

A Public Records Access request has been submitted.

Request By: Christopher Tompkins

Signature: Christopher Tompkins

Request date: 06/08/2016

Address: 225 Broadway Suite 700, New York, NY 10007

Email: AttyChrisTompkins@gmail.com

Phone  
number: 212-962-5363

Personal  
Information Request: NO

Records  
seeking:

For the period of May 31, 2009 to June 1, 2014, concerning the public sidewalk located between W. 178th Street near the intersection with Cabrini Boulevard on the south side of W. 178th Street and the south pedestrian walkway ramp of the George Washington Bridge, please provide copies of Inspection Reports, Accident reports, Permits, and Work Orders pertaining to construction, alteration, renovation or repair, Records of any verbal or written complaints or notifications of any defective conditions in the sidewalk, Records containing the names and addresses of any individuals having notified Port Authority of having sustained an accident involving a trip and fall and/or slip and fall on the sidewalk, Records containing the names and addresses of any individuals having notified Port Authority of having sustained an accident involving a trip and fall and/or slip and fall and Notices of violations issued by any New York City government agency concerning the sidewalk.

THE PORT AUTHORITY OF NEW YORK AND NEW JERSEY  
PUBLIC RECORD ACCESS FORM

PRA #16995

Action by (print / type name):

William Shalewitz

, Freedom of Information Administrator

Signature:



Date:

08/16/2016

On behalf of the Secretary of the Port Authority, as Records Access Officer and Custodian of Government Records of the Port Authority.

- The requested records are being made available.
- Any responsive records that may exist are currently in storage or archived, and a diligent search is being conducted. The Port Authority will respond by:
- A diligent search has been conducted, and no records responsive to your request have been located.
- The requested records that have been located are not being made available, as they are exempt from disclosure for the following specific reasons:

- Some requested records that have been located are being made available. The remainder are exempt from disclosure for the following specific reasons:

- The request does not reasonably describe or identify specific records; therefore, the Port Authority is unable to search for and locate responsive records. Please consider submitting a new request that describes or identifies the specific records requested with particularity and detail.

- Other:

Material responsive to your request can be found on the Port Authority's website at <http://corpinfo.panynj.gov/documents/16995-O/>. Exemptions applied for personal privacy. We have searched our files and found no records responsive to the remainder of the request.

This form is promulgated by the Port Authority pursuant to the Port Authority Public Records Access Policy and is intended to be construed consistent with the New York Freedom of Information Law and the New Jersey Open Public Records Act. It is intended to facilitate requests for Port Authority public records and does not constitute legal advice.

