

<b>Richardson v Chesoni</b>
2020 NY Slip Op 31261(U)
May 8, 2020
Supreme Court, Kings County
Docket Number: 505148/17
Judge: Bernard J. Graham
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At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 8th day of May, 2020.

P R E S E N T:

HON. BERNARD J. GRAHAM,

Justice.

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Index No. 505148/17

SIRENA RICHARDSON, as Administratrix of  
The Estate of PATRICIA MAHMUD, Deceased,

Plaintiff,

-against-

LAURA CHESONI, M.D., ATINUKE KALEJAIYE,  
CRNA, THE BROOKLYN HOSPITAL CENTER and  
NORTH AMERICAN PARTNERS IN ANESTHESIA, LLP,

Defendants.

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The following e-filed papers read herein:

NYSCEF Docket Nos.:

Notice of Motion/Order to Show Cause/ Petition/Cross Motion and _____	<u>111, 112, 127</u>
Affidavits (Affirmations) Annexed Opposing Affidavits (Affirmations) _____	<u>128, 131</u>
Reply Affidavits (Affirmations) _____	<u>133</u>
Other Documents _____	_____

Upon the foregoing papers in motion sequence (mot. seq.) eight, defendant The Brooklyn Hospital Center (BHC) moves for an order, pursuant to CPLR 3212, granting it summary judgment as to its claims for defense and indemnification against co-defendant North American Partners in Anesthesia, LLP (NAPA).<sup>1</sup>

<sup>1</sup> By order dated January 9, 2020, the court granted co-defendant Rita Albano, M.D.'s (Albano) and Advantage Care Physicians, PHP's (Advantage) summary judgment motions, mot. seq. 6 and

### Facts and Procedural Background

This is a medical malpractice action brought by plaintiff Sirena Richardson (plaintiff) on behalf of Patricia Mahmud (decedent), who died on May 16, 2016 following elective laproscopic bilateral salpingo-oophorectomy -- a surgery to remove both ovaries due to a left ovarian mass - - performed on the same day at defendant The Brooklyn Hospital Center (BHC). Co-defendant Laura Chesoni, M.D. (Chesoni), decedent's anesthesiologist, and co-defendant Atinuke Kalejaiye, CRNA<sup>2</sup> (Kalejaiye) were both employed by NAPA and were responsible for administering anesthesia and performing preoperative, operative, and postoperative assessments of decedent as it related to her anesthesia.

After surgery, decedent was transported to the Post-Anesthesia Care Unit (PACU), an intensive care unit (ICU) where patients who received anesthesia during their medical procedures are monitored in order to determine whether they may be safely discharged either to another floor, another ICU, or to their home. According to Chesoni, patients are transferred to the PACU directly from the operating room when they have stable vital signs, when they are supporting their own airway, or when they have a mode of transporting them, if needed. While in the PACU, nurses remain at a patient's bedside, and continuously monitor patients' vital signs. Chesoni expected nurses to notify her of any problems with her patients so she could immediately respond because the PACU is near the operating room. Once a patient stabilized, Chesoni generally moved on to her next patient.

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7, respectively, without opposition, and the caption has been adjusted accordingly.

<sup>2</sup> CRNA stands for Certified Registered Nurse Anesthetist. According to Kalejaiye, a CRNA works in conjunction with anesthesiologist to intubate and extubate the patient, and manage the anesthetic.

