prison.

#### FACTS

29. At all times mentioned herein, each individual Defendant was acting in the course and scope of his or her employment.

30. At all times mentioned herein, each Defendant was acting under color of state law.

31. Timothy Perry had a history of mental illness, psychiatric disorders, and neuropsychological deficits, and he spent much of his short life in the care and custody of the CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS).



32. On or about January 26, 1999, Timothy was admitted for care and treatment of his mental illness to CEDARCREST REGIONAL HOSPITAL.

33. At the time of his admission, Timothy's treating psychiatrists at CEDARCREST, including Defendant ASHA QUSBA, M.D., had diagnosed him as suffering from schizophrenia, schizoaffective disorder, impulse control disorder, borderline personality disorder with anti-social features, major depression and oppositional defiant disorder.

34. CEDARCREST and other DMHAS staff had also diagnosed Timothy as suffering from neuropsychological dysfunction and impairment, with a borderline level of intellectual functioning and IQ of 76.

35. Timothy's illness caused him to engage in assaultive, impulsive and aggressive behavior, and like most of his previous hospitalizations, Timothy was admitted to CEDARCREST in January 1999 specifically because of such behavior.

36. On or about March 27, 1999, Timothy engaged in aggressive and impulsive behavior towards CEDARCREST staff member Defendant ALI FARD, M.D.

37. Timothy's aggressive and impulsive behavior was caused by his illness, and was not properly prevented,

managed or treated by Timothy's psychiatric and medical workers at CEDARCREST and other DMHAS facilities.

38. On or about March 30, 1999, Defendant QUSBA spoke with staff at WHITING FORENSIC DIVISION, including Defendant DENISE RIBBLE, R.N., and Defendant JOSEPH MORE, M.D., concerning whether Timothy should be transferred from CEDARCREST to WHITING.

39. WHITING FORENSIC DIVISION is the Division of DMHAS that is specifically responsible for the care and treatment of psychiatric patients who require maximum security conditions.

40. Timothy should have been accepted to WHITING for care, treatment and supervision; however, Defendants RIBBLE, MORE and QUSBA deliberately refused and prevented his transfer there, knowing and intending that Timothy would be sent to prison and that he would receive inadequate treatment, supervision and care as a result.

41. Following the Defendant's refusal to transfer Timothy to WHITING, CEDARCREST employees, including Defendants QUSBA, FARD and BRZEZINSKI, rather than treat Timothy as a patient with serious psychiatric disorders, instead treated him like a criminal and had him arrested and transferred to the custody of the DEPARTMENT OF CORRECTION.

42. In March 1999, CEDARCREST had mandatory written policies and procedures concerning the assessment of a patient's mental status for potential criminal investigation.

43. These mandatory assessment procedures were put into place to ensure that patients who lack substantial capacity as a result of their mental illness to appreciate the wrongfulness of their conduct or to control their conduct would not be improperly arrested and thrown into prison.

44. In Timothy Perry's case, however, the Defendants had him arrested and sent to prison without following these basic and mandatory assessment procedures.

45. Contrary to the Defendant's assessment of Timothy's mental status on March 27, 1999, Timothy's CEDARCREST psychiatric and medical records are replete with notations that Timothy, in fact, could not control his behavior and did not understand his illness or his aggressive impulses.

46. It was improper, and a violation of mandatory DMHAS procedures, for the Defendants to have Timothy arrested and transferred to prison.

47. Upon Timothy's transfer to the HARTFORD CORRECTIONAL CENTER on March 31, 1999, Defendants QUSBA,

FARD, and BRZEZINSKI failed to ensure that psychiatric and medical staff at the DEPARTMENT OF CORRECTION were adequately informed of Timothy's serious mental illness and medical, mental health and medication needs, and they failed to ensure that Timothy would receive required and proper medication, treatment and supervision while incarcerated.

48. On April 12, 1999, Timothy's 12th day in custody at the HARTFORD CORRECTIONAL CENTER, he once again succumbed to his mental illness, and became severely agitated and anxious.

49. At approximately 7:45 p.m., while Defendants Nurse STOREY, Correctional Officer POWELL and Correctional Officer Cadet ST. JOHN stood by and watched, Defendant Correctional Officer HOWES pushed Timothy backwards, and Defendant Correctional Officers SANELLI, GUERRERO and CAMP descended upon Timothy and restrained him with the use of force.

50. At approximately 8:00 p.m., Defendant POWELL initiated a "code orange," seeking assistance from other correctional officers. Defendant Correctional Officer BRODEUR responded to the "code orange," and he handcuffed Timothy behind his back.

