Model v NYU Hosp. Ctr.
2020 NY Slip Op 30367(U)
January 8, 2020
Supreme Court, New York County
Docket Number: 805097/15
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11

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NANCY M. MODEL, as Administratrix of the Estate of ERIC MODEL, deceased,

INDEX NO. 805097/15

Plaintiff,

-against-

NYU HOSPITAL CENTER,

Defendant.

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JOAN A. MADDEN, J.:

In this action alleging medical malpractice, defendant NYU Hospital Center ("defendant" or "NYU") moves for summary judgment dismissing the complaint against it. Plaintiff opposes the motion, which is granted for the reasons below.

Background

This action arises out of the death of plaintiff's decedent, Eric Model ("Mr. Model" or "decedent") on July 11, 2014. Mr. Model, who was 38 years-old, died during his hospitalization at NYU, where he underwent a coil-augmented pipeline embolization for a life-threatening brain aneurysm on June 17, 2014. After failed extubation attempts on June 20, 2014 and June 30, 2014, a tracheostomy was performed on July 3, 2014. On July 5, 2014, Mr. Model was weaned off a ventilator and successfully used a tracheostomy collar.[1] On July 10, 2014 at approximately 7:00 pm, Mr. Model's #8.0 Shiley tracheostomy tube was replaced with a smaller #6.0 Shiley tracheostomy tube. At approximately 3:32 am on July 11, 2014, Mr. Model's oxygen saturation dropped and a code was called, and he went into acute cardiopulmonary arrest and died.[2]

[1]According to defendant's expert, Dr. Ashtosh Kacker, M.D., a tracheostomy collar is "a medical device used to secure a trachael tube, provide humidified air, and assist with ventilation if necessary."

[2]An autopsy was declined by the family so the cause of death was never determined.

Plaintiff alleges, *inter alia*, that a team of NYU otolaryngologists ("ENT physicians") departed from standards of accepted medical practice in their care and treatment of Mr. Model, and that such departures were a substantial factor in causing Mr. Model's death from respiratory arrest, and further caused him to lose a substantial chance at cure and recovery. Plaintiff alleges that these departures were: the failure to maintain proper aspiration precautions, including by not preventing aspiration pneumonia and "aspiration hypoxia;"the failure to have proper alarms in place to warn of a change in vital signs; the failure to perform canography to measure the carbon dioxide respiratory outflow; the failure to respond to and manage bleeding at the site of the newly changed smaller tracheostomy tube, which allegedly led to the obstruction of Mr. Model's airway with clotted blood; and the failure to timely respond to Mr. Model's respiratory arrest that resulted in his death.[3]

Defendant moves for summary judgment, arguing that the record demonstrates that Mr. Model's post June 17, 2014 pulmonary, critical, and otolaryngological/ENT care was properly managed and within the standards of good and accepted practice. In particular, defendant argues that the record establishes that the Mr. Model's airway was patent, and his tracheostomy tube was in proper position, and unobstructed up until, and including, at the time of his death, and upon examination again through a fiberoptic scope after he was pronounced dead.

In support of its motion, NYU submits the expert affidavits of Dr. Hooman Poor, who is

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[3]Plaintiff also alleged various other departures including the failure to properly place a tracheostomy tube to secure decedent's airway on the evening of July 10, 2014; improperly changing the tracheostomy tube from a size #8.0 cuffed Shiley tracheostomy tube to a size #6.0 uncuffed Shiley tracheostomy tube; the placement of the tracheostomy tube in a manner that prevented a proper airway; the failure to confirm proper placement of the tracheostomy tube with a fiberoptic scope with radiological confirmation, which caused the tube to become dislodged. However, as plaintiff's expert did not opine as to these departures, the court will consider them abandoned. In addition, plaintiff has failed to provide expert testimony in support of her lack of informed consent claim, which is also deemed abandoned.

board certified in critical care medicine, pulmonary medicine and internal medicine, and Dr. Ashutosh Kacker, who is board certified in otolaryngology, as well as the deposition testimony of various witnesses, and the relevant medical records.

