Abbas v Cole
2005 NY Slip Op 30101(U)
October 21, 2005
Supreme Court, Kings County
Docket Number: 0017210/2001
Judge: David Schmidt
Republished from New York State Unified Court System's E-Courts Service. Search E-Courts (http://www.nycourts.gov/ecourts) for any additional information on this case.
This opinion is uncorrected and not selected for official publication.

[* 1]

At an IAS Term, Part 47, of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 21st day of October, 2005

P R E S E N T:

HON. DAVID I. SCHMIDT,

Justice.

- -X

MALIK G. ABBAS,

Plaintiff,

- against -

Index No. 17210/01

ROY FRANCIS COLE,

Defendant.

- -X

The following papers numbered 1 to 5 read on this motion:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1, 2
Opposing Affidavits (Affirmations)	
Reply Affidavits (Affirmations)	
______ Affidavit (Affirmation)	
Other Papers 6/20/01, 11/08/04 & 01/05/05 Transcripts & Evidence	3, 4, 5

Plaintiff Malik G. Abbas seeks damages, after inquest, from defendant Roy Francis Cole in connection with a November 18, 1999 motor vehicle accident. Defendant alleges

that plaintiff failed to sustain a "serious injury" as that term is defined in Insurance Law § 5102 (d).[1]

Procedural History

On August 12, 2003, following defendant's default and a June 20, 2001 inquest on damages, judgment was entered in plaintiff's favor and against defendant in the sum of $200,000 ($100,000 for lost earnings and $100,000 for past, present and future pain and suffering), together with costs and disbursements. Defendant appealed the judgment after inquest to the Appellate Division, Second Department.

In a decision dated May 17, 2004, the Appellate Division unanimously reversed the order of the lower court, finding that the admission into evidence, over defendant's objection, of plaintiff's uncertified hospital records and unsworn medical reports had denied defendant an opportunity to cross-examine plaintiff's witnesses and to present defendant's own testimony and evidence, and that such errors were not harmless (*Abbas v Cole*, 7 AD3d 649). The matter was remanded to this court for a new inquest "at which plaintiff would be required to establish, through admissible evidence, his damages, if any" (*id., citing* Insurance Law § 5102 *and Tamburello v Bensonhurst Car & Limo Service, Inc.*, 305 AD2d 664 [2003]).

A new inquest on damages was conducted before this court on November 8, 2004. Plaintiff testified at both inquests and, at the November 8, 2004 inquest, presented additional

[1] Indeed, the court notes that serious injury is a necessary element to plaintiff's *prima facie* case that had to be, but was not, pleaded in his complaint (*see* CPLR 3016 [g]).

evidence consisting of his certified hospital records and sworn or affirmed medical and diagnostic reports.

Following plaintiff's argument that such evidence was admissible at inquest pursuant to 22 NYCRR 202.46 (b), and defendant's objection on the grounds, *inter alia*, that (1) the medical and diagnostic reports were never exchanged during discovery, and (2) defendant was once again being denied an opportunity to cross-examine the reports' makers, the court conditionally admitted the medical and diagnostic reports into evidence, reserving its final decision on their admissibility.

The court also reserved decision with respect to defendant's motion, made after completion of plaintiff's case, for a directed ruling in defendant's favor on the ground that plaintiff had failed to meet his burden of presenting a *prima facie* case of serious injury as that term is defined under Insurance Law § 5102(d). At the completion of the presentment of all evidence, the court again reserved a final decision on the inquest.

The court has now carefully considered the admissible evidence presented at inquest and the parties' oral arguments and written submissions, including those arguments made to the court during a subsequent, January 5, 2005, hearing.[2] The following constitutes the court's findings of fact and conclusions of law.

---

[2] The court, during the January 2005 hearing, heard argument on the issues reserved at the November 2004 inquest for determination, and struck plaintiff's claim for lost earnings.