51. Defendants Correctional Officer PADILLA and Lieutenant CHOUINARD also responded to the "code orange" and, along with and assisted by the other CORRECTIONAL OFFICER DEFENDANTS, began restraining, subduing and using excessive force against Timothy, even after Timothy was face down on the floor and was handcuffed behind his back.

52. The CORRECTIONAL OFFICER DEFENDANTS carried Timothy face down to south block cell 10, put him face down on the mattress, shackled him with leg irons, continued to use excessive force against him, and asphyxiated him.

53. At or about the time that the CORRECTIONAL OFFICER DEFENDANTS carried Timothy to cell 10 and/or held Timothy in cell 10, Nurse STOREY spoke to DEPARTMENT OF CORRECTION staff psychiatrist Defendant HENSLEY by telephone, and HENSLEY ordered that Timothy be sedated with powerful sedatives and that he be tied down by his hands and feet.

54. The CORRECTIONAL OFFICER DEFENDANTS carried Timothy face down and handcuffed from cell 10 to cell 24, a 4-point restraint cell.

55. During the use of force against Timothy, Defendant GUERRERO obtained a towel from one or more of the other CORRECTIONAL OFFICER DEFENDANTS, and he held the towel over Timothy's mouth and face. The Defendants' use

of the towel in this fashion was improper, it increased the likelihood of Timothy being unable to breath and becoming asphyxiated, and it was itself excessive force against Timothy.

56. The Defendants' use of excessive force against Timothy rendered Timothy unconscious, comatose, dying or dead at or near the time that he was in cell 10 and at and after the time that the Defendants moved him to cell 24.

57. In cell 24, the Defendants put Timothy face down on the bed, and removed his handcuffs, leg irons and clothes.

58. In cell 24, Defendant GUERRERO continued to hold the towel over Timothy's mouth and face.

59. Defendant Lieutenant CHOUINARD was the scene supervisor for the "code orange" and was responsible for supervising the other CORRECTIONAL OFFICER DEFENDANTS throughout the entire incident.

60. Defendant Lieutenant WILLIAM SCOTT assisted in restraining Timothy and in the use of excessive force against him. Defendant SCOTT also observed the other Defendants' excessive force against Timothy, including the covering of Timothy's mouth and face with a towel, and he did nothing to stop it.

61. In cell 24, despite the fact that Timothy did not move or resist in any way, and despite the fact that he was obviously unconscious, comatose, dying or dead, the CORRECTIONAL OFFICER DEFENDANTS continued to restrain him, to use pain compliance techniques against him and to use excessive force against him, and Defendant GUERRERO continued to hold the towel against his mouth and face.

62. Despite the fact that Timothy was unconscious, comatose, dying or dead, Defendant STOREY injected him with powerful sedatives, including Ativan and Haldol.

63. The CORRECTIONAL OFFICER DEFENDANTS then turned Timothy onto his back, they cut and tore off the rest of his clothing, and they tied him down by his wrists and ankles.

64. At approximately 8:30 p.m., the CORRECTIONAL OFFICER DEFENDANTS and Defendant STOREY left Timothy strapped down and alone in the 4-point restraint cell.

65. From the time that he obtained the towel in cell 10 until the Defendants left cell 24, Defendant GUERRERO held the towel over Timothy's mouth and face, the other CORRECTIONAL OFFICER DEFENDANTS and Defendant STOREY knew that GUERRERO was holding a towel over Timothy's mouth and face, and no one did anything to stop it.

66. During Defendant STOREY's telephone conversation with Defendant HENSLEY and afterwards, STOREY deliberately failed to advise HENSLEY, and HENSLEY deliberately failed to inquire, about Timothy's actual medical condition and serious medical needs. Specifically, the Defendants deliberately failed to learn, discuss or report that Timothy was unconscious, comatose, dying or dead at the time that the sedatives and 4-point restraints were ordered and administered.

67. At no time did Defendant STOREY, the CORRECTIONAL OFFICER DEFENDANTS or anyone else check Timothy's pulse, respiration, blood pressure or temperature.

68. At no time did Defendant STOREY, the CORRECTIONAL OFFICER DEFENDANTS or anyone else check Timothy for injuries.

69. Defendant STOREY and the CORRECTIONAL OFFICER DEFENDANTS deliberately failed to perform a medical examination on Timothy and deliberately failed to institute life saving measures after becoming aware of Timothy's need for them.

70. The CORRECTIONAL OFFICER DEFENDANTS and Defendant STOREY deliberately failed to follow proper use of force, restraint and medical procedures to ensure Timothy's health and safety.



