

**Roberts-Robles v New York City Health & Hosps.
Corp.**

2025 NY Slip Op 33156(U)

August 19, 2025

Supreme Court, Kings County

Docket Number: Index No. 516255/2020

Judge: Consuelo Mallafré Meléndez

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This opinion is uncorrected and not selected for official publication.

**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 19th
day of August 2025.**

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

-----X
JOEL ROBERTS-ROBLES, as Administrator of the Estate of
CARRIE ROBERTS,

Plaintiff,

-against-

NEW YORK CITY HEALTH AND HOSPITALS
CORPORATION d/b/a NYC HEALTH +
HOSPITALS/WOODHULL,

Defendants.

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

Recitation, as required by CPLR § 2219 [[a], of the papers considered in the review:
NYSCEF #s: 34 – 36, 37 – 51, 53 – 61, 62 – 63

DECISION & ORDER

Index No. 516255/2020
Mo. Seq. 1

Defendant New York City Health and Hospitals Corporation (“NYCHHC”), sued herein as New York City Health and Hospitals Corporation d/b/a NYC Health + Hospitals/Woodhull, moves (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment in their favor and dismissing Plaintiffs’ Complaint with prejudice. Plaintiff opposes the motion.

Plaintiff commenced this action, as administrator of Decedent’s estate, on September 1, 2020, asserting claims of medical malpractice and wrongful death in connection to care and treatment rendered from December 11, 2018 through Decedent’s death on January 7, 2019.

Decedent was 66 years old at the time of the events at issue. She was a former smoker and had a history of severe asthma, requiring intubation on a prior occasion, and diabetes. On December 11, 2018, she arrived at the Woodhull emergency department at 10:11 p.m. with shortness of breath and worsening respiratory distress over the past hour. She had been

administered IV medications and nebulizer treatment by EMS, and she was noted to be lethargic with cool extremities and oxygen saturation of 60%.

Upon arrival, the emergency department staff attempted to perform an endotracheal intubation. After two unsuccessful attempts, an anesthesia physician, Muhammad Iqbal, M.D. (“Dr. Iqbal”), was called to assist. He noted that “patient vomited and aspirated” during the intubation attempts. Another progress note stated “Patient was intubated upon arrival for respiratory failure. Difficult intubation due to aspiration and food/fluids in airway. Patient was intubated by anesthesia.” Later, a nephrology consult also recorded “intubated on arrival by the 3rd attempt as Anesthesia intervened. The process complicated with vomiting, massive aspiration and ARDS [acute respiratory distress syndrome].”

Decedent was admitted to the ICU with a diagnosis of respiratory failure, hypoxia, aspiration pneumonitis, and severe asthma with acute exacerbation. On December 14, she was diagnosed with multi-organ dysfunction syndrome with elevated liver enzymes and acute kidney injury. On December 15, the nursing staff documented her left foot was cold to the touch, and a surgical consult found no palpable pulses and cyanotic skin and nail beds. A Bellevue vascular surgeon was consulted for possible transfer and interventional embolectomy, but the consult advised that this procedure would have no benefit due to the time that had elapsed and her elevated creatinine levels.

During her admission, Decedent developed a stage II pressure ulcer on the sacrum, first documented on December 23, and two large leg blisters. On January 6, a stage III pressure ulcer on the buttocks was documented.

On December 26, an above-the-knee amputation of her left leg was performed. The pathology report revealed atherosclerotic disease with complete occlusion of the posterior and anterior tibial arteries. She also developed gangrene in the right leg.

Decedent's fever spiked on January 7, and she decompensated due to septic shock. She went into cardiac arrest at approximately 5:19 p.m., was resuscitated by Advanced Cardiac Life Support, but went into two more arrests soon after. After her family consented to DNR and cessation of life support, she was pronounced dead at 6:13 p.m.

An autopsy determined Decedent's cause of death was "acute bronchopneumonia," with findings in both lungs of "inflammation with foreign body type giant cell reaction and colonies of bacteria in association with birefringent polarizable foreign body material, consistent with aspiration pneumonia." Autopsy findings also included bronchial asthma, congestive heart failure with cardiomegaly and left ventricular hypertrophy, severe atherosclerosis, ischemic heart disease, pulmonary edema, liver congestion, diabetic nephropathy, and gangrene of the right leg and foot.

Plaintiff alleges that NYCHHC physicians and staff departed from the standard of care in treating Decedent's aspiration pneumonia during intubation, and that these departures led to her further complications from ARDS, hypoxic-ischemic encephalopathy, multi-organ failure, and death.

In evaluating a summary judgment motion 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]). "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/Woodhull submits an expert affirmation from Mark Silberman, M.D. (“Dr. Silberman”), a licensed physician board certified in internal medicine, critical care medicine, and pulmonary medicine.

