STATE OF NEW YORK
INDUSTRIAL BOARD OF APPEALS

In the Matter of the Petition of: VILLAGE OF PORT CHESTER, Petitioner, To Review Under Section 101 of the Labor Law: A Notice of Violation and Order to Comply, dated June 16, 2016, - against - THE COMMISSIONER OF LABOR, Respondent, PORT CHESTER PROFESSIONAL FIRE FIGHTERS, LOCAL 1971, IAFF, AFL-CIO, Intervenor.	DOCKET NO. PES 16-012 RESOLUTION OF DECISION

APPEARANCES

Cozen & O'Connor, New York (*John Ho* of counsel) and *Bond Schoeneck & King, PLLC*, Garden City (*Emily Iannucci* of counsel) for petitioner.

Pico P. Ben-Amotz, General Counsel, NYS Department of Labor, Albany (*Steven J. Pepe* of counsel) for respondent.

Woodley & McGillivary LLP, Washington, D.C. (*William Li* of counsel) for intervenor.

WITNESSES

Edward Brancati, Dominick Cervi, Michael De Vittorio, Hilary Moreira, Arrion Mulligan, Tony Perez, Edward Quinn, for petitioner.

Heriberto Virella, Ryan Iarocci, PESH Investigator Raygo Veneable, for respondent.

WHEREAS:

On August 15, 2016, petitioner Village of Port Chester (hereinafter "petitioner" or "Village") filed a petition contesting a Notice of Violation and Order to Comply (hereinafter "NOV") issued on June 16, 2016 by the Public Employee Safety and Health Bureau (hereinafter "PESH") of the New York State Department of Labor (hereinafter "DOL"). Respondent answered

the petition on September 15, 2016 and petitioner filed a reply on September 27, 2016. The Port Chester Professional Fire Fighters, Local 1971, IAFF, AFL-CIO (hereinafter "Local 1971") filed a motion to intervene on January 18, 2017, which was granted by the Board on February 1, 2017.

The PESH investigation and NOV arose out of a fire fought by the Village's fire department on March 2, 2016. The NOV includes two citations for violations of the Public Employee Safety and Health Act, Labor Law § 27-a (hereinafter "PESH Act" or "PESHA"), including federal Occupational Safety and Health Act (hereinafter "OSHA") standards applied to the Village by the PESH Act. The first citation included five items and the second contained one item with three subdivisions. The NOV identified all items in Citation 1 as serious violations, and those in Citation 2 as non-serious violations. The NOV ordered the Village to abate each violation by a specified date from July 13 to August 24, 2016 or incur penalty assessments. The petition alleged that all items and subdivisions of both citations were invalid, unreasonable and not supported in fact or law.

Upon notice to the parties, hearings were held on February 7, June 8, June 9, July 24, July 25, September 25, September 26, October 30, and October 31, 2017 in White Plains, New York, before Administrative Law Judge Jean Grumet, the designated Hearing Officer in this proceeding. The petitioner and the respondent 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. Local 1971 was permitted to examine and cross-examine witnesses called by the petitioner or respondent and to make statements relevant to the issues.

SUMMARY OF EVIDENCE

Background: The Fire Department, Fire and PESH Investigation

The Port Chester Fire Department (hereinafter "PCFD"), which is headed by the chief and first and second assistant chiefs, includes seven companies, each with its own bylaws and elected captain and lieutenants, in five firehouses. The PCFD reports to the Village manager and trustees. At the time of the fire on March 2, 2016, the fire department was comprised of eight paid firefighters, who were represented by Local 1971, and 300 volunteer firefighters.

On March 2, 2016, the PCFD fought a house fire, described by witnesses as a very hot and smoky fire on a windy day, which was made more difficult to fight due to changing wind directions and poor visibility caused by the heavy smoke. The fire was first centered in the house's basement but later spread to an electrical breaker box on the second floor. An incident report filed by the Village with the New York State Department of Homeland Security on March 25, 2016 states that 59 Village firefighters helped fight the fire; witnesses agreed that there were also assisting firefighters from neighboring municipalities. The incident report states that the fire started with an electrical wire malfunction, spread through plywood walls and was called in at 1:31 p.m. The first firefighters arrived at 1:34 p.m. and the fire was deemed controlled at 5:43 p.m. Part of the fire was filmed in three videos, each about fifteen minutes long. These videos were posted on YouTube and the parties offered them in evidence as a joint exhibit.

Firefighters Tony Perez (hereinafter "Perez") and Brendan Doyle (hereinafter "Doyle") were injured during the fire; EMTs transported each of them to hospitals. "C-2 forms," which the Village's human resources specialist Edward Brancati (hereinafter "Brancati") testified were submitted to its workers' compensation administrator, state that both injuries occurred at 2:00 p.m. Perez was taken to Greenwich Hospital and treated for electric shock in the emergency room. Doyle was taken to Westchester County Medical Center, where he was admitted with carbon monoxide poisoning and acute kidney injury, transferred to the burn service, and then released two days later. Doyle was medically cleared to return to work five days after his release from the hospital.

PESH investigator Raygo Veneable (hereinafter "Veneable") testified that the PESH investigation was the result of a complaint filed by Local 1971 on March 11, 2016. The complaint alleged that firefighters not certified as interior firefighters had entered a structure without self-contained breathing apparatuses (hereinafter "SCBA"), a firefighter was shocked due to power not being turned off, there was no tracking or monitoring of firefighters entering the structure, firefighters were not fully geared, and that the fire chief, in a March 6, 2016 memo, requested that a firefighter alter details of the incident report of the fire.

Veneable testified that after reviewing the complaint and speaking to Local 1971 president Vinny Lyons (hereinafter "Lyons"), on March 25, 2016, he performed a walkaround inspection of the PCFD headquarters and held a conference with Chief Edward Quinn (hereinafter "Quinn"), first assistant chief Michael De Vittorio (hereinafter "De Vittorio"), second assistant chief Enrico Casterella (hereinafter "Casterella"), Village manager Christopher Steers (hereinafter "Steers"), Lyons (who was a paid fire fighter in addition to being Local 1971 president), and paid firefighters Heriberto Virella (hereinafter "Virella") and Ryan Iarocci (hereinafter "Iarocci"). Veneable also interviewed Virella and Iarocci that same day, and Quinn, De Vittorio, Casterella and Doyle on March 31, 2016. Veneable held a closing conference with the Village on June 16, 2016, the same day he issued the NOV and advised the Village of its issuance.

Hilary Moreira (hereinafter "Moreira"), a lawyer retained by the Village to conduct its own investigation after PESH's issuance of the NOV, testified that she took statements from 22 witnesses and wrote a September 6, 2016 memorandum offered in evidence as a joint exhibit. Moreira's memorandum summarized the witness interviews and her memorandum includes her findings and recommendations pertaining to the NOV based on her interviews, documentary evidence and videos.

Seven firefighters testified about what they saw at the fire. Quinn, the chief at the time of the fire, was the incident commander at the fire and was stationed in front of the building during the fire. Quinn has been a firefighter for 35 years (including 24 years with the Village) and has responded to over 100 fires. DeVittorio, who was forward command in charge of the second floor during the fire, was the first assistant chief at the time. DeVittorio has been a member of the PCFD for 31 years, including eight as a company captain and four as assistant chief; during that time, he responded to over 150 active fires. Virella became a paid firefighter on March 23, 2015 after 14 years as a volunteer firefighter, and while with the PCFD responded to at least five active fires. Iarocci became a paid firefighter on October 9, 2012 after over four years as a volunteer firefighter and another four in the PCFD's "junior program;" he fought six or seven fires as a paid firefighter and ten to fifteen as a volunteer. Perez has been a certified interior firefighter since 1993, responding to about four active fires per year. Arrion Mulligan (hereinafter "Mulligan") had been

a firefighter for over a year when he testified. At the time of the fire he was an exterior firefighter. Dominick Cervi (hereinafter "Cervi"), a firefighter for 39 years, testified that he was certified as an interior firefighter at the time of the fire,[1] and was a past company captain. Cervi served as officer in charge of his company at the March 2, 2016 fire since no current elected officers were present.

