STATE OF NEW YORK
INDUSTRIAL BOARD OF APPEALS

In the Matter of the Petition of:	
NEW YORK CITY FIRE DEPARTMENT,	
Petitioner,	
	DOCKET NO. PES 19-017
To Review Under Section 101 of the Labor Law: A Notice of Violation and Order to Comply issued November 1, 2019,	RESOLUTION OF DECISION
- against -	
THE COMMISSIONER OF LABOR,	
Respondent.	

APPEARANCES

Terryl L. Brown, Deputy Commissioner and Chief Legal Counsel – Legal Affairs and Administration of New York City Fire Department, New York (*Carlos Velez,* Assistant Commissioner of Bureau of Investigations and Trials), for petitioner.

Jill Archambault, *General Counsel*, *NYS Department of Labor*, Albany (*Steven J. Pepe* of counsel), for respondent.

WITNESSES

Public Employee Safety and Health Downstate Program Manager Raynard Caines, New York City Fire Department Deputy Assistant Chief Michael Meyers, New York City Fire Department Director of Occupational Safety and Health Pharreaux Nelson, New York City Fire Department Deputy Director of Bureau of Investigations and Trials Joseph Palazzolo, and Public Employee Safety and Health Supervising Safety and Health Inspector Alex Hippolyte.

WHEREAS:

On December 30, 2019, petitioner New York City Fire Department (hereinafter "FDNY") filed a petition with the Industrial Board of Appeals (hereinafter "the Board") seeking review of a notice of violation and order to comply (hereinafter "violation notice") dated November 1, 2019 issued by the Public Employee Safety and Health (hereinafter "PESH") Bureau of the New York State Department of Labor (hereinafter "the Department" or "DOL"). Respondent Commissioner of Labor answered the petition on May 29, 2020. Petitioner filed a reply to the answer on July 13, 2020. Upon notice to the parties, a hearing was held on March 23, November 3, November 16, and

November 17, 2021, before Matthew Robinson-Loffler, then Associate Counsel for the Board and the designated hearing officer in this proceeding. The parties were afforded a full opportunity to present documentary evidence, to examine and cross-examine witnesses, to make statements relevant to the issues, and to file post-hearing briefs.

Respondent issued violations of the Public Employee Safety and Health Act, Labor Law § 27-a (hereinafter "PESH Act" or "PESHA") and the federal Occupational Safety and Health Act (hereinafter "OSHA") standards on November 1, 2019. Citation 1, Item 1 determined that the FDNY was in violation of 29 CFR 1910.132(d)(1)(i) because it "did not select and have each affected employee use, the types of personal protective equipment that would protect the affected employee(s) from the hazards identified in the hazard assessment." Specifically, PESH found a firefighter died from injuries sustained in a fall from a ladder basket[1] of a height of approximately 50 feet. PESH found that the safety harness that the decedent was wearing was not attached to the safety strap located inside the ladder basket, and that the FDNY failed to ensure the decedent had attached the safety harness to the basket safety strap. Citation 1, Item 2 determined that the FDNY violated 12 NYCRR 802.2(c) by failing to provide PESH with copies, or to allow PESH to review, documents related to their investigation.

The petition asserts that the violation notice is invalid or unreasonable because (1) it was issued after the six month statute of limitations because the incident that was the subject of the violation occurred on April 20, 2017 and the violation was not issued until November 1, 2019; (2) PESH failed to follow its own procedures by not holding a closing conference; (3) FDNY had properly trained the decedent and the equipment was functioning properly; (4) FDNY turned over all relevant documents to PESH and complied with the PESH subpoena for documents by providing an investigation report which summarized interviews; (5) PESH sought documents the FDNY considered privileged and, thus, petitioner did not have to turn over those documents; (6) PESH should have brought the issue of subpoena compliance to a court rather than issue the violation; and (7) both violations were issued in retaliation for perceived non-compliance with the subpoena.

SUMMARY OF EVIDENCE

Documentary Evidence

The following relevant documents were entered in the record. They are not necessarily listed below in the order that they were entered in the record:

1. FDNY Investigative Report from a fatal injury that occurred on April 20, 2017;
2. September 21, 2018 PESH Investigation Narrative;
3. November 1, 2019 Notice of Violation and Order to Comply;
4. November 25, 2019 Informal Conference Notification;
5. December 23, 2019 PESH Informal Conference Report;
6. December 23, 2019 email from PESH to FDNY;
7. PESH Closing Conference informational document;

[1] Documents and testimony use the term "basket" and "bucket" interchangeably to refer to the container at the end of the ladder on FDNY Ladder Truck 125 from which the decedent fell. This decision also uses "basket" and "bucket" interchangeably to mean the same thing.

8. PESH Act document;
9. FDNY Communications Manual, Chapter 9 dated June 6, 2011;
10. FDNY Firefighting Procedures Volume III, Book VI, Tower Ladder Operations, dated March 15, 1997;
11. FDNY Incident Command System Manual, Chapter 1, dated March 23, 2006;
12. FDNY All Units Circular 287 Staffing Guidelines dated March 27, 2014;
13. FDNY Personnel Profiles of decedent and other firefighters;
14. November 1, 2019 FDNY internal email from Pharreaux Nelson;
15. Decedent's FDNY training history;
16. September 24, 2018 email from PESH to FDNY to schedule closing conference;
17. September 26, 2018 email from PESH to FDNY cancelling closing conference.

