Mock v New York City Health & Hosps. Corp.
2025 NY Slip Op 32379(U)
July 1, 2025
Supreme Court, Kings County
Docket Number: Index No. 507694/2022
Judge: Consuelo Mallafre Melendez
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At an IAS Term, Part MMESP – 7 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 1st day of July 2025.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS
---X
YVONNE MOCK as Parent and Natural Guardian of S.D.D., an Infant,

Plaintiff,

-against-

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.
---X

DECISION & ORDER

Index No. 507694/2022
Mo. Seq. 1 & 2

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.

Recitation, as required by CPLR §2219 [a], of the papers considered in the review:

NYSCEF #s: Seq. 1: 28 – 30, 31 – 62, 66 – 70, 71 – 129, 195, 196 – 197, 199 – 200

Seq. 2: 65, 130 – 134, 135 – 193, 195, 196 – 197

Defendant New York City Health and Hospitals Corporation ("NYCHHC") moves (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment in their favor.

Plaintiff opposes the motion and cross moves (Seq. No. 2) for an Order, pursuant to Gen. Mun. Law § 50-e, granting leave to file a late notice of claim and/or deeming the notice of claim served on July 6, 2021 timely *nunc pro tunc.*

With respect to Plaintiff's cross motion, NYCHHC takes no position and does not oppose granting an extension of time for the late notice of claim under Gen. Mun. Law § 50-e (5). The cross motion is therefore **granted**, and the notice of claim dated July 6, 2021 shall be deemed timely served *nunc pro tunc.*

Plaintiff, on behalf of her infant son, commenced this action on March 16, 2022, asserting claims of medical malpractice in connection to prenatal care, labor and delivery, and neonatal care. Plaintiff alleges that the infant sustained hypoxic ischemic encephalopathy at birth as a result of the malpractice of the hospital's physicians and staff.

The causes of action set forth in the Complaint regarding informed consent and spoliation of records were not addressed by the movant and are not before the Court in the motion herein.

The infant's mother treated at Kings County Hospital Center's ob/gyn clinic for prenatal care throughout her pregnancy, beginning on April 12, 2016 when she was approximately five weeks pregnant. She followed up with their "high-risk pregnancy clinic" from June through October 2016 after an episode of bleeding. After missing a high-risk clinic appointment on October 31, she was evaluated at the walk-in ob/gyn clinic on November 3 and scheduled for an ultrasound later in the week. A culture on that date showed group B streptococcus organism, and she was prescribed antibiotics. Her estimated date of confinement was December 6, 2016.

On November 6, at approximately 9:06 a.m., the mother presented at Kings County Hospital with spontaneous rupture of membranes and thick green meconium (a fetal bowel movement in the amniotic fluid). She was admitted to labor and delivery. At 10:42 a.m., the attending ob/gyn Dr. Nader determined a c-section was indicated. Anesthesia was administered at approximately 11:25 a.m., and the infant was delivered by c-section at 11:43 a.m. The infant had the umbilical cord wrapped around his neck and body, no respiration at birth, and was not responsive to suctioning or positive pressure ventilation. He was intubated at two minutes of life, and his Apgar scores were 4 at one minute, 7 at five minutes, and 8 at ten minutes.

The infant was transferred to the NICU and continued to receive respiratory support. While in the NICU, he was diagnosed with disseminated intravascular coagulopathy ("DIC") and

thrombocytopenia (low platelet count) and was treated with blood transfusions. The infant was also noted to have hydrops, a condition where fluid collects in the organs in utero.

The infant was later evaluated for possible seizure episodes and underwent two head ultrasounds on November 7 and November 9, which were deemed within normal limits but could not rule out hemorrhage. He was extubated and transferred to bubble nasal CPAP on November 10. On November 23, the infant underwent an MRI which revealed "parenchymal hemorrhages in the right temporal and occipital lobes."