Dr. Poor opines that "based on the testimony of critical care attending physician Dr. [David] Friedman, nurses and physicians in the ICU appropriately evaluated, assessed, and monitored [Mr. Model's] respiratory status and vital signs at least every four hours [and that] [a]s part of this routine monitoring, the patient was always evaluated for risk of aspiration in accordance with the standard of care." As for the position of Mr. Model's bed, Dr. Poor states that "nursing orders and flowsheets confirm that during this time period (June 17, 2014 through June 22, 2014) and beyond, the head of Mr. Model's bed was kept at greater than 30 degrees and appropriate oral and nasal care was provided to him," citing Medical Records at 482-483, 485, 511-512.

With respect to the attempts to extubate Mr. Model, Dr. Poor opines that "appropriate extubation attempts were made on June 20, 2014 and June 30, 2014." Specifically, he states that:

> On the morning of June 20, 2014, Mr. Model was extubated, but had to be reintubated later that evening due to hypoxemia and respiratory insufficiency. Chest x-rays taken that day were consistent with pneumonia, and the decision was made to have Mr. Model remain intubated due to thick secretions and poor oxygenation. During this period, Mr. Model was treated with broad-spectrum antibiotics and underwent aggressive pulmonary toilet. He was able to follow simple commands during daily awakenings. On June 28, 2014, Mr. Model was noted to be stable and following commands and given his improving respiratory status it was appropriate to attempt a second trial of extubation. The chart reflected that a trial of extubation would be attempted in a few days, and that a tracheostomy was also being considered. On June 30, 2014, a second attempt to extubate the patient was made. However, the following day, July 1, 2014, he became tachycardic, tachypneic, and hypoxemic. Coffee ground fluid was aspirated from his feeding tube. Later that evening, a

> Code Blue was called in response to an acute hypoxemic episode, and Mr. Model was reintubated.

Dr. Poor also opines that:

> the failed extubation attempts were solely due to Mr. Model's compromised neurological status and had nothing to do with any purported failure by NYU staff to monitor the patient for aspiration pneumonia risk or perform a swallow study. It is also my opinion to a reasonable degree of medical certainty that the patient was appropriately monitored, timely assessed, and consistently evaluated for any risk of aspiration, pneumonia or any other respiratory issue or complication while in the ICU. Moreover, while this patient was utilizing a nasogastric (NG) tube, appropriate NG tube care was always being provided to him which always included monitoring NG feeding tube residuals.

In addition, Dr. Poor opines that Mr. Model's change to a smaller tracheostomy tube on July 10, 2014 "was indicated and appropriate given the patient's improving respiratory function and minimal suctioning requirements [noting that].. Mr. Model's ventilator supplied oxygen (Fio2) was lowered from 70% to 40 % that day" (citing Medical Records at 663, 3005-3009). He also opines that "Mr. Model's respiratory status had greatly improved in that on the morning of July 10, 2014, ICU attending Dr. Aaron Lord documented the patient's decreasing oxygen requirements, decreasing suctioning of mucus secretions and most importantly, documented that the patient had now been off the ventilator for more than 24 hours without any issues." (Id at 182-185). Dr. Poor thus opines that "Mr. Model's respiratory status was greatly improved, and was progressing nicely, indicating that he was stable."

As for his vital signs on the date of the tracheostomy tube was exchanged, Dr. Poor states Mr. Model was stable throughout the day, as supported by the deposition testimony of Nurse Meghan Damelio, who cared for Mr. Model from 8:00 a.m. to 8:00 p.m. on July 10, 2014, that his vital signs always remained stable and he remained at his baseline that during that period, (citing Damelio Dep at 19, 27), and the nursing flow sheets for that day, which are electronically

generated each hour and record a patient's vital signs.