The following relevant pictures were entered in the record. They are not necessarily listed below in the order in which they were entered:

1. Ladder Company 135 in position at the scene with ladder fully extended with bucket at roof height;
2. Close shot of basket at roof height from the side showing "L" bracket attachment from ladder to underside of basket;
3. Close-up roof shot of basket over the roof edge showing basket door unlatched;
4. Close-up of "L" bracket from beneath with measurement and damage to parapet coping stone with same width measurement as "L" bracket;
5. Close-up of damage done to coping stone on top of parapet;
6. Close-up of damage to the flange of the "L" bracket from being wedged into the coping stone;
7. Close-up of Ladder Company 135 basket door 1 latched;
8. Close-up of Ladder Company 135 basket door 2 latched.

The following relevant videos were entered in the record. They are not necessarily listed below in the order in which they were entered:

1. Safety demonstration of the Mansaver door latches and restraint bars (1 minute 57 seconds);
2. Safety strap demonstration (30 seconds);
3. Basket movement demonstration (3 minutes 41 seconds);
4. Sidewalk video of Ladder Company 135 ladder basket at second floor height (20 seconds, approximately 14 seconds of which shows the ladder basket going in and out of the viewing frame) (herein referred to as "second-floor video");
5. Sidewalk video at roof level of Ladder Company 135 (28 seconds, approximately 3 seconds of which shows the ladder basket at roof level) (hereinafter referred to as "roof video");
6. Sidewalk video of decedent's fall and after the fall (1 minute 43 seconds);
7. CBS Channel 2 news coverage and interviews with three witnesses regarding decedent's accident (1 minute 42 seconds).

When a dispute arose on the first and second day of hearing regarding whether respondent had additional videos of the subject incident other than those listed above, the parties were directed to resolve that dispute and provide such resolution to the Board in writing. On November 10, 2021,

the parties notified the Board, in writing, that they were unable to reach a stipulation regarding the use of further video evidence other than what respondent provided to petitioner prior to the first day of hearing.

Testimonial Evidence

Testimony of Public Employee Safety and Health Downstate Program Manager Raynard Caines

Raynard Caines (hereinafter "Caines") recalled that this investigation was led by another investigator, Varghese Mathew (hereinafter "Mathew"), who had since stopped working for PESH. However, Caines stated that he reviewed the evidence and final report before it was issued, as did Alex Hippolyte (hereinafter "Hippolyte"), Mathew's immediate supervisor; Len Schwartz, a program manager and Caines' supervisor; Eileen Franko, the PESH director; and respondent's counsel's office. Caines stated that there were videos of the incident, which he viewed, as had Mathew, Kwo Lam (hereinafter "Lam"), another investigator, and possibly two investigators that were training. Caines explained that Mathew had only been an investigator for about a year when he conducted the investigation in this matter, so Lam was training him, as investigators train for about three years.

Caines testified that a safety restraint belt or tether in a firetruck ladder bucket does not permit free movement but does allow for some movement. Caines was shown the second-floor video and testified that he could "not see a tethering for a safety strap." Caines further stated that while he could partially see into the basket attached to the ladder extending from the fire truck, he could not tell from the video if the decedent was tethered in by a security strap. Caines then stated that he had reviewed an additional video which showed more than what is included in the second-floor video entered in the record. After Caines testified regarding a longer video, the parties stipulated that there was no additional video, other than the second-floor video entered in the record, showing the decedent at or near the second floor. Caines was shown the second-floor video again, and again stated that he could not tell if the decedent was tethered or untethered in that video. Caines testified that he did not know how many safety straps were in the basket where the decedent was, nor could he identify the color of the safety straps. When asked what color the decedent's bunker gear was, Caines responded that it was a "dark color with reflective stripe." Caines was shown the video again and he stated that he could not see from that video whether the decedent was tethered, and he could not see the decedent's tether equipment.

Caines was asked to review the September 21, 2018, investigation narrative, specifically the paragraph which states, "one of the obtained videos showed [decedent] inside the basket at approximately the height that was adjacent to the third floor of the fire structure," and that decedent could be seen "leaning over slightly … not completely attached to his entire fall restraint system." After testifying that he read that paragraph to himself, Caines acknowledged that the second-floor video did not show decedent leaning over slightly and he acknowledged that he could not tell from the second-floor video whether decedent was attached or unattached to the restraint system. When asked if he could see the restraint strap inside the basket, Caines answered "[n]ot with the video you showed me."

On a subsequent day of Caines' testimony, several months after his initial testimony, Caines was again shown the second-floor video and Caines testified that he saw in that video that the "gate" of the bucket in which the decedent is located is open, as indicated, according to Caines,

by the gap between the basket and the ladder. Caines further testified that he saw in the video that the decedent was "partially outside of the bucket, and if he had an attachment to his personal harness, which would be under his turnout coat, the coat would not be as tapered." Caines acknowledged that he could not see, in the video, the safety harness that a firefighter would wear to attach to the basket on the ladder, which would be under his coat and not visible typically. Caines also testified that he did not know if the decedent had the harness on that day. Caines then testified that the decedent's personal harness was "review[ed]" by an inspector and was "listed as not being damaged." Caines also stated that the decedent's foot is outside of the basket. While going through the second-floor video second-by-second, Caines testified at each second that he could not see whether the decedent's harness was fastened or unfastened to the safety restraint system. Caines clarified his earlier testimony in which he stated that he saw in the second-floor video that the "gate" of the basket was open and stated that he meant "arm" not "gate," and the parties stipulated that the video did not show whether the "arm" on the basket was opened or closed because the "arm" was not visible. Caines also acknowledged that the informal conference report dated December 23, 2019, and created by Hippolyte, which states that the second-floor video "clearly shows that the firefighter was not tethered from about two stories in elevation," is incorrect. He then testified that the second sentence in that document, which states "[i]n the video, the firefighter showed no restrictions on movement inside the bucket," must be read in conjunction with the first sentence for the report to be accurate.

