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SHORT FORM ORDER

INDEX No. 11-2753

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 37 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH FARNETI
Acting Justice Supreme Court

MOTION DATE 9-12-13 (#001)
MOTION DATE 10-10-13 (#002)
ADJ. DATE 12-5-13
Mot. Seq. # 001 - MG
002 - XMotD

GRACE FEDELE, as Executor of the Estate of ANTHONY FEDELE and GRACE FEDELE, Individually,

Plaintiffs,

- against -

RICHARD H. ROSE, M.D., DOMINICK BASILE, M.D., and INTEGRATED MEDICAL PROFESSIONALS, PLLC, d/b/a NORTH SHORE UROLOGY,

Defendants.

BRAND GLICK & BRAND, P.C.
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Garden City, New York 11530

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Attorney for Defendants Rose, M.D. and Integrated Medical Professionals
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SHAUB, AHMUTY, CITRIN & SPRATT, LLP
Attorney for Defendant Basile, M.D.
1983 Marcus Avenue
Lake Success, New York 11042

Upon the following papers numbered 1 to 39 read on these motions to strike answer and preclude, and vacate supplemental bill of particulars; Notice of Motion/ Order to Show Cause and supporting papers (001) 1 - 17; Notice of Cross Motion and supporting papers (002) 18-31; Answering Affidavits and supporting papers __; Replying Affidavits and supporting papers 32-33; 34-39; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the part of motion (001) by plaintiff, Grace Fedele, for an order striking the answer of defendants Richard H. Rose, M.D. and Integrated Medical Professionals, PLLC d/b/a North Shore Urology for spoliation of critical medical and billing evidence for decedent Anthony Fedele, and the part of the motion for a further order precluding said defendants and their experts from offering evidence on the issue of negligence, liability, informed consent, and causation relative to any care and treatment provided to plaintiff's decedent prior to August 1, 2008 due to such spoliation, are granted, unless, within 20 days of the entry of this order with the Clerk of the County of Suffolk, said defendants serve plaintiffs' counsel with a copy of the subject records from 1997 through August 1, 2008, should they be discovered; and it is further

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ORDERED that motion (002) by defendants, Richard H. Rose, M.D. and Integrated Medical Professionals, PLLC d/b/a North Shore Urology, pursuant to CPLR 3042 (b) and 3043 (b) for an order vacating plaintiff's supplemental bill of particulars as improper and precluding plaintiff's expert from testifying with regard to any new theories of negligence, injuries, or damages, is granted to the extent that plaintiff's supplemental bill of particulars dated December 10, 2012 is stricken with leave to the plaintiff to move for an order granting leave to serve an amended complaint, if so advised.

This medical malpractice action was commenced with the filing of a summons and complaint on January 24, 2011. Causes of action are asserted for negligence, lack of informed consent, wrongful death, and a derivative claim. It is alleged that the defendants negligently departed from good and accepted standards of medical care and treatment in their failure to timely and properly diagnose and treat the decedent for prostate cancer, causing the decedent to develop multiple blastic osseous metastatic lesions throughout the thoracolumbar spine and pelvis, resulting in his death on August 30, 2010.

The plaintiff seeks an order striking the answer of defendants Richard H. Rose, M.D. and Integrated Medical Professionals, PLLC d/b/a North Shore Urology (hereinafter "Rose defendants") as a sanction for their alleged spoliation of critical evidence consisting of medical and billing records pertaining to the care and treatment rendered to decedent, Anthony Fedele, while he was a patient at their office. Plaintiff further seeks to preclude the Rose defendants from offering any evidence at trial on the issue of negligence, liability, informed consent, and causation due to the spoliation of evidence.