As for Mr. Model's vital signs after the smaller tube was placed, Dr. Poor states that:

> The tracheostomy tube was properly placed within Mr. Model's airway, in that the patient's vital signs including, most importantly, his O2 saturation remained stable and at a good level indicating adequate oxygenation for the next eight (8) hours. Mr. Model maintained the same level of O2 saturation both before and after placement of the # 6.0 Shiley. For example, at 7:00 p.m. (prior to the tube exchange) his O2 was 92 %; at 8:00 p.m. (following the exchange) it was 90 %; at 9:00 p.m. it had risen to 96 %; at 11:00 p.m., 94 %. It remained between 94 and 96 % respectively even through the early morning hours of July 11, 2014. Significantly, as of 3:00 a.m., shortly before Mr. Model's death, his O2 saturation was 98 %. (Medical Records at 3005-3009;3089.) Moreover, the testimony and chart make clear that at no time in those ensuing eight hours did Mr. Model demonstrate any symptoms or signs of respiratory distress whatsoever, or any indication of discomfort or pain.

Dr. Poor also states that "[t]he chart also contains documentation of Mr. Model's vital signs and respiratory status including O2 saturation taken every hour," citing Medical Records at 3005-3009. With regard to suctioning mucus secretions caused by coughing, Dr. Poor opines that "coughing secretions is not a sign of respiratory distress[4] ...[and that]... [m]y review of the medical records and testimony further reveal that Mr. Model was appropriately and timely suctioned by ICU staff to help him clear these secretions."

As for Mr. Model's condition in the early hours of July 11, 2014, Dr. Poor opines that Mr. Model "was still in good condition" and notes that "Nurse Suh documented that the patient remained baseline during her entire shift until 3:28 am and that she observed no changes in his neurological status or any other physical changes, and that Dr. Suh documented at approximately 3:28 a.m. that "Mr. Model requested to be washed up" (Medical Records at 670-671) and she

[4]He also opines that such coughing is not evidence of a malpositioned tracheostomy tube; however, as noted above, plaintiff has abandoned allegations that the tube was malpositioned.

testified that "he still looked well, was able to communicate, and was breathing on his own." (Suh Dep at 35, 69). He states that the code was called at 3:32 am when "Mr. Model's oxygen saturation dropped precipitously and he became unresponsive with facial cyanosis." He opines that Mr. Model's death "was most likely caused by a sudden, acute unpreventable event more distal in his respiratory system such as a pulmonary embolism or mucus plug, which had nothing to do with the tracheostomy tube exchange the night prior."

With respect to allegations that defendant departed from accepted standards of medical care in failing to perform capnography, Dr, Poor states that "[p]erformance of capnography or monitoring of carbon dioxide outflow is only performed when a patient demonstrates abnormalities in breathing or other signs of respiratory distress. Moreover, capnography and carbon dioxide monitoring is only typically performed on patients utilizing a ventilator, not those breathing spontaneously using a trach collar as Mr. Model was." He further states that "Mr. Model's respiratory status including his oxygen saturation remained stable during the tube exchange on including his oxygen saturation remained stable during the tube exchange on July 10, 2014 and throughout the next eight hours....[t]herefore, there was no indication whatsoever to utilize capnography or carbon dioxide outflow."

Defendant's other expert Dr. Ashutosh Kacker, who is board certified in otolaryngology, similarly opines that Mr. Model's vital signs, including his O2 saturation, were stable both before, during and after the tube exchange, and that his vital signs and respiratory status, including O2 saturation, were monitored every hour. In this connection, Dr. Kacker opines that: that "exchanging the tracheostomy tube was appropriate and indicated given the patient's improving respiratory function and minimal suctioning requirements at that time as well as the fact that the tracheal stoma was mature to allow for a safe change of a tracheostomy

tube. [and that] [i]n fact, Mr. Model's ventilator supplied oxygen (Fio2) was lowered from 70% to 40 % that day. (Citing Medical Records at 663; 3005-3009)." He further states that "in support of Mr. Model's improving respiratory status, ICU attending Dr. Aaron Lord wrote a progress note that morning documenting Mr. Model's decreasing oxygen requirements, decreasing suctioning of mucus secretions and most importantly, documented that the patient had now been off the ventilator for more than 24 hours without any issues." (Id at 182-185).

