At an I.A.S. Term, Part MMTRP, 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 19th day of March, 2008.

P R E S E N T:

HON. GERARD H. ROSENBERG,
Justice.

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PAULA BELL, as Administratrix of the Goods, Chattels and Credits which were of LILLIAN VILABRERA, deceased,

Plaintiff,

-against-

INTERFAITH MEDICAL CENTER, et al.,

Defendants.

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DECISION & ORDER

Index No. 31215/04

Cal. No. 2007-003608T

Motion Seq. No. 001

The following papers numbered 1 to 4 read on this motion.

	Papers Numbered
Notice of Motion, Affirmation(s)/Affidavit(s) and Exhibits Annexed	1- 2
Affirmation(s) in Opposition and Exhibits Annexed	3
Reply Affirmation(s)and Exhibits Annexed	4

Upon the foregoing papers, and upon oral argument, defendant Faheem Butt, M.D. (Dr. Butt) moves pursuant to CPLR 3212 for an order granting summary judgment.

This is a medical malpractice action, in which it is alleged that plaintiff's decedent, Lillian Vilabrera (the decedent), suffered personal injuries and wrongful death arising out of a fall from a hospital bed at Interfaith Medical Center (Interfaith) on or about September 22,

2002.

In support of the motion, Dr. Butt submits the affirmation of Howard D. Kolodny, a physician board certified in Internal Medicine. Dr. Kolodny states that he has reviewed the Bill of Particulars, the medical records of Lillian Vilabrera from Interfaith, her records from the Center for Nursing and Rehabilitation, the deposition transcripts of Dr. Butt and Nurse Christine Toomer, and Interfaith Hospital Rules and Regulations to the extent that they were provided by Interfaith. Dr. Kolodny opines, to a reasonable degree of medical certainty, that there were no departures from the standard of care by Dr. Butt between September 20, 2002 and September 22, 2002, which proximately caused the injury and death of the plaintiff's decedent. Dr. Kolodny states that this opinion is based upon his review of the aforementioned material, his knowledge and experience as a physician, specifically with respect to hospital and medical practice, as well as the applicable laws pertaining to the use of restraints. A summary of Dr. Kolodny's affirmation is as follows:

> Plaintiff alleges in essence, that based upon the decedent's history and medical condition, that Dr. Butt improperly failed to order physical restraints or "one to one" observation during the time of decedent's admission from September 20, 2002 to September 22, 2002.
>
> Plaintiff's decedent was 86 years old at the time of her admission to Interfaith. She had previously been admitted to the Center for Nursing and rehabilitation on May 2, 2001 from Interfaith where she was treated for rectal bleeding. At the time of her re-admission on May 2, 2001, she was noted to have numerous medical ailments, including hypertension, diabetes mellitus, chronic atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, status post right knee replacement, and c. difficile colitis. She was confined to a wheelchair. From May 1, 2001 until September 20, 2001, decedent was never reported to have been physically restrained, and she had never fallen out of bed or fallen in any way.

The patient was transferred on Dr. Butt's orders from the Center for Nursing & Rehabilitation to Interfaith Hospital on September 20, 2001. The transfer information accompanying the patient to the hospital reported that the reason for the transfer was change in mental status.

On September 20, 2001, the decedent was brought by ambulance to the Interfaith emergency room. The nursing note indicates that she was brought from a nursing home for evaluation of lethargy, changes in mental status and that she had not eaten for two days. She was awake and oriented to person. The emergency room physician noted on physical examination that the patient was elderly, confused and lethargic but responsive. A finger stick blood sugar was reported at 61, which is low. The admitting diagnosis was hypoglycemia and dementia. The patient was admitted to the service of Dr. Butt.

When the patient was admitted she was assessed by the nursing staff. She was oriented to person, alert and lethargic. Functionally, she was weak and was bed bound. She was noted to need assistance in walking, eating, dressing, bathing and toileting. The fall potential assessment noted no history of falls within the last 6 months, and noted only over age 65 as a fall risk. Fall precautions were ordered.

Fall precautions include placing the patient as close to the nursing station as possible, to have side rails in place to prevent the patient climbing out, to put the call bell within the patients's reach, to place the patient's over-bed table with any belongings as close to the patient as possible, and checking on the patient every 15 minutes. Fall precautions also include providing the patient with enough light and keeping the bed height low.