71. No physician was called to examine Timothy Perry after he was subdued by the CORRECTIONAL OFFICER DEFENDANTS or at or after the time that he was strapped down and his body injected with sedatives in cell 24.

72. No physician was called to examine Timothy Perry during the following approximately two hours that he was left alone strapped down in cell 24.

73. Defendant POWELL recorded on videotape some of the events, acts and omissions alleged in the preceding paragraphs. That portion of the videotape that has been produced by the CONNECTICUT DEPARTMENT OF CORRECTION to Plaintiff is attached to this complaint as Exhibit A, and the events, acts, omissions and admissions recorded on that tape are incorporated into this Complaint as if fully alleged herein.

74. Following the use of force against Timothy Perry, Defendant Captain GERALDO TORRES, the HARTFORD CORRECTIONAL CENTER 2<sup>nd</sup> shift commander on April 12, 1999, permitted Defendants GUERRERO and HOWES to privately view the incident videotape in his office, allowing them the opportunity to erase portions of the videotape and violating DEPARTMENT OF CORRECTION rules concerning the preservation and handling of evidence of use of force against inmates.

75. A toxicology analysis conducted by the Office of the Connecticut Medical Examiner after Timothy's death determined that the psychotropic drug Thorazine was found in Timothy's blood stream.

76. Timothy was allergic to Thorazine, his CEDARCREST and DEPARTMENT OF CORRECTION medical records clearly indicated that he was allergic to Thorazine, and by giving him Thorazine, the CORRECTIONAL OFFICER DEFENDANTS, Defendant STOREY and/or Timothy's other treating physicians and medical workers at the HARTFORD CORRECTIONAL CENTER deliberately ignored an obvious risk of harm to him.

77. At approximately 10:30 p.m. on April 12, about two hours after Defendant STOREY and the CORRECTIONAL OFFICER DEFENDANTS left Timothy strapped down and alone in the 4-point restraint cell, another member of the HARTFORD CORRECTIONAL CENTER medical staff, Nurse Yvonne Smith, noticed through the cell window that Timothy's feet were discolored and that he was in the exact same position that he had been in two hours earlier.

78. Nurse Smith had Timothy's cell door opened, and she discovered that Timothy had no pulse, that he was cold, stiff and not breathing, and that he had been dead for some time.

79. Timothy's body was transported by ambulance to Hartford Hospital, where he was officially pronounced dead.

80. The individually named Defendants each acted with reckless or callous indifference to Timothy Perry's dignity as a human being and to his constitutional and statutory rights.

81. As a direct and proximate result of the acts and omissions of the Defendants, Timothy Perry suffered extreme distress, anguish, pain and death.

82. Following the death of Timothy Perry, not one of the CORRECTIONAL OFFICER DEFENDANTS was appropriately punished or disciplined.

83. In August 1999, Defendant STOREY was offered a promotion.

#### FIRST CLAIM FOR RELIEF

(Deliberate Indifference -- Failure to Provide Constitutionally Adequate Medical Care -- against Defendants QUSBA, FARD, BRZEZINSKI, RIBBLE, MORE, HENSLEY, STOREY, and the CORRECTIONAL OFFICER DEFENDANTS, in their individual capacities)

84. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

85. By failing to provide Timothy Perry with constitutionally adequate medical care, and by failing to summon such care, the Defendants knowingly disregarded an excessive risk to Timothy's health and safety and knowingly

subjected him to pain, physical and mental injury, and death, thereby violating Timothy's rights under the Fourth, Eighth and Fourteenth Amendments to the United States Constitution.

SECOND CLAIM FOR RELIEF

(Deliberate Indifference -- Failure to Provide Constitutionally Adequate Medical Care -- Supervisory Liability, against Defendant ARMSTRONG in his individual capacity)

86. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

87. The Defendant was personally involved in and responsible for the deliberate indifference to Timothy Perry's serious medical needs in that:

- a. He created a policy and custom, and he allowed the continuance of a policy and custom, under which inmates would be deprived of adequate medical care; and
- b. He was deliberately indifferent in supervising and training subordinates who committed the wrongful acts described herein.

88. The acts and omissions of the Defendant proximately caused Timothy Perry's suffering, injuries and death.

89. By failing to provide Timothy Perry with constitutionally adequate medical care, the Defendant knowingly disregarded an excessive risk to his health and safety and knowingly subjected him to pain, physical and mental injury, and death, thereby violating Timothy's rights under the Fourth, Eighth and Fourteenth Amendments to the United States Constitutions.

