A **39 year old female** contracted COVID-19 while working at a sleep study facility. The victim worked in the facility as Polysomnographic Tech which conducts onsite sleep studies to diagnose sleep disorders. The facility has eight patient rooms which are monitored with cameras and telemetry by a Polysomnographic Technician.

Patients arrive at the facility, are screened and fitted with sensors on the scalp, temples, chest and legs using an adhesive by the Technicians. Once fitted, the patients are directed to a bedroom where they will sleep for the night under the observation. The Technicians observe the patients from a small room, in close proximity of each other, at a long desk where four computer terminals are located.

Employee and employer interviews indicated that a combination of controls for the facility were not considered, evaluated, or installed to reduce exposure and close contact to coworkers. The facility's manager provided images of the Tech room where the deceased employee worked in the week prior to falling ill. There were no physical barriers installed in the small room where the employees were required to work for the largest portion of a 12-hour shift. Additionally, a second and larger tech room was available for use.

Employees were found to have shared used of a telephone, located in the Tech room, to contact patients to schedule and confirm\appointments. Additionally, employees were not provided with a separate dinning space or required to dine outside. Employees would dine together in the Tech room as there was no breakroom or alternative eating area in the facility.

TOSHA determined this fatality to be likely work-related. The employer was aware of employees working in close proximity to other employees without physical barriers or social distancing practices and had not considered adjusting workspaces per CDC recommendations at that time. An appropriate combination of control measures from the hierarchy of controls including engineering controls, social distancing practices, and effective screening procedures were not utilized by the employer.

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** **$4500**

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).

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The employer did not implement timely and effective engineering and work practice controls to ensure that employees at risk for COVID-19 infection were protected from frequent contact with other staff through the use of barriers, social distancing, and alternative workspaces.

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