Because September 21, 2002 was Dr. Butt's day off, he had arranged for a colleague, Dr. Mohammad Ghumann, to see the decedent. Prior to seeing the patient, Dr. Butt spoke with him to advise him of the patient's condition and the reason for the transfer. At 4:00 a.m. on September 21, 2001, Dr. Ghumann reported that the decedent was referred from the nursing home for lethargy. Upon physical examination, she was found lying in bed in no acute distress. She responded to verbal commands and answered simple questions. She was alert and oriented x 1. After reporting the lab results, the assessment included among other things, altered mental status secondary to hypoglycemia, rule out CVA versus TIA. He admitted the patient to the Medicine floor.

A nursing noted timed at 9:10 a.m. on September 21, 2002 states that the patient was received on a stretcher with her eyes closed but responsive to

verbal stimulation. At 11:05 am. she was noted to be alert and responsive. At 1:30 p.m. the resident noted that the patient was arousable and responsive to verbal and painful stimulus. At 2:30 p.m. a nurse noted that the patient woke up and was more responsive. She was alert, aware and answering questions. On September 21, 2002 at 6:00 p.m., the decedent was noted to have eaten and tolerated clear liquids. She was placed on an accucare mattress, which is a precaution for decubitus ulcers, and it was noted that safety precautions were maintained.

On September 22, 2002, the patient was transferred to the step down telemetry unit. On September 22, 2002 at 6:00 a.m. the patient is noted to be alert and responsible to all stimuli. She was "coherent, not confused at this time." She is also noted to have been visited by her daughter and "good interaction" was noted.

Dr. Butt saw the patient on the morning of September 22, 2202 in the telemetry unit. Dr. Butt reported that the patient was awake, confused, in no respiratory distress but minimal dry cough. She was on IV antibiotics. The assessment and plan included improving hypoglycemia; rule out sepsis; history of persistent C.difficile; possible congestive heart failure as has bilateral rales; atrial fibrillation-rate controlled; and guaiac positive stool possibly secondary to C.difficile vs. peptic ulcer disease; and rule out colonic disease. When Dr. Butt examined the patient his examination included a risk of fall assessment.

At 4:00 p.m. on September 22, 2002, the nursing note indicates that the patient was alert and responsible to all stimuli. There were periods of confusion noted at that time. Side rails were in place for safety precautions. Close observation was reportedly maintained at that time. At 6:00 p.m. the patient was given her medication and at that time, the nurse noted that the patient stated that she could feed herself and, in fact, the patient was able to do so. The patient was under close supervision and safety precautions are specifically stated to have been maintained.

At 7:50 p.m. on September 22, 2002, the patient was noted to be found on the floor. Side rails were noted to be intact. She was awake and alert and talking. The decedent sustained a comminuted fracture of the left femoral head and hematoma of the scalp. She underwent reconstructive surgery for her left hip. She passed away on October 5, 2002 due to congestive heart failure.

Dr. Kolodny then states his opinions as to the care and treatment rendered to the

decedent as follows:

> Physicians and hospitals are not free to order restraints simply because a patient is elderly, confused and/or at risk for falling. State and Federal regulations provide that the patient has the right to be free from physical or chemical restraints. The regulations which govern physicians in these circumstances require that before a patient can be restrained less restrictive measures must be attempted first, and found to be ineffective. It is not the standard of care to use restraints for every patient that is elderly, confused or at risk for falling. Indeed, the standard of care is to avoid the use of restraints, as they can cause physical and emotional injury to the patient. It is a patient's right not be placed in physical restraints in the absence of a showing of necessity to do so, and in the absence of a showing that less restrictive alternatives have been attempted and found to be ineffective. In this case, prior to the patient's fall, there was no indication that the less restrictive measures to protect the patient - the fall precautions noted above - were ineffective. There was, therefore, no reason to restrain the patient; in fact, restraining the patient would have been a violation of Federal and State regulations as well as of the express policy of Interfaith.
>
> At the time the patient was admitted to Interfaith, based upon her medical condition and her history, which included no recent history of falls or of the use of restraints, there was no indication or basis for the use of restraints, and thus, no departure by Dr. Butt in not ordering or directing that the patient be restrained.
>
> After the decedent was admitted, the decedent's condition improved as her hypoglycemia and dehydration were treated, and she was more coherent. There were no occasions during this admission where she attempted to get out of bed. On the morning of September 22, 2002, the decedent was noted to have good interaction with her daughter, who had visited her. Decedent was able to, and did, make her needs known. At 6:00 p.m., shortly before the fall, the decedent asked to feed herself and did so. She did not appear to the nursing staff to be hypoglycemic at that time. To a reasonable degree of medical certainty, it was not a departure from the standard of care for Dr. Butt not to order and not to instruct anyone to order physical restraints for the decedent after she was admitted up until the time she fell on September 22, 2002 at approximately 7:50 p.m. Indeed, the use of physical restraints on this patient prior to the fall would not be justifiable under the standard of care, nor would such use comply with Federal and State law, or with this hospital's policies and procedures.

