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SERIOUS OSHA VIOLATIONS: STRATEGIES FOR BREAKING DANGEROUS PATTERNS

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYMENT AND WORKPLACE SAFETY

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ON

EXAMINING OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) VIOLATIONS, FOCUSING ON STRATEGIES FOR BREAKING DANGEROUS PATTERNS

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SERIOUS OSHA VIOLATIONS: STRATEGIES FOR BREAKING DANGEROUS PATTERNS

TUESDAY, APRIL 1, 2008

U.S. SENATE,
SUBCOMMITTEE ON EMPLOYMENT AND WORKPLACE SAFETY,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in Room SD–430, Dirksen Senate Office Building, Hon. Patty Murray, chairman of the subcommittee, presiding.

Present: Senators Murray, Kennedy, Brown, and Isakson.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Good morning, this hearing will come to order. We have another witness who is trying to get here in a taxi. I know several Senators, including Senator Isakson, will be here shortly, but I'm going to go ahead and begin, and give my opening statement and get us started this morning.

I want to first thank all of our witnesses for being here this morning to discuss a critical and fundamental issue facing too many of our workers and their families across the country today—job safety.

Less than a year ago, I chaired my first oversight hearing on OSHA, to determine whether the agency was fulfilling its responsibility to protect workers on the job. What I heard from our witnesses was a resounding, "No." I learned that OSHA was failing to live up to its mission to, "Assure safe and healthful working conditions for working men and women."

I wish I was here to celebrate OSHA's recommitment of its mission, the issuance of new standards that protect people on the job, or its increased emphasis on workplace inspections. Unfortunately, none of those statements are true.

Instead, the news seems to be full of an endless string of industrial disasters—workers dying unnecessarily in chemical and refinery plant explosions, high-rise cranes falling in New York and Miami, and construction trenches collapsing. What's most disturbing to me, is that these tragedies are happening over and over again, in the same industries, and they are happening far too often at the same companies, where workers are doing jobs that their employers know are dangerous and unsafe.

I'm very concerned, because the evidence shows that in the last 7 years, OSHA has been dangerously ineffective. According to the National Council for Occupational Safety and Health, an average

of 16 workers die on the job every day in America, and close to 4 million suffer serious injuries on their jobs, every year.

Yet, how has OSHA responded? It has sent letters to employers, telling them to be more careful. Rather than holding them to standards set by law, inspecting aggressively, and imposing severe fines on repeat offenders, the agency responsible for workers' safety has insisted on simply asking these repeat offenders to partner with the government on improved safety.

Rather than proactively addressing the root of the problem at the national management level, OSHA has continued to respond to one incident at a time, if at all.

Fortunately, members of the media have taken their job seriously, and have written extensively about the blatant disregard for workers' safety. Five years ago, the *New York Times* shocked all of us with a series of articles about a negligent Alabama pipe company, responsible for the deaths of a number of its workers at facilities around the country. OSHA's response was to fine the company a few thousand dollars, and then it allowed these already paltry fines to be reduced, on appeal.

Recently, we were again reminded of the risks to workers' safety through a series of articles published in the *Charlotte Observer* that focused on horrifying and rampant abuses in the poultry industry in North Carolina. We also know that new hazards, like diacetyl, and the threat of pandemic flu, have been ignored. Despite the number of injuries and deaths caused by well-known hazards like dust or repetitive motion, the Administration has largely expected industry to solve these problems voluntarily.

Clearly, something has to change. That is why I am an original co-sponsor of Senator Kennedy's Protecting America's Workers Act.

Among other important reforms, the bill calls for stiffer fines and criminal penalties for repeat and willful violations of our Nation's health and safety laws. It is passed time for OSHA to take a proactive approach to protecting workers on the job.

I believe that corporate bad actors with a track record of repeat violations must be held accountable. OSHA should work to bring these companies into compliance, under a national safety plan. Our country's economy is built on the back of these hardworking Americans. They deserve a government that works to protect them, just as hard as they work for America—not one that turns a blind eye to the risks they face on the job.

Today, our hearing will address the hazards workers face, and how we can break the dangerous patterns we have seen in the last 7 years of this Administration. Our witnesses have some valuable insight on these important issues, I look forward to hearing from each one of them.

But first, I will turn to Senator Isakson for any opening remarks he may wish, and following his remarks, we'll have Senator Kennedy speak.

OPENING STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Well, good morning, and I want to thank Chairman Murray for calling a hearing on workplace safety, and I want to welcome all of our witnesses here today.

The recent tragedy in my State at the Imperial Sugar Refinery in Savannah remains on the forefront of my mind this morning. As we know, 13 workers lost their lives in that disaster, 8 workers remain in a burn center in Augusta, GA, 3 are listed in critical condition, 1 in serious condition, and only 1 in fair condition, and 3 in good condition. We all rejoice that another worker was released just last week, and a life was saved.

I thank Senator Murray for her strong support, as we await answers to the root causes of that disaster. The Port Wentworth tragedy reminds us all that it is our challenge to persuade every employer and employee to make safety a top priority at all levels within their organization.

For most American companies and all good American companies, their employees are their most valuable asset. When I ran my business, I used to always say, my assets had two legs, and they could walk out the door, or if they were injured, they couldn't work. My first priority was to see to it that the workplace was safe, that all of our company procedures were safe, and the first thing we focused on was the health and welfare of those individuals.

At a glance, numbers show that we're moving in the right direction, through a concerted effort on the part of employers and employees alike, the rate of workplace fatalities is now down to 3.9 deaths per 100,000 workers. Similarly, the national injury and illness rate is down to 4.4 per 100 workers.

Both of those are the lowest levels in the 33-year history of the Occupational Safety and Health Administration.

We all recognize that achieving workplace safety requires efforts on all fronts. OSHA, however, only governs the physical environment in which employees work. It, in no way, regulates workers behavior within that environment, which is every bit as important, nor does it regulate automobile crashes, which are the largest contributor to workplace fatalities.

In closing, I agree with our panelist, former administrator Scannell, who recently wrote, and I quote,

> "Safety should be ingrained in every process and decision that takes place at the company. Values are passed on from employee to employee, and from personal agenda, for the way work is done in that company."

Again, I want to thank Senator Murray, I thank Chairman Kennedy for being here today, and I appreciate the time.

Senator MURRAY. Thank you very much.

Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. Thank you very much.

I want to thank Chairman Murray for her longstanding, continuing, ongoing commitment to workers' safety in this country. It's been an extraordinary commitment, one that she's had since she arrived in the Senate, and I'm enormously grateful for her leadership with our committee today. I thank Senator Isakson, as always, for his presence, his concern, and his interest.

I was here when we passed the OSHA legislation in the Senate a number of years ago. It was a very dramatic time. We had ex-

traordinary testimony about the safety of American workers. There was a common sense, at that time, when Senator Pete Williams and Representative Bill Steiger were able to convince the Senate and the House of the fact that here, in the strongest economy of the world, we shouldn't see progress and profits made at the expense of the health and the safety of American workers; that that was completely inconsistent as a value for our country. It was a very good debate, and very important legislation and its effects were really dramatic. We have people here, on this panel, that remember that.

So, we can look and say, "Well, look, we've made important progress over the period of the years, in terms of the total numbers of deaths, and why are we really bothering having this hearing?" Well, all we have to do is look at what Senator Isakson has said—look what happened in Georgia recently. All you have to do is look at what is happening at MSHA, in mine safety. The report of the Inspector General on the Crandall Canyon disaster, talks about MSHA failing to provide the protections for miners. All we have to do is look at the series of repeated actions by OSHA that has really looked after the low-hanging fruit, and refuses to look at the patterns and practices and dangers, when we have repeated kinds of laxity in safety in the workplace.

All you have to do is listen to someone like Paul O'Neil of ALCOA, Republican, former member of this Administration, and listen to him talk about how he put the safety of the workers first, and saw ALCOA go from a way behind company, to lead the Nation in terms of safety for American workers. It can be done. It can be done. American workers are entitled to have it done, and it is not being done.

That is what we are concerned about today. I'll ask consent that my full statement be put in the record, with the illustrations particular to my own State, of the repeated fatalities that we have seen, particularly in the construction industry. The Chairperson has talked about the poultry industry with the high rates of carpal tunnel syndrome, other kinds of risk factors, but what you have is that companies too often that are seeing the loss of lives, are companies that are cited time, after time, after time, after time, and that is wrong—it doesn't have to be that way.

We have seen enlightened corporate leaders provide the kind of safe sites which American workers are entitled to, and this committee is committed to making sure that the legislation which is out there, that provides the tools to protect American workers, is going to be implemented, and they're implemented correctly. If there are additional kinds of tools that we need, this committee is prepared to act.

We understand the change in the workforce, the change in conditions, in a number of different types of industry. We are always interested in constructive and positive recommendations.

I thank the Chair.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today we consider the important task of keeping the hard-working men and women of America safe on the job. I commend

Senator Murray for holding this hearing and for her dedication to the safety and health of America's workers.

The creation of the Occupational Safety and Health Administration in 1970 has saved thousands of lives and prevented countless injuries. We've reduced the death rate in the workplace by 78 percent and the injury rate by 60 percent. But what was a cutting edge program 40 years ago is out of date today. The workplace is still dangerous for far too many workers. In 2006, over 5,700 workers were killed on the job, and over 4 million became ill or were injured. That's an average of 16 workers dying every day, and nearly 12,000 injured or made ill from dangerous conditions on the job.

Many of these incidents could have been prevented if OSHA had done its job. Too often, its enforcement strategy has been pick the low-hanging fruit, not go after the bigger, more complex problems. OSHA looks only at individual incidents. It doesn't investigate whether a hazard is just an example of a larger problem in the company or industry. It's as if OSHA spends all its time treating the symptoms, but ignores the underlying disease.

Many of these hazards, however, are not one-time events. Instead, they result from a company's or industry's general disregard for worker safety. An example is the poultry industry, which was the subject of a compelling series of press reports last month.

Poultry workers' health and safety is threatened every day in a variety of ways. Their hands are crippled by hours on an assembly line that moves too fast. They are forced to work when they are sick or seriously hurt, in order to create the illusion that their employer maintains a safe workplace. These problems are repeated in plant after plant throughout the poultry processing industry.

Yet, OSHA sits on the sidelines, ignoring such patterns. Every day, poultry workers are paralyzed by carpal tunnel syndrome, slip and fall on floors wet with chickens' blood, or are cut by knives that move too quickly to be controlled. OSHA, however, has reduced the number of poultry plants subject to investigations and inspections. Inspections are now at their lowest level in 15 years. Instead, OSHA issues minimal fines when its inspectors happen to note a violation.

The extent of the problem in the poultry industry is much bigger than the sum of the individual cases that come to OSHA's attention. The real problem is that too many firms in the industry have adopted a policy of sacrificing the health, or even lives, of their workers to improve the bottom line. Such an enforcement strategy does nothing to address the industry-wide attitude.

Similar willful neglect by OSHA affects the construction industry. The safety of thousands of construction workers is jeopardized every year by unsafe ladders and scaffolds. Almost exactly 2 years ago today, three construction workers were killed in downtown Boston when their scaffold collapsed. This kind of violation happens every day somewhere in our country.

Scaffolding accidents are symbolic of the continuing problem at OSHA. Too frequently, the same companies are cited over and over again. But OSHA's enforcement program fails to connect the dots. Instead of asking whether a company that uses unsafe scaffolds at one of its worksites is also doing so at another worksite, OSHA just

walks away. Instead of investigating whether a poultry processor who is indifferent to ergonomic danger is also indifferent to the hazard posed by careless use of deadly chemicals, OSHA just walks away.

To prevent accidents, instead of only assigning blame afterward, OSHA needs to root out the source of these problems. It should look for patterns of violations across companies and industries, and fix such problems on a wide scale. A broad-based approach to enforcement has the power to transform workplace accidents from senseless losses to catalysts for changes that save lives. Every time OSHA fails to take its investigations to the next step—to the corporate or industry-wide level—it loses the opportunity to save lives in the future.

Hopefully today's hearing will encourage Congress to act. We have an impressive group of panelists, and I look forward to hearing from them.

Senator MURRAY. Thank you, Senator Kennedy. Thank you for your lifelong work on this.

Senator Brown.

STATEMENT OF SENATOR BROWN

Senator BROWN. Thank you, Madame Chair, and thank you for your good work—and Senator Kennedy's certainly—on OSHA and occupational safety.

For 7 or 8, years I've worn on my lapel, a depiction of a canary in a bird cage. Remember the mine workers 100 years ago, when going into the mines, carried this canary in a cage and if the canary died from lack of oxygen or toxic gases, the mine worker knew he had to get out of the mines quickly. In those days, he had no union strong enough to help him, nor no government that cared enough to help him.

Things have changed in our country over the years, by and large, we've made incredible progress, but we also have, unfortunately, backslid in the last few years.

In my State, in 2005, there were 168 workplace deaths. That's obviously more than three a week. I'm particularly concerned about food workers' exposure to diacetyl—many have heard of the "Popcorn Lung Disease" hundreds of workers have been diagnosed with, including Keith Campbell in Caledonia, OH.

The danger of diacetyl exposure is well-known and well-documented. Even the companies that make diacetyl recognize the danger and that American workers need protection from it. Yet OSHA denied a petition for a standard to regulate diacetyl exposure, even though the petition was supported by 42 of the country's leading occupational safety and health scientists and experts. OSHA needs to do appreciably better than that.

I'm proud to co-sponsor Senator Kennedy's Protecting America's Workers Act. This builds an important first step toward meeting the new challenges that workers face in this century.

Thank you, Madame Chair.

Senator MURRAY. Thank you.

We have four witnesses before us today. Eric Frumin serves as the Health and Safety Coordinator for Change to Win, and has

worked in the field for 34 years. He is a leading National Trade Union spokesperson on issues of job safety, health and disability, including OSHA standard-setting and enforcement and occupational disease and injury surveillance. From 1983 to 2003, he chaired the U.S. Labor Department's Labor Advisory Committee on Occupational Safety and Health Statistics.

Doris Morrow is a member of the United Food and Commercial Workers International Union Local 227. For the last 12 years she has worked at the Tyson Poultry Plant in Robards, KY as a spreader at the plant, and in other line positions.

Gerry Scannell has 40 years of experience managing safety, health and environmental programs, in both the public and private sector. He was the Assistant Secretary of OSHA from 1989 to 1993 under President George H. Bush. Before his appointment, Gerry served in various positions at the Department of Labor in Washington, DC, including Director of the Office of Federal Agency Safety and Health Programs, Director of the Office of Standards at OSHA, and Special Assistant to the Assistant Secretary of Labor for OSHA.

He has held safety and health positions in private companies, including Johnson & Johnson, and has served as CEO of the National Safety Council.

Carmen Bianco is an Executive Consultant at BST Solutions. He has been with the company since 2006, where he supported new and ongoing implementations of BST's technology in various industries.

Prior to joining BST, Carmen assisted clients at the executive level from around the world in improving operational excellence in safety performance. He has 30 years of experience in corporate safety and loss control, and coaching international business leaders from a wide variety of industries, such as transportation and manufacturing.

The CHAIRMAN. Madame Chairman, if you'd just yield—could I join in welcoming Gerry Scannell?

He has shown remarkable judgment in his career in protecting American workers, but he also shows remarkable judgment in living on Cape Cod.

[Laughter.]

Senator MURRAY. So, there you go.

The CHAIRMAN. So, you don't want to forget that in the summertime.

Senator MURRAY. It is duly noted.

The CHAIRMAN. It is nice to welcome a neighbor.

Mr. SCANNELL. May I?

I owe you something, Senator. Several years ago, my alma mater gave me an Honorary Doctorate Degree, and you showed up for that. I want to thank you very much.

The CHAIRMAN. There you go.

Mr. SCANNELL. I haven't had the opportunity to thank you.

The CHAIRMAN. That's fine, thanks very much.

Mr. SCANNELL. It was very nice of you.

The CHAIRMAN. Thank you.

Senator MURRAY. All right. Very good.

We will begin with Mr. Frumin and work our way down the panel. I would ask that all of our witnesses, please try to keep your testimony to 5 minutes, so that we have enough time for questions from Senators.

Mr. Frumin.

STATEMENT OF ERIC FRUMIN, HEALTH AND SAFETY EXPERT, CHANGE TO WIN, NEW YORK, NY

Mr. FRUMIN. Thank you very much, Senator Murray, Senator Kennedy, and Senator Isakson, for the opportunity to testify today.

I wish that the people depicted in these photographs—Eleazar Torres-Gomez, and Raul Figueroa, depicted with their families, and Oscar Pintado—could be with us today, to tell you about the urgent need to make a workplace safe, but they can't. They were killed in preventable workplace tragedies.

Employers bear the primary responsibility for protecting workers, but too often they would rather squeeze out profits than save workers' lives.

The price paid by fallen workers, their families and their communities is unacceptable. Without stronger laws and enforcement, the tragic human cost of hazardous jobs continues to climb.

Nobody should be killed at work, period. A year ago, Mr. Torres, a Cintas corporation worker in Tulsa, was pulled by an automated conveyor into a giant industrial dryer. He was trapped in 300 degree heat for 20 minutes. Badly burned and bruised, he died on the scene.

The Tulsa workers were under pressure to process tons of laundry every day. He died while trying to un-jam a conveyor feeding wet clothes into the dryer.

Cintas knew that these conveyors were dangerous. Two years earlier, OSHA had cited them for a similar violation. According to OSHA, Cintas management, "Ignored safety and health rules that could have prevented this death."

Senator Murray, after Mr. Torres' death, Washington State inspectors cited Cintas for the similar violations in Yakima, after a worker's arm was dislocated because of, again, substandard guarding on the giant washing machines there.

Later, OSHA cited them in Stockton, CA, Columbus, OH, Senator Brown, and in Mobile, AL. A repeated record, all within the same few months.

Instead of admitting that there was a machinery problem, however, the CEO, Scott Farmer publicly blamed Mr. Torres. This hazard still exists in Cintas laundries. Workers in Illinois just recently filed a new OSHA complaint concerning these problems.

Now, this is not just a fly-by-night small Mom and Pop company. It's the largest company in the uniform industry. It would have only cost about $20,000 to install the equipment, to prevent this tragedy. It had the money, the company has the know-how to prevent these fatalities, but it chose to cut corners, and risk workers' lives.

The meat processing industry is notorious for brutal, filthy and wretched conditions. Smithfield Farms in Tar Heel, NC, relentlessly pushes workers to meet production goals at the world's larg-

est pork slaughterhouse. Injury rates, here in the company's own records, have skyrocketed at that plant.

Workers there suffer from chronic nerve damage, mutilation, unspeakable pain. If the injuries slow their work, employees say they're verbally abused, and even fired.

Exactly 40 years ago, Memphis sanitation workers joined with Martin Luther King to fight for safer jobs, a battle that ultimately took Dr. King's life. Today, the solid waste industry continues to show the need for fundamental changes in labor conditions.

Waste collection and disposal is the 5th most dangerous job in America, and Waste Management, Incorporated—again, the giant company in the industry—sets a shockingly low standard for health and safety. Over the last 5 years, their violations increased by 28 percent, and their trucks have one of the worst safety records in the industry.

Raul Figueroa, a waste management worker in Miami, FL was just killed a couple of months ago, cut in half by a garbage truck. As Senator Kennedy alluded to, the construction industry in Massachusetts—again, unscrupulous developers, failing to take precautions to protect workers.

OSHA cited the Avalon Bay Company in 2006 for repeated violations of fall protection, and a few months later Oscar Pintado falls 45 feet to his death, on another Avalon Bay project.

These companies know how to protect workers from fatal falls, but they don't do it. The OSHA citations and fines are not enough, these companies have to live up to their legal and ethical obligations.

OSHA has failed to stop these problems. In the time allotted for my testimony, another 30 workers will have been injured on the job. In the time allotted for this hearing, another worker will die.

OSHA simply must be given the tools to stop companies like Cintas, Smithfield, Waste Management and Avalon Bay, from making choices that kill workers. Under the current law, the penalties are too weak, as you know. A corporation faces a longer jail term for killing or harassing a wild burro on Federal land than it does for killing a worker with a willful violation.

Even the $3 million, the paltry penalty that OSHA proposed for killing Mr. Torres at Cintas, is about 1 day's worth of profits for that company.

OSHA and America's working families need your help to send a clear message to negligent employers. Worker's lives must be valued ahead of profits. Hazards must be eliminated. Workers must be trained, yes, but not blamed. Managers must be held accountable for health and safety and corporations must be required to behave ethically and legally, or face the most severe consequences.

The Protecting America's Workers Act that you've sponsored is a very good first start, but much more is needed to prevent more families, like the Torres-Gomez family, like the Figueroa family, from mourning because of unsafe jobs.

These workers' lives are in your hands, the time to act is now.

Thank you very much.

[The prepared statement of Mr. Frumin follows:]

PREPARED STATEMENT OF ERIC FRUMIN

Chairman Murray, Ranking Member Isakson and members of the subcommittee, thank you for the opportunity to testify today.

I am Eric Frumin. I serve as the Health and Safety Coordinator for Change to Win (CtW), and have worked in this field for 34 years. CtW is a partnership of seven unions and 6 million workers, in a wide variety of industries, building a new movement of working people equipped to meet the challenges of the global economy in the 21st century and restore the American Dream: a paycheck that can support a family, affordable health care, a secure retirement and dignity on the job. The seven partner unions are: International Brotherhood of Teamsters, Laborers' International Union of North America, Service Employees International Union, UNITE HERE, United Brotherhood of Carpenters and Joiners of America, United Farm Workers of America, and United Food and Commercial Workers International Union.

I wish that Eleazar Torres-Gomez, Raul Figueroa and Oscar Pintado could be here to tell you about the urgent need to stop dangerous working conditions. But they can't. They were killed by preventable workplace tragedies.

Nobody should die on the job. Period.

At the outset, we must establish a basic principle: employers—not the government and not individual workers—have the primary responsibility to protect workers' lives on the job. They are obligated under law to provide workers with safe equipment, a healthy work environment, and effective management systems that deliver that safety, or hold managers accountable when they fail.

Because, too often, companies, including many large and sophisticated corporate employers, do fail, with shameful consequences. On average, every single day 16 workers die from injuries on the job,[1] and an estimated 130 workers die from occupational diseases.[2] Tens of thousands of workers are injured on the job every day.

Increasingly, these victims are Hispanic. Hispanic workers died in greater numbers in 2007 than at any earlier time,[3] and face a stunning 18 percent greater risk of dying on the job than workers generally.[4]

This is a reprehensible record. Worse yet is the fact that we have recently seen a growing pattern of large corporations ignoring or avoiding their obligations to insure a safe workplace.

These dangerous patterns of abuse take several all-too familiar forms:

- Corporate demands for subsidiaries, divisions and local managers to cut costs overwhelm any local requests for critical safety and health investments.
- Production pressures that put increased output and higher profits ahead of the most basic worker protections.
- Corporate safety programs that focus overwhelmingly on "worker behaviors"—blaming workers for alleged carelessness or insubordination for the results of corporate failures—while ignoring management's responsibility to protect workers through safe equipment, systems and management accountability.
- Business models that rely on worker (and environmental) exploitation for profits, combined with unscrupulous employment schemes, instead of using smart engineering and ethical labor practices.

We would not be surprised to read such conclusions about industrial safety in the beginning of the 20th Century when child labor, unbridled corporate control of workers and a laissez-faire approach to government regulation all conspired to kill and injure workers needlessly.

But many of us, and many of our institutions, believed that we had overcome these abusive conditions. In the field of job safety and health, we believed that with the passage of the 1970 Occupational Safety and Health Act (OSH Act), and with comparable and even stronger provisions in our mine safety and environmental laws, we had replaced those abuses with a nation of laws and at least, an expectation of ethical corporate behavior.

Unfortunately, we now see every day that those laws are virtually meaningless to many large corporations. These companies are huge, and when they drive down standards, they drive them down for everyone. They make it impossible for honest and ethical employers to compete. Essentially, they themselves repeal the very laws on which the rest of us rely.

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[1] US BLS, Census of Fatal Occupational Injuries (CFOI), 2006.

[2] Centers for Disease Control and Prevention (CDC). National Occupational Research Agenda. *Morbidity and Mortality Weekly Report* 45:445–446, 1996, cited at US DHHS, "Healthy People 2010"; *http://www.healthypeople.gov/document/html/volume2/20occsh.htm*.

[3] US BLS, CFOI, 2006.

[4] Ibid.

It is time for all of us—Congress, the media, and the ethical employers who know better—to put a stop to this worker abuse. Compliance with our Nation's laws must be a first priority, not an afterthought once profits are counted, bonuses calculated and dividends distributed. Any other outcome is morally indefensible, politically untenable, and on the most personal, human level, fundamentally immoral.

BP—TEXAS CITY

The patterns described above are clearly seen in the case of BP, one of the world's largest corporate entities. BP could have chosen to set the standards for excellence, just as it marketed itself as the new "green" company that was "Beyond Petroleum."

The record, however, shows that BP's leaders chose a different path, with terrible consequences for workers and their families.

In its landmark report on the horrible explosion that killed 15 BP workers in Texas City in March 2005, the U.S. Chemical Safety and Hazard Investigation Board (CSB) pointed to BP's repeated cost-cutting at the expense of safety. The CCSB found that BP failed to fix serious hazards at Texas City, despite repeated pleas from local managers.[5] The CSB cited key admissions by senior BP managers, including the Business Unit leader who commented:

> [S]eeing the brutal facts so clearly defined was hard to digest, including the concern around the conflict between production and safety . . . [while the Texas City plant's $1 billion profit was] "the best profitability [ever] last year—more than any other refinery in the BP system."[6]

The CSB also noted that ". . . BP managers increased site bonuses even in the face of three fatalities in 2004."[7]

Chillingly, the Board even found that just days before the deaths, BP's own managers had predicted the catastrophe:

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[5] U.S. Chemical and Safety and Hazard Investigation Board. *Investigation Report: Refinery Explosion and Fire, BP, Texas City, Texas, March 23, 2005. Report No. 2005–04–I–TX, March 2007.*

Key Organizational Findings.—(1) Cost-cutting, failure to invest, and production pressures from BP Group executive managers at all levels impaired process safety performance at Texas City, (p. 25). (8) Numerous surveys, studies and audits identified deep-seated safety problems at Texas City, but the response of BP managers typically was "too little, too late," (p. 26).

Chapter 10: Analysis of Safety Culture.—The BP Chief Executive and the BP Board of Directors did not exercise effective safety oversight. Decisions to cut budgets were made at the highest levels of the BP Group despite serious safety deficiencies at Texas City. BP executives directed Texas City to cut capital expenditures in the 2005 budget by an additional 25 percent despite three major accidents and fatalities at the refinery in 2004, (p. 189).

Chapter 9: BP's Safety Culture. 9.4.17 2005 Budget Cuts.—In late 2004, BP Group refining leadership ordered a 25 percent budget reduction "challenge" for 2005. The Texas City Business Unit Leader asked for more funds based on the conditions of the Texas City plant, but the Group refining managers did not, at first, agree to his request. Initial budget documents for 2005 reflect a proposed 25 percent cutback in capital expenditures, including on compliance, HSE, and capital expenditures needed to maintain safe plant operations. The Texas City Business Unit Leader told the Group refining executives that the 25 percent cut was too deep, and argued for restoration of the HSE and maintenance-related capital to sustain existing assets in the 2005 budget. The Business Unit Leader was able to negotiate a restoration of less than half the 25 percent cut; however, he indicated that the news of the budget cut negatively affected workforce morale and the belief that the BP Group and Texas City managers were sincere about culture change.

