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## Acts of God, Acts of Man

Jordan Barab

Why does society take the death on the job of some people more seriously than that of others? The deaths of astronauts and soldiers are greeted with great concern by opinion leaders who vow that they will not to be tolerated, but the deaths of day laborers and other blue-collar workers seem to be accepted as an inevitable act of nature. This double standard of death is reinforced by the bifurcated way that the mass media frames the issue. The labor movement and the safety and health community must confront this problem head-on and develop an educational strategy to rectify the distorted idea that some lives are more valuable than others.

ustafa Boyraz, a thirty-four-year-old Annandale, Virginia, construction worker, was crushed to death on January 27, 2003, when a granite slab fell on him at work. Marty Nesbitt, of St. Louis, Missouri, was killed on March 15, 2003, when he fell 30 feet from the grandstand roof at Fairmount Park Raceway while measuring part of the roof.

JORDAN BARAB has worked in the field of workplace safety and health for twenty years. He was an official of the Occupational Safety and Health Administration during the Clinton administration, and he has spent over seventeen years working in the labor movement. Barab is currently a recommendations specialist at the U.S. Chemical Safety and Hazard Investigation Board. His weblog on occupational safety and health issues, "Confined Space," may be viewed at spewingforth.blogspot.com.

The deaths of Boyraz and Nesbitt were not exceptions to the rule. More than 100 workers in the United States are killed by injuries on the job each week, almost 7,000 in 2001. In addition to the personal tragedy, workplace deaths and injuries cost this nation hundreds of billions of dollars every year. (And although this article focuses on fatal occupational injuries, let us not overlook the less well-recognized deaths of 165 Americans every day from occupational diseases caused by exposure to toxic chemicals, infectious agents, and other hazardous substances.)

Like most American workers who never made it home from work at the end of the day, they were "lucky" to get a few inches in their hometown newspapers. These victims of workplace hazards often do unglamorous, dirty jobs on construction sites and roads and in factories. They die alone, only noticed and remembered by their immediate family, friends, and coworkers. We do not hear about them, mainly because they are just regular people, and most of them die one at a time. Some never even seem to have names, because the names are withheld until the next of kin is notified. By the time that happens, the media has often already lost interest.

But the weeks when Boyraz and Nesbitt were killed were not typical. In the week that Boyraz was killed, seven other workplace deaths received days of international headlines. Their names, their faces, their families, and their life stories became familiar to millions, if not billions, of people around the world. In the week of Nesbitt's death, dozens of other "on-the-job" fatalities also achieved much notoriety. Those seven that first week were the astronauts of the space shuttle *Columbia*, and those in the subsequent week were American men and women who died fighting the war in Iraq.

Of course, the invisibility of most workplace death is not just a problem in the United States, as a recent article about the workplace carnage in Brazil shows:

Unfortunately, even as Labor Day approaches, these dramatic figures involving on-the-job deaths, injuries and illnesses simply do not captivate the nation—something statistics on urban violence or traffic accidents accomplish a lot more easily. Crimes, especially involving the

rich and famous, and multiple car crashes with numerous deaths always make headlines, even if they are quickly forgotten. Perhaps the problem with work-related accidents is that the victims are generally part of the masses, "unknowns" from the poor side of town. Outside of their families, there is little concern about their welfare in Brazilian society, so their deaths hardly attract any attention at all.<sup>3</sup>

What determines how much press a workplace death gets? Clearly one factor is the number killed at the same time. The equivalent of a Boeing 747 full of workers are killed on the job in the United States every few weeks. Yet because most workers are killed one or two at a time, no one notices.

Paul Rogat Loeb, chair of the Peace and Justice Alliance, noted in the *Seattle Times* the disparity between media attention to the astronauts and to regular workers: "We don't talk about these people much. Their lives are invisible, far from the media pundits. They're often the immigrants and the poor, those most disposable in our culture."

In one sense, we are victims of our own success. In 1913, the Bureau of Labor Statistics documented approximately 23,000 industrial deaths among a workforce of 38 million, equivalent to a rate of 61 deaths per 100,000 workers.<sup>5</sup> In that environment, it was likely that most people knew someone who had been killed on the job. Today, the workplace death toll has fallen to just under 7,000 deaths each year, a rate of 4.3 per 100,000.<sup>6</sup> Instead of our knowing the people who die in the workplace, "their lives are invisible, far from the media pundits," says Loeb.