After one month of care in the NICU, the infant was discharged home on December 8, 2016. He was subsequently found to have delays in developmental milestones and was diagnosed as microcephalic with significant speech/verbal impairment.

Plaintiff alleges that the defendant's physicians and staff departed from the standard of care, including by delaying delivery by c-section for over one hour and adequately treating the infant with oxygen and therapeutic cooling. Plaintiff further alleges that these departures proximately caused the infant to suffer hypoxic ischemic encephalopathy around the time of his birth and his resultant injuries.

In a medical malpractice action, the Court applies the burden shifting process as summarized by the Second Department: "[A] defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, *or* that the plaintiff was not injured by any such departure" (*Rosenzweig v Hadpawat,* 229 AD3d 650, 652 [2d Dept 2024] [emphasis added]). "In order to sustain this prima facie burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (*Martinez v Orange Regional Med. Ctr.,* 203 AD3d 910, 912 [2d Dept 2022]). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to

demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." (*Rosenzweig* at 652 [2d Dept 2024] [internal quotation marks and citations omitted].) However, "expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact" (*Barnaman v Bishop Hucles Episcopal Nursing Home,* 213 AD3d 896, 898-899 [2d Dept 2023]).

In support of their motion, NYCHHC submits an expert affirmation from Victor R. Klein, M.D. ("Dr. Klein"), a licensed physician board certified in obstetrics and gynecology, maternal fetal medicine, and medical genetics.

Dr. Klein opines that all prenatal care and the management of labor and delivery by NYCHHC complied with the standard of care. He opines that the mother's pregnancy was appropriately monitored and evaluated by the high-risk clinic at Kings County Hospital Center from June through October 2016. He opines that her vital signs and blood pressure remained stable, and her weight gain of only 14 pounds during pregnancy was within normal range for a patient who was already obese. He opines that the mother underwent an appropriate number of sonograms, ultrasounds, and anatomy scans during her pregnancy, which did not reveal any fetal complications. He opines that blood labs, fundal height, and fetal movement were regularly assessed.

He also opines that the mother was tested for all common infections in her third trimester, and she was prescribed antibiotics for her strep infection on November 3. He notes that the mother missed her October 31 ultrasound appointment at the high-risk clinic, and he opines that she was properly assessed and treated as a walk-in patient at the regular ob/gyn clinic on

November 3. He opines that nothing in her presentation warranted an emergency, same-day ultrasound on that visit, and it was within the standard of care to schedule her for a routine ultrasound. However, she had a premature rupture of membranes before that date.

On the morning of November 6, Dr. Klein opines that an emergency c-section was not indicated based only on the rupture of membranes and presence of meconium, and it was within the standard of care to monitor the fetal heart rate and attempt vaginal delivery. He opines that from 9:20 a.m. to 10:41 a.m., fetal heart tracings remained Category II, and it was within the standard of care for Dr. Nader to proceed with a planned c-section based on "minimal variability and new onset intermittent decelerations" at that time. Dr. Klein opines that the c-section was timely initiated and performed in accordance with the standard of care.

The movant also submits an expert affirmation from Joseph Maytal, M.D. ("Dr. Maytal"), a licensed physician board certified in pediatrics, neurology, and psychiatry with special qualification in child neurology.

Dr. Maytal opines primarily on the issue of whether the infant sustained a hypoxic brain injury during birth. He explains that hypoxic ischemic encephalopathy is a condition which "occurs when a fetus has insufficient oxygen supply to the brain in utero, during labor, and/or during the infant's delivery, resulting in brain damage." He opines that the infant in this case did not meet the criteria for diagnosing hypoxic ischemic encephalopathy. Specifically, he opines that the infant's cord blood gas pH of 7.022 (not less than 7) and base deficit of 10 (not greater than 12) puts him outside the criteria for hypoxic ischemic injury at birth.

