Martel v Southampton Hosp.
2013 NY Slip Op 33096(U)
November 29, 2013
Supreme Court, Suffolk County
Docket Number: 07-24175
Judge: Peter H. Mayer
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[* 1]

SHORT FORM ORDER

INDEX No. 07-24175

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 17 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. PETER H. MAYER
Justice of the Supreme Court

MOTION DATE 4-9-13 (#019)
MOTION DATE 4-18-13 (#020)
MOTION DATE 4-23-13 (#021)
ADJ. DATE 9-17-13
Mot. Seq. # 019 - MD
020 - MD
021 - MD

MELINDA MARTEL, as surviving spouse and Administratrix of the goods, chattels and credits which were of ROGER M. MARTEL, deceased, MELINDA MARTEL, as mother and natural guardian of infant plaintiff MITCHELL S. BEYEL, and SARAH M. MERRITT, individually,

Plaintiff,

- against -

SOUTHAMPTON HOSPITAL, MECIKO MUHAREMOVIC, M.D., LOUIS JOHN AVVENTO, M.D., ALEXANDER ZUHOSKI, M.D., and STEVEN PAUL OUZOUNIAN, M.D. and DARIN G. WIGGINS, M.D.,

Defendants.

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Upon the reading and filing of the following papers in this matter: (1) Notice of Motion/Order to Show Cause (019) by the defendant Ouzounian, dated March 18, 2013, and supporting papers 1-33; (2) Notice of Motion (020) by the defendant Southampton Hospital, dated February 15, 2013, supporting papers 34-59; (3) Notice of Motion (021) by the defendants Ouzounian, Avvento, and Zuhoski, dated April 1, 2013, supporting papers 60-63; (4) Affirmation in Opposition by the plaintiffs, dated June 21, 2013, and supporting papers 64-82; (5) Affirmation in Opposition by the plaintiffs, dated June 24, 2013 83-104; (6) Reply Affirmations by the defendant Ouzounian, each dated September 5, 2013 and supporting papers 105-109; 110-111, and by defendant Southampton Hospital dated August 15, 2013, and supporting papers 112-114; (5) Other _ (~~and after hearing counsels' oral arguments in support of and opposed to the motion~~); and now

UPON DUE DELIBERATION AND CONSIDERATION BY THE COURT of the foregoing papers, the motion is decided as follows: it is

ORDERED that motion (019) by defendant Steven Paul Ouzounian, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is denied; and it is further

ORDERED that motion (020) by defendant Southampton Hospital pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against it is denied; and it is further

ORDERED that motion (021) by defendants Louis John Avvento, M.D., Alexander Zuhoski, M.D. Steven Paul Ouzounian, M.D. pursuant to CPLR 3212 for summary judgment dismissing that part of the complaint asserted on behalf of Sarah M. Merritt as a matter of law is denied.

It is noted that the note of issue and certificate of readiness were filed with this court on October 15, 2012. Pursuant to CPLR 3212, the last date upon which a motion for summary judgment could have been made was February 12, 2013. By order dated January 15, 2013 (Mayer, J.), the time in which a motion for summary judgment could be filed was extended to March 19, 2013. By stipulation signed by the parties, the time in which to file summary judgment motions was extended to May 7, 2013, and thus, the within motions are deemed timely.[1] This action has been discontinued as against defendant Darin G. Wiggins, M.D.

In this medical malpractice action premised upon the defendants' alleged negligent departures from the good and accepted standards of medical care, it is alleged that the defendants failed to timely diagnose and treat the plaintiffs' decedent, Roger M. Martel, for pulmonary emboli, causing him to suffer cardiopulmonary arrest resulting in his death on July 15, 2006, at 37 years of age. Causes of action for negligence are asserted as to all defendants. Claims for negligent supervision, hiring and retention are asserted against defendant Southampton Hospital. A claim for wrongful death of the decedent, is asserted by decedent's spouse, Melinda Martel, and decedent's stepchildren, plaintiffs Mitchell S. Beyel and Sarah M. Merritt. Approximately three weeks prior to the decedent's admission to Southampton Hospital by defendant Meciko A. Muharemovic, M.D., the decedent began to experience chills and fever, and his wife noted an erythematous round rash on his back. He had a prior diagnosis of hemolytic anemia. His condition progressed to dyspnea, dizziness, and a dry cough. Upon admission to defendant hospital on July 11, 2006 by Dr. Muharemovic, the decedent was alert and oriented, icteric (jaundiced), and in no acute distress with stable vital signs. A hematological consult was obtained from defendants Louis Avvento, M.D. and Alexander Zuhoski, M.D. Due to a drop in his hemoglobin and hematocrit, on July 13, 2006, the decedent was transfused with two units of packed cells after being premedicated, but the decedent's hemoglobin fluctuated under 7 grams. Rituxan was administered with premedication on July 14, 2006. On July 15, 2006, the decedent continued to deteriorate and was transferred to ICU. He went into cardiorespiratory arrest requiring aggressive resuscitation without success, and was pronounced dead due to severe anemia secondary to full hemolytic anemia. He had the additional diagnosis of Lyme's disease.

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[1] Pursuant to the affidavit of service, motion (020) was served on March 18, 2013, however, the attorney's affirmation and the notice of motion attached to the affidavit of service are both dated April 1, 2013, which is inconsistent.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

Unsigned deposition transcripts are not in admissible form unless they are accompanied by an affidavit or proof of service pursuant to CPLR 3116 to be considered on these motions, however, the unsigned transcripts of non-party witnesses are not admissible (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]). The unsigned but certified copy of the transcript of the examination before trial of a party may be considered if not objected to (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]). The unsigned deposition transcript of a moving defendant can be considered by this court as adopted as accurate by the moving defendant (*see* ***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]).