Analysis

A defendant's default establishes only that he or she was at fault for the accident, not that the plaintiff suffered a serious injury (*Pampafikos v Wander*, 4 AD3d 152, 153 [2004], *citing Reid v Brown*, 308 AD2d 331, 332 [2003] ["before a plaintiff may proceed to damages under Insurance Law § 5102 (d), both fault and serious injury must be established"]; *see also Ortiz v Biswas*, 4 AD3d 151, 152 [2004]; *accord Zecca v Riccardelli*, 293 AD2d 31, 34-35 [2002]).

Thus, "[p]rior to recovering damages, a plaintiff, even at Inquest, must first establish that a 'serious injury' was sustained" (*Zafir v Turbo Trans Corp.*, 190 Misc 2d 292 , 293 [2001], *citing Star v Badillo*, 225 AD2d 610 [1996]; *see also Shaferenko v Fu Cheng*, 5 AD3d 585 [2004]). Further, a defendant, despite his or her default, will at inquest generally be permitted to contest the serious injury issue and to offer proof thereon (*see Toure v Harrison*, 6 AD3d 270, 272 [2004]).

Plaintiff testified at inquest that he was seatbelted at the time of the collision, but lost consciousness following the accident and had to be "dragged" from his vehicle by ambulance or other rescue personnel. That latter testimony was contradicted by the certified hospital records and ambulance call report, which indicate no loss of consciousness and that plaintiff was ambulatory at the scene.

Plaintiff was transported by ambulance to Kings County Hospital Center (KCHC), where he complained of pain to his head, neck, back, both shoulders and right knee. He was

examined, diagnosed with a cervical strain and shoulder contusion, and released with instructions to rest, ice sore spots, take ibuprofen for any pain, and restrain from lifting or exercising for a period of two weeks.[3]

At the time of the accident, plaintiff was employed as a livery cab driver and/or service station attendant. According to plaintiff's testimony, he was confined to his home or bed for a period of approximately one week following the accident and, thereafter, underwent a course of physical therapy. Plaintiff did not attempt to return to work until approximately 1 ½ years following the accident, and testified that such attempt or attempts, when they finally occurred, were unsuccessful due to his continuing pain. At the November 2004 inquest, four years after the accident, plaintiff testified that he still had not returned, and was unable to return, to work.

Plaintiff further testified that he (1) continued to experience pain in his neck, back and right knee, which pain had lessened at the time of the inquests and was further eased by medication, and (2) still had difficulty going up and down stairs and was unable to drive or lift heavy objects. There was, however, no evidence that plaintiff had undergone any surgical procedures as a result of the accident, and plaintiff testified that no medical practitioner had ever suggested he have surgery for his alleged knee injury.

---

[3] Plaintiff also claimed, during inquest, to have undergone x-rays during the emergency room visit. However, in response to a subpoena requesting any such records, KCHC reported that it is in possession of "no evidence of [plaintiff] ever having X-Rays in Kings County Hospital."

[* 6]

Defendant's protests notwithstanding, Part 202 of the Uniform Civil Rules for the Supreme Court and the County Court, dispenses with the need for live testimony at an inquest on damages and allows the requisite proof to be made by way of written statement, signed and sworn to by the witness (*see* 22 NYCRR 202.46[b];[4] Siegel, NY Prac §§ 293 and 295 [4th ed.]; *Otto v Otto*, 150 AD2d 57, 68 [1989]; *Glasser v American Homes of Clifton Park Division of American Homes, Inc.*, 144 AD2d 890, 891 [1988]).

Moreover, defendant was not entitled to disclosure of such statement evidence prior to inquest, since "[a]lthough 'it is well settled that a defaulting defendant is entitled to present testimony and evidence and cross-examine the plaintiff's witnesses at the inquest on damages,' a defendant forfeits the right to discovery by defaulting in answering the complaint" (*Minicozzi v Gerbino*, 301 AD2d 580, 581 [2003], *quoting Santiago v Siega*, 255 AD2d 307 [1998], *and citing Reynolds Securities, Inc. v Underwriters Bank and Trust Co.*, 44 NY2d 568, 573 [1978] and *Yeboah v Gaines Service Leasing*, 250 AD2d 453, 454 [1998]; *see also Toure*, 6 AD3d at 272).

