To commence the statutory time period for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

**SUPREME COURT OF THE STATE OF NEW YORK**
**COUNTY OF WESTCHESTER**

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**DAVID CENELLI, as Administrator of the Estate of CONSTANCE BALLANO,**

**Plaintiff,**

**-against-**

**DECISION & ORDER**
**Index No.: 51014/2017**
**Seq Nos. 1, 2 &3**

**ST. JOSEPH'S MEDICAL CENTER, ST. JOSEPH'S HOSPITAL NURSING HOME OF YONKERS, NEW YORK, INC., ST. JOSEPH'S MEDICAL PRACTICE, P.C., ST. JOSEPH'S VENTURES, LTD and FAISAL NAGARWALA, M.D.,**

**Defendants.**

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**WOOD, J.**

New York State Courts Electronic Filing ("NYSCEF") Documents Numbers 42-104, were read in connection with the motions for summary judgment from St. Joseph's Medical Center ("Hospital"), and St. Joseph's Hospital Nursing Home of Yonkers ("Nursing Home", collectively, "St. Joseph's")) (Seq 1), and from Faisal Nagarwala, MD (Seq 2); and a motion to so order a Stipulation of Discontinuance of St. Joseph's Medical Practice P.C. ("Medical Practice") (Seq 3).

Administrator of estate of the 86 year-old decedent Constance Ballano ("decedent") brought negligence and medical malpractice action against nursing home and hospital for decedent's treatment and care at these facilities.

Now, based upon the foregoing, the motions are decided as follows:

As an initial matter, the Medical Practice's application (Seq 3), to have this court so order the Stipulation of Discontinuance is unopposed by any of the parties. Plaintiff's counsel has consented to said Stipulation with prejudice on behalf of their client, and there are no cross-claims against Medical Practice being made by any co-defendants. While the Stipulation is not executed by counsel for the other defendants, this motion (Seq 3) is unopposed, and the court shall so order the Stipulation of Discontinuance, thereby granting Motion Seq 3.

A statute of limitations defense was raised for the first time in St. Joseph's reply papers. Despite St. Joseph's having served an answer and interposed statute of limitations as an affirmative defense, plaintiff would be prejudiced by St. Joseph's raising of new theories in their reply papers, as plaintiff has not had an opportunity to respond, and no party has made an application to this court pursuant to this Court's Rules, to submit a sur-reply or otherwise address the Statute of Limitations issue (Held v Kaufman, 238 AD2d 546, 548, aff'd as modified, 91 NY2d 425 (1998). Thus, the court will not address this defense at this juncture.

Turning to the merits of Motion Seqs 1 and 2, it is well-settled that a proponent of a summary judgment motion must make a "prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (Alvarez v Prospect Hospital, 68 NY2d 320, 324 [1986]; see Orange County-Poughkeepsie Ltd. Partnership v Bonte, 37 AD3d 684, 686-687 [2d Dept 2007]; see also Rea v Gallagher, 31 AD3d 731 [2d Dept 2007]). Failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the motion papers (Winegrad v New York University Medical Center, 64 NY2d 851, 853 [1986]; see Jakabovics v Rosenberg, 49 AD3d 695 [2d Dept 2008]; see also Menzel v Plotkin, 202 AD2d 558, 558-559 [2d Dept

1994]). Once the movant has met this threshold burden, the opposing party must present the existence of triable issues of fact (see Zuckerman v New York, 49 NY2d 557, 562 [1980]; see also Khan v Nelson, 68 AD3d 1062 [2d Dept 2009]). In deciding a motion for summary judgment, the court is "required to view the evidence presented in the light most favorable to the party opposing the motion and to draw every reasonable inference from the pleadings and the proof submitted by the parties in favor of the opponent to the motion" (Yelder v Walters, 64 AD3d 762, 767 [2d Dept 2009]; see Nicklas v Tedlen Realty Corp., 305 AD2d 385, 386 [2d Dept 2003]). The court's function in considering a summary judgment motion is not to resolve issues, but to determine if any material issues of fact exist (Sillman v Twentieth Century-Fox Film Corp., 3 NY2d 395 [1957]; Stukas v Streiter, 83 AD3d 18, 23 [2d Dept 2011]).

