SUPREME COURT
COUNTY OF KINGS, PART 25
TANIA M. VELAZQUEZ,

Plaintiff,

-against-

THE CITY OF NEW YORK, EDMUND DECIO, PATRICK CLOUGH AND RICHARD D. CLOUGH, ***Defendants.***

Index No.: 3098/07

DECISION/ORDER

Hon. Kenneth P. Sherman

Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion for summary judgment:

Papers	Numbered
Notice of Motion and Affidavits Annexed.....	1-4; 5-6
Opposing Affidavits/Affirmations.....	7-8
Reply Affidavits/Affirmations.....	9
Suppl Affidavit	

In this personal injury and property damage action arising out of an automobile accident, the following motions have been consolidated for consideration and disposition:

(1) Defendant Richard D. Clough moves for an order, pursuant to CPLR 3212, dismissing the complaint insofar as asserted against him on the grounds that (a) he did not breach any duty owed to plaintiff Tania M. Velazquez (plaintiff), and (b) plaintiff did not sustain a "serious injury"as defined in Insurance Law § 5102 (d) (sequence no. 2); and

(2) Defendants the City of New York and Edmund Decio (collectively, the municipal defendants) cross-move for an order, pursuant to CPLR 3212, joining in that branch of Richard Clough's motion which seeks dismissal on the ground that plaintiff did not sustain a "serious injury" (sequence no. 3).

Overview

The dispositive question for this court is whether plaintiff has met the threshold requirement of suffering a "serious injury" so as to avoid the applicability of the New York No-Fault Law, which would otherwise bar her from pursuing her personal injury claims in this court. At this juncture, after discovery has been conducted, depositions have been held and a note of issue has been filed, the court holds that plaintiff has not sustained a "serious injury" and dismisses the first count of her complaint for personal injuries insofar as asserted against Richard Clough and the municipal defendants. Pursuant to CPLR 325 (d), plaintiff's remaining claim against Richard Clough and the municipal defendants for property damage to her car, estimated to be $2,034.41 according to her pre-trial testimony, is removed to the Civil Court of the City of New York, County of Kings, which, if it finds that plaintiff has not been fully reimbursed by her insurance carrier, will consider Richard Clough's additional contention that the use of his car by his brother Patrick was unauthorized.

Background

This is an action for personal injuries and property damage allegedly sustained by plaintiff as a result of several collisions that took place in the afternoon of May 17, 2006 at the intersection of Fifth Avenue and 32nd Street in Brooklyn, New York. Plaintiff owned and operated the first vehicle (a 2004 Honda Civic). Defendant Patrick Clough was the driver of the second vehicle (a 2001 Dodge Intrepid), which was owned by his brother, defendant Richard Clough. Defendant Edmund Decio operated a police cruiser in the course of his employment as a police officer with the NYPD. According to plaintiff's pre-trial testimony, while plaintiff was making a left turn from Fifth Avenue onto the 32nd Street, her car was struck twice on the driver's side, once by Patrick's car, and again "a couple of seconds" later when the police cruiser bumped Patrick's car, causing it to strike plaintiff s car for a second time (Velazquez Tr., at 27-28, 30-31, 33).[1]

At the scene of the accident, a police officer recommended to plaintiff to go to a hospital, but she declined, saying "Okay, after I get the report I will go to the hospital" (Velazquez Tr. at 38). A

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[1] Patrick, who attempted to flee the scene of the accident, was apprehended and arrested by P.O. Decio. He subsequently pleaded guilty to driving with a suspended license in violation of Vehicle & Traffic Law § 509 (1) and paid $150 in fines and surcharges (*see People v Patrick Clough*, Docket No. 2006CK001702 [Crim Ct, Kings County 2006]). He did not appear in this action, and a default judgment was entered against him on April 22, 2008 (Miller, J.), directing that an inquest and assessment of damages be held at the time of trial.

