

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**
(Northern Division)

**Jill Harrington, individually and as
Personal Representative of The Estate of
Alexander LaMorie**

c/o Brown, Goldstein & Levy, LLP

120 E. Baltimore Street, Suite 2500

Baltimore, Maryland 21202

(County of Residence: Prince George's
County),

Plaintiffs,

v.

Howard County, Maryland

3430 Court House Drive,

Ellicott City, Maryland 21043,

(County of Residence: Howard County),

Serve on:

Calvin B. Ball III, County Executive

3430 Court House Drive

Ellicott City, Maryland 21043,

and

Joseph Riebau

c/o Howard County, Maryland

3430 Court House Drive,

Ellicott City, Maryland 21043,

(County of Residence: Frederick County),

and

Joel Rodriguez

c/o Howard County, Maryland

3430 Court House Drive,

Ellicott City, Maryland 21043,

(County of Residence: Howard County),

and

Civil Action No. _____

Cody Bostic

*

c/o Howard County, Maryland

3430 Court House Drive,

*

Ellicott City, Maryland 21043,

(County of Residence: Carroll County),

*

Defendants.

COMPLAINT AND REQUEST FOR JURY TRIAL

Plaintiffs Estate of Alexander LaMorie and Jill Harrington allege as follows:

INTRODUCTION

1. In his September 2026 State of the County address, Howard County Executive Calvin Ball proclaimed: “Public service is a promise. A promise that whe[n] someone calls 911 in the middle of the night . . . , their government will work for them.”¹

2. Howard County broke its promise to Alexander LaMorie and his family.

3. Alex should be alive today. He is dead because in a moment of crisis he called 911 for help. Rather than provide Alex the appropriate emergency response services he needed, Howard County sent four police officers armed with deadly weapons and insufficient mental health resources. After calling out to Alex and urging him to approach them, three of those officers shot Alex dead.

4. On the night of February 28, 2026, Alex was settling into his new home, an apartment in Patuxent Commons, to which he had moved three days earlier. Patuxent Commons is a housing community with 25 percent of its units reserved for people, like Alex, with autism and other disabilities.

5. Patuxent Commons was a landmark project for Howard County, a community that prides itself on its historically inclusive housing practices. In partnership with Mission First Housing Group and the Autism Society of Maryland, over nearly a decade, the County specially developed the apartment building to meet the needs of people with disabilities. The County invested over \$6 million in the development, which it promoted as a “transformational” housing initiative.

¹ County Executive Calvin B. Ball III, *2026 State of the County Address*, at 15, <https://perma.cc/C8WX-K8UD>.

6. In that State of the County address, County Executive Ball touted Patuxent Commons as a crowning achievement of his administration. “Inclusion is not simply inviting someone into a community,” he stated, “it is designing a community with them in mind from the very beginning.”²

7. For Alex, however, the County’s invitation into this community proved fatal.



Alexander LaMorie in front of his new apartment in Patuxent Commons, days before he was shot and killed by Howard County police officers.

8. Alex called 911 that night to seek police assistance with a “sextortion” cyber scam. Soon after, Howard County Police Department (HCPD) officers spoke with Alex directly, and he made statements clearly conveying that he was spiraling into a mental health crisis and

² *Id.* at 17.

was at risk of self-harm. Alex was especially sensitive to shame and embarrassment, a sensitivity arising from his disabilities. Autistic people face a substantially elevated risk of suicide, with emotional dysregulation during acute distress recognized as a significant risk factor.

9. The County and its police force were well aware of the special needs of many Patuxent Commons residents. And the County had specialized training and resources for HCPD to use when providing emergency services to people with mental health disabilities. From the time the responding officers first learned of Alex's mental health crisis until the time shots were fired, there was ample opportunity for Howard County to make use of its resources and modify its emergency response in light of Alex's disabilities, as federal law required.

10. Yet the County dispatched police officers to respond to Alex's call for help with no plan and no specialized resources.

11. Instead, they resorted to a force-first approach, treating Alex solely as a violent threat to be neutralized. That response escalated the situation rather than deescalating it, contradicting the County's own training guidelines and policies and well-established principles of appropriate emergency response to a person in crisis.

12. Crucially, the responding officers did not plan for or attempt to make use of less-lethal force options. When it was too late, they recognized that such options would have been appropriate. While rushing to Alex's location, one officer asked another if he had his taser. He said no. In the final moments before three officers opened fire, an officer called out, "Do we have less lethal?" But none of the four officers brought a taser that night.

13. The County's officers also failed to obtain assistance from its own mental health specialists, contrary to HCPD's own policies, and rushed into engaging Alex without coordinating a plan, and unnecessarily shrank the distance between themselves and Alex, limiting the pathways to deescalation. Coupling these factors with their lack of less-lethal

options, the County's officers drew Alex into an unnecessary lethal confrontation. Alex was not suspected of any crime and made no threats. He had thoughts of self-harm while in a crisis over an embarrassing incident, and he called 911 for help.

14. Shortly before he was killed, Alex told his mother on the phone: "The police are going to come help me." When the officers found Alex, he was over 100 feet away, standing in the Patuxent Commons parking lot right where the officers had parked their patrol cars, waiting for the officers' arrival and assistance. No one else was around. Based on their prior phone call, the officers knew Alex was in the throes of a mental health crisis. That crisis also was immediately recognizable: he was barefoot and wearing a T-shirt on a cold winter night with snow on the ground, making incoherent statements. The small bread knife Alex brought outside from his kitchen did not justify lethal force. An officer even beckoned Alex to come closer initially, and walked towards Alex himself, before the situation then needlessly escalated into an avoidable standoff.

15. The dangerousness of the situation arose primarily from the four police officers with pointed guns who did not de-escalate, held their ground, and, like a firing squad, presented a deadly scenario to an apparently suicidal person.

16. Alex made statements reflecting his suicidality and unstable mental state. Then he walked forward, holding the small knife down at his side, pointed backwards. When he was about 15 feet away from the officers, they opened fire.

17. Alex was 25 years old when his life was taken from him. He was a cherished son, brother, and community leader. The life of Jill Harrington, his loving mother, will never be the same.

18. When Alex called 911 in the middle of the night for help, Howard County did not work for him. Rather than respond to protect Alex from harm in his darkest moment, Howard

County created the very situation that caused his death. Instead of helping Alex when he called the police for assistance, they killed him.

19. Having a mental health disability or struggling with a suicidal crisis is not a crime. Calling 911 for help should not be a death sentence. Alex was entitled to equal access to Howard County's emergency response services and should not have faced lethal force in response.

20. This suit seeks to hold Howard County and HCPD Officers Joseph Riebau, Joel Rodriguez, and Cody Bostic accountable for their violations of law that resulted in Alex's death.