The plaintiff contends that the Rose defendants, in response to plaintiff's demands, provided copies of their treatment and billing records solely for the period of 2008 through 2010, although the decedent had been a patient of their office since approximately 1997. On August 3, 2012, plaintiff served a notice for discovery and inspection upon the Rose defendants for any and all documents, insurance claims, correspondence, checks or receipts evidencing the existence of a flood at defendants' place of business, because Dr. Rose testified that the decedent's records were destroyed in a flood in the winter of 2010 due to melting snow and ice. A proposed agreement dated June 29, 2009 was produced by the Rose defendants, but nothing was produced to substantiate the existence of actual flood damage, such as an insurance claim or other repair work to the office building.

Dr. Dominic Basile, pursuant to a demand served by plaintiff, provided a copy of his office records maintained for the decedent. These records provided by Dr. Basile are from March 13, 2000 through March 29, 2010. It is noted that these records contain a letter by Dr. Carl Mills, II, dated April 26, 2010, which indicated that "[a]ccording to the limited notes that are available from the other urologist, he was diagnosed in 1997 with TIC Gleason 6 NO adenocarcinoma of the prostate. It appears that his treatment has been only hormonal therapy initially with implantable yearly implants, and more recently with 3 month injections. The daughter, the husband and the patient are not aware that he has gotten any other form of therapy." Dr. Mills continued that "I explained the findings to the patient and specifically to his daughter and this patient clearly has recurrent cancer and will be treated with hormones alone ... I have also asked the daughter to get us some of the earlier records from 1997 just to confirm the diagnosis and the work up at that time and whether any other therapy was given."

Richard Rose testified at his examination before trial to the extent Anthony Fedele became his patient in 1997. He saw the decedent as a patient exclusively in his Port Jefferson office. In preparation for his testimony, he reviewed the decedent's electronic medical record. He first began using the electronic medical record in his office in the fall of 2007. The first date for a visit by decedent, as produced from the electronic medical record, is August 1, 2008. Dr. Rose testified that any of plaintiff's records prior to August 1, 2008 were destroyed by a flood in his Port Jefferson office when his office records were stored in the basement. While he billed the decedent for his services, he kept those billing records upstairs, and those records were not destroyed in the flood. However, when he switched patient records over to computer electronic medical records, he changed the billing records to a different electronic billing service, and any billing records that were on the old system were purged. All open billing records were kept, but any closed billing records were not. Between 1997 and 2010, he used the same software for his billing and his appointment records, but then stated that he was unsure when he switched his appointment records to the computer. Prior to that, he kept appointment books, but did not believe he kept the appointment books.

Dr. Rose testified that he believed the flood occurred in the winter of 2010. There was snow on the flat roof of his office which melted and seeped through the walls and cracks in the roof, and made its way into one of the treatment rooms and the basement. He stated that the "overwhelming majority of patient records from Port Jeff were destroyed." He checked for the decedent's records, but did not find them. He did not put in an insurance claim relating to the flood. He had someone who dealt with the effects from the flood, but did not know who it was. He thought he had a cancelled check.

Dr. Rose testified that he had no independent recollection whether he had laboratory, pathology, or radiology reports from 1997 through the flood of 2010. He would have used Quest, Sunrise, or his own laboratories for testing. For the past ten years in his own laboratory, he does PSA evaluations, testosterone blood levels, and some pathology for prostate biopsies. Either a physician or an office worker ran the lab. Prior to 2002, either Quest or Sunrise would be used for PSA evaluations. Dr. Rose testified that he began treating the decedent for cancer of the prostate in 1997. His record from August 1, 2008 has a history which he referred to. He stated that he continued treating the plaintiff for prostate cancer from 1997 through March 26, 2010. Based upon his custom and practice, he would have obtained PSA results periodically on the decedent from the diagnosis in 1997 through March 26, 2010, but would not have obtained testosterone testing. He had no independent recollection of seeing the decedent's PSA results from 1997 through August 2008. He would not have routinely obtained any other laboratory testing. After the flood, he did not request any copies of lab results from the laboratories which processed the decedent's laboratory results. Dr. Rose testified that his office note of August 1, 2008 indicated that a biopsy had been performed, confirming a diagnosis of prostate cancer, however, the report was destroyed in the flood. He made no attempt to obtain any biopsy or pathology reports from any of the laboratories who interpreted decedent's biopsies because the diagnosis of prostate cancer was already made in 1997 pursuant to the needle biopsy.