Two volunteer firefighters, Lieutenant Leslie Murphy (hereinafter "Murphy") and Doyle, were not called by petitioner to testify. According to Moreira's memorandum of her Village-commissioned investigation, Murphy has been a volunteer member of the PCFD since 1971. Quinn testified that Murphy was Doyle's supervisor on the day of the fire.[2] According to Moreira's memorandum, Doyle, whom Moreira interviewed twice, joined the PCFD in April 2015, was an exterior firefighter at the time of the fire in March 2016, and became certified as an interior firefighter in June 2016. De Vittorio testified that Doyle had responded to one or two fires before March 2016.

NOV Citation 1 Item 1

NOV Citation 1 Item 1 states that the PCFD "did not establish and maintain a written respiratory protection program with worksite-specific procedures for its members." The citation states that 29 CFR 1910.134 (c) (1) requires that the program include the following provisions, as applicable:

> "(i) Procedures for selecting respirators for use in the workplace; (ii) Medical evaluations of employees required to use respirators; (iii) Fit testing procedures for tight-fitting respirators; (iv) Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations; (v) Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators; (vi) Procedures to ensure adequate air quality, quantity and flow of breathing air for atmosphere supplying respirators; (vii) Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations; (viii) Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and (ix) Procedures for regularly evaluating the effectiveness of the program."

The citation was to be abated by August 3, 2016.

Veneable testified that during the March 25, 2016 conference, he requested a copy of the petitioner's respiratory protection program. Veneable e-mailed Steers on March 28, 2016

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[1] Cervi testified he was interior trained and certified until September 2016, when he did not take his annual OSHA training.

[2] According to Moreira's memorandum, by the time their captain Louis Marino arrived at the fire, Doyle had already been taken to the hospital.

requesting among other items, "SOGs[3] for Interior FF Accountability Tags, SCBA's [sic], Escape Rope(Bailout Training) [sic]." That afternoon, Steers sent an e-mail to Veneable stating:

> "The SOGs are attached: . . . Interior FF's Accountability Tags, Page 77 . . . SCBA's [sic], page 56 . . . Escape Rope(Bailout Training). Pages 56, and 69-70 [sic]. The membership report with interior vs exterior rating is also attached. I will send the logs and incident reports in a separate email in case it's too large."

The "Case Contact Sheet" indicates that Veneable received Steers' e-mail and the requested pages from the SOGs the following day. The "Case Contact Sheet" indicates that on May 3, 2016, Veneable requested that Brancati provide a copy of the petitioner's respiratory protection program; that Veneable called Brancati on May 11, 2016 regarding the program; and that Veneable made a second request for it on June 10, 2016.

According to the petition filed in this matter, "the SOGs were produced to PESH on June 30, 2016." The 2008 SOGs were entered into the record as a Joint Exhibit. De Vittorio testified that the 2008 SOGs are the most recent version. Veneable testified that the basis for this citation was that the respiratory protection program was untimely provided because he received the petitioner's program only after the citation was issued. Veneable further testified that he would not have accepted the program as adequate even if it was timely submitted because it did not meet the threshold for a compliant program.

De Vittorio testified that the 2008 SOGs included petitioner's written procedures pertaining to SCBAs on page 96 (in a section different from the one Veneable received on March 29, 2016) although De Vittorio also stated that SCBA training was discussed on page 57 (which was sent to PESH on March 28, 2016). When asked where in the SOGs were procedures for the proper use of respirators, De Vittorio referred only to the sentence "person should not remove their breathing apparatus until the air is completely cleared of toxic gasses." When asked whether there were any provisions in the SOGs that provide for how often or how the SOG will be evaluated for effectiveness, De Vittorio pointed to a sentence in the preface of the 2008 SOGs stating "these SOGs are a continuing work in progress and will be amended as warranted." The 2008 SOGs do not contain procedures for selecting respirators for use in the workplace, procedures for proper use of respirators in routine and reasonably foreseeable emergency situations, and procedures for regularly evaluating the effectiveness of the program.

NOV Citation 1 Item 2

NOV Citation 1 Item 2 states that the Village violated 29 CFR 1910.134 (g) (3) (ii), which requires that the employer shall ensure that "[v]isual, voice, or signal line communication is maintained between the employee(s) in the IDLH atmosphere and the employee(s) located outside." According to the citation: "[e]mployee interviews indicate that the employer failed to effectively account for firefighters in an ongoing manner during the time when the firefighters were performing interior structural firefighting, by maintaining visual, voice or signal line communication between the members inside the IDLH and the employees outside the IDLH atmosphere." The citation was to be abated by July 13, 2016. Veneable's March 25, 2016

[3] "SOGs" is an abbreviation for Standard Operating Guidelines.

investigation narrative listed among the conditions he observed was that firefighters did not implement the "two in, two out" rule when entering a structure and did not use their accountability tags as a means of keeping track of which members were inside. IDLH is an abbreviation for immediately dangerous to life or health.

Quinn testified about radio communication between inside and outside the IDLH atmosphere:

> "Q. How is accountability and communication inside the IDLH and outside the IDLH set up?
> A. All units have a set number of radios. All firefighters are told to grab a radio as you're getting off. If it comes down to a firefighter, our officers have a radio. The officer will have the radio because he's the commanding officer of that team and they will radio in and out what's going on.
> Q. And how do firefighters who don't have radios communicate from the interior?
> A. They would have to go to one of the firefighters with a radio and give that message.
> Q. Is there any procedure in place for accountability, keeping track of the people who don't have radios and the people who do have radios? How's it determined who's going in, who's going out?
> A. As far as who has radios and who doesn't, that's just up to who's grabbing the radio as they're getting off the rig....
> Q. What's the procedure for ensuring that if a firefighter is internal without a radio, what's - -
> A. He's with a team member, he's with his team or her team.
> Q. And if an individual without a radio exits the building, he alerts a team member with a radio. Is that correct?
> A. Yeah, he should say I'm going out my, bottle's low or I'm going to get a tool, yes . . .
> Q. . . . How do firefighters who are going back into a structure without radios, how are they accounted for? . . .
> A. They should be checking back with the team leaders.
> Q. How would they do that?
> A. Tap them on the shoulder, say I'm back, what do you need for me to do.
> Q. Would you agree that it's possible that a person entering a structure without a radio would not be able to find their team leader because of the smoke, the visual –
> A. Not to find them as soon as they walk through the door, maybe, but they would.
> Q. So they have to work their way back to their team leader to –
> A. Yes."

While reviewing the video of the fire, Quinn testified that he observed individual fire fighters entering and leaving the structure alone. De Vittorio testified that at the time of the fire, there was no accountability procedure for knowing who had entered the structure and who was outside of the structure but that voice line of communication is maintained through radios: "[E]ach

piece of apparatus carries portable radios produced by the company officers to maintain communication with the chiefs and each other and also with any firefighters that also have portable radios." De Vittorio testified that firefighters who entered the structure should be working on a team with at least one person with a radio. When asked how petitioner ensured that no one got lost or was out of communication with the outside of the structure at the Cottage Street Fire, De Vittorio stated that captains and officers were responsible through direct supervision.

Several of petitioner's witnesses testified that there was limited visibility because the fire was especially smoky and hot. Virella testified that "it was pitch black, we couldn't see anything." De Vittorio agreed that smoke significantly impeded his ability to see while he was inside the structure requiring him to rely on "feeling and hearing" to navigate. De Vittorio also testified that there probably were firefighters without radios on the house's second floor since the firefighter in charge of a hose line would have the radio while others worked the line.