Another factor in determining the public visibility of workplace fatalities is the types of jobs that workers do. Astronauts killed while exploring the frontiers of space and the human imagination will always receive more media attention than a Hispanic construction worker who falls from a scaffold.

The Washington Post's editors, wondering why the astronauts received so much more attention than the deaths in Afghanistan of four U.S. soldiers in a helicopter crash around the same time as the shuttle disaster, suggested that the astronauts embodied "national aspirations of greatness, and human aspirations to reach beyond our-

selves." Their heroism and courage was oft noted. They, like the soldiers, gave their lives for their country.

All of this is true. It takes courage to fly into space, knowing the dangers, knowing that you may die far from home. But what about the courage it takes for an immigrant to go to work on a hazardous construction site to feed his family, unable to change his working conditions and knowing that he may die far from home?

What is the difference between the courage needed to go into space, assured that billions of dollars are being spent to bring every astronaut home alive, versus going down into a deep, unprotected trench, suspecting that your employer is cutting corners on safety to save a few bucks? Millions of workers go to work every day in this country understanding that this society accepts a certain level of death in the workplace, while it demands 100 percent safety in the space program.

President Bush, in his eulogy for the seven astronauts, was most moving when he spoke to their children:

And to the children who miss your Mom or Dad so much today, you need to know, they love you, and that love will always be with you. They were proud of you. And you can be proud of them for the rest of your life.

Yet hundreds of children are left without parents every week due to workplace accidents. Do the children of factory workers or prison guards miss their parents any less than the children of astronauts? And why are "aspirations of greatness" more valued in our society than aspirations of being a good parent and friend and coming home from work safely at the end of the day?

The small number and short length of articles about workplace fatalities make it difficult for Americans to understand the toll that these fatalities take on their families, their coworkers, their communities and our society. But the number of column inches may not be as significant to America's comprehension of workplace fatalities as the content of the articles. How are the causes of the fatalities characterized, and what are the implications for worker safety in this country?

Economist John Mayo, dean of the Georgetown University McDonough School of Business in Washington, D.C., and executive director of the Center for Business and Public Policy, approached one explanation in a *Houston Chronicle* column that appeared shortly after the shuttle disaster.

Why aren't more people concerned? Unfortunately, much of the public thinks accidents are inevitable. The truth is that workplace deaths are especially tragic because most are preventable. Importantly, prevention of injuries and death are [sic] often not the product of expensive, massive investments, but rather simply sound management systems and practices.<sup>7</sup>

If workplace deaths are inevitable, if there is nothing anyone can do about them, then the employer has limited responsibility for workplace deaths and injuries, and the government has no useful role in issuing or enforcing workplace standards. This point was argued by the libertarian Cato Institute in an article entitled "Abolishing OSHA":

[The Bureau of Labor Statistics] also found that 40 percent of recent workplace fatalities were from transportation accidents (almost half the fatal transportation accidents were highway accidents), and about 20 percent of workplace fatalities were from assaults and other violent acts (over 80 percent were homicides and 15 percent were suicides). In other words, only 40 percent of workplace fatalities were caused by dangers thought by most to be unique to the workplace, such as the classic example of falling into a machine. The leading causes of work-related deaths in recent years, transportation accidents and assaults, are unlikely to be reduced much by OSHA inspections.<sup>8</sup>

But highway fatalities dismissed in this article as unpreventable were not so readily dismissed by the U.S. military, which was alarmed at the number of traffic accident fatalities during the first Gulf War. Since that time, the military has made major—and reportedly successful—efforts to reduce injuries and fatalities resulting from driving accidents. As the *Washington Post* reported: "Compared with that from the first Gulf War, data from the latest fighting also reveal a dramatic reversal in the ratio of combat to noncombat casualties."

Twelve years ago, 50 percent more soldiers died in accidents (235) than in battle (147). In the recent war, there were only a third as many noncombat fatalities (36) as deaths in battle (101). The same pattern appears to hold for nonfatal injuries, with the data on evacuated Army troops showing that 107 had noncombat injuries, compared with 118 who had combat wounds.

The army attributed the steep drop in noncombat deaths and injuries in part to the Army's effort to improve driver safety and to ensure that soldiers were well-rested when operating vehicles. In the first Gulf War, motor vehicle accidents alone accounted for about half of all serious injuries. "Because this was such a motorized effort, we expected many more accidents than we actually saw. I think this is a definitive success story," said an Army spokesperson.