In support of motion (019), defendant Ouzounian has submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, his answer, and plaintiffs' verified bill of particulars, plaintiff's amended supplemental verified bill of particulars; copy of the Southampton Hospital record of March 5, 2001, May 12, 2004, and July 11, 2006, various excerpts from medical records; unsigned but certified copies of the transcripts of the examinations before trial of Melinda Martel dated July 27, 2009 and January 9, 2013, Sarah Merritt dated November 17, 2009, submitted without objection and considered herein (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); the signed transcripts of the examinations before trial of defendant Ouzounian dated September 29, 2010, co-defendant Muharemovic dated March 15, 2010; the unsigned but certified transcript of co-defendant Zuhoski; the unsigned copies of the transcripts of the examinations before trial of non-party witnesses Samantha Judice dated January 6, 2010, Claire Iannacone dated June 16, 2011 and May 7, 2012, John Siefken dated August 23, 2011, Amanda Lovett dated August 23, 2012, and Karen Stafford dated August 3, 2012 are not in admissible form; the unsigned copies of the transcripts of the examinations before trial of co-defendant Wiggins dated October 22, 2010, accompanied with proof of service, and June 22, 2012 without proof of service; an uncertified copy of an autopsy report; and the undated expert affirmation of Dan Reiner, M.D.

In support of motion (020), defendant Southampton Hospital has submitted, inter alia, an attorney's affirmation; copies of the summons and complaints, answers served by Southampton Hospital, co-defendants Zuhoski, Avvento, Ouzounian, Muharemovic, Wiggins, plaintiff's verified bill of particulars; copies of the unsigned but certified transcripts of the examinations before trial of Melinda Martel dated July 27, 2009, Sarah Merritt dated November 17, 2009, defendant Avvento date January 6,

2010, defendant Ouzounian dated September 29, 2010; copies of the signed transcripts of the examinations before trial of defendant Muharemovic dated March 15, 2010, non-party witness Samantha Judice dated January 6, 2010, non-party witness John Siefken dated August 23, 2011, non-party Darin Wiggins, M.D. dated October 22, 2010; the unsigned but certified transcripts of the examinations before trial of defendant Zuhoski dated July 30, 2010 with proof of service pursuant to CPLR 3116, non-party witness Claire Iannacone dated June 16, 2011 without proof of service; certified copies of the Southampton Hospital records for decedent; affidavit of Claire Iannacone dated April 17, 2012 with exhibits annexed; uncertified copy of the decedent's death certificate; and uncertified medical records from East End Hematology.

In support of motion (021), defendants Avvento, Zuhoski, and Ouzounian have submitted an attorney's affirmation, copies of the summons and complaint and the moving defendants' answers, and adopt and incorporate the arguments set forth by counsel in motion (020) relative to point IV of the affirmation of Joseph O'Connor.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that 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,*** 221 AD2d 674, 638 NYS2d 700[2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (***Toomey v Adirondack Surgical Assoc.,*** 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.,*** 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson,*** 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

MOTION (019)

In motion (019), defendant Steven Paul Ouzounian, M.D. seeks summary judgment dismissing the complaint as asserted against him. His expert, Dan Reiner, M.D., is a physician licensed to practice medicine in New York State and is board certified in critical care surgery and general surgery. He has not set forth his education and training, or his work experience to demonstrate a basis to render expert opinion in this matter, and has not provided a copy of his curriculum vitae in support of his affirmation. He set forth the medical records and deposition transcripts, as well as the expert disclosures of plaintiffs forensic pathologists, radiologist, and oncology/hematologists, that he reviewed. He stated that the plaintiffs claim that defendant Ouzounian failed to diagnose and treat a transfusion reaction; failed to diagnose and treat hemolytic anemia; failed to palpate the spleen and perform a splenectony, failed to timely diagnose and treat signs and symptoms of thromboemboli during his care and treatment of the decedent, Roger Martel, on July 15, 2006.

Dr. Reiner stated that Dr. Ouzounian saw the plaintiff's decedent on July 15, 2006 on consult for the purpose of establishing intravenous access by placing a CVP line. While Dr. Reiner set forth that Dr. Ouzounian assessed the patient and reviewed the decedent's medical history, he does not set forth the standard of care, Dr. Ouzounian's findings, and whether or not Dr. Ouzounian comported with the standard of care, except to state that Dr. Ouzounian reviewed a CAT scan which showed the decedent had an enlarged spleen. Dr. Ouzounian then attempted to place a CVP catheter, and the post-procedure chest films ruled out that a pneumothorax occurred, that there were no infiltrates or effusions present, and also showed that the heart and mediastinal contours were normal. Dr. Ouzounian did not see the decedent again prior to the decedent's death on July 15, 2006 at 3:25 p.m. The decedent's discharge diagnoses were full hemolytic anemia, severe anemia secondary to full hemolytic anemia, and Lyme's disease. The autopsy report, he stated, attributed the cause of death to bilateral pulmonary embolic and possible heart failure.

Dr. Reiner stated that Dr. Ouzounian, as a general surgeon, was limited to placing the catheter as the decedent was already under the care of medical providers whom Dr. Ouzounian did not supervise. While the decedent, at about 8:40 a.m., exhibited rapid and shallow breathing after the catheter placement, his breathing improved. However, Dr. Reiner does not indicate the basis for this conclusory statement. Dr. Reiner continued that Dr. Ouzounian was not in a position to diagnose and treat the transfusion reaction, hemolytic anemia, and/or thromboemboli which the decedent was suffering at the time, however, Dr. Reiner gives no basis for this conclusory opinion. He continued that Dr. Ouzounian did not fail to palpate the decedent's spleen or fail to perform a spleenectomy on the decedent, and that Dr. Ouzounian did review a CAT scan that showed the decedent had an enlarged spleen. He continued that the CAT scan provided more accurate information than palpation of the spleen which would not have provided any additional information. He continued that the autopsy report showed that the spleen weighed 750 grams, and the CAT scan showed the spleen was 13.5 cm, only slightly enlarged from the normal size. Dr. Reiner stated that it is his opinion that only if Dr. Ouzounian were asked to perform a spleenectomy by the decedent's treating physician, would Dr. Ouzounian determine if he could, and whether the decedent was stable for surgery. Dr. Ouzounian's follow-up would only have been limited to assessing the decedent's ability to survive a spleenectomy in the event it were deemed indicated. Thus, concluded Dr. Reiner, plaintiffs' allegations regarding failure to timely diagnose and treat the decedent for a transfusion reaction and hemolytic anemia do not pertain to Dr. Ouzounian. However, Dr. Reiner has not set forth the

standard of care in light of Dr. Ouzounian examining the decedent on a surgical consult, and noting that there was an enlarged spleen. He does not state how Dr. Ouzounian comported with the standard of care in evaluating the decedent, and whether or not he considered and appreciated the decedent's condition and history.