Veneable testified that he issued NOV citation 1 item 2 based on his interview with Virella, the video showing members entering the structure without partners, and the failure of the PCFD to properly use accountability tags. Veneable testified that PESH chose to cite the violation of 29 CFR 1910.134 (g) (3) (ii) rather than the "two-in, two out" rule (29 CFR 1910.134 [g] [4] [i] and [ii]) because it was more appropriate under the circumstances as firefighters entering the fire alone were without visual, voice or signal contact with the commander outside, and without accountability tags, there was no way of knowing who was in the building. Veneable stated that his reference to the "two in, two out" rule was his attempt to describe a method of maintaining contact, "[i]f you're having two people going, you're able to maintain better contact with someone else, so that's just a reference. I'm not saying that we have to use the two-in, two-out standard." Veneable also testified that no interviewed firefighter stated that they were ever out of radio or visual contact while they were in the interior of the fire nor could he affirmatively identify a firefighter entering or exiting the structure without a radio.

NOV Citation 1 Item 3

NOV Citation 1 Item 3 states that the Village violated 29 CFR 1910.156 (c) (1), which requires the Village to "provide training and education for all fire brigade members commensurate with those duties and functions that fire brigade members are expected to perform. Such training and education shall be provided to fire brigade members before they perform fire brigade emergency activities." According to Citation 1 Item 3, the petitioner permitted an employee who did not have training and education to "perform fire brigade emergency activities in an IDLH atmosphere. The employee entered a house . . . while it was on fire and under heavy smoke conditions." This citation was to be abated by August 24, 2016. Veneable's March 25, 2016 narrative listed among the conditions he observed that a video shows a firefighter "not wearing SCBA entering approximately three (3) feet beyond the front door threshold," and summarized interviews concerning Doyle, the alleged untrained firefighter.

Official PCFD policy was that after initial training, firefighters are certified as "exterior firefighters" but only "interior firefighters," certified as such after additional respiratory training, are permitted to enter structures where conditions are IDLH. PCFD policy further requires that firefighters wear an SCBA when entering a structure in IDLH conditions. Doyle was not an interior trained firefighter at the time of the fire, was not issued SCBA, and as an exterior firefighter, was

only supposed to perform exterior duties. Doyle did enter the burning structure on March 2, 2016, without wearing SCBA.

Doyle's hospitalization followed his entry into an IDLH atmosphere without SCBA. Petitioner's witnesses emphasized that Doyle was only in the building a short time and did not go far inside. In addition, Quinn testified that during and immediately after the fire he did not know that Doyle had entered the building at all, believing instead that Doyle inhaled smoke when the wind shifted while he was footing a ladder outside the building. Quinn "couldn't even venture a guess" as to how long before Doyle collapsed this occurred, and when asked which of the ladders Doyle was footing, Quinn testified "I don't know which ladder it was specifically." Quinn agreed the video shows two different people, one footing a ladder, the other at the front door without SCBA, immediately before Doyle's entry in the burning building.

Mulligan testified that while he was still on the scene of the March 2, 2016 fire packing up after the fire was under control, Murphy (Doyle's supervisor) told Mulligan that Doyle was taken to the hospital because "he got smoke inhalation…I think he went into the building real quick."

Doyle's hospital records state that he was admitted with carbon monoxide poisoning, elevated cardiac enzymes, acute kidney injury, and leukocytosis, and was transferred to the burn service. He was released from the hospital two days later, with the Discharge Problem listed as "Toxic Effect of Carbon Monoxide." The Diagnosis and Treatment Summary states that Doyle reported that he was inside the structural fire and exposed to smoke for approximately 20 minutes. De Vittorio, Quinn, and Cervi testified that would have been impossible. De Vittorio and Cervi testified it might have been possible to stay in the fire for, at most, three to four minutes. De Vittorio testified that when he visited the hospital, he heard Doyle brag to a nurse that he was inside the burning building without an air pack for over 20 minutes.

Doyle recounted what occurred at the fire when Veneable interviewed him on March 31, 2016 in the presence of Village manager Steers, HR specialist Brancati and the Village Attorney. According to Veneable's testimony and interview notes, Doyle stated that a PCFD member "instructed me to bring the hose inside the house. I was not wearing an SCBA. I stepped several feet inside the house for less than 30 seconds before I was overcome by heavy smoke."

At the hearing, Quinn twice agreed that the video showed him make a gesture toward the burning building immediately before Doyle entered it:

> "Mr. Li: Chief, at about 13:15, is it fair that you made some kind of gesture with your right-hand towards the building?
> Mr. Quinn: Yeah….
> Mr. Li: That person who just crossed in front of you, do they have SCBA on?
> Mr. Quinn: No….
> Mr. Li: Can you tell if that person entered the building now?
> Mr. Quinn: Most certainly did.
> Hon. Grumet: And that person didn't have SCBA?
> Mr. Quinn: No, ma'am….
> Mr. Li: …I just want to put on the record that you made a gesture. Is that correct?

> Mr. Quinn: That's correct....
> Mr. Li: Chief...can you tell us, we've paused it at 13:55, it looks like somebody just came out of the building and rushed back by your right shoulder and your head turned. Do you know who that is?...
> Mr. Quinn: Now I know who that is, probably Firefighter Doyle."

Quinn testified that during the fire, however, he never saw Doyle enter or emerge from the house, never saw any firefighter enter the house without SCBA, and if he had seen this, "would have yelled at him to come out, stop what you're doing." Veneable testified that during his April 18, 2016 telephone call with Doyle, Doyle stated that he was not reprimanded for entering the burning building without SCBA.

Virella testified that he had also seen Doyle enter an IDLH atmosphere without SCBA about a month before March 2, 2016, during an alarm at Holy Rosary Church. Virella, Local 1971 president Lyons, Doyle and another firefighter were the first to arrive at the scene. Doyle went into the building before the situation was assessed carrying a hook and wearing only a jacket and pants, but no SCBA or a helmet. Lyons asked Doyle if he was interior certified, Doyle answered no, Lyons asked why he was in the building, and Doyle just shrugged and continued to search the first floor. Lyons reported Doyle's unauthorized presence in the building without SCBA to second assistant chief Casterella, the commanding officer during that alarm.

NOV Citation 1 Item 4

NOV Citation 1 Item 4 states that the Village violated 29 CFR 1910.156 (c) (2) in that "[t]raining and education was not conducted frequently enough to assure that each fire brigade member was able to perform the assigned duties and functions satisfactorily and in a safe manner so as not to endanger fire brigade members." More specifically, the citation states that the Village "did not conduct training and education frequently enough prior to allowing an employee to unsafely vent the side of a fire structure . . . that resulted in an electrical shock to the employee. Training records provided by the employer indicate that Mr. Perez ha[d] not received firefighting training since March 24, 2015." The citation was to be abated by August 24, 2016. 29 CFR 1910.156 (c) (2) provides that "[a]ll fire brigade members shall be provided with training at least annually . . . fire brigade members who are expected to perform interior structural fire fighting shall be provided with an education session or training at least quarterly."

Veneable confirmed that Citation 1 Item 4 related solely to Perez, explaining that while an interior firefighter must be trained at a minimum on a quarterly basis, "it was almost two years since the last time we were able to establish that he received any kind of formal training." Perez testified that his most recent formal training prior to the March 2, 2016 fire was at the beginning of 2016. Training records for Perez from the PESH investigative file (introduced as a joint exhibit) showed training for Perez on April 30, 2015 (annual OSHA training - 8 hours); June 14, 2015 (hose line ops./pump ops. – 2.5 hours); October 11, 2015 (bail-out training – 4 hours); January 27, 2016 (annual OSHA refresher – 8 hours). Veneable testified he had no reason to doubt Perez received this training but he did not receive Perez's training records before issuance of the citation.

According to Veneable, he requested training records for all fire fighters during the March 25, 2016 meeting at Village Hall. He testified that he did not know when he received the training records, but his "best guess" was early April 2016. The "Case Contact Sheet" includes an April 1,

2016 entry, "Rec'd documents from C. Steer re: training." Veneable testified that when he reviewed these training records, he was unable to find quarterly training records for Perez, so he believes, but is not certain, that he verbally requested Perez's individual training records. Veneable could not remember when he made this request and had no documentation to indicate that he specifically requested Perez's training records; the Case Contact Sheet has no record of when he requested or when he received Perez's training records, which he agreed he received at some point because they were in the investigative file.