Dr. Rose testified that as a urologist, he sees Gleason Scores all the time. The Gleason Score goes up to 12 and is used in patients with prostate cancer. In 2012, if a Gleason score was 6 or less, and the PSA was less than ten, staging diagnostic tests (CT Scan and bone scan) were no longer performed. In 1997, however, all prostate cancer was staged. He described Jowett and TNM staging. He stated he could not determine by clinical examination in 1997 if there was lymph node involvement. He had no specific

recollection of the visits with the decedent prior to August 1, 2008, or discussions concerning PSAs or treatment for prostate cancer. He believed the decedent was not communicative as he was aphasic due to a stroke from when he first became a patient. He had no recollection of what he told the decedent's wife or daughter regarding the decedent's prostate cancer. On August 1, 2008, upon review of decedent's paper chart, he attempted to put into the electronic medical record that history which he considered relevant by way of history from the decedent. He then wrote another note on August 1, 2008 concerning his actual visit with the decedent. He stated that the decedent came in once a year for ablation therapy with medication by injection. Dr. Rose stated that in 1997 when the decedent was first diagnosed with prostate cancer, he would have provided a report to Dr. Basile, decedent's primary physician. That report would have contained what was done, the diagnosis, what was prescribed, what tests were ordered, and what options were given.

Dr. Basile testified to the extent that he was decedent's primary physician from January 17, 2001 until May 9, 2006, when the decedent transferred his records to Dr. Samuel Smith, due to convenience in transportation as Dr. Smith made home visits. However, the decedent returned to him again as a patient on November 20, 2006. At the January 17, 2001 visit, he noted the decedent's history of prostate cancer, but he did not obtain any records concerning his treatment of the decedent, and he did not perform a rectal exam as the decedent had already been diagnosed with prostate cancer, and still had it. He indicated that the plaintiff's decedent still had the prostate cancer because the decedent did not have surgery or radiation, and that he was seeing a urologist, Dr. Rose, who was providing treatment with hormone therapy. On February 1, 2000, he gave decedent a referral for three visits to Dr. Rose. He never received any written reports or copies of records from Dr. Rose pertaining to the decedent. He was not provided with copies of the record for decedent's visits with Dr. Rose on August 1, 2008, September 30, 2009, or March 26, 2010. He ordered a baseline PSA on the decedent in 2000, with a result of 0.1, which Dr. Basile stated was a normal result of no concern. On January 4, 2005, decedent's PSA was 1.55, which he stated was within normal limits. However, he was not aware of the normal range of PSA in a patient undergoing hormone suppression. On March 7, 2008, the PSA was 3.04, which he stated was of no significance to him as the patient was under treatment. Additionally, the decedent gave no complaints of any difficulty with other symptoms that would have led him to believe that the decedent was having a problem with prostate cancer.

Plaintiff's expert submitted an affirmation where he/she set forth that he is licensed to practice medicine in New York and is board certified in hematology and medical oncology. He set forth his education and training and the records and materials which he reviewed. He opined within a reasonable degree of medical certainty that the medical treatment and billing records from 1997 through 2007, as well as particularly those records from 2004 through 2007, were not properly maintained by Dr. Rose and North Shore Urology. He continued that the lack of such treatment and billing records are critical pieces of evidence which will further confirm the progression of, and negligent treatment of, Mr. Fedele's prostate cancer. He further opined that based upon the available medical records and deposition testimony of the parties, that at least beginning on or about January 1, 2004, the treatment rendered by Dr. Rose and North Shore Urology was beneath the accepted standards of medical care and proximately caused Mr. Fedele's prostate cancer to metastasize to his bones and ultimately decreased his chances of survival