Plaintiff testified at the June 2001 inquest, but otherwise presented only uncertified or unsworn medical evidence. At the November 2004 inquest, in addition to his own sworn testimony, plaintiff presented evidence which he claimed were newly-affirmed diagnostic and treating physician reports.

---

[4] 22 NYCRR 202.46(b) provides: "In any action where it is necessary to take an inquest before the court, the party seeking damages may submit the proof required by oral testimony of witnesses in open court or by written statements of the witnesses, in narrative or question-and-answer form, signed and sworn to."

Dr. Andrew Robert Miller is an orthopedist who allegedly examined plaintiff following the November 1999 accident in question. Plaintiff attempted, during the November 2004 inquest, to introduce into evidence two reports (dated November 24, 1999 and September 20, 2000) of examinations purportedly conducted by Dr. Miller of plaintiff. However, although written on Dr. Miller's or his medical practice's letterhead, these reports were signed by another physician, Dr. Gary Pros, and were not sworn to by Dr. Pros. A physician cannot swear or affirm to the accuracy of another physician's report. Thus, Dr. Miller's July 27, 2004 affirmation, "affirming under penalty of perjury" the accuracy of Dr. Pros' November 24, 1999 and September 20, 2000 reports, could not establish the reports' admissibility.

Because the subject medical reports are neither sworn to nor affirmed under penalty of perjury by their author, Dr. Pros, they are inadmissible and may not be considered by this inquest court on the issues of serious injury and damages (*see Abbas*, 7 AD3d at 649-650).

Plaintiff also offered into evidence at inquest, the medical reports of neurologist, Dr. Fawzy W. Salama, dated January 6 and 12, 2000. Said reports, though unsworn at the time of the June 2001 inquest, were affirmed under penalty of perjury by Dr. Salama on August 3, 2004 (*i.e.*, prior to the November 2004 inquest at which they were subsequently offered). The court, accordingly, accepts into evidence Dr. Salama's reports of his examinations of plaintiff, to the extent such reports are probative of the issues under consideration.

Dr. Salama's January 6, 2000 neurological examination of plaintiff revealed that plaintiff was "a healthy looking 39 year old male in no apparent distress." Tests on or examinations of plaintiff's mental status, cranial nerves and sensory abilities were all unremarkable or "within normal limits," as was his gait and station. Plaintiff's deep tendon reflexes were symmetrical and equal throughout, "except for decreased right biceps and right knee jerk compared to the contralateral side," and there was weakness of the bilatoral shoulder abductors, bilateral hip flexors, right wrist extensors and right ankle dorsiflexors.

Dr. Salama's examination also revealed local tenderness in the lumbosacral and cervical areas associated with spasms and, while there is no indication that Dr. Salama ever reviewed the actual MRI films, his report notes that diagnostic testing performed on plaintiff's right knee and cervical spine revealed, with respect to the right knee, joint diffusion and a tear of the posterior horn of the medial meniscus, and, with respect to the cervical spine, a disc herniation with impingement at C5-C6.

Based upon his examination, review of the reports of diagnostic testing and plaintiff's subjective complaints of pain, Dr. Salama concluded, in his January 6, 2000 report, that plaintiff had suffered post traumatic cervical and lumbosacral sprains/strains, and right knee joint derangement as a result of the November 1999 accident. His January 6, 2000 report, however, noted only "moderate restrictions of cervical and lumbar spine mobility." Dr. Salama similarly reported in his January 12, 2000 report that, although electromyogram

(EMG) and other studies suggested "bilateral cervical radiculopathy," "[a]ll tested motor and sensory nerves in the upper extremities were within normal limits."