police officer then drove plaintiff in her car to the 72nd precinct (*id.* at 39). After an accident report was prepared, the police had an ambulance come to the 72nd precinct to take plaintiff to a hospital, but she again declined medical treatment (*id.* at 40).[2] Instead, she drove her car home (*id.* at 41). At approximately 5 p.m. on that day, her friend took her to Maimonides Hospital in Brooklyn (*id.* at 42). An X-ray of her neck was performed in the Emergency Room (*id.* at 42). After reviewing it, an ER physician informed plaintiff that "there was nothing wrong with [her]" and that she was "probably going to have [an injury of] soft muscle tissues" (*id.* at 43). She was discharged, without hospital admission, the same day with an instruction to take over-the-counter Tylenol as needed for pain relief (*id.* at 43). Her ER records have not been provided to the court.

Plaintiff, at the time of the accident, was 42 years of age, stood 5 feet tall, and weighed approximately 110 pounds. A part-time caretaker of her two young grandchildren, she was, at that time, unemployed and living with her two sons and her parents in her parents' house in Brooklyn. Her litigation history is notable for a lawsuit in July 1997, stemming from a September 29, 1995 accident, in which she allegedly was injured by a defective entrance door at a Duane Read store and sustained some unspecified "serious personal" as well as "permanent and lasting" injuries (*Velazquez v Duane Read, Inc.*, index No. 23810/97 [Sup Ct, Kings County] [verified complaint, dated July 8, 1997, ¶¶ 8, 11]).[3]

In her verified bill of particulars in this action, plaintiff alleges that, as a result of the accident in question, she sustained a combination of the following orthopedic and neurological injuries:

Orthopedic:

Neck

a. myofascial[4] sprain/strain of cervical spine,

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[2] She testified that "[o]ne of the officers told me that the ambulance was coming or was outside, I can't remember, and I told them that I wasn't going by ambulance because I wasn't hurt, but I was going to go after I got the police report" (Velazquez Tr. at 40).

[3] The court file in that action contains only the complaint and an affidavit of service, thereby indicating that it was either settled or abandoned.

[4] "Myofascial" is defined as "[o]f or relating to the fascia surrounding and separating muscle tissue" (Stedman's Medical Dictionary, 28th ed, at 1272). "Fascia" is defined as a "sheet of fibrous tissue that envelops the body beneath the skin; it also encloses muscles and groups of muscles and separates their several layers or groups" (*id.* at 700).

b. cervical spine sprain/strain,
c. straightening of the cervical lordosis compatible with muscle spasm, and
d. pain, tenderness, and restriction of motion of the neck, and pain radiating down into both shoulders, arms and hands with swelling of hands.

Back

a. upper back and mid-back pain,
b. myofascial sprain/strain of lumbosacral spine,
c. lumbosacral spine sprain/strain,
d. positive straight leg raising test on the left side,
e. decreased sensation in the left leg,
f. tenderness and restriction of motion with a radiating lower back pain,
g. sore muscle sensation, and
h. difficulty bending, rising from a sitting position, and walking.

Other

a. myofascial sprain/strain of shoulders, arms and thighs, and
b. pain, tenderness, and restriction of motion of shoulders, arms, hands, and legs.

Neurological:

a. headache, and
b. insomnia.

Analysis

Plaintiff asserts that her trauma constitutes a "serious injury" as set forth in the last three categories of Insurance Law § 5102 (d), which encompass the following consequences of the sustained injury or condition:

"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 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."

To establish 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 medical evidence in addition to medical opinions of the extent or degree of the limitation and its duration (*see Booker v Miller*, 258 AD2d 783, 784 [3d Dept 1999]; *Burnett v Miller*, 255 AD2d 541 [2d Dept 1998]). 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 the body part (*see Toure v Avis Rent-a-Car Sys., Inc.*, 98 NY2d 345, 353 [2002]).