In February 2005, the BP Group VP and the North American VP for Refining visited Houston, where refinery managers presented details about safety transformation efforts, the Telos cultural assessment, and "Safety Reality" slides. The presentation listed the major Telos findings, including concern about the condition of the refinery, budget cuts, pressure for production overshadowing safety, and inadequate training. Also discussed were the three fatalities in 2004 and the poor PSM action item closure rate. The site's mechanical availability was graded a "D," with little or no progress due to unplanned events such as the UU4 fire. Also identified were the initial 25 percent capital expenditure cuts in the 2005 budget and the amount restored. Texas City managers proposed, in the presentation, that the executive leaders restore an additional $41 million of the 2005 cuts in the 2006 budget.

Chapter 9: BP's Safety Culture. 9.4.18 2005 Key Risk: "Texas City Kills Someone".—The *2005 Texas City HSSE Business Plan* warned that the refinery likely would "Kill someone in the next 12–18 months." This fear of a fatality was also expressed in early 2005 by the HSE manager: "I truly believe that we are on the verge of something bigger happening," referring to a catastrophic incident. Another key safety risk in the 2005 HSSE Business Plan was that the site was "not reporting all incidents in fear of consequences." PSM gaps identified by the plan included "funding and compliance," and deficiency in the quality and consistency of the PSM action items. The plan's 2005 PSM key risks included mechanical integrity, inspection of equipment including safety critical instruments, and competency levels for operators and supervisors. Deficiencies in all these areas contributed to the ISOM incident.

[6] CSB report, p. 175.

[7] Ibid, p. 178.

> [BP's Texas City safety business plan] warned that the refinery likely would "kill someone in the next 12–18 months. . . . [W]e are on the verge of something bigger happening."[8]

In the opinion of Change to Win, the explosion at BP was not an unavoidable accident;[9] but the result of the company's deliberate decision to ignore clear warnings of imminent disaster and put profit before the safety of its workers.

BP got into this trouble in part by misdirecting its systems for preventing workplace hazards. Instead of focusing on the critical area of process safety management for major refinery hazards, the company's own executives and managers focused on controlling workers' behavior. And instead of determining plant safety conditions by looking at previous close calls and small process safety upsets, "BP's approach to safety largely focused on personal safety rather than on addressing major hazards," according to the CSB report.[10]

> A central component of the BP Texas City approach to safety was its behavioral programs which had been in effect in some form since 1997. In 2004, 48,000 safety observations were reported under [a] new program. This behavior-based program did not typically examine safety systems, management activities, or any process safety-related activities.[11]

Unless huge corporations like BP understand that they are obliged to provide safe jobs and that they will be held accountable for bad judgments that hurt and kill people, then we can never expect to see widespread compliance with our fundamental labor and environmental laws. No government agencies, no prosecutors, no journalists are capable on their own of turning this kind of misconduct. It is only the corporate executives themselves who can do this and the day for such a reckoning is long past due. And if corporate leaders won't change, then the Congress has no option but to change the fundamental legal framework itself.

If nothing else, BP has shown us that such fundamental change might indeed be necessary.

THE "MCWANE WAY"

McWane Corp., one of the Nation's largest suppliers of steel pipe with estimated sales in 2003 of $2 billion,[12] shows a different kind of abuse. McWane subsidiaries maintained production levels and sent the profits back to corporate headquarters. But they did so at the expense of workplace safety. In the short space of 7 years, from 1995 to 2003, nine workers died in various plants, and at least 4,600 were injured on the job.[13] In the following 2 years, another two workers died in two of the same plants, even as the company was facing unprecedented investigations from OSHA, EPA and the Department of Justice.[14]

What was the response of McWane's managers and executives to these terrible incidents? Like BP, McWane first blamed their own employees. At the trial of the McWane subsidiary, Atlantic States Cast Iron Pipe Co., in New Jersey, where the company and multiple executives were convicted on a total of 70 counts, including 52 felonies covering conspiracy, worker endangerment, and obstruction of justice,[15] the U.S. Attorney told the jury:

> Welcome to the real Atlantic States, where laborers are intimidated through the words and conduct of their supervisors, who threaten to fire them if they file a worker's compensation claim, if they refuse to lie for the company, or if they hold up production . . . where deception is part of their business, . . . lying to government investigators . . . where blame is part of their business, too, blame the victim, blame the regulators, blame the employees. . . .[16]

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[8] Ibid, p. 177.

[9] See *Hearing before the House Education and Labor Committee*, March 22, 2007. Testimony of Carolyn Merritt, Chair, U.S. Chemical Safety Board, "Mr. Chairman, the accident at BP was avoidable. In my view, it was the inevitable result of a series of actions by the company." *http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname-110__house__hearings&docid=f:33902.pdf*.

[10] Ibid, p. 155.

[11] Ibid, p. 153–154.

[12] *http://www.pbs.org/wgbh/pages/frontline/shows/workplace/mcwane/two.html*.; McWane is privately-owned.

[13] *http://www.nytimes.com/2003/01/08/national/08PIPE.html?ex=1206504000&en=9058011f27f0c422&ei=5070*.

[14] *http://www.pbs.org/wgbh/pages/frontline/mcwane/etc/prosecutions.htm*.

[15] Judge's Memorandum Opinion, *U.S.* v. *Atlantic States Cast Iron Pipe Co., et al., 3: 03–cr-00852 (NJDC 2007)*.

[16] *U.S.* v. *Atlantic States Cast Iron Pipe Co., et al, 3:03–cr–00852 (NJDC 2007). Trial Transcript, April 3, 2006, pp. 4–5.*

But even worse was what veteran government prosecutors found was an unsettling contempt for the law. The former Federal prosecutor who organized the ground-breaking effort to bring McWane to justice himself concluded that McWane was:

> [A] company that was one of the most persistent violators of environmental and workers' safety laws of any company that we had come across in my 17 years at the Justice Department. . . .
>
> [Y]ou don't have the kind of violations that we saw at multiple facilities within a company and not have . . . a culture of lawlessness. . . . That very much was the culture at McWane, or we wouldn't have seen this number of violations at this number of facilities.
>
> [W]e're talking about deliberate, intentional conduct: people lying; people concealing information; people committing workers' safety violations that result in people dying; . . . Doing all of that knowingly, doing all of that intentionally.
>
> They weren't mistakes, they weren't accidents, and they certainly weren't the activities of a few isolated people within the company. This was the McWane way.
>
> So it's fair to say we had never seen a company quite like McWane, and I would hope we would never see a company quite like McWane again.[17]

The U.S. Environmental Protection Agency eventually proposed that McWane be debarred from Federal contractual work, stating that McWane had:

> [A] dreadful history of environmental and worker safety crimes [and that] no taxpayer dollars should be spent at a company with a history as scandalous as that of McWane.[18]

It was largely the pioneering efforts of the mass media and the unparalleled joint intervention of both the career OSHA inspectors and dedicated Justice Department criminal prosecutors that forced any changes at McWane.[19]

The price paid by those workers and communities is completely unacceptable. But worse yet, such a price, tragically, is neither unique nor behind us. It is still happening to workers daily, and will happen again until the McWanes of the Nation—both the corporations and the executives who run them—are finally pursued, corralled and required to obey the law.

CINTAS CORPORATION

Cintas Corporation is another example of a terrible multi-billion dollar company that failed to protect its workers from the hazards of the workplace. Cintas has a history of gruesome worker injuries and Cintas has been cited for over twice as many OSHA violations as its three largest competitors combined.[20]

Cintas is another huge corporate organization, the largest in the uniform industry, with hundreds of laundries, over 34,000 workers, nearly $4 billion in annual sales and profits running almost $1 million per day.[21]

Like BP, Cintas exercises very strict control of capital costs at its local facilities,[22] and the record shows that, like BP and McWane, Cintas failed to provide its workers the protection they needed to avoid death or injury. And throughout the company, the production-first mentality appears to overshadow crucial safety considerations.

In Tulsa, OK, in February and March 2007, Cintas laundry production workers were working hard to keep production levels high. To keep the piles of laundry moving from the washers into the huge industrial dryers, workers climbed up onto unguarded, automated conveyors multiple times per day to un-jam the hundreds of

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[17] *http://www.pbs.org/wgbh/pages/frontline/mcwane/interviews/uhlmann.html*, Accessed December 4, 2007.

[18] *http://www.pbs.org/wgbh/pages/frontline/mcwane/etc/prosecutions.html*.

[19] *http://www.pbs.org/wgbh/pages/frontline/mcwane/interviews/uhlmann.html*.

[20] According to OSHA's *Integrated Management Information System (IMIS)*, available at *http://www.osha.gov/pls/imis/establish.html*, between Feb. 1, 2003 to Feb. 29, 2008, Cintas facilities have received a total of 265 separate violations, including 157 in cases that are officially closed, and another 108 in cases that are still open for a variety of reasons (including potential modification of OSHA's original citation). In contrast, Cintas' three largest competitors Aramark Uniform Services, G&K Uniform Services, and Unifirst, Inc., received a total of 123, of which 14 are still "open" for potential modification.

[21] See: Cintas Corp., *FY 2007 Annual Sales and Profit Announcement*, July 18, 2007. Daily profit calculated by dividing annual profit of $335M by 365, or $918,000 per day.

[22] Cintas Corp. *Policy #C–27, "Capital Expenditure Authorization", rev'd. Dec. 2, 2004.*

pounds of uniforms and mats. The overhead video surveillance camera recorded dozens of such dangerous incidents.[23]

On the morning of March 6, 44-year-old Eleazar Torres-Gomez, a 7-year employee and father of four, was pulled off the conveyor into a huge uniform dryer. The dryer door closed, and it kept operating, at 300 degrees. Mr.Torres-Gomez died inside that dryer. After 20 minutes, another employee reportedly heard a noise, and finally opened the dryer door.[24]

Failing to protect workers from moving conveyors is an extremely dangerous practice, and risks workers' lives. The hazards of unguarded conveyors were well-known to Cintas. In fact, OSHA had cited Cintas in Central Islip, NY, for violating machine-guarding standards on computer-controlled conveyors just 2 years earlier.[25] And before that, OSHA cited Cintas in Rochester, NY for repeated violations of standards on machinery repair and maintenance.[26]

The Department of Labor has said that Cintas corporate officials were well aware of these violations and the need for increased measures to protect workers from hazards on automated conveyors and other dangerous equipment in Cintas plants.[27] And the entire linen and uniform laundry industry—which employs 130,000 workers[28]—long recognized this urgent problem, after multiple fatalities involving the increasingly widespread and dangerous equipment.[29]

But Cintas failed to take the action needed to protect its employees. Its failures in Tulsa and elsewhere, in OSHA's own words, are "willful," "repeated," and "serious." As Assistant Secretary of Labor Edward Foulke said when OSHA issued its citations in Tulsa and Columbus, OH: "Plant management at the Cintas Tulsa laundry facility ignored safety and health rules that could have prevented the death of this employee,"[30]

How did Cintas executives respond to this tragedy? Cintas launched an aggressive defense against OSHA's own efforts, and an attack on workers who wanted safer jobs. Refusing to accept corporate responsibility for the unsafe conditions, Cintas CEO Scott Farmer on March 22 publicly blamed Mr. Torres-Gomez for his own death, less than a month after the incident and when OSHA's inspection had barely begun, "[I]t is clear that our partner did not follow established safety rules which would have prevented this tragic accident."[31]

Rather than focusing solely or primarily on employee behavior, OSHA's standards explicitly require physical safeguards. Yet, once again, as at BP and countless other companies, Cintas blamed "worker behavior," instead of fixing the high-hazard equipment that had just been responsible for a worker's death.

The hypocrisy and inadequacy of this response is clear from the record. Since the tragedy, OSHA has found similar violations in Columbus, OH, in Stockton, CA, and in Yakima, WA, where a worker had his arm mangled in washing equipment less than a month before Torres-Gomez's death.[32]

Four months after the tragedy, when OSHA inspectors in Mobile, AL investigated worker complaints, they found even more "willful" and "repeated" violations of machine safety standards in the wash alley. When OSHA cited Cintas in October, it said:

> As a large, national employer with a history of OSHA inspections and citations for hazards at other facilities, we are disappointed to find so many of the

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[23] OSHA citation 309792216, Tulsa, OK, Aug. 16, 2007.

[24] Marshall, Nicole, "Tulsan killed in industrial laundry facility accident," *Tulsa World*, March 2007.

[25] OSHA citation #307631937, Aug. 11, 2005, Item #2, "Machine guarding violation on conveyor shuttle."

[26] OSHA citation #307843045, Sept. 16, 2004, Repeat lockout violations involving washing equipment.

[27] Personal communication from USDOL Office of the Solicitor to Eric Frumin, UNITE HERE, November 2005 (Rochester case) and May 2005 and March 2007 (Central Islip case)

[28] U.S. Bureau of Labor Statistics, *Employment and Earnings Report*, March 2007.

[29] During 2005 and 2006, the ANSI Z8 Committee on commercial laundry equipment safety, "[Met] . . . in 2004, 2005 and 2006 to review new proposals on the [Z8] standard;" the committee issued a revised standard in Jan. 2006, and reissued the final revised standard in December 2006. See: Forward, *American National Standard for Commercial Laundry and Dry Cleaning Equipment and Operations—Safety Requirements, American National Standard ANSI Z8.1–2006,* American National Standards Institute, Inc., December 2006, p. 8; See also: *OSHA Standard Interpretation: Machine guarding and exposure to hazards from robotic laundry shuttles.*, July 7, 2005.

[30] OSHA press release, Aug. 16, 2007.

[31] Cintas Corp., Media Statement Regarding: March 6 Incident in Tulsa, OK, March 22, 2007.

[32] CalOSHA citation #310545298, Stockton, CA, and OSHA citation #311109973, Mobile, AL.

same or similar hazards at this facility. OSHA will take aggressive action when employers show indifference to the safety and health of their employees.[33]

Cintas is still appealing these violations, and no settlement has yet been reached.[34] Workers continue to report to us that they are exposed to hazardous conditions in the washing operations in other Cintas plants. Just a few weeks ago, Cintas workers in Bedford Park, IL filed yet another complaint regarding these hazards in their laundry plant.

Incredibly, even after all this attention, the company still sticks to the blame-the-victim approach and refuses to accept responsibility for their obligation to undertake the basic engineering and design necessary to fix the equipment. Even today, Cintas' fact sheet on employee safety continues to assert that "[W]orkplace injuries are the result of unsafe actions by individuals, rather than unsafe workplace conditions."[35]

It appears that Cintas executives have chosen to disregard the most fundamental principles of workplace safety management. Like their counterparts at McWane and BP, they would prefer to find fault in their own workers, even though properly guarding the equipment like that which killed Mr. Torres Gomez would have cost $20,000, or less than 10 minutes of profit.

That Cintas is by far the industry's giant makes this inaction much more serious. When the leader goes in the wrong direction, others may follow, and workers across the industry will suffer as well.

POULTRY AND MEATPACKING[36]

Now let's look at the food industry.

After I finish, you will hear next from Doris Morrow, a poultry worker who will tell you much more about these conditions. But let me first review some of the basics.

For over 100 years, the food industry and its workers have suffered from negligent companies which repeatedly violate safety and health standards.

This is not the first time Congress has looked at health and safety problems in the meatpacking industry.[37] And as recently as 2004, Senator Kennedy asked the Government Accountability Office to investigate the work nature and number of injuries, and the effectiveness of OSHA in meatpacking and poultry.[38]

Today, 226,500 workers are employed in meatpacking and 213,800 in poultry two of the most dangerous industries in the United States.

According to the BLS, the average rate of injury in meatpacking is 13 per 100 workers; the average for poultry is 7 per 100 workers. The average rate of injury for all manufacturing in 2006 was 6 per 100 workers.[39] While reported injury rates are higher than other manufacturing industries in the United States, government reports and company records document evidence of underreporting.

OSHA, researchers and unions have all stated that the underreporting of injuries and illnesses is a problem in these two industries.[40] The *Charlotte Observer* investigators recently uncovered more evidence of underreporting based on worker interviews and a review of the OSHA logs at one poultry company, House of Raeford.[41]

The UFCW recently reviewed the 2006 OSHA 300 logs from one Smithfield Foods plant in Sioux City, IA and found 35 cases, 19 percent of the recorded injuries and illnesses, had been removed from the log apparently because the claims were denied by workers' compensation (as noted in the margin), a clear violation of the OSHA recordkeeping standard, 29 CFR 1910.4.[42]

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[33] OSHA press release, Oct. 31, 2007.

[34] OSHRC cases 07–1710 (Mobile, AL), 07–1419 (Tulsa, OK) and 07–1395 (Columbus, OH).

[35] Cintas Corp., *Health and Safety Overview*, downloaded from *www.Cintas.com*, accessed March 23, 2008.

[36] Research Associates of America. *Packaged with Abuse: Safety and Health Conditions at Smithfield Packing's Tar Heel Plant October 2006, revised and updated January 2007.*

[37] *Hearings before a subcommittee of the Committee on Government Operations, House of Representatives, 100th Congress, Washington, DC, (March 19, 1987; May 6, 1987 and September 21, 1987), Underreporting of Occupational Injuries and Its Impact on Workers' Safety, (Parts 1, 2, and 3).*

[38] GAO, *Workplace Safety and Health: Safety in the Meat and Poultry Industry, While Improving, Could be Further Strengthened, GAO–05–96, (Washington, DC: January 2005). Human Rights Watch, Blood, Sweat and Fear: Workers' Rights in U.S. Meat and Poultry Plants, 2004.*

[39] *Annual Survey of Occupational Injuries and Illnesses*, U.S. Department of Labor, Bureau of Labor Statistics, Washington DC, 2006.

[40] GAO report, page 28.

[41] *http://www.charlotte.com/poultry/story/487187.html*, February 10, 2008.

[42] UFCW Research.

The largest proportions of workers in the industries are young, male and/or Hispanic. More than 25 percent of the workers are estimated to be foreign-born noncitizens.[43] Workers are fearful for their jobs and therefore fearful to report injuries or unsafe conditions.

HOUSE OF RAEFORD, SMITHFIELD FOODS AND AGRIPROCESSORS

An especially flagrant failure to observe proper standards of workplace safety killed 25 hard working Americans in 1991 in a gruesome fire at the Imperial Food Products Co., in Hamlet, NC, where 25 hard-working Americans were killed in a gruesome fire, "their bodies found clustered around the blocked doorways or trapped in the freezer, where the workers had fled in vain from the fire's heat and smoke."[44]

In the same article, *Time Magazine* reported:

> The fire also exposed the weakness of measures for ensuring job safety. The 11-year-old Imperial Food Products plant had never been inspected. Like a lot of American workplaces, it fell through the gaping cracks of a system in which there are too few inspectors, penalties are mostly trifling, and the procedures for reporting dangerous conditions can leave workers to choose between risking their jobs and risking their lives. . . .
>
> Labor organizers and workers' rights groups are calling for stronger measures. Some want an independent investigative body . . . with the power to examine accident sites and set in motion industry-wide changes to save lives in the future. Another proposal . . . would make it easier for OSHA to bring criminal charges against individual employers who are repeat offenders.
>
> And why not? When the recklessness of employers becomes lethal, perhaps it is time to call it a crime—and act accordingly.

Have things changed much since the Hamlet fire in the Carolinas poultry industry? According to the recent 2-year-long investigation by the *Charlotte Observer*, things have only gotten worse.

HOUSE OF RAEFORD

The *Observer* looked carefully at the House of Raeford, a privately held company, owned by Marvin Johnson, one of the largest poultry producers in the country, with 6,000 workers in seven factories in the Carolinas who processes 29 million pounds of chicken and turkey every week.

The *Observer* reported the abusive treatment of workers—many of them Latino immigrants—and conditions that are now as bad or worse than at the time of the Hamlet fire. Workers are exposed to loud noise, sharp tools and dangerous machinery. Many must stand for long periods of time in "refrigerators," wielding knives and hooks to slaughter or process meat on a production line that moves at very fast speeds. Workers responsible for cleaning the plants, a task which is largely contracted out, must use strong chemicals and hot pressurized water on running equipment. They suffer serious injuries including amputations and even death.

House of Raeford has repeatedly been cited by State and Federal occupational safety and health agencies: 130 serious safety violations since 2000, among the most of any U.S. poultry company.[45]

This company has shown a similar disregard for environmental regulations and the communities where it does business. In the last 5 years, House of Raeford has been cited and fined nearly $45,000 for violations of State and Federal EPA regulations at five of its plants.[46]

As in 1991, the State officials in North Carolina have utterly failed to carry out their own mandate to protect the people at the House of Raeford. North Carolina Labor Commissioner Cherie Berry blamed the workers for the egregious violations of their own employers. When asked by the *Observer* about the strong evidence the *Observer* found that House of Raeford failed to report serious injuries, Berry addressed the issue as merely a paperwork issue rather than a gross health and safety problem.[47]

And when the reporters asked her about workers who were afraid to speak up because of fear of retaliation, she simply dismissed the problem and placed the burden at the feet of the victims themselves: "They need to call us. If we don't know about them we can't help them."[48]

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[43] GAO report, page 16.
[44] *http://www.time.com/time/printout/0,8816,973801,00.html*, September 16, 1991.
[45] *http://www.charlotte.com/716/v-print/story/488123.html.*
[46] *http://www.epa-echo.gov/echo.*
[47] *http://www.charlotte.com/739/story/528605.html*, March 9, 2008.
[48] *http://www.charlotte.com/739/story/528605.html*, March 9, 2008.

In his letter to readers at the outset of the series, *Observer* Editor Rick Thames asked his readers to pay attention to the newspaper's shocking findings, stating:

> They are our newest subclass. If you look beneath America's entanglements with slavery and child labor, you will find governments that failed famously to balance a free market against the inherent promise of basic human rights.
>
> We should demand that our leaders repair those policies with realistic solutions. But as citizens and consumers, we should also insist on humane treatment for this new subclass of Latino immigrants who now work to the benefit of many in this country. We've learned from our history. We are better than that.[49]

We believe that human treatment is not too much to ask for anyone who works hard, doing a fundamentally unpleasant job, and puts the food on our tables. But apparently, unless a government agency is willing to intervene, too many leaders of the poultry industry fail to adequately secure safe and healthy workplaces.

SMITHFIELD PACKING

Smithfield Packing displays the same problems in the meatpacking industry.

In Tar Heel, NC, in the same part of the same State where the poultry industry exploits workers by the thousands, Smithfield Packing maintains the world's largest single pork packinghouse where approximately 5,000 workers slaughter and process 32,000 hogs a day. Overall, Smithfield slaughters hogs at seven plants in the United States (five in the Midwest and two in the Southeast), with a current slaughter capacity of 101,000 hogs per day.

Like the poultry industry, Smithfield Packing goes to great lengths to maintain production levels at its Tar Heel facility. Not surprisingly, as in the poultry industry, injury rates rose rapidly between 2003 and 2006, especially for the musculoskeletal disorders (MSDs) that plague workers in meatpacking and poultry plants and other industries throughout the economy. An examination of Smithfield's injury data from 2003 to 2006 reveals injury and production rates that dramatically increased at its Tar Heel plant. The production rates at the plant increased from an average of 145,363 hogs per week to 151,713 hogs per week, or an average of 29,073 a day to 30,342 a day. The rate of reported injuries in the plant rose from 318 in 2003 to 696 in 2006—an increase of more than 200 percent.

On November 20, 2003, a 25-year-old Smithfield Packing employee climbed into a tank to clean it out; he was quickly overcome with toxic fumes and killed by asphyxiation. North Carolina Department of Labor's Occupational Safety and Health Administration (NC–OSHA), conducted an investigation of the event and found that the young man had been improperly trained and supervised, and the tanker was not properly labeled as a dangerous confined space. Smithfield Packing was fined $4,323.[50]

On March 2, 2005, NC–OSHA conducted a general walk-through and comprehensive safety inspection of the Tar Heel plant and identified over 50 violations of safety and health laws, the majority of which were categorized as "serious." These included lack of safety training, unguarded blades, missing guard rails, blocked exits, illegible signage, and improper safety procedures. Smithfield Packing paid $17,900 in fines.[51]

On June 28, 2005, NC–OSHA visited the plant after it received a report that 661 pounds of ammonia had been spilled on the roof on June 15, 2005. No injuries were reported, but the kill floor was evacuated and employees arriving for work were not allowed in the plant. While the cause of the spill was found to be related to the improper installation of a refrigeration unit, OSHA determined that it was Smithfield Packing's responsibility to review the changes to the system that were being installed. Smithfield Packing also failed to update training records and operating procedures related to the refrigeration unit. OSHA fined Smithfield Packing $2,275.[52]

A report produced by Research Associates of America, *Packaged with Abuse,* identified several key issues at the Smithfield Tar Heel plant.[53]

• **Smithfield Packing tells workers that "the injury didn't happen on the job."** By refusing to record an injury, Smithfield Packing may deny the workers

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[49] *http://www.charlotte.com/poultry/story/487184.html*, February 10, 2008.

[50] NCOSHA inspection #07215731 closed June 4, 2004.

[51] NCOSHA inspection #308548866 closed October 31, 2005 and #308542513 closed April 13, 2006.

[52] NCOSHA inspection #308782754 closed July 28, 2005.

[53] Research Associates of America, October 2006, *Packaged with Abuse: Safety and Health Conditions at Smithfield Foods Packing Tar Heel Plant* (revised and updated January 2007).

their rights to receive workers' compensation benefits, which they are guaranteed under the law.

• **Smithfield Packing requires workers to return to work before full recovery.** Studies have revealed that insufficient rest and recovery greatly increases the possibility of re-injury or long-term health problems due to incomplete healing. Many workers have been injured multiple times, and some are left with permanent disabilities.

• **Smithfield Packing workers have often lost their jobs after having been injured.** Many workers who can't keep up with production or who take too much time off work after an injury have been terminated. Their health insurance is then cut off, and if they are not receiving workers compensation, they are left with no means of receiving medical treatment.

In reporting his injury, Smithfield Foods worker, James McCormick, revealed that he had been injured years before but had healed. Smithfield told him that he was fired for failing to reveal the prior injury on his job application.

> I got hurt soon after I began working for Smithfield Foods. I was moving heavy pallets around and suddenly I felt my back go "pop." Smithfield Foods told me that they no longer had any use for me at work.—*James McCormick, fired after being injured and left with no access to health care.*

Migadalia Felicia Valdez was 8 months pregnant when she had a miscarriage following a strenuous workday, which she believes was caused by the physical stress of struggling to keep up with the line speed. Valdez was put on the line with seasoned workers though she didn't have adequate training, and says Smithfield Packing doesn't slow the line down for workers in training at the Tar Heel plant.

> We have to put a stop to this. I'm not the only one—there is a pregnant woman on my line who the supervisors know is far along, yet they still put her on the line working with knives.—*Migadalia Felicia Valdez, speaking out of concern for coworkers who may become pregnant and may be in danger of miscarriage.*

To meet production goals at the world's largest pork plant, the processing lines move exceedingly fast. Workers are under extreme pressure to keep up, and some have reported being verbally abused, or even fired, if they fall behind. Others try to keep up to the best of their abilities, but many of those working in this plant have suffered a job-related injury or illness.

Packaged with Abuse also found that at the same time, in other unionized Smithfield Packing plants, injury rates generally have declined during the 2003–2006 period. MSD cases have either declined or increased only slightly during the same period.[54]

Like House of Raeford, Smithfield Packing has shown a similar disregard for environmental regulations and the communities where they do business.

In 2000, after years of hog waste spills and discharges of animal waste in North Carolina, Smithfield Foods and its subsidiaries reached an agreement with the NC State Attorney General to pay $65 million to improve the environment and develop new technologies for processing and treating waste.[55]

In 1997, Smithfield Foods was fined $12.6 million by the Environmental Protection Agency (EPA) for 7,000 violations of the Clean Water Act at its Virginia packing plants.[56]

AGRIPROCESSORS

AgriProcessors is one of the world's largest kosher meat producers. The company is based in Postville, IA where it employs over 800 people and produces beef, poultry, turkey and lamb. The company has a smaller plant in Gordon, NE, which employs roughly 100 workers. AgriProcessors produces meat products under brands such as Aaron's Best, Aaron's Choice and Rubashkin's. The company's products are sold at well-known retailers such as Trader Joe's and Albertsons.