Plaintiff also offered into evidence at the November 2004 inquest, sworn or affirmed radiology reports of (1) X-rays of plaintiff's lumbar, cervical and thoracic spines, chest and right knee, as interpreted by Dr. Steven Prufer on December 7, 1999, and (2) MRIs of plaintiff's cervical and lumbosacral spines, right knee and right shoulder, as interpreted by Dr. Robert Solomon on December 7, 1999. Neither the actual X-rays nor MRI films were offered into evidence.

Defendant, at inquest, in subsequent papers and during the January 2005 hearing, objected to the introduction of this material into evidence on the ground that such affidavit evidence, in the absence of the actual radiographic films, was improper hearsay that denied defendant his right of cross examination and violated both the Second Department's prior determination in the instant matter and the rule set forth in the matter of *Wagman v Bradshaw* (292 AD2d 84 [2002]). Defendant, however, further argued that plaintiff opened the door by submitting and relying upon such evidence, thereby allowing defendant to present its own expert radiologist's testimony without benefit or introduction of the actual radiographic films.

Plaintiff countered that the affirmed radiology reports were admissible under the Court Rules and contended that, because the films were never introduced nor properly attested to, defendant was precluded by CPLR 4532-a and *Wagman* from offering any testimony

regarding the contents of the films. Plaintiff also declined, in the face of defendant's argument of plaintiff having "opened the door" to defendant's expert's testimony regarding the absent radiographic films, to withdraw his proffer of Dr. Prufer and Dr. Solomon's interpretation reports.

Wagman and its progeny (including *DeLuca v Ju Liu*, 297 AD2d 307 [2002]), stand for the proposition that - - because expert opinion evidence must be based upon: (1) personal knowledge of the facts upon which the opinion rests; (2) facts and material in evidence, real or testimonial; (3) material not in evidence, provided that the out-of-court material is derived from a witness subject to full cross-examination; or (4) material not in evidence, provided it is of the kind accepted in the profession as a basis in forming an opinion and is accompanied by evidence establishing its reliability - - - it is error "to permit an expert to offer testimony interpreting diagnostic films such as X-rays, CAT scans, PET scans, or MRIs, without the production and receipt in evidence of the original films thereof or properly authenticated counterparts" (*Wagman*, 292 AD2d at 86-87; *see also DeLuca*, 297 AD2d at 307; *accord Jemmott v Lazofsky*, 5 AD3d 558, 559-560 [2004]; *Beresford v Waheed*, 302 AD2d 342, 343 [2003]; *Finocchiaro v Wall Street Mail Pk-Up Services, Inc.*, 8 Misc 3d 133[A] [2005]; *Matter of Lisa W. v Seine W.*, NYLJ, Sept. 23, 2005, at 18, col 3 [Kings County Fam Ct, 2005]). As relevant herein, the term "counterparts," as used in *Wagman*, has been understood to include the diagnostic reports (*see Jemmott*, 5 AD3d at 560; *Beresford*, 302 AD2d at 343).

There is no merit to defendant's argument that acceptance into evidence of the sworn diagnostic reports would violate the Appellate Division's prior order in this matter. Neither is there merit in plaintiff's argument that the reports must be accepted into evidence merely because of the Court Rule (22 NYCRR 202.46[b]), permitting proof at inquest by way of written affidavit in lieu of live testimony.

A written statement does not satisfy the indicia of admissibility merely by being sworn. To be admissible, the document need also be (1) reliable, and (2) probative of some pertinent issue - - here, the issue of serious injury and, if serious injury is established, then damages.