> It is not the standard of care for all patients who are elderly or fall risks, or who are confused, to be provided with one-to-one observation. The determination of whether to utilize one-to-one observation of a patient is within the clinical judgment of the physician. It was not a departure from the standard of care under the circumstances for Dr. Butt to not order or instruct anyone to order one-to-one observation for the patient when she was admitted, up until the time she fell on September 22, 2002. When the decedent was admitted, she was placed under fall precautions. These precautions include the use of side rails and observation of the patient every 15 minutes. The decedent had no recent history of falls, and there were no occasions during this admission where she attempted to get out of bed. Given the patient's history and condition, there precautions were sufficient for this patient. Maintenance of the fall precautions was an appropriate exercise of clinical judgment by Dr. Butt.

Plaintiff's Opposition

In opposition to the motion plaintiff submits the affirmation of Kenneth Ackerman, M.D., a physician board certified in Internal Medicine. Dr. Ackerman states that he has reviewed the Bill of Particulars, the medical records of Lillian Vilabrera from Interfaith, her records from the Center for Nursing and Rehabilitation, the deposition transcripts of Dr. Butt, Nurse Christine Toomer, plaintiff Paula Bell (decedent's daughter), nonparty witness Petra Thombs, Dr. Kolodny's affirmation, and Interfaith Hospital Rules and Regulations to the extent that they were provided by Interfaith. Dr. Ackerman opines, to a reasonable degree of medical certainty, that Dr. Butt departed from the standards of accepted medical practice between September 21, 2002 and September 22, 2002, when decedent was re-admitted to Interfaith Medical Center, and that these departures were a proximate contributing cause of the injuries and death of the plaintiff's decedent.

Dr. Ackerman states his conclusions as follows:

The admitting diagnosis was dehydration, hypoglycemia and dementia. [The patient] is recorded as weak, lethargic and bed ridden. She is noted to need assistance in walking, eating, dressing, bathing and toileting. The fall potential assessment in the record fails to record "impaired mobility" as a risk factor, and notes only "over age 65" as a fall risk. Fall precautions were ordered. It is critical to note that during her prior admission to Interfaith on March 25, 2001, when she was similarly admitted secondary to hypoglycemia resulting in severe altered mental status and uncontrolled Diabetes Mellitus, she was assigned to "1 to 1" companion for her entire admission for her protection, despite the fact that the patient's speech was recorded as "fluent" and she was able to articulate her chief complaint as "I'm having pain at both legs as a result of a fall in the a.m."

The conditions that led to the assignment of a "1 to1" in March of 2001, were presented again by her when examined by Dr. Butt on September 22, 2002, and in my opinion with a reasonable degree of medical certainty, it was a deviation from accepted medical practice for Dr. Butt not to order the same protection to decedent during her September admission and assign a "1 to 1" aide, which would have prevented her fall, and would in no way have violated Federal or State restraint laws. There was no reason to have permitted history to repeat itself.

According to the deposition testimony of Nurse Christine Toomer, who treated decedent on September 22, 2002 prior to her fall, the fall precautions ordered for decedent that were supposed to be in effect at the time of her fall were: (1) placing the patient as close to the nursing station as possible; (2) placing the side rails up to prevent the patient from climbing out; (3) having the call bell within the patient's reach; (4) placing the patient's over-bed table with any belongings as close to the patient as possible; and (5) checking on the patient every 15 minutes.