Based upon the foregoing, it is determined that defendant Dr. Ouzounian has not established prima facie entitlement to summary judgment dismissing the complaint as asserted against him. Moreover, the plaintiff's expert has raised factual issues which preclude summary judgment.

The plaintiff's first expert affirms that he/she is licensed to practice medicine in New York and New Jersey, with a specialty in hematology-oncology, is board certified in internal medicine and oncology, and has practiced in these specialties for over twenty years. The plaintiff's expert set forth the materials and records reviewed. He stated that there is no refutation by Dr. Ouzouonian of obvious departures in failing to recognize the classic and well-known signs and symptoms of pulmonary embolic, including severe shortness of breath, increased pulse and respiration, sweating, dizziness, anxiety, and cough, all of which are documented in the hospital record for July 11 through 15, 2006. Concomitant with that failure, the plaintiff's expert stated that Dr. Ouzounian failed to perform any bedside monitoring to ascertain the cause of decedent's symptoms, such as CVP monitoring, bedside echocardiogram, and analysis of arterial blood gases on an emergency basis, all of which could have assisted in forming a diagnosis of the absence or presence of multiple emboli within a few minutes, given the decedent's documented clinical symptoms.

The plaintiff's expert set forth Melinda Martel's description of the decedent's presentation, and noted that the EKG demonstrated sinus tachycardia, and the decedent was noted to be anxious on the morning of July 15, 2006. Dr. Ouzounian noted the plaintiff's vital signs and shortness of breath, and ordered a chest x-ray due to the decedent having respiratory difficulty. The plaintiff's expert opined that Dr. Ouzounian departed from the standard of care for any consulting doctor, given the clinical picture and the failure of Dr. Ouzounian to monitor and measure the CVP readings to determine whether pressures were increased in the right side of the heart, consistent with formation of emboli. This would have helped confirm the missed diagnosis of pulmonary emboli and to initiate treatment of the emboli which contributed to the decedent's demise that day. The lack of monitoring was a substantial factor contributing to Dr. Ouzounian's inability to diagnose and treat the emboli with low molecular weight Heparin and consider the insertion of an "umbrella" filter to prevent additional newly forming emboli which would continue to block the lungs.

The plaintiff's expert continued that Dr. Ouzounian failed to order any diagnostic studies to ascertain the decedent's obviously deteriorating condition, and failed to seek immediate assistance from the attending hematologist-oncologist, or any other consultants, such as an intensivist, although Dr. Ouzounian acknowledged that he was present to determine the hemodynamic stability of the patient and to secondarily ascertain whether or not the decedent could undergo spleenectomy at that time. His role, as he noted in his consultation report, was to follow the decedent along with medical services. Thus, stated plaintiff's expert, Dr. Reiner (Ouzounian's expert) mistakenly stated that Dr. Ouzounian's contact with the plaintiff was solely for IV access, when, in fact, he was called in to review the overall condition of the decedent and to ascertain the feasibility of going forward with a spleenectomy to treat the hemolytic anemia. The plaintiff's expert opined that the failure to simply place a monitor to measure the CVP of this critically ill patient was a departure from the standard of care for a consulting surgeon, as it is critical

to record the central venous pressure of the right atrium and vena cava. He further opined that it was a departure from the standard of care for any consultant not to recognize the classic presentation of multiple emboli and provide appropriate treatment, which was a substantial factor in causing the decedent's death. By wasting time, the window of opportunity to avert death from pulmonary emboli passed. The plaintiff's expert further opined that indeed, the additional transfusion that the patient received after Dr. Ouzounian failed to diagnose the decedent's condition resulted in a further incompatible transfusion, and a reaction to the same.

The plaintiff's expert continued that while Dr. Reiner (Ouzounian's expert) stated that the plaintiff's decedent verbalized no complaints, the decedent was so compromised that he was unable to speak. Plaintiffs' expert noted that although Dr. Reiner stated that Dr. Ouzounian's physical examination revealed no specific findings, to the contrary, it is rare when a bedridden, overweight patient with pulmonary emboli exhibits nearly all the classic symptoms of the condition: abnormal EKG, tachycardia, tachypnea, sweating, anxiety, dizziness, history of a fall, and earlier episode of hypotension, all of which Dr. Ouzounian ignored. Plaintiff's expert opined that Dr. Ouzounian essentially abandoned the decedent. The plaintiff's expert continued that while Dr. Reiner baldly asserted that the decedent's breathing improved after the CVP line was inserted, and thus Dr. Ouzounian had no further duty to the patient, that such is contradicted by the hospital record and the accounts of the decedent's family because, at 10:30 a.m. on July 15, 2006, the decedent's pulse rate was 122 and respirations 24, with virtually no improvement.

The plaintiff's expert continued that Dr. Ouzounian properly determined that the decedent's overall picture was hemodynamically unstable, and that a spleenectomy was not feasible. However, plaintiff's expert opined that in view of the fact that the decedent was unstable, Dr. Ouzounian, as a consultant, failed to determine the etiology of his condition, which was a departure from the standard of care and a substantial factor in causing the decedent's death.

The plaintiff's second expert affirms that he/she is licensed to practice medicine in New York and New Jersey, with a specialty in forensic pathology, and is certified in anatomical, clinical, and forensic pathology. He/she was chief medical examiner for Suffolk County from 1995 through 2006. The plaintiff's second expert set forth the materials and records reviewed. He stated that on behalf of Dr. Ouzounian, there was no discussion regarding the autopsy results and slides which the plaintiff's second expert personally reviewed. The plaintiff's pathology expert stated that his review of the autopsy report and the slides confirmed that the death of the 37 year old patient was due to bilateral multiple "recent" pulmonary emboli. He continued that as an obese patient with hemolytic anemia on bed rest, the decedent was at high risk for deep vein thrombosis and/or the formation of pulmonary emboli. The autopsy slides provide definitive evidence that the multiple thromboemboli were forming during the hospital stay as the emboli are of different ages in terms of days, and that there were showers of emboli which commenced days before the decedent's death.