The plant has been the center of controversies for a variety of issues, including health and safety and environmental issues. In the period of April 2001 to February 2006, OSHA records show no less than 20 violations at AgriProcessors Postville plant. Of these, 12 were identified by OSHA as serious. An examination of the

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[54] Ibid., Appendix.

[55] *http://www.edf.org/pressrelease.cfm?contentID=1207.*

[56] *United States* v. *Smithfield Foods, Inc., Smithfield Packing Company, Inc., and Gwaltney of Smithfield, Ltd.* 965 F. Supp. 769 (E.D. Va 1997). Opinion Filed May 30, 1997, Rebecca Beach Smith, U.S. District Court Judge, Supp. 769, 772–81.

Postville plant's OSHA 300 logs reveals five amputations along with dozens of other serious injuries such as broken bones, eye injuries and hearing loss.

On March 20, 2008, the Iowa Occupational Health and Safety Agency (IOSHA) cited AgriProcessors with 39 new health and safety violations with proposed fines totaling $180,000. For perspective, in 2007, IOSHA issued 19 violations for all meatpacking plants in Iowa with fines totaling over $120,000.

From 2000 to 2008, numerous reports in the media and a 2006 investigation by an independent commission of Rabbis have revealed numerous cases of worker mistreatment including lack of training, job favoritism, and unsafe conditions.[57]

MSDS AND LINE SPEEDS IN POULTRY AND MEATPACKING

Musculoskeletal disorders (MSDs) are the most prevalent injury in poultry and meatpacking plants. Workers suffer sore hands, wrists, elbows and shoulders from numbingly repetitive, forceful motions performed thousands of times a day. These disorders became epidemic in the industry when production changes set in motion in the early 1980s changed. "Boxed beef" meant that workers made more cuts at faster pace. UFCW OSHA complaints and inspections under the general duty clause caused changes in the design of the work and medical management for the disorders. The enforcement, however, did nothing to change the pace of the work.

Today, with the Bush administration's rescission of the OSHA Ergonomics Standard in 2001 and lack of OSHA enforcement for ergonomics, workers once again are suffering high rates of injuries. While the rate of MSDs reported to the BLS from the meatpacking industry is 50 per 10,000 workers in meatpacking,[58] a recent investigation of OSHA 300 logs from a major meatpacking multi-national company represented by the UFCW found rates of 10 to 38 per 100 workers.[59]

While poultry processing is much more automated than meatpacking, the conditions that Mark Linder portrayed in 1995 still exist today.

> It is human hands that . . . (must work) at a grueling pace, set by a relentless conveyor belt and reinforced by circulating foremen, while workers are standing in pools of water and grease in temperatures that range from freezing to 95 degrees and being pelted by flying fat globules or dripping blood . . . the painful damage to tendons and nerves can permanently cripple fingers, hands, wrists, arms and shoulders.[60]

Line speeds in these two industries are at meteoric rates. In poultry, some plants slaughter chickens at speeds of 177 birds per minute. The recently proposed USDA "Public Health-Based Slaughter Inspection System" will remove maximum line speed regulations in exchange for increased microbial testing, further subjecting poultry workers to dangerous workplace conditions.[61] In meatpacking, line speeds in pork have increased nearly 80 percent from the 1980s to present. Beef slaughter speeds have increased 25 percent in the last decade.[62]

OSHA is conducting many inspections of meatpacking plants and issuing citations but no inspections are being conducted nor citations issued for the most frequently reported injury on the OSHA 300 logs: musculoskeletal disorders. In a conversation with an OSHA Area Director, there is no support for requiring either inspections or citations for ergonomics from the National OSHA office.[63]

OSHA INVESTIGATIONS IN THE POULTRY INDUSTRY

Workplace safety inspections at poultry plants have dropped to their lowest point in 15 years. OSHA says poultry plants are safer than ever, pointing to a decade of

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[57] *The Forward*, "In Iowa Meat Plant, Kosher 'Jungle' Breeds Fear, Injury, Short Pay," May 26, 2006; "Kosher Slaughterhouse Hit with Lawsuit," May 18, 2007; *Gazette*, Cedar Rapids, IA, "Postville meatpacker hit with 39 citations," March 21, 2008; *Des Moines Register, "Agriprocessors cited for alleged health, safety problems," March 21, 2008; United Synagogue of Conservative Judaism*, "Report of the Commission of Inquiry," *http://www.uscj.org/Report_of_the_Commis7199.html*, December 12, 2006.

[58] BLS, *Table I: Number, incidence rate, median days away from work, and relative standard errors of occupational injuries and illnesses involving days away from work by selected industries with musculoskeletal disorders in private industry for 1992–2006.*

[59] UFCW Research.

[60] M. Linder, *I Gave My Employer a Chicken That Had No Bone: Joint Firm-State Responsibility for Line-Speed-Related Occupational Injuries*, Case Western Reserve Law Review, 1995.

[61] *http://www.fsis.usda.gov/OPPDE/NACMPI/Feb2008/Poultry_Slaughter_Tech_Report.pdf*.

[62] UFCW research by Jackie Nowell, Director Occupational Safety and Health Office, UFCW International Union (mid-1990s–2006).

[63] UFCW communication, Jackie Nowell, Director Occupational Safety and Health Office, UFCW International Union and OSHA Area Director.

declining rates of reported injuries.[64] The *Charlotte Observer* found that the official injury statistics aren't accurate and that the industry is more dangerous than its reports to regulators suggest. The true rate for poultry processors is likely two to three times higher than government numbers suggest, according to Bob Whitmore, an OSHA official on administrative leave.[65] OSHA targeting for inspections is based on injury reporting and inspections targeted at high injury workplaces. Therefore most plants that report low numbers of injury and illness will not be selected for inspection.[66]

WASTE MANAGEMENT, INC. [67]

In another emerging industry—solid waste management—we see the same signs of abusive negligence or willful misconduct that we see so alarmingly at BP, McWane, and Cintas.

The abuses in this industry are not as legendary as in steelmaking, oil refineries or food processing. However, if any one event in our history demonstrated the lengths that waste workers must go to defend their lives and dignity, the 1968 sanitation strike in Memphis, TN, where Dr. King was assassinated, showed us all the need for fundamental change in labor conditions and workers' rights.

Every day, the people who collect and dispose of our trash face danger on a job that is essential to protecting the public health. Sometimes they die at work, like Raul Figueroa, a Waste Management Inc., mechanic, who died alone in a repair bay on January 3, 2008. He was cut in half and crushed to death by the hydraulic arm of the garbage truck he was fixing.[68]

Figueroa's death is one of many fatalities and injuries that sanitation workers incur each year on the job. Since the Memphis sanitation strike of 1968—which was sparked by the deaths of two workers crushed by faulty equipment—safety has been at the heart of sanitation workers' struggle for basic human rights. Today, 40 years after Memphis, sanitation work is still dangerous and deadly.

Sanitation work is another dangerous job, more dangerous than firefighting or police work.[69] A sanitation worker is 10 times more likely to die on the job than the average worker.[70] Waste collection and disposal ranks as the fifth most dangerous job in the United States.[71] Garbage collection and landfill workers are about twice as likely as the average worker to suffer a work-related illness or injury.[72]

Since 1968, as in other sectors of the services industry like industrial laundries, ownership has been concentrated into a few big companies. Again, the largest company dominating this industry has a particularly bad safety record. Waste Management, Inc.(WMI) is by far the biggest company in the solid waste industry. (WMI, Allied Waste/BFI and Republic Services are known collectively as the Big Three.)

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[64] *http://www.charlotte.com/716/story/487177.html.*

[65] *http://www.charlotte.com/716/story/487188.html.*

[66] GAO report, page 44.

[67] National Commission of Inquiry into the Worker Health and Safety Crisis in the Solid Waste Industry. *In Harm's Way: How Waste Management, Inc. Endangers the Sanitation Workers who Protect the Public's Health*. April 2008.

[68] *Miami Herald*, "Mechanic cut in half while fixing truck," January 4, 2008.

[69] Truini, Joe, "Speakers: Greener equals safer," *Waste News*, September 25, 2006. Previous research, although not extensive, has confirmed this conclusion. See for instance Huren An, James Englehardt, Lora Fleming, Judy Bean, "Occupational Health and Safety Amongst Municipal Solid Waste Workers in Florida," *Waste Management and Research,* 17, 5 (October 1999); James D. Englehardt, et al., *Solid Waste Management Health and Safety Risks: Epidemiology and Assessment to Support Risk Reduction,* Florida Center for Solid and Hazardous Waste Management, University of Florida, Report #00–01 (March 2000). The latter study concludes, based on an examination of workers compensation cases, that "the driver/helper occupational group suffered an average of 9.8 WC cases of greater than 7 calendar lost work days (LWD) per 100 workers annually, 7.4 times higher than the rate for the general workforce in Florida" (p. xvi). An earlier study, Geraid Gellin, "Dermatoses acquired by solid-waste handlers," *American Journal of Industrial Medicine*, vol. 8, no. 4–5, pp. 363–70, focusing on skin abrasion found 75 percent of waste collectors had palmar calluses, resulting from repeated pressure and friction. An international perspective is offered in Sandra Cointreau-Levine, *Occupational and Environmental Health Issues of Solid Waste Management*, n.d., accessed at *http://www.ilsr.org/recycling/other/dctransfer/ochealth.pdf*, on December 12, 2007. A major study of the UK trash industry found major industry rates about three times as high as the national average and fatality rates 10 times the national average—numbers comparable to the American industry. See *Mapping Health & Safety in the UK Waste Industry*, Research Report 240 (Berks, UK: BOMEL Ltd., 2004), [ISBN 0717628655].

[70] Source: Bureau of Labor Statistics tables at *www.bls.gov/iif/oshwc/cfoi/cfch0004.pdf*, accessed on March 5, 2008.

[71] Truini, Joe, "Speakers: Greener equals safer," *Waste News*, 25 September 2006.

[72] Source: *Bureau of Labor Statistics*, Industry and Illness Data, Summary Table, 2006, at *www.bls.gov/iif/oshum.htm*, accessed on December 13, 2007.

WMI could set an industry safety standard, yet instead continues to rack up safety violations that threaten workers and the public. WMI employs approximately 50,000 workers and operates 370 transfer stations and 283 landfills. It dwarfs the rest of the top 10 waste hauling companies. Thus, WMI sets the standards in the industry, so any fight for safety and health reforms must start there.

With gross revenues of more than $13 billion in 2007, WMI could easily afford safety reforms. WMI spent $25 to $30 million a year for the last 3 years on advertising and public relations,[73] and on its Web site WMI speaks of safety as a "core value." But WMI's widely documented safety problems tarnish its carefully polished image. In the past 5 years, OSHA has cited WMI for 232 current violations.[74] Included in these are multiple instances of failing to properly fit employees for protective respiratory equipment, as well as exposing employees to electrical hazards and fall hazards.[75]

Like its counterparts-in-shame at BP, McWane, Cintas, House of Raeford and Smithfield Packing, Waste Management's "Life Critical Rules" safety program disregards the science of safety management. Making the same mistakes as BP and Cintas, WMI's program is framed around the antiquated and faulty notion that reducing accidents relies solely on worker behavior. But the first goal of modern safety management is to evaluate the workplace for hazards and develop measures to control and eliminate exposure of workers to hazards. WMI's focus is to blame the worker for human error, and avoid needed workplace safety reforms, an approach in stark contrast to the philosophy upon which OSHA was founded 37 years ago.[76]

WMI's safety record appears to be worsening. WMI's OSHA violations increased by 28 percent between 2003 and 2007.[77] Nearly a third of WMI's OSHA violations over the past 5 years were categorized as "serious," defined by OSHA as violations in which "there is a substantial probability that death or serious physical harm could result."

Workers are closest to virtually every risk that the industry generates. They place their lives in harm's way every day to protect the public's health and keep our streets clean. They face hazards that include being crushed by machinery, inhaling asbestos, handling used medical needles and human feces, and working 13-hour days.

Vehicle accidents are a key occupational and public risk in the solid waste industry, and occur at higher levels than for the trucking industry in general. Garbage trucks are involved in 41 percent more fatal crashes than the average work-related truck.[78] In 2004, 115 members of the general public and 45 sanitation workers were killed in waste industry-related traffic accidents.[79]

Waste Management is putting unsafe trucks on the highways and in our communities. Waste Management's out-of-repair trucks are among those most often pulled

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[73] Deutsch, Claudia H., "A Garbage Hauler Tidies Up Its Image," *New York Times*, February 7, 2008.

[74] *http://www.osha.gov/pls/imis/establishment.html*, January 31, 2008. The 232 violations were not dismissed upon appeal by the company.

[75] Inspections in response to accidents or complaints have discovered other types of WMI safety violations as well. After an employee lost part of his hand in equipment at a Washington facility in 2006, OSHA found that employees were inspecting the equipment while it was operating and with the safety guards removed. Another OSHA inspector found an untrained employee operating a forklift in New Jersey in 2007 after a complaint was filed. Examples: *Department of Labor, Occupational Safety and Health Administration*. OSHA No.(s): 309813004, 309813012, 307926980, 119650307, 309122042, 308640010, 308766054, 310204458.

[76] See *Occupational Safety and Health Act of 1970*, Section 5 (Duties), accessed March 11, 2008, at *http://www.legalarchiver.org/osh.htm*.

[77] These violations do not capture the extent of the safety risks workers face at Waste Management, because OSHA evaluates work sites during regularly scheduled inspections, in response to complaints, following accidents, or in response to referrals from other agencies. Almost all inspections occur at the employer's physical address. This means that for waste companies' trash hauling divisions, the most dangerous work—performing trash pick-up on trucks out on their routes—is not inspected. Off-premise inspections do occur in response to accidents, and can uncover practices that might not be discovered otherwise.

[78] Source: Paul E. Green and Daniel Blower, "The safety profile of work-related trucks," p. 31, prepared for the *National Truck Equipment Association, University of Michigan Transportation Research Institute,* July 2005, at *http://hdl.handle.net/2027.42/13897* accessed on July 17, 2007. Data drawn from *Trucks Involved in Fatal Accidents* data, 1997–2000; 2002 and *Vehicle Inventory and Use Survey (VIUS)*, 2002. Trucks involved in fewer than 100 fatal crashes excluded.

[79] Bureau of Labor Statistics, Census of Fatal Occupational Injuries, "Industry by transportation incidents and homicides, 2004," available at *www.bls.gov/iif/oshcfoil.htm#2003*, accessed December 8, 2007; *Center for National Truck and Bus Statistics, University of Michigan, Transportation Research Institute, Trucks Involved in Fatal Accidents database*, March 2007. Data for 2004 is the most recent available.

off the Nation's highways by the U.S. Department of Transportation (DOT) as unfit to be driven, or "out-of-service." Waste Management trucks, for example, have out-of-service violations 28.6 percent of the time (indicating State police actually stopped the truck from proceeding based upon the severity of the violations discovered), the highest rate among the Big Three.[80] WMI's out-of-service rate is 25 percent higher than the average for the trucking industry as a whole.[81]

More than 59 percent of the Waste Management workers rated WMI's overall truck maintenance as "fair", "poor" or a "failure" in a recent survey by the University of Illinois Occupational Health Services Institute and the Teamsters Solid Waste Division and Safety and Health Department.[82] Only 7.6 percent rated the company's truck maintenance as "excellent."

Long hours for sanitation workers make driving riskier. The hundreds of WMI workers who responded to the survey averaged 10 hours of work a day. Nearly 40 percent reported working 11 or more hours per day. Hours like these mean driver fatigue, which a 2005 DOT report revealed as a key factor in serious crashes.[83]

Exposure to hazardous substances—including used syringes, blood products, and asbestos—is a daily occurrence for WMI workers. In the recent University of Illinois/Teamsters survey, more than 54.1 percent of the WMI workers surveyed reported being in contact with used syringes over the past 3 months; 46.5 percent reported being in contact with medical waste over the past 3 months; 37.7 percent reported coming into contact with blood products and 33 percent came into contact with asbestos. These statistics raise the issue for these workers of lifelong exposure to blood borne pathogens and asbestos.

Nearly half of WMI workers in the survey reported working while injured during the past year; more than a fifth reported working injured on a regular basis. Due to fierce management pressure and intimidation, as well as too few sick days, sanitation workers often continue working even though injured and in pain.

OSHA needs greater enforcement powers regarding companies such as Waste Management, companies with a history of rampant and persistent safety violation. Bad actors such as WMI will not be deterred by "slap on the wrist" fines from OSHA. For example, a WMI worker was killed in Florida in 2005 when he fell under and was crushed by a trash collection vehicle. OSHA found that WMI was using temporary workers as helpers on trash trucks and did not assure that personal protective equipment was "provided, used or maintained wherever necessary."[84] WMI was fined only $1,000 for this violation. This amounted to a token fine for a company that in 2006 took in $268,000 for each worker employed.

It is clear that the sanitation industry, upon whom we all rely on on a daily basis, is long overdue for major changes in its health and safety practices. It is equally clear that leading employers like WMI should be among the companies high on the list for that attention.

AVALON BAY

In the residential construction industry, unscrupulous developers and contractors have tolerated, and in some cases repeatedly allowed, highly hazardous conditions which imperil worker safety.

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[80] In several States, the out-of-service percentage is above 30 percent: Arizona, Colorado, Massachusetts, Minnesota and Virginia. In Illinois, it is 40 percent, and in Orlando, FL, WMI's out-of-service record is 56.7 percent. Source: *United States Department of Transportation, Federal Motor Carrier Safety Administration*, SafeState Online, acc. From ai.fmcsa.dot.gov, accessed on December 11, 2007. The FMCA recorded information for the 30 months up to late October 2007. DOT registration numbers were for Waste Management, Inc. entities with more than 100 power units. For comparison, United Parcel Service has an OOS rate of less than 8 percent.

[81] WMI's vehicle out-of-service rate of 28.6 percent drawn from *United States Department of Transportation, Federal Motor Carrier Safety Administration*, SageStat Online, accessed from ai.fmcsa.dot.gov on Dec. 11, 2007. Information on inspections is from the 30 months up to late October 2007. DOT registration numbers for more than 100 power units. For the trucking industry as a whole, the rate of 22.89 percent is for 2006, drawn from "Program Measures, Roadside Inspections, National Reports, Activity Summary," at ai.fmcsa.dot.gov/ProgramMeasures/RI/NR/NAS/Report.asp?FC=C&RF=T, accessed on March 20, 2008.

[82] National Commission of Inquiry into the Worker Health and Safety Crisis in the Solid Waste Industry. *In Harm's Way: How Waste Management, Inc. Endangers the Sanitation Workers who Protect the Public's Health*. April 2008.

[83] "Large Truck Crash Causation Study database," July 2005, in *U.S. Department of Transportation, Federal Motor Carrier Safety Administration*, "Report to Congress on the Large Truck Crash Causation Study," March 2006, at *www.fmcsa.dot.gov/facts-researchlresearch-technology/report/ltccs-2006.pdf*, accessed on August 15, 2007.

[84] *Department of Labor, Occupational Safety and Health Administration*. "Informal Settlement Agreement in the Matter of Waste Management of North Florida," OSHA No.(s): 309068864. December 13, 2005.

On March 8, 2007, Oscar Pintado, a 27-year-old carpenter, died at an apartment complex in Woburn, MA, where he was working near an elevator shaft. He reportedly fell off a ladder and plunged at least 45 feet inside the shaft. The builder/developer on this project was Avalon Bay Communities, a large national developer and construction manager for residential complexes.[85]

This was certainly not the first time that contractors hired and supervised by Avalon Bay failed to provide the fall protection considered essential on any competently-run construction job site. For instance, throughout New England and New York State, the Avalon Bay company has hired the framing contractor Shawnlee Construction, Inc. In June and August 2006, OSHA inspected job sites of Avalon Bay/Shawnlee site in Newton, MA and Danvers, MA where they found substantial fall hazards. The inspectors found workers without fall protection working at heights of 32 and 22 feet, respectively.[86] At the time of these two inspections, while there had been one incident involving a fall, no one had yet been seriously injured or killed.

The following December, OSHA cited the two companies for repeated violations of OSHA's fall protection standards, with proposed penalties totaling $164,000 for Shawnlee and another $43,000 for Avalon Bay. As OSHA's New England Regional office said at the time:

> OSHA issued two repeat citations to Shawnlee for the fall hazards in Newton and Danvers because the agency had cited the company in 2004 and 2005 for fall hazards at jobsites in Andover and Charlton, MA. Shawnlee was issued an additional repeat citation for exposing employees to overhead hazards at the Newton site, because it was cited in 2005 for similar hazards at job sites in Hudson, MA, and Mt. Kisco, NY. Proposed fines for the repeat citations total $140,000.
>
> Seven serious citations, carrying $24,000 in proposed fines, were issued to Shawnlee for uncovered floor holes at the Danvers worksite and for electrical, fire extinguisher, guard rail, debris, stairway and additional fall protection hazards at the Newton site. OSHA issues a serious citation when death or serious physical harm is likely to result from a hazard about which the employer knew or should have known.

Shortly thereafter, on Avalon Bay's project in Woburn, Oscar Pintado fell and suffered his fatal injury.

Shawnlee was cited by OSHA three more times for "repeat" fall protection violations in the following year, again paying tens of thousands of dollars in penalties.

In total, OSHA has found Shawnlee to have violated critical fall protection standards 21 separate times since 2000 alone. And five times, in four separate inspections, OSHA inspectors cited Shawnlee for "repeated" violations of fall-protection standards.[87]

What will it take to force large companies like Avalon Bay and Shawnlee to stop their reckless and repeated violations of critical, life-saving OSHA protections on fall-protection and other essential construction safety measures?

There is no way to answer that question without acknowledging the critical importance of labor relationships in the construction industry. The labor relations system in construction is increasingly based on shifting liability from powerful construction managers like Avalon Bay, to multiple subcontractors and individuals without resources to ensure job safety, leaving industry leaders looking blameless for the evident failures of the very contractors they select, supervise and pay.

While subcontracting obscures responsibility for critical workplace failures, misclassification of construction workers leaves workers without protection when they are injured. By wrongly classifying their regular employees as "independent contractors," construction contractors (as well as other trucking companies and other industries) evade their obligations to pay workers' compensation or unemployment, withhold payroll taxes, pay overtime, provide employee benefits, or obey a multitude of laws adopted to protect employee rights. Because employers have no legal obligation to the health and safety of independent contractors, disregard for worker safety rules is aggravated by misclassification.

According to a special study done for the U.S. Department of Labor, "the number one reason employers use ICs [independent contractors] and/or misclassify employees is the savings in not paying workers' compensation premiums and not being sub-

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[85] *Woburn Daily Times Chronicle*, "OSHA begins review into fatal fall at Avalon," March 9, 2007.

[86] *http://www.osha.gov/pls/oshaweb/owadisp.show__document?p__table=NEWS__RELEASES&p__id=13284.*

[87] *OSHA Integrated Management Information System, http://www.osha.gov/pls/imis/establishment.html, accessed March 13–14, 2008.*

ject to workplace injury and disability-related disputes."[88] Employers that don't have to pay workers' compensation and other entitlements gain a substantial financial advantage and can underbid law-abiding employers who do provide coverage for their workers.

Oscar Pintado himself was reportedly considered a "subcontractor" at the Woburn site. It is no wonder, therefore, that National Carpentry Corp. appears to have escaped any sanction by OSHA for the hazardous conditions leading to his death.[89] And yet, less than a year later, National Carpentry was cited by OSHA for repeat fall-protection violations at another site, in Stamford, CT.[90]

Typically, Avalon Bay was not even formally included in OSHA's Woburn inspection after Pintado's death. In fact, according to the comprehensive enforcement data on OSHA's Web site, Avalon Bay was repeatedly inspected during the 2003–2008 period and often escaped OSHA's grip.

However, for reasons that OSHA has yet to explain publicly, OSHA withdrew the high-penalty citations against Avalon Bay and Shawnlee issued in MA in December 2006. This failure by the agency to maintain its high enforcement profile can only encourage other contractors and developers to follow Avalon Bay's lead, and continue to expose workers to severe, and even potentially fatal, hazards.

OSHA CAN STOP THESE PROBLEMS WITH ADDED RESOURCES, NEW AUTHORITY AND POLITICAL WILL

OSHA has repeatedly failed in its 37-year history to protect workers. Resources have been a constant problem. In far too many cases, inspectors arriving only after a serious incident or years of neglect, where earlier intervention would have saved lives. In other situations, the problem arises from limits on OSHA's legal authority, like weak or missing standards, or OSHA's inability to compel compliance while employers appeal citations (as contrasted with the fix-first/appeal later rules under the mine safety laws).

This record is not to diminish for a moment OSHA's successes, which are considerable. It is undeniable that the long-term drop in death and injury rates has much to do with OSHA's presence on the industrial landscape, at least in some industries where OSHA has traditionally had a significant presence, demonstrated by both effective standards and consistent enforcement.

Nor do OSHA's repeated failures diminish the dedication of career OSHA staff who have often found themselves a lonely voice of reason and humanity in a world of industrial chaos.

But the biggest single obstacle to effective intervention is simple lack of political will. For many of its years, OSHA has been a captive of entire administrations and their political appointees who were, frankly, hostile to or only mildly supportive of the agency's fundamental mission as an enforcer of strict labor standards. The Bush administration and the current Assistant Secretary Edward Foulke are, unfortunately, no exception. At the State level, many State OSHA plan administrators also suffer from the same hostility and neglect by labor commissioners or State legislatures, assuming that they are even committed to their mandate in the first place.

Front-line OSHA inspectors—even the best of them—are often overburdened and under-trained by the same ineffective agency leaders. Under the circumstances, it can seem like a virtual miracle when a dedicated inspector actually confronts a deceitful employer, finds the most serious and hidden violations, overcomes the legal obstacles, skirts the political minefields, and actually holds an employer accountable. Only rarely do they receive the full support that should be brought to bear routinely. As one observer noted, before the McWane prosecution in New Jersey, employers lied so often to OSHA inspectors that they lied just to stay in practice. And after the McWane convictions, employers in New Jersey now virtually salute the same inspectors.

It should not take the deaths of seven workers to finally get inspectors the kind of support and resources they need. All employers—and especially those who look for loopholes—and all workers should expect that the next OSHA inspection will be competent, persistent, sophisticated and knowledgeable. The evidence before us demonstrates that anything less than that is a recipe for failure.

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[88] "Independent Contractors: Prevalence and Implications for Unemployment Insurance Programs," *Planmatics, Inc.* February 2000, p. iii.

[89] OSHA inspection #310746318, no violations identified, as of March 24, 2008.

[90] OSHA inspection #311550214; citations issued February 8, 2008.

STRONGER CRIMINAL PROVISIONS

However, no civil enforcement agency, no matter how well-motivated or well-funded, can stop all such abuses, especially when committed on such a scale as the likes of major industry leaders like BP, McWane, Cintas, House of Raeford, Smithfield, Waste Management, Avalon Bay and Shawnlee. OSHA will need greatly expanded power and resources if it is ever to seriously come to grips with this level of misconduct. Currently, the law provides criminal sanctions only in the case of fatalities resulting from a willful violation of a specific standard. And even that egregious misconduct is only a misdemeanor, punishable with a maximum 6-month sentence.

OSHA is also incapable of dealing forcefully with employers whose bad behavior, like that of McWane, is deliberately hidden, and simply never shows up on OSHA's radar screen. Unless and until OSHA has both the will and the tools to impose its authority directly on powerful employers—especially those that misrepresent or conceal the facts from inspectors—American workers will never have adequate protection, let alone avoid worker deaths like those of Eleazar Torres-Gomez, Raul Figueroa and Oscar Pintado, who died while citations were pending as yet unremedied.