Caines testified that he could also not see the decedent's personal harness or the safety restraint belt in the basket attached to the decedent's harness in the video of the decedent in the basket at the roof-level of the building. Caines further acknowledged that he could not see in the video of the decedent at roof-level whether the bar or arm on the bucket is open, contrary to what Mathew's investigation narrative states. Caines acknowledged that the statement in Mathew's narrative that the video of the decedent at the roof-level shows the bar or arm in an open position is incorrect. Caines also acknowledged that he watched all the videos entered in the record prior to approving Mathew's narrative. Caines further testified that the decedent's bunker gear was black, and the safety restraint belt is black. He testified that at the time of the incident, the decedent had the personal protective equipment (hereinafter "PPE") "relevant to his duties" on, the safety belt restraint was available to the decedent at the time of the incident, and the decedent was qualified for the work that he was performing. Caines also acknowledged that the petitioner's tower ladder operations manual includes a directive that decedent should have been using the safety restraint belt. Caines stated that he believes that after the decedent fell from the basket, the basket was not moved but the basket door that had been open, was subsequently closed and the "bar" was put down. Caines explained that his recollection was that a witness stated as much but it was not a witness that PESH interviewed; rather, it may have been a witness that Caines saw interviewed on video. Caines did not specify what video he was referring to. Caines testified that the decedent should have "maintained his restraint system." He further testified that at the time the decedent was in the basket, there was no real emergency, nor did he need to dismount from the basket, so the petitioner should have reminded the decedent to use his PPE while in the basket.

Caines testified on the final day of hearing, which was the third day that he gave testimony. During that testimony, he stated that the second-floor video of the decedent was clearer than the one that he was shown during his first and second days of testimony. He testified that he could see that the decedent was not attached to the safety restraint system in the bucket in the second-floor video, despite his previous testimony that he could not see that. Caine's explanation of this discrepancy was that the second-floor video that he was shown during his third day of testimony

was clearer than the second-floor video he was shown during the first and second days that he testified.

When asked to provide the "most compelling" reasons for respondent finding that the decedent was not strapped in, Caines responded that (1) the quick time frame from when the decedent was talking to the chauffeur to when the decedent fell from the basket, (2) the lack of interviews with firefighters on the scene, and (3) an interview in a news report with a bystander who stated that the decedent had opened the door of the bucket, and that the decedent had tried to put his safety strap on when the ladder began to shake. Caines testified that there is a video entered in the record that shows the ladder shaking while the decedent is in the bucket, and he stated that he is unsure what news report interviewee meant when he said that he saw the decedent putting the safety restraint on just prior to falling from the bucket. Subsequently, Caines testified that he thought that the person interviewed described what he believed he saw regarding the safety restraint. Caines also acknowledged that he thought it was possible that the decedent untethered himself to see why the basket was stuck on the roof.

Caines testified that subpoenas were issued in this matter seeking the petitioner's interview notes, which, according to Caines, petitioner did not provide. Caines also stated that the firefighter witnesses refused to be interviewed by PESH, so PESH requested a copy of the FDNY interview notes of them, which, according to Caines, Nelson initially agreed to provide, but then later refused to turn over, even after PESH sought them via a subpoena. Caines testified that PESH does not have to issue a subpoena prior to issuing a citation for failure to provide records. Caines did not know how the Department enforces subpoenas which are not complied with. Caines also testified that initially petitioner indicated that they would provide PESH with their interview or employee notes, and petitioner then stated that they would not provide them, but petitioner did not assert that it was because it was a privileged document, rather they just said that PESH was not permitted to see them. Caines stated that he did not remember his exact words but Palazzolo's testimony that Caines said something akin to "[i]f you had just given us the information, we wouldn't be here," was generally an accurate recount of what Caines said. Caines testified that the issuance of the violation regarding failure to turn over records was not retaliatory, and what he said at the conference was just talking and an attempt to come to an agreement to allow PESH to look at records.

Caines testified that the length of time it took to complete the investigation was not unusual for a fatality investigation. Caines also asserted that the investigation was prolonged based on petitioner not turning over witness interview notes, and while PESH tried to determine if the FDNY had the same videos that PESH had in its possession. Caines stated that PESH waited for the FDNY to complete its own safety investigation report, which also contributed to the length of time that passed before violations were issued.

Testimony of New York City Fire Department Deputy Assistant Chief Michael Meyers

Michael Meyers (hereinafter "Meyers") testified that he was a Deputy Assistant Chief and Chief of Safety Command for the FDNY and that, at the time of his testimony, he had worked for the FDNY for more than 30 years. Meyers stated that the FDNY's command system manual, training, and other procedures were properly followed in the subject incident. He explained that all probationary firefighters are given training on the safe operation of fire engines and tower ladders. Meyers testified that firefighters going into ladder baskets are supervised with voice

commands when in sight and sound of the other firefighters, or through radio commands when they are not. Meyers testified that a Fatal Fire Report (hereinafter "FFR") was created after the incident in question. He explained that a FFR is created after a fatality by interviewing people on the scene and listening to "Handy-Talkie" recordings, among other things, to learn what happened. Meyers further stated that the goal of the FFR is to determine if any new safety procedures are needed so that the same accident does not happen again. Meyers testified that he was not a part of Safety Command when the FFR on this incident was created.

