

REPORT#: 25KY032 REPORT DATE: 05/01/2026

DATE:

05/19/2025

TIME:

07:54 a.m.

VICTIM:

23-year-old white, non-Hispanic male

INDUSTRY/NAICS CODE:

Electrical Contractors & Other
Wiring Installation Contractors /
238210

EMPLOYER:

Commercial Electrician

SAFETY & TRAINING:

Formal safety program

SCENE:

Commercial

LOCATION:

Kentucky

EMPLOYER SIZE:

10 employees

EVENT TYPE:

Electrocution

Electrician Trainee Fatally Electrocuted at Commercial Job Site

SUMMARY

On May 19, 2025, a 23-year-old white, non-Hispanic electrician trainee (victim) was attempting to install new electrical wire in a commercial building renovation project. While doing so, the victim was electrocuted by an energized wire. As a result, the victim succumbed to the injuries he sustained. [Read Full Report>](#)

CONTRIBUTING FACTORS

Key contributing factors identified in this investigation include:

- Failure to isolate energy sources,
- Unqualified personnel performing work near an energized hazard,
- Distraction, and
- Supervision of unqualified workers. [Learn More>](#)

RECOMMENDATIONS

Kentucky investigators concluded that, to help prevent similar occurrences, employers should:

- Adhere to a formal energy control program, which includes lockout/tagout procedures,
- Implement a formal job hazard analysis program,
- train qualified and unqualified personnel on the unique hazards of each job site,
- Implement and enforce a cell phone-free work environment, and
- Develop formal guidelines and clear expectations for qualified employees overseeing unqualified personnel.

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INTRODUCTION

On May 19, 2025, a 23-year-old white, non-Hispanic electrician trainee (victim) arrived at the job site, a commercial office building renovation project (photo 1), at approximately 7:00 a.m. The victim's typical work week was Monday through Friday, 7:00 a.m. to 3:30 p.m. Being a trainee, the victim always worked alongside and under the direction of a licensed electrician. The licensed electrician met the victim at the job site.

As a part of the multi-day renovation project, the victim's job on the day the incident occurred was to install and route new wiring (type mc cable) for the troffer style light fixtures (photo 2) that were installed by the involved company just three days earlier, on May 16, 2025. Once the wiring was routed, the victim's job was to connect the new wire to the newly installed, unenergized lighting fixtures. To perform the task, the victim was required to work on a 6-foot fiberglass ladder to access the ceiling mounted light fixtures and utilize LED work lights and a head lamp to aid with visibility while performing work.

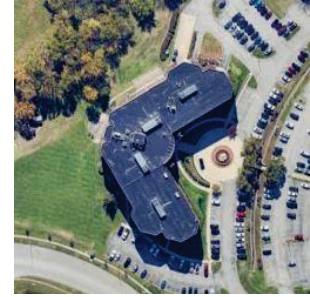


Photo 1: Google Earth photo of the commercial building where the incident occurred.

At approximately 7:54 a.m., 54 minutes after arriving on site, the victim proceeded to connect the new wire he just installed to the light fixtures, a job the victim had completed multiple times in the past, according to a company representative. The newly installed light fixtures and wiring were both de-energized, meaning no source of electricity was connected. While doing so, the victim, in error, accessed an energized lighting whip (photo 3) that was connected to existing lights. The lighting whip had wire nuts installed, covering the exposed energized wire, but no other energy isolation device was present. According to the company, the victim removed the insulating wire nuts without testing for voltage, touched the wires, and was electrocuted by the 277-volt energized wire. The victim fell from his ladder, approximately 3 feet to the concrete surface below (diagram 1). The supervising electrician, who was working in the same room but did not have a line of sight due to the "L" shape of the room, did not see the incident but heard the victim fall. Upon hearing the fall, the electrician rushed to the victim's aid and immediately called 911 to request an ambulance. The electrician performed cardiopulmonary resuscitation on the victim, who was unresponsive, until emergency medical services arrived. The victim was transported to a local metropolitan hospital, where he succumbed to his injuries.

According to the involved company, later that same day, a company employee returned to the job site to retrieve the victim's belongings. Initially, the employee was unable to locate the victim's cell phone. After looking throughout the job site, the employee used a ladder to check the ceiling area where the victim had been working when the incident occurred. The victim's cell phone was located on top of the light fixture where the electrocution occurred. According to the company, the phone had an unsent text message. The involved company states they believe the victim was using the phone to send text messages while working, which distracted the victim, resulting in the error that led to the electrocution and fatal injuries.