"To establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (Stukas v Streiter, 83 AD3d 18,23 [2d Dept 2011]). "A defendant physician seeking summary judgment must make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (Iulo v Staten Island University Hospital, 106 AD3d 696,697 [2d Dept 2013]). To defeat defendant's application, the plaintiff must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. In other words, "this means that if the defendant demonstrates only that he or she did not depart from good and accepted medical practice, plaintiff need only raise a triable issue of fact as to whether such a departure occurred. The plaintiff is required to raise a triable issue of fact as to causation only in the event that the defendant makes an independent prima facie showing that any claimed departure was not a proximate cause of the plaintiff's injuries" (Stukas v Streiter, 83 AD3d 18).

To successfully oppose a motion for summary judgment dismissing a cause of action sounding in medical malpractice, a plaintiff must submit a physician's affidavit of merit attesting to (depending on the defendant's prima facie showing) a departure from accepted practice and/or containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury (Domaradzki v Glen Cove Ob/Gyn Associates, 242 AD2d 282 [2d Dept 1997]; see Arkin v Resnick, 68 AD3d 692,694 [2d Dept 2009]). Conclusory or general allegations of medical malpractice, "unsupported by competent evidence tending to establish the essential elements are insufficient to defeat a motion for summary judgment" (Mendez v City of New York, 295 AD2d 487 [2d Dept 2002]; see Alvarez v Prospect Hospital, supra, at 325).

To establish proximate cause in a medical malpractice action, "a plaintiff needs do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (Johnson v Jamaica Hospital Medical Center, 21 AD3d 881, 883 [2d Dept 2005] citing Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept 1998]; see Clarke v Limone, 40 AD3d 571, 571-572 [2d Dept 2007]). Since the burden of proof does not ask the plaintiff to eliminate every possible cause of her injury, "the plaintiff's expert need not quantify the exact extent to which a particular act or omission decreased a patient's chances [of a cure or increased her injury], as long as the jury can infer that it was probable that some diminution" in the plaintiff's chance of a better outcome (Jump v Facelle, 275 AD2d 345, 346 [2d Dept 2000]; see Flaherty v Fromberg, 46 AD3d 743, 745 [2d Dept 2007]; Calvin v New York Medical Group, P.C., 286 AD2d 469, 470 [2d Dept 2001]). In addition, summary judgment "is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions...such

credibility can only be resolved by a jury" (Feinberg v Feit, 23 AD3d 517, 519 [2d Dept 2005] quoting Shields v Baktidy, 11 AD3d 671, 672 [2d Dept 2004]; see generally Darwick v Paternoster, 56 AD3d 714, 715 [2d Dept 2008]; Adjetey v New York City Health and Hospitals Corp., 63 AD3d 865 [2d Dept 2009]).

As this matter involves negligence and malpractice, notably, "the distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of the facts" (D'Elia v Menorah Home & Hosp. for Aged & Infirm, 51 AD3d 848, 850, [2d Dept 2008]).

Here, decedent had been living at home, and receiving home health services. As she needed long term care, she was admitted to the Nursing Home on January 8, 2013. Her diagnosis upon admission were bipolar disorder, hypertension, atrial fibrillation, congestive heart failure, coronary artery disease, dementia, Paget's disease and end-stage renal failure. She was in remission from non-Hodgkin's lymphoma, and had suffered from a prior stroke and prior myocardial infarction. During her stay at the Nursing Home, she had been admitted on a couple of occasions to the Hospital, including on June 11, 2013, due to altered mental status and was diagnosed with a UTI, and was discharged on June 18, 2013, back to the Nursing Home.

Almost a year later, while at the Nursing Home on the night of May 21, 2014, decedent was found unresponsive, and was transferred to the Hospital on an emergency basis, due to a seizure caused by a lack of perfusion of blood to the brain, as a result of inadequate heart function. At the time of admission to the Hospital, decedent was 86 years of age, with a history

of chronic artial fibrillation, and status post multiple cerebral infacts. While in the emergency room, decedent was found to be septic, with a temperature of 103.8 degrees. She had a marked alveolar-air gradient with oxygen saturation of 89% on 100% F102, prompting immediate endotracheal intubation. Decedent developed pressure ulcers while admitted at the Hospital. Several months after her admission to the Hospital, decedent died on August 2, 2014.

