Cummo v Children's Hosp. of N.Y.

2012 NY Slip Op 31507(U)

June 5, 2012

Sup Ct, NY County

Docket Number: 114166/2006

Judge: Marcy S. Friedman

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[* 1]
SCANNED ON 6/7/2012

SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: MARCY S. FRIEDMAN, Justice

PART 57

Index Number : 114166/2006
CUMMO, CHARLES
VS.
CHILDREN'S HOSPITAL
SEQUENCE NUMBER : 004
SUMMARY JUDGMENT

INDEX NO. ______
MOTION DATE ______
MOTION SEQ. NO. ______
MOTION CAL. NO. ______

this motion to/for summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1
Answering Affidavits — Exhibits	2
Replying Affidavits	3
	4

Cross-Motion: ☑ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion is

DECIDED IN ACCORDANCE WITH ACCOMPANYING DECISION/ORDER.

FILED
JUN 07 2012
NEW YORK COUNTY CLERK'S OFFICE

Dated: 6.5.12

MARCY S. FRIEDMAN, J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☑ FINAL DISPOSITION ☐ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

[* 2]

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 57

PRESENT: Hon. Marcy S. Friedman, JSC

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CHARLES CUMMO and MAUREEN CUMMO, individually and as co-administrators of the Estate of ERIN CUMMO,

Plaintiffs, Index No. 114166/2006

-against-

CHILDREN'S HOSPITAL OF NEW YORK, NEW YORK PRESBYTERIAN HOSPITAL, HERBERT IRVING CHILD AND ADOLESCENT ONCOLOGY CENTER at COLUMBIA UNIVERSITY, MORGAN STANLEY CHILDREN'S HOSPITAL OF NEW YORK PRESBYTERIAN, COLUMBIA UNIVERSITY MEDICAL CENTER, KOMANSKY CENTER FOR CHILDREN'S HEALTH, WEILL CORNELL MEDICAL CENTER and BOVIS LEND LEASE, INC.

Defendants.

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MORGAN CONTRACTING CORP.,

Third-Party Plaintiff,

-against-

MISTER A.C. LTD,

Third-Party Defendant.

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FILED
JUN 07 2012
NEW YORK
COUNTY CLERK'S OFFICE

In this action, in which it is claimed that Maureen and Charles Cummo's 14-year-old

daughter, Erin, died of a fungal infection[1] acquired at defendant New York-Presbyterian Hospital (the Hospital)[2], the Hospital moves for an order, pursuant to CPLR 3212, granting it summary judgment dismissing the complaint and any cross claims. The Cummos oppose the motion and cross-move for an order, pursuant to CPLR 3212, granting them partial summary judgment against the Hospital on the issue of liability.

Erin Cummo's first admission to the Hospital – in particular, to the Morgan Stanley Children's Hospital of New York (CHONY) Tower building (Tower) – was for the period from March 17, 2005 through March 22, 2005. Erin was suffering from pancytopenia, an abnormally low number of blood cells. During this hospitalization, she had a bone marrow biopsy, based on which she was diagnosed with aplastic anemia. This disease, in which the bone marrow fails to make adequate red and white blood cells and platelets, severely compromised her immune system and made her susceptible to life-threatening fungal and bacterial infections. Erin was placed under the care of Dr. Mitchell Cairo, the director of the Hospital's pediatric bone marrow transplant program, and was treated by a team that included Dr. Monica Bhatia. In addition, Erin was worked up for a possible bone marrow transplant. After her discharge on March 22, Erin was followed up as an outpatient.

Erin's second admission was for the period from April 11, 2005 until her date of death on June 12, 2005. On April 11, she presented to the Hospital's emergency room with a history of a

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[1]The terms fungus and mold are used interchangeably by the parties and their experts, and will be used interchangeably throughout this decision.

[2] The Hospital's motion is made only on behalf of New York-Presbyterian Hospital, and plaintiffs' cross motion is made only against one named medically related defendant, Children's Hospital of New York, New York Presbyterian Hospital. Evidently, the parties are in agreement that there is only one properly named medically related defendant in this case.