Additionally, he opines that an infant with hypoxic ischemic injury at birth would have an Apgar score of less than 5 at five and ten minutes of life. In this case, the infant's Apgar score

was 4 at one minute, but improved to 7 at five minutes and 8 at ten minutes. He therefore opines the arterial cord gases and Apgar scores were "inconsistent with a birth-related hypoxic event."

He further opines the infant's November 23 MRI, taken approximately two and a half weeks after birth, was not consistent with hypoxic ischemic encephalopathy, because there was no pattern of injury in the anterior, middle, and posterior cerebral arteries and/or abnormal findings in the basal/ganglia/thalamus pattern.

In light of his opinion that the infant did not have a hypoxic ischemic injury at birth, Dr. Maytal opines that cranial cooling was not indicated. Therefore, he opines the NICU physicians did not depart from the standard of care by failing to institute these measures, because "there are risks associated with cranial cooling," and it was not appropriate for an infant who did not meet the criteria for hypoxic ischemic encephalopathy.

Dr. Maytal also opines that no alleged departures from the standard of care proximately caused the infant's injuries or developmental delays. Instead, he opines that the infant was born with hydrops, a rare condition which "develops in utero and may be caused by chromosomal abnormality, infection, or Rh incompatibility." He opines that the infant's mother exhibited no symptoms during her pregnancy and "the prenatal providers had no reason to suspect hydrops," but ultimately "the infant's fluid accumulation in the abdomen, pleural effusion in the lungs, and enlargement of the liver on imaging" were all indicative of hydrops. Dr. Maytal opines that hydrops was the cause of the infant being born "hypoglycemic, with liver and kidney damage, and at an increased risk of brain damage."

Dr. Maytal also opines that the infant's DIC (bleeding disorder) was a birth condition that developed in utero and could not have been prevented by the defendant physicians and staff. He opines that despite being timely and properly diagnosed and treated for DIC with broad spectrum

antibiotics, blood transfusions, and respiratory support, the infant's intracranial hemorrhage was a risk of DIC. He opines that the inborn condition had "already caused organ damage" and there were "no other treatment modalities available to prevent the risk of hemorrhage" in an infant with DIC. He also opines the hemorrhage occurred sometime between the November 9 head ultrasound and the November 23 MRI, stating the prior ultrasound would have looked abnormal if it had occurred closer to the infant's birth.

Finally, Dr. Maytal opines that the child's later development demonstrates that he did not sustain hypoxic ischemic encephalopathy at birth or continued hypoxia in the NICU. Although the infant remained non-verbal, he exhibited motor skills by the age of three including the ability to "run, jump, scribble, and finger-feed himself," he was not "unable to use [his] arms and/or ambulate," and he did not develop spastic quadriplegic cerebral palsy. Dr. Maytal opines that this is inconsistent with the development of a child who suffered hypoxic ischemic encephalopathy.

Therefore, Dr. Maytal opines that the infant's claimed injuries including developmental delays were not caused by a hypoxic ischemic event, but by hydrops and DIC, two complications which he opines developed in utero in the absence of any negligence from the providers. He opines these conditions led to the infant's intracranial hemorrhage and "resultant stunted brain growth," rather than any negligence on the part of the defendant hospital.

Lastly, NYCHHC submits an expert affirmation from Marty Ellington, M.D. ("Dr. Ellington"), a licensed physician specializing in pediatrics and neonatology.

Dr. Ellington opines, in agreement with Dr. Maytal, that the infant did not suffer from hypoxic ischemic encephalopathy or a hypoxic ischemic event during delivery, based on the cord gas pH and base values, as well as his five-minute and ten-minute Apgar scores. For that reason, she opines that cooling measures "were not a treatment option for this infant" and not required

by the standard of care in the NICU. She opines that the infant was appropriately evaluated with a "complete neurological workup" and his condition "was not correlated with a neonatal neurological syndrome." She also opines that the infant was timely and appropriately treated with respiratory support and infectious disease/sepsis consult.