According to the complaint (among other things), defendants allowed the development and progression of pressure ulcers, and failing to provide necessary treatment and services to promote healing to decedent.

In support of its instant motion for summary judgment, St. Joseph's (Seq 1) on behalf of the Nursing Home and the Hospital, offers the opinion of George C. Fisher, M.D., a physician licensed to practice medicine in New York, and Board Certified in Family Practice since 1993[1]. Dr. Fisher opines that the nutrition and hydration provided to decedent at the Nursing Home, together with the administrations of the medication (with the exception of a brief period when Actonel was not administered without consequence) were carried out appropriately by the Nursing Home staff.

> "After an initial weight loss due to the loss of retained fluid from heart failure and her multiple co-morbidities, as well as muscle atrophy due to minimal mobility, which caused loss of muscle mass, it appears as though the weight stabilized, and in my view, nutrition and hydration were adequate. The record show that Ensure was given as a dietary supplement, and the patient was provided "fortified super foods" including oatmeal, etc. Various notes indicate that skin turgor is good thus suggesting that the patient was properly hydrated. There are specific entries which are part of the attached records which reveal that there were no signs and symptoms of dehydration" (*see Dr. Fisher's Affirmation).*

[1]The Hospital and the Nursing Home used the same expert.

It is his conclusion that in spite of decedent's sedentary manner, adverse co-morbities, hydration and nutrition were maintained in decedent, and there were no departures from good and accepted medical practice in the nutritional management of decedent.

The Nursing Home further contends that decedent on the January 29, 2013 assessment, her weight of 166.5 pounds placed her in the obese category of the body mass index, since decedent was only 5 feet 1 inch. Weight loss was necessary and healthy and not a sign of malnutrition and neglect. Her ideal body weight was 104 to 128 pounds.

Dr. Fisher concludes that the care provided by the staff at the Nursing Home comported with good and accepted practice, and did not depart from appropriate standards in their care and treatment of decedent.

In opposition, plaintiff offers an unidentified doctor's affirmation, who is Board Certified in New York, who has reviewed decedent's medical records, the pleadings and other documents in the record. From the record, plaintiff's expert recites that decedent, then 85 years of age was admitted to the Nursing Home on January 8, 2013 for long term care. Her diagnoses upon admission were bipolar disorder, hypertension, atrial fibrillation, congestive heart failure, coronary artery disease, dementia, Page's disease and end-stage renal failure.

During her admission at the Nursing Home, on January 29, 2013, decedent underwent a Nutrition/Hydration Evaluation where she was noted to be a high nutritional risk. As time went on, decedent was noticeably losing weight. Plaintiff's expert believes she was not meeting her nutritional needs.

At the Nursing Home, decedent's starting weight was 166.5 pounds. Upon readmission to the Nursing Home, decedent was noted with skin intact and weighed 157.2 pounds. By July 13, 2013, she lost eight pounds and weighed 149 pounds. She was again noted as being a high

nutritional risk with inadequate food and beverage intake. Her current diet remained unchanged. On February 3, 2014, decedent was considered a high risk for pressure ulcers. Due to a weight loss of about 10 pounds in the past six months and poor appetite, Dr. Giti Mansouri referred decedent to the dietician on April 17, 2014. It was not until May 6, 2014, that decedent was started on an appetite stimulant.

On the night of May 21, 2014, while still at the Nursing Home, decedent was found unresponsive and was transferred to the Hospital, after suffering a seizure. Upon admission to the Hospital, decedent, was intubated and on a ventilator, it was noted she had no wounds. Her Braden scale was 9, meaning that decedent was at high risk for developing pressure ulcers. The next day she underwent a Nutrition/Hydration Evaluation finding that her nutritional needs were not being met.