The plaintiff's pathology expert stated that Dr. Ouzounian was called on consult to review the decedent's overall condition and to ascertain the feasibility of going forward with a spleenectomy to treat the hemolytic anemia. He stated that the hospital record reveals the potential symptoms of emboli formation were apparent as early as July 14, 2006, prior to the commencement of blood transfusions when the decedent had a fall in the early morning hours at 4:00 a.m., was short of breath, diaphoretic, with a persistent dry cough. When Dr. Ouzounian saw the decedent on July 15, 2006, he failed to recognize

cause of the symptoms. This failure to monitor to ascertain the cause of the decedent's condition was a substantial factor contributing to Dr. Ouzounian's inability to diagnose and treat the emboli, and to prevent further newly forming emboli, which contributed to the decedent's demise.

The plaintiff's forensic/pathology expert opined that in accordance with his autopsy slide review, the age of the multiple thromboemboli demonstrates that they were forming all the while and inhibiting the decedent's ability to breathe. There were numerous thromboemboli present in both lungs, which in his opinion, caused the decedent's death. The plaintiff's expert also explained a saddle embolus and the basis for ruling out the same. He concluded that Dr. Ouzounian should have monitored pulmonary/vascular resistance, arterial blood gases, a CVP monitor, and bedside echocardiogram, and investigated further the etiology of the decedent's condition, and he opined the failure to do so, was a substantial factor contributing to the patient's demise from multiple pulmonary emboli which could have been detected and treated.

Accordingly, motion (019) by defendant Ouzounian for summary judgment dismissing the complaint as asserted against him is denied.

MOTION (020)

Defendant Southampton Hospital has submitted the affidavit of Claire Iannocone in support of its motion to dismiss. Ms. Iannocone set forth that she is the assistant director of the Laboratory at Southampton Hospital. She provided copies of the blood bank policies and procedures in effect in July 2006 related to transfusions, issuance of blood products, and incompatible blood and its release and/or issuance, as well as end of shift log book entries, and grading records for incompatibility for all units transfused to Mr. Martel.

Defendant Southampton Hospital has also submitted the expert affidavit of its expert, Harold S. Ballard, M.D. who avers that he is licensed to practice medicine in New York State and is board certified in internal medicine, oncology and hematology. He set forth his experience in the practice of medicine on a very limited basis, and noted that he is a clinical professor in hematology and oncology. He set forth the materials and records he reviewed, and opined to a reasonable degree of medical certainty that the nurses and staff at Southampton Hospital did not deviate from the accepted standard of care during the care and treatment rendered to Roger Martel. He set forth the departures alleged in plaintiff's bill of particulars relative to Southampton Hospital and its staff.

Dr. Ballard stated that in 2001, Mr. Martel was treated at Southampton Hospital for autoimmune hemolytic anemia, and it was found that the Combs direct and indirect tests were positive. Because he was noted to most likely be very difficult to match for a blood transfusion due to a warm autoimmune antibody (panagglutinin), transfusions were to be used with extreme caution unless he was in a life threatening situation. The plaintiff's decedent was seen on the morning of July 11, 2006 by Dr. Muharemovic. The plan was to rule out tick borne disease and hemolytic anemia as his hemoglobin was 7.8 and hematocrit was 20.5. Platelets were 709,000. He was admitted to Southampton Hospital with a diagnosis of fever, hemolytic anemia, and jaundice, and was typed and screened for a blood transfusion with a unit that had the lowest reaction number. Rocephin and Doxycycline was given for Lyme's disease. Dr. Louis Avvento was called in on a hematology consult. Various blood work was ordered, and Dr. Ballard described the orders, including that the decedent not be transfused unless hemodynamically

unstable. At 10:00 p.m. on July 11, 2006, the decedent's hemoglobin level was 6.6 and hematocrit was 17.1. Additional doses of Solumedol were given, as well as Aranesp to stimulate bone marrow red blood cell production. On July 12, 2006, the decedent had no chest pain, shortness of breath, or other symptomatology for which Dr. Avvento would transfuse him.

On July 12, 2006 at 5:58 p.m., the decedent's hemoglobin was 5.8 and hematocrit was 14.4, and the LDH and bilirubin were elevated. Dr. Ballard continued to set forth the care and treatment ordered and administered. On July 13, 2006, at 6:30 a.m., the plaintiff's decedent's hemoglobin was 4.7 and hematocrit was 11.0, thus Dr. Avvento ordered a transfusion of two units of blood of the least incompatible blood at 7:40 a.m., and blood irradiation or leukoreduction was ordered. At 8:20 a.m., 1+ incompatible, O negative blood was started to treat the decedent's severe anemia, which was causing him to have shortness of breath and tachycardia. The two units of blood were transfused with no signs of reaction. A CT scan of the abdomen and chest revealed an enlarged spleen of 13.5 cm. Thereafter, Dr. Avvento ordered an additional unit of packed red blood cells which was given on July 14, 2006 at 4:30 a.m. Further care and treatment, as well as medications to be administered were described by Dr. Ballard, who stated that because the decedent was very unstable with a low hemoglobin and hematocrit level, there was no window of opportunity to perform a spleenectomy on July 14, 2006. Dr. Zuhoski saw the decedent on the evening of July 14, 2006 as he was covering for Dr. Avvento. Care and treatment was again described by Dr. Ballard.

