Alvarez v NYLL Mgt., LTD
2012 NY Slip Op 33752(U)
December 13, 2012
Supreme Court, Bronx County
Docket Number: 306222/2009
Judge: Betty Owen Stinson
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 FILED Dec 17 2012 Bronx County Clerk

NEW YORK SUPREME COURT - COUNTY OF BRONX
IAS PART 08

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MARTA ALVAREZ

Plaintiff, INDEX No. 306222/2009

-against-

NYLL MANAGEMENT, LTD., and LEONCIO PEGUERO,

Defendants.

Present:
HON. BETTY OWEN STINSON
----------X J.S.C.

The following papers numbered 1 to 4 read on this motion for summary judgment,
Noticed on 08–4-2011 and submitted as No. 23 on the Calendar of 09-1-2011

	PAPERS NUMBERED
Notice of Motion -Exhibits and Affidavits Annexed.....	1
Order to Show Cause.....	
Answering Affidavits and Exhibits.....	2
Reply Affidavits and Exhibits.....	3
Stipulations.....	
Memorandum of Law.....	4

Upon the foregoing papers this motion is decided per annexed memorandum decision.

Dated: December 13, 2012
Bronx, New York

BETTY OWEN STINSON, J. S.C.

 FILED Dec 17 2012 Bronx County Clerk

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------X

MARTA ALVAREZ,

Plaintiff,

INDEX № 306222/2009

-against-

DECISION/ORDER

NYLL MANAGEMENT, LTD., and LEONCIO PEGUERO,

Defendants.

----------X

HON. BETTY OWEN STINSON:

This motion by defendants for summary judgment dismissing the plaintiffs' complaint is granted.

On April 4, 2009, plaintiff was driving her PT Cruiser when she stopped suddenly and was rear-ended by a vehicle owned and operated by defendants. Plaintiff was removed to the Emergency Department of St. Barnabas Hospital where she was evaluated and released. She commenced this lawsuit against the defendants, alleging permanent injuries to her neck, right shoulder and right knee. She filed her note of issue on April 26, 2011 and defendants made the instant motion for summary judgment dismissing her complaint for a failure to demonstrate she had suffered a serious injury as a result of the subject motor vehicle accident.

Summary judgment is appropriate when there is no genuine issue of fact to be resolved at trial and the record submitted warrants the court as a matter of law in directing judgment (*Andre v Pomeroy*, 35 NY2d 361 [1974]). A party opposing the motion must come forward with admissible proof that would demonstrate the necessity of a trial as to an issue of fact (*Friends of Animals v Associated Fur Manufacturers*, 46 NY2d 1065 [1979]).

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In order to recover for non-economic loss resulting from an automobile accident under New York's "No-Fault" statute, Insurance Law § 5104, the plaintiff must establish, as a threshold matter, that the injury suffered was a "serious injury" within the meaning of the statute. "Serious injury" is defined by Insurance Law § 5102(d) to include, among other things not relevant here, a "permanent loss of use of a body organ, member, function or system", a "permanent consequential limitation of use of a body organ or member", a "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 constitutes such person's usual and customary activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment."

The initial burden on a threshold motion is upon the defendants to present evidence establishing that plaintiff has no cause of action, i.e.: that no serious injury has been sustained. It is only when that burden is met that the plaintiff would be required to establish *prima facie* that a serious injury has been sustained within the meaning of Insurance Law § 5102(d) (*Franchini v Palmieri*, 1 NY3d 536 [2003]; *Licari v Elliot*, 57 NY2d 230 [1982]).

To make out a *prima facie* case of serious injury, a plaintiff must produce competent medical evidence that the injuries are either "permanent" or involve a "significant" limitation of use (*Kordana v Pomelito*, 121 AD2d 783 [3rd Dept 1986]). A finding of "significant limitation" requires more than a mild, minor or slight limitation of use (*Broderick v Spaeth*, 241 AD2d 898, *lv denied,* 91 NY2d 805 [1998]; *Gaddy v Eyler*, 167 AD2d 67, *aff'd,* 79 NY2d 955 [1992]). Strictly subjective complaints of a plaintiff unsupported by credible medical evidence do not suffice to establish a serious injury (*Scheer v Koubek*, 70 NY2d 678 [1987]). To satisfy the

requirement that plaintiff suffered a medically determined injury preventing her from performing substantially all of her material activities during 90 out of the first 180 days, a plaintiff must show that "substantially all" of her usual activities were curtailed (*Gaddy*, 167 AD2d 67). The "substantially all" standard "requires a showing that plaintiff's activities have been restricted to a great extent rather than some slight curtailment" (*Berk v Lopez*, 278 AD2d 156 [1st Dept 2000], *lv denied*, 96 NY2d 708).