Photo 2: Troffer style lights in the incident. Photo obtained via open records request.

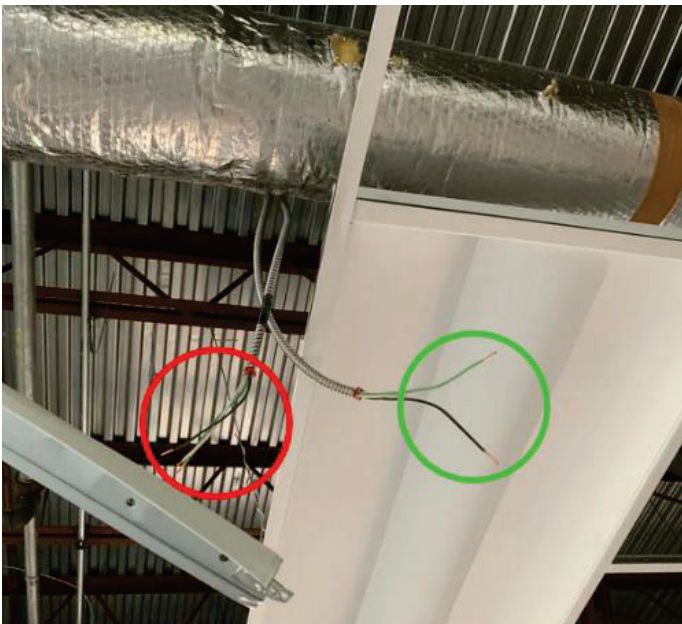
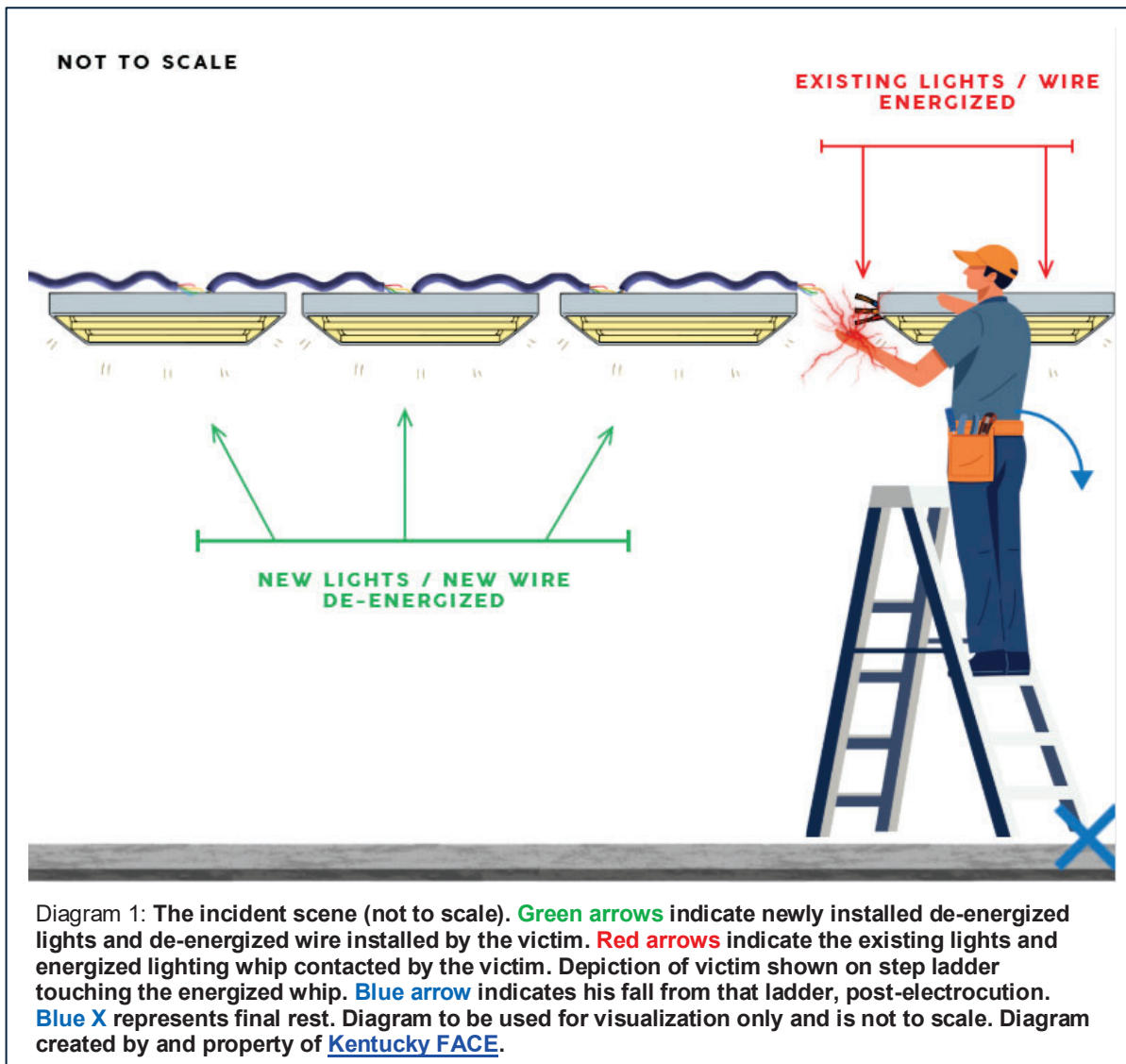