Dr. Ballard continued that the plaintiff's hemoglobin was 4.4 and hematocrit was 10.9 on July 15, 2006, and the decedent was noted to be very dyspneic and in respiratory distress. The Rapid response team was called. Dr. Ballard discussed the continuing care provided by Dr. Zuhoski and P.A. Siefken. Dr. Ballard stated that when the decedent was seen by P.A. Siefken, the decedent's distress level was not as significant as described to him, which prompted him to have the decedent sent to ICU. Siefken, he stated, was more concerned about the severe anemia rather than the possibility of pulmonary emboli, so he ordered a central line be placed, which defendant Dr. Ouzounian attempted to place on July 15, 2006. Dr. Ouzounian was to follow the decedent with the other doctors to see if a spleenectomy would be needed in the future, however, at that time, Dr. Ouzounian did not feel he was a candidate for a spleenectomy. Discussion was held with doctors at Stony Brook University Hospital concerning a spleenectomy if the decedent were sufficiently stable to transfer to that facility. The least incompatible blood was transfused, but during the transfusion of the second unit of blood, the decedent became cool and clammy, his oxygen saturation decreased, his mental status changed, and he became diaphoretic, at which time he was coded.

It is Dr. Ballard's opinion that Southampton Hospital did not hire, supervise, and retain employees who were not qualified, and he set forth the various qualifications of the care givers. Consultations were called for and completed in a timely manner, resulting in the timely diagnosis of autoimmune hemolytic anemia within a few hours of presentation to the hospital on July 11, 2006. Dr. Ballard continued that there is no evidence that the hospital staff departed from the standard of care and treatment of the decedent, and set forth that the nursing staff followed and carried out the physician's orders in a timely and proper fashion, and recorded the decedent's vital signs within the standard of care. All medications were timely and properly administered. Critical laboratory values were timely and properly reported to the medical doctors, and consults were timely called. The course of treatment for the decedent's condition and presentation was dictated by the decedent's treating physicians, who ordered all the tests and medications, as well as the transfusions. The decedent was properly attached to a monitor and pulse oximeter, and vital signs were taken and recorded. The decision to perform a spleenectomy was that of

the physicians, not the hospital staff. The blood used to transfuse the decedent was properly typed and cross-matched, and signed off by Dr. Wiggins. The decedent was properly transferred to ICU by the staff upon the order of the physicians. In the ICU, the decedent was properly monitored, and provided oxygen and medication. Blood work was obtained, and transfusions properly administered. All medications were ordered by the physicians.

Dr. Ballard continued that the autopsy report by Ali Tamsin, M.D. noted bilateral congestion of the lungs with multiple thromboemboli and possible heart failure. This risk of thromboemboli due to the hemolytic anemia was considered by the decedent's treating physicians, and no evidence of a potential thromboembolytic complication prior to the morning of July 15, 2006, was noted. When the decedent's status began to change, the treating providers were notified. Emergency cardiopulmonary bypass and/or emergency thoracotomy rests with the physician and cannot be ordered by nursing or hospital staff.

Based upon the foregoing, it is determined that Southampton Hospital has established prima facie entitlement to summary judgment dismissing the complaint as asserted against it.

In opposition, the plaintiffs have submitted, inter alia, the affirmation of their expert physician who affirms that he/she is licensed to practice medicine in New York and New Jersey, with a speciality in hematology-oncology, and is board certified in internal medicine-oncology. The plaintiffs' expert set forth his education and training, and the materials and records which he reviewed, including the affirmations of the plaintiffs' nursing expert and forensic pathologist.

The plaintiffs' hematology-oncology expert opined that the departures of the nursing staff at the hospital commenced in the early morning hours of July 13, 2006 when the decedent fell to the floor, experiencing dizziness, diaphoresis, and shortness of breath, which plaintiffs' nursing expert indicated was improperly handled by the nurses' failure to report this incident to the attending physicians who were not made aware of the incident. The plaintiffs' expert opined that this type of fall in a patient suffering from hemolytic anemia could have raised suspicions regarding potential formation of emboli in the decedent, and would have alerted the physicians to consider altering their course of treatment with respect to blood transfusion therapy, prompted administration of low dose anticoagulants, and led to other prophylactic antithrombolytic treatments. Arterial blood gases, closer monitoring of pulse oximetry, vital signs, and placing the decedent in the ICU would have been ordered. Thus, this failure by nursing inextricably led to the failure to institute any prophylactic measures to prevent formation of additional and fatal pulmonary emboli, a condition always considered by hematologists-oncologists in patients with acute hemolysis.

Plaintiffs' expert opined that the decedent experienced a transfusion reaction on July 13, 2006 after the first transfusion, as Dr. Muharemovic and Dr. Avvento ordered that prior to administering the next transfusion, the staff must wait until the decedent's temperature dropped, and to premedicate him. He continued that nurse Acierno indicated in her note that the decedent's temperature was 101.3 post-transfusion. Thus, Dr. Ballard's opinion that the increased temperature, dyspnea, and increased heart rate did not constitute a transfusion reaction lacks foundation. The plaintiffs' expert then opined that the hospital's policy on transfusions reactions was not followed, no one from the blood bank was aware of this situation, and the undocumented reaction led to additional contraindicated transfusions.

The plaintiffs' expert further opined that the most significant breach by the nursing staff occurred on the evening of July 14, 2006 into the morning hours of July 15, 2006, prior to decedent's transfer to ICU, when the decedent's condition significantly changed as evidenced by the worsening of the decedent's respiratory status from dyspnea on exertion to dyspnea without exertion, and observation of tea-colored urine which is a sign of delayed transfusion reaction, and which was worsening. This reaction can lead to the formation of emboli. The plaintiffs' expert continued that the other signs and symptoms of worsening emboli (dyspnea at rest) were unreported until a dramatic episode in the early morning hours of July 15, 2006 when the decedent developed hypotension, oxygen saturation of 80%, and extreme dyspnea. He stated that the failure to monitor the vital signs during the overnight period deprived the treating physicians of an opportunity to address the worsening problems until the morning. However, because the covering hematologist, Zuhoski, was attending another hospital, he was unable to see the decedent until the afternoon of July 15, 2006, thus, several opportunities to treat the emboli were missed, and most notably by Dr. Ouzounian. The plaintiff's expert continued that when Dr. Avvento gave the order for the medication Rituximab, it was partially ignored and Dr. Avvento was not contacted when the order was questioned.