And some of those tools must come from the U.S. Department of Justice, to finally make sure that the McWanes and Cintases of the Nation do not escape the full consequences when their willful violations kill workers. Criminal prosecutions for worker deaths are extremely rare, and a person prosecuted for harassing a wild burro on Federal land faces more serious punishment than one prosecuted for a willful OSHA violation that causes the death of an employee.[91] And even the $3 million civil penalty that Cintas faces in OSHA fines is less than 1 percent of its annual profits.

In his recent interview with PBS Frontline, Assistant Attorney General Ronald Tenpas cited the complexity of the McWane and BP cases, especially given the weakness of OSHA compared to environmental laws. He virtually invited this subcommittee to give him the power to pursue outrageous corporate violators of worker health and safety laws:

• *Question.* One of the more startling things we learned early on in our reporting is that if you "willfully" violate an OSHA regulation and a worker dies, it's a misdemeanor under Federal law.

Answer. At the end of the day, we work with the penalties that Congress has decided over time are the appropriate ones to provide.[92]

Congress should provide OSHA with the new tools and resources it needs. This means, first and foremost, treating criminal violations of the OSH Act as felonies, with appropriate sentences. It also means expanding these sanctions to cases of severe worker injury, and, under-appropriate circumstances (which now apply in Federal environment statutes), even the endangerment of workers.

Congress should provide increased penalties as incorporated in the Protecting America's Workers Act, as well as other legislation to complete the necessary reforms.

MORE RESOURCES

OSHA will also need—at long last—the resources they have been denied for so long. Federal OSHA's staffing itself continues to stagnate, with roughly the same number of full-time equivalent staff (FTE's) now as it had in 1983. That represents about a 23 percent drop from the peak staffing achieved in 1980. At this level, it would take OSHA inspectors 133 years to examine every workplace under their jurisdiction. State OSHA plans do not fair much better.[93]

Our economy has grown substantially since then and with only minor variations, OSHA's staff has not kept pace. The number of "establishments" and employees per

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[91] David Barstow, "U.S. Rarely Seeks Charges for Deaths in Workplace," *New York Times*, 22 December 2003.

[92] *http://www.pbs.org/wgbh/pages/frontline/mcwane/interviews/tenpas.html*, December 13, 2007. Tenpas, who directs the Justice Department's Environment and Natural Resources Division, continued: "In some of those cases, McWane being an example, we have found there may be violations related to worker safety, but there are also more serious violations related to the environment where penalties are typically much more significant: maximum 5 years, 10 years, jail time . . . What we do every day is try to protect the environment because environmental violations can cause lots of harm. They can obviously hurt rivers and trees and wildlife, but part of the reason we have environmental statutes is to protect people, too. . . . And we certainly hope that changing conduct is going to have beneficial effects for the workers who are there at the plant."

[93] AFL–CIO, "Death on the Job," 2007.

FTE are now more than what they were when OSHA first began. Like other regulatory agencies whose staff and budgets were cut, OSHA desperately needs the funding and staff resources sufficient to ensure OSHA can do the job that America's employers, workers and their families are counting on it to do.[94] This would include greater assistance for State plans that are often under-funded themselves.

And some of these resources should be shifted from the over-funded compliance assistance programs that have yet to demonstrate their value in either preventing injuries and illnesses or actually increasing employer compliance. While recent evidence again indicates that compliance inspections are indeed associated with reduced injury rates, there is no comparable evidence that the $50 million compliance assistance program produces consistent or positive results.[95] This is clearly unacceptable in an era of limited budgets and congressional scrutiny.

ADOPT AND EXPAND THE PROTECTING AMERICA'S WORKERS ACT

We strongly urge you to adopt the measures that will finally give us a new and stronger OSHA, like that envisioned by S. 1244, the *Protecting America's Workers Act* (PAWAct). It would not only strengthen enforcement, such as criminal sanctions and enhanced penalties for fatal injuries, but also expand rights for the victims and survivors of workplace tragedies. For the first time, it would provide criminal prosecutions for negligent employers who seriously injure workers, actions that now escape criminal sanction entirely. The PAWAct would also expand and strengthen "whistleblower" and anti-retaliation protections for workers who complain about hazards and injuries, as well as—at long last—expand coverage to the millions of public sector workers who currently have no protection at all under the OSH Act.

ADDITIONAL LEGISLATIVE REMEDIES—BEYOND THE PAWACT

Our standards are grossly inadequate. We need not only more and better standards, but also a mandate to force OSHA's current leadership to cease endlessly dragging its feet and relying on hastily announced national emphasis programs that are no substitute for a legal standard with serious enforcement. OSHA should issue standards on well-documented hazards such as diacetyl, cranes and combustible dust, as well as permissible exposure limits generally. And most of all, OSHA should reverse the regrettable repeal of the landmark Ergonomics Program Standard.

We also need a realistic capacity at OSHA to do the kinds of corporate-wide investigations that proved so invaluable at companies like McWane and are still needed at Cintas, Avalon Bay and others. OSHA must make sure that corporate offices—and the corporate officers who work there—are as much the target of investigations as the supervisors and workers who OSHA first interviews. This is especially important when investigations involve either serious consequences, employer deception, or both.

OSHA—and OSHA's practice for 37 years—is designed to determine violations at individual "establishments." In an era of giant corporate entities, we need greatly expanded authority to conduct broader investigations, and take enforcement action on a corporate-wide basis. And OSHA must take such action *before* fatalities or injuries occur, without waiting for the willful, repeated, and egregious violations, which typically trigger the application of broad, but essentially unenforceable, "corporate-wide" settlement agreements. While some of these agreements have worked well, others have not. In any case, they were reactive responses to problems, not preventive approaches in keeping with the overall preventive purposes the Congress intended from the outset.

In order to accomplish those goals, we urge you to make sure that OSHA has, finally, a 21st Century information system; one that keeps close track of employers, even large employers, instead of treating each separate inspection or location like a unique entity, irrespective of the patterns of abuse throughout large multi-site companies. Repeated violations in one location should not escape scrutiny simply because the employer operates under another name, or in a State with a separate State enforcement program.

But OSHA alone can't do it, even if you give the Justice Department the tools to pursue effective criminal sanctions and OSHA finally takes this weapon seriously.

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[94] *Senate Subcommittee on Employment and Workplace Safety*, April 26, 2007. Testimony of Peg Seminario, AFL–CIO.

[95] "The Effect of DOSH Enforcement Inspections and Consultation Visits on the Compensable Claims Rates in Washington State," 2004–2005 *SHARP Technical Report Number: 70–03–2006*, Washington State Department of Labor and Industries, Olympia, WA, December 2006.

Most of all, OSHA will need the political will to seriously administer the OSH Act, an essential ingredient of any regulatory program which has been missing from the Labor Department for a long time.

We also need strict oversight by the Labor Department of companies who refuse to comply with Federal laws on worker health, safety and taxation, as well as on environmental issues, including debarment from Federal contracts from repeated or willful conduct.

If EPA can debar McWane from Federal contracts for polluting the water or poisoning the air, why should not the Secretary of Labor be able to bar McWane for violations that repeatedly kill workers?

Nobody should die on the job. Period.

In 1998, Mr. Gerard Scannell criticized an OSHA/EPA investigation, finding that the agencies had again failed to closely examine the management systems, and asked the fundamental question about corporate accountability for violations of Federal worker safety and environmental rules: "Don't these companies know about the rules? Don't they care?" [96]

We believe that these companies have already answered these questions. They have shown little regard for human life and ethical corporate conduct.

It would have cost these huge companies almost nothing to protect their workers.

America's working families know all too well what will happen if we do not strengthen OSHA. More workers will die because of exposure to well-documented hazards like diacetyl, combustible dust and slipshod site management. More workers will suffer crippling injuries from high production pressures and poor ergonomics. More companies will go unpunished, even when knowingly putting workers in harm's way.

We call upon this subcommittee to adopt these measures. But we also call upon the committee itself to investigate directly the employers who flout our labor laws and enforcement agencies. We ask you to send a clear message to negligent employers:

- Workers' lives must be valued more than profits.
- Hazards must be eliminated.
- Workers must be trained, not blamed.
- No worker should be allowed to die as a result of corporate greed and reckless disregard.
- Managers *must* be held accountable.
- Corporations like Cintas, WMI and Smithfield Packing must behave ethically and legally, or face the most severe consequences.

ADDENDUM

For further information, see the report by the National Commission of Inquiry into the Worker Health and Safety Crisis in the Solid Waste Industry, *In Harm's Way: How Waste Management, Inc. Endangers the Sanitation Workers who Protect the Public's Health*. Published April 2008. *http://www.teamster.org/08news/nr_080325_1.asp*.

See also the report published by Research Associates of America, *Packaged with Abuse: Safety and Health Conditions at Smithfield Packing's Tar Heel Plant*. Revised January 2007. *http://www.smithfieldjustice.com/pressrelease.php.*

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[96] Expert Review of *EPA/OSHA Joint Chemical Accident Investigation Report*, Napp Technologies, Inc., Lodi, NJ, March 1999, EPA 550–F99–004. Congressional dissatisfaction with the EPA/OSHA report was the final straw in the Congress' bi-partisan efforts to force the Clinton administration to withdraw its traditional line-item veto threat that had left the U.S. Chemical Safety and Hazard Investigation Board without funding since its initial establishment by the Congress in 1990. See Weiss, Rick, "*Report on N.J. Blast Revives a Debate; Clinton to Decide on Funding for Chemical Safety Board", Washington Post*, October 23, 1997; also, Weiss, Rick, "Chemical Safety Board Lurching Back to Life," *Washington Post*, October 9, 1997.

[Time in Partnership With CNN—Monday, Sept. 16, 1991]

(By Richard Lacayo)

HOW FAR HAVE WE COME IN 17 YEARS?

ACCIDENTS DEATH ON THE SHOP FLOOR

Nobody who worked at the Imperial Food Products plant in Hamlet, NC, had much love for the place. The job—cooking, weighing and packing fried chicken parts for fast-food restaurants—was hot, greasy and poorly paid. The conveyor belts moved briskly, and the few rest breaks were so strictly timed that going to the bathroom at the wrong moment could lead to dismissal. But, in the sleepy town of 6,200 there was not much else in the way of work. So most of the plant's 200 employees, predominantly black and female, were thankful just to have the minimum-wage job. Until last week, that is.

The morning shift had just started when an overhead hydraulic line ruptured, spilling its volatile fluid onto the floor. Gas burners under the frying vats ignited the vapors and turned the 30,000-sq.-ft. plant into an inferno of flame and thick, yellow smoke. Panicked employees rushed for emergency exits only to find several of them locked. "I thought I was gone, until a man broke the lock off," says Letha Terry, one of the survivors. Twenty-five of Terry's fellow employees were not so lucky. Their bodies were found clustered around the blocked doorways or trapped in the freezer, where the workers had fled in vain from the fire's heat and smoke.

The disaster brought to light the mostly invisible body count of the American workplace. By some estimates, more than 10,000 workers die each year from on-the-job injuries—about 30 every day. Perhaps 70,000 more are permanently disabled. The fire also exposed the weakness of measures for ensuring job safety. The 11-year-old Imperial Food Products plant had never been inspected. Like a lot of American workplaces, it fell through the gaping cracks of a system in which there are too few inspectors, penalties are mostly trifling, and the procedures for reporting dangerous conditions can leave workers to choose between risking their jobs and risking their lives.

"The tragedy that occurred in Hamlet is a direct result of 10 years of the Reagan-Bush philosophy of letting industry police itself," says Deborah E. Berkowitz, top safety expert for the United Food and Commercial Workers International Union. "There's a USDA inspector in every poultry plant to protect consumers from getting a stomach ache, but there's nobody protecting people from getting killed."

By almost every measure, America's regulatory safeguards have grown threadbare. At the top of the frayed system is the 21-year-old Occupational Safety and Health Administration, the Federal body that attempts to oversee the Nation's 6 million workplaces with just 1,200 inspectors—down from a high of 1,388 in 1980. A strained operation at best, OSHA was stretched to the breaking point by Ronald Reagan, who came to office persuaded that businesses should police themselves. Under him, OSHA's budget fell one-fourth.

OSHA has begun a turnaround under Gerard G. Scannell, a former safety chief at Johnson & Johnson who was chosen to head the agency in 1989. After years in which it rarely issued safety guidelines, OSHA has begun adopting them wholesale—though critics complain it too often approves rules drawn up by the industries it is supposed to supervise. Scannell has also brought eye-catching fines against offenders, including $3.5 million against Arco Chemical and a record $4 million against Phillips Petroleum, after giant explosions at their plants left 40 dead. The agency "is more effective today than it has been in any time in its history," insists Alan McMillan, Deputy Assistant Secretary of Labor for occupational safety and health.

But OSHA still lacks the clout to protect most American workers. By one important measure, the jobsite is safer: work-related fatalities have dropped from 12,500 10 years ago to 10,500 last year. But that is partly because there are fewer jobs these days in some of the most lethal industries, including steel, shipbuilding and logging. Meanwhile, job-related illnesses and crippling injuries are on the increase. "The walking wounded are a part of the cost of doing business," says Bruce Raynor of the Amalgamated Clothing and Textile Workers Union.

Twenty-three States have devised their own regulatory schemes, which exempt them from Federal scrutiny, but the results have been mixed. North Carolina, where the Hamlet fire took place, has one of the worst systems. Under Federal guidelines, the State should have 116 inspectors. Instead it has just 27 to oversee 163,053 employers. Last week the *Charlotte Observer* reported that in 1990 inspections declined 35 percent from the previous year and the State returned $453,000 in unspent Federal money that could have been used to perform more inspections.

Changes in the American economy have left employees more vulnerable, especially the ones in unskilled blue-collar jobs. Labor unions, which can step in to remedy unsafe conditions, now represent just 18 percent of the workforce. Some of the most injury-prone industries, like food processing and textiles, have clustered in right-to-work States across the South, where labor organizers get the kind of welcome that used to greet Freedom Riders.

The merger-and-acquisition craze of the past decade also led to imprudent cost cutting. The elimination of relief crews, forced overtime and deferred (meaning neglected) maintenance have resulted in tired workers and worn equipment—a deadly combination. There are further dangers in industries like oil and petrochemicals, where subcontracting has become a common moneysaving move. Barely trained newcomers, many of them aliens with an imperfect grasp of English, are put at the controls of dangerous machinery, with predictable results. In Texas, six major explosions at chemical plants and refineries have killed 47 workers in the past 5 years and injured 1,000 more. Subcontract employees were believed to have been at fault in two, the blasts at Arco and Phillips.

The hazards of poultry factories are typical of the conditions that workers face in many industries. With the demand for chicken rising as it gains on beef in the American diet, the assembly lines in poultry plants move twice as fast as they did a decade ago, often butchering employees as well as poultry. According to the National Institute for Occupational Safety and Health, 1 in 5 poultry workers has been seriously injured in the hands, wrists or shoulders.

In addition to severe cuts, the most common problems are the chronic disabilities that go under the heading of repetitive-motion trauma. Line workers, who gut, clean and divide hundreds of birds each day, typically perform the same movement from 60 to 90 times a minute, thousands of times a day. When the human body is pressed to imitate the tireless actions of a machine, it revolts. The result is chronic tendonitis and carpal-tunnel syndrome, a painful condition of the wrists and forearms that can leave a worker virtually crippled even after corrective surgery.

Like many dangerous industries, poultry processing has the advantage of a docile workforce. Not only is the complaint process an intimidating bureaucratic tangle, but the plant workers are often poorly paid and uneducated women. Anxious to keep their jobs—despite an average industry wage of just $5.50 an hour—they are unlikely to make waves. Many of the 25 who died in last week's fire were so poor that the Textile Workers Union sent dresses and men's suits to Hamlet for use as burial clothes.

This fall Congress will hold hearings on a bill designed to toughen the regulatory system. Sponsored in the House by Michigan Democrat William Ford, the bill would require any company with more than 11 employees to set up a worker-management safety committee empowered to enforce jobsite safety rules. "Then there's no reason for an inspector to show up to unlock a door," says Franklin Mirer, safety director for the United Auto Workers. "The workers can do it."

Labor organizers and workers' rights groups are calling for stronger measures. Some want an independent investigative body, like the National Transportation Safety Board, with the power to examine accident sites and set in motion industry-wide changes to save lives in the future. Another proposal in the Ford bill is more to their liking. It would make it easier for OSHA to bring criminal charges against individual employers who are repeat offenders. "Everyone knows that the subway worker who killed five people in New York was indicted for murder," says Joseph A. Kinney, executive director of National Safe Workplace Institute in Chicago. "When are we going to be asking for indictments against the owners of Imperial Food?"

And why not? When the recklessness of employers becomes lethal, perhaps it is time to call it a crime—and act accordingly.

Note: Reporting by Joe Kane/Atlanta and Elaine Shannon/Washington. Find this article at: *http://www.time.com/time/magazine/article/0,9171,973801,00.htm*.

Senator MURRAY. Thank you very much.

Ms. Morrow.

STATEMENT OF DORIS MORROW, MEMBER, UFCW LOCAL UNION 227, ROBARDS, KY

Ms. MORROW. Thank you, Chairwoman, Senator Kennedy, Senator Isakson, and Senator Brown, for holding this hearing and letting me testify.

My name is Doris Morrow. I am here to tell you what it's like for poultry workers like me. My voice today represents the 1.3 million members of the United Food and Commercial Workers International Union, and my Local 227.

While I was flying to Washington, for my first trip to the Nation's capital, I just kept thinking, "Why me? I am no one special. I am not famous. I live in the small town of Providence, KY with my husband. I am the mother of two grown children, and grandmother of three grandchildren."

For almost 12 years, I have worked at the Tyson Poultry Plant in Robards, KY. I am one of about 1,000 employees at the plant, who go to work every day to support our families.

There are almost a quarter of a million workers like us in poultry plants across the country. My work at the plant has given me a firsthand look at workers in poultry plants. From my experience, I am here today to tell you that there are serious health problems that must be fixed to protect workers in these plants.

Many of the workers in the plants don't complain about the work conditions, because they're afraid they'll lose their jobs. There aren't a lot of other jobs in western Kentucky, so finding another job would be hard. Despite the risk of injuries, we go to work every day to produce the foods that feed the Nation. I am here today to speak for all of those workers.

I would like to briefly describe what it's like to work in a poultry plant. Let's start with the cold. Just to give you an idea right now, in this committee room, it's 70 degrees. That is over 30 degrees warmer than where I work. Our work environment is extremely cold. It is colder than even the coldest days in Kentucky. Imagine, having to stand outside in the winter, all day, with the wind blowing on you. That's what it's like in my plant.

We work while fans blow the cold air to keep condensation from building up on the ceiling and the walls of the plant. We work in refrigerator and freezer-like conditions. In order to try to stay warm, I wear this pile of clothes to work. When I am dressed with all of these layers, I can barely move because of the clothes. It is very uncomfortable, and I am miserable, but it's the only way to survive the cold.

Some of my co-workers have actually gotten frostbite on their hands and feet. Respiratory problems like bronchitis and pneumonia are commonplace among my co-workers. Many workers come to work sick with coughs, because they can't take off from work.

Another hazard of the cold is icy floors. Water, marinating ingredients and other liquids end up on the floors, making the floors slippery and icy. Although my company has put down nonskid coatings on some of the concrete floors, which have helped, the liquid on the floors sometimes freezes, causing icy patches.

Salt is actually spread on some of the floors to minimize the ice buildup, and provide some traction for walking, yet workers do slip and fall. We have also slipped and fallen when the floor grates—which sometimes do not fit properly—are not put back tightly after cleaning.

In addition, workers are injured from repetitive motion and the rapid line speed. Workers are also injured by pushing and lifting pounds of chicken pieces along the line, and by having to lift and

stack tubs of chicken parts that weigh 70 pounds or more, to skids and hoppers to be dumped.

Some of the workers who have been assigned to stack the tubs, which can reach over 5-feet high, are actually shorter than the stack. Lifting and pushing these piles of meat can cause carpal tunnel, as well as back and shoulder problems. Repetitive stress injuries are also a huge problem. Imagine using the same motion thousands and thousands of times a day. Without relief, you can't do that day in and day out without injuring yourself. Think about workers doing the same repetitive motion for 8 or 9 hours a day, 5 or 6 days a week, 51 weeks a year. In my plant, we process between 150,000 and 250,000 chickens a day.

Working at a poultry plant is hard work, but hard work should not be unsafe work. No worker should be allowed to work in an unsafe work environment. I am one of the lucky people in poultry, because I have a union that provides for its members. But a safe plant takes day-in and day-out attention.

I came to Washington, DC to tell you that more needs to be done to protect workers in this country. I am one worker who is here to tell you that we need your help. There are preventable injuries and deaths occurring every day in poultry plants across this country.

There are workers who go to work to support their families, and to provide you with the chicken you eat, who are working in cold, icy and unsafe conditions. I know there are things that government and management can do to make our workplaces safer, if only they would. It is time that OSHA starts protecting workers from safety and health hazards. It is time Congress, OSHA and management listen to the worker's concerns, and take actions to make the workplace safe for all workers.

I thank you for listening to me today, and for allowing me to testify. I urge you to use the power of your offices to help the poultry workers, and all of the workers in this country.

I would be happy to answer any questions you may have.

[The prepared statement of Ms. Morrow follows:]

PREPARED STATEMENT OF DORIS MORROW

Thank you Chairwoman Murray, Senator Isakson, and members of the subcommittee for holding this hearing and for the opportunity to testify. My name is Doris Morrow. I was born and raised in a small town in Kentucky. This is my first time in Washington, DC and I am here today as a worker in this country to tell you my and my coworkers' stories. My voice today represents the 1.3 million members of the United Food and Commercial Workers International Union (UFCW) and my Local 227. It is indeed an honor to be here in Washington to testify today at this important hearing.

I now live in Providence, KY. I am a wife, mother of two grown children and grandmother of three grandchildren. For almost 12 years, I have worked at the Tyson Poultry plant in Robards, KY. I am a "spreader" at the plant, which means I separate parts of the chicken on the line. I work with one other worker in the Individual Quick Frozen area. We stand for our entire shifts in an extremely cold environment. In my years at Tyson Robards, I have also worked in the deboning department with knives.

This experience has given me a first-hand look at workers in poultry plants and I believe there are serious safety and health problems that must be addressed to protect workers in these plants across the country. Respiratory problems like bronchitis and pneumonia are common place given the cold temperatures in the plants. Back and muscular problems are common due to wet, icy and slippery floors and moving heavy tubs of chicken products. Sore hands, carpal tunnel and other Musculoskeletal Disorders (MSDs) are a major problem that workers face because of the rapid line speed and repetitive motion. Many of the workers in plants are afraid to

complain about the work conditions because they are fearful they will lose their jobs. I am here today to speak for all these workers.

I would like to describe in more detail what it is like to work in a poultry processing plant. Let's start with the cold. Typically our work environment is extremely cold and we are standing and working in frigid temperatures for hours at a time. It is especially cold because the company has installed fans to keep condensation, a food safety problem, from building up on the ceiling and the walls of the plant. This produces an additional wind chill affect.

Every day, I wear to work three long-john shirts, one long sleeve shirt, two jackets, long-john pants, pants and two pairs of socks. I purchased a $70 cover-up to wear over all these layers to try to keep myself warm. I also wear two pairs of gloves while I work. I keep an extra pair in my pocket to change into when the first pairs get too cold. By the time I am dressed with all these layers, I can barely move because of the bulk of the clothes. It is very uncomfortable to work in so many clothes and under these conditions and still be cold.

My coworkers on Line 1 have contracted frost-bite on their hands and feet. Let me say that again, my coworkers get frost-bite from working in these freezing temperatures. Sometimes we go to the sink to warm up our hands under the water or take 30 minutes to get totally warm in the bathroom. Management has complained about the time we take to warm up but we need this time to get warm again. Management gives us 10-minute restroom breaks but it takes that long just to get off the production floor to the restroom. After we are warmer, we return to the freezing cold and icy floors. There is a very high rate of respiratory illnesses among my coworkers because of the climate we work in. Many workers come to work with colds and coughs because they can't take time off from work.

OSHA has come in for quick checks of the temperature in the plant but has said that it is fine. We know differently. Stand in the cold for more than a few minutes and you know what cold is. There ought to be OSHA rules about working in this kind of environment.

Another hazard of the cold temperature is the icy floors. Water, marinating ingredients and other liquids end up on the floor, making the floors slippery and icy. Although my company has put down non-skid coatings on some of the concrete floors which have helped, the liquid on the floors sometimes freezes, causing icy patches. Salt is actually spread on some of the floors to minimize the ice build-up and provide some traction for walking. Workers have slipped and fallen on these surfaces. Workers have also slipped and fallen when the floor grates, which sometimes do not fit properly, are not put back tightly after cleaning. These grates are a foot wide.

While I only work next to one other employee, in other departments many workers stand very close to one another all using sharp knifes to cut the chickens. Workers are injured from repetitive motion and the rapid line speed. Workers are also injured by pushing and lifting pounds of chicken pieces along the line every hour. Many workers are injured by having to lift and stack tubs of chicken parts that weigh 70 pounds or more to skids and hoppers to be dumped. Many of these workers are actually shorter than the stack of tubs which can reach over 5½ feet high. Lifting, removing and pushing these piles of meat can cause carpal tunnel as well as back, shoulder and neck problems.

MSDs are a continual health hazard. If you are a line worker removing bones from chicken breasts, you use one motion with your knife thousands and thousands of times a day. You steady the breast then pull the knife towards you to cut the bone free. It is not like cutting hot butter. You are actually making a cut through something that offers resistance. Perhaps not that difficult the first five times but workers are making that same cut or a similar cut 25,000 to 40,000 times a day. Without relief, you cannot do that day in and day out without injuring yourself, especially given all the other hazards surrounding you. Think about workers doing the same repetitive job for 8 or 9 hours a day, 5 or 6 days a week, 50 or 51 weeks a year.

Just imagine working in a freezing environment, on slippery floors, repeating the same motion and pushing pounds of meat down the line. Imagining the typical work day makes it easy to understand why workers' wrists and hands, their elbows and shoulders, and their backs and legs show the wear and tear in very painful injuries. In my plant, we process between 150,000 and 250,000 chickens a day.

Working at a poultry plant is hard work. But hard work should not be unsafe work. I am one of the lucky people in the poultry industry. I have a union that provides safety training and support for its members. We have a safety committee whose members include workers that work with management to correct unsafe conditions.

A safe plant takes day in and day out attention. With the union, we have that. The union has to be constantly vigilant. We need to watch every day. It is an ongoing battle. In non-union plants, that simply doesn't happen.

Without the support of the employers and the government, workers are injured every day. I have seen first hand my coworkers' injuries. I know two coworkers with crippling injuries from working in the poultry plants. I know another coworker who was so severely injured that she had to work in the supply room for over a year because of her injury.

Like I said, I'm lucky because I work in a union plant. Having a union in our plant means that workers can avoid a lot of these injuries. The union has been great for me and my coworkers. We have someone fighting for us. When I first started working at this plant, it was a non-union plant. I know first-hand the difference between a non-union plant when people are too afraid to speak up and a plant where we can turn to the union when we see problems, including safety problems. But there are two problems that still exist—the number of unionized plants in the United States and the total lack of real government intervention in the safety and health of workers in this country.

Only 30 percent of poultry plants in the country have a union.

The 70 percent of the plants without a union have the power to set the standards especially given the lax government intervention that exists today. These non-union plants bring everyone down to their level. And that level causes workers to suffer injuries that are preventable.

