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SHORT FORM ORDER

INDEX No. 06-18114
CAL. No. 08-01814-MM

7-21-09

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

MOT # 1-MD
2-MD
3-MG

PRESENT:

Hon. MELVYN TANENBAUM
Justice of the Supreme Court

MOTION DATE 1-20-09
ADJ. DATE 4-6-09
Mot. Seq. 1,2,3 - ~~mtd~~

MELINDA POST, as Administrator of the Estate of MARY GIUDICE, Plaintiff, - against - COUNTY OF SUFFOLK and ST. CATHERINE'S HOSPITAL OF SIENNA, Defendants.	LITE & RUSSELL Attorneys for Plaintiff 212 Higbie Lane West Islip, New York 11795 CHRISTINE MALAFI, ESQ., Suffolk Cty Attorney By: Diana T. Bishop, Esq. Attorneys for Defendant County of Suffolk 100 Veterans Memorial Highway, P.O. Box 6100 Hauppauge, New York 11788-0099 BOWER & LAWRENCE, P.C. Attorneys for Defendant St. Catherine's Hospital 261 Madison Avenue New York, New York 10016

Upon the following papers numbered 1 to 17 read on these motions; Notice of Motion/ Order to Show Cause and supporting papers 1 - 4; 5 - 8 ; Notice of Cross Motion and supporting papers 9 - 12 ; Answering Affidavits and supporting papers 13 - 15 ; Replying Affidavits and supporting papers 16 - 17 ; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motions by defendant County of Suffolk and hospital St. Catherine of Siena Medical Center pursuant to CPLR 3212 granting summary judgment dismissing plaintiff's complaint are denied; and it is further

ORDERED that the motion by plaintiff, Melinda Post, as Administrator of the Estate of Mary Giudice, for leave to amend to complaint pursuant to CPLR 3025 is granted.

Plaintiff, Melinda Post, alleges that defendant, St. Catherine of Siena Medical Center ("hospital") and its staff, were negligent in the care and treatment of her mother, decedent Mary Giudice from June 2,

2005 through June 7, 2005. Plaintiff also alleges that defendant, County of Suffolk, negligently failed to provide home health care to decedent upon discharge from non-party St. Catherine of Siena Nursing Home ("the nursing home").

Decedent was a patient at the nursing home for approximately three months following surgery to correct a fractured left hip. Decedent's expected discharge date was June 1, 2005. Prior to that time, the Suffolk County Social Services Department consulted with decedent and plaintiff to determine the needed services. A discharge planner at the nursing home coordinated outside providers who would begin home health services on June 2. The record further reveals that decedent arrived home on the afternoon of June 1. Plaintiff testified that she assisted her by moving furniture so that decedent would have a clear path throughout the apartment. Plaintiff left decedent in her bed reading at approximately 9:00 p.m. On June 2, although a home health aide was expected to assist decedent, none arrived. As decedent was making lunch she fell and injured her right hip and right wrist. Decedent was transported to the hospital emergency room and was later admitted.

Non-party Dr. Ianotti, an orthopedic surgeon, examined decedent in the emergency room and testified that the decedent was alert and oriented. On the next morning, while making rounds on the medical-surgical floor, Dr. Ianotti found decedent unresponsive to stimuli and called for a house doctor. A chromotomograph (CT) scan revealed that decedent had sustained a massive right acute subdural hematoma. Decedent died on June 7, 2005. The hospital and County of Suffolk now move for summary judgment dismissing the action.