THIRD CLAIM FOR RELIEF

(Deliberate Indifference To Safety -- Failure to Protect --  
against Defendants QUSBA, FARD, BRZEZINSKI, RIBBLE and  
MORE, in their individual capacities)

90. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

91. By transferring, or by allowing or not objecting to the transfer of, Timothy Perry from CEDARCREST to the HARTFORD CORRECTIONAL CENTER, Defendants knowingly disregarded an excessive risk to Timothy's health and safety and knowingly failed to protect him from harm caused by himself and others, thus subjecting him to pain, physical and mental injury, and death in violation of his rights under the Fourth, Eighth and Fourteenth Amendments to the United States Constitution.

#### FOURTH CLAIM FOR RELIEF

(Deliberate Indifference to Safety -- Failure to Protect --  
against the CORRECTIONAL OFFICER DEFENDANTS and Defendant  
STOREY, in their individual capacities)

92. Plaintiff realleges and incorporates by reference  
each and every allegation in paragraphs 1 through 83.

93. Each of the Defendants knew that the other  
Defendants, and each of them, were using excessive force  
against Timothy and/or were failing to summon or provide  
obvious and urgently needed medical attention.

94. Each Defendant could have taken action to stop  
the use of excessive force, to summon or provide medical  
care, and to prevent injury and death to Timothy, but  
refused or failed to do so.

95. Each defendant failed to protect Timothy from the  
use of excessive force and the deliberate failure to  
provide medical care in violation of the Fourth, Eighth and  
Fourteenth Amendments to the United States Constitution.

#### FIFTH CLAIM FOR RELIEF

(Deliberate Indifference to Safety -- Failure to Protect --  
Supervisory Liability, against Defendant ARMSTRONG in his  
individual capacity)

96. Plaintiff realleges and incorporates by reference  
each and every allegation in paragraphs 1 through 83.

97. The Defendant was personally involved in and  
responsible for the failure of the CORRECTIONAL OFFICER

DEFENDANTS and Defendant STOREY to protect Timothy Perry in that:

- a. He created a policy and custom, and he allowed the continuance of a policy and custom, under which correctional officers and other persons employed at the DEPARTMENT OF CORRECTION are allowed, permitted and/or encouraged to look the other way and to remain silent when excessive force is used against inmates in the correctional system; and
- b. He was deliberately indifferent in supervising and training subordinates who committed the wrongful acts described herein.

98. The acts and omissions of the Defendant proximately caused Timothy Perry's suffering, injuries and death.

99. The Defendant failed to protect Timothy from the use of excessive force and the deliberate failure to provide medical care in violation of the Fourth, Eighth and Fourteenth Amendments to the United States Constitution.

SIXTH CLAIM FOR RELIEF

(Excessive Force, against the CORRECTIONAL OFFICER  
DEFENDANTS and Defendant STOREY, in their individual  
capacities)

100. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

101. The force used by the Defendants against Timothy Perry on or about April 12, 1999, was unreasonable and excessive in violation of Timothy's rights under the Fourth, Eighth and Fourteenth Amendments to the United States Constitution.

SEVENTH CLAIM FOR RELIEF

(Excessive Force, Supervisory Liability, against Defendant  
ARMSTRONG, in his individual capacity)

102. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

103. Defendant was personally involved in and responsible for the excessive force used against Timothy Perry in that:

- a. He created a policy and custom, and he allowed the continuance of a policy and custom, under which correctional officers and other employees of the DEPARTMENT OF CORRECTION are allowed,



permitted and/or encouraged to use excessive force against inmates; and

- b. He was deliberately indifferent in supervising and training subordinates who participated in the use of excessive force against Timothy Perry.

104. The acts and omissions of the Defendant proximately caused Timothy Perry's suffering, injuries and death.

105. By his acts and failures to act, the Defendant subjected Timothy Perry to pain, physical and mental injury, and death in violation of his rights under the Fourth, Eighth and Fourteenth Amendments to the United States Constitution.

#### EIGHTH CLAIM FOR RELIEF

(Violation of Equal Protection, United States Constitution, against Defendants QUSBA, FARD, BRZEZINSKI, RIBBLE and MORE, in their individual capacities)

106. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

107. In March 1999, the rules, policies, and practices of the Connecticut DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES prohibited the arrest or incarceration of patients who lacked substantial capacity as a result of

their mental illness to appreciate the wrongfulness of their conduct or to control their conduct.

108. Plaintiff is informed and believes, and therefore alleges on information and belief, that Timothy Perry was the only patient of CEDARCREST, or one of very few patients, who was arrested and incarcerated despite the fact that he lacked substantial capacity as a result of his mental illness to appreciate the wrongfulness of his conduct or to control his conduct.