Decedent's procedure ended at 10:15 a.m., and decedent left the operating room around 10:35 a.m. Kalejaiye testified that she believed decedent was awake after the surgery because (1) while decedent was morbidly obese, Kalejaiye did not require assistance moving her from the operating table to the stretcher, (2) decedent obeyed Kalejaiye's command to move to the stretcher with minimal assistance, (3) decedent's eyes were open, and (4) Kalejaiye was able to squeeze decedent's hand, and when she called to decedent, decedent answered her. Chesoni, however, could not state whether decedent was wide awake or responsive when she left the operating room. Kalejaiye brought decedent to the PACU with a face mask that delivered supplemental oxygen. Kalejaiye testified that the mask did not have any effect on decedent's lung expansion, and no other devices were used to assist decedent's breathing at that time, nor did she need assistance breathing and was not lethargic. Additional nurses were stationed in the PACU. Kalejaiye testified that she and decedent arrived in the PACU approximately 10:38 a.m. According to Kalejaiye, upon arrival, decedent was still able to talk and move her head. During her transport, decedent's oxygen saturation values were between 94% and 95%, which Kalejaiye testified was adequate for her.

Marie Paderanga (Paderanga), a registered nurse employed by BHC, testified that she was in the PACU when decedent was brought from the operating room. Her duties were to attach patients to a monitor when coming out of the operating room, to make sure the patients' airways were clear, to check patients' vital signs, including oxygen saturation, and to make sure the patients were stable. Paderanga testified that she usually checked patients' vitals every five minutes or so, depending on the patients' condition.

Further, she usually monitors two or three patients at a time but concentrates on the ones just arriving from the operating room. Paderanga testified that it was only when a patient was stable that a “hand off” from the anesthesiology team to the PACU would occur. Paderanga further testified that she took decedent’s vitals and documented them in the chart, but that Kalejaiye remained with decedent the entire time. Kalejaiye confirmed that she stayed with decedent the entire time that decedent was in the PACU until she expired.

Contrary to Kalejaiye, however, Paderanga testified that when decedent was first brought to the PACU at 10:38 a.m., she was asleep and unresponsive to tactile stimuli. Paderanga tried to wake decedent up by touching her and calling her name, but decedent did not respond. Paderanga then observed decedent gasping for breath and knew that she was short of breath by her physical movements. Paderanga testified that Chesoni and Kalejaiye were present and did not leave decedent’s bedside during this time. As previously stated, Kalejaiye confirmed that she did not leave decedent’s side the entire time.

Kalejaiye testified that by the time decedent reached the PACU and was placed on the monitor, her oxygen saturation was 87%, even though decedent was responding to her. Kalejaiye testified that she called for assistance as well as for an AMBU<sup>3</sup> bag to support the decedent’s breathing. Kalejaiye operated the AMBU bag between 10:38 a.m. and 10:44 a.m., synchronizing it with decedent’s respiration to assist her breathing because she was still breathing on her own. Kalejaiye testified that decedent was never unresponsive between 10:38 a.m. and 10:42 a.m. At 10:42 a.m., the decedent’s oxygen

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<sup>3</sup> Artificial Manual Breathing Unit.

saturation was 85%. According to Chesoni, pulse oximetry is sensitive to artifact and fluctuates, and can be 85% one second and 98% the next. Chesoni, who had been working on another patient, was called back to the PACU and arrived at 10:43 a.m. Chesoni testified that at that time, decedent was responding to her name and rubbing her chest and opening her eyes, and Kalejaiye testified that decedent was moving on her own. At 10:44 a.m., Chesoni ordered decedent to be placed on a BiPAP<sup>4</sup> machine. When initially placed on the BiPAP, her oxygen saturation rose to 95%, but dropped to 82% over the next 15 minutes despite being on the machine. A respiratory therapist from BHC, Yasmine Alnowfi (Alnowfi), applied the BiPAP, and thereafter, decedent's oxygen saturation improved to 95%. Kalejaiye testified that between 10:44 a.m. and 11:05 a.m., decedent never became unresponsive, and her oxygen saturation levels stayed between 90% and 95%.