Meyers testified that according to the FDNY reports, on April 20, 2017, the decedent's ladder truck responded to the scene of a fire. According to Meyers, the decedent had 13 years of experience as a firefighter at the time of the incident and was one of two senior firefighters on the scene, both of whom were supervised by Lieutenant Brennan. Meyers testified that, as indicated in the decedent's training transcript, he was extremely well trained through multiple classes, drills and scenarios. Meyers testified that, based on his review of the investigative documents, including the "Handy-Talkie" transcript from the incident, as the basket on the ladder in which the decedent was riding was approaching the building, control of the basket was turned over from the firefighter operating it at the truck, known as the chauffeur, to the decedent, who was located in the basket This was done over the radio. Meyers testified that the basket then got stuck on the parapet of the building, and the decedent asked the chauffer to retake control of the basket, possibly believing that the basket controls on the basket were not working. Meyers stated that this was an unusual request, so the decedent was asked to repeat his transmission. Meyers further testified that the decedent stated "[c]an you lift the bucket off the roof? I'm having trouble with the joystick" and the chauffer responded, "[o]h, okay," meaning he was going to try to lift the basket from the ground controls. At that point, according to Meyers' understanding, the decedent fell from the basket.

Meyers testified that, as indicated in a ladder basket demonstration video entered in evidence, there were two doors in and out of the basket, at approximately ten o'clock and two o'clock from where the operator would be standing. The basket had three safety straps or harnesses, each approximately three feet long. Meyers explained that the operator would be connected to the strap closest to the controls, with the other two straps located behind the operator, on the basket poles. Meyers explained that each firefighter's safety pants are equipped with a harness, which is where the safety strap is attached. He further stated that there are three safety straps in the basket because each basket can hold up to three firefighters.

Meyers stated that while you cannot see if the decedent was connected to the strap in front of him in the second-floor video entered in evidence, his movements turning to the right indicated that he was wearing the strap connected to his right hip as the basket approached the second floor. Meyers further explained that the video indicates that the decedent turned to talk to his right, not his left, because turning to the right enabled freer range of motion, whereas turning to the left would have caused a jerk in the safety strap. Meyers testified that in the roof video entered in evidence, he was not able to not tell if the decedent was strapped in because of a piece that hangs down from the face masks that was obstructing the view of where the strap would be. Meyers later corrected himself and stated that the strap would be clipped on the hip, not the face mask, and he could not tell whether or not the decedent was clipped in at a particular point because the strap would have been clipped on the hip opposite the camera angle, the pants were black with yellow striping, and the safety strap was black. Meyers stated that it appeared the basket, which was near roof level, was jammed on gray coping stone just above the building parapet, so the basket could

not have gotten any closer to the roof. Meyers further testified that he could tell that the decedent was wearing all other applicable safety gear.

Meyers explained that the decedent was directed to shut off the building's electricity, which would require him to get out of the basket on the roof of the building, and to descend the stairs to where he could cut off electrical power. Meyers testified that according to a photograph taken at the scene, which was entered in evidence, one of the basket doors was unlatched, which, he testified, indicated that the decedent was about to exit the basket to the roof to turn off the electricity. Meyers testified that two additional photographs, which were entered in evidence, showed the damage done to the coping stone where the basket was wedged. Meyers testified that he was not aware of this type of accident having ever happened before. Meyers disagreed with the determination in the notice of violation that "the employer had failed to ensure that the employees use the safety life belt that is in the basket platform." He testified that the FDNY provides every firefighter with PPE and trains everyone on use of that PPE. When asked if the "battalion chief" or "battalion commander" on site during an incident is responsible for making sure firefighters have and are using proper PPE, Meyers responded, "I think each member is responsible for ensuring that they're wearing the proper PPE that they're trained to use." Meyers further explained that, pursuant to FDNY regulations, each firefighter was responsible for ensuring their own compliance with the safety regulations and procedures, and a superior officer's role is to direct a firefighter to follow the regulations or to pull them from the scene for not complying with safety procedures. Myers testified that "the firefighter who got into the basket would have to ensure that he – he attaches before he went on, because that's what our regulations and procedures state."

Meyers acknowledged that he was not present at the scene of the fatality and that at some point the decedent had become unfastened from the safety strap. Meyers testified that as the Chief of Safety Command, he is responsible for reviewing procedures, purchasing equipment, ensuring that everything is functioning properly, and making adjustments when necessary. Meyers also stated that he was responsible for investigating FFRs and accidents to make sure they were not repeated. Meyers was present when PESH went to the FDNY to present the investigative findings and violations.

Testimony of New York City Fire Department Director of Occupational Safety and Health Pharreaux Nelson

Pharreaux Nelson (hereinafter "Nelson") testified that he has been the FDNY's Director of Occupational Safety and Health ("OSHA") Unit for approximately 10 years. Nelson stated that Mathew and Lam held an opening conference for the subject investigation on April 25, 2017 and Mathew held an exit conference on August 23, 2017. Nelson stated that during the exit conference, PESH did not inform the FDNY that any violations had been found or that any citations would issue. According to Nelson and as indicated in emails entered in evidence, sometime in early 2018, Mathew emailed Nelson stating that a closing conference was going to be scheduled. Hours later, Mathew both called and emailed Nelson, informing him that the closing conference had been cancelled. Nelson testified that Lam then held a closing conference on October 29, 2019. Nelson testified that at that conference, Lam did not inform the FDNY of what citations would be issued because, according to Nelson, Lam did not know if any citations were going to be issued. Nelson testified that Lam sent Nelson a text 15 or 20 minutes after the conference regarding citations. Nelson testified that PESH ultimately issued citations to the FDNY on November 1, 2019.