It is plaintiff's expert's opinion that decedent was not properly nourished or hydrated while under Nursing Home's care. She started at 166.5 pounds and lost weight in the Nursing Home. The expert claims that contrary to St. Josephs' expert's contention that decedent's weight stabilized, decedent continued to lose weight during her admission at the Nursing Home. Plaintiff's expert points out that in the Hospital's records, decedent was noted with nutrition impairment. The Nursing Home's failure to order additional nutritional consult, test, change decedent's nutrition/hydration plan was a departure from the accepted standards of care, as proper nutrition is necessary to the maintenance of adequate skin care, which was a proximate cause of decent's malnutrition.

From the Nursing Home's submissions, it met its prima facie entitlement to judgment as a matter of law dismissing the subject causes of action, insofar as they relate to its alleged failure to prevent the decedent's malnutrition and dehydration during the relevant period.

However, the affirmation of the plaintiff's expert was sufficient to raise a triable issue of fact, thus warranting denial of summary judgment dismissing those claims. There are questions of fact as to whether it is customary practice for a patient whose diet is being controlled in a skilled nursing to lose weight, or was decedent in fact malnourished.

As for the Hospital, Dr. Fisher opined that:

> "...A Kennedy ulcer is not a product of nursing or medical neglect but occurs as a manifestation of end stage disease as the patient's systems fall. Nevertheless, the patients skin care was maintained through surgical consultation on July 10, 2014, which recommended debridement, as well as the use of air mattress, heel protection, collagnase dressings, appropriate period turning, etc. I find that the skin care met appropriate standards of care at both the Nursing Home and Medical Center..." (*See* Dr. Fisher's Affirmation).

In contravention, plaintiff's expert states that:

> "Further defendant' expert emphasizes that decedent was in the active process of dying. That does not permit a caregiver to deny the patient measures which would preserve comfort and dignity. Instead of receiving comfort, decedent's time spent in the hospital during the last two months of her life was ridden with extreme pain and suffering as a result of the pressure ulcers she developed while under the care and treatment of defendants" (*see Plaintiff's Expert Opinion" at 21)*

It is also plaintiff's expert's opinion that: decedent's skin breakdown at the Hospital was not properly documented within decedent's medical records; and the Hospital failed to accurately and consistently stage and/or size decedent's pressure ulcers throughout the medical records. Between May 24, 2014, and June 1, 2014, decedent was not noted with any wounds and/or pressure ulcers. It wasn't until the next day, June 2, 2014, that decedent was noted with pressure ulcers for the first time during admission at the Hospital, which over time were getting worse. Additionally, frequent turning and positioning of patients in hospitals, particularly those susceptible of developing pressure ulcers, is critical as it distributes pressure to different parts

of the body so that no one part receives pressure for any great deal of time. Decedent was not turned and positioned every two hours, which is a departure that was a proximate cause of the development and deterioration of decedent's pressure ulcers. The ulcer appeared to grow and worsen.

Plaintiff's expert concludes that the actions and inactions of the Hospital were a clear deviation form the good and acceptable standards of medical care and were the proximate cause of decedent's injuries, and were the proximate cause of the development and subsequent progression and deterioration of plaintiff's decedent's pressure ulcers.

Courts recognize that "a hospital may not be held liable for injuries suffered by a patient who is under the care of a private attending physician chosen by the patient where the resident physicians and nurses employed by the hospital merely carry out the orders of the private attending physician, unless the hospital staff commits independent acts of negligence or the attending physician's orders are contradicted by normal practice (Cham v St. Mary's Hosp. of Brooklyn, 72 AD3d 1003, 1004 [2d Dept 2010]). To meet its prima facie burden of proof, the moving defendant is required to address the factual allegations set forth in the plaintiffs' bill of particulars with reference to the moving defendant's alleged acts of negligence and the injuries suffered with competent medical proof (Cham v. St. Mary's Hosp. of Brooklyn, 72 AD3d at 1005.