Moreover, Dr. Kacker opines that "there is no evidence whatsoever in the patient's chart of any signs of respiratory distress, pain, discomfort or change in neurological status between 7:30 p.m. on July 10, 2014 through 3:28 a.m. on July 11, 2014 [and that]... the chart and testimony supports the opposite, namely that Mr. Model's vital signs and O2 saturation remained at an appropriate level and at his baseline during this time period." Specifically, he states that "Mr. Model maintained a good level of O2 saturation both before and after placement of the # 6.0 Shiley. For example, at 7:00 p.m. (prior to the tube exchange) his O2 was 92 %; at 8:00 p.m. (following the exchange) it was 90 %; at 9:00 p.m. it had risen to 96 %; at 11:00 p.m. 94 %. It remained between 94 and 96 % respectively even through the early morning hours of July 11, 2014. Significantly, as of 3:00 a.m., shortly before Mr. Model's death, his O2 saturation was still 98 %." (citing Medical Records at 3005-3009; 3089). Dr. Kacker opines that "Mr. Model's decompensation ... was due to an acute event deep in his respiratory system which had nothing to do with placement of the #6.0 tracheostomy tube nor was it something that could have been anticipated or avoided."

As for the alleged departure related to the failure to perform capnography, Dr. Kacker opines that "the performance of capnography or monitoring of carbon dioxide outflow is only

performed when a patient demonstrates abnormalities in breathing or other signs of respiratory distress [and is]... is only typically performed on patients utilizing a ventilator not those breathing spontaneously using a tracheostomy collar as Mr. Model was." Moreover, he states that "Mr. Model's respiratory status including his oxygen saturation remained stable during the tube exchange on July 10, 2014 and throughout the next eight hours..[and] [t]herefore there was no indication whatsoever to use capnography or carbon dioxide outflow."

Plaintiff efiled opposition papers and an unsigned affidavit from an out-of-state expert, whose name was redacted, on April 22, 2019.[5] On May 9, 2019, plaintiff provided the court with an unredacted and signed affidavit from the expert.

Plaintiff's expert, who is licensed to practice medicine in the State of Rhode Island, and is board certified in internal medicine, pulmonary medicine and critical care medicine opines that defendant's departed from good and accepted standards of care in the management of Mr. Model's airway and in failing to respond to emergent conditions.

He opines that NYU "departed from good and accepted standards of care in failing to maintain proper aspiration precautions on the patient, leading to multiple aspiration events and deterioration of the patient's respiratory condition and ability to recover from the brain surgery." He states that this opinion "is based upon the occurrence of multiple aspiration events in this patient on June 20 and then again on June 30-July 1, which led to aspiration pneumonia and sepsis, and is based in part upon the deposition testimony of Ellen Model, the decedent's mother,

[5]As plaintiff's opposition was submitted ten days after the deadline imposed by the court's interim order dated March 26, 2019, defendant argues it should be rejected as untimely. However, as defendant has not demonstrated prejudice as a result of the delay, in the exercise of its discretion, and in the interest of resolving the action on its merits, the court will consider plaintiff's late opposition. Dinnocenzo v. Jordache Enterprises, Inc., 219 AD2d 219 (1st Dept 1995); CPLR 2004.

and that of the decedent's sister, Dawn Rosenberg, that Mr. Model was laying flat, and that decedent's mother testified that she complained to staff at the hospital that they should raise his head."

Plaintiff's expert states that in light of such testimony and "the occurrence of aspiration events which are documented in the chart, the decedent was not managed with proper aspiration precautions and this was a departure from good and accepted standards of care which required Mr. Model to be elevated in bed at greater than thirty (30) degrees to prevent aspiration." Plaintiff's expert also points to Ms. Rosenberg's testimony that the alarm monitors at the hospital were going off and that the health care providers at the hospital would not respond despite being so advised by decedent's visiting family, and that his family was shown how to silent the alarms rather than to ask the staff to respond. He opines that "[t]his is a classic example of development of institutional 'alarm fatigue'. Rather than address the situation properly by re-working alarm parameters, the staff at NYU Hospital simply chose to ignore the alarms and failed to utilize properly the critical alarm systems in place."