JURISDICTION AND VENUE

21. This Court has jurisdiction over the claims brought under the Americans with Disabilities Act ("ADA"), and Section 504 of the Rehabilitation Act ("Section 504") pursuant to 28 U.S.C. § 1331. It has jurisdiction over the remaining State law claims pursuant to 28 U.S.C. § 1367.

22. Plaintiffs have complied with the Local Government Tort Claims Act, Md. Code Ann. Cts. & Jud. Proc. §§ 5-301, et seq. by giving notice of their claims within one year of the occurrence of Alex's death and timely filing this lawsuit.

23. Venue is appropriate under 28 U.S.C. § 1391 in that the events giving rise to this lawsuit occurred in Maryland and all Defendants are located in Maryland.

PARTIES

24. The Estate of Alexander LaMorie was opened in Prince George's County, Maryland. Alex's mother, Jill Harrington LaMorie is the Personal Representative of the Estate.

25. Jill Harrington is a resident of Bowie, Maryland. She is the mother of Alexander LaMorie and sues individually and as the Personal Representative of the Estate of Alexander LaMorie.

26. Howard County is a political subdivision in the State of Maryland. It has the capacity to sue and be sued.

27. Joseph Riebau of Frederick County, Joel Rodriguez of Howard County, and Cody Bostic of Carroll County (the “Officer Defendants”) are HCPD police officers. At all times relevant to this action, the officers were acting under color of law and within the scope of their employment as agents of Howard County, Maryland.

FACTUAL ALLEGATIONS

The life of Alexander LaMorie

28. Born June 24, 2000, Alex was raised in a family defined by service and duty.

29. His father, a Naval Academy graduate, died while on active duty when Alex was six. Because of Alex’s disabilities, he was qualified as his father’s permanent dependent, which allowed him to be buried alongside his father at a national veteran’s cemetery. Throughout his life, Alex was part of and received support from the Military Surviving and Gold Star communities.

30. His stepfather, LTC David F. Carey, U.S. Army (Ret.), is a decorated combat veteran, and generations of Alex’s family served in the military, law enforcement, and fire service.

31. Diagnosed with autism as a young teenager, Alex became a disability and grief advocate, public speaker, writer, artist, and member of the Autism & Grief Project Advisory Board. He shared his experiences through Autism Speaks, appeared as a panelist at San Diego Comic-Con, and inspired his mother, Dr. Jill Harrington, a licensed clinical social worker,

educator, author, and recognized grief expert, to create Routledge's *Superhero Grief* series, to which Alex contributed as an author and artist.



Jill Harrington with family members at Alex's burial ceremony in Arlington National Cemetery.

32. Alex also took pride in his Native-American heritage through his father and connection to the federally recognized White Mountain Apache Tribe.

33. Three days before his death, Alex moved into the Patuxent Commons housing community, located in Howard County.

34. Patuxent Commons was developed by the Autism Society of Maryland, Mission First Housing Group, and Howard County to help address the housing needs of disabled people like Alex and to foster their social connectedness and community engagement.

35. Howard County worked to bring the project to fruition for nearly a decade, investing more than \$6 million in the project, which opened its doors in November 2025 with 25 percent of its units reserved for people with autism and other disabilities.

36. At the ribbon cutting ceremony (which Howard County hosted, and Alex attended), County Executive Calvin Ball stood alongside other elected leaders and leadership of the Autism Society of Maryland and heralded the project as transformational for the County.



Alex at the Patuxent Commons ribbon cutting ceremony in November 2025.

37. Howard County and its police force were aware of the special needs of the population residing in Patuxent Commons. Before Alex's death, HCPD officers had responded to calls to assist other residents with disabilities at Patuxent Commons.

The events of February 28 and March 1, 2026

38. On the evening of February 28, 2026, Alex was with his family at a bowling alley, celebrating his mother's birthday. A family friend dropped Alex off at home at Patuxent Commons afterwards.

39. Alex called 911 at 11:47 P.M. He reported having exchanged sexual messages with someone online, who had represented themselves to be an adult woman. The person then claimed to be a minor and threatened to expose Alex's messages on social media, unless Alex

provided payment. Over a six-minute phone call with Howard County’s emergency communications personnel, Alex provided his name and his address and requested police assistance, and a call-taker informed him that officers would respond to his location and would call him when they arrived.

40. At 11:52 P.M., HCPD officers Joseph Riebau and Mohammed Sayyad were dispatched to respond to Patuxent Commons. At the time, Officer Sayyad was a trainee, acting under Officer Riebau’s supervision.

41. While en route to the scene, between 11:52 P.M. and 12:06 A.M., Officers Riebau and Sayyad used a department-issued cell phone to call Alex for additional information. The officers spoke with Alex on speakerphone. According to Officer Sayyad, Alex was upset during the call and referred to thoughts of harming himself.

42. Officers Riebau and Sayyad informed emergency communications personnel of the call and stated that they now intended to conduct an “EP,” or emergency evaluation petition, which is a form of police response to evaluate a person for potential mental health hospitalization. *See generally* Md. Code, Health Gen. §§ 10-622 *et seq.* Such petitions are only appropriate when an officer believes a person “has a mental disorder” and presents a danger to self or others. *See id.*

43. Well before arriving at Patuxent Commons, the County and its officers knew of or should have recognized Alex’s disability-based crisis and the need for a specialized crisis response.

44. According to HCPD policy in effect at the time—General Order OPS-07, “Persons Experiencing Mental Health Crisis,” effective April 26, 2023—when an HCPD officer determines a person “has mental illness or is experiencing a mental health crisis” and has determined “that the subject is a possible danger to himself or others,” then “the officer shall

make immediate notification to the appropriate agency such as the Mobile Crisis Team (MCT), the Department of Social Services, or another agency depending upon the circumstances.”

45. Officers Riebau and Sayyad did not notify Howard County’s Mobile Crisis Team resource or otherwise contact the County’s mental health resources or agencies as required by HCPD policy.

46. HCPD officers Joel Rodriguez and Cody Bostic were nearby and, at 12:04 and 12:05 A.M also dispatched to Patuxent Commons. Officers Rodriguez and Bostic also failed to immediately notify the County’s Mobile Crisis Team or the appropriate County agency.

47. All four officers arrived in the parking lot of Patuxent Commons at roughly the same time, at 12:09 A.M., 22 minutes after Alex called 911.

48. Around the same time, Alex walked out of his apartment and headed towards the parking lot to find the incoming police officers and obtain their assistance.

49. The officers gained access to the building at 12:11 A.M. and arrived at Alex’s apartment on the third floor. They did not cross paths with Alex, who ended up standing in the Patuxent Commons parking lot near the officers’ parked cars, barefoot and in a T-shirt in the cold winter night, where he waited for the arriving officers for around 10 minutes.

50. At some point after getting off the phone with 911, Alex had called his mother. He sounded frantic, worked up into a crisis over his shame and embarrassment about the online messages. The emotional crisis arose from Alex’s autism, which can lead to an involuntary stress response and loss of control—often referred to as a “meltdown”—when overwhelmed or emotionally dysregulated. Jill and Alex’s stepfather David began driving towards Alex’s apartment.