NOV Citation 1 Item 5

NOV Citation 1 Item 5 states that the Village violated 29 CFR 1910.156 (f) (1) (i), which requires "that respirators are provided to, and used by, each fire brigade member, and that the respirators meet the requirements of 29 CFR 1910.134 for each employee required by this section to use a respirator." The violation states that "[a]t the house fire . . . on March 2, 2016, five (5) fire brigade members were observed conducting interior firefighting activities without the use of SCBA respirators." The violation was to be abated by July 13, 2016.

Besides Doyle, other firefighters also entered the burning building without SCBA. Watching the video at the hearing, Quinn agreed it shows several firefighters doing so. Witnesses testified that in the past, other firefighters, particularly Murphy, had entered burning buildings without SCBA. Moreira testified that Murphy told her that he knew he was supposed to don SCBA "but because he was a superior officer, nobody would do anything about it."

Virella testified that in his 14 years as a firefighter, he never witnessed Murphy wearing SCBA and that he also witnessed other "old-timers" entering IDLH atmospheres without SCBA. "Old-timers meaning guys that've been – they pretty much call themselves 'smoke eaters,' meaning that they didn't feel they needed SCBA because they were volunteers before SCBAs were even part of the department." Iarocci testified that before March 2016 he saw Murphy without SCBA in IDLH conditions (for example, at the unventilated rear of a theater where breathing was difficult after a child discharged a fire extinguisher), including with chiefs and officers present.

Cervi testified he entered the structure without a respirator because he noticed a kinked hose line going through the front door, so he went in for two to three minutes to unkink the hose, then came out. Cervi admitted that he could have taken a respirator from his engine but did not, even though policy required wearing respirators in the building. This was not the first time he entered a structure without a respirator, something not prohibited when he began serving as a firefighter 39 years ago. Cervi testified he did so numerous times before the prohibition was instituted, which Cervi believes was in the mid-1980s; 30 or 40 times since then; in the last ten years maybe four times; and in the last five years maybe twice. Cervi stated he knows of no discipline to himself or other firefighters for entering a building without SCBAs until he received a written reprimand five or six months after the March 2, 2016 fire.

Quinn testified he is aware of members who repeatedly entered structures without SCBAs and while procedure would be to suspend someone who did so after being warned, Quinn has never disciplined a firefighter for not donning SCBA although he has issued written discipline for other violations. Quinn verbally admonished firefighters for not donning SCBA maybe once or twice. The only firefighter Quinn specifically recalls admonishing is Murphy, who was verbally admonished for failure to wear SCBA more than twice, and it is "accurate to say that as an old-

timer firefighter, Murphy has a propensity to avoid wearing an SCBA while entering a fire." According to Quinn, inexperienced firefighters should be properly supervised, but since Murphy is a company captain (at the time of the fire, a lieutenant, but acting as a captain at the fire[4]), it is up to him to do so. Quinn testified that lieutenants are junior grade officers and are considered supervisory personnel, and that during the fire Murphy was directly responsible for supervising Doyle. Quinn testified that he never disciplined a firefighter in their supervisory role for not properly disciplining a subordinate.

Petitioner issued written disciplinary warnings to Murphy, Cervi and Doyle for entering an IDLH atmosphere without SCBA at the March 2, 2016 fire after Moreira's September 6, 2016 memorandum recommended that they be disciplined. Quinn testified that he was not involved in the discipline of these three firefighters, and only found out from a Village official that they were issued counseling memos.

NOV Citation 2

The NOV's Citation 2, which has one item with three subdivisions, states that the Village violated Department of Labor Regulations (12 NYCRR) § 801.29 (a) in that it "did not use SH 900, SH 900.1, and SH 900.2, or equivalent forms, and associated instructions, for recordable injuries and illnesses." Department of Labor Regulations (12 NYCRR) § 801.29 (a) states that employers "must use SH 900, SH 900.1, and SH 900.2 forms, or equivalent forms, and associated instructions, for recordable injuries and illnesses. The SH 900 form is called the Log of Work-Related Injuries and Illnesses, the SH 900.1 is the Annual Summary of Work-Related Injuries and Illnesses, and the SH 900.2 form is called the Injury and Illness Incident Report.

Respondent's post-hearing brief "concedes that the Petitioner has evidenced substantial compliance in completing the OSHA 300 Form with regard to the injury sustained by Firefighter Brendan Doyle," which concerns the NOV Citation 2 Item (a).

NOV Citation 2 Item 1(b)

Citation 2, Item 1 (b) found that the petitioner violated Department of Labor Regulations (12 NYCRR) § 801.29 (a) because "the 2016 Log did not have a complete description (description of injury or illness, and part of body affected)" for Perez. The Log stated, "electric shock."

The log referred to is an OSHA form (Form 300) which Veneable testified is an acceptable equivalent for the log contained in the SH 900 form. Column F of the OSHA Form 300 is headed: "Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)." Brancati testified he completes the log, filling it in as injuries come to him for annual submission to PESH. All injury reports sent to the Village's human resources department went to Brancati, who looked through them to make sure he had the information needed for the log. Through early March, the 2016 Log listed injuries to ten Village employees unconnected to the PCFD and six firefighters: Quinn on 1/23 ("possible fracture of wrist from fall down stairs"); firefighters on 2/5 ("hit on head pulling out window frame") and 2/8 ("injury to back while participating in drill"); and at the March 2, 2016 fire, firefighters Doyle ("smoke inhalation"), Perez ("electrical shock") and Lawrence

[4] Engine 61 captain, Louis Marino, arrived at the fire after Doyle was taken to the hospital.

Miano ("right thumb contusion"). Veneable testified that the log was deficient with respect to Doyle and Perez because it did not name a body part or identify how their injuries occurred, and that Citation 2 Item 1 (b) was issued because the log "was lacking the appropriate information" concerning Perez.

A March 4, 2016 "Employee Injury Report" of Perez's injury, prepared by Quinn and signed by Perez, stated: "While stripping away exterior siding from house during working fire using axe, contacted live electrical line inside wall being opened." The injury report does not name which of Perez's body parts was injured. Brancati testified that the Form 300 log was updated after PESH issued the NOV in June 2016 to specify that the body part affected was the entire body.

NOV Citation 2 Item 1(c)

Citation 2 Item 1(c) states: "The supplemental C-2 form (equivalent to the SH 900.2 form), provided by the employer was inaccurate as to how B. Doyle suffered from smoke inhalation. The Port Chester Village Fire Department official record regarding the causal circumstances resulting in the employee injury were not consistent with the facts . . ." The C-2 form is a form of the Public Employer Risk Management Association, Inc. (hereinafter "PERMA"), identified on the form as a provider of workers compensation for public entities. Veneable testified that the C-2 form is often used in place of the SH 900.2 form mentioned in Department of Labor Regulations (12 NYCRR) § 801.29 (a), and the Village did not present PESH with any other equivalent form. The C-2 form pertaining to Doyle gave the following accident/injury description: "while footing a ladder at fire, wind changed and pushed the significant amount of smoke being generated by fire." Brancati testified that Kathy DiMattio (hereinafter "DiMattio"), a senior office assistant in the Village police department, prepares C-2 forms based on information from employee injury reports.

Quinn testified that the employee injury report form used to prepare the C-2 form was Village-generated and that he brought employee injury reports to DiMattio at the Police Department so she could complete and file C-2 forms. On March 4, 2016, Doyle went to Quinn's office to sign the Village-generated employee injury report form, which included an Employee Statement, a Supervisor's Report Form, and a Witness Statement. Doyle's signed Employee Statement, witnessed by Quinn and in Quinn's handwriting, declared under the printed words "I was injured in the following manner: While footing a ground ladder on the 'A' side exterior the wind shifted & pushed smoke from the fire into my area, where I inhaled it." A box was checked indicating that Doyle had no knowledge of any witnesses to the incident other than those listed on the employee injury report.

