A **63 year old female** employee died as a result of complications due to the COVID-19 virus. It was determined that during the second and third week of July 2020, six of the 15 employees working in the Mountain View at 153 call center, as well as the company's CEO, became ill with COVID-19.

The facility is a three room office space where employees field call for the company's car service centers. Employees continually answer phone calls throughout the day and schedule service activities for callers.

On 6/20, two employees who were friends outside of the office left for a vacation at the beach. The employees returned to work on 6/29. During the week of Monday 6/29 through Friday 7/3, six employees who would eventually test positive all worked in the office together. On Friday 7/3, a roommate of one of the employees who went on vacation (who does not work at Mtn View at 153) reported that she was having COVID-19 symptoms. On 7/7 it was found that the roommate tested positive. The employee who was her roommate was sent home that day for testing and on 7/10 informed her supervisor that she had tested positive also. On 7/8, the CEO of the company visited the facility briefly.

Since all six employees had worked closely with the victim who tested positive, and then the CEO was exposed to those employees, the office was closed for all employees including the CEO to be tested.

On 7/11, the victim began to have symptoms. All employees aside from the victim either returned to work after completing quarantine or moved to "work from home status" and did not return to the office.

On 7/22, the victim was transported by ambulance to the Memorial Hospital COVID-19 unit due to acute hypoxic respiratory failure. She was initially stable but her condition began to deteriorate after a cardiac event on 7/28. The victim passed away on 8/1/2020. The diagnosis at discharge is described on the discharge summary as hypoxic respiratory failure complicated by multi-organ system failure because of SARS-CoV-2/COVID-19 viral pneumonia.

Employees reported that social distancing was practiced during breaks. Employees were on staggered lunch schedules and took their time off-site or in their cars. The employer also attempted to allow for social distancing by rearranging the workstations in the call-center. Workstations were spaced out and organized so employees were not face-to-face with one another. Despite this effort, a review of the employer's seating plan reveals that it would be nearly impossible for employees to maintain 6ft of distance between each other while in the office. A review of the room A floor plan shows that three employees all would have to pass within at least 3 feet of others'desks to access a restroom, exit, or door to an adjacent room. A review of the room B floor plan shows that anyone accessing the back two desks, or the exit out of the facility in this room would have to pass through the seven foot wide gap between meaning social distancing of six feet between all employees would be impossible. No desks were equipped with barriers, and employees were not required to wear face coverings until July 10th, after the spread of the illness in the office. Additionally, employee interviews revealed that employees of the call center frequently went to the supervisor's office to ask questions.

Although employees reported that sometimes they would just stand at the door, the meetings could have contributed to employees moving about the office and coming into close contact with other employees.

The employer also initially made attempts to limit the number of people working in the office. As recommended by the CDC, the employer identified employees who were at risk for severe illness and offered to allow them to work from home. The employer, however, failed to provide the internet access needed for employees to work from home. The victim was offered the option to work from home but was unable to do so because she did not have WiFi.

Although the employer followed certain CDC guidelines for preventing the spread of COVID-19 in the workplace, and made an effort to ensure the safety of employees, the employer failed to fully implement some key CDC guidelines for preventing the spread of COVID-19 in the workplace. These failures contributed to the spread of the virus throughout the office.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1 **Type of Violation: Serious** **$5400**

TCA 50-3-105(1): The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees:

In that employees worked in close proximity to each other and were exposed to SARS-CoV-2, the virus that causes the Coronavirus Disease 2019 (COVID-2019). The employer did not implement timely and effective engineering controls, administrative controls, work practice controls, and personal protective equipment controls to mitigate employee exposure to SARS-CoV-2. Between July 10, 2020 and July 22, 2020 six employees of the call center tested positive for SARS-CoV-2.

Citation 1 Item 2 **Type of Violation: Serious** **$5400**

29 CFR 1910.141(a)(3)(i): Places of employment were not kept clean to the extent that the nature of the work allowed.

The employer did not ensure that high-touch surfaces including but not limited to light switches, the shared copier, and door handles were disinfected regularly.

Citation 2 Item 1a **Type of Violation: Other-than-Serious** **$1500**

TDLWD Rule 0800-01-03-.05(1)(a)1: Within eight (8) hours after the death of any employee as a result of a work related incident, the employer did not report the fatality to the TOSHA Division of the Tennessee Department of Labor and Workforce Development.

The employer did not report the death of an employee who died on 8/1/2020 due to a COVID-19 infection that was contracted in the workplace until 08/06/2020.

Citation 2 Item 1b **Type of Violation: Other-than-Serious** **Grouped**

TDLWD Rule 0800-01-03-.05(1)(a)2: Within twenty-four (24) hours after the in-patient hospitalization of one or more employees or an employee's amputation or an employee's loss of an eye, as a result of a work-related incident, the employer did not report the in-patient hospitalization, amputation, or loss of an eye to TOSHA.

The employer did not report the hospitalization of an employee due to a work-related COVID-19 infection that occurred on 7/22/2020.

Citation 2 Item 2 **Type of Violation: Other-than-Serious** **$300**

TDLWD Rule 0800-01-03-.05(2)(b)2: Copies of records kept under 0800-1-3 requested by an authorized government representative were not provided within four (4) business hours.

The employer did not provide the following recordkeeping documents within four business hours of request by the Tennessee OSHA representative:

a) 300 and 300A forms for 2016 were requested on 8/6/2020 and received on 8/11/2020.
b) 300 and 300A forms for 2017 were requested on 8/6/2020 and received on 8/11/2020.

Citation 2 Item 3 **Type of Violation: Other-than-Serious** **$300**

TDLWD Rule 0800-01-03-.03(27)(b)1: The log of all recordable work-related injuries and illnesses (OSHA Form 300 or equivalent), was not completed in the detail as required by the rule.

The employer did not complete the 2020 300 Log in the required detail:

a) Column F did not accurately describe the illness and the object/substance directly related to the illness.
b) The date of illness onset was recorded as 8/6/2020, when the employee reported that they began to feel ill on 7/11/2020.
c) A work-related COVID-19 infection was recorded as an injury when it should have been classified as a respiratory illness.