The plaintiffs' hematology-oncology expert concluded that the aforemention departures from the standard of care by the nursing staff at Southampton Hospital were a substantial factor in causing the death of the plaintiff's decedent.

The plaintiff also submitted the affirmation of her expert physician who is licensed to practice in New York and New Jersey with a specialty in forensic pathology and is certified in anatomical, clinical and forensic pathology and by the national board of medical examiners. He set forth the materials and records reviewed, including the autopsy slides and autopsy report concerning the decedent and opined that the autopsy report and slides confirm that the death of the 37 year old patient was due to bilateral multiple "recent" and fresh pulmonary thromboemboli.

The plaintiffs' forensic expert continued that all the thromboemboli were ante-mortem, and that the possible symptoms of thromboemboli formation were apparent as early as July 13, 2006, when the decedent fell in the early morning hours, prior to commencement of blood transfusions, which symptoms are consistent with the age of some of the emboli he observed on the slides. He stated that the staff did not follow up with reporting the incident concerning the decedent's fall to the treating physicians, and thus, there were no prophylactic measures taken or ordered by the internist and other treating physicians to prevent the formation of additional thromboemboli, and no tests were ordered to diagnose the condition. The failure of nursing to report this condition to the treating physicians was a departure from the standard of care, opined plaintiff's expert, and precluded the physicians from utilizing this significant information in the treatment of the decedent.

The plaintiffs' forensic expert further opined that the decedent was given three contraindicated incompatible blood transfusions, worsening the hemolytic process and speeding the formation of emboli. As the decedent's condition worsened during the day of July 14, 2006, his symptoms, consistent with continued formation of emboli, were never reported to any physicians that evening. Disagreeing with defendant's expert, Dr. Ballard, plaintiffs' forensic expert stated that the hospital record demonstrates that from 8:30 p.m. on July 14, 2006 through 5:00 a.m. on July 15, 2006, a nearly nine hour period, the decedent's vital signs were not monitored, departing from the protocol. The decedent's presentation in the early morning of July 15, 2006, was the classic presentation of multiple pulmonary emboli. It was at this

time that the nurses finally notified Dr. Muharemovic through his physician's assistant, Siefkin, and Dr. Zuhoski, of the decedent's rapidly worsening condition. This failure to timely notify the decedent's physicians and properly monitor the decedent's vital signs was a departure from the standard of care and a substantial factor in contributing to the decedent's demise.

Based upon the foregoing, it is determined that plaintiffs' experts have raised triable issues of fact to preclude summary judgment. The experts for both the defendant hospital and the plaintiff offer conflicting opinions with regard to the alleged failure of the hospital staff to comport with the standard of care, as set forth, and whether such departures substantially contributed to the decedent's demise.

Accordingly, motion (020) by Southampton Hospital for summary judgment dismissing the complaint as asserted against it is denied.

MOTION (021)

In motion (021), defendants Louis John Avvento, M.D., Alexander Zuhoski, M.D., and Steven Paul Ouzounian, M.D., as a matter of law, seek summary judgment dismissing that part of the wrongful death claim asserted in the third cause of action on behalf of Sarah M. Merritt, decedent's stepdaughter, by Melinda Martel as the surviving spouse and administratrix of decedent's estate. It is determined, in reviewing the defendants' moving papers, that the cases relied upon by the defendants are not dispositive and are distinguishable from the facts in the instant action.

'"Relative" is defined as: a kinsman, a person connected with another by blood of affinity. "Affinity" is defined as the connection existing, in consequence of marriage, between each of the married persons and the kindred of the other. While ties of consanguinity (blood) do not end, ties of affinity end when the marriage tie is broken. Thus, a stepchild is a "relative" of his parent's spouse by operation of "affinity" principles so long as the marital tie is unbroken' (***Randolph v Nationwide Mutual Insurance Co.***, 170 Misc2d 364, 650 NYS2d 964 [Sup Ct, Erie County 1966]). Death of the parent ends the bond of affinity between stepchild and stepfather (***Randolph v Nationwide Mutual Insurance Co.***, *supra*). Whenever used in a statute or instruments, unless a contrary intention is expressed therein, the term "heirs," "heirs at law," "next of kin" or any term of the like import means the distributees, as defined in EPTL § 1-2.5 (*see* EPTL § 2-1.1).4

Family Court Act § 415 and Social Services Law § 101 (1), each provide that the spouse or parent of a recipient of public assistance or a person liable to become in need thereof, if of sufficient ability, is responsible for the support of such person or child under age 21 years. Both state that stepparents shall in like manner be responsible for the support of children under the age of 21 years. The law imposes an obligation to support a stepchild on a husband. That obligation continues as long as the relationship exists between the stepfather and mother. It ceases when that relationship is terminated and the erstwhile spouse of the child's mother is no longer her husband. It continues only as long as he is the stepfather (***Matter of Marie Ewell v Sisson***, 81 Misc2d 1070, 367 NYS2d 711 [Fam Ct, Yates County 1975]). Thus, a relationship between a stepfather and stepchild ends when the parties' divorce becomes final (***Peake v Peake***, 205 Misc 393, 138 NYS2d 631 [Dom Rel Ct, Kings County 1954]; ***Kaiser v Kaiser***, 93 Misc2d 36, 402 NYS2d [1978]).

In the absence of a clear statutory provision continuing the obligation of a stepparent after the death of either party to the marriage, the relationship and obligation on the part of the survivor terminates (***Erie County Board of Social Welfare v Schneider***, 6 Misc2d 374, 163 NYS2d 184 [Children's Ct, Erie County 1957]). In ***Slockhowsky v Lavine***, 73 Misc2d 563, 342 NYS2d 525 [Sup Ct, Nassau County 1973], the court stated that the "general obligation of support imposed upon a natural or adoptive father does not turn on a child's dependence upon public assistance, and, indeed, exists regardless of the child's own resources and those of his mother. Moreover, unlike the stepparent liability, a natural father must support his child even after the death or divorce of the natural mother (citation omitted). The provision for the support of a child is certainly on a broader basis and has deeper roots than the provision for support of stepchildren." Once a marriage dissolves, be it by divorce, death, or for any other reason whatsoever, a stepparent relationship ceases (***Decker v Grant Seamon***, 18 Misc3d 1101A, 856 NYS2d 23 [Fam Ct, Otsego County 2007, citing ***Rita F. v Neil F.***, 12 Misc3d 894, 819 NYS2d 439 [Fam Ct, New York County 2006]).