At Chesoni's direction, Narcan was administered to decedent, however, decedent's breathing did not change as a result. Kalejaiye testified that the decedent was intubated at 11:05 a.m.<sup>5</sup> and placed on a ventilator. Kalejaiye testified that decedent was intubated because her lung volumes were not adequate on the BiPAP, meaning that her lungs were not filling up, and that the BHC respiratory therapist, Alnowfi, noted that the volumes were low. According to Kalejaiye, low oxygen volumes can lower oxygen saturation, which will generally lead to decreased tissue perfusion. Kalejaiye testified that Alnowfi

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<sup>4</sup> The record refers to this machine in different deposition transcripts as a BiPAP or a CPAP machine. Kalejaiye testified that a BiPap machine is a form of CPAP but it assists not only with inspiration pressure, but also with expiratory pressure, and in that way works like an advanced CPAP machine by assisting the lungs breathe in and out. The court will refer to the machine as a BiPap machine.

<sup>5</sup> Paderanga noted that Chesoni intubated the decedent at 11:00 a.m. Kalejaiye testified that either she or someone else intubated decedent at 11:05 a.m.

never indicated to her that she did not believe decedent's lung volumes were inappropriate. Kalejaiye testified that she was able to observe the lung volume on the BiPAP monitor.

Kalejaiye testified that after decedent was intubated, she remained in the recovery room but that the nurses were monitoring the decedent at this point, so she "handed over the care to the nurses" and they, not she, were keeping a record of decedent's vital signs. Kalejaiye testified that at 11:14 a.m., she and the nurses observed bradycardia<sup>6</sup> on the monitors, and that thereafter, ACLS<sup>7</sup> protocols were initiated. Kalejaiye testified that when an ACLS code is initiated, that the Anesthesia personnel were responsible for running the code but that enough hands would be in the room to assist. Kalejaiye testified that she did not participate in the code and did not know what caused the condition that necessitated the code. When asked if BHC ever directed her care with respect to decedent, Kalejaiye did not respond directly, but stated that the one thing she knew was that she did not order antibiotics. It is the surgeon who determines what they want given and it is the surgeon who handles administering same. The decedent ultimately experienced oxygen desaturation to the 60s, became pulseless and thereafter expired at 12:00 p.m.

At her deposition, Paderanga testified that she did not observe the decedent make any movement, purposeful or otherwise. However, the evening that decedent passed away, Paderanga entered an addendum to her hospital note stating that she observed non-purposeful movement in the decedent. She testified that she did not make the note contemporaneously because she was attending to decedent and did not have time. While

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<sup>6</sup> A slower than normal heart rate.

<sup>7</sup> Advanced Cardiovascular Life Support.

she did not recall whether she made changes to her contemporaneous notes, she testified that she did not alter decedent's vital signs because they came out of a monitor printout. Paderanga also testified that she observed the Narcan being administered, but that the Narcan did not reverse decedent's condition.

Plaintiff commenced this action on March 15, 2017 and served BHC on March 27, 2017. Thereafter, on November 6, 2018, BHC requested indemnification from NAPA under a 2009 indemnification agreement (contract) entered into between them. Under the terms of the 2009 contract, as amended October 1, 2014, NAPA agreed to indemnify BHC and its agents from any and all claims caused by NAPA's negligent acts or omission (Contract, Section 20 [A]). On December 19, 2018, NAPA declined the request on the ground that it was premature because liability had not yet been found against NAPA, and because NAPA contended that BHC did not provide it with prompt notice. NAPA also noted that the indemnification provisions in the contract are mutual, and that if BHC is found liable, they must likewise indemnify NAPA for its share of liability. On July 30, 2019, BHC notified NAPA that it continued to reserve its right to pursue indemnification.

### **Parties' Contentions**

#### **A. BHC's Contentions**

BHC contends that decedent died of complications from anesthesia and denies that it is liable for decedent's death. It asserts that the claims against it are vicarious in nature, and that the facts of this case warrant indemnification under the contract.