Allegations of sprains and contusions do not fall into any of the categories of serious injury set forth in the statute (*Maenza v Letkajornsook*, 172 AD2d 500 [2nd Dept 1991]). Where surgery resolved the injury, with no permanent loss of use or limitation, there is no issue of permanent serious injury (*Fortune v Sacks & Sacks*, 272 AD2d 277 [1st Dept 2000]).

"Proof of a herniated disc, without additional objective medical evidence establishing that the accident resulted in significant physical limitations, is not alone sufficient to establish a serious injury" (*Pommels v Perez*, 4 NY3d 566 [2005]). Nor is evidence of radiculopathy (*Casimir v Bailey*, 70 AD3d 994 [2nd Dept 2010]). A plaintiff's subjective complaints of pain are insufficient, without more, to establish that herniated discs constitute a serious injury (*Pierre v Nanton*, 279 AD2d 621 [2nd Dept 2001]).

The defendant may rely on medical records and reports prepared by plaintiff's treating physicians to establish that plaintiff did not suffer a serious injury causally related to the accident (*Franchini*, 1 NY3d 536). Once the burden has shifted however, an affidavit or affirmation by the person conducting a physical examination of the plaintiff is necessary to establish a serious injury, unless plaintiff is offering unsworn reports already relied upon by the defendant (*Grossman v Wright*, 268 AD2d 79 [3rd Dept 2000]; *see also Zoldas v Louise Cab Co.*,108 AD2d 378 [1st Dept

1985]). The affirmation must set forth the objective medical tests and quantitative results used to support the opinion of the expert (*Grossman*, 268 AD2d 79). "An expert's *qualitative* assessment of a plaintiff's condition also may suffice, provided that the evaluation has an objective basis and compares the plaintiff's limitations to the normal function, purpose and use of the affected body organ, member, function or system (cite omitted)" (*Toure v Avis Rent A Car Systems*, 98 NY2d 345 [2002]). A conclusory affidavit of the doctor does not constitute medical evidence (*Zoldas*, 108 AD2d 3778; *see also Lopez v Senatore*, 65 NY2d 1017 [1985] [conclusory assertions tailored to meet statutory requirements insufficient to demonstrate serious injury]).

In support of the motion, defendants offered copies of the pleadings; the note of issue; the bill of particulars; the police accident report; the FDNY Emergency Medical Services ("EMS") report; the St. Barnabas Hospital Emergency Department record; an Initial Examination Report from the Office of Alex Veder, M.D., performed by Dr. Ketan Vora; x-ray and MRI reports; the Lennox Hill Hospital operative records; the affirmations of Dr. Peter A. Ross and Dr. Edward M. Decter and plaintiff's deposition testimony. The bill of particulars alleged injuries including a torn tendon in plaintiff's right shoulder, chondromalacia of plaintiff's right knee with synovitis, and bulging cervical discs at C2-3 through C4-5. Plaintiff alleged she was confined to her bed and home for three weeks following the subject accident and three more weeks after each of her two surgeries, making a total of approximately 63 days she was allegedly unable to carry out substantially all of her normal and customary activities in the first 180 days after the accident.

The EMS report recorded plaintiff as complaining, "I have a slight headache", that she has a prior medical history of depression and takes Levothyroxine, Zoloft and Calcium. She refused a cervical collar, "head bed" or long board. The report continued:

> 40 y/o (female) pt fnd ambulatory on scene. Pt sts that she stopped quick after seeing an RMP IFO her and the vehicle behind her rear-ended her vehicle. No damage to pts vehicle - minor damage to the vehicle that hit pts vehicle. Pt sts that she is basically really nervous.

Plaintiff's chief complaint in the Emergency Department of St. Barnabas was headache and she also complained of right shoulder pain. She reported that her air bags did not deploy in the accident and her prior medical history included thryroid surgery, arthritis, depression and anxiety. Range of motion in all her extremities was "intact". The final diagnostic impression, after a negative CT scan of her brain, was closed head injury and right shoulder sprain.