Quinn filled out the Supervisor's Report Form. In response to the question, "Did you look for witnesses & interview same?" Quinn checked yes, gave the date of the search as Wednesday, March 2, 2016 at 1400 hrs (the date and time of Doyle's hospitalization), and listed himself, but no one else, as a witness. In response to the questions "Was anything done in an unsafe manner?" and "Was anything defective, in unsafe condition, or wrong with method?" Quinn checked no. He checked yes to the question "Was employee wearing issued/required protective?" and in response to a line below that question stating "Explain" wrote: "full PPE[5], no SCBA." In response to the question "What recommendation would you make to prevent a similar situation in the future?" Quinn replied: "As Prob FF Doyle is not rated for interior work he was assigned to outside duties,

[5] "PPE" is an abbreviation for Personal Protective Equipment.

which includes setting & footing ground ladders. This requires PPE, but not SCBA." Quinn's Witness Statement, which he certified was a true and accurate account of what he witnessed, stated:

> "While footing a ground ladder the wind shifted and as I was also in the immediate area, was engulfed in a significant amount of smoke. Prob. FF Doyle inhaled an unknown amount & became ill. He was taken to EMS, which was already on scene, and then transported to the County Medical Ctr."

Quinn testified that he fills out injury reports for firefighters because if they do it themselves, he gets the form back a day later from the police department complaining that the handwriting is illegible, requiring firefighters to return and either rewrite it or cross things out. Quinn testified that Doyle reviewed the report, which he "absolutely" gave Doyle ample opportunity to review before signing and signed it without objection or pressure from Quinn. At one point Quinn testified that he wrote the Employee Statement before presenting it to Doyle, at another point, he testified that the report was completed in Doyle's presence as Quinn asked Doyle for an explanation of how his injury occurred.

Veneable testified that Quinn told him that he had filled out the forms in advance and presented them to Doyle to sign, and that Doyle told him that Quinn filled out the form, that Doyle did not review it and that he merely signed it at Quinn's request. Moreira's memorandum states that Quinn told her that he filled out the forms prior to meeting with Doyle and that he told Doyle to review the forms and sign if they were accurate.

In addition to the C-2 form, the employee incident report on which the C-2 form was based, and the OSHA 300 Log, petitioner filed an incident report on March 25, 2016, with the Office of Fire Prevention and Control, which is part of the New York State Department of Homeland Security. Quinn testified that an incident report is prepared "every time we roll, so even if it's a cat up a tree" and is not used to improve employee safety. Quinn stated he reviews drafts for correctness and uses them to train the drafters. For this fire, the incident report was drafted by Virella, the first time he did this for a structure fire. A draft Virella prepared on March 3, 2016, the day after the fire, stated he and Iarocci "were the first members to enter the structure. Two members... were not able to make entry due to not having their SCBA pack on. One volunteer member collapse[d] on the street and was taken by EMS to Greenwich Hospital."

In a memorandum Quinn testified he wrote on March 6, 2016, Quinn objected to Virella's making it sound as if a hospitalized firefighter was one of the two that tried to enter the structure and stated that Doyle was hurt outside footing a ladder. Quinn testified he sent Virella comments rather than make changes himself to help Virella learn, but senior paid firefighters advised Virella not to make the changes. Virella testified he sought feedback from others because he thought a report's drafter is responsible for its accuracy, he knew Doyle tried to enter the building, and he believed Doyle's smoke inhalation did not occur while footing a ladder. As finally filed on March 25, 2016, the incident report states that "E-58 members" (not Virella and Iarocci specifically) were the first to enter the structure and "Two members of E-61 were not able to make entry due to not having their SCBA pack on. One volunteer member collapse[d] on the street do [sic] to the smoke he inhaled at the front door." There is no mention of a ladder or of hospitalization.

Veneable's June 16, 2016 investigation narrative stated that when Veneable interviewed Doyle, he stated that he did assist with footing a ladder shortly after his arrival on the scene but the injury happened when he entered the house without wearing SCBA, as stated in Virella's draft. According to the narrative, Doyle stated that when he came to the firehouse at Quinn's request to sign the incident report, it "had already been completely filled out when he arrived at Chief Quinn's office. [Doyle] was not involved in filling out any part of the report other than signing it. He signed the report without reading it because Chief Quinn told him to sign it." Veneable testified that Doyle stated that although Quinn told him to read the report before signing, Doyle did not. Veneable testified that when he interviewed Quinn on March 31, 2016, Quinn confirmed that he wanted Virella to change the incident report, stated he did not observe any PCFD member at the fire enter the house without SCBA, and said that he observed Doyle sustain his injury as a result of footing a ladder.

Quinn testified that during and immediately after the fire he did not know that Doyle had entered the building at all, believing instead that Doyle inhaled smoke when the wind shifted while he was footing a ladder outside the building. Quinn "couldn't even venture a guess" as to how long before Doyle collapsed this occurred, and when asked which of the ladders Doyle was footing, Quinn testified "I don't know which ladder it was specifically."

STANDARD OF REVIEW

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," and any objections not raised shall be deemed waived (*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]).

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.

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 (*Matter of Goldstein v N.Y. State Indus. Bd. of Appeals*, 292 AD2d 706, 706 [3d Dept 2002]; *Hartnett v N.Y. City Tr. Auth.*, 86 NY2d 438, 442 [1995]).

As required under the PESH Act, Labor Law § 27-a (4) (a), DOL has adopted the federal OSHA standards, including the General Industry Standards found in Part 1910 (29 CFR 1910). DOL has also adopted and publishes a Field Operations Manual (FOM) for its PESH program, which sets forth DOL's policies and procedures regarding conducting inspections, issuance of violations and other PESH activities.

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 . . . ."

Matter of Hartnett v Village of Ballston Spa (152 AD2d 83, 84-86 [3d Dept 1989]), held that volunteer firefighters are included within the PESH Act's definition of "employees" and noted that New York's plan codified in PESHA "adopted all OSHA standards (Labor Law § 27-a [4]), including the Federal fire brigade standard." The PESH Act required the Village to provide reasonable and adequate protection to its fire department members' lives and safety, including but not limited to compliance with relevant New York regulations such as Department of Labor Regulations (12 NYCRR) § 801.29 (a) and OSHA regulations such as 29 CFR 1910.134, which governs respiratory protection, and 29 CFR 1910.156, which governs fire brigades.

The Board has held pursuant to Labor Law § 27-a (6) (a) (requiring that an order to comply describe particularly the nature of the violation) that a citation, supplemented by "other factors such as the Narrative" accompanying the citation, must "inform the employer of the standard violated and provide some indication of the facts constituting the violation" (*Matter of NYC Dept. of Transportation*, Docket No. PES 06-004, at p. 11 [Dec. 17, 2008]; *cf. Natl. Realty & Constr. Co. v OSHA*, 489 F2d 1257, 1264 [DC Cir 1973]). Labor Law § 27-a (6) (a) defines a serious PESHA violation as one involving "a substantial probability that death or serious physical harm could result from... practices... in use... unless the employer did not know, and could not, with the exercise of reasonable diligence, know of the presence of the violation." A non-serious violation is defined as "any violation that does not fall under the definition of serious violation."

The NOV in the present case identified all items in Citation 1 as serious violations, and in Citation 2 as non-serious violations.

NOV Citation 1 Item 1 Is Affirmed

The NOV Citation 1 Item 1 was issued on June 16, 2016 and found that the Village violated 29 CFR 1910.134 (c) (1) by failing to maintain a written respiratory protection program. The "Case Contact Sheet" indicates that on May 3, 2016, Veneable requested that Brancati provide PESH with petitioner's respiratory protection policy. Veneable followed up with a phone call to Brancati to discuss the respiratory protection program on May 11, 2016 and made a second request for the policy on June 10, 2016. Petitioner admitted in the petition that "the SOGs were produced to PESH on June 30, 2016" which was two weeks after the issuance of the NOV. Veneable testified that Citation 1 Item 1 was issued because the petitioner's respiratory procedure program was not provided at the time of the issuance of the NOV, and that even had it been submitted on a timely basis, it did not meet the threshold for a compliant program.

