

**Carson v Institute for Community Living Inc.**

2021 NY Slip Op 31608(U)

May 4, 2021

Supreme Court, Kings County

Docket Number: 517435/2017

Judge: Ingrid Joseph

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At an IAS Term, **Part 83** 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 4th day May, 2021.

**P R E S E N T:**

**HON. INGRID JOSEPH**

Justice.

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PRISCILLA CARSON, as Administratrix of the ESTATE OF CAMRYN ARIYUN a/k/a MALIK ISAIAH KAREEM CARSON, deceased,

Plaintiff,

- against -

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INSTITUTE FOR COMMUNITY LIVING INC. and MIGUEL CORDONA and JOHN DOES,

Defendants.

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The following e-filed papers considered herein:

E-Filed Papers Numbered

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In this matter, plaintiff Priscilla Carson, as Administratrix of the Estate of Camryn Ariyun a/k/a Malik Isaiiah Kareem Carson, deceased (“plaintiff”), filed an omnibus motion (Motion Sequence 14) on or about December 9, 2020 to strike the Answer of defendant, Institute for Community Living Inc. (referred to as “defendant” and “ICL”); or, alternatively for an order compelling ICL to schedule a continued examination before trial of its first EBT witness for a date certain and in person access to documents and further, for an order compelling ICL to produce records of its mediation or conflict resolution involving Camryn Ariyun a/k/a Malik Isaiiah Kareem Carson (“decedent”) and defendant, Miguel Cordona (“Cordona”). Plaintiff also requests an in camera inspection of the “sentinel,” or post accident investigation report (“sentinel report”). ICL cross moves (Motion Sequence 15) for a protective order

pursuant to CPLR § 3103(a), prohibiting disclosure of the sentinel review and any questioning of witnesses about the document. Additionally, defendant seeks sanctions, attorneys fees and costs against plaintiff. That branch of the parties' respective motions related to the disclosure of the sentinel report, originally returnable in the Compliance Conference Part, was referred to this court for a written decision.

Plaintiff commenced this action by the filing of a Summons and Verified Complaint on September 18, 2017, to recover damages for the alleged wrongful death of the decedent, who was involved in a physical altercation on April 16, 2016 with Cordona, also a resident in ICL's half-way house. It is alleged that Cordona and the decedent, who had a contentious history, were embroiled in a verbal dispute that escalated to Cordona's use of a make-shift knife, "shank," to fatally injure the decedent. Essentially, plaintiff asserts that ICL failed to keep its half-way house in a reasonably safe manner by allowing Cordona, an allegedly known violent and erratic resident, to maintain and use a shank during the dispute with the decedent and further, by passively watching as the decedent expired from the wound inflicted by Cordona.

A review of the record reveals a protracted discovery process that has necessitated the filing of multiple motions. The motions have consisted primarily of plaintiff's requests that the court issue orders compelling ICL to produce deposition witnesses and remit the documents demanded in multiple discovery devices, including Cordona's medical and psychiatric records, and incident reports involving Cordona and the decedent. ICL has consistently responded to plaintiff's motions by cross moving for protective orders, based upon ICL's contention that the information plaintiff seeks is not discoverable pursuant to HIPPA and the New York Education and Mental Hygiene laws.

The instant motion concerns the parties' most recent impasse: plaintiff's request for a report, couched differently by the parties as a "sentinel report," "sentinel review," and "sentinel post accident investigation report" (referred to herein as "sentinel report"), which ICL maintains is privileged under Section 29.29 of the New York Mental Hygiene Law and New York Education Law § 6537(3). In

support of its position, ICL provided the affidavit of Howard Goldberg (“Goldberg”), who is employed as ICL’s Chief Quality Compliance Officer. Goldberg states that his duties entail assigning personnel to investigate incidents that involve residents of ICL, for quality assurance and reporting purposes, in accordance with the NY Mental Hygiene and Education laws. Goldberg further states that “ICL undertook a Sentinel Review with respect to the alleged incident involving [the decedent] and [Cordona]” on June 15, 2016. Goldberg explains that a “sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, [and further, that] [a] Sentinel Review is for the purposes of quality assurance and mandatory reporting, and to investigate root causes of a subject incident and to formulate any next action steps that needed to be taken.” Goldberg reiterates that the “Sentinel Review,” in this case, was solely generated for such investigation, and specifically undertaken for quality assurance purposes pursuant to Education Law § 6521(3), Mental Hygiene Law § 29.29, and for compliance with Federal and State incident management requirements.