Ten days after the accident, on April 14, 2009, plaintiff was examined by Dr. Ketan Vora. She complained to him of pain in her head, chest, neck, mid back, right shoulder and both knees. Her occupation was listed as a medical assistant, not currently working.

Dr. Vora found spasm and tenderness in plaintiff's cervical spine and pain upon range of motion, but negative Spurling's and Cervical Distraction tests. She had decreased range of motion in the cervical spine, expressed numerically and compared to normal measurements. There was no tenderness or spasm in the thoracic spine. Dr. Vora found spasm and tenderness in plaintiff's lumbar spine, decreased range of motion with expressions of pain, but a negative straight leg raising test and negative heel and toes test. A test for pain in the sacroiliac joint was positive. He initially concluded that plaintiff had suffered hyper extension/ hyper flexion (whiplash) in her cervical and lumbar spine.

Although plaintiff complained of pain in her right shoulder with movement, her range of motion in *both* shoulders was decreased by the same amount and in the same planes of motion. Her Drop Arm sign was negative. There was no sign of painful arc impingement. Both knees had

full range of motion with no effusion, no pain and a negative McMurray's sign. There was minimal swelling at the posterior aspect of the right knee. Dr. Vora's diagnostic impressions included post-traumatic headache; acute cervical, thoracic and lumbar spine sprain/strain; and right shoulder and right knee sprain/strain.

X-ray studies of plaintiff's right and left shoulders and right and left knees, performed in Dr. Veder's office by Dr. Stephen B. Losik, showed no acute fractures or dislocations. The articular surfaces were intact. There were no significant soft tissue abnormalities. The AC joints of plaintiff's shoulders were intact. The knees showed no significant joint effusion. X-rays of plaintiff's cervical, thoracic and lumbar spine were also negative for fractures or dislocations.

MRI studies at Socrates Medical Health, P.C., included an MRI of plaintiff's right shoulder on May 1, 2009 performed by Dr. Charles DeMarco and showing a subacromial spur impinging upon the supraspinatus muscle tendon complex. The increased signal in her supraspinatus tendon was "consistent" with a partial tear or with tendinosis. Another signal abnormality in the humeral head was consistent with a contusion or with a bone bruise.

The MRI of plaintiff's right knee performed on April 17, 2009 by Dr. Ronald J. Roskin was entirely normal. The MRI of plaintiff's cervical spine performed on April 25, 2009 by Dr. Roskin showed desiccation and posterior bulging of intervertebral discs at C2-3, C3-4 and C4-5.

Handwritten notes by Dr. Mark McMahon, dated April 20, 2009; May 14, 2009; June 11, 2009; July 6, 2009 and August 14, 2009 were extremely brief and only partially legible. They show plaintiff complained to him of pain in her right shoulder and right knee. Dr. McMahon suggested arthroscopic surgery for both areas. The post-surgical notes recorded that plaintiff was "progressing well" and "doing well". There were no final evaluations beside the one documented

visit following each surgery and noting a plan to continue physical therapy. There were no final range of motion evaluations or any other type of evaluation offered after the physical therapy was competed.

Dr. Peter Ross affirmed that he reviewed the MRI of plaintiff's right shoulder performed on May 1, 2009. He found degenerative changes in the anterior and posterior glenoid labra and lateral down-sloping of the acromion, which, together with hypertrophic changes at the AC joint space resulted in an impingement and tendinosis. The down-sloping was developmental and not caused by the accident. There were no tears evident on the film. Dr. Ross stated that the degenerative bony productive changes and resulting impingement were all chronic in nature, pre-existing, could not have developed in the 27 days after the subject motor vehicle accident, and were not caused by the accident. The tendinosis changes were degenerative in nature, associated with the chronic impingement and pre-existed the subject accident.

Dr. Ross also reviewed the MRI of plaintiff's right knee, performed on April 17, 2009, and found mild degenerative changes with no evidence of tears in the medial or lateral menisci. The ACL was intact. There were mild degenerative changes under the patella, and no fractures, dislocations or bone bruises. The changes were not acute, but chronic in nature, pre-existed the accident and could not have been caused by the subject accident.