At the hearing, De Vittorio could point to no specific provisions in the SOGs for procedures for regularly evaluating the effectiveness of the respiratory procedure program or for the proper use of respirators in routine and reasonably foreseeable emergency situations. The 2008 SOGs provided to PESH on June 30, 2016 failed to meet three requirements of 29 CFR 1910.134 (c) (1): procedures for selecting respirators for use in the workplace; procedures for proper use of respirators in routine and reasonably foreseeable emergency situations; and procedures for regularly evaluating the effectiveness of the program. Despite this, De Vittorio testified that the 2008 SOG remains the current edition and is in still in the process of revision. We find that the NOV Citation 1 Item 1 is reasonable and valid and we affirm this citation.

NOV Citation 1 Item 2 Is Affirmed

The NOV Citation 1 Item 2 found that the Village violated 29 CFR 1910.134 (g) (3) (ii) by failing to ensure maintenance of visual, voice or signal line communication between firefighters inside the IDLH atmosphere and employees outside the IDLH atmosphere.

As stated in the OSHA Respiratory Protection Final Rule, 63 FR 1152, 1242 (1998) pertaining to 29 CFR 1910.134 (g) (3) (ii):

> "The margin for error in IDLH atmospheres is slight or nonexistent because an equipment malfunction or employee mistake can, without warning, expose the employee to an atmosphere incapable of supporting human life. Such exposure may disable the employee from exiting the atmosphere without help and require an immediate rescue if the employee's life is to be saved."

Quinn testified that interior and exterior communication is maintained using radios: "All units have a set number of radios. All firefighters are told to grab a radio as you're getting off. If it comes down to a firefighter, our officers have a radio. The officer will have the radio because he's the commanding officer of that team and they will radio in and out what's going on." De Vittorio also testified that PCFD policy was to use radios to establish voice communication and that all firefighters entering the structure were to work on a team with at least one radio.

Quinn testified that when firefighters without a radio needed to exit the structure that they should alert their superior officer, who should have a radio, and check back with them again upon their return. Quinn testified that a firefighter without a radio may not be able to find their team leader "as soon as they walk through the door," but would be able to do so.

Several of petitioner's witnesses testified that there was limited visibility because the fire was especially smoky. Virella testified that "it was pitch black, we couldn't see anything." De Vittorio also testified that smoke in the house was so dense that he had to rely on "feeling and hearing." It is undisputed that individual members of the PCFD are seen in the video entering and exiting the structure alone during the fire.

We find that that it was reasonable for respondent to determine that petitioner failed to implement a system that *ensured communication at all times* between those inside the IDLH atmosphere and those outside the IDLH atmosphere as required by 29 CFR 1910.134 (g) (3) (ii). Both Quinn and De Vittorio testified that firefighters who did not themselves have radios "would have to go to one of the firefighters with a radio" to maintain communication with firefighters outside the IDLH atmosphere. The record also reflects that the PCFD did not maintain accountability of individual members entering and exiting the structure alone. Quinn also acknowledged that a firefighter without a radio may not be able to find their team leader "as soon as they walk through the door." There is no other information in the record showing the existence of a system that would ensure communication at all times between those in the IDLH atmosphere and those outside the IDLH atmosphere.

Petitioner's post-hearing brief argued that Citation 1 Item 2 was unreasonable because a different subsection of 29 CFR 1910.134 (g), the "two-in, two-out rule" (29 CFR 1910.134 [g] [4] [i] and [ii]), was more specifically applicable than 29 CFR 1910.134 (g) (3) (ii), and therefore should have been cited in the latter's stead pursuant to Labor Law § 27-a (6) (a)'s requirement that NOVs "describe particularly the nature of the violation including a reference to the provision ... alleged to have been violated." The "two-in, two-out rule" requires that at least two employees inside an IDLH atmosphere must "remain in visual or voice contact with one another" and at least another two must be outside the IDLH atmosphere. We find, based on the record, that while PESH could also have also determined that petitioner violated the "two-in, two-out rule," it was reasonable and valid to cite a violation of 29 CFR 1910.134 (g) (3) (ii) as PESH did.

Veneable testified that PESH chose to cite the violation of 29 CFR 1910.134 (g) (3) (ii) instead of the two-in, two out rule (29 CFR 1910.134 [g] [4] [i] and [ii]) because of the heavy smoke conditions and the video evidence showing firefighters entering the structure alone. He further testified that his reference to the "two in, two out" rule was his attempt to describe a method of maintaining contact, "[i]f you're having two people going, you're able to maintain better contact with someone else, so that's just a reference. I'm not saying that we have to use the two-in, two-out standard." It was reasonable and valid for PESH to determine that petitioner violated 29 CFR 1910.134 (g) (3) (ii) because any firefighter without a radio who may have exited or entered the structure alone would be out of communication until that firefighter located another firefighter with a radio, a circumstance which Quinn testified would occur.

That respondent did not identify specific firefighters who lost communication also does not make the citation for failing to ensure communication invalid or unreasonable. 29 CFR 1910.134 (g) (3) (ii) requires that the village ensure communication at all times between those

inside the IDLH atmosphere and those outside the IDLH atmosphere. The combination of the conditions posed by this specific fire, the lack of accountability regarding firefighters entering and exiting the structure as described by Quinn and De Vittorio, and the video evidence of firefighters entering and exiting the structure alone is sufficient to support respondent's determination. Thus, we affirm this citation.

NOV Citation 1 Items 3 and 5 Are Affirmed

The NOV Citation 1 Items 3 and 5 both relate to firefighters' entry into an IDLH atmosphere without SCBA. Item 3 states that the Village violated 29 CFR 1910.156 [c] [1], which requires adequate training and education before fire brigade members perform fire emergency services, by allowing an employee without adequate training to enter a burning house. Item 5 states that the Village violated 29 CFR 1910.156 [f] [1] in that "five (5) fire brigade members were observed conducting interior firefighting activities without the use of SCBA respirators." At the hearing, it was undisputed that official PCFD policy was that only "interior firefighters" certified after receiving respiratory training were to enter structures with IDLH conditions, and then only while wearing SCBAs, yet undisputed testimonial and video evidence also showed that Doyle, who was not trained as an interior firefighter, entered the burning structure without SCBA, and admitted doing so to both Veneable and Moreira.

According to Virella, a month before the March 2, 2016 fire, Doyle also entered an IDLH atmosphere without SCBA at a church, wearing only bunker pants and his jacket when he entered the church holding a hook. Virella testified that Doyle refused to leave when Virella told him that he should not be in the building. Union president Lyons brought Doyle's failure to wear SCBA inside the church to Casterella's attention; there was no evidence rebutting this or indicating that petitioner took any disciplinary action against Doyle for his earlier entry without SCBA.

At least two senior firefighters at the March 2, 2016 fire (Murphy and Cervi) also entered without SCBA. Cervi, who was also acting company captain at the fire, admitted that he entered the burning structure without SCBA and testified that he has violated the decades-old rule against entering IDLH atmospheres without SCBA on at least two other occasions in the past five years without previously being disciplined for it. This testimony was supported by Moreira's testimony, that Murphy admitted to Moreira that he never put on an SCBA at any time during the fire. Moreira testified that Murphy told her that he knew he was supposed to don SCBA "but because he was a superior officer, nobody would do anything about it."

The Board and court in *Matter of Village of Tarrytown* (Docket No. PES 11-003, at p. 11 [February 6, 2013] *affd* 124 AD3d 788, 789 [2d Dept 2015]), found a violation where "little or no effort was made to effectively communicate" a proper policy with the result that although the policy restricted employees from entering confined spaces, a practice of doing so existed. Federal OSHA precedent similarly holds that an adequate written rule is insufficient if not effectively communicated and enforced (*see, e.g.*, *Hamilton Fixture*, 1993 OSAHRC LEXIS 53, *62, *affd*, 28 F3d 1213 [6th Cir 1994]). Furthermore, if supervisors — such as Murphy and Cervi in the present case — not only fail to enforce but personally flout safety rules, that in itself "permits an inference that the employer's safety program has not been adequately enforced" (*D.A. Collins Constr. Co. v Secretary of Labor*, 117 F3d 691, 695 [2d Cir 1997] citing *Brock v L.E. Myers Co., High Voltage Div.*, 818 F2d 1270, 1277 [6th Cir 1987]; *see also Natl. Realty & Constr.*, 489 F2d at 1267 n 38). Quinn's own testimony, including that he was aware of members who repeatedly entered structures

without SCBAs but never disciplined them in accordance with department procedure, establishes that he knew department policy was often not observed yet he took no action to prevent it.