The elements of proof in an action to recover damages for medical malpractice are deviation or departure from accepted practice in the medical community and evidence that such departure was a proximate cause of injury or damage (***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *lv denied* 92 NY2d 814; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [1994]). To prove a prima facie case of medical malpractice, a plaintiff must establish that the defendant's negligence was a substantial factor in producing the alleged injury (*see*, ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 224 AD2d 674, 638 NYS2d 700 [1996]. Generally, a hospital will be charged under the doctrine of respondeat superior, where the employer is liable for a tort committed by its employee. This tort is considered to be negligence, not medical malpractice (*see*, ***Sutherland v New York Polyclinic Medical School & Hospital***, 273 AD 29, 75 NYS2d 135 [1947], *reh den* 298 NY 794 [1948]; ***Yaniv v Taub***, 256 AD2d 273, 683 NYS2d 35 [1st Dept 1998]). To establish a prima facie case of negligence, the plaintiff must show that the defendant's negligence was a substantial factor in bringing about the injury (***Mortensen v Memorial Hospital***, 105 AD2d 151, 157, 483 NYS2d 264 [1st Dept 1984]; *see also*, ***Harding v Noble Taxi Corp.***, 182 AD2d 365, 370, 582 NYS2d 1003 [1st Dept 1992]).

In support of the hospital's motion for summary judgment, it submits, *inter alia*, the pleadings, bill of particulars, and the examination before trial testimonies of Kevin Olson, M.D., Sandra Iannotti, M.D., Isabelle Hunsucker, RN and the plaintiff. By way of the bill of particulars, plaintiff alleges that defendant hospital failed to render appropriate medical services to decedent, that the employees were reckless, indifferent and negligent. In addition, plaintiff alleges that the hospital staff failed to detect decedent's condition, and failed to provide appropriate medical services.

Dr. Olson testified that he was decedent's internist and had treated her since August, 2003. He stated that her medical history included hypertension, mini strokes, smoking, emphysema, cataracts, glaucoma, peripheral vascular disease, hypercholesterolemia, and that she had gall bladder and breast surgery. He also noted that decedent had kidney problems and that a renal sonogram showed an atrophic right kidney. He stated that decedent had become confused and had visual hallucinations after the first hip surgery. A CT scan performed on March 25, 2005 showed atrophy and microvascular changes. He stated that after the fall on June 2, 2005, decedent was admitted to the hospital for a right hip fracture. On June 3, decedent experienced a respiratory arrest and was transferred to ICU. He reviewed the coroner's report which listed the cause of death as blunt force head trauma. He concluded that the head trauma happened as a result of the June 2 fall. He agreed that the emergency room notes showed no indication of head trauma.

Dr. Ianotti testified that she was the first doctor to see decedent on the morning of June 3 and reported her finding to the nurse and called for a house doctor to evaluate decedent. She denied that she found decedent on the floor, but that she was lying in the hospital bed.

Nurse Hunsucker, testified that on June 3 she was assigned to care for decedent. She stated that she was otherwise engaged with the night nurse at the time that Dr. Ianotti found decedent to be unresponsive. Ms. Hunsucker wrote the transfer note to ICU. She further stated that there was no report by Dr. Ianotti or any staff member of the hospital that decedent had fallen to the floor. She further stated that if a fall had occurred, she would have written an incident report and charted the incident in the nurse's notes.

Plaintiff testified that she is decedent's daughter. She was present when decedent was discharged from the nursing home on June 1 and was distressed that a home health aide would not be available until June 2. She stated that she was running a business at the time and was unable to stay with decedent during the day and returned on the evening of June 1 to be sure her mother was settled for bed. She stated that she left her mother at 9:00 p.m. The next morning, she called her mother every hour to check if the home health aide had arrived, but none had appeared. A nurse from Catholic services visited with decedent for approximately one hour and after she left, decedent fell. After the fall, plaintiff met decedent in the emergency room at the hospital and noted that her mother was irate that the aide did not come to her home and felt that she would not have fallen if someone was there to help her prepare lunch.

Dr. Chacko testified that he was called to perform a neurological consultation on June 3 in the ICU. He noted that decedent was unresponsive and comatose. She was on a respirator. He stated that the decedent's chart contained a note that she could not be aroused that morning. He stated that the CT scan which was performed that day showed that a hematoma had been present at that location for several days, or even weeks and fresh bleeding occurred over the hematoma. He did not observe any trauma to the head.