Nelson testified that he later participated in an informal conference at the PESH office on December 3, 2019, which was also attended by Assistant Commissioner Carlos Velez, Deputy Director Joe Palazzolo, Caines, Hippolyte, Lam, Chief McHugh, and FDNY OSHA Unit deputy director Marc Blaise. Nelson stated that Caines did most of the talking at that informal conference and, according to Nelson, Caines said, "we would not be here if you have give[n] – given us the document."

Nelson explained that past practice was that the FDNY would complete its "safety command final report" and turn it over to PESH. In this case, according to Nelson, after PESH received the safety command final report from the FDNY, PESH requested a video of the incident and interview records, which were not provided when requested. Nelson testified that the video was not provided because it was in the news and was not FDNY property. Nelson stated that PESH also requested FDNY interview records, which were not turned over because "we say we didn't have any specific interview records. What we have, really, is the investigator note [sic] because during the investigation, there are some question [sic] not only about the … incident that occur but about … the emotional stress of the firefighter and their life after we have a fatality, their family life, and what type of impact that may have on them, really." Nelson explained that that document is not interview statements, which is what PESH requested.

Nelson stated that he did not know how many people were interviewed during the FDNY investigation because he did not conduct the interviews, but he acknowledged that FDNY investigators interviewed the firefighters that were on the scene. Nelson did not know whether the investigators took notes of those interviews, but he believed that they had. Nelson acknowledged that PESH asked him to produce those records. When asked why he did not provide them, Nelson answered, "[b]ecause I didn't have them. I – they asked. I asked for it. They say it was not available." Nelson further stated that he did not know if the investigation records could be redacted to remove private and family information from them, and then turned over. Nelson further testified, "unless PESH was looking for a smoking gun to issue some type of citation they could find at the time, really, they were looking – they were asking for every – every little document," and that the FDNY did turn over "a lot of them then."

Testimony of New York City Fire Department Deputy Director of Bureau of Investigations and Trials Joseph Palazzolo

Joseph Palazzolo (hereinafter "Palazzolo") testified that he is the FDNY Deputy Director of the Bureau of Investigations and Trials, which conducts internal investigations when there are allegations that an employee has violated regulations. Palazzolo testified that in response to a subpoena issued by PESH for interview notes and other documents regarding the subject incident, the FDNY's General Counsel's office sent a letter to PESH stating that the FDNY had already provided information to PESH and was not required to turn over any other material. Palazzolo agreed that the subpoena from PESH specifically asked for investigators' notes and interview notes supporting the FDNY's final report. According to Palazzolo, the subpoena sought documents that were "an internal work product that the – that the Department of Labor was not entitled to, was not privy to," and that respondent should have taken the FDNY to court to enforce the subpoena, not issue a violation for not providing records.

Palazzolo testified that he attended the December 3, 2019, informal conference at the PESH office, which was requested by the FDNY to discuss its disagreement with the citations issued.

Palazzolo testified that he understood Caines to have stated that PESH issued the citations in retaliation for its perception that the FDNY did not comply with the subpoena.

Testimony of Public Employee Safety and Health Supervising Safety and Health Inspector Alex Hippolyte

Hippolyte testified that he worked for respondent, first in the Asbestos Control Bureau, and then in PESH, most recently as Supervising Safety and Health Inspector. Hippolyte supervised Mathew and Lam in this matter. Hippolyte testified that he reviewed the videos in evidence during the investigation, as well as the investigation report, and he agreed with the determinations that were made. After being asked to read the section of respondent's investigation report that states that one of the videos showed the decedent leaning over slightly and not completely attached to the safety strap, Hippolyte was asked which video showed what was stated in the report. Hippolyte responded that there was not really a video showing the decedent not being restrained, but rather that the video showed the decedent with free range of movement inside the basket which indicated that he was not tethered. Hippolyte further asserted that he could see the decedent was "not attached to anything" from the video, and that "it looks like he stepped out of the bucket altogether on this one." Hippolyte was shown the second-floor video and asked to point out where he could see that the decedent was not attached to the safety strap. Hippolyte responded that it was the free movement inside the basket which indicated he was not attached to the strap because "it's analogous to a seat belt … it doesn't allow you to be – to be so free," and that the safety straps "are meant to keep people inside of the bucket, so if you're outside of the bucket, you're not --- you're not attached … that's the inference."

Hippolyte was asked why the investigation report was written to state that a video showed the decedent could be seen untethered, rather than written to state that respondent concluded the decedent was untethered because of his movement. Hippolyte answered, "[y]ou know – I – well that's how it was written. I mean, we can't take it back, but that's how it was written at the time." He further stated that there was "[n]othing like we can – we can visually confirm, but again, by inference, we can tell you that he's [sic] free movement wouldn't be allowed if he was fully attached with the fall restraint system."

Hippolyte was asked about the finding in the investigation report that states that a second video showed the basket at or about roof level with the gate latch in the open position, and the decedent "also appeared not to be attached to a fall protection system." In response, Hippolyte acknowledged that there was no video clearly showing that. He stated "[y]ou can't clearly see, because it's a black belt." Hippolyte testified that he had never been in a ladder basket and further stated that he could tell that the decedent was partially out of the basket in a video because part his leg obstructed in the view of the outside of the basket.