Dr. Ellington further opines that the infant's low platelet count and DIC were timely recognized, blood transfusions were ordered, and his low platelet count was stabilized.

Dr. Ellington opines that "the infant was born severely ill due to hydrops" and that no alleged departures from the standard of care by the defendant proximately caused his claimed injuries. Dr. Ellington explains that hydrops is an inborn condition "wherein fluid builds up in the fetal tissues and organs causing extensive swelling," the etiology is often unknown, and the only treatment is delivery. The expert opines that the neonatal findings of swelling in the chest, abdomen, and right side of the neck, fluid collection in the abdomen, and enlarged liver were evident of hydrops.

Dr. Ellington also opines that the infant's DIC was an inborn condition, "caused by underlying issues with the fetus" and not any malpractice from the providers, and this disorder increased his risk of hemorrhage despite the fact it was promptly treated with blood transfusions. The expert opines that "no further interventions could have been implemented to prevent an internal bleed," surgical intervention would have only increased his risk of bleeding, and therefore the intracranial hemorrhage he sustained was unavoidable and not caused by any acts or omissions of the defendant.

In sum, Dr. Maytal and Dr. Ellington opine that the infant did not have hypoxic ischemic encephalopathy and "did not suffer neurological damage as a consequence of anything the defendant did during labor and delivery or while the infant was in the NICU." They opine that

infant was born severely compromised due to hydrops and DIC, and these underlying issues resulted in his intracranial hemorrhage and developmental delays.

Based on the expert submissions, Defendant has established prima facie entitlement to summary judgment on the issue of whether the NYCHHC physicians and staff complied with the applicable standard of care in prenatal treatment, labor and delivery, and treatment of the infant following his birth. Furthermore, the movants have met their prima facie burden on the issue of proximate causation, offering the opinions of Dr. Maytal and Dr. Ellington that the infant's claimed injuries were the result of hydrops and DIC that developed in utero, not hypoxic ischemic encephalopathy brought on by any acts or omissions of NYCHHC. Thus, the burden shifts to Plaintiff to raise an issue of fact as to whether the infant did sustain a hypoxic brain injury at birth, and whether the alleged departures from the standard of care proximately caused this injury.

In opposition, Plaintiff submits an expert affirmation from Bruce Halbridge, M.D. ("Dr. Halbridge"), a licensed physician board certified in obstetrics and gynecology.

Dr. Halbridge opines that the physicians and staff of NYCHHC at Kings County Hospital Center departed from the standard of care in the prenatal and labor and delivery period. He opines, among other things, that Kings County Hospital Center failed to appropriately evaluate the infant's mother's high-risk pregnancy by performing fetal heart rate monitoring, non-stress testing, and biophysical profiles. He counters the movant's expert that the mother's weight gain of only 14 pounds was healthy and expected; he opines that serial ultrasounds should have been performed during the third trimester, which he opines would have shown "lagging fetal growth" due to placental insufficiency. He opines that the standard of care required the mother be brought in a minimum of every two weeks for non-stress testing and monitoring of the fetal heart rate, in

light of her "high-risk" status and risk factors including prior miscarriages, low HCG hormone levels, and an episode of shaking belly and stomach tightening in August 2016.

Dr. Halbridge also opines that the physicians at Kings County Hospital failed to timely deliver the infant by emergency c-section. On the morning of November 6, the mother presented to the hospital with ruptured membranes and thick green meconium. He opines the release of meconium is often a sign of fetal distress from decreased oxygen. He also opines in detail that from the outset, the fetal heart rate was a "profoundly non-reassuring" Category III tracing, "categorized by a lack of variability and recurrent decelerations of the heart rate." He opines that an emergency c-section should have been undertaken and completed no later than 10:20 a.m., and the attending ob/gyn departed from the standard of care by delaying c-section delivery over an hour to 11:43 a.m.