Here, the Hospital demonstrated its prima facie entitlement to judgment as a matter of law through the submission of an affirmation of a board-certified physician and decedent's medical records, which established that there was no departure from good and accepted practice by the defendants (Lefkowitz v Kelly, 170 AD3d 1148, 1150 [2d Dept 2019]). However, under these circumstances, triable issues of fact precludes summary judgment on

decedent's negligence and malpractice claims against the Hospital. Plaintiff raised a triable issue of fact through an expert affirmation from a physician, who opined with a reasonable degree of medical certainty that the Hospital departed from the accepted standard of care.

Turning next to Dr. Nagarwala's motion for summary judgment (Seq 2), according to the complaint, Dr. Nagarwala failed to prevent the development and the subsequent deterioration of plaintiff's decedent's sacral pressure ulcer during her Hospital admission of May 21, 2014, to August 2, 2014, when she died.

In support of Dr. Nagarwala's motion for summary judgment, he offers the affirmation of Philip Gelber, MD, FACC, licensed to practice medicine in New York, and specializes in the fields of Internal Medicine, Critical Care Medicine, and Cardiovascular Disease. After reviewing decedent's medical records, and the pleadings and discovery material, the expert opined that the decedent was treated properly. She was administered respiratory support, given triple antibiotic therapy, anticoagulant, as well as an IV of labetolol for her elevated blood pressure, and a blood work-up was done. After a couple of months of this treatment, the decedent showed little signs of improvement; a brief trial extubation failed, and she underwent a tracheotomy. She subsequently developed renal failure and underwent dialysis, and was continued on antibiotics. It is the doctor's opinion, that based upon decedent's renal failure, respiratory failure, age, co-morbidities, prior CVAs obtundation point, nursing home history, and the NIH criteria for evaluation of sepsis, the decedent's mortality risk stood at greater than 90% at this point. Even with the odds against decedent, the staff withheld nothing in her management, which in his opinion was exemplary.

Dr. Gelber continues that as for Dr. Nagarwala, one of the physicians involved in her care, he conducted appropriate consultations and continued to provide proper treatment. Sores

are not uncommon, and are not always treatable or preventable in a clinical context. While it would ordinarily be the province of the nursing staff to turn and position the decedent to reduce the risks of bed sores, in a chronic ventilator patient, that is not always feasible. The doctor characterizes Dr. Nagarwala's care as he treated decedent, to be aggressive and heroic.

In contravention to Dr. Nagarwala's expert, plaintiff offers an unnamed expert, who is Board Certified in Internal Medicine, Geriatric Medicine, and am a Diplomate of the National Board of Medical Examiners. After reviewing the record, and plaintiff's medical records, plaintiff's expert opines that the care and treatment rendered to decedent by Dr. Nagarwala was not in accordance with good and accepted medical practice, and that there were departures and deviations from the accepted standards of care.

Plaintiff's expert recites that Dr. Nagarwala examined decedent on numerous occasions and was one of decedent's attending physicians/ a hospitalist during her admission to the Hospital. On June 2, 2014, decedent was noted with pressure ulcers for the first time during her hospital admission. Plaintiff's expert emphasizes that Dr. Nagarwala examined decedent on that same day, but did not note any pressure ulcers and/or wounds. Nagarwala examined decedent again on June 3, 2013, and June 10, and 11, 12 2014, and again did not mention any pressure ulcers and/or wounds in his report. Every time that Nagarwala examined decedent from June 14, 2014 through June 30, 2014, he did not mention any pressure ulcers, wounds or redness anywhere on decedent's body, despite there being notations all over the records regarding decedent having sacral pressure ulcers and redness on her bilateral heels. In nursing notes and care notes, but not in any of Nagarwala's narrative notes, from June 14, 2014 through June 27, 2014, decedent was continuously noted with a stage III sacral pressure ulcer, stage II sacral pressure and redness on bilateral heels. By June 28, 2014, decedent's sacral pressure

ulcer had deteriorated to Stage IV. She was also noted with a stage II sacral pressure ulcer and redness on her bilateral heels.

Based on the record, plaintiff's expert concludes that it was a departure in the standards of good and accepted medicine for Dr. Nagarwala to fail to accurately and consistently size decedent's pressure ulcers throughout his notes, and this departure was a proximate cause of the substantial deterioration of plaintiff's pressure ulcers.