Hippolyte acknowledged that he drafted the December 23, 2019 Informal Conference Report that was entered in evidence, with supervisory approval. He was directed to the "Determination" section of the report he drafted, specifically to the section which read, "A video clearly shows that the firefighter was not tethered from about two stories in elevation. In the video, the firefighter showed no restrictions on movement inside the bucket." Hippolyte agreed there was no video which "clearly shows" the decedent untethered and stated that the determination was made "by inference."

STANDARD OF REVIEW AND RELEVANT LAW

When a petition is filed, the Board reviews whether an order issued by the Commissioner is "valid and reasonable" (Labor Law § 101 [1]). A petition must state "in what respects [the order on review] is claimed to be invalid or unreasonable" (*id*. § 101 [2]). The Labor Law provides that an order of the Commissioner shall be presumed valid (*id*. § 103 [1]). Petitioner has the burden to prove by a preponderance of the evidence that the orders are not valid or reasonable (Industrial Board of Appeals Rules of Procedure and Practice (hereinafter "Board Rules") [12 NYCRR] § 65.30; State Administrative Procedure Act § 306; *Matter of Angello v National Fin. Corp.*, 1 AD 3d 850, 854 [3d Dept 2003]).

The PESH Statutory Scheme

The federal Occupational Safety and Health Act, 29 USC §§ 651 – 678, was enacted "to assure so far as possible [to] every working man and woman in the Nation safe and healthful working conditions" (29 USC § 651 [b]). OSHA "was not enacted for the principal purpose of punishing employers . . .; rather, '[i]t authorizes the promulgation of health and safety standards and the issuance of citations in the hope that these will act to prevent deaths or injuries from ever occurring'" *People v Pymm*, 76 NY2d 511, 518 [1990] quoting *Whirlpool Corp. v Marshall*, 445 US 1, 12 [1980]). OSHA permits states to seek federal approval for plans to develop and enforce safety and health standards for public employees (29 USC § 667 [b]). A state's plan will be approved if it contains "satisfactory assurances that such State will, to the extent permitted by its law, establish and maintain an effective and comprehensive occupational safety and health program applicable to all employees of public agencies of the State and its political subdivisions, which program is as effective as the standards" promulgated under OSHA (29 USC § 667 [c] [2] and [6]).

Pursuant to this federal mandate the New York Legislature enacted PESHA (Labor Law § 27-a) in 1980 to provide individuals working in the public sector with the same or greater workplace protections as are provided to employees in the private sector under OSHA (*Hartnett v New York City Tr. Auth.*, 86 NY2d 438, 442 [1995]; *Matter of Goldstein v New York State Indus. Bd. of Appeals*, 292 AD2d 706, 706 [3d Dept 2002]). As required under the PESH Act, Labor Law § 27-a (4) (a), DOL adopted the federal OSHA standards, including the General Industry Standards found in Part 1910 (29 CFR 1910). Every public employer in New York has the duty to comply with the safety and health standards promulgated under PESHA (Labor Law § 27-a [3] [a] [2]). Additionally, Labor Law § 27-a (3) (a) (1) requires employment "free from recognized hazards that are causing or are likely to cause death or serious physical harm," "reasonable and adequate protection to … lives, safety or health," and compliance with safety and health standards by both public employers and public employees. PESH enforcement procedures are detailed in Labor Law § 27-a (6) and provide that "[i]f the commissioner determines that an employer has violated a provision of this section, or a safety or health standard or regulation promulgated under this section, he or she shall with reasonable promptness issue to the employer an order to comply which shall describe particularly the nature of the violation including a reference to the provisions of this section, standard, regulation or order alleged to have been violated . . . ."

OSHA requires the employer to conduct a hazard assessment pursuant to 29 CFR 1910.132 (d) and where hazards are present, to select PPE that protects employees from the identified hazard, have each affected employee use such PPE, and select PPE that properly fits the employees

exposed to the hazard (29 CFR 1910.132 [d] [1]).

Authority for DOL to Conduct Inspections

The implementing regulations of PESHA permit PESH employees to conduct inspections. 12 NYCRR 802.2 provides:

> "Safety and health inspectors and hygienists of the Department of Labor (hereinafter referred to as "D.O.L. inspector") are authorized, for the following purposes, to enter without delay and at reasonable times any building, institution, facility, construction site, establishment or other area, workplace or environment where work is performed by a public employee:
>
> (a) to inspect and investigate during regular working hours, and at other reasonable times and within reasonable limits and in a reasonable manner, any such place of public employment, and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein;
> (b) to question privately any employer or employee; and
> (c) to review records required by Labor Law, section 27-a, and the regulations promulgated thereunder, and other records which are directly related to the purpose of the inspection."

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Board makes the following findings of fact and conclusions of law pursuant to Board Rules (12 NYCRR) § 65.39.

Respondent's Finding in Citation 1 Item 1 is Unreasonable

As stated, above, OSHA regulations require that employers "have each affected employee use" PPE that responds to identified hazards and that properly fits the affected employee (29 CFR 1910.132[d][1]). Respondent determined that petitioner violated 29 CFR 1910.132(d)(1) in that the decedent "did not affix the required safety/life belt to" his harness, and the "employer had failed to ensure that their employees used the safety/life belt that is in the basket/platform." Respondent's determination regarding this violation, as indicated in the investigation narrative report, initial conference report, and Caines' and Hippolyte's testimony regarding those documents from the investigation, was based on what was described as video that *clearly* shows that the decedent did not have the safety restraint system in the ladder basket attached to his personal harness. Petitioner challenges this violation and citation, in part, because, according to petitioner, the decedent was properly trained on operations of the equipment and PPE, the PPE was provided by the FDNY, and PESH acknowledged that the PPE was working properly.