He opines that the infant's depressed state at birth, low Apgar scores, and acidotic cord gas levels were proximately caused by this delay in prompt delivery in the face of the infant's signs of hypoxia.

Plaintiff also submits an expert affirmation from Stephen J. Thompson, M.D. ("Dr. Thompson"), a licensed physician board certified in pediatrics and neurology with a special qualification in child neurology.

Dr. Thompson opines that the defendant hospital departed from the standard of care in failing to timely and properly resuscitate and oxygenate the infant, notably because he was "born with absolutely no respiratory effort, had no response to positive pressure ventilation, and required intubation at 2 minutes of life." Dr. Thompson opines that this documents the infant's "severe hypoxic ischemic shock in utero" and "that the infant would require the highest level of respiratory support for a protracted period of time," yet an unsuccessful effort was made to

extubate him and place him on 60% oxygen before he was reintubated and transferred to the NICU. Once in the NICU, he was extubated and placed on nasal CPAP, which again led to oxygen desaturation and a need for re-intubation. Dr. Thompson opines that the standard of neonatal care is to wean the infant onto room air “very gradually,” and it was a deviation for the hospital staff to “abruptly lower both the means of respiratory support and the oxygen concentration,” rather than consistently using “intubation and mechanical ventilation for at least the first hours of life.”

Dr. Thompson also opines that the defendant hospital failed to timely diagnose and treat the infant for his “extremely low platelets,” based on his bloodwork showing platelet values of 38 at 12:43 p.m. and 29 at 2:54 p.m. The expert notes the normal range is 130-400, and the infant’s readings were extremely low and placed him “at an increased risk of intraventricular hemorrhage.” The expert opines it was a departure from the standard of care to not treat the infant with blood transfusions until approximately 8:00 p.m., hours after the low platelets were documented.

Additionally, Dr. Thompson opines that the infant was not timely treated for hypoglycemia. Although he was started on IV glucose at 12:33 p.m., his results remained extremely low for several hours after his birth, and the expert opines that the standard of care required administering a rapid intravenous bolus of dextrose solution and continuous infusion until his levels improved.

Finally, Dr. Thompson opines that the NICU physicians departed from the standard of care by failing to institute therapeutic cooling within the first six hours after delivery, using a cooling blanket or cap, to prevent or minimize brain injury. Dr. Thompson counters the movant’s expert opinions that cooling was not indicated, stating that the criteria was met: the infant was

greater than 36 weeks gestation, and there was "evidence of an acute perinatal event that may result in" hypoxic ischemic encephalopathy, demonstrated by his non-reassuring fetal heart tracings, release of meconium, tight nuchal cord wrapped around his neck, and neonatal depression with no respiratory effort. Dr. Thompson rejects the criteria set forth by Dr. Maytal and Dr. Ellington, based on the infant's cord blood gas pH and base deficit alone. He opines this criteria is "absurdly restrictive" and does not constitute the standard of care, opining that the infant's blood gas was acidotic, and all circumstances pointed toward "symptoms of hypoxic ischemic encephalopathy" which mandated therapeutic cooling. He also opines that the infant's improved Apgar scores of 7 at five minutes and 8 at ten minutes only reflect that he had been intubated, which raised his respiratory score, and did not show any improvement in his ability to breathe on his own.

On the issue of proximate causation, Dr. Thompson opines that the infant sustained an injury to the brain due to hypoxia during birth, and further metabolic acidosis due to lack of proper oxygenation after his birth. Dr. Thompson opines that hypoxia ischemia during delivery was "the most obvious explanation" for the infant's low platelet results, which put the infant at greater risk of hemorrhage. He also opines that hypoglycemia is a known result of hypoxic ischemic encephalopathy and organ dysfunction.