Here, though they are sworn, the proffered diagnostic reports, which consist of no more than the opinions of the medical practitioners who prepared them, are not supported by any facts in the record or independent evidence or proof of the reliability of their content (*i.e.*, the actual X-rays and MRI films), and can, at inquest, be the subject neither of demonstration nor cross-examination (*see Wagman*, 292 AD2d at 88 [derivative evidence of unproduced X-rays or MRI films offered in the form of a diagnostic interpretative report, where the actual films were not lost, destroyed or otherwise unavailable, was inadmissible pursuant to the hearsay and best evidence rules]).[5]

---

[5] As an example, photographs of plaintiff's vehicle were offered into evidence during the inquest. Had a written statement of defendant or another person's interpretation of those picture's been introduced instead of the actual photographs, such statement evidence, even if sworn and in the absence of an explanation that the photographs had been lost or destroyed, would suffer the same reliability, hearsay and best evidence infirmities as do the proffered diagnostic reports.

The diagnostic reports, moreover, fail to address the issues of permanency and causation and, thus, have not been shown, standing alone, to be probative on the pertinent question of serious injury (*see e.g. DeLuca*, 297 AD2d at 307; *Matter of Lisa W.*, NYLJ, September 23, 2005, at 18). It is further noted that Dr. Salama failed to personally review the X-rays and MRI films and, to the extent he relied, in making his diagnoses, upon "another healthcare provider's interpretation of what [ ] unproduced [X-rays] and MRI film purport[] to exhibit," such diagnoses is nothing more than conjecture and hearsay, not properly before the court (*Wagman*, 292 AD2d at 87; *see also Toure*, 98 NY2d at 357-358; *Mahoney v Zerillo*, 6 AD3d 403 [2004]; *Philippe v Ivory*, 297 AD2d 666 [2002]).

The court finds that the proffered diagnostic reports are, by themselves, not probative of the threshold question of serious injury, and that plaintiff failed, at inquest, either (1) to demonstrate that the reports are independently reliable, or (2) to sufficiently connect the reports to the action and issues at hand by demonstrating that they served as a proper basis for the opinion of another medical practitioner. The reports are, accordingly, not admissible on the threshold issue of serious injury, even under the Court Rules, and there is no need for the court to address the issue of their admissibility under *Wagman*.

To the extent plaintiff might meet his burden of demonstrating serious injury, and consideration of the diagnostic reports on the issue of damages then prove necessary, plaintiff's December 7, 1999 interpretative reports of his X-rays suggest negative studies of the lumbar spine and right knee; a negative or unremarkable study of the chest; with respect

to the cervical spine, straightening of the normal cervical lordosis; and with respect to the thoracic spine, "mild thoracic spondylosis" and "minimal levoscoliotic deformity."

Plaintiff's December 7, 1999 interpretative reports of his MRIs suggest a disc herniation of the cervical spine with impingement at C5-C6; with respect to his right knee, joint effusion and a tear at the posterior horn of the medical meniscus; bulging discs of the lumbosacral spine with effacement at L4-L5 and L5-S1; and impingement of the right shoulder.

Plaintiff presented no relevant or admissible evidence, other than that addressed above, and defendant moved, at the close of plaintiff's case, for a directed verdict in defendant's favor dismissing the action. The court reserved decision on defendant's directed verdict motion, and finds herein that such motion should be granted for plaintiff's failure to present a *prima facie* case of serious injury.

It was plaintiff's burden at the inquest, in order to satisfy the statutory serious injury threshold,[6] to submit objective findings, in addition to opinions, as to the significance of his injuries (*see Toure v Avis Rent A Car Systems, Inc.*, 98 NY2d at 349; *see also Licari v Elliott*, 57 NY2d 230, 238 [1982]; *Armstrong v Wolfe*, 133 AD2d 957 [1987]).

---

[6] Insurance Law § 5102 (d) defines "serious injury" as a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of a use of a body organ or member; permanent consequential limitation of use of a body organ or member; significant limitation of the use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

Resolution of the issue of whether a serious injury was sustained involves a comparative determination of the degree or qualitative nature of an injury based on the normal function, purpose and use of a body part (*see Toure*, 98 NY2d at 353).