51. Jill tried to soothe her son. They had discussed how to manage emotional crises, and even had a “safety plan,” with steps Alex should follow if he was thinking of self-harm,

which included calling 911 for help. Before their call ended, Alex told Jill: “The police are going to come help me.”

52. Meanwhile, having received no response from inside Alex’s apartment, the officers decided to open the unlocked door. With guns drawn, they swept the unit and found it empty. Officers Rodriguez and Bostic exited to search the rest of the floor, while officers Riebau and Sayyad continued looking around inside.

53. At 12:16 A.M., someone referred to “Grassroots” over the radio, which is a third-party contractor Howard County uses for mental health co-response services and technical assistance with mental health emergency responses, among other services. The Grassroots phone number was read out over the radio. A few minutes later, Officer Bostic remarked to Officer Rodriguez, “This is supposed to be part Humanim too.” Humanim is another third-party contractor Howard County uses for the same or similar services as Grassroots.

54. At no point did any officer or emergency communications personnel take any action to obtain any form of specialized assistance from Grassroots or Humanim.

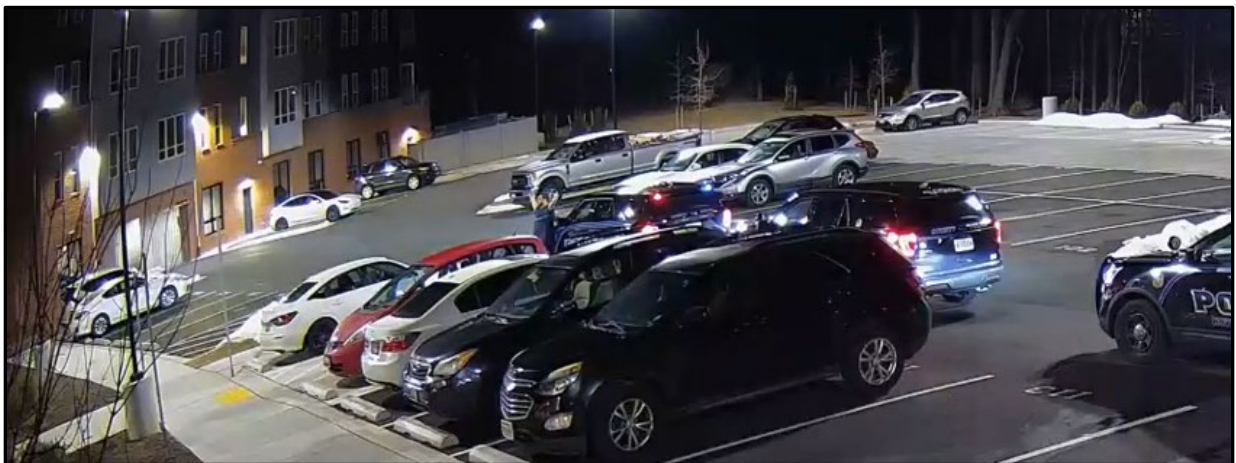
55. At 12:18 A.M., not finding Alex nearby, the officers prepared to leave the apartment unit. They noticed Alex’s wallet and ID by the door and looked at the picture to recognize Alex’s appearance.

56. The officers asked the emergency communications center to “ping” Alex’s cell phone to try to locate him, and they were told the ping showed Alex across the street from the building. Officers Riebau and Sayyad went to look outside, while officers Rodriguez and Bostic stayed by the apartment in case Alex returned.

57. At 12:20 A.M., upon exiting the building, beyond a long walkway extending from the building’s front door, officers Riebau and Sayyad could see Alex waiting in the parking lot.

He was leaning against one of the police cars, which the officers had left unparked in the middle of the lot. No one else was present. The officers were a significant distance from Alex at this moment, about 120 feet away.

58. Officer Riebau beckoned for Alex to come towards them. At the same time, he took around 13 steps towards Alex. When the officers walked outside, Alex initially held his hands up in the air. Then, in response to being waved in, he complied by walking towards the officers.



Still image from Patuxent Commons surveillance footage showing Alex's position while waiting for the officers and raising his hands upon seeing them.



Still image from Patuxent Commons surveillance footage showing Officers Riebau and Sayyad exiting the building and waving for Alex to come forward.

59. A few seconds later, Office Riebau radioed that Alex was holding a knife.

60. Officers Rodriguez and Bostic, still waiting inside the building at Alex's apartment, began rushing to the scene outside. While riding in an elevator to the ground floor, Officer Rodriguez asked Officer Bostic, "Do you have your taser?" Officer Bostic replied, "No." He speculated that the trainee (Officer Sayyad) might have one.

61. In fact, none of the officers were carrying a taser, none of the officers were required to carry a taser, and Howard County had an insufficient number of tasers in its inventory to properly equip its public-facing officers. The County had fewer than half the number of tasers it would have required to equip each of its public-facing police officers.

62. After walking forward for about 15 seconds in response to being waved in, Alex stopped walking, still a significant distance away from the officers. He made comments reflecting his emotional crisis and suicidality, referring to the pain he was in, and wanting the pain to end. He then held out his arms in front of him and said, "Go ahead."



Still image from the start of Officer Riebau's body-worn camera footage at 12:20 A.M., showing Alex at the edge of the parking lot, where he paused after initially walking forward.

63. At 12:21 A.M., officers Rodriguez and Bostic reached the others and walked forward to where officers Riebau and Sayyad were standing, about 13 steps towards Alex and away from the building.

64. The four officers were standing next to each other, roughly in a half-circle, pointing their guns at Alex. Officer Riebau attempted to communicate with Alex and repeatedly ordered him to drop the knife.

65. Alex began walking towards the officers again. He held the small kitchen knife down at his side, pointing backwards. He slowly and steadily continued walking.

66. As he drew nearer, an officer called out, “Do we have less lethal?” Another officer called out, “We’re getting cornered!” Just afterwards, at 12:22 A.M., as Alex was about 15 feet away, officers Riebau, Rodriguez, and Bostic opened fire.



Still image from Patuxent Commons surveillance camera showing the officers and Alex when shots were fired.

67. The officers fired twelve shots. According to the medical examiner’s report, Alex had eleven gunshot wounds. He fell to the ground, still conscious initially, suffering immeasurable fear and pain.

68. Additional officers arrived almost immediately after. Officers began to provide aid until EMS reached the scene. Alex was pronounced dead at 12:34 A.M.

69. Jill and David were on the road, driving to Patuxent Commons. From the car, Jill had called a suicide and crisis hotline to report Alex's crisis and seek assistance. She was eventually routed to 911 and spoke with Howard County emergency communications personnel. She informed them of her call with Alex and gave more information about his background and disabilities. She spoke with 911 at 12:23 A.M., one minute after Alex was shot.