Additionally, Dr. Thompson addresses the opinions of Dr. Maytal and Dr. Ellington that the infant's injuries, including his hemorrhage and developmental delays, were the result of preexisting and unavoidable hydrops and DIC. Dr. Thompson notes that the hospital's own neurological staff refer to his "history of perinatal insult." The expert notes that the few times hydrops is noted in the medical record, it was repeatedly referred to as "mild hydrops." He also notes that throughout the mother's pregnancy, she had no symptoms of hydrops such as

decreased fetal movement, enlarged uterus, or preeclampsia. Instead, he notes the infant "was small for gestational age" and there was never decreased fetal movement, preeclampsia, or any sign of hydrops in ultrasound imaging. Thus, he opines that any fluid buildup "was minimal and did not harm the fetus," and the infant's injuries including DIC and hypoglycemia were instead a direct result of a hypoxic ischemic event.

Dr. Thompson also counters the defendant's expert opinions that the infant's DIC was inborn and not the result of a birth injury. All the parties' experts agree that DIC increased his risk of intracranial hemorrhage. Plaintiff's expert Dr. Thompson opines that DIC itself is "commonly caused by (and in this instance [was] the result of) an in utero hypoxic ischemic event," rather than an "underlying condition" unrelated to the infant's delayed c-section, as argued by the defendant.

Plaintiff also submits an expert affirmation from Sunil Kini, M.D. ("Dr. Kini"), a licensed physician board certified in diagnostic radiology.

Dr. Kini opines, based on his personal review of the infant's medical records and radiological images, that "the infant suffered a hypoxic ischemic insult to the brain during the labor and delivery period, resulting in an intracranial hemorrhage." Dr. Kink notes that the non-reassuring fetal heart tracings prior to delivery and his depressed state and acidosis at birth are consistent with a hypoxic ischemic event.

He also notes that on November 7, approximately 25 hours after delivery, the infant underwent a head ultrasound which could not rule out hemorrhage, and an MRI was recommended. A repeat head ultrasound on November 9 also reported "no definite hemorrhage" but could not rule out that a hemorrhage occurred. Dr. Kini opines that in his review of these

images, they "show clear evidence of a developing hemorrhage, consistent with a perinatal insult during the labor and delivery period."

The MRI on November 23 showed a large hemorrhage which had "progressed and grown bilaterally." In Dr. Kini's opinion, this hemorrhage was "smaller though present" in the November 7 ultrasound and progressed in the infant's first week of life. He opines that if the bleed had occurred prior to delivery, it would have been more fully developed in the head ultrasound, but if the bleed occurred later it "would not have been appreciable on the [head ultrasound] done at 25 hours of life." Therefore, he opines that the timing of the injury supports a finding of hypoxic ischemic injury at birth.

On the issue of whether the defendant departed from the standard of care, Plaintiff's experts have raised issues of fact as to multiple alleged deviations during the prenatal period and labor and delivery, including a failure to monitor the fetal heart rate and timely perform a c-section delivery. The experts also raise issues of fact regarding the infant's neonatal treatment and whether the defendant hospital failed to timely diagnose and treat the infant's low platelets, hypoglycemia, and institute therapeutic cooling. Thus, summary judgment is precluded on this issue as a matter of law.

On proximate causation, Plaintiff's submissions counter the movant's experts in detail, setting forth conflicting opinions as to whether the infant's injuries, including DIC, intracranial hemorrhage, and subsequent developmental disabilities, were the result of unavoidable birth defects or were proximately caused by a delayed c-section and other departures from the standard of care, resulting in hypoxic ischemic injury.

The Court notes that Plaintiff submitted a "reply" to their unopposed cross motion which substantively addressed aspects of Defendant's summary judgment motion, essentially acting as

a sur-reply. Upon application of the parties at oral argument, the Court permitted Defendant NYCHHC to submit sur-sur-reply papers to address any additional arguments made on their original motion.