For plaintiff to establish that he suffered a permanent loss of use of a body organ, member or function, such loss must be total (*Oberly v Bangs Ambulance, Inc.*, 96 NY2d 295, 297 [2001]). To establish that he suffered a permanent consequential limitation of use of a body organ or member, and/or a significant limitation of use of a body function or system, plaintiff must show more than "a mild, minor or slight limitation of use" and is required to provide objective evidence in addition to opinions of the extent or degree of the limitation and its duration (*see Grossman v Wright*, 268 AD2d 79, 83 [2000]; *Booker v Miller*, 258 AD2d 783, 784 [1999]; *Burnett v Miller*, 255 AD2d 541 [1998]; *King v Johnston*, 211 AD2d 907 [1995]; *Beckett v Conte*, 176 AD2d 774 [1991]).

Here, plaintiff has failed to submit any admissible proof, either current or contemporaneous with the accident, showing any range of motion restrictions or an expert's qualitative assessment of plaintiff's condition which compares plaintiff's limitations to the normal function, purpose and use of the affected body organ, member, function or system (*see Jason v Danar*, 1 AD3d 398, 399 [2003]).

Other than the radiologist interpretation reports, the only admissible medical practitioner evidence submitted by plaintiff is Dr. Salama's January 2000 reports. Dr. Salama, however, fails to allege (and, therefore, does not quantify) that plaintiff has sustained

any significant limitations or loss of range of motion. Dr. Salama, in fact, asserts only that plaintiff has sustained cervical and lumbosacral strains and sprains and a right knee joint derangement, and fails to allege or reach any conclusion of permanency, much less a total, or permanent and significant loss or limitation of use of a body organ or system.

Further, although the MRI reports, if they were to be considered by the court on the issue of serious injury, do indicate, *inter alia*, a bulging and herniated discs, such diagnosis does not constitute a serious injury in the absence of objective evidence of a related disability or restriction (*see Rudas v Petschauer*, 10 AD3d 357 [2004]; *Pierre v Nanton*, 279 AD2d 621, 621-622 [2001]; *see also Toure v Avis Rent A Car Systems, Inc.*, 98 NY2d 345, 353 [2002]; *Chinnici v Brown*, 295 AD2d 465, 465-466 [2002]; *Davis v New York City Transit Authority*, 294 AD2d 531 [2002]; *Espinal v Galicia*, 290 AD2d 528 [2002]; *Duldulao v City of New York*, 284 AD2d 296, 297 [2001]). Plaintiff, at inquest, presented no such objective evidence.

Nor, as relevant herein, do mere straightening of the lordotic curve or strained shoulder muscles which do not disrupt overall functioning qualify as significant limitations of use of a body function or system (*Williams v Ritchie*, 139 F Supp 2d 330, 341 [EDNY 2001], *citing Thrall v City of Syracuse*, 60 NY2d 950 [1983]). Finally, plaintiff presented no competent evidence that plaintiff's alleged knee injury caused him any significant or permanent loss of use or range of motion.

Plaintiff's failure to provide any medical evidence of the extent or degree of alleged physical limitations resulting from the disc, knee and shoulder injuries, to allege or

demonstrate any permanency, to demonstrate that his alleged limitations of motion can be considered "significant" or "consequential," and to offer any non-conclusory medical proof of causation is fatal to a claim of a "permanent loss" of a body organ, member or function (*see Oberly*, 96 NY2d at 297), and claims under the "permanent consequential limitation of use of a body organ or member" and "significant limitation of use of a body function or system" categories of serious injury.

In the alternative, plaintiff must prove that he sustained a medically determined injury or impairment which prevented him from performing "substantially all" of the material acts which constituted his usual and customary activities for 90 out of the 180 days immediately following the accident (*see Gaddy v Eyler*, 79 NY2d 955, 958 [1992]; *Licari*, 57 NY2d at 236; *Crandall v Sledziewski*, 260 AD2d 754, 757 [1999]). The 90 days set forth in the statute are strictly construed (*see e.g. Abrahamson v Premier Car Rental of Smithtown*, 261 AD2d 562 [1999]).