Howard County's specialized resources for crisis response

70. Howard County has resources for responding to a person in a mental health crisis aside from patrol officers armed with firearms.

71. The County has acknowledged that it knows that "[p]olice officers are often the first people to make contact with someone in a mental health crisis," so the County "has focused significant resources on preparing officers for these encounters," including "partnering with clinicians," to "prevent people who may be in crisis from hurting themselves or someone else, and to refer them to appropriate services."³

72. HCPD trains its officers on various less-lethal force options, including less lethal weapons such as electroshock devices, chemical sprays, and non-lethal projectiles.

73. HCPD operates a "mobile crisis team" resource, which is a form of alternative response or co-response service in which mental health professionals respond instead of, or alongside, police officers "to help people who may be experiencing emotional, traumatic or psychiatric crises."⁴ According to Howard County, it operates two 24/7 mobile crisis teams, and

³ Howard County, HCPD, *Mental Health*, <https://perma.cc/33U5-NXGU>.

⁴ *Id.*

“[t]hese trained professionals can bring a higher level of clinical care and offer rapid access to resources.”⁵

74. HCPD contracts with two third-party organizations, Grassroots and Humanim, to provide crisis response and other mental health services. Grassroots and Humanim are both involved in HCPD’s mobile crisis team resources. Grassroots also operates a crisis intervention center with a 24/7 “hotline” for responding to crisis calls, including by assisting police with responding to emergency calls with a mental health component. Police and dispatchers can also refer callers in crisis directly to the hotline.

75. The County strives for all HCPD patrol officers and dispatchers to receive a 40-hour Crisis Intervention Team (CIT) training course on appropriate response to mental health crises. CIT training covers issues like deescalation, trauma-informed response, and recognizing and responding to mental health conditions and developmental disabilities.

76. HCPD also maintains a dedicated CIT section, staffed by a police sergeant, two police officers, and a licensed mental health professional. According to Howard County, the CIT section “addresses issues related to police calls for mental health crises, suicides and suicide attempts, and emergency petitions, in which people are taken by police to the hospital if they pose a risk to themselves or someone else.”⁶

77. HCPD’s emergency communications personnel receive training related to emergency response to calls arising from mental health disabilities, and they have processes for flagging calls with a mental health component for appropriate response and resources.

⁵ *Id.*; Howard County, HCPD, *Mental Health Crisis Resources*, <https://perma.cc/N479-V3W5>.

⁶ Howard County, HCPD, *Mental Health*, <https://perma.cc/33U5-NXGU>.

78. HCPD also has specialized critical response units trained to respond to certain high-risk incidents, including standoffs with an armed subject.

79. HCPD officers receive various standard trainings related to crisis response, suicide response, mental health conditions, developmental disorders, deescalation, and more. HCPD also specifically trains its officers on interacting with persons with autism and persons in crisis, and on how and when to use all of the above specialized resources.

80. For example, in a collaboration between Howard County and the Autism Society of Maryland, HCPD officers have received training on safely interacting with people with autism in a crisis. The training covered: recognizing characteristics of autism, understanding how autism creates distinct vulnerabilities during a crisis, and implementing modifications and de-escalation techniques specific to people with autism in crisis.⁷

Howard County's failure to use its specialized resources

81. Consistent with HCPD training and policy, these resources should have been used to reasonably modify the County's response to ensure Alex received effective communication and equal access to emergency services, as required by federal law.

82. Especially after officers Riebau and Sayyad spoke with Alex directly by cell phone, in addition to knowing of his residence at Patuxent Commons, Howard County knew or should have known of Alex's disability-based crisis.

83. However, none of the responding officers or emergency communications personnel took sufficient steps to modify the response appropriately in light of Alex's disabilities.

⁷ Autism Society of Maryland, *Police Training on Autism*, <https://perma.cc/4D7P-SFZ5>.

84. As soon as the County and its officers recognized that Alex was in a mental health crisis and at risk of self-harm, they should have requested a mobile crisis team response and CIT-section response and taken all other available steps to obtain assistance from the County's specialized mental health resources.

85. The officers also should have coordinated to formulate a plan for their response on scene and any engagement with Alex, including on issues such as how to deescalate and communicate in light of his disabilities; how to create sufficient time, space, and distance to deescalate any confrontation; and how to ensure the County's mental health resources were the primary response, rather than use of force.

86. In formulating that plan, the County and its officers should have ensured that less-lethal force options were available, and they should have planned for how the various less-lethal force options available to them should be used to achieve deescalation.

87. But the County and its officers failed to take any of these steps, despite having the requisite knowledge, opportunity, and capacity to do so. No one initiated the mobile crisis response process or otherwise made use of the County's specialized mental health contractors, despite multiple Howard County agents expressly referring to Grassroots and Humanim—with the Grassroots phone number even being read out on the radio—showing they recognized such a response was appropriate and would have been beneficial. Nor did any Howard County agent call for or obtain the assistance of the CIT section or a critical response unit.

88. And the four officers on scene engaged Alex with no plan, without coordinating with each other, and without the less-lethal force options, like tasers, they only realized they needed when it was too late. As a result, the confrontation was frantic and all too brief, and the officers failed to make use of the available potential to deescalate and avoid a lethal standoff.

89. The County had sufficient opportunity to properly implement these resources and modify its response as required by federal disability law. Four officers present with one subject at a distance is an appropriate circumstance to deploy less-lethal force options, as the officers can delegate responsibility and maintain lethal cover even as less-lethal force is attempted. Also, with four officers on scene, and more already en route or close nearby, there was sufficient capacity to coordinate and implement these resources. Although the encounter with Alex was relatively brief, the County had sufficient time to make use of all these resources earlier in the response, at the time it became aware of Alex's disability-based crisis.

90. Indeed, the brevity of the ultimate encounter was itself a result of the failure to modify the response and implement these resources. The responding officers' rush to force, lack of planning, lack of less-lethal options, and other tactical failures (including beckoning Alex forward) all worked together to create the violent confrontation.

91. Properly implementing the County's crisis response resources would more likely than not have changed the outcome and saved Alex's life by avoiding the officers' rush into a lethal standoff. Additional officers were only seconds away, and Alex's mother was on the phone with the County providing more information about Alex's disabilities as the final standoff was taking place. Additional time is critical to deescalation in general, and here it would have resulted in greater resources and information on scene, such that lethal force would have been unnecessary. In particular, less-lethal force options would have improved the responding officers' ability to deescalate and avoid the use of deadly force.

92. The heavy-handed, uncoordinated, force-first response of patrol officers armed with guns but without the proper less-lethal options and mental health supports was fuel on the fire in this scenario. Alex posed no danger to anyone else. When officers first encountered him, he held his hands up. He was not volatile, never made fast or sudden movements, and made no

threats. The four officers lined up in a compromised position and, like a firing squad, held their ground and pointed their guns at a person they knew to be suicidal.