BHC argues that its tender to NAPA was not premature because courts may render a conditional judgment as to contractual indemnity pending determination of the underlying action so that the indemnitee may obtain the earliest possible determination as

to extent of the reimbursement. BHC asserts that since courts can enter conditional indemnity orders, whether or not plaintiff can ultimately prove BHC's liability is irrelevant to the issue of indemnification. BHC also contends that NAPA's refusal to indemnify based on notice is improper because NAPA had been a defendant in the case from inception and NAPA was on notice of plaintiff's allegations from the outset of this case because it was served with the summons and complaint. BHC further argues that NAPA is aware of its indemnification obligations because it was a signatory to the contract.

In addition, BHC contends that NAPA employees Chesoni and Kalejaiye never relinquished control of the decedent to BHC's PACU nurse, that "handoff" to BHC did not occur, and that any liability is solely through NAPA actors. In this regard, BHC asserts it is uncontested that: (1) Kalejaiye remained at decedent's bedside until she expired because decedent had not completely recovered from the effects of anesthesia, (2) Chesoni was urgently called to the PACU to reverse the effects of the anesthesia, administered Narcan and intubated decedent prior to cardiac arrest, and (3) BHC did not have any role in administration of anesthesia and that anesthesiology was solely responsible for monitoring decedent's vitals during the surgery. BHC contends that since it was not involved in decedent's surgery, nor any pre, intra or post-operative actions concerning decedent, the facts of the case warrant assumption of BHC's defense by NAPA.

In further support of this contention, BHC submits the affidavit of its expert anesthesiologist, Manuel Fontes, M.D. (Fontes), who opines that it remained NAPA's responsibility, via Chesoni and Kalejaiye, to monitor decedent postoperatively until the

residual effects of anesthesia wore off, and that it remained NAPA's responsibility to monitor decedent's breathing, circulation, activity level, consciousness and oxygen saturation, taking action when any of these are abnormal. Fontes opines that a patient in the PACU remains under the care of the peri-anesthesia nurse, here Klejaiye. Fontes further opines that the anesthesia team cannot "hand off" a patient until there has been adequate recovery, and for this time period, the patient's condition remains the anesthesia team's responsibility.

Fontes alleges that BHC did not make any decisions with respect to the decedent's treatment – that it was her primary care physician, Albano, that independently evaluated and cleared her for surgery, and that all pre-anesthesia related events, such as interview, medical history review, the type of anesthesia used, and verifying interactions with the patient – were all at NAPA's discretion and clinical judgment, and that BHC had no role in any of the pre-surgical anesthesia review and evaluation. While Fontes acknowledges that Paderanga attended to decedent in the PACU after the surgery, her role was solely to monitor patient's vitals and that there was never a "handoff of care" from NAPA to BHC.

#### **B. NAPA's Contentions**

NAPA contends that summary judgment as to indemnification is premature because BHC has not satisfied its burden of proving that it was not negligent in causing decedent's death, and because NAPA has not yet been found liable. NAPA asserts that by not filing a summary judgment motion as to its liability, BHC has tacitly conceded that a question of fact remains concerning its liability. NAPA argues that the issue of contribution among the parties is a factual one for the trier of fact to decide.

NAPA also contends that the testimonies of BHC staff, Kalekaiye, and Chesoni raise significant questions of fact with regard to the propriety of care rendered by BHC. It alleges that BHC employees took “active and autonomous” roles in caring for decedent and therefore their actions or inactions may have contributed to her death. In this regard, NAPA contends that BHC relied on Paderanga’s notes when it concluded that decedent was deeply sedated upon admission to the PACU and to claim that no “hand off” occurred, and that BHC’s expert overlooked Kalejaiye’s testimony that decedent was awake and responsive upon entering the PACU and awake, alert, stable and spontaneously ventilating when the BiPAP was placed. NAPA argues that Paderanga played a significant role in decedent’s care while in the PACU, and that the BHC respiratory therapist who applied the BiPAP machine was also responsible for her care for monitoring her vital signs.