Dr. Ross reviewed the MRI of plaintiff's cervical spine, performed on April 24, 2009. He found mild desiccation of the cervical discs at C2-3 and C3-4 and minimally at C4-5. He saw no herniated or bulging discs or anything that could have been caused by the subject accident.

Dr. Ross reviewed an MRI of plaintiff's lumbar spine performed on May 8, 2009 finding spondylosis changes from L4 through S1 and desiccation of lumbar discs from L4-5 and L5-S1.

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There were no herniations or bulges except for a herniated disc at L4-5 and a bulging disc at L5-S1, with clinical correlation of that impression recommended. All these conditions pre-existed the subject accident and could not have been produced in the one month and four days after the accident. The bulging disc at L5-S1 and herniated disc at L4-5 are degenerative in nature and associated with vertebral and discogenic changes.

The Operative Report by Dr. Mark McMahon records arthroscopic surgery of plaintiff's right shoulder on June 23, 2009. Dr. McMahon found a partial tear of the supraspinatus tendon, an inflamed rotator cuff/bursa, and fibrotic and synovial-like tissue, all of which was "gently debrided". He released the coracromial ligament and burred the acromion until it was smooth. His post-operative diagnosis was right shoulder supraspinatus partial tear with impingement bursitis, synovitis and fibrosis.

The Operative Report of arthroscopic surgery involving plaintiff's right knee, performed by Dr. McMahon on August 6, 2009, shows he shaved damaged cartilage. He found the menisci and ACL to be intact and normal. His post-operative diagnosis was right knee chondomalacia of the patella with synovitis and fibrosis.

Dr. Edward Decter examined plaintiff for the defendants on September 21, 2010. She complained of pain in her right shoulder, right knee, cervical spine and lumbar spine. She reported total decreased sensation in her right upper extremity in a non-anatomical distribution which did not make sense to Dr. Decter. He found full range of motion in plaintiff's right shoulder, right knee, cervical spine and lumbar spine, measured numerically and compared to the normal. There was no tenderness in the cervical or lumbar spine and muscle testing in the upper and lower extremities was normal. Hawkin's and O'Brien's tests of the right shoulder were

negative. Plaintiff had full extension of her right knee, and there was no crepitus, effusion or medial joint line pain. Lachman's sign and anterior drawer tests were negative.

Dr. Decter's impression, after his physical examination of the plaintiff and independent review of the MRI films and operative records, was that plaintiff had some osteoarthritis of her AC joint in her right shoulder with some tendinitis. The subacromial spur and impingement were not causally related to the subject accident. Regarding her right knee, she had no signs of a residual chondromalacia, there was no crepitus under the patella, no effusion and no pain under the patella. He saw evidence of degenerative discogenic disease at L4-5 and L5-S1 in her lumbar spine.

It was Dr. Decter's opinion, within a reasonable degree of medical certainty, that plaintiff has not sustained a permanent orthopedic injury to the right shoulder or right knee. Based on the "minimal" findings on the MRIs, he did not believe that she had required surgery in either area. Regarding her cervical and lumbar spine, plaintiff complained of non-anatomical decreased sensation in her right upper arm and right lower leg , but did not exhibit any objective mechanical or neurogenic abnormalities to support those complaints of numbness in non-anatomical positions. Her subjective complaints were not consistent with the objective findings. It was Dr. Decter's further opinion that plaintiff has not sustained permanent injuries to the right shoulder, neck, low back or right knee.

Plaintiff testified that she is 4' 11" tall and weighed about 141 pounds at the time of the subject accident (deposition, August 18, 2010 at 15). She struck her right shoulder on the seat and her right knee on the dashboard (*id.* at 22). She also injured her neck and low back (*id.* at 22-23). She complained of headache at the hospital (*id.* at 30). She was confined to her home for about

two weeks after the accident and again for about 3 and one half weeks after each operation (*id.* at 49-50). The cost of repairing her PT Cruiser after the accident was $45.00 for the replacement of two brake lights in the back (*id.* at 24).