"Although [spoliation was] originally defined as the intentional destruction of evidence arising out of a party's bad faith, the law concerning spoliation has been extended to the nonintentional destruction of

evidence...Under New York law, spoliation sanctions are appropriate where a litigant, intentionally or negligently, disposes of crucial items of evidence... before the adversary has an opportunity to inspect them. [Dismissal is a] viable remedy for loss of a key piece of evidence that thereby precludes inspection...[d]rastic sanctions are not necessarily unduly harsh sanctions when a critical item of evidence is not preserved," ***(Kirkland et al v New York City Housing Authority et al,*** 236 AD2d 170, 666 NYS2d 609 [1st Dept 1997]).

"Spoliation of evidence occurs when a party alters, loses, or destroys key evidence before it can be examined by the other party's expert. Spoliation was originally limited to the intentional destruction of evidence arising out of a party's bad faith. However, spoliation has since been expanded by the courts to include the destruction of evidence based on negligence since a party's negligent loss of evidence can be just as fatal to the other party's ability to present a defense...[t]he trend toward the expansion of sanctions for the inadvertent loss of evidence recognizes that such physical evidence often is the most eloquent impartial witness to what really occurred and further recognizes the resulting unfairness inherent in allowing a party to destroy evidence and then to benefit from that conduct or omission" (***Cordero v St. Vincent's Hospital and Medical Center of New York,*** 2008 Misc Lexis 3315, 239 NY Slip Op 3134[U] [Sup Ct, New York County 2008], citing ***Kirkland v New York City Housing Authority,*** *supra*).

"The spoliation doctrine is distinguished from sanctions to dismiss under NY CPLR 3126 in that it is applied even if the destruction of key evidence occurs through negligence rather than willfulness, and even if the evidence is destroyed before the spoliator became a party, provided it is on notice that the evidence might be needed for future litigation" (***Klein et al v Seenauth et al,*** 180 Misc2d 213, 687 NYS2d 889 [Civil Ct, Queens County 1999]).

Under New York Education Law § 6530 (32), physicians must maintain a record for each patient and must retain a patient's record for at least six years. Failure to maintain and retain a patient's record for at least six years is considered unprofessional conduct (8 NYCRR § 29.2 [a] [3]). While the court does not condone the practice of destroying original medical records, neither provision specifies that a record for each patient which accurately reflects the evaluation and treatment of the patient requires that the record be the original record (***DeSantis v Zito, M.D.***, 2011 NY Slip Op 30377[U] [Sup Ct, New York County 2011]).

In the instant a action, it is undisputed that the decedent had been a patient of the Rose defendants since 1997 on a continuing and ongoing basis. Dr. Rose testified that he first began using the electronic medical record in his office in the fall of 2007. The first date for a visit by decedent, as produced from the electronic medical record, was August 1, 2008. He did not scan decedent's records prior to that date into the computer. Dr. Rose testified that any of plaintiff's records prior to August 1, 2008 were destroyed by a flood in his Port Jefferson office while his office records were stored in the basement. Dr. Rose obtained a bid for roof repair on June 29, 2009 and provided a copy of that proposal which provided for repair in the amount of $6,100.00. He thereafter obtained an undated proposal, along with references from Brian Michalec dated January 12, 2010 for the roof repair in the amount of $10,500.00. The redacted bank account shows two transactions in the amount of $4,500.00 for check # 1041 on January 21, 2010, and $6,000.00 for check # 1042 on January 28, 2010. Copies of the faces of those checks have been provided. However, Dr. Rose has submitted no evidentiary proof that a flood did occur in his basement, who cleaned up the basement, or how the records were disposed, except for his conclusory and unsupported assertions.