"Although permanent pain, even of an intermittent character, may form the basis of a serious injury, subjective complaints unsupported by credible medical evidence do not suffice" (*Dwyer v Tracey*, 105 AD2d 476, 477 [1984]). Rather, any subjective claim of pain and restriction of motion must be sustained by verified objective medical findings, based on a recent examination of plaintiff (*Grossman*, 268 AD2d at 84).

At inquest, plaintiff contended that he was confined to bed or his home for approximately one week, and did not return or attempt to return to work for more than 1 ½ years following the accident. Plaintiff did not, however, either assert or demonstrate that he

was advised by a medical practitioner to curtail his work or other activities (*see Barbarulo v Allery*, 271 AD2d 897, 901 [2000]), and presented no admissible contemporaneous evidence of medically determined injuries that would have prevented him from going to work or performing substantially all of his usual daily activities (*see Ersop v Variano*, 307 AD2d 951 [2003]; *Dabiere v Yager*, 297 AD2d 831, 832-833 [2002]; *Cassese v Leister*, 291 AD2d 350 [2002]; *McKinney v Lane*, 288 AD2d 274 [2001]; *Blanchard v Wilcox*, 283 AD2d 821, 824 [2001]; *Curry v Velez*, 243 AD2d 442 [1997]; *see also Gaddy*, 79 NY2d at 958; *Licari*, 57 NY2d at 236; *Nelson v Distant*, 308 AD2d 338, 340 [2003]; *Lichtman v Heit*, 300 AD2d 242 [2002]). Given the lack of any medical corroboration for a claim that he was incapacitated for the requisite statutory period, plaintiff also failed to prove he sustained a serious injury under the 90/180 day category (*see e.g. Rudas v Petschauer*, 10 AD3d 357 [2004]; *Gjelaj v Ludde*, 281 AD2d 211, 212 [2001]).

As such, the court finds that the evidence presented by plaintiff at inquest was insufficient as a matter of law to establish that plaintiff sustained a serious injury within the meaning of Insurance Law § 5102(d), and that defendant is, therefore, entitled to a directed verdict dismissing the action (*see Shafarenko*, 5 AD3d at 585; *Zafir*, 190 Misc 2d at 296).

Were the court to find that plaintiff had met his initial burden of presentment, the court, upon review of defendant's evidence at inquest, would fully credit the testimony of defendant's orthopedic expert, Dr. Lawrence Miller, that Dr. Miller examined plaintiff on March 3, 2000; conducted a series of well-known diagnostic tests and an orthopedic evaluation of plaintiff's shoulders, right knee and cervical and lumbosacral spines; and found

that plaintiff had sustained only lumbosacral spine, bilateral shoulder and bilateral knee strains/sprains, which had fully resolved at the time of the examination, and that there was no evidence of plaintiff having sustained a permanent disability or loss or limitation of range of motion (*see Schultz v Von Voight*, 216 AD2d 451, 452 [1995] [limitation of motion that has resolved itself, insufficient to establish a significant limitation]).

The court would find, based upon such testimony, and upon a fair interpretation of all of the admissible evidence presented at inquest, that plaintiff had not, as a result of the subject November 1999 accident, sustained a serious injury within the meaning of Insurance Law § 5102(d).

Given the above, the court need not determine the admissibility under the *Wagman* and *DeLuca* rules of defendant's radiologist expert's testimony regarding his interpretation of the non-produced X-ray and MRI films.

Conclusion

Based upon the foregoing, the complaint is dismissed after inquest.

The foregoing constitutes the decision, order and judgment of this court.

E N T E R,

J. S. C.

HON. DAVID I. SCHMIDT