Kiszkiel v Inter-County Motor Coach, Inc.
2008 NY Slip Op 30262(U)
January 7, 2008
Supreme Court, Suffolk County
Docket Number: 0011354/2002
Judge: John J.J. Jones
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SHORT FORM ORDER

INDEX NO.: 0011354/2002
SUBMIT DATE: 8/29/2007
MTN. SEQ.#: 002

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 10 SUFFOLK COUNTY

Present:

HON. JOHN J.J. JONES, JR.
Justice

MOTION DATE: 4/11/2007
MOTION NO.: MG;CASEDISP

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EVE KISZKIEL,

Plaintiff,

-against-

INTER-COUNTY MOTOR COACH, INC., BABYLON TRANSIT, INC., and "RONALD DOE": the last name being a fictitious name, being and intended to be the individual operating the subject vehicle on April 23, 2001,

Defendants.

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HAROLD STEUERWALD, ESQ.
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Upon the following papers numbered 1 to 31 read on this motion for an order granting summary judgment; Notice of Motion/Order to Show Cause and supporting papers 1-18 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 19-23 ; Replying Affidavits and supporting papers 24-31 ; Other ____; it is

ORDERED that this motion by defendants, Inter-County Motor Coach, Inc. and Babylon Transit, Inc., for an order granting summary judgment in their favor dismissing the complaint of plaintiff, Eve Kiszkiel, is granted and the complaint is hereby dismissed.

Plaintiff commenced this action to recover damages for personal injuries allegedly

sustained on April 23, 2001 while she was a passenger on a bus which was en route for a day trip from Suffolk County, to Atlantic City, New Jersey. It is alleged in the complaint that at approximately 12:30 pm on the day of the accident, the driver of the bus caused it "to suddenly veer to one side and stop abruptly, without warning, thereby causing the Plaintiff to be thrown [from the front seat] into the well and/or entrance steps of the subject vehicle." It is alleged in the bill of particulars that as a result of the occurrence plaintiff sustained "a concussion, internal bleeding, bruises to her face, forehead, both eyes, back, shoulders, left arm, ten stitches to the back of her head, pain and numbness in her upper and lower back, numbness and pain in both of her legs, nerve damage causing numbness on her right side from her neck down to her foot, injury to her right toe, herniated disks in her neck and back . . . headaches, dizziness and vertigo." Additional claims of an injury to her eyes and a stomach condition were withdrawn by stipulation. She was initially treated and released in the emergency room, and subsequently she sought additional care from numerous medical providers. It is alleged in the bill of particulars that she was confined to bed for one week following the accident and confined to home for three weeks.

Plaintiff admitted at her deposition that she had sustained a prior injury to her lower back in 1996 during the course of her employment at Off-Track Betting. Thereafter, she sought treatment from numerous providers, including Stony Brook University Hospital, Dr. DeLanerolle and Dr. Bautista, and she filed a workers' compensation claim. At the time of plaintiff's deposition on July 28, 2004, she was still receiving monthly benefit checks.

In order to effectuate the purpose of no-fault legislation to reduce litigation, a court is required to decide, in the first instant, whether a plaintiff has made out a *prima facie* case of "serious injury" sufficient to satisfy the statutory requirements (***Licari v Elliott***, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088 [1982]; ***Brown v Stark***, 205 AD2d 725, 613 NYS2d 705 [2d Dept 1994]). If it is found that the injury sustained does not fit within the definition of "serious injury" under Insurance Law § 5102(d), then the plaintiff has no judicial remedy and the action must be dismissed (***Licari v Elliott***, *supra*, at 57 NY2d 238; ***Velez v Cohan***, 203 AD2d 156, 610 NYS2d 257 [1st Dept 1994]). A "serious injury" is defined as a personal injury which "results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of 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 s ubstantially all of the material acts which constitutes 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" (Insurance Law § 5102 [d]).

In support of their motion for summary judgment, defendants submitted a copy

of a report dated December 9, 1996 pertaining to an MRI taken of plaintiff's cervical spine which was addressed to plaintiff's treating physician, Dr. deLanerolle. It identified "a central, subligamentous disc herniation" at C4-5 which deformed the anterior subarachnoid space and abutted the anterior margin of the cervical cord. In addition, a central left disc bulge at C5-6 was identified, and anterior hypertrophic changes at C6-7 were noted. Hyperlordosis of the cervical spine was noted and findings were reported to be consistent with degenerative arthritis at C5-6. In addition, defendants submitted a report to the workers' compensation board dated April 30, 1997 from plaintiff's chiropractor, who indicated that plaintiff was undergoing treatment "for herniated discs in her cervical and lumbar spines."