And while there is no OSHA regulation addressing the problem of workplace violence, federal OSHA and several state OSHA plans have issued guidelines containing numerous recommendations that have been proven to substantially reduce the number of violence-related workplace fatalities. <sup>10</sup> Panic alarms and adequate staffing in mental health institutions and video cameras and lock-drop safes in all-night convenience stores are just a few measures that have been shown to be effective in preventing "inevitable" fatalities resulting from workplace violence. <sup>11</sup>

Unfortunately, it is still not uncommon for the public and the media to assume that workers are to blame for many workplace accidents, even though it has been thirty years since the Occupational Safety and Health Act gave the employer responsibility for providing safe working conditions. On one level, this "blame the worker" philosophy is the result of unawareness. Even union representatives often find it easy to believe in blame-the-worker theories, not because of a disdain for their members, but because identifying the root causes of accidents seems too technical, and they have not been trained to identify those causes or preventive measures.

For example, highway construction workers are frequently struck and killed by construction equipment in the work zone. Other than inattentiveness, what can explain a worker walking right into the path of a moving vehicle? Not until one spends time closely observing those who do the job—sometimes for ten hours at a stretch—can one understand how noise, heat, dust, fatigue, work pace, and disorganization can lead to a moment of "inattentiveness."

Blame-the-worker theories are nothing new, but they have recently become "legitimized" into the concept of behavioral safety: instead of management's taking responsibility for eliminating hazards providing safe working conditions, blame is placed on workers who make mistakes. Workers are therefore encouraged to "be careful," either by providing incentives for not being injured or by punishing workers who get injured on the job.

In a recent memo to its employees, Sysco Food Services of Baltimore announced that "All accidents or incidents resulting in accidents that involve work-related injury, damage to equipment, merchandise or other property will be assigned points." Points were also "awarded for Workers' Compensation claims and lost time." Twelve points leads to "verbal counseling," twenty-four points to a three-day suspension without pay, and thirty points leads to termination.<sup>12</sup>

In the story about the death of Marty Nesbitt that opened this article, no mention was made of the fact that required fall-protection measures had not been provided. In fact, the final paragraph left readers wondering if Nesbitt had not gotten what he deserved:

A toxicology test showed no alcohol in Nesbitt's system. Madison County Deputy Coroner Ralph Baahlmann said that at some point prior to the accident Nesbitt had used marijuana and that he may have been under the influence of marijuana at the time of the accident.<sup>13</sup>

And an article about a criminal indictment handed down against two California employers for the asphyxiation deaths of two of their employees in a manure pit contained the following curious statement by the owners' attorney: "Neither of these guys [the owners] did anything. They're charged with not doing something," he said. "The poor, unfortunate victims made choices on their own." <sup>14</sup>

In some ways, even coworkers feel more comfortable believing the worker was at fault, rather than the working conditions. It is easier to

live in denial with the belief that "It could never happen to me because I would never be so careless as that guy" than to understand that unsafe working conditions caused the death of your coworker—conditions that could just as easily have left your own children without a parent.

If working conditions and not individual failure is at fault, then you either need to be scared—or you have to do something to change the working conditions. Confronting the boss about safety conditions or even requesting an OSHA inspection are not generally comfortable options for American workers, especially for the majority who do not have the protection of a union.

In addition to blaming workers for workplace injuries and fatalities, employers often blame "acts of God" or the "whims of Mother Nature" to explain such "unpredictable" tragedies as the collapse of a twelve-foot-deep trench on top of a construction worker or the asphyxiation of a sewer worker in an unmonitored confined space. "Who could have predicted it?"