As set forth in 68 A.L.R.3d 1220, the right of stepchildren to maintain an action for the death of a stepparent under various wrongful death statutes has been discussed by the courts in only a few cases. Although a stepchild has been held entitled, under a particular wrongful death statute, to maintain an action for the death of a stepparent, courts in certain other cases, construing particular wrongful death statutes, have held that an action by or for the benefit of a stepchild to recover damages for the death of a stepparent could not be maintained. In the cases discussed in the annotation, courts have engaged in statutory construction in order to determine whether a stepchild was included within the meaning of the relevant provisions of various wrongful death statutes. Those courts which have held that an action could not be brought by or for the benefit of a stepchild have emphasized that wrongful death statutes, being in derogation of common law, must be strictly construed. Constitutional arguments advanced in favor of stepchildren have been rejected in certain cases.

In New York, it is well settled that the damages recoverable in a wrongful death action are limited by the Estates Powers and Trusts Law to fair and just compensation for the pecuniary injuries suffered by the survivors of a decedent for whose benefit an action is commenced (*see* N.Y. Est. Powers & Trusts Law § 5-4.3). A cause of action to recover damages for wrongful death is a property right belonging solely to the distributees of the decedent and vest in them at the decedent's death. An individual's status as distributee is determined as of the date of the decedent's death (*see* ***Carter v New York City Health and Hospitals Corporation,*** 47 AD3d 661, 851 NYS2d 588 [2d Dept 2008; ***DeLuca v Gallo***, 287 AD2d 222, 735 NYS2d 596 [2d Dept 2001]). The wrongful death statute is a derogation of common law, and therefore must be strictly construed (***Farrar v Brooklyn Union Gas Co.***, 73 NY2d 802, 537 NYS2d 26 [1988]; ***Gonzales v New York City Housing Authority,*** 77 NY2d 663, 572 NYS2d 598 [1991]).

The standard by which damages in a wrongful death action are measured is to be fair and just compensation for the pecuniary injuries resulting from the decedent's death to the persons for whose benefit the action is brought. Despite the fact that the standard for recovery is couched in terms of pecuniary loss, recovery is not limited to compensation for loss of money or property. It has long been recognized that pecuniary advantage results as well from parental nurture and care, from physical, moral, and intellectual training, and that the loss of those benefits may be considered within the calculation of pecuniary injury (***DeLong v Estate of DeLong, deceased***, 89 AD2d 376, 455 NYS2d 887 [4th Dept 1982]). Damages relating to pecuniary injuries sustained by the next of kin on account of the death are not confined to the actual present loss, which could be proved, but prospective loss also. In ***Tilley v The***

Hudson River Railroad Company, 29 NY 252, 1864 NY Lexis 27, the court held that injury to the children by the death of the mother is a legitimate ground of damages, and that in estimating such damages the jury has a right to consider the loss to the children of the deceased in reference to such intellectual, moral, and physical training, and such instruction as they would otherwise have received at her hands. In ***McKee v Colt Electronics Co., Inc.,*** 849 F2d 46 [2d Cir 1988]), the court stated that children may not recover for grief or loss of society, affection, and conjugal fellowship, which are all elements of the generic phrase loss of consortium. Pecuniary loss is defined as the economic value of the decedent to each distributee at the time of decedent's death and includes loss of income and financial support, loss of household services, loss of parental guidance, as well as funeral expenses and medical expenses incidental to death (*see* ***Milczarski v Walaszek***, 108 AD3d 1190, 969 NYS2d 685 [4th Dept 2013]). Pecuniary loss to a decedent's distributees which is recoverable in a wrongful death action includes amounts the deceased might reasonably have been expected to spend for support and maintenance of the distributees (Estates Powers & Trusts Law § 5-4.3, ***DeLuca v Gallo***, 287 AD2d 222, 735 NYS2d 596 [2d Dept 2001]).

In ***Warren's Heaton on Surrogate's Practice***, at section 9-124.03, a wrongful death action is distinguished from a survival action for personal injuries suffered by the decedent. It states, "[u]nlike a wrongful death action which is brought pursuant to EPTL 5-4.1 on behalf of the distributees, an action for the personal injuries sustained by the decedent is brought on behalf of the estate. Accordingly, any recovery from a personal injury action passes to the decedent's estate, and is distributed to the decedent's beneficiaries pursuant to the terms of the decedent's will or in accordance with the laws of intestacy. The recovery from a wrongful death action, on the other hand, does not belong to the estate but is distributed directly to those distributees of the decedent who have sustained pecuniary injuries. Thus, it escapes creditors claims and estate taxes. As emphasized above, the distribution of the wrongful death award is not made pursuant to the strict formula of intestate succession, but rather in proportion to the pecuniary injuries proven to be suffered by each distributee." It continues that "[a] personal injury action is brought to recover the damages sustained by the decedent from the injury (and prior to death), such as pain and suffering, loss of wages, loss of consortium, and medical expenses. If the injury leads to the person's death, the damages recovery for the injury are limited to those accruing before death and do not include damages resulting from death, except for funeral expenses in some instances. In contrast, a wrongful death recovery is compensation for the pecuniary injuries of the decedent's distributees resulting from the decedent's death."

Defendants rely upon, inter alia, ***Pizzuto v County of Nassau***, 240 F Supp2d 203, 2002 U.S. Dist. Lexis 25280 [US Dist Ct, ED NY 2002]. ***Pizzuto*** involved the death of a prisoner wherein the decedent's parents commenced an action pursuant to 42 USCS § 1983, and asserted, inter alia, a cause of action for wrongful death of the decedent. The court stated that a parent has a constitutionally protected liberty interest in the companionship, care, custody, and management of his or her children, and that the United States Supreme Court has invoked this principle only where parents or guardians have sought to protect their right to decide matters of child custody and family living arrangements. The court also noted that under New York's Estates, Powers, and Trusts Law, a cause of a action to recover damages for wrongful death may only be brought by the distributees of the decedent, namely, that when a decedent dies intestate and is survived by a spouse and issue, his spouse and issue are the sole distributees of the estate. In that the plaintiffs in ***Pizzuto***, the parents of the 23 year old decedent who lived separately and independently from his parents, were not distributees of their son's estate, they were not entitled to recover damages for the wrongful death of their son. The issue of whether or not a wrongful death claim may be asserted on

behalf of stepchildren was not the subject of that action.