<b>PATRON ACCIDENT OR PROPERTY DAMAGE REPORT</b> (Other than Vehicles or P.A. Employees) <b>CONFIDENTIAL REPORT TO MANAGER,</b> <b>CLAIMS ADMINISTRATION</b>				<input checked="" type="checkbox"/> N.Y. <input type="checkbox"/> N.J.	<input checked="" type="checkbox"/> PATRON ACCIDENT	<input type="checkbox"/> PROPERTY DAMAGE	(1-4)
FACILITY <b>QWB</b>	EXACT LOCATION OF ACCIDENT: (WHEN HELPFUL, ATTACH A DIAGRAM TO THIS FORM ONLY, ON PLAIN PAPER) <b>SIDEWALK ENTRANCE TO SOUTH WALKWAY ON 178 ST AND CABRINI</b>					MAINT. W.O. NO.	
ACCIDENT DATE <b>05/31/14</b>	DAY OF WEEK <b>SATURDAY</b>	TIME <b>0930</b>	TO WHOM REPORTED? <b>PO ESPINOZA</b>	DATE REPORTED <b>05/31/14</b>	TIME <b>2240</b>	OTHER JOB NO. <b>146-08</b>	
FULL NAME <b>GLORIA M. LOZANO</b>		ADDRESS (HOME)		HOME PHONE #	BUSINESS PHONE #	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	AGE <b>45</b>
OCCUPATION <b>TECHNICAL DESIGN DIRECTOR</b>		NAME & ADDRESS OF EMPLOYER <b>LFUSA / OXFORD CORRECTION</b> <b>1359 BROADWAY N.Y. 10018</b>					
<input type="checkbox"/> STATIONARY STAIRS <input type="checkbox"/> MOTOR STAIRS	GOING <input type="checkbox"/> UP <input type="checkbox"/> DOWN	GETTING <input type="checkbox"/> ON <input type="checkbox"/> OFF	RIDING <input type="checkbox"/>	MOTOR STAIR STOPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO	STAIR NO.	BY WHOM	HOW LONG AFTER FALL
TIME RESTARTED	<input type="checkbox"/> AM <input type="checkbox"/> PM	RESTARTED BY			STATIONARY STAIR #	INJURED WAS GOING <input type="checkbox"/> UP <input type="checkbox"/> DOWN	
CONDITION OF AREA <b>DRY / CLEAR</b>							
MEDICAL DATA	<input type="checkbox"/> NO TREATMENT		<input type="checkbox"/> FIRST AID AT SCENE BY:			IF RENDERED FIRST AID ELSEWHERE, STATE WHERE, BY WHOM AND NAMES OF THOSE PRESENT	
	AMBULANCE CALLED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		IF YES, TIME CALLED <input type="checkbox"/> AM <input type="checkbox"/> PM		ARRIVED <input type="checkbox"/> AM <input type="checkbox"/> PM		
	NAME AND CITY OF HOSPITAL INJURED TAKEN TO (IF ANY)						
	DOCTOR'S NAME AND ADDRESS <b>DR. MICHAEL A. STEIN, HOLY NAME HOSPITAL TEANECK NJ</b>						
PROPERTY DAMAGE	NATURE AND EXTENT OF INJURY (INCLUDE PART INJURED)						
	ITEM(S) DAMAGED AND DESCRIPTION OF DAMAGE						
DID YOU WITNESS ACCIDENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YES, DESCRIBE FULLY. IN ANY EVENT, TELL WHAT THE INJURED AND/OR WITNESS(S) SAID. GIVE THE EXACT STATEMENT IN PERSON'S OWN WORDS, IDENTIFYING INDIVIDUAL(S) MAKING STATEMENT, TO WHOM STATEMENT WAS MADE, AND IN WHOSE PRESENCE:					
SUBJECT STATED " I WAS WITH MY COUSIN, WE STARTED TO JOG AND THE NEXT THING I KNOW I WAS ON THE GROUND. THE FALL KNOCKED THE WIND OUT OF ME. I FELL DUE TO THE BROKEN / CRACKED SIDEWALK. "							
SUBJECT ALSO STATED THAT IT HAPPENED AT 0930 IN THE MORNING AND THAT SOMEBODY GAVE HER A RIDE TO HOLY NAME HOSPITAL IN TEANECK N.J.							

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NAMES OF ADDITIONAL WITNESSES MAY BE INCLUDED IN AVAILABLE SPACE OR ON AN ADDITIONAL SHEET