Dr. Silberman opines that the Woodhull physicians and staff did not depart from the standard of care in their treatment of ARDS and prevention of hypoxic-ischemic encephalopathy. He opines that all care rendered beginning at Decedent’s arrival in the emergency department was appropriate, as the physicians promptly recognized her respiratory distress and applied supplemental oxygen and intubation. He notes that her intubation was complicated by vomiting and “gastric contents obstructing the airway,” but it was successfully completed on the third attempt by Dr. Iqbal. He opines that this vomiting and aspiration was “secondary to her critical medical condition,” not any error in intubation, and that the anesthesia physician was appropriately called to assist in the procedure. Dr. Silberman opines that throughout the rest of her admission, her mechanical ventilator was appropriately managed “to optimize recovery from ARDS.”

Dr. Silberman further opines that no alleged departures from the standard of care caused Decedent’s injuries or death, which resulted from “the severity of the decedent’s acute medical illness superimposed on her chronic medical comorbidities.” He opines that Decedent’s history of smoking, diabetes, hypertension, and asthma increased her risk of ARDS. He also notes that

her oxygen saturation was as low as 42% when she was treated by EMS prior to her arrival at Woodhull, and she had labored breathing and a change in mental status. He opines that based on this oxygen saturation and shallow breathing, “respiratory arrest was imminent” when she arrived despite proper treatment.

Dr. Silberman opines that Decedent’s additional complications “including respiratory injuries, kidney injuries, extremity injuries, and death” were caused by her severe asthma and comorbidities, and that her “hypoxic respiratory failure caused multi-organ dysfunction and progressive decline.”

NYCHHC also submits an expert affirmation from George Todd, M.D. (“Dr. Todd”), a licensed physician board certified in general surgery and vascular surgery.

Dr. Todd opines that the Woodhull staff complied at all times with the standard of care, specifically in diagnosing and treating the patient’s blood clots and limb ischemia. Dr. Todd opines that a Doppler examination is the “gold standard” for diagnosing limb ischemia, and it is the standard of care to perform this test when a limb is cold. He opines that there was no indication for a Doppler examination until nursing staff reported left leg coldness on the evening of December 15, 2018, and therefore, the testing for limb ischemia was timely.

Dr. Todd opines that it was the “correct decision” not to transfer Decedent to Bellevue for surgery on December 15, due to the futility of performing an interventional embolectomy. He opines that based on the findings of no Doppler signal and no capillary refill, there was no blood flow to the left foot, and Decedent had “unreconstructible disease” from the left thigh to ankle. Additionally, he opines that Decedent was medically unstable, and surgery could not be undertaken until she could be put under anesthesia.

Dr. Todd opines that Decedent had a history of peripheral vascular disease, and that “while leg functionality was lost at Woodhull in 2018, the disease process started in 2014.” He

opines that even if limb ischemia had been diagnosed months before her admission, it would “not have been surgically fixable” and an earlier diagnosis would not have prevented her eventual outcome of amputation. Further, upon her arrival at Woodhull, he opines that she was “in a shocked state, with severe hypotension, respiratory failure, and occluded blood vessels,” and that her lower extremity arteries became clotted in the absence of any departure from the standard of care.

Finally, NYCHHC submits an expert affirmation from Lawrence Diamond, M.D. (“Dr. Diamond”), a licensed physician board certified in geriatric and family medicine.

Dr. Diamond opines primarily on any allegations that the physicians and staff at Woodhull failed to provide proper skin and wound care to prevent the development and worsening of pressure ulcers and gangrene.

Dr. Diamond opines that beginning December 12, 2018, a skin integrity plan was implemented, and the efforts to prevent and manage Decedent’s pressure injuries “exceeded the standard of care” and included a pressure-reducing mattress, skin moisturizers, and elbow/heel protectors. He opines that although there was no way to cure the wounds that developed due to vascular insufficiency, “palliative wound care” was instituted, and a left above-the-knee amputation was properly performed.

Despite this, Decedent developed a stage II decubitus sacral ulcer and stage III buttocks pressure ulcer. Dr. Diamond opines that Decedent’s “lower extremity issues, including any pressure ulcers and gangrene diagnosis, were exacerbated by decedent’s hypoxic episodes in addition to her pre-existing vascular disease, necessary intubation due to her respiratory failure, and hypotension requiring vasopressor treatment.” He opines that Decedent was “clearly experiencing a blockage” in the left leg due to hypoxia and circulatory issues, which led to the left leg developing gangrene and “mummified” toes. Additionally, he opines that Decedent’s

necessary intubation and vasopressors reduced blood flow to both extremities. He opines that all pressure ulcers she developed were an unavoidable result of thrombolysis.

Based on these submissions, the movant has established prima facie entitlement to summary judgment, offering expert opinions that the NYCHHC physicians did not depart from the standard of care in timely diagnosing and treating Decedent for respiratory failure, ARDS, limb ischemia, and pressure ulcers. The experts also establish prima facie that Decedent's injuries, including ARDS, leg amputation, sepsis, and death, were not proximately caused by any departure from the standard of care by the movant hospital, but instead were an unavoidable outcome of her severe respiratory distress and hypoxia upon admission, history of vascular disease, and other comorbidities.

The burden therefore shifts to Plaintiff to raise an issue of fact on both the standard of care and proximate causation.