Plaintiff's expert also opines that NYU "departed from good and accepted standards of care in failing to respond to and manage bleeding at the site of a newly changed tracheotomy tube on July 10 to July 11, 2014, which led to obstruction of the decedent's airway with clotted blood and ultimately contributed to the occurrence of respiratory arrest." Specifically, he states that "eight (8) hours prior to [Mr. Model's] death, and after the initial change of a tracheostomy tube on the evening of July 10, 2019, that blood tinged sputum and blood around the trach site was noted by medical staff." He opines that "the medical providers attending to Mr. Model at that time failed to adequately respond to bleeding at the trach site by calling further ENT or other

medical consults, and failed to address the condition of blood at the trach site with fibrillar packing or cliange of the trach tube back to a cuffed tube to prevent blood and clotting blood from obstructing the patient's airway."

In support of this opinion, plaintiff's expert cites the deposition testimony of Dr. Dylan Roden, a second year resident, who participated in the placement of both of Mr. Model's tracheostomy tubes, and was paged when the code was called for Mr. Model on July 11, 2014. At the time he was paged, Dr. Rodin testified that it was reported to him that the patient had some blood coming from the trach site. (Dr. Rodin at 45-46, 58-60). Plaintiff's expert also refers to the deposition testimony of Nurse Suh in which she indicates that she was suctioning blood tinged sputum from the mouth and trach of the patient in the hours leading up to his death (Suh Dep at 50).

Plaintiff's expert also opines that NYU failed to use capnography to measure the carbon dioxide respiratory outflow was required by the standard of care in 2014 for the management of critical care patients such as Mr. Model with respiratory compromise and that the "failure to use capnography more likely than not contributed to delays in discovering the onset of respiratory distress in this patient, and deprived him of a chance of cure and recovery."

Plaintiff's expert further opines that the medical records and the testimony of Nurse Suh show that "a 30+ minute delay in responding to respiratory arrest in the decedent during the early morning hours of July 11, 2014 shortly before his death." Specifically, the expert notes that Nurse Suh testified that at about 3:00 a.m. Mr. Model was well and that she stepped out of his room for four minutes (Suh Dep at 41) to get materials to wash him up, and that when she stepped back into the room he was blue and cyanotic and that a code was called at that time.

However, plaintiff's expert states that according to medical chart the code was called at 3:38 a.m., which the expert opines "indicates a significant delay of 30+ minutes in calling a code and in recognizing onset of respiratory arrest, which was a departure from standards of care." (Suh Dep. at 34-50). In addition, plaintiff's expert opines that "[t]his delay was likely further contributed to by the improper use of the patient alarm systems that were in place at the NYU at the time of these events, ...and confirmed by an arterial blood gas drawn at 3:56 a.m. on 7-11-14 which revealed a result of 7.158, and indicative of a long period of oxygen deprivation."

With respect to causation, plaintiff's expert opines that the departures from the standard of care "were all substantial contributing factors causing decedent's death from respiratory arrest, and further caused him to lose a substantial chance at cure and recovery." The expert further states that "[t]he medical records indicate that the pipeline and coil embolization procedure was successful and that Mr. Model's death, more likely than not, was precipitated by a respiratory arrest triggered by the failure to properly manage his airway and timely respond to his distress..." Plaintiff's expert also opines that "the medical records do not support a claim that Mr. Model's death was caused by a pulmonary embolism or deep vein thrombosis.[6]"

In reply, NYU argues that the conclusory opinions of plaintiff's expert fail to controvert its prima facie showing entitling it to summary judgment and that plaintiff's expert asserts new theories of liability and causation for the first time which should not be considered by the court. With respect to the new theories, NYU maintains that plaintiff's expert does not refute the opinions of NYU's experts and abandons the theories in the Bills of Particulars, or in the expert exchanges. Moreover, NYU argues that the plaintiff's expert opinions are unsupported by the

[6]It appears that this opinion is based on Dr. Poor's opinion that an acute event such as a pulmonary embolism or mucus plug caused Mr. Model's death.

record.

Discussion

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy the burden, a defendant in a medical malpractice action must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Id.

In claiming that the medical treatment at issue did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. See Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2d Dept 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio–Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dept 2010). A defendant's expert opinion must "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 (1st Dept 2003)).