A recent article describing the background to the 2002 Pennsylvania coal mine flood that ended in the rescue of the trapped miners illustrates this point. The owner/operator of the mine, David Rebuck, had received multiple warnings about the inadequacy of a map that showed adjacent mines that had been flooded. Despite these warnings, Rebuck called the flooding an "act of God" in one local TV interview, and many commentators credited divine assistance in the rescue. As University of Pennsylvania Professor Charles McCollester wrote,

The flood of testimonials to the mercy of God threatens to obscure the very human factors that led to the near-disaster. God may well have had a hand in the rescue, but human avarice and more than a century of fierce corporate manipulation and struggle for profit and control were behind the wall of water that swept into the Quecreek mine.<sup>15</sup>

Another convenient explanation frequently cited by managers is that the fatality was the result of a "freak" occurrence. A search of the Internet quickly produces large numbers of articles ascribing common workplace fatalities to "freak" occurrences. Tarrytown Worker Dies in Freak Accident: A day on the job turns deadly for a maintenance worker at the Hackley School in Tarrytown after the machinery he was using rolled over and crushed him.<sup>16</sup>

Freak Trench Accident Kills Worker: 23-Year-Old Man Had Been Crushed in the Collapse of a Trench Sidewall. . . . <sup>17</sup>

Freak Accident Kills Man at Bowling Alley: A machine that resets pins appears to have come on while Devan Young, 29, was working on it.<sup>18</sup>

### Sometimes "freak accidents" even come in pairs:

Williams Selyem Winery Accident: Officials are investigating the death of a 20-year-old winery worker found unconscious, apparently asphyxiated, in a production tank at Healdsburg's Williams Selyem Winery late Thursday afternoon.

Taylor James Atkins, a Forestville resident, likely died of exposure to nitrogen gas in what would be the second such freak accident since November 1997, when . . . 49-year-old Jose Villareal was found dead at the bottom of a 50,000-gallon tank filled with nitrogen. 19

As a matter of fact, the wine industry seems to be full of "freak" and "bizarre" confined space accidents.

#### B.C. Wine-Country Residents Shocked by Freak Deaths

VANCOUVER (CP)—British Columbia's winemaking industry is at a loss to explain how two winemakers died in a freak accident no one has ever heard of happening before. Victor Manola, owner of the Silver Sage Winery in the Okanagan town of Oliver, B.C., died Sunday after falling into a fermentation tank. Winemaking consultant Frank Supernak died when he fell in, too, attempting to rescue Manola. It's believed the men suffocated because of the carbon dioxide generated in the enclosed tank by the fermenting wine.<sup>20</sup>

The *Merriam-Webster Dictionary* defines "freak" as "a seemingly capricious (unpredictable) action or event." In fact, the hazards of asphyxiation in confined spaces due to odorless nitrogen gas (as well as other asphyxiants) are well known. According to OSHA's records, at least twenty-one people died in the United States between 1990 and early 1996 in incidents involving the use of nitrogen in confined spaces. In March 1999, after investigating the death of a worker from nitrogen

asphyxiation in a Union Carbide plant, the U.S. Chemical Safety and Hazard Investigation Board recommended that the National Institute for Occupational Safety and Health (NIOSH) "conduct a study concerning the appropriateness and feasibility of odorizing nitrogen in order to warn personnel of the presence of nitrogen when it is used in confined spaces." NIOSH has so far declined to conduct such a study.

There is clearly more work to be done on the issue of confined spaces, especially related to nitrogen asphyxiation. It may be that nitrogen gas should be odorized. It may also be that better guidelines or regulations should be issued. What is crystal clear, however, is that there is nothing "freak" about workers dying of nitrogen asphyxiation or other asphyxiants in confined spaces.

Lisa Cullen, in her recent book *A Job to Die For*, discusses the problem with ascribing workplace injuries and fatalities to "freak accidents":

An accident can be defined as an unexpected and unintentional happening that results in damage to people or property. Although it is common to say, "Hey, accidents happen," they are more complicated than that. In hindsight, most can be seen building from several causes, each representing a missed opportunity to step in and prevent the forthcoming damage. In fact, the safety and health profession is so averse to the term accident that the word incident has been widely substituted.

In the workplace, few real accidents occur because the surroundings and operations are known; therefore, hazards can be identified. When harm from those hazards can be foreseen, accidents can be prevented.<sup>22</sup>

Blaming deaths and injuries on "freak accidents" and other "excuses" often works—at least for public consumption—because they are generally quoted in the typical one-day story in the local newspaper. By the time experts are found (if anyone bothers) or the OSHA report comes out, the local media has lost interest.