93. Had the County and its personnel instead made use of the County's specialized resources for crisis response and reasonably modified the response provided to Alex in light of his disabilities, the standoff would more likely than not have been avoided altogether or resolved without the use of deadly force.

Howard County's policy violations and deficiencies

94. Given the frequency of police encounters with people experiencing mental health crises, HCPD had enacted policies specific to such responses, including General Order OPS-07, "Persons Experiencing Mental Health Crisis," effective April 26, 2023.

95. That policy acknowledged HCPD's awareness that people with disabilities, including those in mental health crisis, have the right "to receive appropriate and safe police response." It required that all incoming HCPD officers receive training on identifying and responding to mental health disabilities and crises, and that all HCPD officers receive annual training on "how to handle persons with a mental illness or experiencing a mental health crises."

96. OPS-07 also required that all HCPD officers "be alert to signs of persons experiencing a mental health crisis," which include: "confusion," "delusions," "depression, deep feelings of sadness, hopelessness, or uselessness," "incoherence," or "non-responsiveness." The policy also lists "environmental characteristics" including "clothing inappropriate for season."

97. OPS-07 expressly instructs that HCPD officers be alert to these indications because "the ADA requires law enforcement agencies to make reasonable adjustments to routine procedures, on a case-by-case basis, to provide equitable service to all."

98. Upon recognizing a mental health crisis, HCPD officers and communications personnel are required to attempt to obtain information about the person, their disabilities, and

their crisis. Then, the policy gives guidelines for engaging the subject in crisis, including: “use non-threatening body language”; “call the person’s caregiver”; and “prepare for a lengthy interactions” because “the person may need more time to process information or describe events” and “the person should not be rushed unless there is an emergency.” The policy cautions, “Do not automatically interpret odd behavior as belligerence.”

99. If officers determine the person in crisis is a risk of harm to self or others, the officers “shall make immediate notification to the appropriate agency such as the Mobile Crisis Team (MCT), the Department of Social Services, or another agency depending upon the circumstances.”

100. The policy also governed the Mobile Crisis Team. It expressly provided that “HCPD members are encouraged to request the MCT for cases of psychiatric or behavioral emergencies and situations that may result in an emergency petition,” including “suicide threats or attempts.”

101. The policy expressly anticipates Mobile Crisis Team being called even during chaotic or unsecure police responses. For example, it states that MCT should also be called for “barricade or hostage events with evidence of mental illness.” And it provides procedures for circumstances in which MCT is responding but the scene is not entirely secured: “Members of the MCT will respond to the general area of a call for service when requested by the HCPD but will not enter the scene until directed by the officer(s) on the scene”; “Officers will remain at the scene until it is mutually agreed that it is secure and there is no threat to the safety of the MCT or citizens involved in the incident.”

102. Therefore, under Howard County policy, HCPD officers were expressly instructed to report suicidal crisis calls to the Mobile Crisis Team for assistance, and the Mobile Crisis Team was expressly authorized to respond in some form, even if the scene was unsecured.

The policy only discouraged Mobile Crisis Team responses for “intoxication,” “domestic violence unrelated to psychiatric emergency,” and “emergencies involving significant criminal offense or violence,” none of which applied here.

103. OPS-07 specified that the Mobile Crisis Team was accessible not only by phone, but also via the police dispatch radio.

104. The policy stated that Grassroots would “provide training as needed to the HCPD . . . as requested by the HCPD regarding the role of the MCT and the management of psychiatric emergencies.”

105. In its response to Alex LaMorie’s mental health crisis, Howard County failed to comply with OPS-07, violating its own policy. The County’s responding officers expressly intended to carry out an Emergency Petition, but they did not notify and request assistance from the Mobile Crisis Team or another appropriate agency as required. Despite the appropriateness of a Mobile Crisis Team response to this incident, and despite the responding officers and communications personnel expressly discussing Grassroots and Humanim during the response, the County failed to obtain the assistance of the mobile crisis team and the County’s mental health professionals and/or failed to ensure these resources were reasonably available.

106. More generally, deficiencies in Howard County’s policies, practices, and procedures, and in its training practices, contributed to its failure to modify its response as required. Howard County’s policies and training regarding police responses to people in crisis are inadequate, giving officers few tools for managing such situations.

107. First and foremost, prior to this incident, Howard County policy allowed HCPD officers discretion to choose whether to carry a taser or not. And Howard County maintained a severely deficient inventory of tasers, with fewer than half the number of tasers needed to fully equip all its public-facing officers.

108. In 2023, recognizing the utility and importance of equipping officers with less-lethal tools, Howard County mandated that all *incoming* officers be trained and equipped with tasers. However, this policy change did not address existing public-facing officers who were untrained or unequipped.

109. Further, even after making this change on paper, Howard County failed to successfully implement it in practice. Soon after Alex’s killing, HCPD Lieutenant James Laffin—who was the Commander responsible for HCPD’s Police Education and Training Division—reported to state authorities that, leading up to this incident, only three out of the five most recent annual graduating classes of incoming HCPD police officers received taser training, specifically because of deficient inventory. Without enough tasers to equip the other two classes, HCPD apparently decided not to train and certify them.

110. Similarly, in practice, contrary to its written policy and public claims, Howard County had a pattern and practice of limiting the circumstances in which its mobile crisis teams could deploy, allowing them to respond only to secure scenes and only during certain operational hours. Those limitations unreasonably excluded calls on which a mobile crisis team response could still be highly valuable. For example, Anne Arundel County maintains a mobile crisis team resource that is explicitly authorized to always deploy when requested, including to high-risk scenes. While certain precautions are taken for civilian personnel in high-risk scenarios, the mobile crisis team still deploys to provide its often life-saving assistance to other responding officers in a safe manner.

111. Although Howard County publicly represents that its mobile crisis team services were available 24/7, in practice its teams had far more limited operating hours, including a lack of availability overnight.

112. Howard County did not properly authorize or train its emergency response personnel on requesting the assistance of its mobile crisis teams.

113. Howard County did not have a comprehensive policy governing how its emergency communications personnel handle all calls related to mental health crises, including with authorization for such personnel to independently implement the County's specialized mental health resources where appropriate. Howard County's existing policy for communications personnel was limited to a subset of calls in which no police response is necessary and callers are referred out for response by mental health resources exclusively.

114. The County's call-takers and dispatchers also did not receive sufficient training and/or authorizations in responding to mental health-related calls and implementing the County's resources available to respond to mental health crises, including training on mental health disabilities, CIT, deescalation, disability law requirements, and how to appropriately deploy specialized resources.

115. The County's policies governing HCPD use-of-force, mental health, CIT, and crisis response did not sufficiently incorporate authorizations and guidance on when and how to implement the County's specialized resources.

116. CIT training was not mandatory for all public-facing HCPD police officers. And, only a single one-time training course was required for indefinite CIT-certification. Absent refresher trainings, some HCPD CIT-certified officers may not have received any CIT training in years.