"Where a party destroys essential physical evidence and the party seeking that physical evidence is 'prejudicially bereft of appropriate means to confront a claim with incisive evidence, the spoliator may be sanctioned by the striking of its pleadings" (***Cammarata v Drexel, et al***, 5 Misc3d 1014A, 798 NYS2d 707 [Sup Ct, Queens County 2004] [internal citations omitted]). The court is permitted to shape a penalty in each case adequate to its own particular facts (***Baker v General Mills Fun Group, Inc. et al,*** 101 Misc2d 193, 420 NYS2d 820 [Sup Ct, New York County 1979]), and may preclude an expert from testifying at trial (***State Farm Mutual Automobile Insurance Company, a.s.o Nancy Meyer v AAAA Bestway Tires & Service, Inc.,*** 2006 NY Slip Op 52386U, 14 Misc3d 1202A, 831 NYS2d 363 [Civil Ct, Kings County 2006]). Dismissal is a viable remedy for loss of a key piece of evidence that thereby precludes inspection. Drastic sanctions are not necessarily unduly harsh sanctions when a critical item of evidence is not preserved," (***Kirkland et al v New York City Housing Authority et al,*** *supra*). Spoliation sanctions are not limited to cases where the evidence was destroyed wilfully or in bad faith, "since a party's negligent loss of evidence can be just as fatal to another party's ability to present [a case] or a defense.... Thus, while courts are reluctant to dismiss a pleading absent wilful or contumacious conduct, it may be warranted as a 'matter of elementary fairness' (***Puccia v Farley***, 261 AD2d 83)" (***Cammarata v Drexel, et al***, *supra*).

While there is no proof that the Rose defendants intentionally destroyed decedent's records from prior to August 1, 2008, it is determined that the decedent's records were negligently maintained permitting them to become destroyed. Plaintiff's medical expert affirms that based upon the available medical records and deposition testimony of the parties, at least beginning on or about January 1, 2004, the treatment rendered by Dr. Rose and North Shore Urology was beneath the accepted standards of medical care and proximately caused Mr. Fedele's prostate cancer to metastasize to his bones and ultimately decreased his changes of survival. Thus, due to spoliation of those missing records, plaintiff is prejudicially bereft of appropriate means to maintain a claim with incisive evidence prior to August 1, 2008 as plaintiff has been denied discovery of critical evidence. Therefore, while no wilful or contumacious conduct is found, the fundamentals of elementary fairness dictate that the offending defendants' answer be struck and that defendants' testimony, and their expert's testimonies, and any evidence concerning any care and treatment rendered to the plaintiff's decedent prior to August 1, 2008, be precluded.

Accordingly, motion (001) by plaintiff, Grace Fedele, for an order striking the answer of defendants Richard H. Rose, M.D. and Integrated Medical Professionals, PLLC d/b/a North Shore Urology for spoliation of critical medical and billing evidence for decedent Anthony Fedele, is granted, and said defendants and their expert are precluded from testifying at trial on the issue of negligence, liability, informed consent, and causation due to such spoliation of those records relative to any care and treatment provided to plaintiff's decedent prior to August 1, 2008, unless, within 20 days of the entry of this order with the Clerk of the County of Suffolk, said defendants serve a copy of those records from 1997 through August 1, 2008, should they be discovered.

In motion (002), defendants seek an order vacating plaintiff's supplemental bill of particulars and to precluding plaintiff's expert from testifying with regard to any new theories of negligence, new injuries, or new damages.

Pursuant to CPLR 3042 (b), in any action or proceeding in which a note of issue is required to be filed, a party may amend the bill of particulars once as of course prior to the filing of a note of issue.

Pursuant to CPLR 3043 (b), a party may serve a supplemental bill of particulars with respect to claims of continuing special damages and disabilities without leave of court at any tine, but not less than thirty days prior to trial. Provided however that no new cause of a action may be alleged or new injury claimed and that the other party shall upon seven days notice, be entitled to newly exercise any and all rights of discovery but only with respect to such continuing special damages and disabilities.

