Mulroe v New York-Presbyt. Hosp.
2020 NY Slip Op 34114(U)
December 11, 2020
Supreme Court, New York County
Docket Number: 162310/2015
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

Justice

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CYNTHIA MULROE and JAMES MULROE,

Plaintiffs,

- v -

NEW YORK-PRESBYTERIAN HOSPITAL, DAVID KUTLER, JOEL FRIEDMAN, and JACK KAUFMAN

Defendants.

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INDEX NO. 162310/2015

MOTION DATE 10/20/2020

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 129, 133, 138, 139, 140, 141, 142, 153, 154, 155, 156, 157, 158, 159, 160, and 161 (Motion 004)

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

In this action to recover damages for dental malpractice and lack of informed consent, the defendants New York-Presbyterian Hospital (NYPH), David Kutler, M.D., and Joel Friedman, D.D.S. (collectively the NYPH defendants) together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiffs oppose the motion. The motion is granted to the extent that summary judgment is awarded to the NYPH defendants dismissing the lack of informed consent cause of action insofar as asserted against them, and the motion is otherwise denied.

Many of the facts underlying this dispute have been developed in detail in this court's December 8, 2020 order, granting in part and denying in part the motion of the defendant Jack Kaufman for summary judgment dismissing the complaint insofar as asserted against him (SEQ 003). In short, in 2011, the plaintiff Cynthia Mulroe (the patient) had implants placed by periodontist Michael Voskian at the locations where teeth numbers 28 and 30 previously had

been extracted, but, by late 2013, had developed swollen and irritated gums near the latter implant site. Voskian treated the symptoms with antifungal agents, but the treatment did not alleviate the symptoms. Voskian noted the presence of bony sequestra. The patient thereafter presented Kaufman with symptoms of swollen, irritated gums in the lower right posterior quadrant that were distal and lingual to an existing dental implant at tooth location number 30. In early 2014, Kaufman performed a biopsy of a lesion near that implant site and removed the implant. Kaufman treated the symptoms with streroidal anti-inflammatory agents and some antibiotics. The biopsy revealed the presence of fragments of nonviable bone, that "bacterial colonies were present focally," and that "chronic inflammatory cells were present." Kaufman diagnosed the patient with "epithelial hyperplasia with overlying keratosis," also known "hyperkeratosis," that was distal and lingual to the subject implant. The biopsy tests also were positive for fungus that caused "fungal mucositis." Kaufman did not diagnose osteomyelitis. Kaufman referred the patient to Kutler and Friedman in February 2014 for assessment and further treatment of the lesion, and did not discuss with them the possibility that the patient was suffering from osteomyelitis. Kutler, after having treated the patient for 10 months, issued a report, dated December 10, 2014, noting that the patient "had a CAT scan of the neck and mandible region which showed signs of chronic osteomyelitis and a lytic bone lesion." The patient later went on to have several more surgeries that were performed by other health care providers, including a mandibulectomy and subsequent revision surgery.

In their bill of particulars as to the NYPH defendants, the plaintiffs alleged that all of those defendants departed from good and accepted medical and dental care by failing properly to examine the patient, take a proper medical history, be aware of the patient's past medical history, and recognize the significance of the patient's past medical history. They further asserted that the NYPH defendants failed properly to report or chart the patient's maxillofacial examination, appreciate the significance of the patient's symptoms taken together as a whole, properly and timely read CT scans, seek additional medical advice about those scans, and

appreciate the significance of the scans. In addition, the plaintiffs asserted that the NYPH defendants failed properly and timely to evaluate biopsies, seek additional medical advice about the patient's biopsies, appreciate the significance of the biopsies, or take and evaluate additional X-rays, CT scans, blood tests, and biopsies. In their bill of particulars, the plaintiffs also alleged that the NYPH defendants failed to recognize the significance of existing bone loss and resorption and history of marginal mandibulectomy/alveolectomy, as well as the presence of a thick white irregular lesion of the right posterior mandibular alveolar ridge extending around the patient's dental implant, a paste-like material around the lateral aspect of the mandible, focally necrotic bone, acute inflammation and microabscess formations, exposed bone along the anterior aspect of the alveolar ridge region, parotid and masseter region swelling, focal areas of cortical erosion/dehiscence, draining purulent material, and bone chips. Crucially, the plaintiffs alleged that the NYPH defendants deviated from good and accepted dental and medical practice in failing to recognize that those signs and symptoms should have led to a timely diagnosis of osteomyelitis, with the concomitant timely care and treatment of that condition, such as the timely and proper prescription of antibiotics to the patient and related minimal surgery. They contended that the unnecessary delay caused the patient to require additional surgery, thus leading to additional conscious pain and suffering.

