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 360 Adams Street, Brooklyn, New York, on the 5th day of December, 2023.

PRESENT: HON. INGRID JOSEPH, J.S.C.
SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF KINGS

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DUANE PORTER, Individually and as Administrator of the Estate of YVONNE PORTER, Deceased,
Plaintiff,

-against-

CLIFFSIDE NURSING HOME, INC.,
Defendant.

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DECISION AND ORDER

Index No. 517534/18

Mot. Seq. No. 4

The following e-filed papers read herein:	NYSCEF Doc. Nos.:
Notice of Motion, Affirmations, and Exhibits Annexed	98-110
Affirmations (Affidavits) in Opposition and Exhibits Annexed . .	112-120
Reply Affirmation	124

("Plaintiff") Duane Porter, Individually and as Administrator of the Estate of his deceased mother, Yvonne Porter ("The Patient") commenced this action by filing a summons and complaint on August 28, 2018, and issue was joined on October 5, 2018. In his complaint, Plaintiff seeks to recover damages for (among other things) alleged medical malpractice, wrongful death, and violations of Public Health Law ("PHL"). Defendant Cliffside Nursing Home, Inc. ("Defendant") moves for an order, pursuant to CPLR § 3212 (b) and (g), (1) granting it summary judgment dismissing the complaint in its entirety with prejudice; or (2) granting it summary judgment dismissing the demand for punitive damages; or (3) granting it partial summary judgment as to any claim and/or theory of liability which the court finds that Plaintiff has failed to raise an issue of fact. The Defendant additionally seeks limitation of issues of fact for trial pursuant to CPLR 3212(g).

In support of its motion, Defendant submits its own medical records for Yvonne Porter, her hospital records from NewYork-Presbyterian Queens Hospital ("NYP Queens Hospital"), Plaintiff's pretrial testimony, the expert affirmation of Gisele Wolf-Klein, M.D., a board-certified internist with a sub-certification in geriatric medicine ("Dr. Wolf-Klein"), and the expert affirmation of Ian Newmark, M.D., a board-certified internist with sub-certifications in pulmonary medicine and critical care ("Dr. Newmark").

Plaintiff opposes by submitting the EBT testimony of Defendant's respiratory therapist Dominique Philoxy ("RT Philoxy"), the pretrial testimony of defendant's registered nurse Florence H. Haynes ("Nurse Haynes"), the expert affidavit of registered nurse Olive W. Brown ("Nurse Brown") and the expert affirmation of Bruce Charash, M.D. ("Dr. Charash"), a board-certified internist with a sub-certification in cardiology.

In a medical malpractice case, a defendant moving for summary judgment must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) that such a departure was a proximate cause of the plaintiff's injuries and, where wrongful death is alleged, of wrongful death as well (*see Rosenthal v Alexander*, 180 AD3d 826, 827 [2d Dept 2020]; *Mandel v New York County Pub. Adm'r*, 29 AD3d 869, 871 [2d Dept 2006]). When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition (*Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] [internal citations omitted]).

Pursuant to the PHL, "any residential health care facility that deprives any patient of said facility of any right or benefit . . . shall be liable to said patient for injuries suffered as a result of said deprivation . . . (PHL § 2801-[d] [1]). The basis for liability under Public Health Law § 2801-d is neither deviation from accepted standards of medical practice nor breach of a duty of care. It contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule (*Schwartz v Patridge*, 179 AD3d 963, 965 [2d Dept 2020]).

Here, Defendant has established its prima facie case of entitlement to summary judgment on Plaintiff's medical malpractice/wrongful death claims, by its own medical records as well as those of NYP Queens Hospital and the affirmations of its medical experts, Dr. Wolf-Klein and Dr. Newmark. As part of Defendant's prima facie showing on the departure element of the medical malpractice/wrongful death claims, Defendant's first expert Dr. Wolf-Klein opined, to a reasonable degree of medical certainty, that the care rendered by Defendant to the Patient conformed to the applicable and then-prevailing standards of care. Furthermore, the Patient was properly evaluated by doctors, nurses, and therapists during her stay at the Defendant's facility. Dr. Wolf-Klein additionally found that the Defendant properly monitored and responded to the

patient's signs and symptoms and that the Defendant implemented appropriate plans of care, including skin, pain, infection control, and treatment for mobility and ability to perform activities of daily living as well as maintenance of proper hydration and nutritional status (Dr. Wolf-Klein's Aff., ¶¶ 45-46).