fever and chills. An infection was diagnosed, and she was readmitted to the Tower building. After discussions with the Cummos and Erin, it was decided that an allogeneic cord blood stem cell transplant would be performed as a potential cure, as a suitable bone marrow donor could not be located. Beginning on April 25, to prevent transplant rejection, Erin underwent chemotherapy to destroy the remnants of her immune system. In early May, blood cord infusions were performed. Erin developed a rash that spread, necessitating an abdominal biopsy that was reported as consistent with Graft Versus Host Disease (GVHD), a complication which occurs when the donor's T-cells attack the recipient's T-cells, and a course of steroids was commenced. (Bhatia Dep., at 254.) On June 2, Erin developed sepsis with fever. (Autopsy Report, Clinical Summary.) On June 5, she was transferred to an isolation room in the Pediatric Intensive Care Unit (PICU), located on the ninth floor of the Hospital's Central building. On June 5, Erin began experiencing increased fluid retention. On June 6, she was transferred to the transplant unit in the Tower building. A CT scan of June 6 showed pleural and pericardial effusions and "marked thickening of the distal esophagus most likely secondary to hemorrhage or infection." (Bhatia Dep., at 394.) Erin's condition worsened over the next few days. On June 10, she was returned to the PICU. An Aspergillus Galactomannan test, used in helping to diagnose invasive Aspergillus in high risk patients, was performed on a blood sample collected from Erin on June 11, and tested positive. Erin developed fixed pupils on the morning of June 12. A CT scan of her chest and abdomen revealed increasing effusions. (Autopsy Report, Clinical Summary.) A procedure was performed to drain fluid, but Erin died that morning.

According to the autopsy report, Erin had a "diffusely invasive fungal infection" that invaded the distal one-third of her esophagus, aorta, pericardium, and other organs. The

effusions seen on her CT scans were "most likely induced by the invasive fungal process." The autopsy report noted that there were "islands of rejuvenating hematopoietic cells. Thus, it appears that engraftment was occurring, albeit slowly." The report further noted: "The only fungus grown in culture was Candida lusitaneae but the fungal morphology is not consistent with this species, instead it appears to be Aspergillus. Although no Aspergillus grew in culture, this infection was most likely a result of a species of Aspergillus." The report concluded that "[t]he patients [sic] cause of death is consistent with diffuse, invasive fungal infection secondary to aplastic anemia."

The Cummos commenced this action not only against the Hospital but against various contractors involved in the construction or renovation of the operating room where Erin's biopsy was performed during her first admission. The action has since been discontinued against the contractors.

The complaint, as amended, asserted five causes of action, amplified by plaintiffs' bill of particulars. The first cause of action alleged that Erin had been exposed to and died as a result of "fungus, toxic airborne particles, bacteria, Aspergillus and legionnares [sic]," and that defendants were negligent in that they had notice of and failed to correct the unsafe conditions, and to monitor the air, post warnings of unsafe conditions, and properly clean, inspect, and maintain the Hospital, including its ventilation system. (Bill of Particulars, ¶¶ 1-2, 5-16, 18; Second Amended Compl., ¶¶ 156-164.) The pleading also alleged that the Hospital created a dangerous condition by performing construction. (Bill of Particulars, ¶ 5.) The second cause of action alleged that defendants failed to warn of the hazards and dangers in the Hospital. (Second Amended Compl., ¶¶ 165-169.) The third cause of action alleged that defendants knowingly or negligently falsely

represented to plaintiff and the general public that the Hospital was clean and safe, and omitted from its advertisements and promotions that the Hospital was unsafe due to "Aspergillus and Legionnaires fungi." (Bill of Particulars, ¶ 34-35; Second Amended Compl., ¶¶ 170-177.) The fourth cause of action alleged that defendants breached their contract to provide a clean, safe, toxic-free environment. (Second Amended Compl., ¶¶ 183-188.) The fifth cause of action set forth the Cummos' derivative claims. It is undisputed that this action does not allege a cause of action for medical malpractice.

Discussion

The standards for summary judgment are well settled. The movant must tender evidence, by proof in admissible form, to establish the cause of action "sufficiently to warrant the court as a matter of law in directing judgment." (CPLR 3212[b]; Zuckerman v City of New York, 49 NY2d 557, 562 [1980].) "Failure to make such showing requires denial of the motion, regardless of the sufficiency of the opposing papers." (Winegrad v New York Univ. Med. Ctr., 64 NY2d 851, 853 [1985].) Once such proof has been offered, to defeat summary judgment "the opposing party must 'show facts sufficient to require a trial of any issue of fact' (CPLR 3212, subd. [b]." (Zuckerman, 49 NY2d at 562.)

It is further settled that in a premises liability case, the owner is required to keep its premises in a reasonably safe condition under the circumstances. (Basso v Miller, 40 NY2d 233, 241 [1976].) The Hospital was therefore required to exercise reasonable care in the maintenance of its facilities. (See Holtfoth v Rochester Gen. Hosp., 304 NY 27, 32 [1952].) The duty of reasonable care "is [to be] measured by the plaintiff's physical . . . infirmities, as known by the defendant[s]." (See Campbell v Cluster Hous. Dev. Fund Co., 247 AD2d 353, 353-354 [2d Dept

1998] [explaining duty of reasonable care of operator of halfway house to residents]), which in this case included Erin's immunocompromised condition. Under general negligence standards, liability may be imposed on the Hospital if a dangerous condition existed, the Hospital created or had actual or constructive notice of it and failed to correct it within a reasonable period of time, and injury to the plaintiff resulted. (See Penn v Fleet Bank, 12 AD3d 584 [2d Dept 2004].)