If the movant makes a prima facie showing in medical malpractice action, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez v. Prospect Hosp., 68 NY2d 320, 324-325. Specifically, this requires, in a medical malpractice action, that a plaintiff opposing a defendant's summary judgment motion "submit evidentiary facts or materials to rebut the prima facie showing by the defendant

physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact.... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant physician's summary judgment motion." Id. at 324–25.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 307 (1st Dept 2007) (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation… the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 N.Y.2d 542, 544 (2002). On the other hand, "[t]he law is well settled that when competing experts present adequately supported but differing opinions on the propriety of the medical care, summary judgment is not proper." (See Rojas v. Palese, 94 A.D.3d 557 (1st Dept 2012))

Here, defendant has made a prima facie showing entitling it to summary judgment, based on the opinions of their experts that Mr. Model was appropriately monitored for respiratory distress and the risk of aspiration, including that he was elevated 30 degrees; that his vital signs were monitored; that Mr. Model was appropriately and timely suctioned by ICU staff; and that the performance of canography was not warranted as Mr. Model did not show any signs of respiratory distress until his oxygen saturation dropped precipitously shortly before his death; and that in light of his normal oxygen saturation until shortly before his death and his decreasing oxygen requirements and mucus secretions, that Mr. Model's decompensation was not caused by the placement of the #6.0 tracheostomy tube on the evening before, or something that could have

been anticipated or avoided, but rather an acute and sudden respiratory event deep in Mr. Model's respiratory system. Based on the foregoing, defendant has established that the departures alleged by plaintiff were not a proximate cause of Mr. Model's death.

As defendant has made a prima facie showing entitling it to summary judgment, the burden shifts to plaintiff to raise a triable issue of fact. Alvarez v. Prospect Hosp., 68 NY2d 320, 324-325. As a preliminary matter, contrary to defendant's argument, plaintiff's expert does not assert new theories of liability and causation, as these theories of liability are adequately set forth in plaintiff's first amended bill of particulars dated October 11, 2018.

Plaintiff contends that defendant's failure to maintain proper aspiration precautions with regard to the care and treatment of Mr. Model, which lead to multiple aspiration events and caused the deterioration of Mr. Model's respiratory condition. In this connection, the court notes that Dr. Friedman, an attending critical care physician who treated Mr. Model, testified that elevating the patient more than 30 degrees is an aspiration precaution (Friedman Dep at 38). While there is evidence that Mr. Model's bed was elevated at times during his hospitalization, plaintiff points to the testimony of Mr. Model's sister and mother[7] that Mr. Model's head was not raised, together with aspiration events in the chart, to support the opinion of her expert that the failure to consistently elevate Mr. Model's bed resulted in the aspiration events. In addition, the aspiration events to which plaintiff refers are, as previously stated, related to events on June 20 and June 30/July 1, when attempts were made to extubate Mr. Model.

However, plaintiff's expert's opinion fails to address the issues raised by defendants' experts regarding Mr. Model's improved medical condition, including the decrease in Mr.

[7]Defendant argues that decedent's sister testified that he was lying flat when intubated and contends that aspiration was impossible. However, it can be inferred from the testimony of decedent's mother that she observed and complained about Mr. Model not be properly elevated over an extended period of time and not only when he was intubated.

Model's oxygen needs from 70% to 40%, the decrease in his mucus secretions, and his stable vital signs and lack of respiratory distress in the period preceding his death. Significantly, plaintiff's expert does not connect the two aspiration events to Mr. Model's death, and therefore fails to raise a triable issue of fact as to causation. Accordingly, even if defendant departed by failing to maintain adequate aspiration precautions, plaintiff has failed to raise a triable issue of fact that such failure was a proximate cause of Mr. Model's death.