Plaintiff argues that ***Benton v Brookfield Properties Corporation***, 02 Civ. 6862 (JFK), 02 Civ 8947 (JFK) [US Dist Ct, SD, NY June 8, 2004] is controlling. ***Benton*** was brought by Delores Benton as the administratrix of the estate of her deceased husband, James Benton, and on her own behalf against defendant Brookfield Properties Corporation, et al, and was decided with a separate action wherein the plaintiffs alleged defendants were negligent in causing the wrongful death of their relatives. Subject matter jurisdiction was premised upon diversity of citizenship. Defendants were New York entities. One of the issues decided by the court was defendants' motion to dismiss portions of plaintiff Benton's claims for loss of pecuniary support and parental guidance made on behalf of the plaintiff's decedent's stepchild and step grandchildren. Ravon Mitchell-Benton, daughter of plaintiff Delores Benton and a man named Larry Foreman, was never adopted by the decedent, James Benton. Ravon Mitchell-Benton had children. The defendants argued that New York Estates Powers and Trusts Law does not deem stepchildren who are not adopted by the decedent to be issue of the decedent, and therefore, Ravon Mitchell-Benton and her children possess no right to file a wrongful death action and to recover from the decedent's estate.

The court determined that because Ravon Mitchell-Benton and her children resided with the decedent, shared his surname, and because decedent referred to them as his children and listed them on his tax returns as "dependents," and because they were covered persons under his insurance plan, the decedent thus considered them to be his children or issue, although none were actually of his blood or formally adopted by him. The court continued that to argue otherwise is to advance style over substance and elevate labels over conduct. Moreover, it would require ignoring the practical realities of the society in which we live today. The court further stated that the cases cited by the defendants, ***DeLuca v Gallo***, *supra*, and ***Alberino v Long Island Jewish-Hillside Med. Ctr.***, 87 AD2d 217, 450 NYS2d 857 [2d Dept 1982], were distinguishable, and thus, the court permitted Ravin Mitchell-Benton and her children to advance their claims for loss of pecuniary support, leaving it to the trier of fact to decide whether they demonstrated that they suffered a loss for which they were entitled to recover.

In the instant action, Sarah Merritt testified that her biological father is Mark Stillwachs, with whom she never lived, and never met until she was 18. Although, she maintained contact with him for about one year by phone and over the holidays, she does not talk to him anymore. She testified that her biological father does not provide financial support to her, and that he never married her mother. In 1992, her mother married Shawn Beyel, and she lived with him and her mother from about five years of age until she was about ten or eleven. She testified that Shawn Beyel provided support for her, as well as emotional support, and helped with her homework. She stated that he was more distant, but "its not like he wouldn't be there if I needed him." Her mother and Shawn Beyel obtained a divorce, however, she sees Shawn Beyel periodically when she goes to his house to pick up her brother, Mitchell Beyel. While living with Shawn Beyel, she considered him to be her stepfather, however, he never adopted her. She did not know if he gave her mother support money for her, or if there was a court agreement.

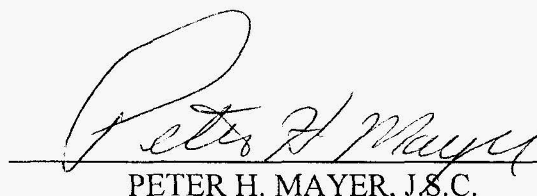
Sarah Merritt continued that she met Roger Martel when she was about ten or eleven, and began residing with him when she was in sixth or seventh grade. Roger Martel did not adopt her or her brother, and he had no children of his own. She could not remember when, but thought that when she was in about ninth grade, about age fourteen, a discussion occurred between him and her mother about Martel adopting her, however, he never did. No steps were taken in furtherance of an adoption procedure because she did not want to be adopted. She stated she never had a father figure and Martel never

pressured her. There was no further discussion about adoption after that discussion when she was in ninth grade. Prior to Roger Martel and her mother marrying, she would receive lunch money from him if they went out somewhere. He helped with her homework and went to games when she played sports. They went on vacation to Florida one time. She stated that he treated her like she was his own, but she did not consider him to be her father, only her stepfather. She trusted him and could talk with him. Sometimes they did not agree on things. She did not know if she had health insurance when her mother was married to the decedent. Upon his passing, all of the decedent's assets went to her mother, and she received no money from any source as a result of his passing. In July 2006, at the time of the decedent's death, she was seventeen years of age.

In the instant action, Sarah Merritt's biological father is still living. Pursuant to EPTL 5-4.1, she may inherit from his estate as a distributee upon his death, as his biological daughter. Sarah Merritt does not claim that she received parental support, parental guidance, or intellectual, moral, and physical training from her biological father, but she did from her stepfather, the decedent. At issue, is whether, as a stepchild, if she received parental support, parental guidance, or intellectual, moral, and physical training from the decedent prior to his death, and whether she should be permitted to recover for the pecuniary loss pursuant to a wrongful death claim.

Based upon the precedent set forth in ***Benton v Brookfield Properties Corporation***, *supra*; and in the absence of any statutory construction in New York State specifically prohibiting a stepchild from recovering damages for pecuniary loss for the wrongful death of a stepparent, a determination of whether or not Sarah Merritt suffered pecuniary loss for which she is entitled to recover on the wrongful death cause of action asserted on her behalf is deferred to the trier of fact for determination.

Accordingly, motion (021), for an order dismissing the complaint insofar as it is asserted by Sarah M. Merritt is denied.



Dated: 11/29/13

PETER H. MAYER, J.S.C.