In their bill of particulars, the plaintiffs also asserted that NYPH defendants failed to advise the patient of the risks associated with the tests and procedures performed.

In support of their motion, the NYPH defendants submit, among other things, transcripts of the parties' depositions. At his deposition, Kutler testified that he was and is a full-time employee of Weill Cornell Medical Center, which is part of the New York Presbyterian Hospital-Weill Cornell Medical Center group. He asserted that he is a board certified otolaryngologist and head and neck surgeon. Kutler testified that he reviewed a report of a biopsy of a growth or lesion conducted by Kaufman, who had referred the patient to him, and that the report revealed that the patient exhibited verrucous hyperplasia (a wart-like thickening of the lining of the mouth)

in the right posterior alveolar ridge, that is, along her right rear gums. Kutler explained that the presence of verrucous hyperplasia may be an indication that a patient suffers from verrucous carcinoma. He also explained that Kaufman had conducted a prior biopsy that yielded a diagnosis of epithelial hyperplasia with overlying hyperkeratosis (keratin debris overlying the thickened area), but that the prior diagnosis described a pathology distinct from verrucous hyperplasia. Kutler asserted at his deposition that the presence or absence of necrotic bone tissue in the biopsy sample was irrelevant to any diagnosis or course of treatment, but he conceded that osteomyelitis could cause the presence of necrotic bone tissue. He asserted that signs of osteomyelitis include periosteal elevation (the formation of new bone in response to injury or other stimuli of the periosteum surrounding the bone), as well as erosion, resorption, or fracture of the affected bone.

Kutler averred that he operated on the patient on March 18, 2014 to remove the lesion, along with Friedman, who simultaneously performed a marginal mandibulectomy, with Kutler thereafter prescribing antibiotics. Kutler asserted that, as of May 19, 2014, after the patient had discontinued the first course of antibiotics, her swelling and pain recurred and increased. Kutler prescribed additional antibiotics to treat what he believed was post-operative cellulitis arising from an infection of the tissues in and around the cheek area, albeit not in the mandible bone itself.

Kutler testified that he first ordered a CT scan for the patient on June 25, 2014, or four months after she had first been referred to him. He explained that osteomyelitis occurs when a bone becomes infected with bacteria. Kutler asserted that he did not believe that the patient was suffering from osteomyelitis when he first operated on her on March 18, 2014, on May 19, 2014, when she presented with continuing swelling, irritation, and pain after discontinuing antibiotics, or on June 25, 2014, when he took the first post-operative CT scan, or on September 15, 2014, when he took a second post-operative CT scan. Kutler concluded on those occasions that the patient had granulation, or chronic inflammatory tissue, that did not

suggest the infection of any bone. He stated that he only diagnosed the patient with osteomyelitis in her right ramus and posterior body of mandible, that is, the right rear of her lower jaw bone, after he took a third post-operative CT scan on October 29, 2014. He explained that this diagnosis necessitated further surgery. Kutler nonetheless suggested that the patient may have had some sort of carcinoma or cancer in the jaw or along the alveolar ridge. In any event, he and Friedman performed a debridement of the mandible in December 2014. Kutler could not give an opinion on whether the onset of osteomyelitis had occurred before or after the March 18, 2014 surgery.