Photo 3: Unenergized wire (green circle) installed by the victim and energized wire contacted by the victim (red circle), which resulted in the fatal injuries. Photo obtained via open records request.



EMPLOYER

The employer is a privately held commercial electrical contractor. The company was established in 2002 and consists of 10 employees. The company specializes in commercial electrical renovation projects, installing new fixtures, rewire projects, panel upgrades, and electrical maintenance.

WRITTEN SAFETY PROGRAMS and TRAINING

- The employer has a written injury and illness prevention program in place. The company informed investigators that new employees are required to obtain their Occupational Safety and Health Administration (OSHA) 10 certification, which includes topics such as introduction to OSHA, workers' rights and responsibilities, walking and working surfaces, emergency action plans, fire prevention and exit routes, electrical safety, personal protective equipment, hazard communication, and introduction to bloodborne pathogens. The company also requires employees to complete a lockout/tagout safety course.

WORKER INFORMATION

- The victim was a 23-year-old white, non-Hispanic male. The decedent was a college graduate and had worked for the employer for 11 months as an electrician trainee. According to the employer, the victim was scheduled to attend an employer-sponsored electrician apprenticeship program. The comprehensive third-party program takes four years to complete; graduates earn their state-issued electrician license upon successful completion of the program. According to the company, the victim was a very intelligent and eager employee who showed great potential.
- Wage (response options to be circled/checked):
 - ☒ Hourly
 - ☐ Salary

SUPPLEMENTAL DEMOGRAPHIC INFORMATION

- Preferred language:
 - ☐ Interpretation services
- Race/ethnicity (response options to be circled/checked):
 - ☐ American Indian or Alaska Native
For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
 - ☐ Black or African American
For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
 - ☐ Hispanic or Latino
For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
 - ☐ Middle Eastern or North African
For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
 - ☐ Native Hawaiian or Pacific Islander
For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
 - ☒ White
For example, English, German, Irish, Italian, Polish, Scottish, etc.
 - ☐ Asian
For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
 - ☐ Other

INCIDENT SCENE

The incident occurred inside a 134,000-square-foot, four-story commercial office building (photo 4). The building, which was erected in 1989, is constructed of brick and hosts multiple business suites on each floor. The incident took place in a suite that was being renovated (photo 5). The victim and his supervisor were working within the same room; however they did not have a clear line of sight due to the L-shaped design of the room. The victim was working around a corner, on the shorter side of the L-shaped room, while the supervisor was on the opposite end completing a task when the incident occurred.



Photo 4. The building in which the incident occurred. Photo property of Kentucky FACE.



Photo 5: The scene of the incident. Photo obtained via open records request.

WEATHER

The weather on the day of the incident was approximately 62 degrees Fahrenheit, 70% humidity, with a 3-mph wind from the west. The weather is not believed to have been a factor in this incident.¹

CAUSE OF DEATH

According to the death certificate, the cause of death was electric shock.

CONTRIBUTING FACTORS

Workplace injuries and fatalities are often the result of one or more contributing factors or key events in a larger sequence of events that ultimately result in injury or fatality. Kentucky investigators identified the following unrecognized hazards as key contributing factors in this incident:

- Failure to isolate energy sources,
- Unqualified personnel performing work near an energized hazard,
- Distraction, and
- Supervision of unqualified workers.