Additionally, as part of Defendant's prima facie showing on the departure element of the medical malpractice/wrongful death claims, Defendant's second expert Dr. Newmark opined, to a reasonable degree of medical certainty, that the Defendant adhered to the standard of care in performing its routine tracheostomy care on the patient, that the suctioning of the Patient's tracheostomy was properly ordered and performed every shift, as well as when needed, and that her tracheostomy was properly changed every three months. Furthermore, Dr. Newmark states that the Defendant appropriately instituted aspiration precautions in light of the permanent nature of her tracheostomy and her history of dysphagia, that the Patient was properly monitored for the signs and symptoms of the nursing-home-acquired pneumonia and her latest bout with pneumonia had been resolved six days before the anoxic event. Moreover, Dr. Newmark claims that the Patient's episodes of respiratory distress were properly monitored and treated and that the Defendant adhered to the standard of care in changing the size of the tracheostomy from eight to six, and that such change did not (or could not) cause or contribute to the Patient allegedly developing a mucus plug as a potential cause of the anoxic event, because the inner cannula continued to be changed every shift as part of the overall tracheostomy care (Dr. Newmark's Aff., ¶¶ 45-51).

Accordingly, Dr. Newmark found that the Defendant adhered to the standard of care in providing appropriate respiratory care to the Patient prior to the anoxic event; and that the Defendant's staff properly performed cardiopulmonary resuscitation on the Patient following the anoxic event and before her transfer to NYP-Queens Hospital (*Id.*).

As to the causation element of the medical malpractice/wrongful death claims, Dr. Wolf-Klein opined, to a reasonable degree of medical certainty, that the underlying anoxic event which the Patient suffered at Defendant's facility on January 18, 2018, was of the cardiac rather than of the pulmonary origin because the cardiac origin of the anoxic event dovetailed with the Patient's atrial fibrillation, coronary artery disease, hypertension, history of pulmonary embolism, and her other comorbidities; and the Defendant's care of the Patient (or the alleged lack thereof) neither proximally caused, nor significantly contributed to, any of her injuries, inclusive of her

subsequent death at NYP Queens Hospital on February 3, 2018 (Dr. Wolf-Klein's Aff., ¶¶ 51-52).

Additionally, as part of Defendant's prima facie showing on the causation element of the medical malpractice/wrongful death claims, Dr. Newmark opined, to a reasonable degree of medical certainty, that the anoxic event at defendant's nursing home and the Patient's ensuing death at NYP Queens Hospital both originated from a cardiac arrest rather than from a mucus plug or respiratory distress, which is reflected in the NYP Queens Hospital's medical records. Furthermore, nothing in the records of either Defendant or NYP Queens Hospital indicates that the anoxic event originated from a mucus plug (Dr. Newmark's Aff., ¶¶ 52-53).

In addressing Plaintiff's claims under the PHL, Dr. Wolf-Klein opined, to a reasonable degree of medical certainty, that the Defendant fulfilled its statutory obligations to ensure that the Patient received necessary treatment and services; and at no time did Defendant violate the patient's statutory rights or deprive her of any statutory benefits, inasmuch as its evaluation and treatment of the Patient was timely, thorough, and appropriate in all respects in the course of her stay at its facility (Dr. Wolf-Klein's Aff., ¶¶ 53-56).

Inasmuch as Defendants have made the requisite prima facie showing, the burden of production shifts to Plaintiff to raise one or more triable issues of material fact warranting a trial (*see McHale v Sweet*, 217 AD3d 666, 668 [2d Dept 2023]; *Russell v River Manor Corp.*, 216 AD3d 827, 829 [2d Dept 2023]; *see generally Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]).