In the alternative, plaintiff must prove that she sustained a medically determined injury or impairment which prevented her from performing substantially all of the material acts which constituted her usual and customary daily activities for 90 out of the 180 days immediately following the subject accident (*see Licari v Elliott*, 57 NY2d 230, 236 [1982]). This category refers to any medically determined non-permanent injury which endures for 90 days or more, and substantially limits performance of daily activities (*see Hezekiah v Williams*, 81 AD2d 261, 265 [2d Dept 1981]).

1. The Permanent Consequential Limitation and Significant Limitation of Use Claims

The moving defendants contend that the affirmed reports of Drs. Stanley W. Bleifer and Kuldip K. Sachdev demonstrate, prima facie, that plaintiff did not suffer a permanent consequential limitation of use of a body organ or member or a significant limitation of use of a body function or system.

(a)

Dr. Bleifer, a board-certified, New York State-licensed orthopedic surgeon, conducted an

independent medical examination of plaintiff on August 12, 2009. In his affirmed report, Dr. Bleifer detailed his findings based upon his review of plaintiff's medical records and his personal observations and objective testing. He noted that plaintiff was a driver in a vehicle that was hit from the left side and that she sustained no fractures or lacerations, nor lost consciousness. Dr. Bleifer stated that plaintiff presented with complaints of pain in the neck, back, and both shoulders, and that she had difficulty sleeping and lifting. As related by plaintiff to Dr. Bleifer, plaintiff stopped receiving treatment in December 2006 and that she was feeling "somewhat better."

Specifically, Dr. Bleifer examined plaintiff's cervical spine and shoulders, lumbar spine, knees, elbows, and wrists. Results of range of motion testing of the cervical spine were reported to be: normal 45 degrees of forward flexion; normal 60 degrees of extension, normal 45 degrees of right lateral flexion, normal 45 degrees of left lateral flexion, normal 80 degrees of right rotation, and normal 80 degrees of left rotation. There was no tenderness or muscle spasm noted on palpation of the cervical paraspinal muscle.

Results of range of motion testing of both shoulders were reported to be: normal 180 degrees of flexion, normal 40 degrees of extension, normal 180 degrees of abduction, normal 45 degrees of abduction, normal 55 degrees of internal rotation, normal 45 degrees of external rotation. There was no acromioclavicular joint, bicipital groove, or other shoulder joint tenderness.

Results of range motion testing of lumbosacral spine were reported to be: normal 90 degrees of flexion, normal 30 degrees of extension, normal 30 degrees of right and left lateral bending, normal 30 degrees of right and left rotation. There was no tenderness or muscle spasm to palpation.

After testing plaintiff's knees, Dr. Bleifer reported the following results: negative for swelling, effusion, or tenderness; range of motion from a normal 0 degrees of extension to a normal

of 135 degrees of flexion; normal 20 degrees of internal and external rotation.

After testing plaintiff's elbows, Dr. Bleifer reported the following results: negative for tenderness or swelling; normal 135 degrees flexion, normal 130 degrees extension, normal 90 degrees supination and pronation. In addition, Dr. Bleifer tested plaintiff's muscles and reflexes, as well as conducted a sensory examination of her spine from C4 down to S1, and found all of the results to be normal.

For his diagnosis, Dr. Bleifer opined, as follows:

> "1. Cervical sprain, resolved.
> 2. Lumbosacral sprain, resolved.
> 3. Bilateral shoulder sprain/strain, resolved.
> 4. Bilateral knee contusion, resolved.
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> [Plaintiff] sustained injuries to her neck, back, bilateral shoulders and bilateral knees and it was diagnosed and documented in the clinical records. Based on my examination, review of the submitted medical records and clinical experience [plaintiff's] condition was caused by the May 17, 2006 accident. [Plaintiff's] prognosis is good. [Plaintiff] is able to return to preloss activity levels including occupational duties without any restrictions. [Plaintiff] has reached pre-injury status. There is no permanency to her injuries and no residuals."