The “quality assurance privilege” set forth in Education Law § 6527(3) exempts, from the discovery provisions of Article 31 of the CPLR, any records related to quality assurance functions (*See* Education Law § 6527(3)). The statute provides, in pertinent part, that “[n]either the proceedings nor the records relating to performance of a quality assurance review function, nor any report required by the department of health pursuant to section twenty-eight hundred five-1 of the public health law, including the investigation of an incident reported pursuant to Section 29.29 of the Mental Hygiene Law, shall be subject to disclosure under article thirty-one of the civil practice law and rules” (Education Law § 6527 [3] [emphasis added]). Section 29.29 of the Mental Hygiene Law mandates the establishment of patient care and safety teams at the facility level to investigate and report to the facility director, *inter alia*, violent behavior exhibited by patients or employees (MHL § 29.29, sub. ii) and recommendations for corrective actions in response to incident reports to ensure the care and safety of all patients (MHL § 29.29, sub. vii). MHL § 29.29 further requires that facilities establish a cumulative record of incident

reports which identifies patient and employee involvement, aggregate the data, and remit such information at least semi-annually to the commissioners of the offices of mental health and people with developmental disabilities (MHL § 29.29, et seq.).

It is understood that the purpose of the quality assurance privilege is to promote the quality of care through self-review without fear of legal reprisal and to enable institutions to ameliorate the causes of untoward incidents through unfettered investigation (*Katherine v State of New York*, 94 NY2d 200, 205 [1999]). The party seeking to invoke the quality assurance privilege bears the burden of demonstrating that the documents sought were prepared in accordance with the relevant statutes (*Kivlehan v Waltner*, 36 AD3d 597, 598 [2d Dept 2007] citing *Marte v Brooklyn Hosp. Ctr.*, 9 AD3d 41, 46 [2d Dept 2004]).

In this case, ICL relies upon the affidavit of Goldberg. However, the court finds that Goldberg's statements alone are insufficient to demonstrate that the sentinel report in issue consists solely of documents that were generated in accordance with ICL's statutory obligation and thus, fall within the ambit of the quality assurance privilege. Goldberg fails to affirmatively identify ICL's quality assurance procedure for verbal/physical altercations that result in injury, or death, nor that the subject sentinel report was developed, and has been maintained, in accordance with that review procedure. Additionally, ICL provided no information pertaining to the sentinel report, its components, or that explains the purpose for which ever component of the sentinel report was prepared. In fact, it is unclear whether the sentinel report is one document that consists of several pages, or if the sentinel report consists of multiple documents that were prepared by varied ICL personnel as part of ICL's quality assurance protocol.

Thus, the court finds that an in camera review is warranted to determine what, if any, portions of the sentinel report, is discoverable under Article 31 of the CPLR.

Accordingly, ICL, within twenty (20) days of receiving a copy of the instant order with notice of entry, shall provide a privilege log of each document comprising the sentinel report that ICL deems is privileged, quality assurance material. ICL shall further provide an affidavit from an individual with

personal knowledge who explains ICL's quality assurance review protocol and how the material in issue was developed pursuant to that protocol. Such information shall be sent electronically to [KSCCVPart83@nycourts.gov](mailto:KSCCVPart83@nycourts.gov), Adobe Acrobat .pdf format.

This constitutes the decision and order of the court.

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**HON. INGRID JOSEPH, J. S. C.**

*Ingrid Joseph*  
Suffolk County Justice