RECOMMENDATIONS/DISCUSSION

Recommendation #1: Adhere to a formal energy control program, which includes lockout/tagout procedures.

Discussion: OSHA standard [29 CFR 1910.333](#) sets forth requirements to protect employees working on electric circuits and equipment. This section requires workers to use safe work practices, including lockout and tagging procedures. These provisions apply when employees are exposed to electrical hazards while working on, near, or with conductors or systems that use electric energy.²

In this incident, an unlicensed electrician trainee (victim), also referred to by OSHA as an “unqualified person” was working to install wiring for newly installed troffer style lights. The lights themselves were de-energized. However, a lighting whip that was connected to existing lights was energized, within the vicinity of the victim and controlled by a wall mounted switch. The victim, in error, removed a wire nut and made contact with the 277-volt energized wire.

A lockout/tagout program could be beneficial in removing the risk of electrical shock in similar scenarios. Even if lockout is not possible, a tagging system (photo 6) can warn employees of electrical shock risk, helping the employee mitigate the exposure.

The lockout/tagout [standard](#) establishes the employer’s responsibility to protect employees from hazardous energy sources. The standard gives each employer the flexibility to develop an energy control program suited to the needs of the particular jobsite. This is generally done by affixing the appropriate lockout or tagout devices to energy isolating devices, such as a guarded junction box on the energized wiring whip and/or a wall switch lockout device (photo 7), and by de-energizing machines and equipment. The standard outlines the steps required to do this. Additionally, [29 CFR 1910.147 App A](#) may be used as a guide by the employer to develop the minimum requirements necessary to develop procedures specific to the standard.²

Once the program is established, employees need to be trained to ensure that they know, understand, and follow the applicable provisions of the lockout/tagout procedure. The training must cover at least three areas: aspects of the employer’s energy control program, elements of the energy control procedure relevant to the employee’s duties or assignment, and the various requirements of the OSHA standards related to lockout/tagout.² The involved employer provided lockout/tagout training as required by its energy control

program; however, procedures were not followed or implemented at the job site. A wiring whip in the vicinity of the victim's work area, though protected with wire nuts, was not guarded and locked out, nor was the wall-mounted switch that controlled the flow of electricity to the whip de-energized or locked out at the time the incident occurred.

To help prevent similar incidents, Kentucky FACE investigators suggest that employers implement, train, and adhere to a formal energy-control program, which includes lockout/tagout procedures.



Recommendation #2: Implement a formal job hazard analysis program, train qualified and unqualified personnel on the unique hazards of each job site.

Discussion: One of the best ways to determine and establish proper work procedures is to conduct a job hazard analysis. A job hazard analysis is a technique that focuses on job tasks to identify hazards before they occur. It focuses on the relationship between the worker, the task, the tools, and the work environment. After uncontrolled hazards—in this case an energized wire within the vicinity where an unqualified employee would be performing work—are identified, steps are taken to eliminate or reduce them to an acceptable risk level.

When determining what jobs need a hazard analysis, OSHA recommends that the following are prioritized:

- Jobs with the highest injury or illness rates;
- Jobs with the potential to cause severe or disabling injuries or illness, even if there is no history of previous accidents;
- Jobs in which one simple human error could lead to a severe accident or injury;
- Jobs that are new to your operation or have undergone changes in processes and procedures; and
- Jobs complex enough to require written instructions.



When performing a job hazard analysis, ask:

- What can go wrong?
- What are the consequences?
- How could it happen?
- What are other contributing factors?

Supervisors can use the findings of a job hazard analysis to eliminate and prevent hazards in their workplaces and to train employees, both at time of hire and before beginning work at a new job site.³

Recommendation #3: Implement and enforce a cell phone-free work environment.

Discussion: According to the company involved, the victim was using a cell phone while working. Cell phone use on a job site may result in employee distraction. Distraction as it relates to cell phone usage is generally broken down into four primary categories:

1. Visual distraction: Taking your eyes off your surroundings to focus on your mobile device.
2. Manual distraction: Holding a cell phone, inhibiting your ability to react quickly.
3. Cognitive distraction: Loss of awareness due to focus on your phone.
4. Audible distraction: Sound produced by a cell phone that results in lack of attentiveness to your surroundings.