Friedman testified at his deposition that he is a Doctor of Dental Surgery, with a specialty in oral and maxillofacial surgery, and was employed during 2014 and 2015 by New York Presbyterian Hospital, but paid by Weill Cornell Medical Center, a division of NYPH-Weill Cornell. He confirmed most of Kutler's deposition testimony. As relevant to this motion, Friedman asserted that CT scans are a preferred testing method for diagnosis of osteomyelitis. He stated that:

> "By definition, osteomyelitis is a disease that waxes and wanes. By that, I mean it becomes subacute, so that you can't tell a person has it any longer, and then it flares up again in an adjacent area. Which is why I say that radiographs in and of themselves don't answer -- give you that answer. It's the clinical course and some blood test,"

such as a CBC differential test or an eosinophilic sedimentation rate test. He confirmed that the development of bony sequestra may be an indication of the osteomyelitis disease process. Friedman also explained that bone scans can reveal the presence of osteomyelitis, as

> "[t]here are a number of isotopes that can be injected into a patient that shows up in areas of infection, shows up in areas of growing bone; shows up in areas of dead bone-- or it doesn't show up in the area of dead bone, so you know it's dead. There are a number of substances. And some also tag white blood cells, which is more helpful in dealing with osteomyelitis than in other areas."

Friedman averred that there is a risk with all dental implants, including a risk of infection, but that not all infections cause osteomyelitis. He asserted that there are occasional cases of acute osteomyelitis, but that "osteomyelitis usually starts as a localized infection and it spreads,

and it's basically characterized by its chronicity, namely the length of time it's there. Friedman further explained that osteomyelitis frequently does not get better and that, even when it seems to get better, it can "reignite." He also described pain, swelling, and redness in the gums and cheeks as indicia of an infection in an adjacent mandible.

Friedman testified that it was sometimes difficult to rule out osteomyelitis, but if an infection did not return after an abatement of symptoms for approximately four to six weeks, he would conclude that the condition was probably not osteomyelitis, but that if it returned, it was more likely to be osteomyelitis.

In support of their motion for summary judgment, the NYPH defendants also submitted the expert affidavit of Adam Jacobson, M.D. Based on his review of the patient's records and the transcripts of the parties' depositions, Dr. Jacobson explained that, after the NYPH defendants examined or treated the patient on several more occasions during 2014, the patient consulted with other health-care providers, ultimately undergoing a right partial mandibulectomy (partial resection of the mandible) and reconstruction of the right mandible and temporomandibular joint on March 24, 2015, and follow-up surgeries in February 2016 and March 2016, the latter of which was a revision surgery.

Dr. Jacobson opined, within a reasonable degree of medical and dental certainty, that the NYPH defendants' examinations, treatments, and diagnoses adhered to, and fell within, the applicable standard of care. He asserted that the March 18, 2014 surgery to remove the lesion was appropriate and properly performed by both Kutler and Friedman in combination. As Dr. Jacobson described it,

> "Dr. Friedman's marginal mandibulectomy was also in accordance with the standard of care as he excised irregular pieces of bone and hydroxyapatite [a paste like substances that was used to affix the previous implant(s)] and properly shaved down the alveolar mandible until there was nothing left but healthy bone. The lesion and fragments of the mandibular bone were appropriately sent to pathology for analysis. In sum, the performance of the March 18, 2014 surgery was properly performed in accordance with good and accepted practice."

Dr. Jacobson further opined that the NYPH defendants' provision of post-operative care and management was proper and did not deviate from the standard of care, and informed the patient that she might need further surgery if cancer cells were observed upon biopsy. As he stated in his affidavit,

> "Dr. Kutler appropriately relied on the consensus findings of the NYPH pathology department who determined that the plaintiff did not have cancer in the margins, and thus the plaintiff did not require additional excisional surgery. The consensus findings appeared to be confirmed when Dr. Westra from Johns Hopkins also reviewed the pathology specimens and agreed that there was no cancer, including in the margins. Dr. Kutler and Dr. Friedman did not have the responsibility to determine which of the pathologists' opinions should have been relied upon. Rather, it is the duty and responsibility of the NYPH pathology department to analyze pathology specimens and to reach a conclusion as to a diagnosis. Dr. Kutler and Dr. Friedman have no expertise in analyzing pathology, so they must rely on the pathology department for analysis. The above said, notwithstanding that the consensus diagnosis was that there was no malignancy, both Drs. Kutler and Friedman both testified that they never ruled out that the plaintiff had an underlying cancer."