Respondent's September 21, 2018 Investigation Narrative states, in relevant part, "[t]he video shows [decedent] inside the basket at an approximate height that was adjacent to the third story of the fire structure and was observed to be leaning over slightly. The video shows [decedent]

was not completely attached to his entire fall restraint system. The second video shows [decedent] approximately at or above the roof of the fire structure, sidewalk facing with the door of the basket and the gate latch in the open position. [Decedent] also appeared not to be attached to a fall protection system." The investigation narrative further states, "video documentation revealed that [decedent]'s fall protection PPE (harness) was not secured to the basket before the ladder basket was fully deployed to the building." The December 23, 2019 Informal Conference Report states, in relevant part, "[a] video clearly shows that the firefighter was not tethered from a height of about two stories. In the video, the firefighter showed no restrictions on movement inside the bucket." The investigation documentation does not indicate that the decedent was not trained properly, or that there was any malfunction of the safety equipment.

Despite the clear and unambiguous language in two different reports created by PESH that the videos "clearly" showed the decedent was not tethered to his safety strap, both Caines and Hippolyte acknowledged in their testimony that the videos did not, in fact, clearly show that the decedent was not tethered to the safety restraint system. The videos entered in evidence corroborate Caines and Hippolyte's testimony that they could not see in the video whether the decedent was attached to the safety restraint system. Caines repeatedly insisted that there was a video that showed what was indicated in the reports, but no such video was entered into evidence, nor did Caines specify where that video came from or who took it, and only testified repeatedly that he saw another unidentified video. Despite a lengthy adjournment between hearing dates and clear direction and agreement between the parties that respondent would attempt to locate and share the video that Caines insisted existed, no such additional video was entered in evidence. After no such additional video was entered in the record, Caines testified that it was inferred from the videos that the decedent was not attached to the safety restraint system and he acknowledged that was not visible in the videos entered in the record. Hippolyte concurred that the videos did not show the decedent untethered, but rather that it could be inferred from the range of motion exhibited by decedent in the basket. Hippolyte and Meyers agreed that the safety strap would not be seen because it is the same black color as the overcoat worn by the firefighter. While respondent attempted to explain their determination that the videos "clearly show" something to mean "it can be inferred," we disagree that those mean the same thing. We also do not find that respondent meant "can be inferred" by using the term "clearly show" because while the written records created by PESH describe perceived limitations in movement, such description is not linked to the finding of what the "video clearly shows" in some sort of inferential chain in those records. The finding regarding the video stands on its own. The initial September 21, 2018 Investigation Narrative, states "[t]he video shows [decedent] was not completely attached to his entire fall restraint system," and "[decedent] also appeared not the be attached to a fall protection system." The language changed from that report to the later December 23, 2019 Informal Conference Report, to then find that "[a] video clearly shows that the firefighter was not tethered from about two stories in elevation." No PESH employee explained why these reports contain different language in the findings, which further undermines respondent's contention that the addition of the word "clearly" should be understood to mean "can be inferred."

We find that based on the videos entered in evidence and the testimony of Caines and Hippolyte, all of which contradict the statements regarding what is contained in the videos in the PESH investigation documents, it was unreasonable for respondent to determine that petitioner violated 29 CFR 1910.132[d][1]. Citation 1 Item 1 was based on factual findings made by respondent which are not consistent with the evidence, and, thus, it is invalid and unreasonable and we revoke Citation 1 Item 1.

We make no finding regarding petitioner's assertion that the statute of limitations, the absence of a closing conference, and that Citation 1 Item 1 was issued in retaliation for FDNY not providing PESH requested records are grounds to revoke the violation regarding PPE as we need not do so because we revoke it for another reason.

Petitioner Failed to Prove Citation 1 Item 2 Was Invalid or Unreasonable

The authority for PESH to conduct inspections is found in 12 NYCRR 802.2 which states, in relevant part, that PESH is authorized to enter the workplace and "review records required by Labor Law section 27-a, and the regulations promulgated thereunder, and other records which are directly related to the purpose of the inspection" (12 NYCRR 802.2 [c]). Respondent issued a violation and citation indicating that petitioner did not provide PESH records of witness interviews/statements and/or FDNY investigator notes taken during witness or employee interviews that were in the possession of the FDNY, despite PESH requesting such records. Petitioner asserted that it did provide PESH with a comprehensive Safety Battalion Final Investigation Report that included summaries of witness interviews and that if PESH believed that did not satisfy its subpoena, PESH should have sought to enforce the subpoena that it issued to the FDNY. Petitioner further asserts that the request for interview notes was burdensome and potentially interfered with the FDNY's deliberative process, and thus, those notes were privileged. Additionally, petitioner asserted that prior to PESH issuing Citation 1 Item 2, PESH failed to hold a closing conference as required by its own procedures, that citation was issued in retaliation for PESH's perceived refusal to cooperate by the FDNY, and that the issuance of Citation 1 Item 2 was beyond the statute of limitations.