My union, the UFCW, has monitored some of these non-union plants and has found broken or missing safety equipment and unguarded blades, unbelievably fast line speeds, excessively long work days, tiled floors with no traction when they are wet, factories with no emergency lighting to provide illumination to get out of messy and dangerous plants when there are power outages, ammonia leaks, and limited or no safety training or any training for employees. There are so many hazards at these plants that when workers, who are often afraid to complain for fear of losing their jobs, do complain they are often ignored. If workers go to the health centers with injuries, they are given ice packs, ibuprofen or ointment to take care of the problem and are then sent back to work.

UFCW has always fought to prevent worker injuries. The union began working specifically on repetitive stress injuries in the 1980s. We worked with Senator Dole when she was Secretary of Labor to begin developing an OSHA ergonomic standard. After 10 years of work and scientific analysis we got an ergonomics standard for workers. But when President Bush took office, he had the standard repealed. Due to the lack of OSHA enforcement for ergonomics, workers are once again suffering high rates of injuries. Repealing this crucial standard was only the first backwards step in protecting workers.

A lot of management in the poultry industry will say that injuries are not real. Management will argue that repetitive stress injuries don't happen at work. They say that they happen at home. But I am here to tell you the truth. Nothing we do at home requires that kind of repetition like we do at work—making 40,000 cuts in a single shift. Workplace ergonomic hazards are injuring and crippling workers. Changes in job station and work design can prevent these injuries. My employer has made some changes to Line 3 at my plant but more are needed. It is time to demand that the government and companies protect workers and prevent these injuries.

Management will also tell you that they have to keep our work stations so cold to keep the condensation from forming on the plant's ceiling. Clearly, I do not have to work in a refrigerator to produce safe food for consumers. Having almost 180 workers call in sick in one day is a clear sign that something is wrong in these plants. It is time to turn the thermostats up to protect the workers.

Management will tell you that they try to keep the floors clean and dry but that is simply not always the case. One worker injury on a wet and icy floor is one too many. Too many workers are getting injured by falling on the floors. More can be done to the floors to prevent these injuries.

I have seen first hand the problems in poultry plants. I have seen first hand the injuries of my coworkers. I know there are things we can do to make our workplaces safer. It is time that we think about the workers and protect us from these safety and health hazards.

Thank you again for the opportunity to testify today and tell you the stories of workers in poultry plants across this country. I urge you to use the power of your offices to help the workers who provide the food for this Nation by protecting our safety and health at work. Again, thank you for your time and I would be pleased to answer any questions that you may have.

Senator MURRAY. Thank you very much. Thank you for coming all the way to Washington, DC and being a voice for many people who can't. Thank you.

Mr. Scannell.

STATEMENT OF GERARD F. SCANNELL, FORMER OSHA DIRECTOR AND FORMER CHAIR OF THE NATIONAL SAFETY COUNCIL, WASHINGTON, DC

Mr. SCANNELL. Good morning, Chairwoman Murray, Ranking Member Isakson, Chairman Kennedy and Senator Brown.

I want to thank you for the opportunity for me to speak with you today, and to testify and maybe after my testimony we can chat a little bit about more specifics on what can be done.

I am Jerry Scannell, I am retired, living in Venice, FL and Cape Cod, MA. My prior experience covers 40 years managing safety and health environmental programs. A few of those positions were as Safety Director of Bristol plant of Rohm & Haas Company, Vice President of Safety & Health, Johnson & Johnson, Assistant Secretary of Labor for the Occupational Safety and Health Administration and President and CEO of the National Security Council.

What the past 40 years of experience has proven to me is that safety and health programs must be fully integrated in the overall company management system. I think Senator Isakson was really saying that, when he was talking about his experience with his company.

Paul O'Neill, one of the great CEOs for safety and health, and I would like to talk about Paul a little later on, about some of my experiences with Paul.

The CEO, or equivalent, must hold the next layer of management accountable for all aspects of management. That I see as one of the problems in our country today—business hires people, they give them the responsibility, but they don't hold people accountable. You need to have that cascading effect of each layer of management, holding the next layer accountable—not only for production, and EEOC and others, but safety and health.

It happens to be safety, so often, is the one that you don't spend your time on. If they don't spend their time on—if I'm a boss, and I ask a person under me what is he doing about the safety and health conditions and so forth, he or she will probably spend some attention on that, at least some time. But if I never ask that person, what are they doing for safety and health, he or she probably won't put much time in that. It's just human nature.

Holding the people accountable, is key to making a successful program, in all aspects of business. When the accountability of safety is missing, the communications between management gets fuzzy, or at best, poor.

Back in the early 1990s, I talked to CEOs of companies who were involved in catastrophic explosions. One common denominator in several explosions was a breakdown in the vertical communications. Almost every CEO said, "No one ever told me that we were at risk." Yet, executives and managers at a very high level knew exactly the risk, and did not want to take the bad news to the boss. As a result, there were major explosions, multiple deaths, it was

one explosion after another. ARCO, BASF, it went on and on and on.

Good companies, but there was a management failure in the system, and that's what I call, one of the major problems in our organizations today, is a management system failure. Some part of management failed to do something.

Now, we all know the OSHA Act clearly places responsibility on the employer for maintaining a safe workplace. However, complying with current OSHA standards and regulations will not guarantee a safe workplace. You need more than that. You need the management involvement, the management system, to be assured those safety standards and regulations are followed through. You need additional training and education that may not be called for in the OSHA standards, at this particular time.

There needs to be a management system, fully integrated, in the OSHA standards and other requirements. There are many companies that have safety management systems models, and I'd like to maybe talk about that, after everyone has an opportunity to deliver their testimony.

I think there's leadership lacking in our country, in industry. You know, boy—I'll get it, I'll take it on the chin later on—but what about the U.S. Chamber of Commerce? Great organization. Why don't they take some leadership and provide some of the knowledge that Paul O'Neill has, and that I think we have at Johnson & Johnson, certainly DuPont, and gather those CEOs together, and communicate what is needed, what they should do? We need that leadership.

The Occupational Safety and Health Act was passed in 1970, due largely in dedication to two individuals, and Senator Kennedy mentioned them—Senator Pete Williams from New Jersey, and Bill Steiger from Wisconsin. They're not with us anymore today, but I suspect they're looking down on us, and want to be sure that we're going to do things right today.

Thank you very much.

[The prepared statement of Mr. Scannell follows:]

PREPARED STATEMENT OF GERARD SCANNELL

Chairwoman Murray, Ranking Member Isakson and members of the subcommittee, thank you for the opportunity to testify today.

I am Jerry Scannell. I am retired and living in Venice, FL and Cape Cod, MA.

My prior experience covers 40 years managing safety, health and environmental programs. A few of those positions were, Safety Director, Bristol PA plant, Rohm & Haas; VP Safety & Health, Johnson & Johnson: Assistant Secretary of Labor, Occupational Safety and Health Administration; President and CEO, National Safety Council.

What the past 40+ years of experience has proven to me is that Safety and Health programs must be fully integrated in the overall Company Management System! By that I mean, Safety and Health responsibility starts at the top of a company as with everything else in that company. The CEO or equivalent must hold the next layer of management accountable for all aspects of managing the company business. That layer of management must then hold the next layer of management accountable for their responsibility. It then cascades down to the lowest level of management. If managers are not held accountable for some aspect of their job, then guess what? They probably won't spend much time on it. If it happens to be safety as so often happens, then the safety effort will suffer and something or someone will be harmed.

When the accountability of safety is missing, the communications between management gets fuzzy or at best poor. Back in the early 1990s I talked to CEO's of

companies who were involved in catastrophic explosions. One common denominator in several explosions was a breakdown in vertical communications. Almost every CEO said "no one ever told me we were at risk." The communications stopped at the mid-executive level. There were executives and upper level managers that knew the company was at risk. The words most often used at that time were "cut costs." Here we are years later and I'm hearing the same words from the BP and other incidents.

We are having management systems failures.

We all know the **OSHA ACT** clearly places responsibility on the employer for maintaining a safe workplace. However, complying with currant OSHA standards and regulations will not guarantee a safe workplace. There needs to be a management system fully integrated into the OSHA standards and other requirements in order to insure a safe working environment.

There are many companies that have safety management system models that can be used to show how to operate a safe program. I will show you just one that I had documented for use at J&J. For other companies, I would suggest you contact DuPont, The National Safety Council, or ORC.

In conclusion, I want to express my appreciation to the subcommittee for allowing me to share my thoughts with you on this important issue for all Americans, and I thank the Chair and all members of the subcommittee for your dedication to safety and health.

The Occupational Safety and Health Act was passed in 1970 due largely to the dedication and persistence of two individuals: Senator Pete Williams of New Jersey and Congressman William Steiger of Wisconsin. Few people know that when OSHA was established, I served as the Director of Safety and Health Standards for the agency. Even fewer know that in those days Senator Williams and Congressman Steiger would call me directly, and frequently, to tell me that they are watching and keeping an eye on what I and the rest of standards professionals are doing. They expected us to do the best job, not only for the agency, but for the benefit of the American worker and the American public. While many years have passed since those early years and while Senator Williams and Congressman Steiger are no longer with us, I still feel that they are watching us and judging us to see if we are doing the best possible job.

Thank you for your attention.

The CHAIRMAN. Thank you.

Mr. Bianco.

STATEMENT OF CARMEN BIANCO, EXECUTIVE CONSULTANT, BEHAVIORAL SCIENCE TECHNOLOGY, INC., OJAI, CA

Mr. BIANCO. Good morning, Chairman Kennedy, Chairwoman Murray, Ranking Member Isakson and distinguished members of the U.S. Senate, Employment and Workplace Safety Subcommittee. Behavioral Science Technology thanks the subcommittee for the opportunity to present this testimony on achieving safety excellence through the use of employee engagement and leadership enhancement to create a strong culture.

BST was founded back in 1979 by Dr. Thomas R. Krause and Dr. John Hidley. Doctors Krause and Hidley recognize that most safety initiatives at the time, focused on equipment and procedures, but not the organizational and cultural causes of workplace injuries and accidents.

Doctors Krause and Hidley adapted the research on applied behavioral analysis to reflect the teachings of Dr. W. Edwards Deming, and the experience of other practitioners in organizational change.

As this approach evolved, approximately 8 years ago, BST expanded its focus to work more explicitly on leadership behaviors, and its relationship to organizational culture as a critical factor in achieving safety excellence.

By working with executives, managers, supervisors, and individual contributors to enhance their effectiveness as safety leaders, we have helped organizations build on their existing success to achieve step-changes in safety performance. The comprehensive technology has subsequently been customized and adapted for more than 2,000 client locations, in more than 50 countries.

In addition, BST has worked successfully in both union, and nonunion environments, with approximately half of our work at union locations, and half at nonunion sites.

BST's technology has been applied successfully in the mining, petroleum, chemical, metals, paper, food, utility, railroad, and healthcare industry, as well as by government agencies.

Following the space shuttle Columbia tragedy, BST was asked to assess NASA's culture, and recommend an intervention approach to help address the findings of the Columbia accident investigation board.

BST's approach targets the reduction of exposure in the workplace, through the identification of system issues that predispose at-risk behavior, in addition to creating a culture at which at-risk behavior is minimized, and the effectiveness of safety systems is maximized.

Located throughout the United States, Canada, Europe, South America and Asia, BST's staff includes experts in safety, behavioral science, engineering, management, industrial hygiene, statistics, quality and operations. The approach taken by BST is holistic, recognizing that leadership at all levels creates the culture that supports or inhibits the effectiveness of safety programs.

BTS's approach involved employees at all levels in the continuous improvement of safety, through identification of hazards, measurement of safe practices, and improvement of underlying systems. It is these systems that lead to the creation of exposure.

This approach is a proactive process that improves the systems, producing safety-related behavior, and exposures upstream before accidents occur. It is based on measurement, upstream sampling of key variables, problem-solving, and employee involvement.

Data collection and feedback are key aspects of the approach, which identifies and corrects existing systems that produce at-risk behavior, and develops new systems that encourage safe behavior.

Another aspect of BST's approach is working with individual leaders throughout the organization to build critical leadership skills, and employ those skills to support organizational value for safety improvement. This work includes a mixture of individual coaching and group training sessions, with feedback to individuals on their leadership effectiveness.

We begin by assessing the organization's culture, to understand how to tailor an implementation to the specific organization. Using a cultural diagnostic instrument that is shown to be predictive of safety outcomes, we identify the organization's strengths and weaknesses. For example, we may find that the credibility of senior management is good, but the first-line supervisors may be weak in safety leadership skills.

After the planning, we typically work with an organization's leadership to help them understand the issues identified, and their role in supporting the initiative. We also work with an implementa-

tion team, comprised largely of front-line employees from the organization. We teach that team to identify the critical exposures at their location, to do informational meetings with other employees, to sample at-risk behaviors that are indicative of exposures, usually through a peer observation process. We then teach the team to train other employees to do this sampling.

Part of the sampling process is a feedback step done to reinforce safe behaviors, and to gain understanding of the causes of observed at-risk behaviors. Data is captured, and used to evaluate and mitigate the system-based factors that cause at-risk behavior.

Through this process, an organization builds a strong safety-supporting culture. The organization has an improved understanding of the exposures that it must manage, and a new ability to identify and address the underlying causes of exposure, enabling employees to work safely, and providing reinforcement when they do.

Managers and supervisors improve their ability to support safety initiatives, and communicate with frontline employees. Employees develop a strong enhanced ability to communicate with each other, and with leadership, about effective, about employee—about safety issues. Employees at all levels are engaged in the ownership for safety.

In working with more than 2,000 organizations, we have found that addressing leadership and culture is an important addition to the traditional safety programs, such as training, audits and policies. It is important to understand that this approach does not substitute for those traditional programs, which must be present for safety excellence, but those traditional programs alone are not sufficient to give organizations excellence and continuous improvement.

On average, our clients have achieved a 25 percent improvement in their insuring rates during the first year, with further improvement reaching more than 65 percent in the next 4 years.

The process also has proven sustainability. In a study conducted several years ago, we determined that over a 13-year period, more than 90 percent of our implementations remain active.

BST's approach incorporates mechanisms for addressing not only the exposures, under the direct control of workers, but also exposures that are dictated by facilities, equipment, design and procedures. In doing so, it promotes engagement and collaboration at all levels of the organization.

In conclusion, BST's comprehensive culture and leadership-based approach to safety is a powerful method for engaging employees at all levels in the collaborative identification and mitigation of exposures to safety hazards in the workplace. This approach helps organizations build a strong culture that not only supports safety, but also contributes to overall organizational excellence. With a proven track record, unparalleled by other approaches, this approach should be considered by any organization interested in safety improvement.

I thank you for having me here today to provide testimony on such a critical topic, and I'm available to answer any of your questions. Thank you.

[The prepared statement of Mr. Bianco follows:]

PREPARED STATEMENT OF THOMAS R. KRAUSE, PH.D., CHAIRMAN, R. SCOTT STRICOFF, PRESIDENT, AND CARMEN J. BIANCO, EXECUTIVE CONSULTANT

Chairwoman Murray, Ranking Member Isakson and distinguished members of the U.S. Senate Employment and Workplace Safety Subcommittee, the Behavioral Science Technology, Inc. (BST®) thanks the subcommittee for the opportunity to present this testimony on achieving safety excellence through the use of employee engagement and leadership enhancement to create a strong culture.

BST'S BACKGROUND

BST was founded in 1979 by Dr. Thomas R. Krause and Dr. John Hidley. Drs. Krause and Hidley recognized that most safety initiatives at that time focused on equipment and procedures, but did not help us understand the organizational and cultural causes of workplace injuries and accidents. Drs. Krause and Hidley adapted the research on applied behavior analysis to reflect the teachings of Dr. W. Edwards Deming and the experience of other practitioners in organization change. As this approach evolved, approximately 8 years ago BST expanded its focus to work more explicitly on leadership behavior and its relationship to organizational culture as critical factors in achieving safety excellence.

By working with executives, managers, supervisors, and individual contributors to enhance their effectiveness as safety leaders, we have helped organizations build on their existing success to achieve step changes in safety performance. The comprehensive technology that has resulted has subsequently been customized and adapted for more than 2,000 client locations in more than 50 countries. In addition, BST has worked successfully in both union and non-union environments, with approximately half of our work at union locations and half at non-union sites. BST technology has been applied successfully in industries such as mining, petroleum, chemical, metals, paper, food, utilities, railroads, and health care, as well as by government agencies. Following the Space Shuttle Columbia tragedy, BST was asked to assess NASA's culture and recommend an intervention approach to help address the findings of the Columbia Accident Investigation Board (see case history section). BST's approach targets the reduction of exposure in the workplace through identification of systems issues that predispose at-risk behavior in addition to creating a culture in which at-risk behavior is minimized and the effectiveness of safety systems is maximized.

BST today has a staff of approximately 170 located throughout the United States, Canada, Europe, South America, and Asia. BST's staff includes experts in safety, behavioral science, engineering, management, industrial hygiene, statistics, quality, and operations. BST is the only organization in the field that has published long-term results of its overall client experience in an independently-reviewed technical journal (*Safety Science*, 32 (1999) 1–18.)

WHAT IS BST'S APPROACH?

The approach taken by BST is holistic, recognizing that leadership at all levels creates the culture that supports or inhibits the effectiveness of safety programs.

One aspect of BST's approach involves engaging employees at all levels in the continuous improvement of safety through identification of hazards, measurement of safe practices, and improvement of underlying systems. It is these systems that lead to the creation of exposures. This approach is a proactive process that improves the systems producing safety-related behaviors and exposures upstream, before accidents happen. It is based on measurement, upstream sampling of key variables, problem solving, and employee involvement. Data collection and feedback are key aspects of the approach, which identifies and corrects existing systems that produce at-risk behavior, and develops new systems that encourage safe behavior.

Another aspect of BST's approach is working with individual leaders throughout the organization to build critical leadership skills and employ those skills to support organizational values for safety improvement. This work includes a mixture of individual coaching and group training sessions, with feedback to individuals on their leadership effectiveness.

We begin by assessing the organization's culture to understand how to tailor an implementation to the specific organization. Using a cultural diagnostic instrument that has been shown to be predictive of safety outcomes, we identify the organization's strengths and weaknesses. For example, we might find that the credibility of senior management is good, but first-line supervisors are weak in safety leadership skills.

After the planning, we usually work with an organization's leadership to help them understand the issues identified and their role in supporting the initiative. We

also work with an implementation team comprised largely of front-line employees from the organization. We teach that team to identify the critical exposures at their location, to do informational meetings for other employees, and to sample at-risk behaviors that are indicative of exposures, usually through a peer-observation process. We then teach the team to train other employees to do this sampling. Part of the sampling process is a feedback step done to reinforce safe behaviors and to gain understanding of the causes of observed at-risk behaviors. Data is captured and used to evaluate and mitigate the systems-based factors that cause at-risk behavior.

Through this process an organization builds a strong safety-supporting culture. The organization has an improved understanding of the exposures that it must manage and a new ability to identify and address underlying causes of exposure, thereby enabling employees to work safely and providing reinforcement when they do. Managers and supervisors improve their ability to support safety initiatives and communicate with front-line employees. Employees develop a strongly enhanced ability to communicate with each other and with leadership about safety issues. Employees at all levels are engaged and take ownership for safety.

The BST approach is described in Dr. Krause's book, *Leading with Safety* (John Wiley & Sons, 2005).

BENEFITS OF THIS APPROACH

In working with more than 2,000 organizations, we have found that addressing leadership and culture is an important addition to traditional safety programs such as training, audits, policies, etc. It is important to understand that this approach does not substitute for those traditional programs, which must be present for safety excellence. But those traditional programs alone are not sufficient to give organizations excellence and continuous improvement.

On average, our clients have achieved 25 percent improvement in their injury rates during the first year and further improvement reaching more than 65 percent over the next 4 years. The results are representative of our complete body of clients and have been published by an independently reviewed safety management journal reflecting long-term (5 year) results (*Safety Science*, 32 (1999) 1–18.)

The process also has proven sustainability. In a study conducted several years ago we determined that over a 13-year period, more than 90 percent of our implementations remained active.

BST's approach incorporates mechanisms for addressing not only the exposures under the direct control of the worker but also exposures that are dictated by facilities, equipment, design, or procedures. In doing so it promotes engagement and collaboration of all levels of the organization.

This approach is truly data based, providing upstream measures of safety. This allows data-driven management of process quality, and discriminates between significant and random performance variation. This data-based approach allows the process to impact the conditions, systems, and cultural issues that encourage at-risk behavior at all levels of the organization.

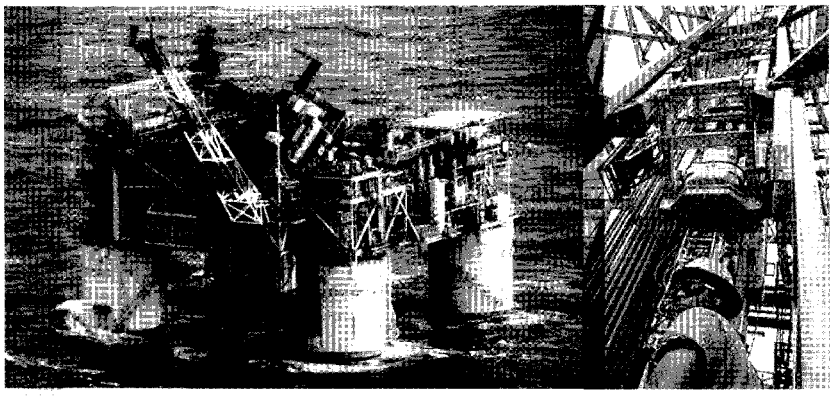
SUCCESS STORIES

Attached to this document is a series of articles that describe the individual experience of various organizations in implementing BST's approaches.

CONCLUSION

BST's comprehensive culture and leadership-based approach to safety is a powerful method for engaging employees at all levels in the collaborative identification and mitigation of exposures to safety hazards in the workplace. This approach helps organizations build a strong culture that not only supports safety, but also contributes to overall organizational excellence. With a proven track record unparalleled by other approaches, this approach should be considered by any organization interested in safety improvement.

I thank you for having me here today to provide testimony on such a critical topic. I am happy to answer any questions.



SHELL'S MARS PLATFORM.—SAFETY IN KATRINA'S WAKE

(By Nicholas Zepeda)

SITUATION

Hurricane Katrina significantly damaged the deepwater tension-leg Mars platform, operated in the Gulf of Mexico by Shell and co-owned with BP. Four hours of 170 mph winds and 200 mph wind gusts and wave run-up heights of up to 100 feet overtaxed the massive clamps holding the 1,000-ton drilling rig, causing the structure to fail and topple onto the deck. The storm also set adrift a mobile drilling rig in the Mars platform vicinity and dragged its anchor over the Mars underwater export pipelines, cracking them. Mars' oil and gas production, the largest (by daily volume) platform in the Gulf of Mexico, shut in advance of the storm and would stay at zero for some time.

Shell Operations Manager Floyd Landry led the salvage and reconstruction project. Despite the risk issues involved with working around bent steel, collapsed superstructures, and sunken materials, Shell was able to put the Mars platform back in operation staying true to their safety goal: zero serious injuries and all workers return home safely.

HOW THEY DID IT

Shell made sure they had the right technical equipment and experts for the project. They contracted a Finnish ice breaker and Dutch derrick barges for removing the toppled drilling rig structure and ferrying it to shore for repairs. They brought in a five-story Hotel (floating hotel) with a unique, deepwater mooring system from the North Sea for the living space needed for the extra 600 specialists. In addition, they used remote-controlled robotic units and a specially designed pipe repair kit to fix damaged pipelines 2,700 ft. below the surface.

Throughout the salvage and repair operation, Shell maintained a comprehensive and rigorous safety regimen. They conducted daily management and weekly safety staff meetings, safety walkthrough, and job site environmental audits. The Behavioral Accident Prevention Process® (BAPP®) safety initiative, Continuous Observation Awareness Technique (C.O.A.T.), remained active around the clock, training everyone on site in behavior-based safety (BBS). Interpreters enabled the work crew, made up of technicians from around the world, to fully understand the training.

Personnel from throughout Shell experienced in BBS assisted Mars with safety work sponsorship. This extra help enabled C.O.A.T. to observe all types of work involved in the project. The sponsors coached new observers in side-by-side observations. Through more than 2,600 behavior-based observations, the process tracked exposures and critical behaviors for trends that revealed barriers to safe work. One observer identified fall protection exposures under Deck 1 where much of the work was over water. The personal flotation devices workers were wearing made crawling around and among piping difficult. The observation data prompted Shell to provide a new type of fall protection with built-in flotation devices.

The presence of C.O.A.T helped everyone on the platform stay focused on safety. The site was able to remove or mitigate 365 exposures to risk identified by observations during the project.

RESULTS

The Mars platform went back on line in May 2006. The safety numbers showed no recordable injuries during 1 million work hours. By the time the drilling rig was put back on in March 2007, the site had logged 1.2 million salvage and reconstruction work hours without a recordable injury. The site also added other safety features to their operations: new clamps capable of withstanding 2 million psi, four times as strong as the previous clamps, improved communications systems critical for monitoring approaching storms, more on-call helicopters and ships for evacuations, and a greater number of spare parts available for emergency repairs. Shell also began a study of alternate ways to get oil to refineries when pipelines are damaged. In addition, the company participated in a joint industry effort to develop more robust mooring systems and practices for offshore drilling rigs.

Marvin Odum, executive vice president and head of Shell Exploration & Production in North and South America says,

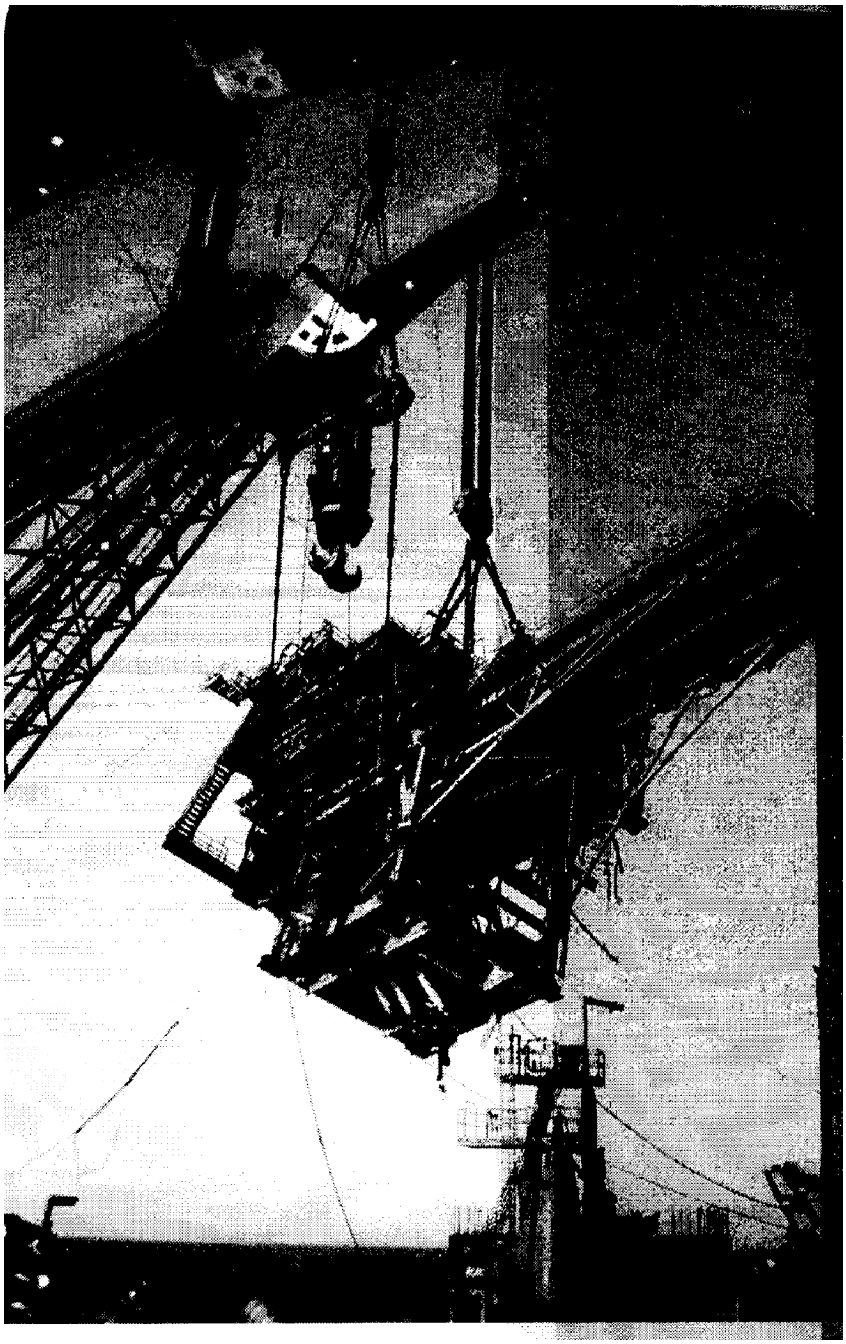
> "The Mars platform recovery and deepwater pipeline repairs were among the most technologically complex operations in the world, and our people were up to the task, completing the work safely and ahead of schedule."