Dr. Jacobson further opined that Kutler appropriately prescribed an additional round of antibiotics when the patient complained of renewed and continuing post-operative swelling and irritation in May 2014, and properly and seasonably ordered a CT scan in June 2014. Dr. Jacobson further asserted "that Dr. Kutler reasonably believed that the findings on the CT scan, including sclerosis of the right mandible with periosteal reaction as seen on the scan, and thickening of the bone, was related to his original March 18, 2014 surgery," and not from an ongoing infection of the jaw bone constituting osteomyelitis. Dr. Jacobson concluded that

> "it is my opinion that any changes that were seen on the June 25, 2014 CT scan were either related to the surgery (as Dr. Kutler suspected) or related to the plaintiff's rare form of squamous cell carcinoma that had not yet been diagnosed. In other words, I agree with Dr. Kutler that the plaintiff did not have osteomyelitis as of June 25, 2014. To the extent the plaintiff had any infection she was properly managed with oral antibiotics prescribed by Dr. Kutler."

Dr. Jacobson asserted that, after the patient returned to Kutler's office on July 31, 2014, Kutler's diagnosis of dysplasia of the alveolar ridge was appropriate and that, in light of the prior biopsy results, examination of the patient, and symptoms and signs presented by the patient, it was not a deviation from good practice to have declined to diagnose osteomyelitis at that juncture. He

also opined that, when the patient returned to Kutler's office on September 15, 2014 with continuing complaint, it was reasonable for him to recommend a CT scan, and reasonable to perform an additional scan on October 29, 2014 when she again presented with worsening symptoms. As stated by Dr. Jacobson,

> "The October 29th CT revealed bone erosion, which Dr. Kutler reasonably attributed to inflammation, infection, or recurrent cancer. . . . [I]n my opinion, the bone erosion was from cancer. Nevertheless, Dr. Kutler's prescription for oral antibiotics was appropriate under the circumstances considering his suspicion that the plaintiff may have an infection.
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> *****
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> "Since the plaintiff's condition did not improve on IV antibiotics by the time of a return office visit on December 10th, Dr. Kutler and Dr. Friedman appropriately performed debridement and biopsy of the right mandibular ramus. Dr. Friedman correctly suspected the plaintiff had a malignant neoplasm as documented in his pre-operative diagnosis for the surgery. However, pathology reported the specimens were reactive bone and infection and there was no cancer or dysplasia."

Accordingly, Dr. Jacobson reasoned that it was only by December 2014 that "the defendants reasonably believed the plaintiff had osteomyelitis of unknown etiology." Dr. Jacobson ultimately concluded, however, that "[t]he plaintiff had a rare atypical form of squamous cell carcinoma that was difficult to diagnose which caused all of the plaintiff's post-operative complications."

In opposition to the NYPH defendants' motion, the plaintiffs relied upon the affidavits and exhibits that those defendants submitted to the court. The plaintiffs also submitted the expert affirmation of a Doctor of Dental Medicine who is licensed in New York and is a Diplomate of the American Board of Oral Maxillofacial Surgery. Based on the review of the deposition transcripts, dental records, and medical records, the plaintiffs' expert opined, within a reasonable degree of medical certainty, that Kutler and Friedman deviated from good and accepted practice, and that the deviation was a substantial factor in causing injury to the patient.

Many details described in the plaintiffs' expert's affidavit are set forth in this court's December 8, 2020 order. As relevant to the NYPH defendants, the expert noted that the patient

saw Kutler for the first time on February 12, 2014, and that, two days later, she saw Friedman, who told her that she had a lesion that was suspicious for oral cancer, and thus ordered a CT scan. The expert further noted that a February 27, 2014 CT scan revealed a "significant bone loss along the medial aspect of the mandibular implant #30 area and 1.9 cm. submandibular lymph node." The expert explained that, after Kaufman removed the dental implant in order for the patient to undergo surgery to address the lesion, Kutler, on March 18, 2014, excised a mandibular lesion on the right, while Friedman simultaneously performed a marginal mandibulectomy at NYPH's Weill-Cornell Medical Center.