The petition in the present proceeding alleged that Doyle and any other "firefighter who performed interior firefighting activities ... without a suitable SCBA respirator did so without knowledge or direction of any supervisor and thus such conduct would constitute employee misconduct." Unpreventable or unforeseeable employee misconduct is an affirmative defense to an OSHA citation, requiring "the employer to show that it: (1) created a work rule to prevent the violation at issue; (2) adequately communicated that rule to its employees; (3) took all reasonable steps to discover noncompliance; and (4) enforced the rule against employees when violations were discovered;" the doctrine is "ultimately 'bottomed' on fairness" and the need to avoid liability for "an isolated incident of unforeseeable or idiosyncratic behavior" (*Comtran Group v U.S. DOL*, 722 F3d 1304, 1308, 1316-1317, quoting *N.Y. State Elec. & Gas. Corp.*, 88 F3d at 106-107; *D.A. Collins*, 117 F3d at 695; *see also Nat'l Realty*, 489 F2d at 1266 [impossible to eliminate risk of "demented, suicidal, or willfully reckless employee.... Congress intended to require elimination only of preventable hazards"]). Where, however, "supervisory personnel permitted untrained employees" to work "in a setting which presented maximum peril and was devoid of rudimentary safety equipment," risk of death or physical harm was known to the employer and was not a case of unexpected employee conduct (*REA Express, Inc. v Brennan*, 495 F2d 822, 826 [2d Cir 1974]).

Quinn testified he is aware of members who repeatedly entered structures without SCBAs, never disciplined a firefighter for not donning SCBA and only verbally admonished firefighters for not donning SCBA maybe once or twice but took no further action. Despite the fact that Quinn knew Murphy had a propensity to avoid wearing an SCBA while entering a fire, he did nothing to check that propensity and allowed him to continue supervising probationary fire fighters. With respect to Doyle, the unrebutted evidence is that Union president Lyons brought Doyle's presence inside the church to Casterella's attention. There is no evidence that petitioner took any disciplinary action for this violation of department policy. In fact, the first time the Village ever disciplined anyone for violating the policy was following Moreira's investigation and recommendation, months after the March 2, 2016 fire and after the PESHA violations were issued. The evidence shows that firefighters were permitted, on multiple occasions, to enter IDLH atmospheres without SCBA. Cervi admitted doing so during the March 2, 2016 fire and the video evidence also shows other unidentified firefighters, either trained or untrained, entering the structure without SCBA.

We find it was valid and reasonable for respondent to determine that there was a serious violation of the PESH Act because petitioner failed to meet its obligation to take feasible steps to prevent untrained firefighters from entering IDLH atmospheres without SCBA, as well as its obligation to prevent all firefighters from entering IDLH atmospheres without SCBA. We affirm Citation 1 Item 3 and Citation 1 Item 5.

NOV Citation 1 Item 4 Is Revoked

The NOV Citation 1 Item 4 found that the Village violated 29 CFR 1910.156 (c) (2), which requires quarterly training for interior firefighters, in that there was insufficient training to prevent Perez's electrical shock. Veneable testified that this citation was issued because "it was almost two years since the last time we were able to establish that [Perez] received any kind of formal training." Yet Perez testified his most recent formal training before the March 2, 2016 fire was

around the turn of 2016, and the training record which Veneable confirmed was part of the investigative record shows training for Perez on April 30, 2015, June 14, 2015, October 11, 2015, and January 27, 2016. Veneable testified that after the petitioner supplied training records for all firefighters, he reviewed them and was unable to find training records for Perez. He believed, but was not certain, that he made a second request specifically for Perez's training records, but he cannot remember when the request was made and has no record of the request. He admitted that he did receive Perez's training records at some point, because they were in the PESH investigative file.

Based on the evidence presented at the hearing, this citation was not reasonable or valid and we revoke it.

NOV Citation 2

PESHA compels the Commissioner to "prescribe regulations requiring employers to maintain accurate records and to make public periodic reports of work-related deaths, and injuries and illnesses other than minor injuries requiring only first aid treatment and do not involve lost time from work, medical treatment..." (Labor Law § 27-a [9] [b]). Department of Labor Regulations (12 NYCRR) § 801.29, requires employers to use specific forms, SH 900, SH 900.1, and SH 900.2, or equivalent forms and follow the instructions for the SH 900, SH 900.1 and SH 900.2 to report on injuries and illnesses. The petitioner did not enter into the record any SH 900, SH 901, or SH 902 forms, nor did petitioner prove that such forms were maintained but petitioner, and instead, used other forms. The record indicates that PCFD was cited in the NOV Citation 2 Items 1(a) and (b) for maintaining an incomplete "OSHA 300 Log of Work Related Injuries and Illnesses," which was used in lieu of the SH 900 Log. The record also indicates that the supplemental C-2 form (equivalent to the SH 900.2 form) provided by the employer was not consistent with the facts revealed during the investigation.

NOV Citation 2 Item 1(a) is Revoked

Respondent, in its post-hearing brief, conceded that the petitioner evidenced substantial compliance in completing the OSHA 300 form with regard to the injury sustained by Doyle, and asserted that petitioner was in violation of only two of the three counts of Department of Labor Regulations (12 NYCRR) § 801.29 (a). Accordingly, we revoke the NOV Citation 2, Item 1(a).

NOV Citation 2 Item 1(b) is Affirmed

The NOV Citation 2 Item 1(b) found that the Village violated Department of Labor Regulations (12 NYCRR) § 801.29 (a) because the 2016 Log did not contain a complete description of Perez's injury and body part affected. The parties entered into the record as a joint exhibit a 2016 "OSHA Form 300 Log of Work Related Injuries and Illnesses," which petitioner apparently used in lieu of the SH 900 form. This log described Perez's injury as "electric shock," even though the OSHA 300 form and the SH 900 form both require a description of the injury, the parts of the body affected, and the object/substance that directly injured the person "e.g. Second degree burns on right forearm from acetylene torch." Other entries in the Log for petitioner's employees, such as "hit on head pulling out window frame" gave more detail. We do not believe it was unreasonable or invalid for PESH to conclude that the Log required information more detailed than "electric shock."

At the hearing, Brancati testified that to abate the violation after the issuance of the NOV, petitioner filed a revised log, stating that electrical shock affects the entire body. However, in light of the purposes mentioned in Labor Law § 27-a (9) (a) especially "developing information regarding the causes and prevention of occupational accidents," we find it was reasonable and valid to require a description of what injured Perez more enlightening and specific than "electric shock." Requiring an adequately detailed description was especially reasonable since Brancati testified that unlike C-2 forms, which had to be completed quickly, the log of injuries is submitted yearly, leaving time to obtain complete information.

Petitioner's post-hearing brief argued that a "technical violation" in completing the log would be de minimis since "there is little, if any, correlation between the alleged violation and employee safety...[u]nder such circumstances, there is no basis to impose an abatement requirement or assess a penalty." We disagree. The precedents petitioner cites applied an OSHA provision, 29 USC § 658 [a], that authorizes "notice in lieu of citation for de minimis violations" and has no PESH Act equivalent. More fundamentally, the NOV properly characterized Citation 2 as a non-serious violation, that is, one not involving substantial probability of death or serious harm. This does not mean there was no connection to developing information regarding the causes and prevention of occupational injuries (*see* Labor Law § 27-a [9] [a], quoted above). Omission of relevant information was not just a "technical violation," and requiring abatement was reasonable and valid. As for penalty assessment, PESH Act penalties become payable pursuant to Department of Labor Regulations (12 NYCRR) § 830.3 only if an employer fails to abate a violation. Veneable testified that this is one of the significant differences between OSHA and PESHA. Brancati's testimony that petitioner abated this violation as directed in the NOV was undisputed, so no penalty had to be paid.