Unfortunately, blaming a workplace fatality on God, freak occurrences, or a careless worker is a way of thinking that the media often fall into and that some employers encourage. After all, if a workplace fatality is unpredictable and unpreventable, then no great public outcry is warranted. If someone's inattentiveness or stupidity or lazi-

ness (or drug problem) or God's will led to the death, then it is a tragedy for the family and friends, but no real investigation is needed, no lessons are to be learned, no changes in the workplace are demanded, no new OSHA regulations are needed, no enforcement is appropriate, and no wider social problems need to be addressed.

Where willful management negligence kills or seriously injures a worker, high fines or even jail may be appropriate. But it is also im-

Unfortunately, public blame still tends to fall upon individuals who may not be responsible for controlling a worksite's safety systems.

portant not to lose sight of the root causes of workplace incidents while looking for a guilty party. Sometimes the press, courts, or enforcement agencies miss the real causes of incidents and misallocate the blame.

Root causes of workplace incidents are often not readily evident to untrained observers. The National Transportation Safety Board, which investigates airplane, transportation, and pipeline accidents, as well as the U.S. Chemical Safety Hazard Investigation Board, which investigates incidents among chemical manufacturers and users, look for the "root causes" of accident. These root causes are usually found not in the error of specific individuals, but in the management safety systems.

Unfortunately, public blame still tends to fall upon individuals who may not be responsible for controlling a worksite's safety systems. A recent example is illustrative:

On June 10, 1999, a sixteen-inch-diameter steel pipeline owned by Olympic Pipe Line Company ruptured and released about 237,000 gallons of gasoline into a creek that flowed through Whatcom Falls Park in Bellingham, Washington. About one and a half hours after the rupture, the gasoline ignited and burned approximately one and a half miles along the creek. Two ten-year-old boys and an eighteen-

year-old young man died as a result of the accident. Eight additional injuries were documented.<sup>23</sup>

In October 2002, the NTSB issued a report identifying five main causes of the incident:

- damage done to the pipeline by adjacent construction five years before the accident;
- Olympic Pipe Line Company's failure to examine the damaged pipe;
- Olympic's failure to test safety devices at a new facility;
- Olympic's failure to investigate and correct the repeated unintended closing of an inlet block valve;
- Olympic's practice of performing database development work on the computer system that controlled the pipeline while the system was being used to operate the pipeline, which led to the system's failing at the same time that the leak pipeline break occurred.

In other words, according to the NTSB, there was a total breakdown in the entire management safety system that led to a series of interrelated system failures, ultimately concluding in a catastrophic event. Yet in December 2002, criminal indictments were handed down against three midlevel managers who happened to be operating parts of the fatally flawed system. As the father of one of the children killed insightfully noted, "These three guys are really victims of an industry. It's the industry that needs to change."<sup>24</sup>

Contrast this to a recent New York City event where there was a knowledgeable union that challenged a finding of blame against the crew supervisor. Within days of each other, two New York City subway workers were struck by trains and killed while working near the tracks last fall. The *New York Times* initially intimated that perhaps at least one of the workers was not paying attention:

On Thursday, Nov. 21, at 11:19 A.M., Joy Antony was peering into a glass box just north of the West 96th Street subway station to test whether a warning light several yards away was working properly, when

a northbound express train approached. Standing on a narrow slab of concrete between tracks, he leaned back a little. Maybe the rush of air pushed him another inch. He got too close to a southbound train behind him, and something on the side caught him and scooped him under.<sup>25</sup>

Following an investigation, however, the Metropolitan Transit Authority acknowledged its own failure to provide adequate staffing for flaggers while track work was being conducted. The *New York Times* reported that the "sweeping" changes to safety rules would require "hiring more workers or paying more overtime, thus costing the agency more money in a time of serious budget problems."

Yet this admission did not stop the Transit Authority from disciplining the supervisor, Deanroy Cox, who was on duty the night Antony was killed. The Transport Workers Union objected to the discipline, even though the supervisor was not a union member.

Union officials said that the problem was in staffing levels and that Mr. Antony's death would have been prevented if an additional worker had been assigned to his crew. They said Mr. Cox pulled him away from his flagging assignment because he was needed to work on a subway signal.