Ed Attard (Administrative Director of Regulatory Affairs and Risk Management at the hospital), asserts that he searched for but found no incident report regarding any fall by decedent. He further stated that it is the policy of the hospital for the nurses to complete an incident and/or accident report when they witness a fall by a patient.

In opposition, plaintiff's attorney asserts that in the absence of a note in the ambulance run sheet and the emergency room record that decedent suffered a head injury prior to admission to the hospital, that such injury was sustained while a patient in the hospital sometime between the evening of June 2 and the morning of June 3. Plaintiff submits, inter alia, the death certificate which states that the cause of death was blunt force trauma, due to an accident on June 2, 2005 in Kings Park at decedent's home.

To establish a prima facie case, a plaintiff need only offer sufficient evidence of negligence not a guess, speculation or surmise from which it is reasonable to conclude that it is more probable than not that the injury was caused by the defendant (***Kennedy v Peninsula Hospital Center***, 135 AD2d 788, 522 NYS2d 671 [2d Dept 1987]; or that defendants actions were a proximate cause (***Lahr v Tirrill***, 274 NY 112, 1937 NY LEXIS 824 [1937]). The record on the motion contains proof of acts of negligence or departures from accepted medical practices. It is an issue of fact whether the hospital failed to diagnose and treat the decedent's subdural hematoma caused by a fall in her home. Thus, plaintiff has raised an issue of fact which would require a trial. The hospital's motion for summary judgment is therefore denied.

Turning to the motion by the County of Suffolk, defendant submits, *inter alia*, the bill of particulars and the examination before trial testimony of Nurse Pat Chieffo. The County contends that it had no responsibility for the scheduling or commencement of home health services to be provided by an outside vendor to decedent at her home after discharge from the nursing home. By way of the bill of particulars, plaintiff alleges that the County of Suffolk Department of Social Services failed to provide a home health aide on June 2, 2005 after advising decedent and plaintiff that one would be present. She further alleges that the County is negligent for failing to render appropriate services and allowing decedent to function unattended at home.

Ms. Chieffo testified that she was the nurse for the Medical Services Bureau. Ms. Chieffo stated that her duty was only to authorize the services of a personal care aide for a patient if there is a medical necessity, not to coordinate them. The discharge planner has the duty to coordinate the services provided to the patient, and, in any event, when home health aides are assigned there is no specific time that they are to arrive at the client's home. She evaluated medicaid recipients for home care and evaluated decedent on May 31, 2005 at the nursing home. Ms. Chieffo stated that she received a call from the discharge planner at the nursing home before decedent was discharged to home. She was told that the contractor of the service, Utopia, did not have an aide to place for June 1 at decedent's home and it was not scheduled to begin until June 2. Ms. Chieffo stated that she would not give authorization for decedent's discharge without an aide and that the discharge was made by plaintiff. This assertion is disputed by plaintiff and is an issue of fact.

An agency of government is not liable for the negligent performance of a governmental function unless there existed "a special duty to the injured person, in contrast to a general duty owed to the public" (***Laratro v City of New York***, 8 NY3d 79, 828 NYS2d 280 [2006]). Such a duty, "a duty to exercise reasonable care toward the plaintiff," is "born of a special relationship between the plaintiff and the governmental entity" (***Pelaez v Seide***, 2 NY3d 186, 198, 778 NYS2d 111 [2004]). A special relationship can be formed in three ways: (1) when the municipality violates a statutory duty enacted for the benefit of a particular class of persons; (2) when it voluntarily assumes a duty that generates justifiable reliance by the person who benefits from the duty; or (3) when the municipality assumes positive direction and control in the face of a known, blatant and dangerous safety violation (***Pelaiz v Seide***, supra). Here, the plaintiff has

shown a special relationship with the County giving rise to a special duty. Accordingly, the County's motion is denied.

Dated: July 21, 2009

J.S.C.
MELVYN TANENBAUM