Dr. Bleifer concluded that "[b]ased on the orthopedic clinical evaluation, [plaintiff] revealed no functional disability at the present time. [Plaintiff] may continue with activities of daily living and is able to perform work activities."

(b)

Dr. Sachdev, a board-certified, New York State-licensed neurologist, conducted an independent medical examination of plaintiff on August 20, 2009. In his affirmed report, Dr. Sachdev recounted plaintiff's history, noting that plaintiff's X-rays of her neck were negative for fractures. He indicated that at the time of his examination, plaintiff stated to him that she "has pain in her neck that comes and goes . . . [t]he pain radiates to her shoulders and is aggravated by neck

bending and turning"; that she "has constant mild and lower back pain with radiation up to her tailbone . . . [t]he pain is aggravated by sitting, standing and walking. She stated that she cannot sleep on her side," but she had no numbness or weakness in her extremities.

Dr. Sachdev reported that he performed several tests, which yielded the following results: higher mental function (speech, language, and mood were normal); cranial nerve examination (the visual fields were full; pupils were equal and reactive to light; the extra-ocular movements were full; there was no nystagmus or diplopia; hearing was normal; the tongue was midline and the palate moved symmetrically; deep tendon reflexes (symmetrical and 2+ in all extremities); motor examination (normal tone in all extremities); sensory examination (normal sensations to light touch, pain, vibration, and position in all extremities; Tinel's sign and Phalen's sign (the tests for carpal tunnel syndrome) were negative bilaterally); coordination (finger-to-nose and heel-to-shin tests were normal bilaterally); gait (normal); Romberg's test (performed while the subject is standing with feet together, eyes closed) was negative; straight leg raising in supine position was at 60 degrees bilaterally of normal 90 degrees; straight leg raising in sitting position was at normal 90 degrees bilaterally; the thoracic spine and thoracic paraspinal muscles were normal (no tenderness or spasm); the muscle tone was normal in all extremities and the muscle strength was 5/5 in all extremities. Dr. Sachdev further reported that he tested the range of motion of plaintiff's neck, lumbar spine, and shoulder joints and obtained the following results:

Neck: normal 45 degrees flexion, extension, and right and left lateral flexion; right and left lateral rotation at 70 degrees out of normal 80 degrees.

Lumbar spine: flexion at 60-70 degrees out of normal 90 degrees, extension at 15 degrees out of normal 25 degrees, right and left lateral flexion at 15-20 degrees out of normal 25 degrees, and

right and left lateral rotation at 15-20 degrees out of normal 30 degrees. There was minimal vertebral tenderness at L4, L5, and S1 spine. There was no paraspinal muscle tenderness on the right or left side. There was no tenderness over the sciatic notch.

Shoulders: 180 degrees normal flexion, 50 degrees normal extension, 180 degrees normal abduction, 30 degrees normal adduction, 40 degrees normal internal rotation, and 90 degrees normal external rotation. There was no tenderness over the right or left shoulder joint.

Dr. Sachdev concluded that plaintiff had a normal neurological examination, that her cervical, thoracic and lumbar spine sprain/strain have been resolved, that there is no neurological disability and she was not disabled from working or from activities of daily living, and that there was no permanency to the cervical, thoracic or lumbar spine sprain/strain and there were no residuals as a result of the subject accident.