WITNESS NO. 1	FULL NAME AND ADDRESS <b>JUAN LOZANO</b> [REDACTED]				
	PHONE NO. [REDACTED]	RELATIONSHIP TO INJURED <b>COUSIN</b>	ACCOMPANIED INJURED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	WORK AT FACILITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	P.A. EMPLOYEE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
WITNESS NO. 2	FULL NAME AND ADDRESS				
	PHONE NO.	RELATIONSHIP TO INJURED	ACCOMPANIED INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WORK AT FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	P.A. EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO
TOTAL P.A. DAMAGE	<input checked="" type="checkbox"/> NONE <input type="checkbox"/> \$100 OR LESS <input type="checkbox"/> OVER \$100		SIGNATURE OF PERSON REPORTING ACCIDENT <b>POD. E. [REDACTED] # 2014</b>		DATE <b>5/31/14</b>
<b>COMPLETE THIS SECTION ONLY IF CASES OF ACTUAL OR PROBABLY PERSONAL INJURY</b>					
WHO REPORTED ACCIDENT? <b>GLORIA M. LOZANO</b>		DID INJURED WEAR GLASSES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		TYPE OF GLASSES <input type="checkbox"/> BI-FOCAL <input type="checkbox"/> TINTED GLASSES <input type="checkbox"/> OTHER:	
WHO ASSISTED INJURED OFF STAIRS OR POINT WHERE FOUND? <b>HER COUSIN</b>					
HOW WERE YOU CALLED TO SCENE? <input checked="" type="checkbox"/> PHONE <input type="checkbox"/> PUBLIC ADDRESS <input type="checkbox"/> OTHER:					
WHAT WAS YOUR POST ASSIGNMENT? <b>31</b>					
OTHER P.A. PERSONNEL AT SCENE: NAMES & TITLES <b>NONE</b>					
WHERE DID YOU FIRST SEE INJURED? IN WHICH POSITION? <b>SITTING ON A CHAIR IN THE BUS STATION</b>					
DID YOU ATTEMPT TO GET IDENTITY OF WITNESS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			WEATHER CONDITIONS? <input type="checkbox"/> WET <input checked="" type="checkbox"/> DRY <input type="checkbox"/> SNOWING <input type="checkbox"/> RAINING		
ANY APPARENT DISABILITY OTHER THEN FROM FALL? <b>NONE</b>					
WHAT DID INJURED ALLEGE CAUSED FALL? <b>CRAZY / BROKEN SIDEWALK</b>					
KIND OF SHOES WORN BY INJURED <input type="checkbox"/> HIGH HEELS <input type="checkbox"/> MEDIUM HEELS <input type="checkbox"/> FLAT HEELS <input type="checkbox"/> GALOSHES <input checked="" type="checkbox"/> OTHER: <b>RUNNING SNEAKERS</b>					
WHAT DID INJURED CARRY? <b>A SMALL TOWEL IN THE LEFT HAND AND CELL PHONE IN THE RIGHT HAND.</b>					
WAS INJURED TRAVELING ALONE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		IF NO, WHO ACCOMPANIED? <b>JUAN LOZANO</b>			
ANY EVIDENCE OF ALCOHOL? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, DESCRIBE: <span style="float: right;"><input type="checkbox"/> SPEECH <input type="checkbox"/> ODOR <input type="checkbox"/> GAIT <input type="checkbox"/> OTHER:</span>					
IF TAKEN TO FIRST AID, HOW? <input checked="" type="checkbox"/> WALKING <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> STRETCHER <input type="checkbox"/> OTHER:					
HOW DEPARTED FROM FIRST AID? <input type="checkbox"/> WALKING <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> STRETCHER <input type="checkbox"/> OTHER:					
WAS INJURED FAMILIAR WITH TERMINAL? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN <input checked="" type="checkbox"/> DOES NOT APPLY			WAS INJURED USING HANDRAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input checked="" type="checkbox"/> DOES NOT APPLY		
DID CITY POLICE RESPOND? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IDENTIFY: <b>PAPD</b>					
<b>TO BE COMPLETED BY SUPERVISOR</b>			<b>IF THE FOLLOWING SECTION CANNOT BE COMPLETED IMMEDIATELY, FORWARD THIS REPORT AS IS, AND WHEN THIS INFORMATION IS OBTAINED IT SHOULD BE FORWARDED AS A SUPPLEMENT TO THE REPORT.</b>		
PERSONNEL ASSIGNED TO AREA			AREA LAST CLEANED BY B.A. <span style="float: right;"><input type="checkbox"/> AM <input type="checkbox"/> PM</span>		
INSPECTED MOTOR STAIRS, STATIONARY STAIRS AT <span style="float: right;"><input type="checkbox"/> AM <input type="checkbox"/> PM</span>			HOW?		
CONDITION			SIGNATURE OF B.A.		
LAST COATING OF AREA (IF APPLICABLE)			AREA LAST INSPECTED BY B.A. <span style="float: right;"><input type="checkbox"/> AM <input type="checkbox"/> PM</span>		
SIGNATURE			CONDITION		
DATE		SIGNATURE OF PERSON MAKING INSPECTION		DATE	
<b>INSTRUCTIONS</b>					
1. PRINT IN BLACK INK.			5. FORWARD THIS FORM TO MANAGER, CLAIMS ADMINISTRATION.		
2. IDENTIFY ALL WITNESSES.			6. IF P.A. PROPERTY IS DAMAGED, PREPARE MAINTENANCE WORK ORDER FORM PA 2302. WRITE "ACCIDENT DAMAGE" IN DESCRIPTION OF JOB. ALSO INDICATE M.W.O. NUMBER IN APPROPRIATE BOX ON REVERSE SIDE OF THIS FORM.		
3. CHECK ALL APPROPRIATE BOXES.					
4. SUBMIT PROMPTLY ADDITIONAL INFORMATION, AS AVAILABLE, TO MANAGER, CLAIMS ADMINISTRATION.					