Here, plaintiffs' and defendant's claims as to the safety of conditions at the Hospital are based on the opinions of experts. The court may not give probative force to an expert's opinion if it is "speculative or unsupported by any evidentiary foundation." (Diaz v New York Downtown Hosp., 99 NY2d 542, 544 [2002]. An expert's opinion is insufficient to raise a triable issue of fact where it is "conclusory and devoid of analysis or reference to scientific data." (Abalola v Flower Hosp., 44 AD3d 522 [1st Dept 2007].)

In moving for summary judgment, the Hospital focused on plaintiffs' claim that Erin had died of an Aspergillus infection. The Hospital submitted extensive evidence that a dangerous Aspergillus condition did not exist at the Hospital. This evidence included the opinions of its expert, Bruce Farber, M.D., Chief of the Divisions of Infectious Diseases and the epidemiologist for North Shore University Hospital and Long Island Jewish Medical Center, as well as the opinions of treating doctors and scientists from the Hospital.

The Hospital claimed that during Erin's admissions, she was placed in a safe environment. It submitted its 2004 and 2005 air sampling tests, conducted periodically in the fifth floor transplant unit rooms and the PICU, pursuant to a surveillance program under the direction of Dr. Lisa Saiman, CHONY's epidemiologist, and cultured in the Hospital's microbiology lab under the direction of Phyllis Della Latta, Ph.D. These tests (Ex. L to Aff. of

Glen Pewarski [D.'s Attorney] In Support Of D.'s Motion [Pewarski Aff.]) isolated no Aspergillus anywhere within the CHONY fifth floor bone marrow transplant unit or Pediatric Intensive Care Unit, and only found Aspergillus in the air outside the Hospital.

The Hospital maintained that it is impossible to completely eliminate the risk of Aspergillus in hospitals because it is an ubiquitous mold which is present in the air and on clothing, among other objects, and can be brought into the Hospital from the community. (Saiman Dep., at 132, 161; Farber Aff., ¶¶ 12-13 [Ex. H to Pewarski Aff.]; Farber Reply Aff., ¶¶ 6, 25 [Ex. E to Pewarski Reply Aff.]; Cairo Aff., ¶¶ 7, 9 [Ex. I to Pewarski Aff.].) The Hospital also asserted that it is impossible to completely prevent Aspergillus infections in immunocompromised patients (Farber Aff., ¶ 12), that it is one of the most common causes of death in immunocompromised allogeneic transplant patients (Cairo Aff., ¶ 7), and that patients in every transplant unit in this country develop such infections. (Id.) According to the Hospital, statistics show that between seven and eight percent of allogeneic stem cell transplant patients develop Aspergillus infection after transplant, with a fatality rate of 75 percent. (Id.) The Hospital claimed that the safety of its environment, at the time of Erin's admissions, is supported by its lower than average Aspergillus infection rate, and by its lack of Aspergillus infection clusters in 2004 or in 2005. (Farber Aff., ¶ 15; see also Saiman Dep., at 67; Cairo Aff., ¶ 11.) Accordingly, the Hospital claimed that there was no evidence, and that it lacked notice, of any dangerous Aspergillus contamination in the Hospital at the time of Erin's hospitalizations. (Pewarski Aff., ¶ 65.)

Further, the Hospital asserted that it took the necessary steps to minimize its transplant patients' risk of acquiring that infection. (Cairo Aff., ¶ 9.) These measures included daily and

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terminal cleaning of the transplant unit's patient rooms (Bhatia Dep., at 94; Cairo Aff., ¶ 10), maintaining positive pressure in those rooms, placing transplant patients in rooms with HEPA filters which trap 99.9% of the air's particulate matter (Cairo Aff., ¶ 10; see also Dep. of John De Rose [Building Systems Manager], at 58; Bhatia Dep., at 64), filtering to 95% all of the Hospital's air before it entered the ductwork (De Rose Dep., at 46, 47), and performing routine preventive maintenance on the Hospital's HVAC systems, including changing filters. (Id., at 46, 79-85, 87, 90-92.) In addition, whenever a transplant patient, including Erin, had to leave his/her room and go through areas of the Hospital which were not HEPA filtered, the patient would wear a mask (Cairo Aff., ¶ 10; Bhatia Dep., at 75; M. Cummo Dep., at 208), as recommended by Center for Disease Control (CDC) "Guidelines for Environmental Infection Control in Health-Care Facilities." (Ex. F to Pewarski Reply Aff.; Farber Reply Aff., ¶ 25.)