As the plaintiffs' expert summarized the three post-operative pathology reports, NYPH pathologists concluded that the patient did not have cancer, Beth Israel concluded that she had squamous cell carcinoma, and Johns Hopkins determined that the she did not have cancer. The plaintiffs' expert noted that, despite these markedly inconsistent pathology conclusions, all of the defendants decided to treat the patient as if she had squamous cell carcinoma. Although the expert acknowledged Dr. Jacobson's opinion that the patient suffered from that condition from the beginning of her symptomology, the plaintiffs' expert concluded that, "[c]ontrary to that assertion, the fact remains that the pathology results do NOT confirm that she had squamous cell carcinoma. This is important since Dr. Jacobson bases the majority of his opinion on this incorrect conclusion."

The plaintiffs' expert thus concluded, within a reasonable degree of medical probability, that Friedman

> "failed to obtain informed and written consent. He failed to formulate a differential diagnosis and as a result, failed to treat [the patient] in a timely fashion leading to a delay in diagnosis and treatment. Dr. Friedman failed to prescribe antibiotics in a prudent manner and did not follow antibiotic protocol. He prescribed an incorrect antibiotic for a strain of cultured E. coli present in the culture and sensitivity report and provided an incorrect route of antibiotic delivery. He needed to change to a different antibiotic after 48 hours and if not effective, order an ID consult and IV delivery of antibiotics. He also failed to refer [the patient] to an infectious disease specialist in a timely fashion.

> "Dr. Friedman failed to recognize, review, consult and apply radiological studies to formulate a differential diagnosis and thus a working diagnosis and failed to treat [the patient] in a timely fashion.
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> "Dr. Friedman failed to arrive at a definitive diagnosis and a result, [the patient] sustained delayed, prolonged and significantly more morbidity.
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> "Dr. Friedman failed to appropriately submit specimens for pathological examination. For example, on implant removal, the implant was not submitted as a specimen. Also, the later biopsy did not include hydroxyapatitete in the specimen (bone graft) submitted to pathology."

As to Kutler, the plaintiffs' expert opined that he departed from good and accepted care because he

> "failed to obtain informed and written consent. He failed to formulate a differential diagnosis in a timely fashion and failed to diagnose, initiate appropriate, definitive and timely care. He failed to review or recognize the lesion of the right angle/ramus of the mandible and failed to recognize and review existing radiological studies in a timely fashion. For example, Dr. Kutler only recognized the existence of the 2/27/14 CT scan in his 4/10/14 progress note.
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> "Dr. Kutler failed to address significant osteolytic lesion at the right angle/ramus of the mandible as of 3/18/14 surgery. This resulted in significant, prolonged morbidity as a result of delay of timely definitive treatment of the patient. He failed to surgically operate judiciously on 3/18/14 by neglecting to reflect an appropriate flap (p. 302 Kutler EBT) to expose pathology. As will be explained below, Dr. Kutler also failed to follow the standard of care when he allowed the patient to dictate her own treatment without providing appropriate informed consent.
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> "Dr. Kutler failed to appreciate the radiologic report depicting 'Microabscesses in bone with drainage fistulas,' all of which lead to the diagnosis of osteomyelitis. He failed to follow appropriate antibiotic protocol and failed to recognize that the patient's trismus was due to a masticator space infection and not temperomandibular dysfunction. This further delayed adequate, definitive and timely treatment."
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> "The record reveals that Dr. Kutler failed to interpret and treat the culture and sensitivity result of E. coli as foreign to the head and neck (oral) area and its potential for serious morbidity and mortality. The record also reflects that Dr. Kutler failed to consult in a timely fashion with an infectious disease specialist and failed to consult and document any such consultation."

Applying the appropriate legal standards, as articulated is this court's December 8, 2020 order, the NYPH defendants established their prima facie entitlement to judgment as a matter law through their deposition testimony, the medical records, and the affidavits of their expert.