In opposition, Plaintiff submits an expert affirmation Ronald J. Simon, M.D. ("Dr. Simon"), a licensed physician board certified in adult critical care medicine, trauma surgery, and general surgery. The expert sets forth his qualifications to opine on the issues of this case, including familiarity with the standard of care for patients with "severe asthma requiring intubation, diabetes, ARDS, sepsis, [and] aspiration," and his experience intubating patients and treating patients with aspiration in the context of emergency and intensive care.

Dr. Simon opines that the Woodhull physicians and staff departed from the standard of care in failing to timely diagnose and treat ARDS, allowing Decedent to aspirate food, and failing to properly treat aspiration pneumonia, which led to Decedent developing hypoxic-ischemic encephalopathy and sepsis.

Dr. Simon notes that aspiration of vomit is a known risk of endotracheal intubation. He opines that this creates an "urgent medical situation," as food particles can block the patient's

airway, the bacteria in the lungs may cause pneumonia, and stomach acid and gastric juices can further cause irritation/pneumonitis. Dr. Simon opines that the standard of care for treating aspiration of vomit is administering 5-10 ccs of normal saline into the endotracheal tube and suctioning the liquid multiple times to remove stomach contents and dilute stomach acid. He states that there is no evidence in the medical record that this treatment was administered to Decedent, and failing to do so was a departure from the standard of care.

Dr. Simon also opines that a bronchoscopy must be performed through the endotracheal tube “to visually inspect for food blockages” and remove solid particles. He opines that it was a departure from the standard of care not to perform a bronchoscopy.

On the issue of proximate causation, Dr. Simon opines that these departures proximately caused Decedent to develop pneumonia and acute respiratory distress syndrome. He counters the opinion of Dr. Silberman that she entered the emergency department already experiencing “imminent” respiratory distress syndrome. Dr. Simon opines that while she entered the facility with respiratory failure, it worsened to ARDS after and resulting from the aspiration. He supports this opinion with citations to the medical record, including a resident on December 11 who documented she was “treated for ARDS 2/2 [secondary to] aspiration pneumonitis,” and the attending physician on December 19 summarized her condition as “Acute respiratory failure/status asthmaticus, complicated with bilateral aspiration pneumonitis, ARDS.”

Dr. Simon further opines that Decedent’s additional complications including multi-system organ failure affecting her liver and kidneys, skin breakdown and pressure ulcers, vascular compromise, sepsis, and ultimately her death, were all complications ARDS and aspiration pneumonia. He notes that the autopsy report determined bronchopneumonia as the primary cause of death with clear findings of foreign-body material and bacteria in the lungs. He

opines that the defendant's failure to properly treat the aspiration of vomit deprived Decedent of a substantial chance of survival.

Based on evaluation of these submissions, Plaintiff has raised issues of fact sufficient to preclude summary judgment in favor of the movants. Plaintiff's expert opines as to specific deviations from the standard of care in responding and treating Decedent's aspiration from vomit during her intubation on December 11, 2018, opining that the physicians failed to administer saline, suction particles and stomach acid, and perform a bronchoscopy.

Plaintiff's expert also provides a conflicting opinion as to whether the alleged departures during and after Decedent's intubation were a proximate cause of her development of ARDS and aspiration pneumonia. The Court notes that while the experts dispute whether she was "hypoxic and in respiratory failure upon arrival" or whether her condition was worsened by the acts and omissions of NYCHHC, the experts on both sides agree that ARDS and hypoxia contributed to her multi-organ failure, exacerbation of her vascular disease, pressure ulcers, and death.

For these reasons, the Court finds there are issues of fact with respect to the treatment of Decedent's aspiration following her endotracheal intubation, and issues of fact as to whether these alleged departures proximately caused her injuries and wrongful death. "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 motion for summary judgment is therefore granted to the extent of dismissing Plaintiff's claims related to diagnosing and treating limb ischemia and treatment of pressure ulcers, and the motion is otherwise denied.

Plaintiff does not rebut the movant's experts or raise any issues of fact as to specific departures from the standard of care regarding the diagnosis and treatment of limb ischemia or alleged failure to prevent pressure ulcers during her hospital admission. It is noted, however, that

Plaintiff's expert raised issues of fact that these injuries stemmed from the alleged improper intubation. As such, while claims of malpractice in the diagnosis and treatment of these conditions are dismissed, the leg ischemia and pressure ulcers remain in this case as injuries allegedly resulting from the intubation claims.

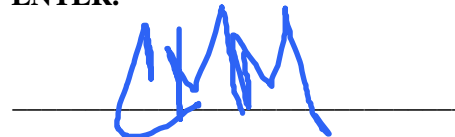
Accordingly, it is hereby:

ORDERED that NYCHHC's motion (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment in their favor and dismissing Plaintiff's Complaint, is **GRANTED TO THE EXTENT** of dismissing claims regarding diagnosis and treatment for limb ischemia and pressure ulcers, and the motion is otherwise **DENIED**; and it is further

ORDERED that the parties' counsel shall appear for a virtual Settlement Conference on September 11, 2025. A link and time to be provided.

This constitutes the decision and order of this Court.

ENTER.



Hon. Consuelo Mallafre Melendez
J.S.C.