Mr. Cox "basically had to choose between flagging protection and getting his work done," said John Samuelsen, a spokesman for Local 100. "He's a symptom of a much larger problem and is now being used by management as a scapegoat."<sup>26</sup>

The *Columbia* shuttle accident is, of course, perceived much differently than a typical workplace fatality. The astronauts clearly did not meet their ends because of their own inattentiveness, nor is anyone publicly dismissing it as an act of God or just a freak accident. The disaster was clearly a result of failed management safety systems. People are outraged at reports of warnings unheeded and close calls unreported. We are seeing serious discussions about whether enough money is being spent to keep America's astronauts safe. Have we bumped up against technological barriers? Have we cut spending for the space program too much? Did NASA dismiss potential whistle-blowers? No cost will be spared in an effort to identify the causes and

develop safety systems and equipment that will make sure that nothing like that ever happens again.

Most workplace fatalities have nothing to do with stretching the limits of technology. They are caused by a failure of the employer to address well-recognized unsafe workplace conditions and implement effective safety programs in their workplaces. Saving workers' lives is much less about technological challenge than it is about better enforcement of the Occupational Safety and Health Act, more regulation of hazardous substances and unsafe working conditions, more research into occupational diseases, and more pressure on employers to take responsibility for making their workplaces safe.

Yet OSHA's budget does not approach the level needed to fulfill its congressional mandate. (The National Institute for Occupational Safety and Health, responsible for the nation's research into workplace injury, death, and illness, is similarly underfunded.) In FY 2003, there are at most 2,144 federal and state OSHA inspectors responsible for enforcing the law at nearly 8 million workplaces.

At its current staffing levels and inspection levels, it would take federal OSHA 115 years to inspect each workplace under its jurisdiction just once. In four states (Florida, Georgia, Louisiana, and Mississippi), it would take more than 150 years for OSHA to pay a single visit to each workplace. In eighteen states, it would take between 100 and 149 years to visit each workplace once. Inspection frequency is better in states with OSHA-approved plans, yet still far from satisfactory. In these states, it would now take the state OSHAs combined 60 years to inspect each worksite under state jurisdiction once, as compared to once every 62 years in FY 2000.<sup>27</sup>

On one hand, this society's failure to equip OSHA with the means to accomplish its mission is a result of the invisibility of "normal" workplace death and injury. The visibility of the space program, its place in the public imagination, and the worldwide human interest in the lives of the astronauts ensure that this society will never tolerate the same level of attention to safety in the space program that it tolerates in American workplaces.

But in another sense, the underfunding of OSHA, its lack of mis-

sion, and the dearth of media attention and public outrage over preventable workplace deaths are also the result of another, more significant failure. The labor movement and the occupational health and safety community in general have not succeeded in igniting a successful educational and political campaign within their institutions and within society that will achieve the same level of intolerance for the death and injury of American workers as we have seen for the death of the astronauts.

So, why is it important to fight for more and better media attention to workplace fatalities and injuries? In one sense, media attention is not important. No amount of media will bring back a loved one. In another sense, however, media attention that accurately reflects the causes of workplace fatalities is central to the fight for safer workplaces. Seeing the faces and knowing the stories of workers killed on the job transform them from statistics into people—just like the people we know and love. The shock, the sorrow, and the basic unfairness and injustice of those deaths spur action.

But media attention is not necessarily good in itself unless it accurately reflects the real causes and preventability of workplace injuries and fatalities. As long as people believe workplace injuries and fatalities are unpreventable or are caused by the mistakes of individual workers, effective local or national efforts to prevent similar occurrences will be stymied.

To better educate the public and to raise the level of intolerance for workplace death, unions need to educate their members and field staff about why injuries and illnesses happen and how they can be prevented. Unions, working with health and safety professionals, need to develop an active voice in media stories about workplace fatalities, emphasizing that most accidents can be prevented, identifying the safety and health standards that may have been violated, and stressing that the accident is not the fault of the worker. Where unions are present, they should call for and participate in a full investigation of the incident even if OSHA chooses not to investigate or if OSHA does not cover the worker. Finally, these voices must join locally and nationally on a political level to make sure that this society creates the institutions that

will, in the words of the OSH Act, assure "every working man and woman in the Nation safe and healthful working conditions."

More media attention may not bring back the dead, but it can result in more resources to prevent future fatalities. And more attention and more resources can bring home safely thousands of parents, wives, and husbands every year.

The nation's great emotional and human attachment to the lives and deaths of the astronauts may be human nature—our human and historical admiration for mankind's explorers, and rightly so. But while we are mourning the astronauts, let us also not dismiss the tragedy that befalls thousands of "regular people" every year and the hope that, collectively, we can take action to save their lives as well.

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