In support of this contention, NAPA submits an affirmation from its expert, Mark DiSciullo, an anesthesiologist, who disagrees with Fontes and opines that “the course of care for surgical patients is not divided neatly amongst providers” as Fontes believes. Rather, DiSciullo asserts that each medical provider assigned to decedent’s care was required to both follow orders and act on an individual basis to ensure her safety and health. DiSciullo contends that decedent was treated “in the framework of a redundant system,” where both BHC and the anesthesia team were responsible for ensuring decedent’s stability and care. DiSciullo also disagrees with Fontes’ claim that Paderanga’s role in the PACU was merely to monitor the patient’s vital signs, and that there was never a handoff. DiSciullo explains that the PACU staff are trained to care for patients recovering from anesthesia and are tasked with, and able to, deal with emergency

situations involving complications from anesthesia, and to do so autonomously. DiSciullo makes note that Paderanga's testimony concerning her PACU duties -- to ensure a clear airway, responsiveness to stimuli, and to check vital signs and ensure patient stability -- demonstrate that her role was not merely to monitor decedent's vital signs but also to take an active role in ensuring her stability, even in the presence of an anesthetist or CRNA. DiSciullo also points to Alnowfi's active role in placing and configuring the BiPap as raising a question of fact as to whether there was a "hand off." DiSciullo ultimately concludes that decedent was not solely under the care of anesthesia team and that BHC was "not captive to the anesthesia team" either, but that rather each group had autonomy to satisfy their responsibility to ensure the decedent's stability and well-being.

NAPA further questions the accuracy of Paderanga's testimony and notes, as she made multiple additions to the medical record after decedent's death but could not recall the nature of the changes. NAPA alleges that a trier of fact rather than a court should reconcile the inconsistencies in her testimony and records.

### **Discussion**

A party moving for summary judgment bears the burden of making a prima facie showing of entitlement to judgment as a matter of law and must tender sufficient evidence in admissible form to demonstrate the absence of any material factual issues (see CPLR 3212 [b]; *Alvarez v Prospect Hospital*, 68 NY2d 320, 324 [1986]; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; *Korn v Korn*, 135 AD3d 1023, 1024 [3d Dept 2016]). Failure to make this prima facie showing requires denial of the motion (see *Alvarez*, 68 NY2d at 324; *Winegrad v New York University Medical Center*, 64 NY2d

851, 853 [1985]). Once this showing has been made, the burden shifts to the party opposing the motion to produce evidence in admissible form sufficient to establish an issue of material fact requiring a trial (*see* CPLR 3212; *Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). “[A]verments merely stating conclusions, of fact or of law, are insufficient to defeat summary judgment” (*Banco Popular North America v Victory Taxi Management, Inc.*, 1 NY3d 381, 383 [2004] [internal quotations omitted]). The court must view the totality of evidence presented in the light most favorable to the non-moving party and accord that party the benefit of every favorable inference (*see Fortune v Raritan Building Services Corp.*, 175 AD3d 469, 470 [2d Dept 2019]; *Emigrant Bank v Drimmer*, 171 AD3d 1132, 1134 [2d Dept 2019]).

Summary judgment is a “drastic remedy” that “should not be granted where there is any doubt as to the existence of such issues or where the issue is ‘arguable’; issue-finding, rather than issue-determination, is the key to the procedure” (*Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957], *rearg denied* 3 NY2d 941 [1957] [internal citations omitted]). “The court’s function on a motion for summary judgment is ‘to determine whether material factual issues exist, not resolve such issues’” (*Ruiz v Griffin*, 71 AD3d 1112, 1115 [2d Dept 2010] quoting *Lopez v Beltre*, 59 AD3d 683, 685 [2d Dept 2009]).