The Hospital further asserted that it exceeded the requisite hospital standards of care when it implemented its air sampling program, given that such routine air testing was not recommended by bodies such as the CDC or the Infectious Disease Society of America because air testing is "not clinically useful." (Saiman Dep., at 48-50; Farber Aff., ¶ 20; see also Farber Reply Aff., ¶¶ 20-23; CDC "Infection Control in Hematopoietic Stem Cell Transplant Recipient," Infection Control Surveillance section [Ex. A to Pewarski Reply Aff.].) According to Dr. Farber, the standard of care, as evidenced by the publications of such bodies, only required testing of a hospital area if an outbreak of infection had occurred in that area. (Farber Reply Aff., ¶¶ 20-23.)

Saiman testified that, at the time in issue, even though there was no standard for what constituted an acceptable level of Aspergillus, when air sampling revealed two or more

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Aspergillus colonies, the Hospital would remove a patient from the offending room, which would then be cleaned and retested. (Saiman Dep., at 48-50.) Besides air testing, the Hospital had other policies aimed at discovering, through positive cultures, autopsy specimens, and histopathology (microscopic examination), whether patients were acquiring Aspergillus infections and, thus, ascertaining whether there were clusters of Aspergillus infection, related in time and locale, within the Hospital. (Id., at 64, 66-67.) Saiman also testified that when the air sampling revealed molds other than Aspergillus, including Penicillium, nothing would be done because those other molds were not "generally" pathogenic (invasive). (Id., at 51.)

The Hospital further urged that Erin's death was caused by "an infection" secondary to her severe aplastic anemia and the side effects of chemotherapy and steroids, which left her immunocompromised, and by her hyperacute GVHD, failed transplant engraftment, and prolonged neutropenia. (See Cairo Aff., ¶¶ 5-6; Farber Aff., ¶ 11.)

In its initial moving papers, the Hospital also adduced evidence that plaintiffs' allegations regarding Legionella lacked merit because Legionella was confined to the Milstein building. As to plaintiffs' claims that the renovation of operating room #5 created an unsafe condition, the Hospital detailed precautions taken to avoid contaminating the Hospital with airborne particles. (See Aff. of Thomas DeMonse [Hosp. Architect] [Ex. N to Pewarski Aff.].)

In opposition, plaintiffs did not dispute that the Hospital lacked notice of a dangerous Aspergillus condition, that the Legionella claim lacked support, and that the Hospital was not negligent with respect to the renovation of operating room # 5 in which plaintiff had her biopsy during her first admission. Nor did plaintiffs take issue with the manner in which the Hospital performed the routine measures used in the pre-filtering of the Hospital's air, the maintenance of

the Hospital's ventilation system, and the cleaning of the transplant unit's patient rooms, although plaintiffs did claim that these measures were insufficient. Rather, plaintiffs took the position that Erin's death was caused by an unsafe Penicillium condition at the Hospital during the time of Erin's admissions.

As the Hospital correctly observes, prior to opposing the summary judgment motion, plaintiffs had not expressly pleaded a Penicillium condition. (See supra, at 4.) In fact, during Dr. Bhatia's January 10, 2010 deposition, plaintiffs' counsel stated that plaintiffs were claiming that Erin had contracted Aspergillus. (Bhatia Dep., at 301-303.) The court, however, rejects the Hospital's claim that plaintiffs should be precluded from asserting the Penicillium condition. Plaintiffs did plead Erin's exposure to, and death, not only from Aspergillus but from fungus generally. (Bill of Particulars, ¶¶ 1-2, 6-16, 18.) As a fungus other than Aspergillus was not newly raised in opposition to the summary judgment motion, the Penicillium claim may be entertained. (Compare Abalola, 44 AD3d at 522 [new theory of liability raised for first time in opposition to summary judgment motion, which was not set forth in complaint or bill of particulars, not properly considered].)