Plaintiff served a verified bill of particulars dated April 13, 2011 in which plaintiff clearly set forth claims that the defendants departed from the accepted standard of care and treatment of plaintiff's decedent, itemizing specific acts and failures in timely and appropriately diagnosing, treating, testing the plaintiff's prostate cancer, and in not referring the decedent to specialists for proper care and treatment, including surgical intervention, radiation therapy, and chemotherapy, causing the decedent's cancer to progress and to metastasize from the prostate.

By letter dated April 28, 2011, the moving defendants demanded that the plaintiff set forth the names of the contraindicated procedures allegedly performed by defendants. Defendant, by counsel, John Yoon, set forth that the correspondence was a good faith effort at obtaining further and/or supplemental bills of particulars.

Plaintiff served a supplemental verified bill of particulars dated April 29, 2011, wherein it was set forth that defendants administration of, and reliance solely upon hormone manipulation/therapy was contraindicated considering decedent's symptoms and clinical evidence of progression of prostate cancer. It is determined that the plaintiff did not assert a new cause of action, injury or damages, but unnecessarily further particularized defendants' alleged negligent departures from the standard of care, as set forth in the verified bill of particulars of April 13, 2011.

Plaintiff served a supplemental verified bill of particulars dated September 17, 2011, setting forth, inter alia, that defendants negligently administered and relied solely upon hormone manipulation/ therapy which was contraindicated; failed to take any steps to treat the plaintiff's recurrence/growth of decedent's prostate cancer; and failed to properly treat decedent's prostate cancer from the beginning of its diagnosis; failed to inform the decedent and his family that hormone suppression therapy would not cure prostate cancer, or of the treatment alternatives; failed to perform PSAs with appropriate frequency; permitted decedent's prostate cancer to grow and spread, permitting the progression and metastasis of prostate cancer. It is determined that plaintiff did not set forth any new injuries or damages, but further particularized defendants' alleged negligent departures from the standard of care. As set forth, causes of action for negligence, lack of informed consent, wrongful death, and a derivative claim were plead in the complaint of this action. It is also noted that said supplemental verified bill of particulars further responds to defendants' demand letter of April 28, 2011 by counsel Yoon.

Plaintiff served a supplemental bill of particulars dated September 20, 2011, wherein it was plead that defendants were negligent in that they failed to perform, order or refer the plaintiff for various tests which plaintiff itemized; failed to monitor the progression of the prostate cancer; failed to perform digital rectal exams and biopsy the prostate and lymph nodes in the pelvis and seminal vehicles; failed to order transrectal ultrasound and MRI; and failed to perform, order, or refer the decedent for certain diagnostic testing, as itemized, and failed to consider having decedent undergo alternative treatments to hormone manipulation therapy, which treatments are itemized. Again, the plaintiff has further particularized the

defendants' alleged departures from the standards of care and treatment, but has not set forth new damages, injuries, or causes of action.

Plaintiff served an amended supplemental verified bill of particulars dated September 27, 2011, wherein it was plead that the defendants negligently failed to perform, order, or refer the decedent for certain diagnostic testing, as itemized, and failed to consider having decedent undergo alternative treatments to hormone manipulation therapy, which treatments are itemized. It is determined that the plaintiff did not assert a new cause of action, injury or damages, but unnecessarily further particularized and repeated defendants' alleged negligent departures from the standard of care, as set forth in the verified bill of particulars of April 13, 2011.

On December 10, 2012, plaintiff served a supplemental bill of particulars wherein plaintiff pled that defendants additionally negligently departed from the standard of care in violating Education Law § 6530 (32), Public Health Law § 18 (1) (e), and Business Corporation Law § 1504 (c); and negligently failed to salvage or reconstruct those portions of the decedent's medical and billing records as were able to be reconstructed by freeze drying, or photocopying, and negligently failed to notify the New York State Board of Registration and/or The Centers for Medicaid & Medicare Services by filing an attestation form, and to timely notify the decedent that such loss occurred.