117. HCPD's policies and procedures did not properly implement CIT practices beyond the training certification itself—such as by authorizing emergency communications personnel to identify and dispatch CIT-certified officers to calls with a mental health component;

mandating that a CIT-certified officer serve as lead on such call responses; or sufficiently using the dedicated CIT section to respond to crisis calls or provide technical assistance.

118. Beyond CIT training, the County insufficiently trained its police force on its mental health resources, and on proper crisis response for people with mental health disabilities, including the appropriate use of less-lethal options like tasers. Howard County did not properly train its emergency response personnel on how and when to request the assistance of the CIT section and critical response units in the context of mental health crisis responses.

Howard County's failures contradict federal guidance on the disability statutes

119. Deficiencies and violations of Howard County's policies were especially egregious given the well-known need for modified police responses to mental health emergencies by the time of this incident.

120. Mental health disabilities affect millions of Americans and their families each year, with nearly a quarter of all adults in the U.S. experiencing some form of mental illness, and more than 1 in 20 adults experiencing a serious condition.⁸ Suicide is the second leading cause of death among young people, and suicidality and other serious mental health conditions are a leading cause of hospitalizations across demographics.⁹

121. Police are often the first responders to mental health-related emergencies, with as many as ten percent of all police calls involving a person with a serious mental health

⁸ Nat'l Alliance on Mental Illness, *Mental Health by the Numbers*, <https://perma.cc/5EWM-LSQW>.

⁹ *Id.*

disability.¹⁰ “This has led some to characterize law enforcement officers as the so-called secret social service for their role in triaging individuals with mental health needs.”¹¹

122. Yet, police response to people in crisis is disproportionately forceful, using violence to respond to manifestations of disability. Researchers estimate that roughly 17% of all use-of-force incidents and 20% to 25% of all police killings involve a person with a serious mental health disability, and that population is more than 11 times more likely to face police use-of-force than people without disabilities.¹² “One study found that the death rate for people who had signs of a mental illness during police interactions (20 deaths per million) is nearly seven times higher than it is for people without signs of a mental illness (3 deaths per million).”¹³

123. Given the prevalence of mental health responses in modern policework, policy and training experts in policing and in disability have increasingly studied and issued guidance on appropriate emergency response services for people in mental health crisis. Research supports that the disproportionate use-of-force against and killing of people with disabilities is avoidable, and appropriate modifications based on disability can allow police to safely and effectively do their jobs. Evidence-based interventions to improve policing outcomes in responses to people in mental health crisis include co-response and alternative response teams.¹⁴

124. Traditional policing approaches—relying on forceful authority, verbal commands, and threatened or applied physical force—tend to escalate interactions with people with mental

¹⁰ DOJ & HHS, Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities, 2 (2023), <https://perma.cc/9PEE-GHFX> (“DOJ & HHS Guidance”).

¹¹ Cong. Rsch. Serv., R47285, Issues in Law Enforcement Reform: Responding to Mental Health Crises 1 (2022), <https://perma.cc/2G9G-QPZJ> (“CRS Report”).

¹² DOJ & HHS Guidance, *supra*, at 2.

¹³ CRS Report, *supra*, at 1.

¹⁴ *Id.* at 3–10.

health disabilities. For example, pointing guns and yelling commands at people at risk of suicide tends to escalate the risk of violence. In recent years, expert consensus and police training programs instead provide that officers should refrain from pointing guns at suicidal individuals, and, while only one officer communicates with the subject, other officers on-scene should focus on coordinating the response and assigning roles, maintaining a perimeter, and requesting additional or specialized resources.

125. Arising from this increasing consensus among subject-matter experts, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS)—the federal agencies charged with enforcing the federal disability statutes—have issued resources, guidances, and investigative findings related to policing and people with mental health disabilities.

126. In March 2023, DOJ and HHS issued joint federal guidance to states and localities on compliance with federal disability law in providing emergency response services to people with disabilities.

127. The guidance specified that, under the Americans with Disabilities Act, “[e]qual opportunity requires that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response.”¹⁵ “[F]or example, if call centers would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or a diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability.”¹⁶

¹⁵ DOJ & HHS Guidance, *supra*, at 2–5.

¹⁶ *Id.*

128. Therefore, public entities must make reasonable modifications to ensure equal opportunity, such as dispatching alternative responses or co-responses of mental health professionals. “Jurisdictions should not assume that the proper response to a crisis is always to send law enforcement, but instead should assess reasonable modifications to their usual practices where appropriate,” and even in circumstances “[w]here a police response is called for,” reasonable modifications could include “dispatching a co-responder team.”¹⁷ Likewise, the effective communication requirement under the ADA may require modifications to ensure “effective communication for people with neurodevelopmental communication disorders, including . . . people with autism spectrum disorder.”¹⁸

129. The Substance Abuse and Mental Health Services Administration (SAMHSA), a subdivision of HHS, issued similar federal guidances on emergency responses by public entities to disability-based crises in 2020 and 2025, emphasizing the frequency of disability-based encounters, proper suicide prevention techniques, and proper coordination among police, communications personnel, and 24/7 mobile crisis responses.¹⁹

130. In 2023 and 2024, DOJ issued findings arising from investigations of misconduct in the Louisville Metro, Minneapolis, and Phoenix police departments, formally finding in each case that failures to modify emergency responses to disability-based crises violated federal disability law. Specifically, DOJ found that each jurisdiction violated the Americans with Disabilities Act by failing to make reasonable modifications when responding to mental health crises, including by resorting to police responses and use-of-force where unnecessary to do so,

¹⁷ *Id.* at 3–4.

¹⁸ *Id.*

¹⁹ HHS, SAMHSA, National Guidelines for Behavioral Health Crisis Care (2020), <https://perma.cc/65GY-TL23>; HHS, SAMHSA, 2025 National Guidelines for a Behavioral Health Coordinate System of Crisis Care (2025), <https://perma.cc/3HGJ-DTKP>.

failing to provide adequate mobile crisis response, failing to properly apply deescalation training, failing to properly coordinate responses in the emergency communications center, and more.²⁰

131. For example, in its Phoenix investigative findings, DOJ found ADA violations where emergency communications personnel “default to sending regular patrol officers, even though they have options” for specialized resources, and the responding officers then “often use force that could be avoided” and “rarely use” the specialized mental health resources available to them.²¹ DOJ also found that police used excessive force, including shootings, even when “officers knew or should have known the person had a disability” and “could have safely made reasonable modifications, such as calling in the assistance of a mobile crisis team.”²² DOJ instructed: “The duty to avoid ‘confrontational tactics’ and accommodate a person in crisis is not diminished when that person fails to immediately follow commands, reacts poorly to an officer’s arrival, or behaves unexpectedly.”²³

132. DOJ is charged with construing, enforcing, and providing technical assistance for the Americans with Disabilities Act, including Title II, which was binding on Howard County as a local public entity. HHS is charged with construing and enforcing Section 504 of the Rehabilitation Act, which was binding on Howard County as a local public entity receiving federal funds. The guidances, publications, and enforcement actions of DOJ and HHS as to these

²⁰ DOJ, Investigation of the Louisville Metro Police Department and Louisville Metro Government, at 49–69 (2023), <https://perma.cc/822F-KEXB>; DOJ, Investigation of the City of Minneapolis and the Minneapolis Police Department, at 57–67 (2023), <https://perma.cc/D2MF-FUNC>; DOJ, Investigation of the City of Phoenix and the Phoenix Police Department, at 86–101 (2024), <https://perma.cc/LYD8-FMMF>.