(SEE INSTRUCTIONS)

NAMES OF ADDITIONAL WITNESSES MAY BE INCLUDED IN AVAILABLE SPACE OR ON AN ADDITIONAL SHEET

Witness No. 1	Full Name and Address								
	Phone No.	Relationship to Injured	Accompanied Injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work at Facility	<input type="checkbox"/> Yes <input type="checkbox"/> No	P.A. Employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Witness No. 2	Full Name and Address								
	Phone No.	Relationship to Injured	Accompanied Injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work at Facility	<input type="checkbox"/> Yes <input type="checkbox"/> No	P.A. Employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Total P.A. Damage	<input checked="" type="checkbox"/> None <input type="checkbox"/> \$ 100 or less <input type="checkbox"/> Over \$ 100		Signature of Person Reporting Accident <i>P.O. Sullivan #2239</i>				Date <i>7 16 12/11</i>		
<b>COMPLETE THIS SECTION ONLY IN CASES OF ACTUAL OR PROBABLY PERSONAL INJURY</b>									
Who Reported Accident? Subject			Did Injured Wear Glasses <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Type of Glasses <input type="checkbox"/> Bi-Focal <input type="checkbox"/> Tinted Glasses <input checked="" type="checkbox"/> Other: Sun Glasses				
Who Assisted Injured Off Stairs or Point Where Found?									
How Were You Called To Scene? <input type="checkbox"/> Phone <input type="checkbox"/> Public Address <input checked="" type="checkbox"/> Other: <i>Passing Patron</i>									
What Was Your Post Assignment? <i>Post 31</i>									
Other P.A. Personnel At Scene: Names & Titles <i>Post 31A</i>									
Where Did You First See Injured? In Which Position? <i>Sitting on sidewalk leaning against metal gate on the GWB/BS</i>									
Did You Attempt To Get Identity of Witness? <input type="checkbox"/> Yes <input type="checkbox"/> No			Weather Conditions <input type="checkbox"/> Wet <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Snowing <input type="checkbox"/> Raining						
Any Apparent Disability Other Than From Fall? <i>No</i>									
What Did Injured Allege Caused Fall? <i>Rubber gasket separating sidewalk</i>									
Kind Of Shoes Worn By Injured: <input type="checkbox"/> High Heels <input type="checkbox"/> Medium Heels <input checked="" type="checkbox"/> Flat Heels <input type="checkbox"/> Galoshes <input type="checkbox"/> Other:									
What Did Injured Carry? <i>Small bag</i>									
Was Injured Traveling Alone? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, Who Accompanied?									
Any Evidence of Alcohol? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Describe: <input type="checkbox"/> Speech <input type="checkbox"/> Odor <input type="checkbox"/> Gait <input type="checkbox"/> Other:									
If Taken to First Aid, How? <input type="checkbox"/> Walking <input type="checkbox"/> Wheel Chair <input checked="" type="checkbox"/> Stretcher <input type="checkbox"/> Other:									
How Departed From First Aid? <input type="checkbox"/> Walking <input type="checkbox"/> Wheel Chair <input checked="" type="checkbox"/> Stretcher <input type="checkbox"/> Other:									
Was Injured Familiar With Terminal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Does Not Apply			Was Injured Using Handrail? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Does Not Apply						
Did City Police Respond? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Identify:									
<b>To Be Completed By Supervisor</b>				If the following section cannot be completed immediately, forward this report as is, and when this information is obtained it should be forwarded as a supplement to the report.					
Personnel Assigned to Area				Area Last Cleaned by B.A. <input type="checkbox"/> am At <input type="checkbox"/> pm					
Inspected Motor Stairs, Stationary Stairs At <input type="checkbox"/> am <input type="checkbox"/> pm				How?					
Condition				Signature of B.A.					
				Area Last Inspected by B.A. <input type="checkbox"/> am At <input type="checkbox"/> pm					
Last Coating of Area (If Applicable)				Condition					
Signature			Date		Signature of Person Making Inspection			Date	
<b>INSTRUCTIONS</b>									
1. Print in Black Ink				5. Forward this form to Manager, Claims Administration					
2. Identify all witnesses				6. If P.A. Property is damaged, prepare Maintenance Work Order Form PA 2302. Write "Accident Damage" in description of job. Also indicate M.W.O. number in appropriate box on reverse side of this form.					
3. Check all appropriate boxes									
4. Submit promptly additional information, as available, to Manager, Claims Administration.									