In opposition to the medical malpractice/ wrongful death claims and on the PHL claims, Plaintiff has raised multiple triable issues of material fact. Plaintiff submits in part the expert affidavit of Nurse Brown and the expert affirmation of Dr. Charash. In her affidavit, Nurse Brown opined, to a reasonable degree of nursing/medical certainty, that the Defendant "departed from good and accepted nursing practices, violated state . . . laws regarding staffing, . . . record keeping, . . . the provision of trach[eostomy] and respiratory care . . . , and failed to ensure the provision of adequate and appropriate care" for the Patient." Additionally, Nurse Brown found that such failures contributed to her respiratory code, *i.e.*, the anoxic, event on January 18, 2018, and, subsequently, to her death (Nurse Brown's Aff., ¶ 21). Specifically, Nurse Brown opined that on date of January 18, 2018, between the hours of 5:30 p.m. -7:30 p.m., the Patient was found unresponsive, however the notes are unclear as to the timing of events versus the timing of when they were being recorded. Nurse Brown claims that while there is an earlier note by Nurse

Haynes on January 18, 2018, at 7:25 am, regarding her prior 11:30 pm-7:30 am shift that stated that vent suction and Trach care had been done by a Respiratory Therapist, there is no corresponding supporting respiratory therapist documentation to validate that this procedure was performed and that the same is true with regard to most of the nursing entries about Trach care (Nurse Brown's Aff., ¶ 8).

Additionally, Nurse Brown's affidavit cites to Respiratory Therapist Philoxy's EBT testimony wherein she testified that she did not recall if on the incident date whether the ventilator and/or tubing was connected or disconnected for the Patient when she was found unresponsive after the anoxic event. Moreover, Philoxy testified that she was not sure if she even saw the Patient that day. In Nurse Brown's professional opinion, the absence of documentation regarding the Patient's physical condition and the condition of the trach and ventilator equipment that enabled her to breathe, when she was found unresponsive prevents a professional conclusion that the respiratory care was actually provided (Nurse Brown's Aff., ¶ 10). According to her further deposition testimony, on January 18, 2018, Philoxy was assigned to cover a total of 19 ventilator-dependent patients during her daytime shift from 7 a.m. to 7 p.m. in the Patient's area. Her duties included administering treatments, checking tube connections, suctioning secretions and making sure that the ventilators were operating properly.[1] Nurse Brown states that considering the number of Patients' at the time, the Defendant "was understaffed for trach patients and, because of the understaffing, she was deprived of her rights as a nursing home resident that afforded her sufficient staffing to attain or maintain her highest practical physical wellbeing and her right to be treated in a dignified manner. Such understaffing contributed to the insufficient frequency of trach care and suctioning, especially in the presence of bacterial and, perhaps, viral infections, that led to the respiratory/anoxic event in this case (Nurse Brown's Aff., ¶¶ 13, 17).

Nurse Brown also cites to the EBT of Nurse Haynes' who was one of the two daytime nurses assigned to the area covering a total of 19 trach/ventilator patients, wherein she testified that Philoxy, rather than Nurse Haynes or the other assigned nurse would perform all trach care

[1] *See* RT Philoxy's EBT tr at page 16, line 12 to page 17, line 9; page 18, lines 3-23; page 75, line 17 to page 77, line 23; page 79, line 12 to page 80, line 4; page 85, lines 17-20.

for all the patients in her area, as more fully set forth in the footnote (Nurse Brown's Aff., ¶ 20).[2] and that the Defendant's failure to keep complete and accurate records regarding the Patient's trach and ventilator care, as well as her condition and care performed during her code on January 18, 2018, violated standards of care and constitute departures in policies that strongly suggest that the failure to provide appropriate trach care led to her code on January 18, 2018 and, ultimately, to her death (Nurse Brown's Aff., ¶ 11). In that regard, Plaintiff's pretrial testimony