109. By seeking and allowing the arrest and incarceration of Timothy Perry, the Defendants intentionally treated him differently from other CEDARCREST and DMHAS patients who engaged in similar behavior and suffered from similar psychiatric disabilities, but who were not arrested or incarcerated.

110. There was no rational basis for the Defendants' differing treatment of Timothy Perry; the treatment was irrational and arbitrary.

111. The Defendants' differing treatment of Timothy Perry violated his right to Equal Protection under the Fourteenth Amendment to the United States Constitution.

NINTH CLAIM FOR RELIEF

(Violation of Conn. Gen. Stat. § 17a-542 -- failure to provide humane and dignified treatment -- against all Defendants)

112. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83.

113. At all times mentioned herein, Timothy Perry was a "Patient" within the meaning of Conn. Gen. Stat. § 17a-540(b).

114. The facilities of the CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES, including CEDARCREST REGIONAL HOSPITAL and WHITING FORENSIC DIVISION, and the facilities of the CONNECTICUT DEPARTMENT OF CORRECTION, including the HARTFORD CORRECTIONAL CENTER and the UNIVERSITY OF CONNECTICUT HEALTH CENTER, are "Facilities" within the meaning of Conn. Gen. Stat. § 17a-540(a).

115. During the period that Timothy Perry was a patient at DMHAS facilities and during the period that he was incarcerated at the DEPARTMENT OF CORRECTION, including but not limited to the period January to April 1999, the Defendants failed to provide humane and dignified treatment to him, in violation of Conn. Gen. Stat. § 17a-542.

116. As a direct and proximate consequence of the Defendants' acts and omissions, Timothy Perry's mental illness was inadequately treated, he was deprived of the ability to live a productive life, he suffered extreme fear, agitation, pain and anguish, and he was killed.

117. This Count is brought pursuant to Conn. Gen. Stat. § 17a-550.

TENTH CLAIM FOR RELIEF

(Violation of Conn. Gen. Stat. § 17a-542 -- failure to  
provide a specialized treatment plan -- against all  
Defendants)

118. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83, 113 and 114.

119. During the period that Timothy Perry was a patient at DMHAS facilities and during the period that he was incarcerated at the DEPARTMENT OF CORRECTION, including but not limited to the period January to April 1999, the Defendants failed to treat and monitor Timothy Perry in accordance with a specialized treatment plan suited to his disorders and to his psychiatric circumstances, including treatment for his impulsive and aggressive behavior, in violation of Conn. Gen. Stat. § 17a-542.

120. As a direct and proximate consequence of the Defendants' acts and omissions, Timothy Perry's mental

illness was inadequately treated, he was deprived of the ability to live a productive life, he suffered extreme fear, agitation, pain and anguish, and he was killed.

121. This Count is brought pursuant to Conn. Gen. Stat. § 17a-550.

ELEVENTH CLAIM FOR RELIEF

(Violation of Conn. Gen. Stat. § 17a-545 -- failure to conduct psychiatric examinations -- against all Defendants)

122. Plaintiff realleges and incorporates by reference each and every allegation in paragraphs 1 through 83, 113 and 114.

123. During the period that Timothy Perry was a patient at DMHAS facilities and during the period that he was incarcerated at the DEPARTMENT OF CORRECTION, including but not limited to the period January to April 1999, the Defendants failed to conduct, or to ensure Timothy's receipt of, proper physical and psychiatric examinations, in violation of Conn. Gen. Stat. § 17a-545.

124. As a direct and proximate consequence of the Defendants' acts and omissions, Timothy Perry's mental illness was inadequately treated, he was deprived of the ability to live a productive life, he suffered extreme fear, agitation, pain and anguish, and he was killed.

125. This Count is brought pursuant to Conn. Gen.  
Stat. § 17a-550.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff R. BARTLEY HALLORAN,  
ADMINISTRATOR OF THE ESTATE OF TIMOTHY PERRY, prays for  
relief as follows:

1. For compensatory damages according to proof;
2. For punitive damages;
3. For costs and reasonable attorneys fees; and
4. For such further relief as the Court deems just  
and proper.

Dated: April 11, 2001

Richard A. Bieder  
Antonio Ponvert III

By: \_\_\_\_\_  
Antonio Ponvert III  
CT 17516  
Attorneys for Plaintiff

DEMAND FOR JURY TRIAL

Pursuant to Fed. R. Civ. P. 38(b), Plaintiff, R.  
BARTLEY HALLORAN, ADMINISTRATOR OF THE ESTATE OF TIMOTHY  
PERRY, hereby demands trial by jury.

Dated: April 11, 2001

By: \_\_\_\_\_  
Antonio Ponvert III  
CT 17516  
Attorneys for Plaintiff