At a Glance

The Mars platform is moored in 3,000 feet of water 130 miles south of New Orleans.

Over 2,600 behavior-based safety observations identified 365 exposures on site.

Shell's post-Katrina repairs to the Mars platform were completed with no recordable injuries during 1.2 million work hours.



CASE STUDY.—MAKING GOOD LEADERSHIP EVEN BETTER: ACCELERATING EXCELLENCE AT AN AGRICULTURAL PRODUCTS PRODUCER

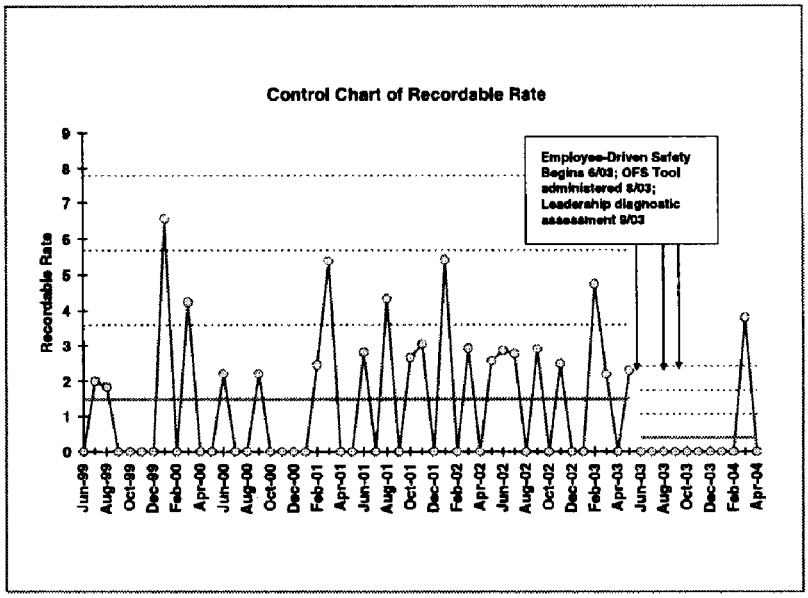
The Florida operations of this phosphates business had already received an Agri-Business of the year award when it decided to improve its safety leadership. Made up of three major facilities over a 4-mile radius, the 620-employee operation has an annual capacity of 3.6 million tons of phosphate rock and 1 million tons of phosphoric acid. Maintaining this level of production, and its status as the low-cost producer in the industry, is serious business that takes high functioning leaders at all levels in three facilities. When the Florida operations implemented an employee-driven safety system early in 2004, it recognized the need to develop even better coordination across areas and functions as it captured data on exposure to risk. Each location had its own facilitator to oversee process activities, however managing resources across such a large area would require finely-tuned alignment on what the company wanted to accomplish and how.

DEVELOPING A VISION

Leaders at this location knew that one of the keys to creating alignment would be fostering a strong safety vision. If they could articulate where they wanted the company to be in the future and how it was going to get there, they could in turn determine the kind of time and resources to put into safety. The key was making sure that all leaders, from the process facilitators on up, had the skills to maintain a consistent message in their words and actions. So when a corporate-wide initiative called for managers at all sites to engage in leadership development, the managers jumped at the chance: they wanted to use their development activities to become better at articulating and implementing a safety vision for the company's 620 employees.

The management team invited BST to design a solution that would help them meet their goals. BST helped the client assess the leadership characteristics of each leader. This included the facilitators of the employee-driven safety processes in the management group. Results showed that many of these leaders were already strong and influential and that they were viewed positively by others in the organization. However, even the strongest leaders tended to experience diminishing effectiveness across the locations or outside of their immediate workgroup.

Before crafting a leadership development strategy, BST worked with the client's leaders—including the facilitator—to define what their vision of safety was. Working with this group of leaders, a BST consultant challenged them to think outside of traditional safety visions and articulate their own vision in strategic terms. By asking questions like, What does safety really mean to your organization? Where does it fit in the scheme of other objectives and initiatives? What does it mean to your place in the market and the bottom line? The BST consultant was able to help the leaders reframe their thinking of leadership in safety. As a result, they developed a list of principles that they wanted to define their actions: Uphold the safety regulations even if cost or production is at stake; Communicate frequently and effectively up, down and across the organization; Ensure that people have the information, authority and resources they need; and Treat others with dignity and respect.

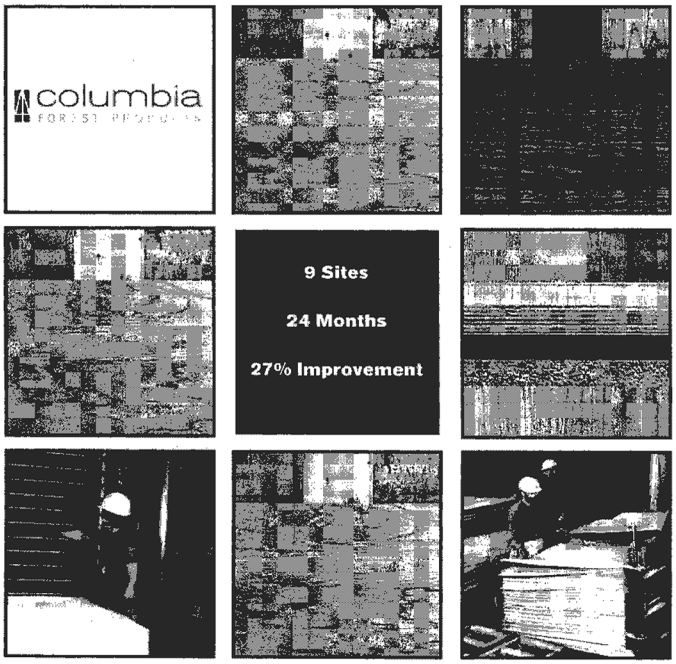


With a clear picture of what they wanted their leadership to look like, they then worked individually with BST consultants to design personal strategies for improving their interactions with those who report to them, and enacting their new vision. In particular, they had to define what their successes would look like. BST then helped them identify ways to gain feedback on how well they measured up to the new safety values. Once the managers had drafted their individual plans, they worked with BST to trickle the new safety vision down through the organization more effectively by learning how to coach their own reports and help them develop similar coaching plans for themselves.

OUTCOMES

Less than a year after starting the new initiative, the client was able to reduce its injury rate by more than half, including a 6-month streak without a recordable injury. And within just a few months of defining their new safety vision and starting their personal action plans, most leaders were able to document changes in their relationship with departments, showing that the new safety vision is working.

Leading with Safety at Columbia Forest Products



How this 2,400 employee division engaged employees from the millfloor to the corporate office to redefine its culture, performance, and safety leadership

Rebecca Nigel, Steven Luttrull, Stan Owens & Don Carter

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Like many international companies, Columbia Forest Products contends with the challenge of maintaining a consistent standard of performance across multiple sites. The 49-year-old employee-owned company has 18 manufacturing locations in the United States and Canada, making it North America's largest manufacturer of hardwood plywood and hardwood veneer products, and through its subsidiary Columbia Flooring, the leading producer of hardwood and laminate flooring. Recognized as an industry leader, the company prides itself on responsive customer service as well as leading advancements in the field, most recently launching a new low-cost alternative to formaldehyde-based adhesives in its plywood products. Attributing its market leadership to a spirit of innovation and employee empowerment, in 2004 the company embarked on a new venture; pioneering an all-employee safety approach in the plywood division's nine sites, covering 2,800 employees. Adapting practices that target culture and leadership in addition to exposures at the millfloor, the division has in 24 years realized a near 30 percent reduction in injuries.

CHANGING HOW SAFETY IS MANAGED

Achieving performance consistent with Columbia's high standards has long been one of the plywood division HR manager **Don Carter**'s goals. In 2004 Carter and plywood president **Brad Thompson**, recognized an opportunity to both strengthen the company's position within its industry and create a platform for motivation and engagement: safety performance. While each of the division's nine sites were already actively managing safety through traditional compliance practices, the methods—and results—varied widely by location. "Our employees are our most important asset. How do you run a business well if you don't value that first?"—*Don Carter, HR Manager, Plywood Division.*

At the crux of the problem, according to Carter, was that a lack of consistent practices meant a lack of standardized indicators by which the division as a whole could manage safety efforts. Columbia, like many organizations, relied largely on outcomes, such as incident rates and workers compensation costs, to steer the company's efforts. That bothered Columbia management, who were used to managing other metrics upstream. Recognizing an opportunity, Thompson and Carter suggested a progressive solution; why not run safety like any other critical business objective?

Columbia enlisted help from BST to design a safety practice that resembled the processes and practices the company relied on for other business functions. In addition to providing a steady stream of safety indicators the division could act on upstream, the company wanted the approach to include clear roles and responsibilities for leaders from the supervisor up to the division staff. "We felt like for this to be successful we needed to lead this from the division level," says Carter. In this way, the company hoped not only to establish a safety process that was sustainable, but to foster a culture where safety led performance in other areas.

A COMPREHENSIVE STRATEGY

BST proposed a multi-tiered approach. At the heart of the initiative would be implementations of Behavioral Accident Prevention Process' (BAPP®) technology at the individual mills. The BAPP initiatives would serve to engage mill employees in systematically identifying, measuring, and reducing exposures at the working interface, where employees interact with technology and systems. These efforts would also serve as a common focus for the division and provide a standard measure and vocabulary for safety performance.

Just as important, however, would be targeted leadership development activities designed to support both the mill-level BAPP initiatives and foster the safety climate and organizational culture across the division that Columbia was striving for. At the division level, the company's senior leaders would participate in workshops and individual coaching. Senior leaders at the mill level would also participate in a leadership assessment and improvement activities designed to enhance their ability to support the company's safety goals and develop leadership skills generally. Finally, mill supervisors would receive their own development training aimed at strengthening their skills for supporting the safety improvement process.

Columbia management saw the strategy as helping them provide a foundation for accountability and engagement as well. To begin the project, BST administered the *Organizational Culture Diagnostic Instrument* (OCDI) to determine the strengths and areas of improvement in the local culture. Measures of the instrument score a workgroup on nine dimensions empirically linked to downstream outcomes, providing focus points for development.

CREATING A ROLE FOR LEADERSHIP

Columbia leaders led the way by beginning the safety initiative at the division level. The cultural diagnostic had raised issues surrounding the perceived commitment of the division's leaders for safety. This in turn translated into a culture where safety was seen as of lesser value than other performance metrics. The problem, says BST consultant Stan Owens, wasn't that the commitment wasn't there. In fact, says Owens, he was struck by the strong value that several of the division leaders expressed for safety. "It was really a visibility issue," he says. In part, the gap was caused by the way the organization was structured; company business rarely brought senior leaders to the mills in person and usually only then for production reasons, leading many mill employees to assume that safety wasn't on their radar. In addition, says Owens, many simply hadn't been trained how to communicate their commitment in a way that resonated down to the floor employees. To help CFP's leaders leverage their influence on safety, and make their commitment a felt presence, Owens, and BST consultant Steven Luttrull designed a development strat-

egy that involved individual diagnostics, one-on-one coaching, and continual alignment for the division's leaders.

Carter, Thompson, and five others first underwent a 360° diagnostic instrument that asked peers, reports, and the leaders themselves to rank how often and well they used identified best practices for safety leadership. Results of the instrument were then used to design personal action plans for each leader that defined specific behaviors they could employ in their day-to-day jobs that support Columbia's desired safety performance. For some, this included specific goals the leader would set within the organization, for others it would be messages that he or she would communicate, or practices to use in meetings. Every leader was assigned a BST coach who worked one-on-one to troubleshoot action plans and provide feedback on their progress.

In addition to defining behaviors, the division's leaders put in place a system for tracking their progress electronically and selected peers and people at site locations to provide feedback on how well they were doing. Leaders each had to report on their progress each period. In addition to individual goals, every leader took on an objective of participating in three mill-level safety activities for the year. As the safety strategy rolled out, Columbia went through the same process with each of the line managers, plant managers, and supervisors at each of the division's nine sites. Carter says that the process has been very positive; "The fact that we put (leadership activities) together with all of the other safety components is very important," he said. By giving leaders concrete activities, says Carter, it enables leaders at all levels to support employees as they run their safety process. "We're beginning to get leaders involved in participating in steering team, participating in observations and beginning to be held accountable to make sure observations in their areas are done."

REDUCING EXPOSURE AT THE WORKING INTERFACE

With a leadership component in place, Columbia launched the employee-driven portion of its safety strategy, with BAPP implementations at the mill level. The first implementations were initiated at three pilot locations beginning in late 2004, Nipigon and Heart in Ontario, Canada, and Craigsville, WV, in the United States. In early 2005, CFP implemented the process at the remaining five Plywood locations; Chatham, WV, Klamath Falls, OR, Trumann, AR, Old Fort, NC, and St. Casimir, Quebec. Each mill followed a similar process. Hourly employees were recruited to form a steering team and worked with a BST consultant to identify behaviors critical to safe work at that mill. The team was then trained how to operationally define each of the behaviors so that they could be observed, and then train other employees how to collect data on those behaviors through two-way observation and feedback. Finally, the steering teams would be trained how to analyze the collected data to identify and remove barriers to safe work.

Helen Ecks, facilitator of the BATS (Better Achievements Through Safety) process at the Old Fort, NC, mill says that she was initially skeptical that such an approach would last. "Everything before has always been management-driven," she says. Ecks says that going through the training, and getting acquainted with Thompson and other division leaders helped convince her that the company was serious about supporting an employee-driven approach. "I didn't meet Brad [Thompson] until I got this position. I'd seen him walk through the mill, but we'd never met," she says, "Now I can sit down and hold a conversation with him."

Ecks says that the rapport that she and facilitators from other sites built with division leaders helped to build bridges with all employees. Faced with resistance early in the process, Ecks called Thompson directly for help, "I just called Brad and said, *'Listen, these people are saying you can't walk the walk'. 'I need you to come answer these questions'*." Thompson's reply was immediate. "He just said, *'Let me know when you need me there*'. People couldn't believe I just called him." Ecks says that mill and division leaders' support and openness helped win over floor employees. At Old Fort, Carter attended observer training with mill employees. "They loved having Don in there just being one of them—not running the show. He didn't interrupt, he let us completely lead it. He showed us right there that he'd completely support the process."

Facilitator Kim Elliot for the SWAT (Safe Workers Analysis Team) process at the Trumann, AR, mill says that she joined the process in part because she was frustrated with the existing safety procedures. While a long-time member of the mill's safety team, Elliot says "We didn't have authority or resources to get things done." Having a data-driven process and a dedicated Barrier Removal Team has helped change that. "The SWAT process has been able to give us those resources," says Elliot. "That's one of the reasons we've been successful." "I feel so honored and proud to work for Columbia Forest Products and to not have barriers that others do with

management and leadership. It's made me prouder to be an employee owner."—*Kim Elliott, Swat Facilitator, Trumann, AR.*

In addition to reducing the mill's injury rate by 66 percent in the first year, Eliot says that the SWAT process has helped to transform the culture. "Employees feel comfortable intervening with each other—it's not uncommon now for someone to walk through the plant and say '*You need earplugs, or safety glasses*'," says Elliot. "The skills that we've been taught and teach in our mill—and how things are working in the process—have given them the freedom."

DRIVING CULTURE & PERFORMANCE

Since one of the key objectives of the safety initiative was creating a uniform safety management practice throughout the division, Columbia Forest Products leaders worked with BST to develop a system for managing critical process metrics. Each mill now completes a safety dashboard that is reviewed monthly by division leaders. The dashboard reports on indicators of how the employee-driven safety process is functioning, such as levels of observation activity, barrier patterns, and participation rates. The dashboard gives division leaders greater visibility of actual safety activities, and allows them to quickly respond to challenges as they are occurring.

Another key objective for CFP was to leverage safety performance to create a more unified, and higher-performing, culture. In addition to managing individual safety processes at the mill level, division leaders created a series of intersection points for safety activities among the division's nine sites and with the division headquarters itself. The company now hosts an internal users conference where representatives from the division's nine mills get together to share best practices and brainstorm solutions. To foster cross-company collaboration, facilitators from individual mills are assigned to inter-site teams to problem solve common exposures to injury, such as splinters and pinch points. Division leaders are also expected to participate actively in safety activities; in 2006 each leader was tasked with attending at least three site-level training or steering team meetings. When an accident does occur, the company's new policy is that a leader will personally call the injured person to ask how they're doing and solicit their input on what the company can do to improve safety. "We're interested in them as individuals, not just as a number," says Carter.

RESULTS

Since launching the safety initiative in 2004, the company has realized a 27 percent reduction in injury rates across the division, with many sites experiencing even more dramatic improvements. The severity of injuries across the division has dropped a staggering 81 percent. While the company continues to refine its safety approach, Carter says that the initiative has already helped the company align itself around its core principles. "Our employees are our most important asset. How can you run a business well if you don't value that first?"

Company representatives also point to other gains. The principles used in the employee-driven safety process are being leveraged for a division-wide quality initiative and communication among employees of all levels has increased significantly. "We have found if you run an operation safely you also run it efficiently and if you run it efficiently you also have profitability benefits that run beyond safety. And we've seen that, we've seen operations greatly improved," says Carter. For facilitator Elliot, the gains are more personal. "I learned that there are some awesome ideas and people in the plant and we just never utilized them," she says. "I feel so honored and proud to work for Columbia Forest Products and to not have barriers that others do with management and leadership. It's made me prouder to be an employee owner."

REFINING SAFETY AT U.S. SUGAR CORPORATION

The United States Sugar Corporation (U.S. Sugar) is an enterprise in transformation. Based in Clewiston, FL, the 74-year-old company is the Nation's largest producer of cane sugar, a product prized by confectioners and bakers for its low melting point and high blendability. Beginning in 2002, the corporation added a new designation: that of rising star in the field of safety. Since that time the company has reduced workers compensation costs by more than 55 percent and overall injury rates company-wide by close to 30 percent.

U.S. Sugar Vice President of Environmental Compliance & Programs **Peter Briggs** attributes much of the improvement to an implementation of BST's Behavioral Accident Prevention Process (BAPP) technology. The employee-driven approach

engages frontline workers in capturing information about workplace exposures and uses the data to make improvements in the configuration of equipment, systems, and what people do. "We've probably had 20,000 discussions with two peers talking to each other about safety, where before that, we hadn't had one," says Briggs. In addition to providing a steady stream of data about safety conditions, Briggs says that the process is also helping the company transform its culture. "We've got people meeting people who didn't even know they worked for the same company. There's been cross-fertilization between different organizations that has been very good."

Driving Culture Change Across 300 Square Miles

AN INDUSTRY LEADER

Founded in 1931 with a single sugar mill on the south end of Lake Okeechobee, U.S. Sugar is today a multi-million dollar company operating on 300 square miles in south central Florida. Working the 196,000 acres of farmland, and the facilities that process its harvest, takes 3,500 employees and operations that could run a small country: two sugar mills, a refinery, a water treatment facility, a small railroad, and even a small hotel that is on the national registry of historic sites. The end result is an annual yield of 700,000 tons of cane sugar. Operations at U.S. Sugar are divided into three basic units. The Ag Department, which runs the farms; Sugar Houses, which consist of two mills, a refinery, a water plant, and the railroad; and Ag Services which provides maintenance and other services throughout the operation. Hourly employees in the Ag Department are non-union. Hourly employees in the Sugar Houses and Ag Services departments are represented by the International Association of Machinists (IAM).

MAKING THE MOVE TO EMPLOYEE-DRIVEN SAFETY

Since it first began farming, U.S. Sugar, as most other growing operations, cut sugarcane by hand. Increasing competition and pricing regulations in the 1990s, drove the company toward extensive modernization that included introducing both new machinery and new ways of organizing employees. It was during this time that the idea to initiate an employee-centered safety system first emerged. High incident rates were generating costs in injuries and workers compensation rates into the millions of dollars. More important than the financial implications was that ethically, the organization wanted to do a better job of protecting its employees. At the time, such an approach had gained a reputation for producing significant improvements in both injury rates and employee engagement and culture. Leaders at the organization were attracted to the approach's emphasis on identifying exposure ahead of injuries, and capturing data that would help the organization's direct improvement efforts. Up to that point, says Bryant Mill Manager **Darrel Collier**, "Behavioral safety issues were only addressed if someone got hurt." The new approach could help the organization become more proactive. "We can look at it as preventive maintenance for the body," says Collier. "We don't have to wait for an injury to make small corrections."

Still, not everyone was comfortable with the idea. At the time, employee-driven safety was more commonly known as "behavior-based safety" a phrase that caused some concern with U.S. Sugar's union employees. In part, says Briggs, the problem was cultural. "There were trust factors in there and communication factors . . . areas that we needed to improve greatly on," he says. Union representatives were concerned that it would be a way for management to avoid responsibility or a means to discipline employees who didn't follow safety rules. The idea was put on hold until 2002 when Briggs and other senior management personnel championed a new look at the approach. This time, U.S. Sugar provided the means for union representatives to see the approach in action for themselves. Representatives visited a chemical manufacturing site in Kentucky that had been using BAPP technology successfully in a union environment for years. The visitors were intrigued and said they would support an implementation like the one in Kentucky. With this new interest, the company decided to pilot the approach in the Ag Department, and if successful, move the initiative to the Sugar Houses and Ag Services.

ESTABLISHING A BASELINE

One of the critical objectives for U.S. Sugar in implementing an employee-driven safety approach was to realize its vision of a "safety first" culture; leaders wanted to create an organization where employees approached jobs from a mindset of finding the safest way to do the work rather than a "get it done" mentality. "It was always everybody's vision," says Briggs, "But how do you get that?" In order to develop a strategy that would address this concern, U.S. Sugar enlisted BST's help

in administering a cultural diagnostic instrument that would establish a baseline of the organization's culture and identify areas that required special attention during the implementation process. The instrument surveyed employees across the organization to measure perceptions of nine cultural dimensions linked to safety performance, with scores expressed as percentiles ranking the organization against hundreds of others that had taken the same diagnostic.

Results from the diagnostic showed that U.S. Sugar had strong cultural assets to leverage in starting the new initiative. In some groups, key organizational dimensions such as Procedural Justice, Management Credibility, and Perceived Organizational Support, were ranked very high, indicating that employees perceived the organization and its processes favorably. By striking contrast, however, the instrument also showed that throughout the organization, the safety dimension of Approaching Others scored very low. This dimension, which measures the extent to which employees feel free to speak to one another about safety concerns, is predictive of involvement and initiative, individual commitment to safety, and the likelihood that workers will raise safety concerns. A low score on this dimension signaled a serious challenge for implementing an employee-driven safety process where success relies on open communication among employees about exposures and solutions to safety challenges. In order to compensate for this score, BST consultant **Alan Grant** tailored the implementation strategy to include extra time on interaction skills training for the employees who would serve on the steering committee and as observers, and special attention to rolling out the process to other employees.

On the Impact of Leadership on Safety—and Safety on Leadership

"The old saying of 'lead by example' is not really accurate. If you're in a position of leadership you lead by example whether you want to or not. The only choice you have is whether you lead with a good example or a bad one."—*Calvin Cauley, BASS Facilitator, Ag Department.*

"Once supervisors started to say to their employees it is okay and we want you to go out there, [the observers] started to loosen up and go out and do it. There's a direct correlation between the support and the number of observations."—*Fermin Cardona, IBIS Facilitator, Clewiston Sugar House.*

"It used to be there were supervisors who didn't want to hear about a problem or just wanted to hear that it had been solved . . . Now guys—men and foremen—feel like they have the power to say something. Safety and production are now equal."—*Wren Herring, JAWS Facilitator, Ag Services.*

"Each of our areas is run by people who've made it a top priority . . . Just about every meeting you walk into now, one of the first topics they talk about is safety as well as behavioral safety."—*Jack Webb, Former JAWS Facilitator, Ag Services.*

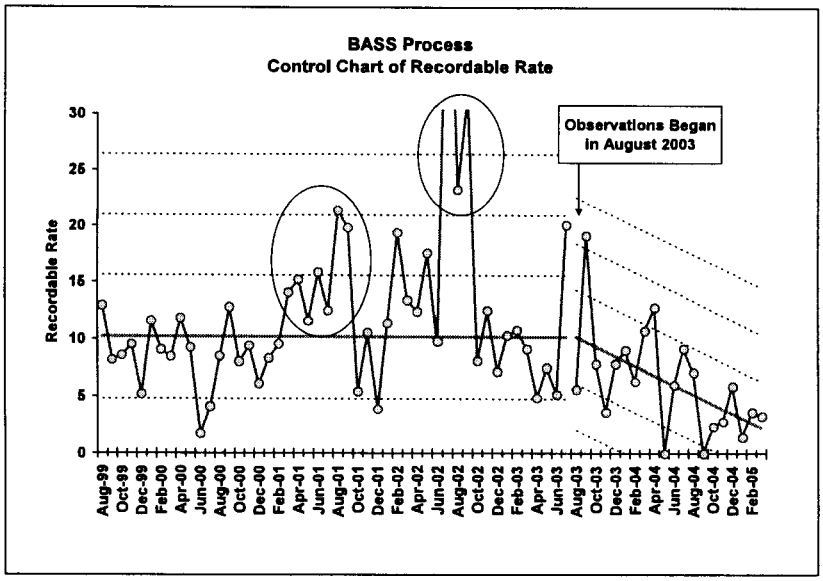
BASS IN THE AG DEPARTMENT

The first phase of U.S. Sugar's safety initiative called for implementing an employee-driven safety process in the Ag Department. The department encompasses the organization's 196,000 acres of farms worked by an employee population that varies from a low of 120 in the off-season to more than 400 at the peak of harvesting. In addition to the frequently fluctuating employee population, this group faced other unique challenges. Many employees do not read or write well, many do not speak English, and all work over such a large area that opportunities for conducting peer-to-peer observations are sporadic.

In August 2003, hourly employees from the Ag Department formed the *Behavioral Awareness Strengthens Safety* (BASS) team. Supervisor Calvin Cauley was recruited to be the BASS facilitator. "I had kind of the same reaction that a lot of other people had [to the process]," says Cauley, "Here we go again trying something else new that isn't going to be around long." Still, Cauley gave the new approach a try. Together with eight other hourly employees who would make up the steering committee, Cauley went through training that covered behavioral science principles, data gathering and use, and of course, interaction skills. The training began with reviewing past injuries and other data to identify work where employees might be exposed to risk of injury. Once identified, the BASS team was trained to define these interactions in a way that would allow observers to collect data on work being performed (whether safe or at-risk) and to capture information on barriers to performing the work safely.