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[2] *See* Nurse Haynes's EBT tr at page 43, lines 15-21 ("[the] function of [caring for a trached patient on the ventilator] is *not* being done by the nurse"); page 47, lines 3-10 ("Q. When the patient is on the ventilator, why do they have to be suctioned every two hours around the clock? A. The ventilator . . . patients that I am working with, it is *not* the nurses that take the responsibilities for [suctioning]."); page 53, lines 13-16 ("*Q. [D]uring that time that you took care of [the patient], did you ever once suction her endotracheally? A. No.*"); page 56, lines 8-15 ("Q. [I]f the patient is bucking the vent [*i.e.*, fighting the ventilator], and no respiratory therapist [is] there, wouldn't it [be] your responsibility to make sure their airway is open as a nurse on shift? A. If the patient is bucking, . . . the respiratory therapist will be right there."); page 56, line 16 to page 58, line 7 ("Q. Assume for the purposes of the question [that] each respiratory therapist [–] per your co-worker they have nineteen patients that are trached to the vent and they're not available [–] and your patient . . . is bucking the vent and needs to be suctioned, you're telling me that you don't know how to suction your own patient? . . . A. The [respiratory] therapist is there. Q. So you just let [the patient] buck the vent and not give oxygen because it's not your job, is that your testimony? A. The [respiratory] therapist is there."); page 60, lines 11-21 ("*Q. [A]ssume for the purpose of the question, that when you made rounds on [the patient] she needed to be suctioned, could you [Nurse Haynes] suction her? . . . A. Therapi[st]s [are] always there. I do not [suction my patients].*"); page 61, lines 15-17 ("*I could suction [the patient], but the therapist will be right there, so I would not have to do it. [The respiratory therapist is] there.*"); page 61, line 21 to page 62, line 17 ("Q. You would let the patient drown in their own mucus before you would touch that catheter to suction her even though you know that's need[ed] to keep a patient's airway on a patient that is trach dependent. Is that your testimony? . . . A. The [respiratory] therapist will be right there. . . . The [respiratory] therapist will be right there as soon as anything triggers. Q. She's got eighteen other patients. A. No, the [respiratory] therapist will be there."); page 66, lines 19-22 ("Q. So you have no idea how to suction a trached patient at Cliffside in 2018, no concept? A. They [Cliffside] have their own [respiratory] staff."); page 68, lines 15-25 ("*[B]ut we [nurses] don't have to do that. . . . [T]here is no need for us to do that. Therapi[st] [are] always there. . . . Always there. . . . You know how to do [the trach suctioning], but we do not have to [do it].*"); page 69, lines 16-18 ("*[Y]ou don't have to [suction a patient] because all the time there is always a [respiratory] therapist present there.*"); page 70, lines 11-19 ("[T]he [respiratory] therapist [is] always . . . sitting there in the hallway. Q. How can the therapist always be sitting in the hallway waiting for the [patient's ventilator] alarm to go off if she had nineteen other patients, explain that one? A. She's not waiting for the alarm to go off, but as soon as an alarm goes off, she will be there."); page 74, lines 3-21 ("[I]s your testimony [that] . . . no matter what, your handing [of the patient is] don't touch the trach, is that your testimony, no matter what? . . . A. *No. I don't have to do that.*"); page 81, lines 22-23 ("*the respiratory therapist[s] suction [the trach patients]*"); page 83, line 19 to page 84, line 16 ("*Q. When you come on shift, what are you responsibilities for all . . . eight to ten ventilated trached to ventilator patients, what are all the responsibilities you have to do? . . . A. You're making rounds, you look at [the patients], how they [are] lying, the position they're lying in. You check that they are well positioned. You check the tube for placement the G tube site[,] you . . . check the [G] tube for placement, you see they're comfortable, you check for incontinence, if they wet, and you give your assignment to the people you [are] working with, then you get prepared for . . . to administer the evening routine, their medication, and their feed, and general nursing.*"); page 87, lines 3-25 ("Q. If [the patient] in January of 2018 had a problem where the tach tubing disconnected frequently from the ventilator, would that be something that you would as her nurse assigned to her care, would call [the assigned ENT physician] and alert him to the issue? A. There's a respiratory staff[,] and they would be the person that would look. . . . *We [nurses] would not have to do that because there's a supervisor for [the] respiratory [staff,] and the respiratory staff is there.*") (emphasis added).

that he would often find his mother's trach out and that he would replace it by himself, without any documentation in the chart of his complaints to staff confirms another departure from record keeping at this facility (Nurse Brown's Aff., ¶ 19).

Plaintiff's second expert Dr. Charash opined, to a reasonable degree of medical certainty, that the underlying anoxic event was in the nature of a primary *respiratory* arrest rather than of a primary cardiac arrest as asserted by defendant's expert Dr. Newmark (Dr. Charash's Aff., ¶ 4). In support of his opinion, Dr. Charash explained that from a cardiological perspective, in the year following her bypass (approximately one year before the incident date), the Patient was not at risk and coronary disease was not a threat to her well-being. Therefore, the likelihood that she would have suffered a coronary event within a year of the bypass is extremely low (Dr. Charash's Aff., ¶ 6). Additionally, Dr. Charash states that from August 26, 2017, until late October 2017 the Patient was strong enough to attempt breathing on her own and had been attempted to be weaned off the ventilator, at increasing intervals. In fact, she was able to remain off the ventilator for 24 hours until suffering a vomiting episode on October 25, 2017" (Dr. Charash's Aff., ¶ 7).