In brief, Plaintiff's supplemental expert affirmation from Dr. Thompson and Defendant's supplemental expert affirmation from Dr. Maytal, both pediatric neurology experts, further address the issue of whether the infant met the criteria of hypoxic ischemic encephalopathy. The defendant expert Dr. Maytal again cites to the American College of Obstetricians and Gynecologists criteria to support his opinion, stating that this condition is characterized, among other things, by umbilical cord gas pH of less than 7 (the infant's was 7.022) and base -12 or greater (the infant's was -10).

Plaintiff's expert Dr. Thompson opines the ACOG criteria as overly narrow and "not widely accepted or relied upon in the pediatric neurology community." He opines that neurologists "who actually make the diagnosis and treat these children" use a different standard: "(1) evidence of fetal distress (e.g., fetal heart rate abnormalities, meconium-stained amniotic fluid), (2) depression at birth, and (3) an overt neonatal neurological syndrome in the first hours and days of life." He opines all these signs of hypoxic ischemic encephalopathy were clearly present in the infant's delivery, status at birth, and seizure activity and neurological symptoms, all of which are associated with hypoxic ischemic encephalopathy. He also states that not all infants with hypoxic ischemic encephalopathy develop cerebral palsy, and therefore disputes the movant's expert that the child's ability to use his arms and ambulate is not consistent with the claimed injury.

Dr. Thompson also restates his opinion that the infant's hydrops was mild and not the cause of his injuries, and DIC was a *result* of the infant's hypoxia. He notes that even if the

infant's brain injury was related to hydrops and not hypoxia, this would not eliminate issues of fact as to whether the alleged *failure to institute therapeutic cooling* and other alleged deviations in neonatal care substantially contributed and worsened his outcome.

In his supplemental affirmation, Defendant's expert Dr. Maytal opines that the ACOG criteria is the "gold standard" for diagnosing hypoxic ischemic encephalopathy at birth, and the infant's cord gas pH/base levels and his five- and ten-minute Apgar scores fell short of that diagnosis. Therefore, he reiterates his opinion that therapeutic cooling was not warranted by the standard of care, and that the infant's intracranial hemorrhage was "caused by a distinct and separate set of conditions, including DIC," not proximately caused by hypoxic ischemic injury during delivery/birth.

Based on review of all the submissions, there are clear issues of fact presented by the detailed affirmations of the parties' experts, including the opinions set forth by the pediatric neurologists on whether or not the infant suffered from hypoxic ischemic encephalopathy during delivery/birth, and whether that was the proximate cause of his various complications including DIC and intracranial hemorrhage. Although Defendant's experts opine that he did not meet the criteria and attribute any brain damage he sustained to other inborn conditions, Plaintiff's expert Dr. Thompson offers a detailed counter-opinion that these complications were secondary or directly caused by hypoxia in utero.

"When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution" (*Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022], citing *Russell v. Garafalo,* 189 A.D.3d 1100, 1102, [2d Dept. 2020]). The Court finds that even the initial opposition papers were sufficient to show issues of fact as to the standard of care and proximate causation. The additional expert affirmations only highlight these

issues of fact and credibility, which must be resolved by a jury. Accordingly, NYCHHC's motion for summary judgment is **denied** in its entirety.

It is hereby:

ORDERED that Defendant NYCHHC's motion (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment in their favor, is **DENIED;** and it is further

ORDERED that Plaintiff's cross motion (Seq. No. 2) for an Order, pursuant to Gen. Mun. Law § 50-e, granting an extension of the time to file a notice of claim, is **GRANTED** without opposition, and the notice of claim served on July 6, 2021 is deemed timely *nunc pro tunc;* and it is further

ORDERED that counsel shall appear for an in-person Settlement Conference on August 6, 2025, at 10:30 a.m. in Courtroom 561.

This constitutes the decision and order of the Court.

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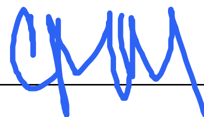

Hon. Consuelo Mallafre Melendez
J.S.C.