

Two **male** employees (ages 27 & 42) were **electrocuted** when they came into contact with an overhead powerline while in the process of setting up a 28' tall shingle hoist for roofing a residential home. A third employee was shocked and admitted to the hospital.

The employer did not report the in-patient hospitalization of the surviving employee and did not report the fatalities to TOSHA within the required timeframes; therefore, the inspection took place about a month after the incident occurred.

The incident occurred on the first day of this project. The three victims were erecting a 28-foot tall TP250 TranzSporter powered shingle hoist to carry shingles to the roof when it was discovered by one of the employees that the hoist platform was on the wrong way. As the three employees moved the hoist away from the side of the roof to correct the problem, they inadvertently made contact with an overhead power line (12kV). The powerlines were approximately 12' away from the roof. As a result, the three employees received an electric shock.

Through a detailed investigation, it appears that the employer did not establish effective measures to prevent employee exposure to hazardous conditions in the workplace, such as, not posing any warning signs or advising of protective measures to be taken while erecting and/or dismantling the powered shingle hoist beneath or near overhead power lines.

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

\$600

29 CFR 1926.50(c): In the absence of an infirmary, clinic, hospital, or physician, that is reasonably accessible in terms of time and distance to the worksite, which is available for the treatment of injured employees, a person who has a valid certificate in first-aid training from the U.S. Bureau of Mines, the American Red Cross, or equivalent training that can be verified by documentary evidence, was not available at the worksite to render first aid.

In that there was no one at the jobsite, at all times while employees were working, trained to render first aid.

Citation 1 Item 2 **Type of Violation: Serious** **\$4,000**

29 CFR 1926.416(a)(1): Employee(s) were permitted to work in proximity to an electric power circuit that the employee could contact in the course of work and was not protected against electric shock by de-energizing the circuit and grounding it or by guarding it effectively by insulation or other means:

In that employees were allowed to work with the 28 ft shingle ladder hoist when working 12-15 ft from energized power lines, resulting in the fatal injuries of two employees and electrical burn injuries to another employee.

Citation 1 Item 3 **Type of Violation: Serious** **\$4,000**

29 CFR 1926.416(a)(3): Before work is begun the employer did not ascertain by inquiry or direct observation, or by instruments, whether any part of an energized electric power circuit, exposed or concealed, was so located that the performance of the work would bring any person, tool, or machine into physical or electrical contact with the electric power circuit. The employer did not post and maintain proper warning signs where such a circuit exists. The employer did not advise employees of the location of such lines, the hazards involved, and the protective measures to be taken.

In that:

- a. employees were not made aware of the energized power lines by posting warning signs, resulting in serious injuries to one employee and fatal injuries to two employees.
- b. employees had not been advised of protective measures to be taken while erecting and/or dismantling the powered shingle hoist beneath or near overhead power lines "such as but not limited to how far away to stay from the energized lines."

Citation 2 Item 1 **Type of Violation: Other-than-Serious** **\$1,000**

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.

In that two workplace fatalities were not reported to the Tennessee Department of Labor and Workforce Development (TOSHA) in the following instances:

- a. the fatality of an employee that occurred as a result of injuries sustained during an accident on 09/08/2020

b. the fatality of an employee that occurred on 09/25/2020 as a result of injuries sustained during an accident on 09/08/2020.

Citation 2 Item 2

Type of Violation: Other-than-Serious

\$200

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, you must report the in-patient hospitalization, amputation, or loss of an eye to TOSHA.

In that an employee was involved in an incident on 08SEP20 at approximately 1030 that resulted in an inpatient hospitalization. The employer did not notify TOSHA within 24 hours after the in-patient hospitalization occurred.