²¹ DOJ, Investigation of the City of Phoenix and the Phoenix Police Department, at 88 (2024), <https://perma.cc/LYD8-FMMF>.

²² *Id.* at 95.

²³ *Id.*

statutes carry significant interpretive weight, are entitled to deference, and inform compliance by regulated entities and enforcement decisions by courts.

133. Based on these federal guidances and formal findings, Howard County knew or should have known of the deficiency of its practices and of its obligation to modify its response during the Alexander LaMorie incident.

CONCLUSION

134. Alexander LaMorie should be alive today. His decision to call 911 while in crisis should have been a life-saver, not a death sentence.

135. Howard County had the opportunity and resources to send a modified emergency response with less-lethal force options to Alex based on his disabilities, which would have likely resulted in a different outcome.

136. Instead, it sent armed police officers who pointed their guns at a suicidal subject, held their ground, and, like a firing squad, created the circumstance where they believed the use of lethal force was necessary.

137. In so doing, Howard County failed to modify its police response as required by federal disability law. As a result, Alex lost his life while still a young man with tremendous potential, and his mother Jill lost her cherished son. Plaintiffs suffered immeasurable damages in anguish, pain, suffering, medical expenses, expectation-interest damages, lost-opportunity damages, consequential damages, dignitary damages, incidental damages, nominal damages, and all other damages stemming from the following claimed violations of law.

138. This suit alleges the following claims to hold Defendants accountable for the violations that caused Alex's death and to obtain the relief the law makes available for Alex's family, though it could never be sufficient to truly account for this loss.

CAUSES OF ACTION

COUNT I

Title II of the Americans with Disabilities Act – Survival Action (Estate of Alexander LaMorie against Howard County)

139. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if restated fully herein.

140. Alexander LaMorie was a qualified individual with a disability protected by the Americans with Disabilities Act (“ADA”), *see* 42 U.S.C. §§ 12102, 12131(2). Alex had autism spectrum disorder and was experiencing a suicidal crisis, which are disabilities within the meaning of the ADA.

141. Howard County is a local government and, therefore, a public entity subject to Title II of the ADA.

142. Howard County operates HCPD and an emergency communications center. Under the ADA, public entities are responsible for the discriminatory actions of their employees.

143. Title II of the ADA guarantees qualified individuals with disabilities an equal opportunity to access the services, programs, or activities of a public entity. 42 U.S.C. § 12132.

144. Emergency response services are a program, service, and/or activity within the meaning of Title II. Police work involving the public, including stops, seizures, investigations, and arrests, are programs, services, and/or activities within the meaning of Title II.

145. Under Title II, a public entity may not, on the basis of disability, “[d]eny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service.” 28 C.F.R. § 35.130(b)(1)(i). Discrimination under Title II of the ADA includes the failure to make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability. 28 C.F.R. § 35.130(b)(7)(i).

146. A public entity also may not, “[a]fford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others” or “[p]rovide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others.” 28 C.F.R. § 35.130(b)(1)(ii)–(iii).

147. Under Title II, a public entity also must “take appropriate steps to ensure that communications with . . . members of the public. . . with disabilities are as effective as communications with others.” 28 C.F.R. § 35.160(a)(1).

148. Howard County emergency responders, including police and communications personnel, are obligated to modify their policies, practices, and procedures when necessary to avoid discrimination on the basis of disability in violation of the ADA, and to ensure effective communication with people with disabilities.

149. Defendant Howard County failed to reasonably modify its approach to the provision of emergency response services to Alex, and any investigation or seizure of Alex, when it knew or should have known that modifications were necessary based on his disabilities.

150. Reasonable modifications under the circumstances would have included dispatching officers equipped with less-lethal force options; appropriately applying de-escalation techniques and refraining from escalatory tactics; effective communication techniques for a person with autism or in a mental health crisis; dispatching someone trained in handling a person in a mental health crisis, such as the Mobile Crisis Team, or at least obtaining technical assistance from the same; dispatching an appropriate combination of the County’s other specialized mental health crisis response resources, including the CIT section, a critical response

unit, etc. Defendant Howard County's failure to provide Alex with reasonable modifications violated Title II of the ADA.

151. Because Howard County knew or should have known that Alex was in a mental health crisis and was contemplating self-harm, failing to provide less-lethal force options and personnel trained in handling a person in a mental health crisis, despite having such resources available to it, violated Title II of the ADA.

152. HCPD officers shot and killed Alexander LaMorie as a direct, consequential, and proximate result of Howard County's failure to modify its emergency response and to ensure effective communication in light of Alex's disabilities. In doing so, Howard County denied Alex equal access to the County's emergency services based on his disabilities.

153. To ensure compliance with the ADA, public entities, including police departments and emergency communications centers, also must provide training adequate to ensure that individuals with disabilities are provided services in a manner that complies with the ADA.

154. Defendant Howard County failed to provide adequate training to its police and emergency communications personnel concerning how to identify, dispatch, and provide appropriate services to individuals suffering from mental health disabilities and experiencing mental health or emotional crises. Defendant Howard County failed to train its police and emergency communications personnel to appropriately identify and respond to calls regarding mental health crises and dispatch and provide less-lethal force options and mobile crisis teams, even though its personnel are all likely to encounter situations where such resources and skills are essential.

155. Howard County fails to provide adequate training to its police and other emergency response personnel on proper emergency response to people with mental health

disabilities and on the availability and use of Howard County's specialized resources for the same.

156. Defendant Howard County's violations of Title II of the ADA were taken with deliberate indifference to the likelihood that pursuit of its actions and inactions would result in a violation of federally protected rights.

157. Defendant Howard County's violations of Title II of the ADA proximately caused the death of Alexander LaMorie.

158. Defendant Howard County's violations of the ADA caused Alexander LaMorie to sustain severe, conscious pain and suffering between the time of injury and death, among other damages.

COUNT II
Section 504 of the Rehabilitation Act – Survival Action
(Estate of Alexander LaMorie against Howard County)

159. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if restated fully herein.

160. Alex was a qualified individual with a disability protected by Section 504 of the Rehabilitation Act. *See* 29 U.S.C. § 794(a); 45 C.F.R. § 84.3(j). Alex had autism spectrum disorder and was experiencing a suicidal crisis, which are disabilities within the meaning of the ADA.