(c)

The court holds that based on the experts' affirmations, the moving defendants have satisfied their initial burden of making a prima facie showing that plaintiff has not sustained a serious injury under the permanent consequential limitation and/or significant limitation of use categories of Insurance Law § 5102 (d). While Dr. Sachdev noted some limitations in the range of motion of plaintiff's cervical and lumbar spine, as well as a decreased leg raising angle in the supine position, these limitations do not establish either a "permanent consequential" or "significant" injury: plaintiff's loss in the range of motion was low and limited to a few areas; her overall ability to function was not affected; she had no atrophy and required no surgery (*see Licari v Elliott*, 57 NY2d 230 [1982] [minor, mild, or slight limitations insufficient to establish a serious injury]; *Style v Joseph*, 32 AD3d 212, 214 n 1 [1st Dept 2006] [while defendant's expert found that plaintiff had a

minor restriction of motion of 160 degrees out of 180 degrees in forward elevation and abduction in her left shoulder, such a minimal limitation of the use of a shoulder did not establish a serious injury]; *Gaddy v Eyler*, 167 AD2d 67, 69-70 [3d Dept 1991], *affd* 79 NY2d 955 [1992] [a diagnosis of chronic cervical and lumbosacral strain evidenced only by impaired rotation of the spine and decreased leg raising was insufficient to survive a motion for summary judgment in the absence of further medical evidence of a specific injury suggestive of a permanent loss of use]).

The burden thus shifts to plaintiff to establish that there are triable issues of fact as to whether she suffered a "serious injury" under the permanent consequential limitation and/or significant limitation of use categories (*see Pommells v Perez*, 4 NY3d 566, 579 [2005]). In this regard, plaintiff must submit quantitative objective findings, in addition to opinions as to the significance of her injuries (*see Grossman v Wright*, 268 AD2d 79, 84 [2d Dept 2000]).

(d)

In opposition to the instant motions, plaintiff submits the affirmed report of her treating physician Dr. Mathew Lefkowitz, a board-certified, New York State-licensed anesthesiologist with a sub-specialty in pain medicine. He first treated plaintiff between May and December 2006 with respect to the subject accident. He later treated her between January and May 2007 with respect to her subsequent January 2007 accident. He next saw her in November 2009 and January 2010.

According to his affirmed report, Dr. Lefkowitz first saw plaintiff on May 25, 2006, or eight days after the subject accident, when she complained primarily of pain originating in the lower back, which radiated to the thighs bilaterally, as well as pain in both feet; mid-back pain; and neck pain radiating through the shoulders, down the arms to the hands bilaterally with marked pain in both elbows. She also complained of insomnia secondary to

pain. At the initial visit, Dr. Lefkowitz performed a musculoskeletal/neurologic examination, which yielded the following results:

Neck: Decreased range of motion. Positive pain on palpation of the bilateral paravertebral and superior trapezius musculature. No pain on palpation of the cervical facet joints.

Upper Extremities: Sensory and motor functions were equal bilaterally. No evidence of muscle atrophy. Reflexes were 2+ bilaterally.

Shoulders: Decreased range of motion of both shoulders. No swelling or pain with palpation.

Elbows and Wrists: Full range of motion; no swelling or pain with palpation.

Lower Back: Positive pain on palpation of the bilateral lumbar paravertebral musculature. No pain on extension, flexion, or rotation of the torso. No pain on palpation of the lumbar facet joints. No pain on palpation of the sacroiliac joints.

Lower Extremities: Positive straight leg raising test on the left. Decreased sensation in the left leg. The motor exam was normal. No evidence of muscle atrophy. Reflexes were 2+ bilaterally.

Knees: Decreased range of motion of the left knee secondary to pain. No swelling or pain with palpation.

Hips and Ankles: Full range of motion, no swelling or pain with palpation.

He diagnosed her with a myofascial sprain/strain of the neck, shoulders, arms, lower back, and thighs. He prescribed her a pain-reliever (a Lidoderm patch every 12 hours) and a sleeping aid (Trazadone). He referred her to physical therapy, which plaintiff had with a "Dr. Wong" between May and December 2006 (Velazquez Tr. at 15-16).[5]

Dr. Lefkowitz further stated that between June and December 2006, he treated plaintiff conservatively: medication management, a bilateral sacroiliac joint injection, and a home exercise program, which all provided moderate-to-good results. The bilateral sacroiliac joint injection,

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[5] No physical therapy records or reports have been submitted to the court.

performed in July 2006, was effective at providing a 30% pain relief for the ensuing several months.