In April 2010, plaintiff began again treating at Bronx Lebanon Hospital for pain in her right arm (*id.* at 42). She has received three injections (*id.* at 45). She was not clear whether the injections were for pain in her arm or in her back, both of which she mentioned in connection with the injections. She carries a cane for the "hernia" in her back and uses it about three times a week (*id.* at 45, 50). Presently, her neck, low back and right shoulder bother her all the time (*id.* at 51). She feels "discomfort" all the time in her right knee (*id.* at 52). She cannot walk or clean house "a lot" (*id.* at 53). Her husband and son have to help (*id.*). Her husband must help with shopping; she cannot shop as before (*id.* at 54-55). She can only babysit her four-year-old son now (*id.* at 53). She does not go out much (*id.* at 55).

In opposition to the motion, plaintiff offered her own affidavit, an affirmation by Dr. McMahon, and the same operative reports and MRI reports by Dr. DeMarco and Dr. Roskin offered by defendants. Plaintiff stated in her July 21, 2011 affidavit that, "immediately" after the accident, she felt pain in her right shoulder, right knee and in her neck. She also stated that she felt that pain the day after the accident. A few days later she saw Dr. McMahon and he referred her to Dr. Veder. She had physical therapy for about nine months. She discontinued her therapy because she "was told" it would provide only temporary relief and she was not improving, her no-fault benefits had expired and she could not afford more treatment. Her ability to lift "heavy objects", raise and use her right arm and do household chores has been "dramatically affected": she still has "difficulties" doing these things. Before the accident, she could do these things pain-

free. She had no prior or subsequent injuries and is still in pain now. All her present physical, social and occupational limitations (otherwise unspecified) were caused by the subject accident. She was "advised" her injuries were not degenerative.

Dr. McMahon stated in his affirmation dated August 4, 2011 that he examined the medical records in connection with this accident and first examined plaintiff on April 20, 2009. She told him she had sustained injury to her neck, back, right shoulder and right knee in a rear-end accident. She told him she had suffered no prior or subsequent injury to those areas. Plaintiff had decreased range of motion when examined. MRIs showed bulging cervical spinal discs and a partial tear of the supraspinatus tendon in plaintiff's right shoulder. Dr. McMahon's initial diagnosis was rotator cuff tear in right shoulder, torn meniscus and chondromalacia of the patella in her right knee. Dr. McMahon performed surgery on her right shoulder and right knee. He was "advised" that she discontinued her physical therapy treatments in December 2009 when she was told she had reached maximum medical improvement, was receiving only temporary relief from treatment and her no-fault benefits had expired.

He stated that, on July 25, 2011, approximately two years after her surgeries, plaintiff came back to him for a "follow-up" examination. She complained of pain in her neck, back, right shoulder and right knee. She has had three trigger point injections in her cervical spine. Range of motion in plaintiff's right shoulder, right knee and cervical spine was restricted, measured numerically and compared to normal measurements. Dr. McMahon made no mention of plaintiff's lumbar spine. Dr. McMahon concluded that plaintiff has reported slight improvement but has not demonstrated full and complete recovery. Dr. McMahon's prognosis for a full and complete recovery is "guarded without additional treatment". On the basis of her subjective

complaints, the history of her injury and his physical examination findings, Dr. McMahon concluded that plaintiff suffered cervical muscle spasms and radiculopathy, bulging cervical discs at C2-3 through C4-5, and internal derangement of her right shoulder and right knee. These injuries are serious, significant and permanent. Dr. McMahon stated that plaintiff has sustained a permanent significant loss of the use and function of her cervical spine, right shoulder and right knee. Plaintiff has sustained permanent injuries and disabilities which are causally related to the subject automobile accident and "not degenerative changes".

Defendants have established their entitlement to summary judgment which plaintiff has not refuted with admissible medical evidence. Defendants met their burden with the EMS record stating that plaintiff complained of no more than a slight headache at the scene of the accident. At the emergency room, she added a complaint of right shoulder pain, but no mention of neck injury, low back injury or right knee injury. She noted a positive history of arthritis. It was not until ten days later that she complained of pain in her head, chest, neck, mid-back, right shoulder and both knees. Although Dr. Vora found decreased range of motion in plaintiff's shoulders, the range of motion was the same in both the allegedly injured and uninjured shoulder. Both knees had full range of motion and no pain. Dr. Vora's initial impression was that plaintiff had suffered only whiplash injuries to her neck and back and only sprains in the other areas.