In claiming that an unsafe Penicillium condition existed at the Hospital during Erin's hospitalizations, plaintiffs rely largely on the opinion of their expert, Irene Grant, M.D., an infectious disease specialist who helped develop the Department of Infectious Disease at Bronx Lebanon Hospital Center and was actively involved in developing the infection control committee and policies, including infection control air quality issues, for that hospital. (Grant Aff. In Support Of Ps.' Cross-Motion [Grant Aff.], ¶ 2.) Dr. Grant stated that the Hospital's air quality testing showed that between September 2004 and July 2005, "Penicillium and/or

misidentified Aspergillus (both mycotoxin producing) were present in the hospital."[3] (id., ¶ 24); that the areas where they were present were areas in which Erin stayed, including the fifth floor patient rooms and ninth floor Pediatric Intensive Care Unit (id., ¶¶ 24, 26); and that the documented counts of airborne fungus increased over time. (Id., ¶ 27.) Dr. Grant opined that the "[p]rolonged presence" of fungus in the air during Erin's hospitalization "impl[ied]" that it was "actively proliferating somewhere in the building" and becoming airborne. (Id., ¶ 24.) She further maintained that because chronic exposure to low level mold can increase an immunocompromised person's risk of developing invasive fungal infection, once mold is discovered it requires professional remediation, involving opening ceilings, walls, and floors to find the source, followed by "cleaning and/or removal of contaminated . . . sites." (Id., ¶¶ 13-14.) Dr. Grant stated that the measures taken by the Hospital, such as use of HEPA filters and wearing of masks, were insufficient to protect immunocompromised patients from fungal infection. (Id., ¶ 16.) She explained that "[t]hese measures protect only one room, and only if that room's incoming air is also not contaminated." (Id.) She concluded that had remediation been performed, Erin would not have sustained a fungal infection and resulting death. (Id., ¶ 29.) She also disputed the opinion of the Hospital's experts that Graft versus Host disease was a cause of Erin's death, citing (unidentified) notes in the Hospital chart that the doctors were not sure if Erin was suffering from this disease or a fungal infection. (Id., ¶ 30.)

In response, the Hospital contends that there is no evidence that Erin had an infection

[3]In referring to "misidentified Aspergillus," Dr. Grant apparently meant that Aspergillus was likely present but not identified. Air quality tests performed between September 2004 and July 2005 (D.'s Ex. L) did not show any Aspergillus counts. But it was Dr. Grant's position that there were "likely undocumented counts of Aspergillus," as it is the most ubiquitous of all fungi. (Grant Aff., ¶ 28.) In addition, Dr. Grant cited inadequate specimen culturing – in particular, insufficient incubation – as the reason for the "alleged paucity of mold infections at CHONY." (Id., ¶ 17.)

from Penicillium or that Penicillium was a proximate cause of Erin's death. The Hospital relies on the autopsy report for the proposition that the cause of Erin's death was found to be an Aspergillus infection. It also relies on a positive Aspergillus Galactomannan test of Erin's blood, drawn on June 11, 2005. The Hospital then charges that Dr. Grant's opinion that Penicillium was the cause of Erin's infection is based on speculation that the pathologist may have made a mistake in finding that the cause of infection was Aspergillus, or that the Aspergillus Galactomannan test may have been a false positive. (Pewarski Reply Aff., ¶¶ 19, 26.)

This claim mischaracterizes Dr. Grant's position, which is not that the autopsy report and test may have been in error, but that they are not conclusive of the identity of the fungus that caused Erin's infection. The court agrees with that position. The autopsy report was qualified, as it found only that the infection was "most likely a result of a species of Aspergillus." Dr. Grant opined, and the Hospital does not dispute, that Penicillium also causes a positive Aspergillus Galactomannan test. (Grant Aff., ¶¶ 20, 22.) That test therefore also was not determinative.

Moreover, the parties sharply dispute the conclusiveness of the identification of the fungus based on the microscopic examination (i.e., examination of tissue) that was performed in connection with the autopsy. Dr. Grant stated that "looking at the fungus microscopically will only identify the hyphae; it will not identify the species of fungus. The fungus was not cultured and therefore, positive identification of the species of fungus is not possible." (Grant Aff., ¶ 22.) She further stated: "Aspergillus and Penicillium appear identical under a microscope." (Id.) Dr. Della Latta, the Hospital's director of microbiology, characterized these statements as "wrong." (Della Latta Aff., ¶14 [Ex. B to Pewarski Reply Aff.].) She further stated that "[w]hen the

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fungus is observed from a tissue specimen alone . . . the fungus cannot be identified to the species level. However, Aspergillus and Penicillium refer to the 'genus' of fungi, of which there are various 'species'. . . ." (Id., ¶ 15.) Dr. Lisa Saiman, the Hospital's epidemiologist, gave deposition testimony that was apparently consistent with Dr. Grant's, stating: "So the histopathology of the organisms involved were consistent with aspergillus, but no aspergillus grew in culture. And so there are other molds that can histologically look just like aspergillus. And unless you have a culture, you can't totally confirm if it's aspergillus or not." (Saiman Dep., at 30.) Fitzroy Edwards, plaintiffs' expert who was employed as a microbiologist at Memorial Sloan Kettering Cancer Center from 1974 until his retirement in 2010, stated, similarly, that Dr. Della Latta's "assertion that she can tell from the pathology slides that the fungus is Aspergillus is inaccurate. Unless a fungus is grown in culture, no microbiologist can definitively differentiate Aspergillus from Penicillium." (Edwards Aff., ¶ 6.)