Petitioner admits that it did not provide PESH with the documents that were requested and did not establish that petitioner was not required to provide PESH with such documents. 12 NYCRR 802.2 does not contain a carve out providing that respondent is not entitled to review certain documents relevant to the investigation if an employer provides an investigation report of its own summarizing the documents in its possession. Such a carve out would permit employers to refuse PESH access to the documents relevant and possibly necessary to an investigation.

Petitioner failed to assert a recognized legal basis for either its refusal to provide PESH with access to its investigation records, or its insistence that PESH is required to enforce a subpoena before acting on the FDNY's unreasonable refusal. Petitioner asserted that providing the requested interview notes to respondent would be burdensome, but petitioner failed to detail how the request was burdensome. Nelson testified that PESH had previously accepted the FDNY investigation reports, rather than reviewing the underlying investigation notes but this testimony did not explain how such a request was burdensome, nor does PESH's past practice limit what records they may request in subsequent investigations. Nelson did not know if investigators took notes of the interviews, but believed such notes existed. Nelson stated that when asked for these records, he did not have them in his possession and requested them, but "they say it was not available." Nelson did not identify who told him that records were not available or why they were not available. Nelson described PESH's request for those records as PESH looking for a "smoking gun" to issue a violation and he expressed his discontent that PESH asked for so many documents, without quantifying the amount he believed was excessive. None of Nelson's testimony supported petitioner's assertion that the PESH records request was burdensome.

Petitioner also asserted that interview notes could not be provided to PESH because of the FDNY's deliberative process, but petitioner failed to explain why the interview notes should be protected as privileged under a theory of deliberative process, nor did petitioner establish that there is a work product exception to PESH's right to review records as stated in the PESH Act. Palazzolo testified that the FDNY's legal department treated the requested documents as "internal work product," and asserted that respondent should have taken the FDNY to court if it disagreed with the FDNY interpretation. We are unaware of any work product exception in the PESH Act and its regulations, and petitioner failed to provide a basis for the assertion that such an exception exists.

Nelson also asserted that the FDNY did not turn over the interview records because the FDNY considered those records to be an "investigator note" rather than an interview statement. The Board does not find this assertion a credible or persuasive basis for not providing the requested material. There is nothing ambiguous about the demand for records that PESH made in this matter, and Nelson's testimony that the FDNY did not think that PESH was asking for their notes from witness or employee interviews is disingenuous.

Nelson did not know if the demanded material could have been redacted to remove information regarding the mental health information of witnesses or information about family members, which he expressed as a reason why those records could not be turned over. There is no evidence in the record that petitioner attempted to cooperate with PESH's request for records by offering redacted versions of documents or to otherwise limit what notes were provided through negotiating an agreement with PESH. Instead, petitioner refused to provide PESH with interview or investigator notes of witnesses to the subject incident. DOL itself was found to have impermissibly redacted personally identifying information from material requested by a union. In that matter, the Appellate Division affirmed a lower court ruling which reversed this Board, but for different reasons than the lower court, and stated, "there is nothing in the cited regulation or the enabling legislation that authorizes the Department to redact what it unilaterally has deemed to be confidential information" (*Matter of Goldstein v N.Y.S. Indus. Bd. of Appeals*, 292 AD2d 706, 709 [3d Dept 2002] *aff'g Goldstein v State*, 188 Misc.2d 524 [Aug. 29, 2001]). While petitioner is correct that respondent could have sought to enforce her subpoena in court, respondent is also able to issue violations for failure to provide records and petitioner cites to no source indicating that respondent only has one remedy for non-compliance with a subpoena. Petitioner did not prove that it was invalid or unreasonable for respondent to have determined the FDNY was in violation of the PESH Act for failing to provide PESH with documents and material relevant to the investigation.

As discussed above, we declined to make a finding on petitioner's argument that Citation 1 Item 1 should be revoked because it was issued long after the statute of limitations had run. With respect to Citation 1 Item 2, because we find that petitioner failed to prove that it was invalid or unreasonable for respondent to issue that violation, we must consider petitioner's statute of limitations argument with respect to Citation 1 Item 2. As the subject of Item 2 is regarding petitioner's failure to turn over records requested by PESH, that violative act is ongoing in nature and, thus, if there is a statute of limitations that might apply in these cases, in this specific instance, as long as petitioner continued to not turn over records that PESH reasonably requested, which the record here reflects, any statute of limitations that might apply did not yet begin to run. We find that petitioner's statute of limitations argument is not applicable to Citation 1 Item 2. We make no finding under these circumstances as to whether there is a statute of limitations by when respondent must issue a violation after occurrence.

We also do not find that the purported absence of a closing conference is a basis for us to revoke Citation 1 Item 2. Petitioner did not assert a legal basis to find that the alleged failure to hold a particularly titled conference necessarily requires a finding that any determination from that investigation is invalid or unreasonable. Finally, we do not find that petitioner established that the issuance of Citation 1 Item 2 was retaliatory because petitioner did not provide sufficient evidence or legal argument to support that theory. Rather, the record reflects that petitioner admittedly did not provide respondent with the records that she asked for and, as discussed above, petitioner did not establish a sufficient basis for doing so.

We affirm Citation 1 Item 2.

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The petition is granted in part and denied in part; and

2. Respondent's determination on Citation 1 Item 1 is revoked.

3. Respondent's determination on Citation 1 Item 2 is affirmed.

Dated and signed by the Members
of the Industrial Board of Appeals
on November 15, 2023.

Molly Doherty, Chairperson

Michael A. Arcuri, Member

Najah Farley, Member

Patricia Kakalec, Member

RECUSED
Sandra Abeles, Member