According to the testimony of non-party witness, Petra Thombs, decedent's daughter (which again was not reviewed by defendant's expert Dr. Kolodny), she also saw decedent on September 21, 2002, the day before her fall. At the time of her visit, she testified her mother was disoriented, no longer ambulatory and talking about going outside. She was talking "like she's out of her mind" and "didn't know where she was." She reported this to a nurse who came into the room and the nurse told her not to worry, that "she was watching her." The mattress appeared to be "flush with the frame" as opposed to something that was supposed to have a barrier. Ms. Thombs testified that "There was no barrier."

Ms. Thombs further testified that before she left the hospital on the 21st, she spoke to another nurse at the nursing station about her concerns. She told the nurse that the nursing station was a long distance from her mother's room, that her mother was not herself and "talking out of her head" and that she was concerned about her being watched. She testified she was again told by a nurse, "we'll take care of it."

According to Dr. Butt's testimony, he saw the patient in the morning of September 22, 2002 in the Telemetry Unit. His note is untimed. According to the record, Dr. Butt reported that the patient was awake, but confused at the time of the examination, and she was on IV antibiotics. He testified that he makes a full assessment, including falls, on every patient, and that the standard fall precautions at Interfaith for patients like decedent, including having the bed rails up and the bed low, were ordered and in effect at the time of his exam and he did not order anything additional to protect the patient. Based on all of these facts and circumstances, that decision was a deviation from accepted practice.

Dr. Butt further testified that restraints are only ordered if the patient is at risk of hurting herself or others and it wasn't indicated here, and she was not a candidate for a "1 to 1", because generally you need aggression, agitation or combative behavior for that. He did not see the patient again that day, prior to her fall.

Based on the testimony of plaintiff Paula Bell, nonparty witness Petra Thombs and the testimony of Nurse Christine Toomer, it is clear that at the time of Dr. Butt's examination on the morning of September 22, 2002, even the standard fall precautions ordered for the decedent, specifically, proper guardrails on the bed and her room being located near the nursing station for properly monitoring, were not implemented. In addition, based on the record, her blood sugar had not yet been properly stabilized as it ranged from 40 at 3:55 a.m. to 192 at 6:50 a.m.

Under these circumstances, it is my opinion, within a reasonable degree of medical certainty, that it was a deviation from accepted practice for Dr. Butt not to order additional safety measures to protect the safety of decedent, specifically ordering a "1 to1" companion, which had been assigned to her during the March 25, 2001 admission under similar circumstances, and to ensure that the particular bed in which decedent was not was properly equipped with guardrails and/or extended full side rails.

Based on the record and testimony . . . decedent, an 86 year old women . . . remained confused and disoriented, with blackened discoloration and severe weakness in her lower extremities, at the time she was examined by Dr. Butt, up until the time of her fall, most likely secondary to unstable blood sugar levels. Her labs further showed that her bun and creatinine levels were elevated and at the time of Dr. Butt's examination, she was still at massive risk for blood sugar fluctuations effecting her mental status. As testified to by decedent's daughters, the guardrails on this bed, even to non-medical personnel, were obviously not sufficient to secure the patient in her bed, because as recorded in the record the guardrails were still "intact" at the time of the fall, and if proper guardrails were on the bed, decedent, in her condition, would not have fallen off the bed. The fact that she hit the back of her head on the side table during the fall is, again, consistent with decedent falling out of bed.

It is my opinion, within a reasonable degree of medical certainty, that Dr. Butt failed to properly assess decedent's safety and risk of fall at the time of his examination on September 22, 2002, which was a proximate cause of her fall. Based on decedent's unstable blood sugar level and her massively high risk of further fluctuations causing further severe disorientation and confusion, it was a deviation, until the patient's blood sugar levels and mental status had been properly stabilized and she became oriented to her environment, not to order a "1 to1" companion, and not to properly assess and remedy the fact that the standard nonrestrictive "risk precautions" that were ordered by another physician, to wit: a bed equipped with proper and/or extended side rails and a room proximate to the nursing station, were clearly not being properly implemented.