161. The Rehabilitation Act mandates that “[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” 29 U.S.C. § 794(a).

162. Defendant Howard County, including its police department and emergency communications center, receives federal financial assistance as that term is used in Section 504,

and is therefore covered by the Rehabilitation Act. Howard County is responsible under Section 504 for the discriminatory acts of its employees.

163. Emergency response services and communications are a program, service and/or activity within the meaning of Section 504. Police work involving the public, including stops, seizures, investigations, and arrests, are programs, services, and/or activities within the meaning of Section 504.

164. Discrimination under Section 504 includes failing to “[a]fford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others,” or providing qualified handicapped persons with “an aid, benefit, or service that is not as effective as that provided to others.” 45 C.F.R. § 84.4(b)(1)(ii)–(iii); *see* 45 C.F.R. § 84.52(a)(2)–(3).

165. Defendant Howard County is obligated to modify its policies, practices, and procedures when necessary to avoid discrimination on the basis of disability in violation of Section 504.

166. Defendant Howard County failed to reasonably modify its approach to the dispatch of emergency services to Alex, and any investigation or seizure of Alex, when it knew or should have known that modifications were necessary based on his disabilities.

167. Reasonable modifications under the circumstances would have included dispatching officers equipped with less-lethal force options; appropriately applying de-escalation techniques and refraining from escalatory tactics; effective communication techniques for a person with autism; dispatching someone trained in handling a person in a mental health crisis, such as the Mobile Crisis Team, or at least obtaining technical assistance from the same; dispatching an appropriate combination of the County’s other specialized mental health crisis response resources, including the CIT section, a crisis negotiator, a critical response unit, etc.

Defendant Howard County's failure to provide Alex with reasonable modifications violated Section 504.

168. Because Howard County had sufficient reason to believe that Alex was in a mental health crisis and was contemplating self-harm, failing to provide less-lethal force options and personnel trained in handling a person in a mental health crisis, despite having such resources available to it, violated Section 504.

169. HCPD officers shot and killed Alexander LaMorie as a direct, consequential, and proximate result of Howard County's failure to modify its emergency response and to ensure effective communication in light of Alex's disabilities. In doing so, Howard County denied Alex equal access to the County's emergency services based on his disabilities.

170. To ensure compliance with Section 504, public entities, including police departments and emergency communications centers, must provide training adequate to ensure that individuals with disabilities are provided services in a manner that complies with Section 504. Defendant Howard County failed to provide adequate training to its police and emergency communications personnel concerning how to identify, dispatch, and provide appropriate services to individuals suffering from mental health disabilities and experiencing mental health or emotional crises. Defendant Howard County failed to train its police and emergency communications personnel to appropriately identify and respond to calls regarding mental health crises and dispatch and provide less-lethal force options and mobile crisis teams, even though its personnel are all likely to encounter situations where such skills are essential.

171. Howard County fails to provide adequate training to its police and other emergency response personnel on proper emergency response to people with mental health disabilities and on the availability and use of Howard County's specialized resources for the same.

172. Defendant Howard County's violations of Section 504 were taken with deliberate indifference to the likelihood that pursuit of its actions and inactions would likely result in a violation of federally protected rights.

173. Defendant Howard County's violation of Section 504 proximately caused Alexander LaMorie's death.

174. Defendant Howard County's violations of Section 504 caused Alexander LaMorie to sustain severe, conscious pain and suffering between the time of injury and death, among other damages.

COUNT III
Negligence – Survival Action
(Estate of Alexander LaMorie against all Defendants)

175. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if restated fully herein.

176. The Officer Defendants failed to exercise reasonable care in responding to Alexander LaMorie's 911 call, including in their use of lethal force and failure to bring or use less-lethal force options.

177. Rather than acting as a reasonable officer in their circumstances would have and using less-lethal force and calling for use of Howard County's specialized mental health resources, the Officer Defendants breached their duties as police officers and escalated the encounter with Alex by resorting to deadly force.

178. The Defendants knew, had reason to know, or should have known of the risks of escalating an encounter with someone with disabilities, in mental distress, contemplating self-harm.

179. The Defendants' negligence proximately caused Alex's death, and his death was a foreseeable result of such negligence.

180. As a direct, consequential, and proximate result of the conduct of the Defendants, Alex endured severe conscious pain and suffering between the time of injury and death.

COUNT IV
Gross Negligence – Survival Action
(Estate of Alexander LaMorie against all Defendants)

181. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if restated fully herein.

182. The Officer Defendants failed to exercise reasonable care in responding to Alexander LaMorie's 911 call, including in their use of lethal force and failure to bring or use less-lethal force options.

183. Rather than acting as a reasonable officer in their circumstances would have and using less-lethal force and calling for use of Howard County's specialized mental health resources, the Officer Defendants breached their duties as police officers and escalated the encounter with Alex by resorting to deadly force.

184. The Defendants knew, had reason to know, or should have known of the risks of escalating an encounter with someone with disabilities, in mental distress, contemplating self-harm.

185. The Defendants' gross negligence proximately caused Alex's death, and his death was a foreseeable result of such gross negligence.

186. As a direct, consequential, and proximate result of the conduct of the Defendants, Alex endured severe conscious pain and suffering between the time of injury and death.

COUNT V
Wrongful Death
(Jill Harrington against All Defendants)

187. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if restated fully herein.

188. Jill Harrington is the mother of Alexander LaMorie. At the time of his death, decedent was an unmarried resident of Howard County with no children. Jill Harrington is the primary beneficiary in this action pursuant to Md. Code Ann., Cts. & Jud. Proc. § 3-904. No other individuals are entitled by law to recover damages for Alex's death.

189. By the wrongful acts set out above, Defendants caused Alex's death.

190. As a direct, consequential, and proximate result of Defendants' wrongful acts in causing the death of Alex, Jill Harrington has sustained anguish, pain, and suffering, medical expenses, loss of society, loss of companionship, loss of comfort, and loss of opportunity, among other damages.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that the Court:

- a. Enter judgment in Plaintiffs' favor and against Defendants;
- b. Award damages to Plaintiffs jointly and severally against all Defendants to the full extent allowed by law, including damages for physical pain and suffering, physical injury and/or illness, medical expenses, expectation-interest damages, lost-opportunity damages, consequential damages, dignitary damages, incidental damages, nominal damages, and all other damages stemming from the claimed violations of law;
- c. Award punitive damages to Plaintiffs against the Officer Defendants;
- d. Award the Estate of Alexander LaMorie attorneys' fees and costs pursuant to 42U.S.C. §§ 1988 and 12205; and
- e. Issue any and all other further relief as this Court may deem just and proper.

DEMAND FOR JURY TRIAL

Plaintiffs hereby request a trial by jury.

Dated: October 29, 2026

Respectfully submitted,

/s/ Andrew D. Levy

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