The original MRI reports showed a spur in the right shoulder and a possible partial tear versus tendinosis. The right knee was reported to be normal and the cervical spine showed a degenerative condition with bulging discs. No conclusions as to causation were noted. When the MRI studies were reviewed by Dr. Ross, he found degenerative conditions in the cervical spine, right shoulder and only a mild degenerative condition in the right knee. An MRI of plaintiff's

lumbar spine was also reviewed showing a degenerative condition as well. All positive findings were deemed to be pre-existing, chronic, degenerative conditions that could not have developed in the short time following the subject accident. Dr. McMahon's Operative Reports recorded his surgery as correcting the partial tear and the impingement in the right shoulder and the right knee chondromalacia that he found upon arthroscopic inspection. The most recent examination by Dr. Decter showed full range of motion in all relevant areas of plaintiff's body and no permanent orthopedic injury to plaintiff's right shoulder, right knee, neck or low back. Dr. Decter found no objective evidence to support plaintiff's subjective complaints of pain.

Finally, plaintiff's testimony as to her present condition produced only vague complaints of daily "discomfort" and "bother" from the disputed areas and an inability to go out "much" or clean "a lot", insufficiently detailed descriptions of specific serious injuries. Her claims of two weeks of confinement to her bed and home after the accident and three and one-half weeks of the same after each surgery do not add up to 90 days of an inability to perform substantially all her material acts out of the first 180 days following the accident. At most, they would constitute 70 days, assuming the recovery period after arthroscopic surgery to be so substantially confining as to conform with the statute's definition of serious injury. Plaintiff also testified that she continued to "baby-sit" her own four-year-old child.

In sum, defendants demonstrated by admissible evidence that any of the claimed pain and limitations suffered by plaintiff were either as transitory as whiplash or were minor and caused entirely by pre-existing degenerative conditions unrelated to the subject accident.

Plaintiff's submissions in opposition do not raise an issue of fact for trial. Her vague and subjective complaints of pain and limitation are not sufficient to defeat summary judgment. Her

claim that she felt pain in her neck and right knee "immediately" after the accident, is contradicted by the documentary evidence. There is no mention of such injuries in either the EMS report or the hospital emergency department records. Ten days later, Dr. Vora found range of motion in both plaintiff's shoulders to be the same, although she complained of pain only in the right shoulder. The "injured" shoulder was no more limited in movement than the uninjured one. Both knees were capable of full range of motion with no effusion or pain. A minimal swelling at the back of her right knee was the only abnormal finding. Dr. Vora's impression as to her neck and back was sprain and strain, insufficient to constitute a serious injury. No evidence was offered that Dr. Vora changed that impression.

Dr. McMahon's affirmation does not offer an evaluation of his own for the final result of the surgeries he performed on plaintiff's right knee and right shoulder to determine whether they provided any benefit at all. He attempts to ignore the gap in her treatment with an inadmissible hearsay explanation, saying only that he saw her again a year and a half after he was "advised" she discontinued physical therapy. Although he stated that he found restricted range of motion in plaintiff's right shoulder, right knee and cervical spine, there was no mention of any other tests performed during his July 25, 2011 examination. Based on plaintiff's subjective complaints and the initial MRI reports containing no opinion as to causation, Dr. McMahon concluded that her claimed injuries were serious, significant and permanent, matching the language of the statute. This statement is inconsistent with his earlier statement, in the same affirmation, that plaintiff's prognosis is guarded "without additional treatment". He also concluded, with no further explanation, that plaintiff's injuries, such as they were, were caused by the subject motor vehicle accident, ignoring all evidence from the emergency room which did not record any complaints of

knee or neck injury, or from Dr. Vora's examination finding full range of motion in plaintiff's knees and the same restrictions in both her shoulders, and the opinion of Dr. Ross who found degenerative conditions in plaintiff's neck, right shoulder and right knee. A failure to address these latter findings, other than with the simple conclusory statement that plaintiff's injuries were "not degenerative", is fatal to plaintiff's case. It is also inconsistent with plaintiff's own statement to emergency room personnel that her medical history was positive for arthritis.

The complaint is, therefore, dismissed in its entirety. Movant is directed to serve a copy of this order with notice of entry on the Clerk of Court who shall enter judgment dismissing the plaintiffs' complaint.

This constitutes the decision and order of the court.

Dated: December 13, 2012
Bronx, New York

Betty Owen Stinson

BETTY OWEN STINSON, J. S.C..