At a minimum, under the circumstances, these are the least restrictive measures that should have ordered and implemented in the morning of September 22, 2002, which would have prevented her fall and her ultimate death.

Although technically physicians and hospitals are not free to order restraints, even though, as here, they are medically necessary, unless less restrictive measures have been determined to be ineffective, a physician, likewise, as here, cannot ignore the severe and obvious risk to his patient by failing to order and ensure implementation all nonrestrictive means to safeguard her well being. Of interest is that after the fall, at 9:00 p.m., Nurse Toomer testified that she applied a vest restraint to the patients for safety without a physician's order. She didn't see an order in the record, "but sometimes for safety reasons you can apply . . . a vest to the patient for safety

measures to prevent any further injuries." Decedent remained in a vest restraint at Interfaith until she was transferred to the ICU.

The decedent died on October 5, 2002, five days after the surgery. It is my opinion, within a reasonable degree of medical certainty, that the cause of decedent's death was a deterioration of her physical condition caused by the fall, resulting in the fracture and the subsequent surgery necessitated by the fall.

In reply, Dr. Butt argues that plaintiff has failed to raise any triable questions of fact. Specifically Dr. Butt argues that neither plaintiff's expert nor her attorney contends that there was a departure from the standard of care for Dr. Butt not to have ordered physical restraints to be used on the decedent prior to her fall. Dr. Butt further argus that plaintiff's expert's claims are conclusory and filled with inconsistencies with respect to the issues of 1 to 1 observation, bed rails, and the closeness of the decedent's bed to the nurses' station.

Analysis

Summary judgment should only be granted where there are no triable issues of fact (*Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957]). In order to prevail on a motion for summary judgment, the movant must present a prima facie case demonstrating entitlement to judgment as a matter of law (*Prince v Di Benedetto*, 189 AD2d 757, 759 [1993]; *Zarr v Piccio*, 180 AD2d 734, 735 [1992]). Once the movant has established his or her prima facie case, the party opposing the motion bears the burden of "produc[ing] evidentiary proof in admissible form sufficient to require a trial of material questions of fact . . . mere conclusions, expressions of hope or unsubstantiated allegations or assertions are insufficient" (*Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; *see also Romano v*

St. Vincent's Medical Center of Richmond, 178 626 [1991]). Stated differently, "the plaintiff must establish the existence of material facts of sufficient import to create a triable issue" (*Shaw v Time-Life Records*, 38 NY2d 201, 207 [1975]). In addition, the evidence presented on summary judgment must be scrutinized in the light most favorable to the party opposing the motion (*Goldstein v Monroe County*, 77 AD2d 232, 236 [1980]). Since summary judgment deprives a party of his or her day in court (*Henderson v City of New York*, 178 AD2d 129 [1991]), it is a drastic remedy that will only be awarded when there is no triable issue of fact and the court can render a decision as a matter of law (*Barclay v Denckla*, 182 AD2d 658 [1992]).

"The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted medical practice and evidence that such departure was a proximate cause of injury or damage" (*Wiands v Albany Med Ctr.*, 29 AD3d 982, 983 [2006]; *see also Furey v Kraft*, 27 AD3d 416, 417- 418 [2006], *lv denied* 7 NY3d 703 [2006]; *Taylor v Nyack Hosp.*, 18 AD3d 537, 538 [2005]; *Williams v Sahay*, 12 AD3d 366, 368 [2004]; *Cahill v County of Westchester*, 226 AD2d 571, 572 [1996]). Accordingly, defendants in a medical malpractice action are able to fulfill "their prima facie burden of establishing their entitlement to summary judgment by adducing expert opinion evidence that they did not deviate from good and accepted medical practice in their treatment of the [plaintiff]" (*Dandrea v Hertz*, 23 AD3d 332, 332 [2005]). "In opposition, the plaintiff must submit a physician's affidavit attesting to the defendant's departure from accepted practice, which departure was a competent producing cause of the injury" in order to defeat the defendant's motion (*Rebozo*

v Wilen, 41 AD3d 457, 458 [2007])