“A court may render a conditional judgment on the issue of contractual indemnity, pending determination of the primary action so that the indemnitee may obtain the earliest possible determination as to the extent to which he or she may expect to be reimbursed” (*Jamindar v Uniondale Union Free School Dist.*, 90 AD3d 612, 616 [2d Dept 2011], quoting *Correia v Professional Data Mgt.*, 259 AD2d 60, 65 [1st Dept 1999];

see also *Jardin v A Very Special Place, Inc.*, 138 AD3d 927, 930 [2d Dept 2016]; *George v Marshalls of MA, Inc.*, 61 AD3d 931, 932 [2d Dept 2009]). “To obtain conditional relief on a claim for contractual indemnification, ‘the one seeking indemnity need only establish that it was free from any negligence and [may be] held liable solely by virtue of . . . statutory [or vicarious] liability’” (*Jamindar*, 90 AD3d at 616; see also *Graziano v Source Builders & Consultants, LLC*, 175 AD3d 1253, 1260 [2d Dept 2019]; *Jardin*, 138 AD3d at 931; *George*, 61 AD3d at 932). “However, where a triable issue of fact exists regarding the indemnitee’s negligence, a conditional order of summary judgment for contractual indemnification must be denied as premature” (*Jamindar*, 90 AD3d at 616). Further, “[t]he right to contractual indemnification depends upon the specific language of the contract, and [t]he promise to indemnify should not be found unless it can be clearly implied from the language and purpose of the entire agreement and the surrounding facts and circumstances” (*McDonnell v Sandaro Realty, Inc.*, 165 AD3d 1090, 1096 [2d Dept 2018] [internal citations and quotation marks omitted]).

Here, BHC has not met its burden of demonstrating that it was free from negligence (see *Graziano*, 175 AD3d at 1260; *Jamindar*, 90 AD3d at 616). While Kalejaiye testified that she transported decedent to the PACU and never left her side until she expired, and that Chesoni also treated decedent in the PACU by ordering the BiPAP and Narcan treatments, there is also evidence that BHC employees, in particular, Paderanga and Alnowfi, the respiratory therapist, at the very least monitored decedent’s vital signs and administered the BiPAP. There is also a question as to the extent of Paderanga’s involvement in decedent’s treatment, and whether her testimony that she did not observe decedent moving is credible in light of her note that she observed non-

purposeful movement and that she revised the note after decedent passed away. Such credibility determinations are not appropriately resolved on a motion for summary judgment but are for a trier of fact to resolve (*see Cassidy v Allstate Insurance Company*, 63 AD3d 869 [2d Dept 2009]). Thus, there is evidence in the record here to support DiSciullo's conclusion that decedent was not solely under NAPA's care while in the PACU, but rather that BHC staff also treated decedent. As there is a dispute between the experts as to whether decedent was "handed off" to BHC in the PACU, on this record, there is a question of fact as to whether BHC or its employees departed from acceptable medical practice that may have contributed to decedent's demise (*see Johnson v Queens-Long Island Medical Group*, 23 AD3d 525, 527 [2d Dept 2005]; *Taylor v Nyack Hosp.*, 18 AD3d 537 [2d Dept 2005]). These issues preclude granting BHC conditional indemnification from NAPA at this time, as BHC's freedom from negligence has not been conclusively determined.

As BHC has failed to make its prima facie burden on the instant motion, that burden does not shift to NAPA to produce evidence in admissible form sufficient to establish an issue of material fact requiring a trial (*see Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). Accordingly, BHC's motion is denied without regard to the sufficiency of NAPA's opposing papers (*Alvarez*, 68 NY2d at 324; *Smalls v AJI Industries, Inc.*, 10 NY3d 733, 735 [2008]).

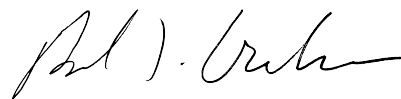
Conclusion

Accordingly, it is

**ORDERED** that defendant BHC's motion, mot. seq. 8, for an order, pursuant to CPLR 3212, granting it summary judgment as to its claims for defense and indemnification against co-defendant NAPA is denied.

This constitutes the decision and order of the court.

ENTER:



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J.S.C.