Additionally, frequent turning and positioning of patients in hospitals, particularly those susceptible of developing pressure ulcers, is critical as it distributes pressure to different parts of the body so that no one part receives pressure for any great deal of time. For a patient like decedent, good and accepted medical practice would have been to re-position more often than every two hours, and the lack of consideration given to postural alignment was a deviation from good and accepted medical practice, and a proximate cause of decedent's development and deterioration of pressure ulcers.

It is also plaintiff's expert's opinion, that Dr. Nagarwala's failure to arrange for the wound care team to timely assess decedent's pressure ulcers constitutes a deviation from good and accepted medical practice. It was not until July 10, 2014, that he first noted decedent had a pressure ulcer and/or wound, even though nurses and other providers noted pressure ulcers and/or wounds prior to this date, and that failure was a proximate cause of plaintiff's development and deterioration of pressure ulcers. The expert also points out that the mattress used by plaintiff may not have been gel, foam and sheep skin surface-based mattresses and overlays are of particular utility in high risk patients.

Further, despite plaintiff's co-morbities, the etiology of pressure ulcers is pressure. The various co-morbities the plaintiff suffered from were consistent throughout the time of her

admission. Moreover, the following should be noted: hypertension, atrial fibrillation, congestive heart failure, coronary artery disease, dementia Page's disease, end stage renal failure bipolar disorder does not cause pressure ulcer. It is a medical fact that unrelieved pressure causes pressure ulcers. It is plaintiff's expert's opinion that Dr. Nagawala should have more timely, appropriately, and on an ongoing basis evaluated decedent's pressure relieving surfaces, evaluated decedent's risk for pressure ulcers, evaluated the frequency and compliance with repositioning, and evaluated all pressure ulcer interventions. In plaintiff's expert opinion, these failures led to the development and deterioration of decedent's pressure ulcers.

Finally, it is plaintiff's expert's opinion that decedent's medical history did not make her incapable of healing from a pressure ulcer, and did not make the development of a pressure ulcer clinically unavoidable. Decedent's pressure ulcers could have been avoided with the proper medical and nursing care, provided by and under the supervision of Dr. Nagawala.

Based upon the foregoing, and in particular the Hospital's expert affidavit, the court finds that the Hospital demonstrated prima facie that it did not depart from good and accepted medical practice in their treatment of decedent, and did not cause decedent's alleged injuries. In opposition, plaintiff raised triable issues of fact through the expert's affidavit (Muniz v Mount Sinai Hosp. of Queens, 91 AD3d 612, 617 [2d Dept 2012]).The opinion of the plaintiffs' medical expert is not conclusory or without evidentiary value, thus, summary judgment is not appropriate here, where the parties adduce conflicting medical opinions and raise credibility issues which can only be resolved by a jury (Barrocales v New York Methodist Hosp., 122 AD3d 648, 649 [2d Dept 2014]).

The court has considered the remainder of the factual and legal contentions of the parties and to the extent not specifically addressed, finds them to be without merit or rendered moot by other aspects of this decision. This constitutes the decision and order of the court.

Accordingly, based upon the stated reasons, it is hereby

ORDERED, that St. Joseph's Medical Center, St. Joseph's Hospital Nursing Home of Yonkers, motion for summary judgment (Seq 1) is **denied** ; and it is further

ORDERED, that Faisal Nagarwala, M.D. motion for summary judgment (Seq 2) is **denied**; and it is further

ORDERED, that St. Joseph's Medical Practice, P.C., to have this court so order the Stipulation of Discontinuance (Seq 3) is **granted** simultaneously executed as of this date; and it is further

ORDERED, that plaintiff is to serve this Decision and Order on all parties and the Clerk's Office no later than 15 days from the date of the Decision and Order; and it is further

ORDERED, that the parties are directed to appear on 6/18/19 2019 at 9:15 A.M. in Courtroom 1600, the Settlement Conference Part, at the Westchester County Courthouse, 111 Dr. Martin Luther King Jr. Blvd., White Plains, New York 10601.

Dated: May 31, 2019
White Plains, New York

**HON. CHARLES D. WOOD**
**Justice of the Supreme Court**

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