According to Cauley, one of the largest challenges was launching the data gathering element of the BASS process. Employees in the group were uncomfortable approaching others to talk about safety. In addition, the workgroup's unique makeup required tailoring the observation process to make it accessible to all employees and translating the CBI® definitions/examples and observation sheets into Spanish. The BASS team, with the support of Briggs and Ag Department managers and super-

visors, started by setting the expectation that all employees would be involved in the process (both hourly and supervision/management), either as observers or by being observed. The BASS team recruited and trained observers from its corps of year-round employees to ensure consistent observation activity and made sure that all employees (year round or seasonal) were acquainted with their role in the process. Observers who had difficulty reading or writing were coached to ask the employees they observed or their observer coach to help them complete the comments on their data sheet. And to accommodate the groups dispersed workforce, the BASS team deployed a strategy of "opportunistic" observations, observations coordinated at times when employees and observers would be in the same place and timed to capture information representative of all the different tasks workers performed.



BASS Process Results: Since observations began in August 2003, the Ag Department has shown a marked downward trend in recordable injuries.

Two years later, Cauley says the strategy has paid off. "Before we started, one employee would basically not talk to another about anything safety related." Two years later the BASS process has logged more than 7,000 one-on-one conversations, with many more occurring outside of formal observations. "We'll even get an hourly employee reminding his supervisor to wear his safety glasses, for example." With the data collected through these observations, the BASS team has been able to complete action plans to address persistent barriers to safe work, including an aggressive plan around seat belt use that improved the behavior's safe use to more than 98 percent. Even more impressive, the injury rate for the department has shown a strong trend downwards; maintaining a 68 percent drop for more than 21 months.

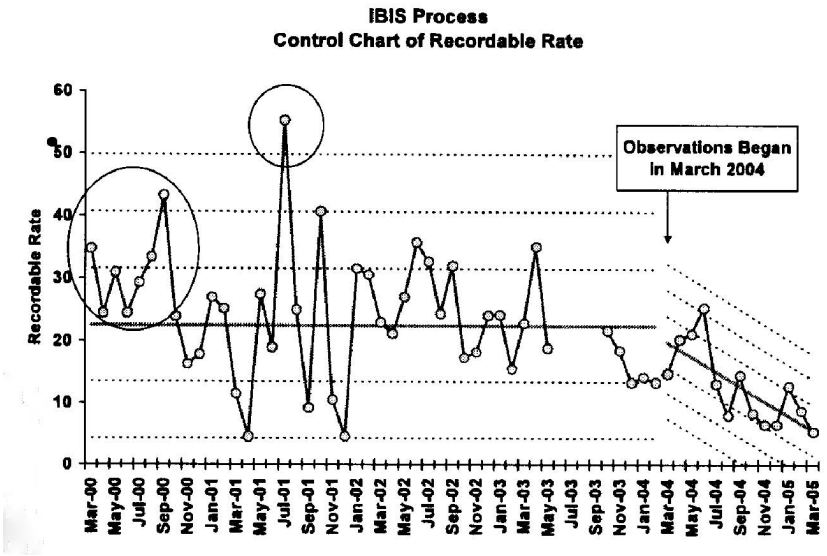
Currently, the BASS process has 122 out of the 135 total year-round people (both hourly and supervision/management) trained as observers. Of those, 17 percent are supervisors and managers. "Because the expectation has been set that doing observations is as much a part of an employee's job as production we can set a goal for the number of observations for each observer to conduct each month and achieve the goal," says Cauley. "That also allows us to maintain a contact rate of 1.00 to 1.10 with very little variation, and has allowed us to establish and use an effective observer rotation cycle."

Cauley says that his initial hesitation about the process has been replaced by a strong belief in the power of employee-involvement. He also says that serving as facilitator has taught him about leadership. "The old saying of 'lead by example' is not really accurate. If you're in a position of leadership you lead by example wheth-

er you want to or not. The only choice you have is whether you lead with a good example or a bad one.

IBIS IN THE SUGAR HOUSES

Following the success of the BASS process, U.S. Sugar rolled out the approach in March 2004 to the organization's two Sugar Houses in Clewiston and Bryant, where the company's sugar cane is turned into raw sugar. Starting at the operation's mill, harvested cane is pulverized for its juice. The juice then goes to the Sugar Houses to be evaporated, treated, and boiled down again to make sugar crystals. At this point, the raw sugar is ready to be taken to the refinery to be melted down again to create refined white sugar.



Within the Sugar Houses, the initiative is called IBIS for *Integrating Behavior into Safety* and covers approximately 700 employees. Hourly technician **Jack Webb** was tapped as the IBIS process' first facilitator, "I knew absolutely nothing at that point. My first reaction was I thought it was a good idea—then it was, 'How in the world are we going to start something this drastic in a place this spread out and old?'" **Fermin Cardona**, who is currently taking over facilitator duties for Webb at Clewiston after starting as an observer at Bryant, says that many people were skeptical. "They thought it was another fly-by-night, flavor-of-the-month safety program." Unlike the Ag Department, culture indicators showed low perceptions of management credibility and organizational support. Briggs understood their concern, "We had some trust issues."

Briggs felt that the key to overcoming the lack of trust was defining roles for managers and employees that matched the intensity of the company's work. "There's nothing subtle about our workforce. We rip, tear, boil, and cut. It's not like a chemical reaction. We're very hands on." Before rolling out the employee-driven safety effort, Briggs established clear expectations for the company's managers, "I told them that it isn't enough to be on board, you need to show the flag and show you're sincere." Briggs followed his own advice and went through steering committee training alongside hourly employees. "In a week I went from being 'Mr. Briggs' to 'Peter'," he says. "When we all went through that training, we realized we all want the same things and all have the same gripes. The camaraderie that was built has helped to build bridges even 2 years later."

To date the IBIS team has trained 100 observers who engage in one-on-one conversations with their co-workers about safe work. As in the Ag Department, the process starts when an IBIS observer approaches a coworker and asks to watch him or her work for a few minutes followed by a discussion of all safe and any at-risk behaviors observed. During the discussion, the observer makes a note of any barriers that prevent the employee from working safely. Barriers range from enabled (within the control of the employee) to non-enabled (impossible for the employee to do in the current configuration or systems and equipment) or difficult (possible but requiring significant effort). Data are then added anonymously to a database that the IBIS team uses for problem solving and action planning.

Webb says support from managers and supervisors played a large part in the success of the IBIS process. "Each of our areas is run by people who've made it a top priority," says Webb. "Just about every meeting you walk into now, one of the first topics they talk about is safety as well as behavioral safety." This support has translated into more training in the process for supervisors. "Increased supervisor training leads to increased management training and support," says Cardona who credits this support with helping observers engage more readily in the process. "Once supervisors started to say to their employees it is okay and we want you to go out there, they started to loosen up and go out and do it. There's a direct correlation between the support and the number of observations."

ENABLING SAFE WORK

In the Sugar Houses, many of the barriers identified go directly to the joint union-management safety committee which oversees solutions such as maintenance items or supplying new equipment. When the root cause of an exposure is not so easy to determine, the IBIS team takes on the problem to develop a more comprehensive solution.

Early in the IBIS process, the team discovered that fall protection was consistently scoring at a low 70 percent safe. This number indicated that approximately 3 out of every 10 times where fall protection was necessary to complete a job safely, the protection was either used improperly or not at all. In reviewing the data collected by observers, the IBIS team found that there were a range of reasons why employees were not using their fall protection. In some cases, the safe practice was enabled but the employees didn't think they needed to use it. In other cases, the practice was difficult or non-enabled (for instance, the employees didn't know how to use it, the fall protection equipment was hard to access, or the equipment didn't fit).

To increase the frequency of adequate fall protection use, the IBIS team developed an action plan that addressed these various aspects, making it a practice that was both easy for the employee to do and supported by the organization. The IBIS team arranged training in fall-protection use, coached supervisors to include a discussion of the practice in pre-job planning, and worked with management to ensure that fall protection was accessible where it needed to be. Within a few weeks, IBIS observers documented a marked increase in the frequency of adequate fall protection use. According to Webb, fall protection use was a classic example of moving work practices toward a new culture. "In the past our company was more production-driven than safety-driven. Unfortunately a lot of employees still had that state of mind." The IBIS process and the action plan helped to show employees that the organization was serious about changing how employees worked. According to Bryant Safety Manager **Kenny Williams**, the BASS process has helped the group live up to the organization's value for communication, "Communications are to be open, honest, and direct. This is lived up to hundreds of times per month with each observation completed."

JAWS IN AG SERVICES

U.S. Sugar's Ag Services department functions as a mobile resource of support and maintenance services for the company's sugar houses and farms. Within Ag Services, the BAPP initiative is known as JAWS for *Job Awareness Worker Safety*, and is facilitated by **Wren Herring**. Work in the Ag Services department is as varied as the territory it covers. "We're kind of the firemen of U.S. Sugar," says Herring referring to the group's mission of keeping U.S. Sugar's various operations running smoothly in its 300-square mile territory. Ag Services' 105 employees perform everything from repair and operation of heavy equipment and facilities, to maintenance, carpentry, and electrical work.

Herring says that he initially shared the same concerns as other employees when starting the process, in particular that his coworkers would not want to be observed. However, "There was nowhere near as much resistance as I thought," he says. According to Herring, the bigger obstacle was in changing the old "just get it done" working culture. "We had the normal little safety meetings . . . we'd watch a safety film, talk about it a little bit and that's the last time it was mentioned." As the JAWS process rolled out, however, employees started to see safety take a more integral role in every day work life. "We've now had almost 1,200 times that people have talked to each other about safety," says Herring. The power of these contacts has been reinforced by the improvements that follow from them, oftentimes with a simple phone call from Herring to a manager who knows how to fix equipment or procedures that are contributing to exposure. "The communication line with management has been gradually changing over the years. But with the JAWS process it has gotten even better." Herring says that sometimes foremen and managers now approach him with safety problems looking for help. "It used to be there were supervisors who didn't want to hear about a problem or just wanted to hear that it had been solved," says Herring. "Now guys—men and foremen—feel like they have the power to say something. Safety and production are now equal."

RESULTS

Bryant Mill Manager Collier says that the process has been extremely worthwhile." I don't think our company's incident rates have ever maintained such a low running average." In addition to achieving improvements in numbers, U.S. Sugar has also seen dramatic changes in how employees approach management, safety issues, and each other.

Webb says that an Ag Services employee working in the Clewiston sugar house exemplifies the culture change experienced at U.S. Sugar. Crane operator and JAWS observer **Chris Musgrave** was working with Clewiston Sugar House employees (an area outside of the process he is a part of) when he noticed they were unfamiliar with crane work. Since a crane operator relies on those he works with for

signaling and rigging to keep the load secure, inexperienced riggers presented exposure to themselves and others in the area. Webb says that rather than keeping quiet, as the culture might have encouraged in the past, Musgrave approached the foreman. He explained the situation and volunteered himself as a trainer. The foreman agreed and helped Musgrave arrange classes on rigging and hand signals. "I don't think this would have happened before," says Webb. "Before, either the guys who did receive the training would have blown it off or [Musgrave] might not have even been willing to step forward . . . But he brought it up and said 'Here's how we can solve it and I'm willing to do it'." The culture change, says Webb, is not just that employees are speaking up, but that managers are collaborating with them to reconfigure work and reduce exposure.

Briggs is especially proud of the facilitators and steering team members who have helped to make the safety initiatives successful. "Beginnings and endings usually get a lot of attention. The middle, the maintenance stuff, the real two-in-the-morning gutsy stuff to keep going, is what I'm seeing from our guys. There's been days when they encourage me."

EXCERPTS FROM "LEADING WITH SAFETY" BY THOMAS R. KRAUSE, PH.D.

NASA'S APPROACH TO TRANSFORMING ITS ORGANIZATIONAL CULTURE & SAFETY CLIMATE

(Written by Scott Stricoff)

The National Aeronautics and Space Administration (NASA) was established in 1958 to lead efforts in space exploration and aeronautics research. Today NASA has roughly 19,000 employees at its headquarters and nine Centers throughout the United States, and more than 5,000 additional staff at the Jet Propulsion Laboratory which is operated for NASA by the California Institute of Technology. NASA's programs in space exploration, space science, and aeronautics research are widely known, with some of its most visible programs including the Space Shuttle and the International Space Station.

On February 1, 2003, the Space Shuttle Columbia and its crew of seven were lost during their return to Earth. A group of distinguished experts was appointed to comprise the Columbia Accident Investigation Board, which spent 6 months conducting a thorough investigation of the accident.

The Accident Investigation Board issued its report in August 2003 with findings focused on three key areas: (1) systemic safety, cultural, and organizational issues, including decisionmaking, risk management, and communication; (2) requirements for returning safely to flight; and (3) technical excellence. The Board found that NASA's culture and related history contributed as much to the Columbia accident as any technical failure. Specifically, the Board identified the following organizational cause of the Columbia accident:

> "The organizational causes of this accident are rooted in the Space Shuttle Program's history and culture, including the original compromises that were required to gain approval for the shuttle program, subsequent years of resource constraints, fluctuating priorities, schedule pressures, mischaracterizations of the Shuttle as operational rather than developmental, and lack of an agreed national vision. Cultural traits and organizational practices detrimental to safety were allowed to develop, including: reliance on past success as a substitute for sound engineering practices (such as testing to understand why systems were not performing in accordance with requirements/specifications); organizational barriers that prevented effective communication of critical safety information and stifled professional differences of opinion; lack of integrated management across program elements; and the evolution of an informal chain of command and decisionmaking processes that operated outside the organization's rules." [1]

The Board made specific recommendations calling for a number of structural changes to the organization and identified a number of gaps in leadership practices important to safety. While there were no recommendations explicitly addressing leadership practices, the report identified many examples of gaps in the leadership practices that support safety, such as:

- Failing to follow NASA's own procedures;
- Requiring people to prove the existence of a problem rather than assuming the need to assure there was not a problem; and

[1] *Columbia Accident Investigation Board Report*. August 2003. Vol. 1, Chapter 7: 177.

• Creating a perception that schedule pressure was a critical driver of the program.

As a result of the Accident Investigation Board investigation and related activities, NASA established the objective of completely transforming its organizational and safety culture. At a minimum, it targeted making measurable progress in changing its culture within 6 months and having broad changes in effect across the Agency in less than 3 years. The 6-month marker was identified as particularly critical as the Agency prepared to return to flight.

After reviewing proposals from more than 40 organizations, NASA selected our firm in January 2004 to assist in the development and implementation of a plan for changing the culture and the safety climate agency-wide. We were asked to provide for a systematic, integrated, NASA-wide approach to understanding the prior and current safety climate and culture norms, and to diagnose aspects of climate and culture that did not support the Agency's effective adoption of changes identified by the Columbia Accident Investigation Board. We were further asked to propose a course or courses of action to change behaviors and to introduce new norms that would: (1) eliminate barriers to a safety culture and mindset; (2) facilitate collaboration, integration, and alignment of the NASA workforce in support of a strong safety and mission success culture; and (3) align with current initiatives already underway in the Agency.

We began with an assessment of the current status, and the development of an implementation plan. NASA asked that both be completed within 30 days. Following the assessment and the development of a plan, we began implementation. The result: significant progress towards the longer-term goal of strengthening NASA's culture. This chapter describes the assessment and its results, the plan implemented to influence the culture, and the results obtained from that plan after the initial 6-month period.

ASSESSING THE EXISTING CULTURE AND CLIMATE

Before we could change anything, we first had to understand the current culture and climate at NASA and identify focus areas for improvement. We approached this task with the belief that there was much that was positive about NASA's culture. Our challenge was to build from those positive aspects, strengthen the overall culture, and at the same time, address the issues raised in the Accident Investigation Board report.

In undertaking this work, we focused on the difference between "culture" and "climate." By culture we mean the shared values and beliefs of an organization—commonly described as "the way we do things around here." The culture can also be thought of as the shared norms for behavior in the organization, often motivated by unstated assumptions.

Climate refers to the prevailing influences on a particular area of functioning (such as safety) at a particular time. Thus, culture is more deeply embedded and long-term, takes longer to change, and influences organizational performance across many areas of functioning. Climate, on the other hand, changes more quickly, and more immediately reflects the attention of leadership.

The significance of this distinction for NASA was that in the aftermath of the Columbia tragedy there was a strong safety climate; however, we were concerned that in the absence of properly focused efforts, the culture would not change, and over time the safety climate was likely to be compromised by the inevitable schedule, budget, and operational pressures that occur in any organization.

As described below, the culture assessment was based on review of previous work, a survey of NASA employees, and a program of interviews.

Previous Studies

In late 2003, NASA Administrator Sean O'Keefe commissioned a detailed review of the Columbia Accident Investigation Board report to determine which recommendations, observations, and findings had agency-wide applicability to NASA and to develop measures to address each one. The internal NASA team that conducted this review produced a detailed report that identified a number of concrete improvement actions and recommended assignment of these actions to various units within NASA. According to the report, the team had focused on the organizational (as opposed to physical) causes identified in the Board report, but it "did not do a broad, in-depth assessment of the cultural changes needed to address the organizational causes."

The NASA team's recommendations were divided into seven major topics: Leadership; Learning; Communication; Processes and rules; Technical capabilities; Organizational structure; and Risk management.

The team recognized that there was a broader need for culture change that they were not addressing. According to the report, "Some of the recommended actions are those one might expect in an organization trying to change its culture, but the goals offered by the Team are intended only as a first step in the process."

The NASA team also reviewed previous culture surveys conducted at the Agency to provide historical perspective for this assessment.

During 2003, the Federal Office of Personnel Management (OPM) conducted a survey throughout the Executive Branch entitled "Best Places to Work." This survey measured employee attitudes about various aspects of the government's agencies and resulted in an overall ranking of agencies and locations within agencies. NASA ranked highest among all agencies, and several NASA locations were on the list of the top 10 locations in the entire Federal Government. The survey found strengths in teamwork, employee skills-mission match, and strategic management. It was also designed to identify areas in which each agency could make improvement, and at each NASA center the general category of "Leadership" was identified as an improvement target.

These findings were generally consistent with results NASA had obtained in its own previous surveys. While NASA had not conducted an agency-wide culture survey in many years, there had been such surveys at several of the individual Centers within the last few years. These surveys identified leadership as a top area for improvement. However, they had not clearly defined the nature of the leadership improvement opportunity.

Safety Climate and Culture Survey

We conducted a specially modified version of our Organizational Culture Diagnostic Instrument (OCDI) at all 11 NASA locations. We asked all NASA employees plus Jet Propulsion Laboratory (JPL) employees to complete the survey via a web-based link. As previously described in Chapter 4, the OCDI measures the underlying organizational determinants of organizational culture and safety climate.

We administered the survey to solicit information about mission safety, which was defined as follows: "the prevention and avoidance of injury or damage to the mission or its hardware in all aspects of NASA missions."

In addition to the basic survey scales, we added questions specifically designed for use in NASA. Those questions were designed to evaluate the current situation in comparison to the desired state and to gather data on several specific culture-related issues raised by the Accident Investigation Board report.

An overall response rate of 45.2 percent was obtained for NASA employees, comparable to response rates obtained on previous NASA culture surveys. We evaluated potential response bias in the sample of people who responded, and these tests indicated that the respondent group was comparable to the overall NASA population.

Agency-wide response to the basic survey scales is shown in Figure 12–1 (percentile scores) and Figure 12–2 (raw scores). The percentiles in Figure 12–1 reflect comparison of NASA with a normed database compiled using this survey.

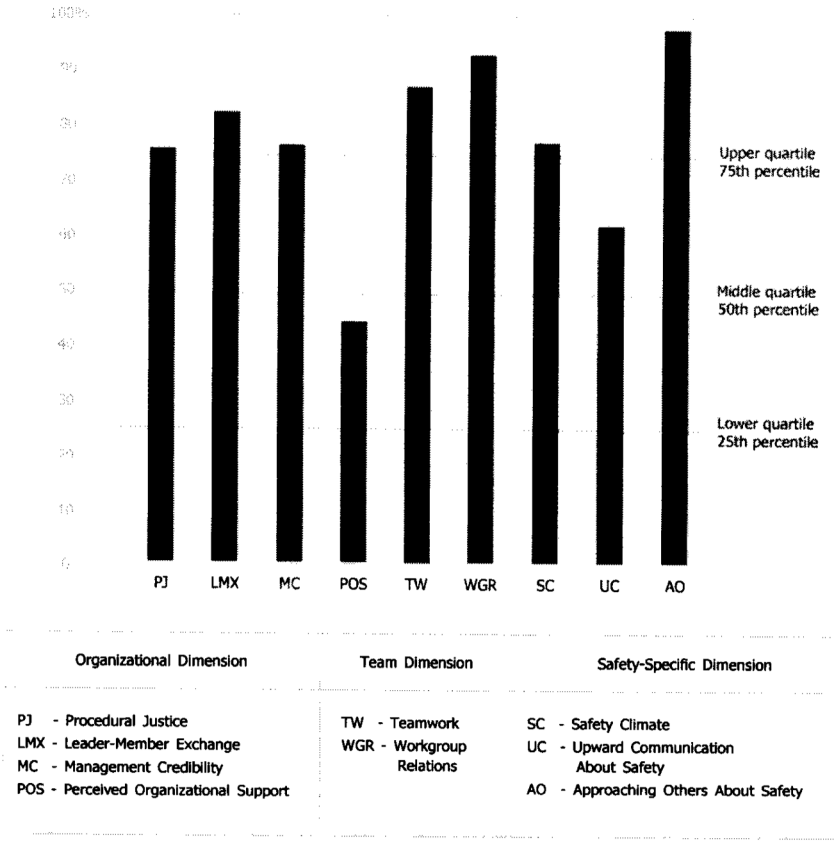


Figure 12-1. Combined OCDI scores for NASA showing overall percentiles for all locations.

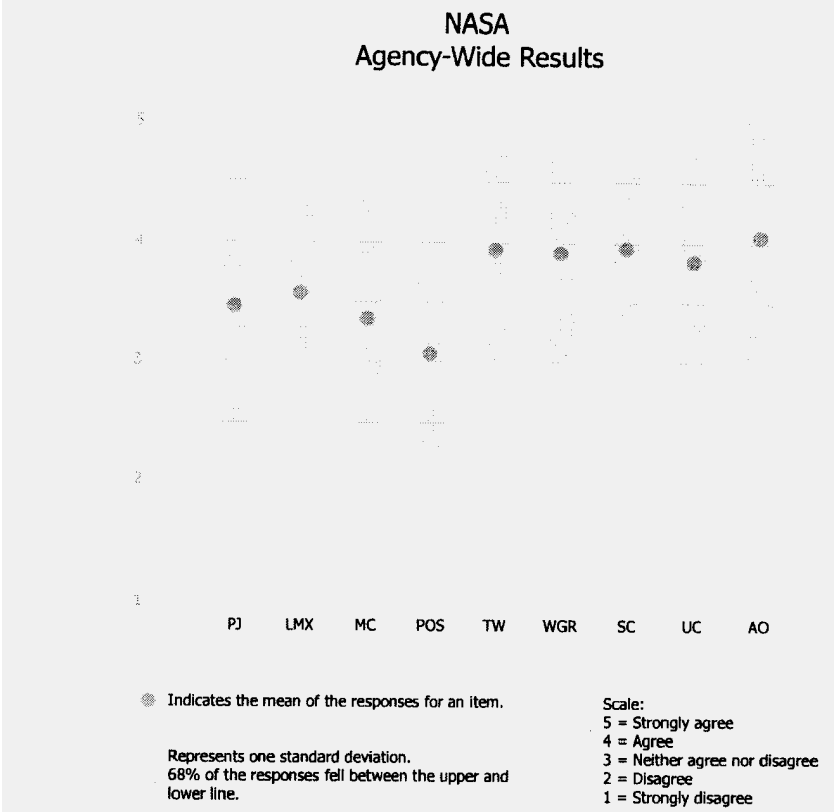


Figure 12-2. Raw scores of OCDI scales for NASA (mean and standard deviation).

At an agency-wide level, NASA scored well in relation to other organizations in the database on most of the scales comprising the survey. It scored above the 90th percentile on Approaching Others, and Workgroup Relations, and between the 80th and 90th percentiles for Teamwork, and Leader-Member Exchange. These results indicated that across the Agency there was generally effective team functioning at the local level, with employees who have the ability and inclination to speak up to peers.

NASA scored lowest on two scales: Perceived Organizational Support (46th percentile) and Upward Communication (62nd percentile). Perceived Organizational Support (POS) measures employees' perceptions about the organization's concern for their needs and interests. Those perceptions in turn influence beliefs about the organization's values for safety. This influences employees' willingness—or unwillingness—to raise safety concerns. Upward Communication (UC) measures perceptions about the quality and quantity of upward communication about safety, the extent to which people feel encouraged to bring up safety concerns, and the level of comfort discussing safety-related issues with the supervisor.

Lower scores on POS and UC indicated areas for particular focus during the culture change effort. Senior management and the behaviors they stimulate through the management chain influence both of these dimensions. These dimensions are also a strong influence on the culture in ways that relate directly to mission safety.

FINDINGS

To help provide context for the survey results, we conducted a series of interviews with more than 120 people at representative locations—NASA headquarters, the Glenn Research Center, and the Johnson Space Center. At each location we interviewed individual members of senior management and met with representative groups of individual contributors, and supervisors and managers. The purpose of these interviews was to provide general background to help us interpret survey data.

In general, the interviews disclosed a strong sense of dedication and commitment to the Agency's work. However, we also found frustration about a number of things.

During the interview program, we received a number of indications that there were impediments to speaking up at NASA. On more than one occasion individuals would hang back at the end of a group session and either make comments after others had left or leave written notes expressing thoughts they had not brought up in front of others. These comments tended to be on the topic of barriers to communication. This was consistent with the Upward Communication survey result and indicated that there was a group of non-managers within NASA who felt that open communication was impeded.

We also heard many comments indicating that not all managers and supervisors had the leadership skill levels that many considered appropriate. A common theme was the issue of respect for individuals and the need for some managers to act in ways that better reflect that value.

Safety & Mission Success Week Data

In November 2003, 9 months after the shuttle disaster, NASA held Safety and Mission Success Week. During this week each Center Director was asked to collect feedback from his workforce on the Columbia Accident Investigation Board report and the issues it raised.

NASA analyzed data from the centers, identifying major themes. We received the summary of this data as the assessment report was being prepared and found it was consistent with the findings of the assessment. Several of the themes and specific issues identified were important to culture change at NASA, including:

- Lack of a process for delivering upward feedback. This was reflected in the survey scores for Upward Communication.
- Leaders do not follow words with actions. This contributes directly to lower Management Credibility.
- Message of "what" delivered without the "why." This is likely to contribute to lower Management Credibility and lower Perceived Organizational Support.
- Need a culture that values and promotes respect and cooperation. This relates to Perceived Organizational Support.
- Need a renewed emphasis on respect for each other, and cooperation.
- Minority opinions need to be embraced—create an open atmosphere in which disagreements are encouraged and new ideas/alternatives are pursued. (This was consistent with survey findings that Upward Communication was one of the weakest scales measured).
- Contractors are treated as second-class citizens. This can result in inhibiting communications, with the potential for impeding performance excellence.

Conclusions

The assessment found that the NASA culture reflected a long legacy of a can-do approach to task achievement, but did not yet fully reflect the Agency's espoused values of safety, The NASA Family, Excellence, and Integrity. The culture reflected an organization in transition, with many ongoing initiatives and lack of a clear sense at working levels of "how it all fits together."

Examining NASA's espoused values, we found that:

• *Safety was something to which NASA personnel were strongly committed in concept, but NASA had not yet created a culture that was fully supportive of safety*.—Open communication was not yet the norm, and people did not feel fully comfortable raising safety concerns with management.