Dr. Lefkowitz reported that plaintiff next returned to his office on December 21, 2006, complaining of pain originating in the lower back and radiating to the legs bilaterally. He diagnosed a "myofascial strain/sprain, as well as lumbosacral plexus lesion" and performed trigger point injections to the bilateral lumbar paravertebral musculature. He stated that plaintiff tolerated the procedure well and noted positive pain relief upon rest and recovery.

Dr. Lefkowitz next saw plaintiff on January 8, 2007, shortly after plaintiff was involved in another motor vehicle accident earlier that day (the subsequent accident), which engendered yet another lawsuit.[6] The verified complaint in that action alleges that plaintiff, at that time a full-time employee of a private bus company, was injured at 9:10 a.m. on January 8, 2007 when the school bus in which she was a passenger collided with a double-parked municipal sanitation truck (*see Velazquez v City of New York*, index No. 9694/08 [Sup Ct, Kings County]).[7] She sustained injuries to her neck, shoulder, back, and lower back in the subsequent accident (Velazquez Tr. at 9). She presented to Dr. Lefkowitz with complaints of pain originating in the neck and radiating through the superior trapezius musculature downward into the thoracic and lumbar paravertebral musculature, as well as to the coccyx. Her pain was associated with numbness and tingling in the thoracic paravertebral musculature and was aggravated the most while walking or standing. Sitting, forward bending, and rising to a standing position were also painful.

On January 8, 2007, Dr. Lefkowitz performed a musculoskeletal/neurologic examination,

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[6] Plaintiff's pre-trial testimony that this accident occurred on January 7, 2007 was incorrect (Velazquez Tr. at 8).

[7] The 2008 action was settled four months after its commencement (Velazquez Tr. at 7; Stipulation of Discontinuance with Prejudice, dated July 7, 2008).

which, despite the occurrence of the subsequent accident earlier that day, yielded better results than was the case when he first saw plaintiff in connection with the subject accident. Specifically, he found that:

Neck: Full range of motion. Positive pain on palpation of the superior trapezius musculature bilaterally. No pain on palpation of the cervical paravertebral musculature. No pain on palpation of the cervical facet joints.

Upper Extremities: Sensory and motor functions were equal bilaterally. No evidence of muscle atrophy. Reflexes were 2+ bilaterally.

Shoulders: Full range of motion of both shoulders. No swelling or pain with palpation.

Elbows and Wrists: Full range of motion; no swelling or pain with palpation.

Lower Back: Positive pain on palpation of the thoracic paravertebral musculature. No pain on extension, flexion, or rotation of the torso. No pain on palpation of the lumbar facet joints. No pain on palpation of the sacroiliac joints.

Lower Extremities: Negative straight leg raising test for both legs. Sensory examination was normal. The motor exam was normal. No evidence of muscle atrophy. Reflexes were 2+ bilaterally.

Knees: Full range of motion. No swelling or pain with palpation.

Hips and Ankles: Full range of motion, no swelling or pain with palpation.

At the January 8, 2007 visit, Dr. Lefkowitz diagnosed plaintiff as suffering from "neck pain secondary to myofascial strain/sprain." He prescribed her a muscle relaxant (Skelaxin) and referred her to physical therapy.

Between February and May 2007, Dr. Lefkowitz continued to treat plaintiff conservatively – medical management and a home exercise program, which all provided moderate-to-good results. In May 2007, he found that the myofascial sprain/strain had resolved, but he recommended that she continue with a home exercise program.

Dr. Lefkowitz next saw plaintiff approximately 2½ years later, on November 30, 2009, when

she presented with a primary complaint of "localized, non-radiating, left-side equally to right-side, low back pain," which was "aggravated most by sitting and forward bending." Her secondary complaint was neck pain, with the right side being greater than the left. She advised Dr. Lefkowitz that during the period between the visits, she self-medicated with over-the-counter Tylenol (500 mg.) as needed and performed home exercises, plus stretching, which all provided moderate-to-good pain relief. She denied undergoing a surgery, receiving any other injections, or seeing any other doctor since her prior visit to Dr. Lefkowitz 2½ years earlier.