A report to Dr. deLanerolle of an evaluation undertaken on February 23, 1998 by Dr. Choi indicated that plaintiff, a 73-year-old female, complained of low back pain with tingling and numbness in both legs, and pain in her neck on the right with tingling and numbness in her fingers. Plaintiff noted that her legs tended to give out during ambulation. All symptoms were reported to have been "a result of a work injury" in 1996. Plaintiff also complained of sleep disturbances. Range of motion testing of the cervical spine was reportedly restricted to 40 degrees right and 50 degrees left rotation. Lateral bending was restricted to 15 degrees on the right and 10 degrees on the left, but there was full flexion and extension. Range of motion testing of the lumbar spine was restricted to 80 degrees forward bending and 5 degrees extension, and lateral bending was 10 degrees bilaterally. There was decreased strength in the right hand grip, and decreased sensation to pin prick and touch on the fourth and fifth fingers bilaterally. Straight leg raising was full. A diagnosis of myofascial pain syndrome due to a work-related injury of the cervical and lumbar spine was reported.

Defendant also submitted the affirmed report of an examining orthopedic surgeon who saw plaintiff on March 23, 2005, at which time plaintiff admitted to the prior injury to her lower back but she reported that she had been "doing well" until her accident on the bus. At the time of the examination, plaintiff complained of generalized neck and lower back pain with weakness in the right leg and numbness in her upper left leg. Examination of the cervical spine revealed that plaintiff could lower her chin to her chest "easily" but upwards gaze stopped at 50 degrees, and lateral gaze was 20 degrees bilaterally. Lateral tilt was symmetrically halted at 5 degrees bilaterally, but there was no spasm. Deep tendon reflexes at the triceps, biceps and brachioradialis measured +1 and were brisk and equal bilaterally. Normal lordosis of the lumbar spine was preserved, but forward bending was limited to 45 degrees with complaints of pain. Lateral bending was also limited to 5 degrees in each direction by complaints of pain, but no spasm was noted. Straight leg raising was 90 degrees in the seated position. Deep tendon reflexes at the knees and ankles measured +1 and were brisk and equal bilaterally. There was no decreased sensation over the lower extremities. The doctor concluded that the plaintiff had a normal orthopedic/neurologic examination for a woman of her age with no evidence of any local focal neurologic injury secondary to the underlying accident and

no impairment. An additional affirmed report was submitted following a review by the orthopedist of records obtained from plaintiff's treating physicians, including the aforementioned MRI report. A review of office notes from plaintiff's treating physicians indicated that in 1999 plaintiff had an additional accident when she fell down 13 stairs and injured her lower back. The orthopedist concluded that he found no evidence of impairment that was causally related to the underlying accident on the bus.

Defendants also submitted the affirmed report of a neurologist who examined plaintiff on February 28, 2005, at which time she complained of numbness in the left lower extremity, neck pain, diffuse low back pain and blurred vision in the left eye. On examination it was noted that there was no para-cervical or para-lumbar spasm to palpation, but straight leg raising was 45 degrees bilaterally with complaints of pain. Gait was normal and strength in the upper and lower extremities was 5/5. There was reduced pin, temperature, touch and vibratory sense in the entire left lower extremity "in a nonorganic pattern," but sensation in the right lower extremity and upper extremities was normal. He concluded that plaintiff had no objective abnormalities and that she did not sustain any neurological injury or disability as a result of the bus accident. While there were findings relating to the left eye, they relate to an ophthalmologic problem that is not accident-related.

The affirmed report of a radiologist who reviewed the MRI study of plaintiff's lumbar spine taken on March 15, 2004 was also submitted by defendants. It was noted that plaintiff had a moderate upper lumbar dextroscoliosis, but the vertebral bodies were within normal limits in configuration, signal intensity and alignment. There was "an old, mild compression fracture deformity of the L3 vertebral body, with smooth concave depression of the superior endplate." There was also multi-level degenerative disc disease and disc desiccation with disc space narrowing, most severe at L4-5. There was mild central lumbar canal stenosis at the L2-3 level, and moderate lumbar canal stenosis at L3-4 and L4-5 levels. It was concluded that the study showed advanced multi-level degenerative disc disease and degenerative spondylosis, but no findings that were causally related to the 2001 accident.

The defendants met their initial burden of establishing, as a matter of law, that plaintiff did not sustain a serious injury within the meaning of Insurance Law § 5102(d) (*see* ***McCauley v Ross***, 298 AD2d 506, 748 NYS2d 409 [2d Dept 2002]; *see also* ***McKinney v Lane***, 288 AD2d 274, 733 NYS2d 456 [2d Dept 2001], citing ***Gaddy v Eyler***, 79 NY2d 955, 591 NE2d 1176, 582 NYS2d 990; ***Licari v Elliott***, 57 NY2d 230, 441 NE2d 1088, 455 NYS2d 570).

In opposition to the motion, plaintiff submitted her own affidavit in which she makes numerous self-serving but unsubstantiated claims about her injuries, for example, that she had a concussion. According to her affidavit, she was confined to bed for approximately one week following the accident and confined to her home for

approximately three weeks. She acknowledges the prior 1996 work-related injury that occurred when a seat broke and she fell to the floor. She claims, however, that she did not have any problems with her back at the time of the 2001 accident, and that before the accident she had been doing housework and going to the gym three times a week. It is averred that since the 2001 accident, plaintiff has been unable to walk for a long distance, go to the gym or do housework without pain.