Dr. Charash claims that as of as of January 22, 2018, four days after the incident, the Patient's left ventricular fraction ejection was 55%-60%. Dr Charash states that this is a normal measurement of the amount of blood the heart should pump, reflecting that she had not experienced a previous or large-scale heart attack causing damage affecting her heart. Furthermore, Dr. Charasha asserts that both the arterial 'plumbing' and the heart 'pump' were functioning properly and, therefore, the Patient was at an extremely low risk of a spontaneous arrythmia (Dr. Charash's Aff., ¶¶ 8-9). Dr. Charash further states that in the weeks before her respiratory arrest on January 18, 2018, the Defendant's records reveal that the Patient developed a fever of 102 degrees Fahrenheit and exhibited yellow secretions. It was determined she had "nursing-home-acquired" pneumonia and was started on a course of antibiotic therapy. While the Defendant's personnel considered the pneumonia cleared on January 12, 2018, the large yellow secretions were again observed just three days later, on January 15, 2018.While the Defendant's personnel were ordered to provide frequent suctioning, it is unclear from the records if more frequent suctioning was, in fact, performed. The Patient continued to cough until the date of her emergency (Dr. Charash's Aff., ¶ 12).

Dr. Charash states that it is clear from the NYP Queens Hospital records that following the anoxic event, the Patient's pulse and heart rate were restored while at the Defendant's

nursing home employing CPR procedures, without the use of any extraordinary measures or medications. The CPR performed by the Defendant's staff and EMS personnel allowed the patient to survive the anoxic event and produce a pulse. Dr. Charash claims that this would not have been possible had the Patient suffered a primary cardiac event (ventricular fibrillation or asystole) given the amount of time that had passed from finding her unresponsive until the time that EMS personnel arrived after seven rounds of CPR had been administered to the patient while still at defendant's facility" (Dr. Charash's Aff., ¶¶ 13-15.)

Dr. Charash states that had the anoxic event been in the nature of a primary cardiac event as Defendant's expert Dr. Newmark contends, the Patient could not have been resuscitated by CPR alone and her heart would not have corrected to a sinus rhythm with electrical shock or medication, such as epinephrine. Rather, the return of spontaneous circulation and pulse is indicative of an airway blockage which was corrected when CPR was performed, including oxygen provided through protocol ambu-bagging. Thus, in Dr. Charash's professional opinion, the fact that she was resuscitated without advanced life support is also indicative that this was not a primary cardiac event. Inasmuch as the anoxic event could only have been in the nature of a respiratory event, then it would have occurred due to a failure of the Defendant's personnel to provide suction and appropriate trach care with sufficient frequency and adequacy considering the Patient's excessive secretions and cough following her bout with pneumonia" (Dr. Charash's Aff., ¶¶ 16-18). Dr. Charash believes that the primary respiratory arrest resulted in anoxia, depriving the brain of necessary oxygen, which was a competent contributing cause of the Patient's subsequent death (Dr. Charash's Aff., ¶¶ 19-20).

Contrary to Defendant's contention, Plaintiff's expert submissions are not speculative or conclusory, but rather have sufficiently raised triable issues of material fact warranting denial of the initial branch of Defendant's motion which is for summary judgment dismissing the entirety of his complaint (*see Rosario v Our Lady of Consolation Nursing & Rehabilitation Care Ctr.*, 186 AD3d 1426, 1428 [2d Dept 2020]; *Joyner v Middletown Med., P.C.*, 183 AD3d 593, 594-595 [2d Dept 2020]; *Sancimio v Richmond Ctr. for Rehabilitation & Specialty Healthcare*, 2019 NY Slip Op 34902[U] [Sup Ct, Richmond County 2019]; *Polanco v Kings Harbor Health Serv., LLC*, 61 Misc 3d 1216[A], 2018 NY Slip Op 51542[U] [Sup Ct, Bronx County 2018]; *accord Morisette v Terence Cardinal Cooke Health Care Ctr.*, 8 Misc 3d 506, 507 [Sup Ct, NY County 2005]; *see generally Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005] ["Summary judgment is

not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury"]).