After examination, Dr. Lefkowitz diagnosed plaintiff as suffering from "low back pain secondary to lumbar facet disease and lumbago, as well as neck pain secondary to cervicalgia." He performed trigger point injections to the bilateral lumbar paravertebral musculature. Plaintiff tolerated the procedure well and noted positive pain relief upon rest and recovery.

Dr. Lefkowitz last saw plaintiff on January 5, 2010 when she informed him that the trigger point injections were effective at providing excellent (100%) pain relief lasting approximately two weeks, but that her complaints had returned. Dr. Lefkowitz re-affirmed his diagnosis of November 30th and "advised the patient to continue with her medication, as well as her home exercises." He administered no trigger point injections at the January 5th visit.

In summation, Dr. Lefkowitz states that "there is a causal relationship between the patient's . . . diagnosis, symptoms, and treatment and the incident occurring on May 17, 2006."

(e)

The court holds that Dr. Lefkowitz's affirmation fails to raise an issue of fact in opposition to the moving defendants' prima facie showing that plaintiff has not suffered either a permanent consequential limitation of use of a body organ or member or a significant limitation of use of a body

function or system (*see DeFilippo v White*, 101 AD2d 801, 802 [2d Dept 1984]). First, when he initially examined plaintiff on May 25, 2006, Dr. Lefkowitz failed to set forth her actual ranges of motion and to compare those findings to normal ranges of motion (*see Johnson v Tranquille*, 70 AD3d 645 [2d Dept 2010]). Second, his January 8, 2007 findings indicated that plaintiff had normal range of motion readings. Third, he failed to obtain plaintiff's neck X-ray from Maimonides hospital, nor did he order any MRIs, CT scans, or additional X-rays. Fourth, he avoids opining as to whether plaintiff has suffered a permanent or significant serious injury; rather, he only states that there is a causal relationship between the subject accident and plaintiff's diagnosis, symptoms, and treatment. Essentially, he indicates that plaintiff sustained soft tissue injuries which are of an insignificant nature and which have resolved (*see Barzey v Clarke*, 2004 WL 5529076 [Sup Ct, Queens County 2004], *affd* 27 AD3d 600 [2d Dept 2006]). Plaintiff's subjective complaints of continuing pain do not support her claim (*see Scheer v Koubek*, 70 NY2d 678, 679 [1987]).

Moreover, even where there is medical proof, when additional contributory factors interrupt the chain of causation between the accident and claimed injury – such as a gap in treatment or an intervening medical problem – summary dismissal of the complaint may be appropriate (*see Charley v Goss*, 54 AD3d 569, 570 [1st Dept 2008], *affd* 12 NY3d 750 [2009]). Here, there is an unexplained gap in plaintiff's treatment. Dr. Lefkowitz treated plaintiff with respect to the subject accident from May to December 2006. He re-examined her in January 2007 as a result of the subsequent accident and he treated her with respect to the subsequent accident from January to May 2007. He next saw her in November 2009, or more than 2½ years afterward, apparently in response to the moving defendants' summary judgment motions. In addition, plaintiff re-injured her neck, shoulder, back, and lower back in a subsequent accident in January 2007. Accordingly, plaintiff's submissions are

insufficient to raise a triable issue of fact as to whether she sustained a serious injury under the permanent consequential limitation and/or significant limitation of use categories of Insurance Law § 5102 (d).