While the Hospital claims that the tissue slides of the autopsy are consistent with Aspergillus and not with Penicillium, the parties' experts also dispute the description of the angles at which the hyphae of the two types of fungus branch. (Compare Della Latta Aff., ¶ 17 with Edwards Aff., ¶ 6.)[4]

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[4]Plaintiff's microbiologist did not contest the other features on which the Hospital's microbiologist relied – namely, angioinvasion, the diameter of the hyphae, and the presence of foot cells – in identifying the fungus on the autopsy pathology slides as Aspergillus rather than Penicillium. (See Della Latta Aff. ¶ 17; Edwards Aff., ¶ 6.)

It is noted that plaintiffs' microbiologist did not examine the slides. The parties dispute plaintiffs' diligence in pursuing discovery of the slides. While plaintiffs assert generally that the Hospital's refusal to produce the slides warrants denial of its summary judgment motion, they do not claim that the absence of this discovery impaired their ability to defend the motion. (See Aff. of John Bailly [Ps.' Atty] in Support of Cross-Motion,¶¶ 27-28 [misnumbered 30].) On the contrary, plaintiffs themselves moved for summary judgment. Any claim that the slides were necessary to oppose the Hospital's motion would be unavailing in any event, as both of plaintiffs' experts asserted that the pathology slides were inconclusive, and that the identity of the fungus that caused Erin's infection could not be definitively determined without a culture, which concededly does not exist. (See supra at 12-13.)

The parties' experts also dispute whether Penicillium is a pathogen that was capable of causing Erin's infection. The Hospital cites Dr. Della Latta's opinion that Penicillium is "almost never pathogenic or invasive." (Della Latta Aff., ¶ 24.) In support of her opinion, she stated that in 10 years as Director of the Clinical Microbiology Laboratory at the Hospital, she had never seen an instance of invasive Penicillium in a patient from the bone marrow transplant unit. (Id.) She also noted that there is an invasive species of Penicillium that is endemic to southeast Asia, and stated that other instances of a Penicillium species being a pathogen are so rare that the occurrence would be the subject of a case report in medical literature. (Id., ¶ 25.) Dr. Grant categorically disagreed with Dr. Della Latta's statement that Penicillium is not pathogenic or invasive. In support of her opinion, she cited reports in the medical literature, which she annexed, including a 2004 University of South Carolina School of Medicine Study that attributed four deaths to Penicillium infections in connection with stem cell transplants, and a 1990 Ohio State University Hospitals report of heavy contamination of operating room air by Penicillium, resulting in two surgical wound infections. (Ex. A to Grant Reply Aff.)

The court finds, based on the disputed expert evidence discussed above, that plaintiffs raise triable issues of fact as to whether Penicillium is a pathogen that was capable of causing Erin's infection, and as to whether Erin suffered from a Penicillium rather than an Aspergillus infection. The court accordingly turns to the issue of whether the infection – even if from Penicillium – was contracted as a result of an unsafe condition at the Hospital.

In contending that Erin's infection was not caused by an unsafe Penicillium condition, the Hospital points to a critical error in Dr. Grant's affirmation as to the Penicillium counts in the rooms in which Erin stayed during her hospitalizations. In her initial affirmation, Dr. Grant

stated that between March 31, 2005 and June 29, 2005, the Penicillium colony count in rooms 509 and 510 had "markedly increased" to a life threatening level, and that "Erin was in room 510 during this period." (Grant Aff., ¶ 10.) The Hospital correctly points out that Erin occupied room 510 during her first admission between March 17 and March 22, 2005, and that testing on October 1, 2004 found 1 Penicillium spore, and testing on March 31, 2005 found "No molds isolated." (Pewarski Reply Aff., ¶ 60; D.'s Ex. L [test results].) As the Hospital further notes, while testing on June 29, 2005 showed greater than 50 Penicillium colonies in room 510, that testing was performed over three months after Erin last stayed in that room.