Plaintiff has also failed to raise an issue of fact with respect to the remaining departures. As for her expert's opinion that there was a failure to adequately respond to alarms generally, plaintiff has failed to provide an adequate nexus between this alleged departure and any injury to decedent. Moreover, the record is devoid of evidence supporting plaintiff's expert's statement that there was a 30 minute delay in calling the code and recognizing onset of respiratory arrest, or that such delay was the caused by any failure of the alarm system. In this connection, while plaintiff's expert cites Nurse Suh's testimony that "it was around 3:00 am" that she left Mr. Model's room and that a code was called at 3:34 am, a review of Nurse Suh's testimony and the record fails to provide evidentiary support for plaintiff's opinion that there was a 30 minute delay.

Nurse Suh testified that during the night "at around 3:00 am, [Mr. Model] was unable to sleep and he indicated to her that he wanted to be "washed up" (Suh Dep at 35). She further testified that when she went to "grab linens for him, the monitor outside the rooms at the nurses' station rang, so I looked at it. His oxygen saturation was lower than normal for him [a]nd I immediately went into the room. He was unresponsive. So me and another nurse Ambu vac'd him (referring to the use of a Ambu bag mask) while another nurse called a code" (Id). When asked what time he was unresponsive, Nurse Suh responded "it was 3:32 am. So all that

happened within a matter of minutes from him asking to be washed up to him being unresponsive" (Id. 35-36). Thus, Nurse Suh's testimony indicates that the alarm was functioning and that Nurse Suh and hospital's stuff immediately responded to it.

The medical records also indicate that Nurse Suh stepped out of Mr. Model's room to obtain linens at 3:28 am, that at 3:32 am the alarm went off, and the code blue was called at 3:34 am (Medical Records at 671). In addition, as stated by defendant's expert, the medical records show that there were no changes in Mr. Model's neurological status or any other physical changes, until after 3:28 am. Next, although plaintiff's expert states that results of an arterial blood gas drawn at 3:56 a.m. on July 11, 2014, indicated a long period of oxygen deprivation, such finding is not inconsistent with a code being called at 3:32 am.

With regard to the alleged departure relating to the failure to use capnography to measure the carbon dioxide respiratory outflow, plaintiff's expert fails to address the opinions of defendant's expert that canography was not indicated as Mr. Model did not show any signs of respiratory distress, and his oxygen saturations levels were good until shortly before his death, nor does the expert provide a sufficient nexus between the alleged failure to use capnography and any injury to Mr. Model.

As for the alleged departure related to the failure to respond to and manage bleeding at the site of a newly changed tracheotomy tube on July 10 to July 11, 2014, while there is evidence that blood tinged sputum was suctioned during the hours leading up to Mr. Model's death and that there was blood at the trach site, the record is devoid of evidence that any clotted blood obstructed decedent's airway and contributed to the occurrence of respiratory arrest. Specifically, as noted above, defendant's experts pointed out that the record shows that Mr. Model did not experience respiratory distress until shortly before his death. And while plaintiff's expert relies

on the testimony of Dr. Roden (who was called to assist with the code) as evidence that clotted blood blocked decedent's airway, Dr. Roden's testimony does not support this position.

To the contrary, Dr. Rodin testified that "I never had any reason to believe this patient's respiratory compromise was due to a trach issue, whether it be a trach malposition issue, or a trach obstruction issue, or even a bleeding from the trach issue...Because the patient...for several hours after the trach change had been saturating in his normal level, the mid to high 90s." (Rodin Dep at 49). Moreover, after decedent died, Dr. Rodin testified that he used a flexible fiber scope to look into decedent's trachea and saw "a small amount of blood that was clotted within the right main stem bronchus, but the tube was in the right place, and there was not any kind of ...major airway obstruction that could be attributed to a respiratory compromise." (Id at 58). He further testified that with respect to the non-obstructing blood clot that it "the right mainstem bronchus is like a cylinder. I saw a blood clot on the inferior part of it with a patent airway on the superior part of it" (Id at 60). When asked how large to clot was, Dr. Rodin testified that "[i]t was maybe 20 percent. It would not be large enough to cause...[a] significant respiratory problem." (Id).

Conclusion

In view of the above, it is

ORDERED that defendant's motion for summary judgment is granted; and it is further

ORDERED that the Clerk of the Court is directed to enter judgment dismissing the complaint.

DATED: January 8, 2020

J.S.C.
HON. JOAN A. MADDEN