2. The 90/180 Claim

Plaintiff's additional legal theory is that her injuries prevented her from performing "substantially all" of her customary daily activities in some significant way for 90 days of the first 180 days immediately following the accident. In *Licari*, the Court of Appeals held that:

> "The words 'substantially all' should be construed to mean that the person has been curtailed from performing his usual activities to a great extent rather than some slight curtailment. As to the statutory 90-180 day period of disability requirement, it should be considered a necessary condition to application of the statute" (*id.* at 236).

The conclusion reached by the moving defendants' physicians that plaintiff did not sustain a serious injury, which was based on examinations performed more than three years after the accident, is insufficient to establish she did not sustain a "serious injury" in the 90/180 category (*see Frier v Teague*, 288 AD2d 177, 178 [2d Dept 2001]). Nevertheless, the moving defendants may rely on plaintiff's bill of particulars and her deposition testimony to disprove her 90/180 claim (*see Walcott v Ocean Taxi, Inc.*, 22 Misc 3d 1117 [A], 2009 WL 241733, *2, 2009 NY Slip Op 50158 [U] [Sup Ct, Kings County 2009]).

In her bill of particulars, plaintiff alleged that she was "substantially, although not totally confined to home and to bed from May 17, 2006 to September 1, 2006, except for visits to the doctor." At her examination before trial in May 2009, she testified in a conclusory fashion tailored to meet statutory requirements, that she was confined to her home "for a few months" or "probably three months" (Velazquez Tr. at 51-52). She did not testify that her injuries substantially impacted

on all of her activities of daily living (*id.* at 53), except to the extent that she could not "really pick up [her] grandchildren for too long," jog as many miles as she did before the subject accident, wear high heels, and carry a lot of grocery bags (*see Pacheco v Conners*, 69 AD3d 818 [2d Dept 2010]; *Auguste v PTM Mgt. Corp.*, 22 Misc 3d 1102 [A], 2008 WL 5431384, *8, 2008 NY Slip Op 52581 [U] [Sup Ct, Kings County 2008]).

The record is further devoid of any medical evidence as to the effects of her alleged injuries on her ability to function. Dr. Lefkowitz's affirmation is silent as to whether he directed that plaintiff curtail any of her daily activities, nor did he indicate whether any of plaintiff's alleged injuries rendered her unable to perform normal, daily tasks (*see Atkinson v Oliver*, 36 AD3d 552, 553 [1st Dept 2007]; *Mu Ying Zhu v Zhi Rong Lin*, 1 AD3d 416, 417 [2d Dept 2003]). Plaintiff has submitted no X-rays or other radiological studies to provide objective confirmation of the claimed injuries. In view of the overall insufficiency of her allegations, plaintiff has failed to raise a triable issue of fact in the form of competent objective evidence substantiating her 90/180-day claim (*see Sainte-Aime v Suwai Ho*, 274 AD2d 569, 570 [2d Dept 2000]).

Based on the foregoing, and mindful of the legislative intent to limit personal injury actions in these matters to cases of significant injury (*see Dufel v Green*, 84 NY2d 795, 798 [1995]), it is the opinion of the court that plaintiff has failed to raise a triable issue of fact on "serious injury" (*see* CPLR 3212 [b]); therefore, Richard Clough and the municipal defendants are entitled to summary judgment dismissing the first count of her complaint (*see George v Suarez*, 2010 NY Slip Op 01919 [2d Dept 2010]).

Conclusion

Richard Clough's motion and the municipal defendants' cross motion are granted to the

extent that plaintiff's first cause of action, insofar as asserted against them, is dismissed for lack of a "serious injury." Pursuant to CPLR 325 (d), plaintiff's remaining cause of action against Richard Clough and the municipal defendants for property damage to her car is removed to the Civil Court of the City of New York, County of Kings. Payment of further fees of such character as may have been paid in this court shall not be required in said civil court, and such fees shall be deemed to have been paid herein. The county clerk is directed to transfer all papers on file in this action to said civil court.

The foregoing constitutes the decision and order of the court.

March 31, 2010

Kenneth P. Sherman
Justice Supreme Court