A 57 year old male employee contracted COVID-19 while working as a machining supervior at a die shop. The employer designs, builds, or repairs speciality dies for customers.

The victim supervised the programming, running, and operation of machining centers in the Die Shop. He was potentially exposed to COVID-19 while working in close quarters with a coworker who tested positive approximately a week prior.

On September 3, 2021, a co-worker tested positive for COVID-19. Since the beginning of the pandemic, no positive tests had been documented at the facility. The employee did not return to work after testing positive. After the co-worker tested positive, 10 other employees, including the victim, tested positive for COVID-19 within a week of each other. The victim tested positive for COVID-19 on September 12, 2021, and was admitted to the hospital on September 15, 2021 and passed away on October 9, 2021,

According to interviews, employees were not required to wear masks, social distance, and sneeze guards were not in place to protect employees from COVID-19. Minimal disinfecting was taking place prior to the first employee testing positive for COVID-19 at the facility. Only two of the employees in the Die Shop were vaccinated. The victim was vaccinated on September 2, 2021.

Since the COVID-19 outbreak at the facility, the employer has provided soap, water, and hand sanitizers. The employer has also been providing Lysol Spray, Lysol Disinfecting Wipes, Great Value Disinfecting Wipes, and Scrubbing Bubbles which are all listed on the EPA N-List of approved disinfectants.

It was determined that the employer did not implement effective measures to prevent the spread of COVID-19 in the workplace prior to the outbreak of COVID. Deep cleaning and disinfecting of surfaces were not conducted in areas where confirmed cases of COVID-19 occurred. While employees could remain six feet apart while on the shop floor, partitions and sneeze guards were not placed at desks in the supervisor's office when social distancing was limited. Administrative controls, including rotating break and lunch schedules, were not implemented to prevent potential exposures. The number of employees accessing office space was not limited to ensure adequate distancing and isolation.

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 \$4,000

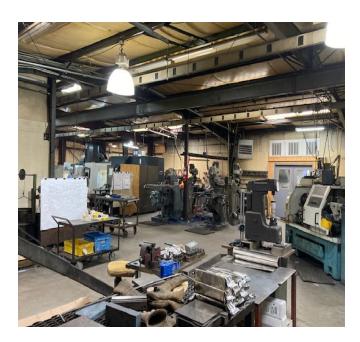
TCA 50-3-105(1): The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees, in that employees worked in close proximity to each other and were exposed to SARS-Co V-2, the virus 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-Co V-2. Between September 3, 2021 and September 13, 2021, eleven employees in the Die Shop tested positive for SARS-Co V-2.

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

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, door handles, and office equipment were disinfected regularly to reduce the risk of COVID-19 infection.



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