The parties are in agreement that during Erin's subsequent hospitalization, she stayed in the following rooms in the fifth floor transplant unit: 503, which she occupied from April 20 through May 2, 2005; 501, which she occupied from May 2 through June 5, 2005; and 504, which she occupied from June 6 through June 10, 2005. The Hospital makes a prima facie showing, based on its air quality testing, that there were no Penicillium colonies in these rooms as of March 31, 2005, the last periodic test date before her occupancy, and no Penicillium colonies in these rooms as of June 29, 2005, the periodic test date after her occupancy, with the exception of room 503, which had 2 Penicillium spores on June 29, 2005, nearly two months after her occupancy. (Pewarski Reply Aff., ¶ 60; D.'s Ex. L.)

In response, Dr. Grant did not acknowledge the error in her initial affirmation. Rather, she asserted generally that on the fifth floor "[t]he same mold spores were persistently found and were increased in March [2005] relative to October [2004] and then dangerously increased in June of 2005. . . . The finding of a dangerous increase in the same mold on the fifth floor on the same month of the death is highly suggestive that this mold proliferated between March and June

of 2005." (Grant Reply Aff., ¶ 2.)

Significantly, plaintiffs make no showing, based on Dr. Grant's opinion or otherwise, that the air sampling tests undertaken for the fifth floor transplant unit rooms detected a proliferation of Penicillium in any fifth floor room that was actually occupied by Erin, at any time during or proximate to Erin's stay in such room. Nor do plaintiffs make any showing of an unsafe mold condition in any room outside the fifth floor transplant unit that Erin occupied or in which she was treated during her hospitalizations.

As discussed above, the only room Erin occupied during her first hospitalization was 510, and elevated Penicillium colonies were not found in that room until over three months after her occupancy. While Erin had a biopsy in operating room # 5 during that hospitalization, plaintiffs have abandoned their claim that the operating room was in an unsafe condition at the time. (See supra at 9, 14.)

With respect to Erin's second hospitalization, in addition to occupying rooms on the fifth floor, she was in the Pediatric Intensive Care unit bed 7 (a/k/a room 907) on June 5, 2005, and bed 11 (a/k/a room 911) from June 10 until her death on June 12. While air sampling of these units on September 27, 2004 detected 1 column and 6 columns of Penicillium, respectively, retesting on March 10, 2005 found "No molds isolated." In addition, from April 11 to April 20, 2005, the outset of her second admission, Erin stayed in room 613 on the sixth floor while waiting for a bed in the transplant unit. It is undisputed that the Hospital did not perform routine air sampling on this floor, but that this room was HEPA filtered and that the room had positive air pressure, which means that its air would push out when the door was opened in an attempt to keep corridor air – and, with it, potential contaminants – out of the room. (DeRose Dep., at 39-

40.) While Dr. Grant pointed out that this room was never tested (Grant Reply Aff., ¶ 6), she did not assert that rooms that were not in the transplant unit should have been tested. Rather, she acknowledged that "there are no CDC requirements that the air quality testing be performed. . . ." (Grant Reply Aff., ¶ 4.) Although she opined that once the Hospital performed such tests and found positive results, it had an obligation to perform proper testing" (id.), she did not claim that because mold was found on the fifth floor, any other floor of the hospital should have been tested. On the contrary, referring to the Penicillium found in 2004 and 2005 on the fifth floor, she stated: "At a minimum, monthly testing should have been performed of all the rooms and areas on that floor." (Id., ¶ 13 [emphasis supplied].) Further, Dr. Grant did not so much as suggest that it was an unsafe practice for the Hospital to have placed an immunocompromised patient such as Erin in a room on a floor (the sixth) in which regular testing was not performed.

Plaintiffs also do not make any showing of an unsafe mold condition in any common area to which Erin was brought during her hospitalizations. Dr. Grant noted, for example, that on January 6, 2005, two Penicillium colonies were detected outside the pediatric blood drawing unit, and it was never retested; and that on March 31, 2005, six colonies of Penicillium were found on the fifth floor outside lobby, and it was not retested until July 5, 2005, when 2 colonies were found. (Grant Reply Aff., ¶ 12.) However, the Hospital submitted evidence that it followed CDC guidelines in having patients wear a mask when transported to common areas, and that Erin did so. (See supra at 8.) Dr. Grant did not dispute that the CDC Guidelines recommend use of masks for severely immunocompromised patients when they are transported to common areas. While she stated generally that measures such as HEPA filters and masks were inadequate, her reasoning was that these measures protect only one room. (See supra at 11.) Dr. Grant did not

specifically contest that the use of masks was a sufficient protective measure for patients when they were in common areas.