All four distraction types resulting from phone usage could inhibit an employee's ability to see, identify, or react to hazards on the job site. Implementing and enforcing a phone-free work environment may help reduce job injuries and fatalities by eliminating employee distraction.

Some elements of an effective phone-free work environment policy could include requiring phones to be powered off while work is being performed, stored in vehicles, placed in airplane mode, or relinquished to site supervisors until scheduled breaks. A policy can be uniquely designed to fit the needs of each employer and reduce the risk associated with job site distraction.

Kentucky FACE investigators suggest employers implement and enforce a cell phone-free work environment policy to prevent the recurrence of similar events.

Recommendation #4: Develop formal guidelines and clear expectations for qualified employees overseeing unqualified personnel.

Discussion: Guidelines set by OSHA and the [National Fire Protection Association \(NFPA\) 70E standards](#) outline the requirements for a qualified employee overseeing and/or supervising an unqualified employee. In this incident, a qualified employee was on site but not in direct contact with the unqualified employee.

A qualified person (licensed electrician) overseeing an unqualified person must provide direct, continuous supervision and ensure that the unqualified person never works on or near exposed energized parts. Key guidelines for the qualified person are outlined below:

- **Maintain direct supervision:** A qualified person must remain in direct, continuous sight and sound communication with the unqualified person. This is especially critical when the unqualified person is in a limited approach boundary—the area where a shock hazard exists.

- Provide specific training: The qualified person must ensure that the unqualified person has been trained on the electrical safety-related practices necessary for their job. This training, according to NFPA 70E, must be tailored to the specific risks the unqualified person faces.
- Prohibit energized work: Never allow an unqualified person to work on or test energized equipment operating at 50 volts or more.
- Define and enforce limited approach boundaries: The qualified person must clearly communicate and enforce the limited approach boundary. For systems from 50V to 750V, this is generally 42 inches (3.5 feet). The unqualified person must be kept outside this boundary unless escorted by the qualified person and properly protected.
- Implement physical barriers: If practical, install barricades or other protective measures to restrict unauthorized access to the work area.
- Conduct pre-job briefings: Before work begins, the qualified person must lead a job briefing to discuss the electrical hazards, work procedures, any special precautions, and necessary personal protective equipment.
- Monitor and correct unsafe acts: The supervisor is responsible for observing the unqualified person's work and taking immediate corrective action if unsafe practices are observed.
- Select proper safety equipment: The qualified person must ensure that all required safety measures are in place, such as grounding, insulation, and the use of appropriate tools and test instruments.
- Manage lockout/tagout: While an unqualified person may be an "affected employee" in a lockout/tagout procedure, only a qualified person can execute the procedure. A qualified person must perform all energy-control tasks, such as verifying equipment is de-energized and cannot be restarted.

Guidelines for the unqualified person are as follows:

- Receive safety training: Unqualified personnel must receive training to recognize and avoid the electrical hazards relevant to their work.
- Follow safety procedures: Always follow the safe work practices and procedures established by the employer and communicated by the qualified supervisor.
- Respect approach boundaries: Never cross into a limited or restricted approach boundary without explicit permission and supervision from the qualified person.
- Report unsafe conditions: Immediately report any damaged electrical equipment, faulty wiring, or other potential electrical hazards to the supervisor.
- Never work on energized parts: Do not attempt to perform work, troubleshoot, or make repairs on any exposed energized electrical components.
- Know your limitations: An unqualified person may be capable of performing some electrical-related tasks, such as resetting a circuit breaker, but only if they have been trained and are authorized to do so. They must not perform tasks reserved for qualified personnel.

To prevent similar incidents from occurring, Kentucky FACE investigators recommend that employers develop formal guidelines and clear expectations for qualified employees overseeing unqualified personnel.

REFERENCES

¹Weather Underground. <https://www.wunderground.com/history>

²OSHA Fact Sheet. <https://www.osha.gov/sites/default/files/publications/OSHA3529.pdf>

³OSHA Job Hazard Analysis. <https://www.osha.gov/sites/default/files/publications/OSHA3071.pdf>

INVESTIGATOR INFORMATION

This investigation was conducted by Beau Mosley, Fatality Investigator, Fatality Assessment and Control Evaluation, Kentucky Injury Prevention and Research Center, University of Kentucky College of Public Health.

ACKNOWLEDGMENT

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DISCLAIMERS

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