The detailed affirmation of the plaintiffs' expert, however, is more than sufficient to raise a triable issue of fact as to whether Kutler and Friedman deviated from good and accepted medical practice (*see Castro v Yakovaskvilli*, 187 AD3d 403 [1st Dept 2020]; *Lesniak v Huang*, 186 AD3d 1512, 1513 [2d Dept 2020]) by failing timely to establish a final diagnosis of osteomyelitis despite all of the indicia suggesting that osteomyelitis was the patient's actual condition, a departure that, in turn, delayed the appropriate treatment, causing the osteomyelitis to worsen and proximately causing the patient to undergo additional surgeries and adverse sequellae (*see Fonseca v Hershkin*, 2018 NY Slip Op 33138[U]. 2018 NY Misc LEXIS 5961 [Sup Ct, N.Y. County, Dec. 3, 2018]; *see also Castro v Yakovaskvilli*, 187 AD3d at 403; *Lesniak v Huang*, 186 AD3d at 1513; *Lucas v Filangeri*, 2016 NY Slip Op 31809[U], 2016 NY Misc LEXIS 3508 [Sup Ct, Suffolk County, Apr. 16, 2016]). Moreover, inasmuch as both Kutler and Friedman were employed by NYPH during the time that they treated the patient at the Weill Cornell campus of that organization, and "[a] hospital may be held vicariously liable for the negligence or malpractice of physicians who act in its employ or as its agents" (*Shafran v St. Vincent's Hosp. & Med. Ctr.*, 264 AD2d 553, 557 [1st Dept 1999]; *see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]), there is a triable issue of fact as to whether NYPH may be held vicariously liable for Kutler and Friedman's alleged malpractice.

The elements of a cause of action for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]). For the claim to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

Here, the documentary evidence submitted by the NYPH defendants establishes that patient was informed, in writing, of the risks of the two surgeries that they performed upon her, consisting of the March 2014 removal of the subject lesion and marginal mandibulectomy, and the December 2014 debridement and subsequent biopsy of the right mandibular ramus, as to which the patient was informed that she might require a blood transfusion. In connection with the March 2014 procedure, the patient confirmed in writing that she was informed of

> "The nature, purpose, and the reasonably foreseeable risks and benefits of the procedure; the alternatives, including not performing the procedure, as well as the reasonably foreseeable risks and benefits of the alternatives;
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> "That the practice of medicine is not an exact science and the procedure may not result in the intended benefits;
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> "That there are risks associated generally with anesthesia, surgery, use of medication, medical procedures and treatments not ordinarily anticipated which can cause adverse consequences to my life or health; and
>
> "That other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the surgery."

With respect to the December 2014 procedure, the patient was informed in writing of the potential risks thereof, including the risks of catheterization, such as bleeding/hematoma at the catheter insertion site, accidental cut or break of catheter, air in the catheter, infection, nerve damage, venous air embolism, phlebitis/irritation of the vein, movement of the catheter, abnormal heart rhythm, catheter blockage/clot, arterial puncture, and perforation/laceration of a blood vessel (*see Cole v Tischler*, 68 AD3d 1595, 1596 [3d Dept 2009]). No persuasive argument or evidence in opposition has been submitted by the plaintiffs. In fact, the affirmation of the plaintiffs' expert is conclusory in this regard (*see Alvarado v Miles*, 9 NY3d 902, 903 [2007]). Accordingly, the branch of the NYPH defendants' motion seeking summary judgment dismissing the cause of action for lack of informed consent against them must be granted.

Accordingly, it is,

ORDERED that the motion of the defendants New York Presbyterian Hospital, David Kutler, and Joel Friedman for summary judgment dismissing the complaint insofar as asserted

against them his granted to the extent that the cause of action to recover for lack of informed consent is dismissed insofar as asserted against them, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

12/11/2020
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		**CASE DISPOSED**			X	**NON-FINAL DISPOSITION**	
		GRANTED		**DENIED**	X	**GRANTED IN PART**	**OTHER**
APPLICATION:		**SETTLE ORDER**				**SUBMIT ORDER**	
CHECK IF APPROPRIATE:		**INCLUDES TRANSFER/REASSIGN**				**FIDUCIARY APPOINTMENT**	**REFERENCE**