PHL § 2801-(d) (2) provides, in relevant part, that "where the deprivation of any . . . right or benefit of a nursing-home patient is found to have been willful or in reckless disregard of his or her . .. lawful rights. . . . punitive damages may be assessed" under the circumstances of "a high degree of moral culpability which manifested a conscious disregard for the rights of others or conduct so reckless [on the defendant's part] as to amount to such disregard" (*Valensi v Park Ave. Operating Co., LLC*, 169 AD3d 960, 961 [2d Dept 2019]). Here, Defendant has established its prima facie entitlement to judgment as a matter of law dismissing the request for punitive damages under the Public Health Law by demonstrating that its alleged acts (and/or omissions) were not in willful or reckless disregard of the Patient's rights (*see* PHL § 2801-d [2]; *Valensi*, 169 AD3d at 962; *Vissichelli v Glen-Haven Residential Health Care Facility, Inc.*, 136 AD3d 1021, 1023 [2d Dept 2016]).

Plaintiff's allegations in the Verified Complaint fail muster when held to the standards for gross negligence and recklessness. In paragraphs 68 through 72 of the Verified Complaint, Plaintiff alleges in a conclusory fashion that Defendant's acts and omissions were "pervasive, persistent and continuous, grossly negligent, and evinced a reckless disregard for the safety, well-being and lawful rights" of the Patient. In paragraph 73 through 75, Plaintiff advances several vague allegations that as a result of the foregoing, he is entitled to among other things an award of punitive damages.

The Court finds that Plaintiff's allegations are woefully inadequate to raise a triable issue of fact on the subject of punitive damages (*see Vissichelli*, 136 AD3d at 1023; *Domoroski v Smithtown Ctr. for Rehabilitation & Nursing Care*, 95 AD3d 1165, 1166 [2d Dept 2012]; *Everett v Loretto Adult Community, Inc.*, 32 AD3d 1273, 1274 [4th Dept 2006]; *Reed v Concord Nursing Home, Inc.*, 2022 NY Slip Op 33388[U], *7 [Sup Ct, Kings County, Joseph, J.]).

As relevant here, CPLR § 3212 (g) provides that "if a motion for summary judgment is denied or is granted in part, the court, by examining the papers before it and, in the discretion of the court, . . . shall, if practicable, ascertain what facts are not in dispute or are incontrovertible. It shall thereupon make an order specifying such facts and they shall be deemed established for all purposes in the action." CPLR 3212 (g) is a seldom used procedural device contained within CPLR 3212 that serves alongside its more frequently used legal cousins – the motions for summary judgment and partial summary judgment. It can serve as a sort of consolation prize for

the unsuccessful movant for summary judgment wherein the main motion is denied but a judicial finding of those facts not in dispute is achieved for potential later use at trial (*Launt v Lopasic*, 189 AD3d 1740, 1744 [3d Dept 2020]).

In light of the unresolved multiple factual issues, the Court declines defendant's alternative request made pursuant to CPLR § 3212 (g) for an order limiting the issues to be tried (*see Reid v State*, 61 AD3d 1063, 1065 [3d Dept 2009]; *Van Ostberg v Crane*, 273 AD2d 895, 896 [4th Dept 2000]; *S&R Med., P.C. v Geico Gen. Ins. Co.*, 52 Misc 3d 133[A], 2016 NY Slip Op 51013[U] [App Term, 2d Dept, 2d, 11th & 13 Jud Dists 2016]).

Accordingly, it is hereby,

ORDERED that defendant's motion is granted to the extent that Plaintiff's demand for punitive damages (as alleged in ¶ 75, and as reiterated in the Wherefore clause, of his Verified Complaint) is dismissed and stricken out, and the remainder of its motion is denied; and it is further,

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this decision and order with notice of entry on defendant's counsel and to electronically file an affidavit of service thereof with the Kings County Clerk; and it is further,

ORDERED that the parties are reminded on their next in-person appearance for a settlement conference at JCP-1 on December 1, 2023, at 10 a.m.

This constitutes the decision and order of the court.

HON. INGRID JOSEPH, J.S.C.

Hon. Ingrid Joseph
Supreme Court Justice