NOV Citation 2 Item 1(c) Is Affirmed

The NOV Citation 2 Item 1(c) found that the

> "C-2 form (equivalent to the SH 900.2 form) provided by the employer was inaccurate as to how B. Doyle suffered from smoke inhalation. The Port Chester Village Fire Department official record regarding the causal circumstances resulting in the employee injury were not consistent with the facts revealed during the inspection, based on witness interviews and a video recording of the event resulting in injury."

Labor Law § 27-a (9) (b), the PESHA provision authorizing respondent's record-keeping requirements including Department of Labor Regulations (12 NYCRR) § 801.29 (a), calls for "accurate records." The C-2 form which petitioner filed to obtain workers' compensation for Doyle, (as discussed below, we find the C-2 form to be the equivalent of the SH 900.2 form) stated that Doyle's injury occurred "while footing a ladder" when the "wind changed," rather than (as shown by testimony, the video recording, and witness interviews conducted during both the DOL's and Moreira's investigations) when Doyle entered a burning building without SCBA or adequate training. In view of this significant contradiction between the facts stated in the C-2 form and what actually occurred, it was clearly reasonable and valid for PESH to find the C-2 form and the PCFD official record regarding the causal circumstances resulting in Doyle's injury inconsistent with the facts.

Not only was the C-2 form's summary of how Doyle suffered smoke inhalation and the causal circumstances resulting in his injury inaccurate, the more detailed employee injury report form used in accordance with Village practice to generate the C-2 form also had inaccuracies contradicted by undisputed testimony at the hearing. For example, both the Employee Statement signed by Doyle but prepared by Quinn and the Supervisor's Report Form prepared and signed by Quinn were misleading with regard to witnesses. A checked box on the Employee Statement indicated Doyle knew of no witnesses, and the Supervisor's Report Form, while claiming Quinn looked for and interviewed witnesses, listed none other than Quinn himself. There were several firefighters, including Doyle's supervisor, Murphy, who Quinn could have listed. Moreover, while Quinn portrayed himself in the witness statement as actually observing Doyle footing a ladder at the exact moment his injury occurred, Quinn testified that he did not witness Doyle being overcome by smoke and "couldn't even venture a guess" as to how long before Doyle collapsed that he actually observed Doyle footing a ladder nor could Quinn identify which ladder Doyle was footing at the fire prior to collapsing. We do not find Quinn's testimony that Doyle was injured while footing a ladder credible.

Quinn gave conflicting accounts of how the Employee Injury Report was presented to Doyle, first testifying that he filled it out in advance and presented it to Doyle for review, then claiming that he asked Doyle questions and filled the report out in response to Doyle's replies. Quinn testified that did not remember by whom or when he was told that Doyle told medical professionals he was in the burning building for 20 minutes; he did not remember what De Vittorio told him when De Vittorio called Quinn from Westchester Medical Center. Moreover, petitioner failed to call as witnesses both Doyle and his supervisor, Murphy.

Other material inaccuracies in the Supervisor's Report Form on which the C-2 form was based and which formed part of the PCFD record of the causes of Doyle's injury include Quinn's checking of "no" boxes in response to the questions "Was anything done in an unsafe manner?" and "Was anything defective, in unsafe condition, or wrong with method?," and a "yes" box for the question "Was employee wearing issued/required protective?" Quinn qualified the latter answer by stating that Doyle had "full PPE, no SCBA" and "was assigned to outside duties, which includes setting & footing ground ladders," but Doyle, in practice, clearly did not restrict himself and was not restricted by the PFCD "to outside duties." While the C-2 form seeking workers' compensation benefits for Doyle and therefore the Village-generated employee injury report on which it was based had to be prepared quickly, evidence indicated that even if he somehow failed to notice Doyle enter or emerge from the burning building on March 2, 2016, Quinn should have been attuned to that possibility.

De Vittorio visited Doyle at the hospital on March 2, 2016 and overheard him tell a nurse that he was in the burning structure for 20 minutes. Quinn himself visited Doyle at the hospital the evening of the fire and recalled speaking to De Vittorio while at the hospital. Many of petitioner's witnesses testified that immediately after the fire, there were rumors that Doyle was injured after he entered the burning building. Even if Quinn somehow remained unaware when Doyle was hospitalized that Doyle's injury was the result of his entry into a burning building without SCBA, not a wind change while he footed a ladder outside, Quinn should have made inquiries as to how Doyle sustained his injuries by March 4, 2016, when he filled out the Supervisor's Report asserting that he looked for witnesses and interviewed them. Neither the C-2 form nor Quinn's Supervisor's Report Form was later corrected, as they could have been, when their inaccuracy should again have come to Quinn's attention.

While the C-2 form is a workers' compensation rather than a PESH form, Veneable testified it is often used in place of the SH 900.2 (Injury and Illness Incident Report) form mentioned in Department of Labor Regulations (12 NYCRR) § 801.29 (a), which permits use of "equivalent forms." Veneable testified that "if you're using it as an equivalent to our SH 900.2," the C-2 form must be accurate. The SH 900.2 form, available on the DOL website,[6] states that it is "used with the Log of Work-Related Injuries and Illnesses [the SH 900 form also referred to in Department of Labor Regulations (12 NYCRR) § 801.29 (a), for which the OSHA 300 form discussed earlier is an equivalent] to help the employer and PESH develop a picture of the extent and severity of work-related incidents" and that "[s]ome state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form." The SH 900.2 form asks, among other things, "14) What was the employee doing just before the injury occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific . . . 15) What happened? Tell us how the injury occurred. *Examples*: 'When ladder slipped on wet floor, worker fell 20 feet . . .'" Petitioner did not contend it used the SH 900.2 form or some other equivalent in addition to the C-2 workers' compensation form, as Department of Labor Regulations (12 NYCRR) § 801.29 (a) would have permitted; on the contrary, both Brancati and Quinn testified the Village police department prepares and files C-2 forms based on Village-generated employee injury reports, in this case, the one which Quinn filled out and had Doyle sign on March 4, 2016.

In light of all the evidence, including the essentially undisputed inaccuracy of the C-2 form with respect to what caused Doyle's hospitalization and evidence that Quinn knew or should have known of that inaccuracy when completing both the Employee Statement and Supervisor's Report Forms on which the C-2 form, consistent with Village practice, was based, we find it was valid and reasonable for the DOL to issue Citation 2 item 1(c).) because petitioner violated the duty imposed by Labor Law § 27-a and Department of Labor Regulations (12 NYCRR) § 801.29 (a) to file "accurate records," including an accurate SH 900.2 form or an equivalent.[7]

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[6] https://www.labor.ny.gov/workerprotection/safetyhealth/pdfs/pesh/sh900_2.pdf. The Board takes administrative notice of the form's contents.

[7] As already discussed in connection with Citation 2 Item 1(b), this citation was for a non-serious violation, that is, one not involving substantial probability of death or serious harm, and resulted in an order of abatement without a monetary penalty.

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The Notice of Violation and Order to Comply with respect to Citation 1 Item 4 and Citation 2 Item 1(a) is revoked; and

2. The Notice of Violation and Order to Comply with respect to Citation 1 Items 1, 2, 3 and 5 and Citation 2 Items 1(b) and (c) is affirmed; and

3. The petition for review be, and it hereby is, denied in part and granted in part.

Dated and signed by the Members
of the Industrial Board of Appeals
on December 11, 2019.

Molly Doherty, Chairperson
New York, New York

Michael A. Arcuri, Member
Utica, New York

Gloribelle J. Perez, Member
New York, New York

Patricia Kakalec, Member
New York, New York

Najah Farley, Member
New York, New York

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