Defendants' counsel, affirms that on October 1, 2012, she corresponded with plaintiff, rejecting the pleading of September 27, 2012, in that it was served without leave of court. She now argues that it is her position that any items claimed in plaintiff's third, fourth, fifth, or sixth bills of particulars are not proper without leave of court. She requests that the bills of particulars be struck and plaintiff precluded from offering any evidence contained with new theories and/or claims.

Generally, courts have allowed amendments to pleadings and bills of particulars, even at or after trial, absent proof of actual prejudice to the other party, unless the proposed amendment is patently insufficient or devoid of merit (***Unger v Leviton***, 25 AD3d 689, 811 NYS2d 691 [2d Dept 2006]; ***Dimino v Rosenfeld***, 306 AD3d 371, 760 NYS2d 859 [2d Dept 2003]; ***Loomis v Civetta Corinno Constr. Corp.***, 54 NY2d 18; ***Kurnitz v Croft***, 91 AD2d 972, 457 NYS2d 560 [1983]). Where plaintiffs have shown a *prima facie* basis for their additional claims, and defendants have claimed no prejudice, leave to supplement a bill of particulars should be freely given (***Jesselli v City of New York***, 59 AD2d 755, 398 NYS2d 701 [2d Dept 1977]). A bill of particulars in a medical malpractice action, as in any a action for personal injuries, requires a "general statement of the acts or omissions constituting the negligence claimed" (***Pirelli v Victory Memorial Hospital***, 45 AD2d 856, 358 NYS2d 537 [2d Dept]).

The purpose of a bill of particulars is to amplify pleadings, limit proof, and prevent surprise at trial, not to provide evidentiary material. It must provide a general statement of the acts or omissions constituting the alleged negligence. In a medical malpractice case, there is no need for a plaintiff to set forth the manner in which the physician failed to act in accordance with good and accepted medical practice, since a physician is chargeable with knowing those medically accepted standards applicable to the proper care and treatment of the plaintiff (***Toth v Bloshinsky***, 39 AD3d 848, 835 NYS2d 302 [2d Dept 2007]). Here, however, the plaintiff has unnecessarily done so, and has not plead new theories of negligence as the new pleadings amplify the negligent failure to timely and properly diagnose, test, and treat

the decedent's prostate cancer, with the exception of the supplemental bill of particulars dated December 10, 2012.

With regard to the supplemental bill of particulars dated December 10, 2012, wherein plaintiff pled that defendants additionally negligently departed from the standard of care in violation of Education Law § 6530 (32), Public Health Law § 18 (1) (e), and Business Corporation Law § 1504 (c); and negligently failed to salvage decedent's records, it is determined that plaintiff has asserted new allegations not asserted in the complaint,[1] which violates CPLR 3043 (b), and said supplemental bill of particulars dated December 10, 2012 must be stricken (***Jurado v Kalache***, 93 AD3d 759, 940 NYS2d 300 [2d Dept 2012]), although such pleadings are supported by the record submitted, including defendant Rose's testimony.

Accordingly, motion (002) by defendants, Richard H. Rose, M.D. and Integrated Medical Professionals, PLLC d/b/a North Shore Urology, pursuant to CPLR 3042 (b) and 3043 (b) for an order vacating plaintiff's supplemental bills of particulars as improper and precluding plaintiff's expert from testifying with regard to any new theories of negligence, injuries, or damages, is granted to the extent that plaintiff's supplemental bill of particulars dated December 10, 2012 is stricken with leave for the plaintiff to move to amend the complaint, if so advised.

Dated: February 20, 2014

Hon. Joseph Farneti
Acting Justice Supreme Court

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION

[1] While defendants have not submitted a copy of plaintiff's complaint, in searching the record the court refers to the copy of the complaint contained in plaintiff's moving papers submitted with motion (001).