Plaintiff submitted the affidavit of her treating neurologist, Dr. deLanerolle, who averred that plaintiff "was evaluated initially by me on August 16, 2001 because of injuries she sustained in a bus accident that occurred on April 23, 2001." At that time it was noted that plaintiff had straightening of the cervical spine and mild bilateral cervical para-vertebral spasm with "mild limitation" of movement. There was also mild to moderate bilateral lumbar para-vertebral spasm with spinal extension to 10 degrees, forward flexion to 30 degrees, rotation and left lateral flexion to 15 degrees. The straight leg raising test was "unremarkable on the right" but restricted to 70 degrees on the left. Motor systems evaluation showed normal tone, bulk and strength of all extremities, and deep tendon reflexes were 2+ and symmetrical, except for ankle jerks, which were depressed. Sensory examination was intact and gait was normal. Subsequent examination on June 24, 2002 of the cervical spine showed extension at 5 to 10 degrees, and flexion to 30 degrees. Lateral flexion and rotation were 30 degrees. Lumbar extension was limited to 5 degrees, flexion was 30 degrees, and lateral flexion was limited to 15 degrees on either side. Straight leg raising was negative. When she was seen on July 15, 2002, plaintiff "appeared extremely depressed and anxious" and the examination revealed a "moderate limitation" of cervical and lumbar spinal movement with spasm. The report outlines purported findings made during periodic visits through September 2002 and it is noted that the plaintiff was treated with physical therapy through the end of 2003. She was seen again in March and April 2004 for complaints of low back pain and was referred for x-rays and MRI tests. Although reference is made to purported findings in the MRI reports, the doctor's reliance on the unsworn report of another physician is improper (*see* ***Porto v Blum***, 39 AD3d 614, 833 NYS2d 245 [2d Dept 2007]). Plaintiff continued to complain of pain and numbness during visits in May 2006, May 2007 and June 2007, and findings of "moderate limitation of the cervical and lumbar spine" were noted. Although the plaintiff was also diagnosed with carpal tunnel syndrome, such injury is not alleged in the bill of particulars to be causally related to the underlying accident. The doctor opined that the "cervical lumbar disc disease with radiculopathy became symptomatic following the bus accident."

The medical evidence submitted by plaintiff fails to raise a triable issue of fact. In this case, defendants submitted persuasive evidence through the cervical MRI report prepared in 1995, coupled with the 1998 report of Dr. Choi, that plaintiff's pain, restriction of motion and other symptoms are related to pre-existing injuries and medical conditions. The burden then shifted to plaintiff to come forward with evidence addressing defendants' contention that plaintiff's injuries are not causally related to the

underlying accident on the bus (*see* ***Pommells v Perez***, 4 NY3d 566, 830 NE2d 278, 797 NYS2d 380 [2005]). The affidavit of Dr. deLanerolle, however, fails to adequately address the plaintiff's previous accidents in which she injured some of the same parts of her body that she claims were injured in this action (*see* ***Munoz v Koyfman***, ___ AD3d ___, 2007 NYAppDivLEXIS 11359 [2d Dept 2007]; *see also* ***Allyn v Hanley***, 2 AD3d 470, 471, 767 NYS2d 885 [2d Dept 2003]). Furthermore, the doctor fails to adequately quantify any alleged restriction of motion during the most recent examinations, claiming that on June 12, 2007 the plaintiff had "moderate limitation of cervical spinal movement" and "moderate limitation of lumbar spinal movements" (*see* ***Chinnici v Brown***, 295 AD2d 465, 744 NYS2d 186 [2d Dept 2002]). Moreover, the plaintiff's submissions do not demonstrate an objective basis for the conclusion that such limitations are causally related to the accident (*see* ***Dominguez-Gionta v Smith***, 306 AD2d 432, 761 NYS2d 310 [2d Dept 2003]).

Plaintiff's submissions are insufficient, therefore, to raise a triable issue of fact as to whether she sustained a "serious injury" within the meaning of Insurance Law § 5102(d), since they fail to establish that her injuries are permanent in nature, or that she sustained a significant limitation of use, or that she sustained a medically determined injury or impairment of a non-permanent nature which prevented her from performing substantially all of the material acts which constitutes her usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence. Accordingly, plaintiff has failed to successfully oppose defendants' application by demonstrating that she suffered a "serious injury" as defined in Insurance Law § 5102 (d) (*see* ***Claude v Clements***, 301 AD2d 554, 756 NYS2d 57 [2d Dept 2003]; *see also* ***Weaver v Derr***, 242 AD2d 823, 661 NYS2d 684 [3d Dept 1997]; ***Napoli v Cunningham***, 273 AD2d 366, 710 NYS2d 919 [2d Dept 2000]; ***Vitale v Carson***, 258 AD2d 647, 685 NYS2d 788 [2d Dept 1999]).

DATED: 7 January '08

HON. JOHN J.J. JONES, JR.
J.S.C.

CHECK ONE: [X] FINAL DISPOSITION [ ] NON-FINAL DISPOSITION