Defendant's expert establishes Dr. Butt's prima facie entitlement on the issue of restraints, insofar as Dr. Kolodny opines that based on the relevant law and regulations (Public Health Law §2803-c; 42 CFR 482.13 [as existed in September 2002]; 10 NYCRR 405.7) and hospital protocols it was not the standard of care to employ physical restraints on the decedent upon her admission to Interfaith in September 2002. The affirmation of plaintiff's expert does not rebut this part of Dr. Kolodny's affirmation. While Dr. Ackerman does mention the issue of restraints, he does so only in the context of admitting that restraints were not required in this case, but that other, nonrestrictive means were appropriate in order to avoid a fall. The failure of a plaintiff's expert to address salient issues with respect to the alleged departure by the defendants from good and accepted medical practice renders such expert's opinion insufficient to defeat the defendants' motion for summary judgment (*see generally, Ross*, 44 AD3d at 923; *Wager v Hainline*, 29 AD3d 569, 571 [2006]). Dr. Butt is therefore awarded summary judgment as to the issue of the use of restraints.

Plaintiff has, however, created questions of fact which mandate denial of the summary judgment motion, among them the issue of the use of 1 to 1 observation, bed rails, and the proximity of the decedent's bed to the nurses' station. Dr. Ackerman clearly states that the conditions which led to the assignment of 1 to 1 observation during the decedent's prior admission to Interfaith in March of 2001 were present when decedent was admitted in September 2002, and that it was a deviation from accepted medical practice for Dr. Butt not to order a 1 to 1 aide during the September 2002 admission. Dr. Ackerman further opines that

had such an aide been assigned this would have prevented decedent's fall and death.

In support of Dr. Ackerman's opinion that it was a departure not to place decedent as close to the nursing station as possible and to not place the bed rails up to prevent a fall, Dr. Ackerman cites the testimony of non-party witness Petra Thombs, decedent's daughter, that on the day of the fall Ms. Thombs reported to a nurse that her mother was disoriented, no longer ambulatory and talking about going outside. In fact, Ms. Thombs testified that her mother was talking "like she was out of her mind" and "didn't know where she was." Dr. Ackerman opines that both Ms. Thombs and plaintiff Paula Bell testified that the guardrails did not appear sufficient to secure the patient in the bed, with Ms. Thombs testifying that the mattress appeared "flush with the frame."

Dr. Butt testified that he examined decedent on the morning of the day she fell, and that standard fall precautions for a patient such as decedent included having the bed rails up and the bed low, and that these precautions were ordered and in effect at that time. Dr. Ackerman opines that it was a departure for Dr. Butt at that time, in light of decedent's unstable blood sugar levels and mental status, to not order a 1 to 1 companion and to not properly assess and remedy the fact that the risk precautions which had been ordered by another physician (i.e., proper bed rails and a room proximate to the nursing station) were not being properly implemented.

It is well settled that "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" as "[s]uch credibility issues can only be resolved by a jury" (*Feinberg v Feit*, 23 AD3d 517, 519 [2005]; *accord*

Bengston v Wang, 41 AD3d 625, 626 [2007]; *Graham v Mitchell*, 37 AD3d 408, 409 [2007]; *Dandrea*, 23 AD3d at 332; *Barbuto v Wintrop Univ. Hosp.*, 305 AD2d 623, 624 [2003]; *Fotinas v Westchester County Med Ctr.*, 300 AD2d 437, 439 [2002]; *Halkias v Otalaryngolgy-Facial Plastic Surgery Assocs.*, 282 AD2d 650, 651 [2001]; *Viti v Franklin General Hosp.*, 190 AD2d 790, 790-791 [1993]).

Here the court finds that issues of fact exist which preclude the granting of summary judgment, and these medical issues are set forth in the affirmations of the parties' respective experts. Plaintiff's expert's opinions that Dr. Butt departed from accepted standards of medical practice and that such departures were a substantial factor in causing the decedent's injuries and death are not "[m]ere conclusory statements, expressions of hope, or unsubstantiated allegations [which are] insufficient to defeat the motion" (*Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966, supra). When considered against defendant's expert's narratives and findings of an absence of departures and proximate cause, issues of fact have been raised which require resolution by a jury.

Accordingly, the motion by Dr. Butt for summary judgment is denied, except as to the extent indicated with respect to the issue of restraints.

This constitutes the decision and order of the court.

ENTER,

HON. GERARD H. ROSENBERG
J. S. C.