To the extent that Dr. Grant suggested that more frequent air testing or longer culturing would have detected proliferation of molds in the rooms that Erin occupied during or at times more closely proximate to her occupancy, that suggestion is wholly speculative and without probative value. The suggestion that testing should have been performed more frequently also is contradicted by Dr. Grant's acknowledgment that the standard of care generally does not require periodic testing. Dr. Grant's general assertion that remediation of mold on the fifth floor would have prevented Erin from sustaining an infection is also speculative, given the absence of any evidence that there were dangerous levels of mold in any room that Erin actually occupied during or at times closely proximate to her occupancy. In light of the absence of any cultures showing dangerous levels of mold in those rooms at such times, and of any showing of a violation of accepted safety standards in the use of masks when transporting Erin to common areas, plaintiffs fail to raise a triable issue of fact as to the Hospital's negligence.

In so holding, the court rejects plaintiffs' claim that they are entitled to a finding of negligence under the res ipsa loquitur doctrine. This doctrine is not a theory of recovery (Scope v Federated Dept. Stores, Inc., 26 AD3d 226 [1st Dept 2006]), and is "nothing more than a brand of circumstantial evidence" which allows the finder of fact to infer negligence. (Morejon v Rais Constr. Co., 7 NY3d 203, 211-212 [2006].) It may be raised at any time as justified by the facts, and does not have to be pleaded. (Olson v 625 Ocean Co., 40 AD3d 828 [2d Dept 2007].) However, a plaintiff seeking to rely on the doctrine is required to show that the event is one that does not usually happen absent negligence, that it was caused by an instrumentality or agent in

the defendant's exclusive control, and that no act or negligence on the plaintiff's part contributed to the happening of the event. (States v Lourdes Hosp., 100 NY2d 208, 211[2003].) "The exclusive control requirement, as generally understood, is that the evidence must afford a rational basis for concluding that the cause of the [occurrence] was probably such that the defendant would be responsible for any negligence connected with it." (Dermatossian v New York City Tr. Auth., 67 NY2d 219, 227 [1986] [internal quotation marks and citations omitted; see also Fernandez v Ramos, 300 AD2d 348, 348-349 [2d Dept 2002].)

In the instant case Dr. Grant conceded that fungi are ubiquitous, a sentiment echoed by the Hospital. Further, plaintiffs do not dispute that Erin could have come into the Hospital with an Aspergillus infection, as its incubation period is unknown. Accordingly, plaintiffs have failed to show that Erin could only have contracted a fungal infection as a result of negligence. (Smith v City of New York, 91 AD3d 456 [1st Dept 2012].) Plaintiffs have also failed to refute the showing that fungi are on clothing, magazines, books, food, and other objects, and, thus, could have been transported into the Hospital. Therefore, plaintiffs have failed to establish the requisite exclusive control element. Nor have plaintiffs demonstrated that this is one of those rare instances in which their circumstantial evidence is so strong and the opponent's proof so weak as to permit the court, in the context of a summary judgment motion, to draw an inference of negligence. (See Morejon, 7 NY3d at 209.)

Finally, plaintiffs do not argue that the failure to warn cause of action or the non-negligence causes of action are viable.

The court recognizes that the depth of plaintiffs' loss is incalculable. The record does not, however, support the imposition of liability on the Hospital.

It is accordingly hereby ORDERED that the branch of New York-Presbyterian Hospital's motion, which seeks an order awarding it summary judgment dismissing the complaint, is granted, and the branch of New York-Presbyterian Hospital's motion, which seeks an order dismissing any cross claims, is moot in light of the discontinuance of the action as to Bovis Lend Lease, Inc., Morgan Contracting Corp., and Mister A.C. Ltd.; and it is further

ORDERED that plaintiffs Charles and Maureen Cummo's cross motion for an order granting them summary judgment against New York-Presbyterian Hospital, sued herein as Children's Hospital of New York, New York-Presbyterian Hospital, Herbert Irving Child and Adolescent Oncology Center at Columbia University, Morgan Stanley Children's Hospital of New York Presbyterian, Columbia University Medical Center, Komansky Center for Children's Health, and Weill Cornell Medical Center, on the issue of liability is denied; and it is further

ORDERED that the Clerk shall enter judgment accordingly.

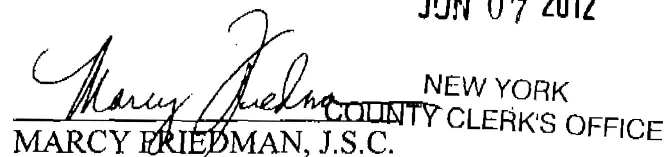
This constitutes the decision and order of the Court.

FILED

JUN 07 2012

NEW YORK COUNTY CLERK'S OFFICE

Dated: New York, New York
June 5, 2012



MARCY FRIEDMAN, J.S.C.