• *The NASA Family value was inconsistent with the fact that people felt disrespected and unappreciated by the organization*.—As a result, the strong commitment people felt to their technical work did not transfer to a strong commitment to the organization. People in support functions frequently did not fully understand or appreciate their connection to the Agency's mission, and people in technical positions did not fully value the contribution of support functions to their success.

• *Excellence was a treasured valued when it came to technical work, but was not seen by many NASA personnel as an imperative for other aspects of the organiza-*

tion's functioning (such as management skills, supporting administrative functions, and creating an environment that encourages excellence in communications).

• *Integrity was generally understood and manifested in people's work*.—However, there appeared to be pockets in the organization in which the management chain had sent signals—possibly unintentionally—that raising negative issues was unwelcome. This was inconsistent with an organization that truly values integrity.

In summary, we identified an opportunity and needed to strengthen the culture's integrity by helping NASA become an organization that lives the values.

THE INTERVENTION

Overview

Based on this assessment, we recommended that the culture change initiative should build on the strengths shown in the safety climate and culture survey. NASA employees generally worked well as teams, liked and respected each other, and felt comfortable talking to peers. These strengths could be harnessed to create reinforcement mechanisms for behaviors that support the Agency's values and desired culture.

In addition, we recommended that the culture change initiative should focus on helping managers and supervisors maintain an effective balance between task orientation and relationship orientation. At NASA many managers had a natural inclination toward task orientation, which is not unusual for technical organizations. However, strong task orientation at the expense of relationship orientation can lead to inhibition of Upward Communication and weak Perceived Organizational Support. By taking steps to help managers and supervisors improve their balance between task and relationship orientation, NASA could move toward integrating its values of Safety and People and create a culture that would more effectively support the Agency's mission.

We believed that NASA needed to avoid falling into the organizational "trap" of viewing its response to the Board report purely in a project-driven manner. The NASA culture tended to think in terms of identifying problems and solving them through discrete projects. Over the years NASA had proven to be outstanding at defining and executing projects. However, a project is, by its very nature, something that has a start and an end. If it came up with separate projects to address specific issues in the report, the Agency could fail to address the underlying culture issues that gave rise to many of the problems in the first place. This may explain why safety climate changes observed after previous accidents (e.g., the Shuttle Challenger accident) did not generalize and become part of the ongoing culture.

To address NASA's needs and build on its strengths, we developed a culture change plan based on one core concept: *Organizational values must underlie the definition of desired culture*.

The Importance of Values

Values underpin everything an organization does to ensure that objectives are reached. They help inform everyone in the organization about the considerations that should be reflected in day-to-day actions and decisions. Values set out the basis for the strategic considerations necessary for success and help ensure that everyone understands the organization's expectations of them.

An organization cannot create specific rules covering every situation and variation. In the complex world in which NASA functions, the Agency must be able to rely on individuals making independent judgments about unexpected and unforeseen situations. Having organizational values that are well understood and embraced by everyone will reduce the variability with which these judgments are made.

According to the assessment results, there was no uniformity of adherence to the espoused organizational values that would lead to safety performance excellence. The implementation plan recognized the importance of values for a safety-supporting culture being widely disseminated and embraced within NASA and actively reflected in the leadership practices of individuals at all levels of the organization.

Addressing Culture and Climate

Both climate and culture are important. While identifying values was an important first step, building these values into the fabric of the Agency required transforming the culture.

Organizational climate often changes very quickly after a significant incident, but the underlying organizational culture may not change sufficiently to prevent further incidents. Since climate that is inconsistent with culture will not be sustained, a fa-

vorable safety climate following an incident does not assure real improvement unless steps are taken to shift the culture.

As we developed the implementation plan, the current climate for safety in NASA was very strong and favorable. Since favorable organizational climate is a condition for successful culture change, this situation presented a limited-time opportunity to introduce new principles that could lead an agency-wide cultural change initiative.

How Leaders Drive Culture Change

The key to changing culture is through leadership. Leaders influence safety through what they do and what they don't do. They can express this influence intentionally or unintentionally. However, leaders with the right knowledge and skills can move the culture in desired ways and do so with accelerated results. Therefore, the key is to make leaders more effective, and the best way to do that is through the use of behavioral tools.

Using Behavioral Tools. Behavioral tools are the most practical and effective way to transform culture; culture changes when new behavioral norms are established. Because behavior is definable and measurable, it lends itself to change efforts. By using behavior-based tools, organizations can undertake very concrete and specific initiatives to accelerate cultural transformation and can measure progress toward results.

Behavioral tools may be used to create accelerated change within organizations as well as to ensure that future leaders are selected and developed to sustain the desired culture. Our assessment results confirmed the opportunities to use these tools for the change desired by NASA.

Focusing Culture-Change Efforts. There should be one, single culture change initiative. NASA was in a period of change, with many active teams and task forces. Many of these had identified issues that relate to culture, and this raised the possibility that there could be overlapping, or even contradictory initiatives.

For culture change at NASA to be successful, there needed to be a consistent culture change initiative that incorporated all of its culture-related issues.

THE CULTURE CHANGE PLAN

The specific plan we developed for the initial 6-month period was designed to begin the culture change while validating the adaptation of the approach to fit NASA. To do this we focused on three NASA locations—the Glenn Research Center, the Stennis Space Center, and two large directorates of the Johnson Space Center (Engineering and Mission Operations). These organizations collectively comprised approximately 3,600 people.

Changing the culture involves two thrusts. The first engages leadership and individual contributors in changing the current cultural environment; the second assures that the culture is sustained by grooming future leaders who can support the desired culture. This initial phase of the effort focused on the former objective.

At the outset, NASA's senior leadership re-examined the organization's core values and reaffirmed those to which the Agency aspires. Those values were used to articulate a vision of the future state that would exist following successful culture change:

> "The objective of this effort is to strengthen the organizational culture and safety climate at NASA. In this desired future state, each individual feels highly valued as an individual and knows that his or her contributions are appreciated. Everyone at the Agency, in all roles and at all levels, understands the important ways they contribute to the Agency's exciting mission, feels like an integral part of the larger Agency team, understands the way that others contribute to the larger team effort, and is committed to the success of the Agency and its overall mission. Managers and executives at every level of the Agency, from top to bottom, routinely treat people with respect. People are comfortable in raising issues, and confident that the issues raised are considered and appropriately factored into decisions. There is a high level of trust in management, and a sense that management, in turn, trusts each individual.
>
> In this desired future state, safety is widely recognized as an integral component of mission success, and is considered by every individual in everything they do. The Agency is recognized for its pursuit and outstanding achievement of cutting edge endeavors, as well as its extraordinary safety record, all of which are understood as compatible goals."

In designing a strategy to achieve the culture change objective, we began with the recognition that culture is a reflection of shared perceptions, and beliefs and behaviors. It is related to unstated assumptions. If we change those perceptions and beliefs, we change culture.

Individuals' perceptions and beliefs are influenced by a variety of factors subject to intervention. For example, perceptions and beliefs about the organization are strongly influenced by individuals' interactions with their immediate supervisors. These interactions inform the individual about the organization's real values and shape his or her views about the organization. There are dozens of these interactions each week. A change in the leadership behavior of the immediate supervisor will influence culture, but is unlikely to occur unless there are changes in the leadership behavior of that supervisor's supervisor. Similarly, we must change behavior up through the leadership chain.

To change individuals' perceptions and beliefs, we wanted to change their supervisors' leadership behaviors to more consistently reflect behavior that reflects the desired culture. The new behaviors we wanted to encourage in NASA's first-line supervisors—Branch Chiefs—were a set of critical behaviors that exemplify NASA's core values. The behaviors we wanted to encourage up through the chain of command—through Division Chiefs, Directors, and Center Directors—were those that exemplify the values and encourage the use of these behaviors by subordinate managers.

There is a large set of behaviors that supports NASA values, including both leadership behaviors and individual contributor behaviors. To change culture we needed to focus on a manageable subset of those behaviors, selected for their leverage in affecting perceptions and beliefs related to areas in which we wanted the culture to change. For example, survey results showed that NASA's culture was strong in the area of Workgroup Relations. While there are behaviors related to Workgroup Relations, those were not the ones on which we chose to focus as they were already comparatively strong. However, in an area like Upward Communication, where NASA needed to improve, the related leadership behaviors would be considered "critical behaviors." Critical behaviors for NASA at this time related to communication, consideration for individuals, management consistency (credibility), and decisionmaking.

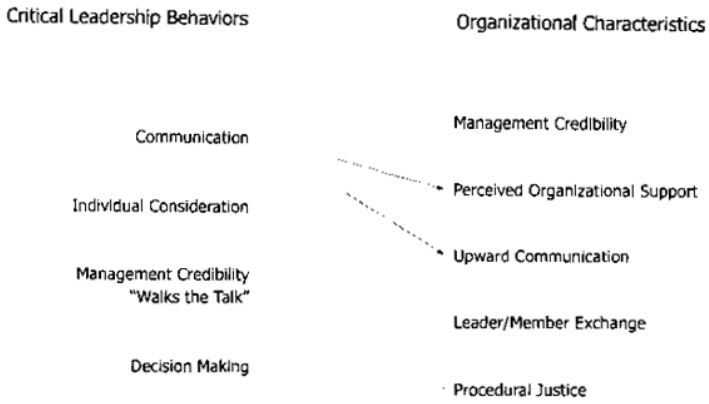


Figure 12-3. The relationship between critical leadership behaviors and key organizational characteristics.

Critical behaviors were identified based on a variety of data sources such as the Columbia Accident Investigation Board report, the OCDI, NASA's internal review of the broad applicability of the Board recommendations, and Safety & Mission Success Week findings. A foundational set of critical leadership behaviors was identified based on those data sources. This foundational set of critical behaviors was then reviewed by each location at which the culture change effort was to be implemented. This review verified the relevance of the behaviors to each location and developed examples of how each behavior was manifested at the location, to embellish the definition for local use.

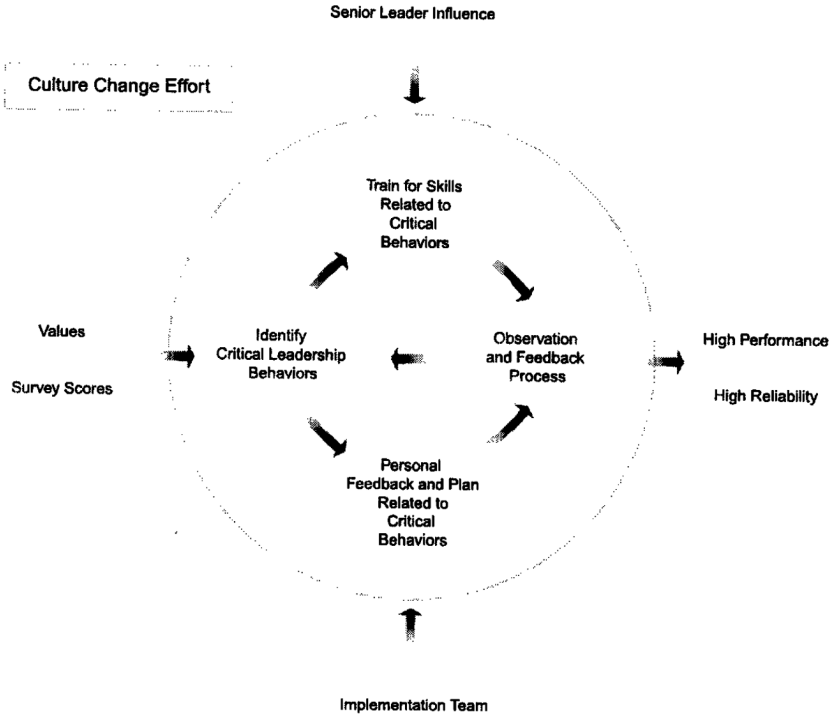


Figure 12-4. Implementation strategy for individual NASA locations.

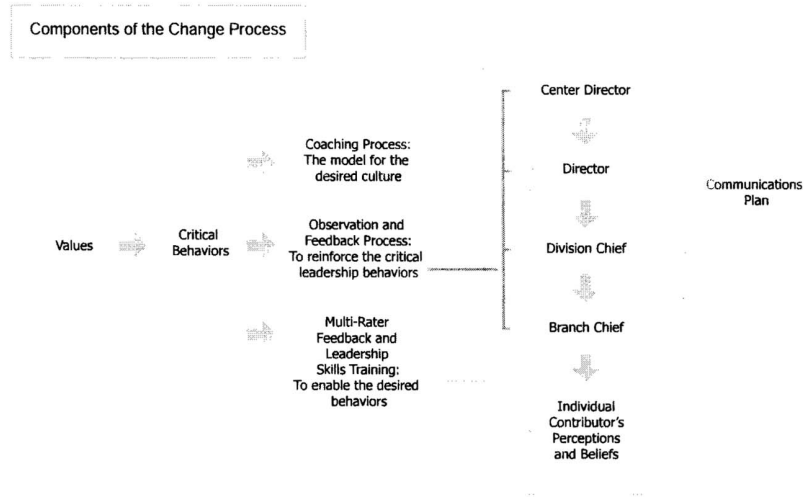


Figure 12-5. Key components of the change process at NASA centers.

We designed a multi-pronged approach of specific activities that included introducing leadership coaching for senior-level leaders, implementing a behavioral observation and feedback process for all leaders, and providing multi-rater feedback

and skills training for all leaders. A communications effort was also launched at each location to inform people about the changes occurring.

Coaching

The senior-most leaders in the organization have an important, but indirect, influence on the perceptions and beliefs of most individual contributors. Therefore, the senior-most leaders must possess strong leadership skills and a solid understanding of how they can exert influence. It is important that they set the direction for the culture through everything they do and that they create consequences that cause their reports to do the same. To help senior-most leaders support the culture change, we employed a leadership coaching process. This helped the leaders improve their ability to support the critical behaviors (as well as practice these behaviors themselves) and helped them learn how to meaningfully support the other elements of the change process.

The coaching process was designed to help senior leaders understand their leadership strengths and weaknesses and to work with them in developing individual action plans. The process began with a detailed individual assessment including a 360 diagnostic survey plus a series of assessment interviews with subordinates, peers, and managers. The assessment resulted in a detailed feedback report that assessed the individual's leadership style and practices. Because this report was based on information from individuals familiar with the leader and provided detailed examples of his or her leadership behavior, it filled a vacuum that most senior leaders have—a lack of direct feedback on their leadership.

The coach reviewed the feedback report with the leader and then helped to develop a coaching action plan. This plan identified areas for the leader to concentrate on, drawing on the critical behaviors, the actions needed to drive support for NASA's values, and leadership best practices. Once the plan was developed, the coach provided the leader with guidance as the coaching action plan was implemented.

The coaching process was used for senior leaders, beginning at the top of the Agency and extending down through the management chain to the senior-most levels of the Center.

Behavioral Observation and Feedback

All leaders in the organization were required to adopt and consistently use the critical leadership behaviors. A behavioral observation and feedback process was implemented to promote use of these behaviors. Leaders receiving regular, structured reinforcing feedback on their use of critical behaviors and guidance feedback on missed opportunities to use these behaviors would change their behavior. When their use of critical behaviors was encouraged by those senior to them in the organization (as a result of the coaching process), this change would be further encouraged.

Anonymous data was gathered during these observations, allowing the local implementation team to track progress in promoting critical behaviors, analyze the reasons for non-performance, and design corrective action as appropriate.

Multi-Rater Feedback

We provided each leader with individual multi-rater survey feedback to help him understand which types of behavior represented existing strengths, and which represented areas for focusing improvement efforts. We used a 360 diagnostic survey to gather feedback on each individual leader's use of leadership and management best practices. Leaders attended a workshop to review and discuss the results and to develop individual action plans focused on increasing their use of leadership behaviors that supported the organization's values.

Skills Training

The objective of the skills training was to improve skills leaders need to perform the critical behaviors and support the desired culture. Managers received 2 days of training, which covered cognitive bias awareness and feedback skills (day 1) and influential leadership skills such as building trust, valuing minority opinion, and influencing skills (day 2). Each of these segments was explicitly tied to critical behaviors being addressed in the culture change initiative.

Communications

The fifth element of the near-term culture change process was communications, and there were two aspects of this challenge.

At the individual Centers where culture change activities were occurring, it was important that there be communication about these efforts. "What" was occurring and "why" had to be communicated at the outset. Then, as implementation pro-

ceeded, it was especially important to communicate about early indications of progress.

The specific mechanisms for this communication varied from Center to Center based on the communications vehicles available locally. Existing communications channels such as site newsletters, intranets, and all-hands meetings were used to help relay information about this effort. In addition, managers were encouraged to speak about it at their staff meetings.

More globally, it was important that NASA's overall communications reflect consistency with the culture change effort and the desired culture. Even on topics not directly related to the culture change effort, senior leaders indirectly send messages about how seriously they take the desired culture. When members of NASA's senior-most leadership spoke or sent written messages, the content of those messages needed to reflect specific consideration for the cultural undertones of the communication.

RESULTS

For 5 months beginning in mid-April 2004, we worked with the Glenn Research Center, Stennis Space Center, and the Engineering and Mission Operations Directorates of the Johnson Space Center. This initial phase of work was designed to provide a mechanism to learn how best to deploy the culture change approach while meeting the objective of achieving measurable progress in 6 months.

As the work progressed, various forms of results data became available.

Anecdotal Data

Soon after implementation work began, we started hearing anecdotal evidence that the effort was having an effect. Examples of the anecdotal evidence are listed in Table 12–1. This evidence provided early indications that the culture change effort was beginning to have an impact.

Early Anecdotal Data

"Helps me be less judgmental & see myself as others do"
– an observer

"I wasn't sure of this thing in the beginning. Now I am convinced that it will help us; we need to support it. I have invited observers to my meetings; I encourage you to do the same."
– Division Chief

Division Chief asks that two meetings be observed

"I found myself conducting my Branch meetings and day-to-day interactions differently as part of this effort. I am convinced that others will also change their habits; even if they are not bad right now but improvement is good."

One Implementation team had a well-known skeptic as a member. After observer training he got up and told the group that he hadn't been in favor of this, but now that he understood it he thought it was going to make a big difference.

Individuals requesting to have 360 leadership survey done to provide them with feedback

Training evaluations consistently indicating that participants arrived as skeptics and left as believers ("prisoner" to "advocate")

Division Chiefs giving each other feedback in a staff meeting, referring to the coached behaviors

Observer invited to observe MMT meeting

Table 12-1. Examples of early success indicators in the change process at NASA.

Behavioral Data

As data began to accumulate from the behavioral observation and feedback process, we started seeing improvement in the percentage of times an observed behavior was observed being done, rather than observed as a missed opportunity. Figure 12–6 shows early data from one location. Several of the specific behaviors are showing an improvement trend. Other behaviors did not show improvement this rapidly, but the data produced by the process provided a mechanism to know where to place emphasis in seeking further improvement.

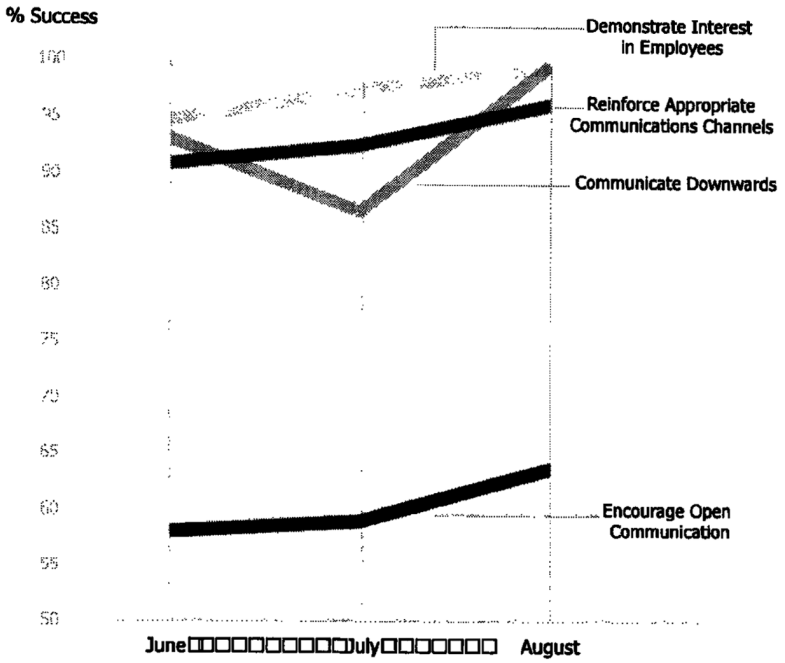


Figure 12-6. Early data from one NASA location showing improvement.

Culture Survey

Approximately 6 months after the start of the culture change efforts, we administered the OCDI again to the groups where culture change work had been undertaken. This was the same survey used in the initial assessment phase of the effort, and we used the same email-prompted, web-based survey administration method.

The response rate was quite good, and at most locations it exceeded the rate obtained in the original (February) survey administration, as well as the rates obtained on previous NASA culture surveys. The response rate by location is shown in Table 12–2.

	February Response Rate (%)	September Response Rate (%)
Glenn	32.4	65.2
Johnson (Engineering & MOD)	52.6	45.8
Stennis	45.2	71.5
Overall	**45.2** (Nasa-Wide)	**57.9**

Table 12-2. NASA survey response rate by month.

Tests to evaluate potential response bias in the sample of people who responded indicated that the sample was representative of the total surveyed population.

The Glenn Research Center and Stennis Space Center had survey scores during the initial assessment that were low compared to the NASA overall averages. The Johnson Space Center had scores that were high relative to the NASA average. The results of the intervention at these centers are interesting to compare.

GLENN RESEARCH CENTER AND STENNIS SPACE CENTER RESULTS

All scales on the basic Safety Climate and Culture survey showed improvement at the Glenn Research Center (GRC). These results are shown in Figure 12–7 (percentile scores) and Figure 12–8 (raw scores.) The September results (after intervention) show significant improvement over the February results (pre-intervention).

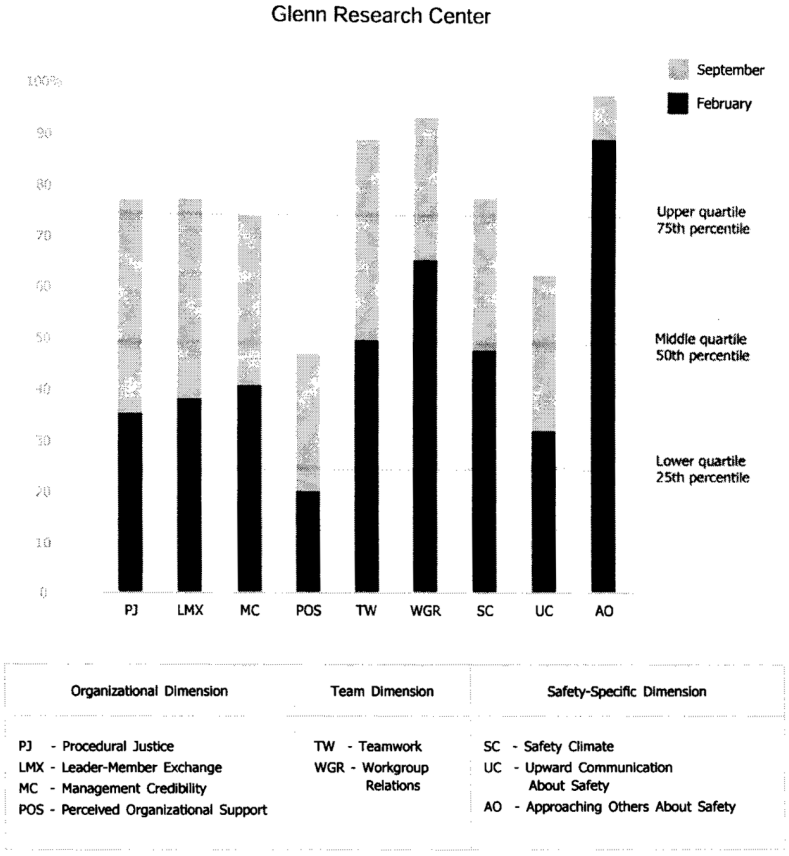


Figure 12-7. OCDI percentile scores for NASA's Glenn Research Center showing results from before and after start of intervention.

Figure 12–8 shows the comparison of these results with their confidence intervals. Where confidence intervals do not overlap, the differences are statistically significant.

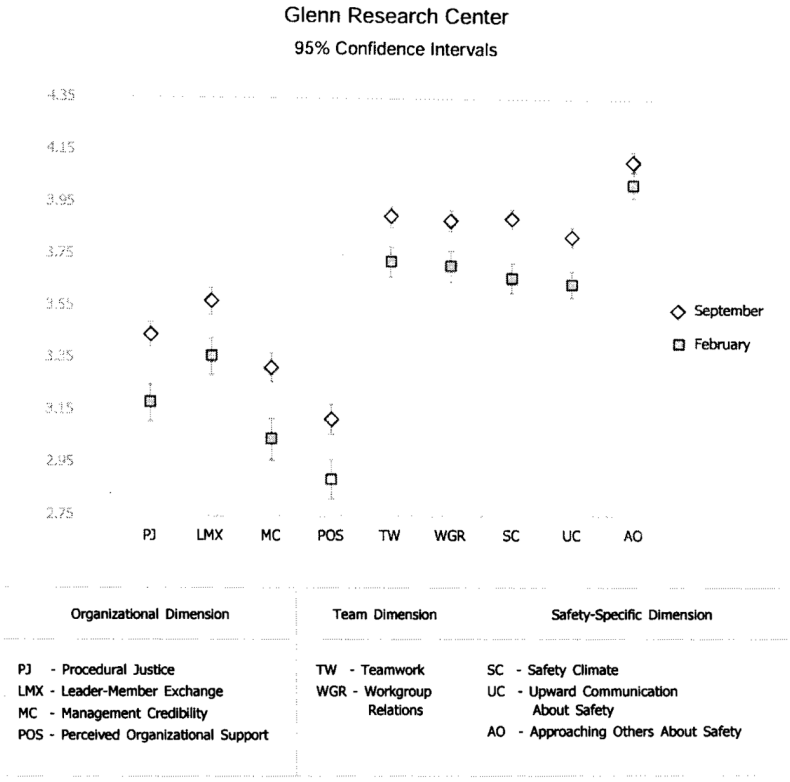


Figure 12-8. OCDI raw scores for NASA's Glenn Research Center.

Scale : 5 = Strongly agree
4 = Agree
3 = Neither agree nor disagree
2 = Disagree
1 = Strongly disagree

Comparing managers' responses to non-managers' responses at GRC, we found a greater change in survey scale results among managers than among non-managers. This is consistent with what we would expect after just 6 months: the culture change strategy was to work with leadership as the mechanism for driving culture change. Initial activity in the culture change effort focused primarily on managers at all levels. After just 6 months, one would expect to find managers seeing greater change than individual contributors, and that is what the results indicated.

The final question in the survey was open-ended: "What changes have you seen in NASA's culture in the last 6 months?" Among GRC managers, 46 percent of respondents provided comments, and among non-managers 44 percent provided comments.

In analyzing the comments provided by managers, we found that 32 percent mentioned specific indicators of culture improvement such as seeking input from others,[2] while 10 percent indicated they had seen no change, and 4 percent indicated that

[2] Only comments mentioning changes to cultural characteristics were counted. Many other comments mentioned activities undertaken during the last 6 months, such as training or meetings, but descriptors of activities—as opposed to characteristics of culture—were not counted for analysis.

the culture had worsened. Among managers providing comments, 21 percent indicated an improved safety climate, while 4 percent indicated the safety climate was worse.

Among non-managers, 22 percent mentioned specific indicators of culture improvement, with 16 percent indicating no change, and 4 percent indicating a worsening of the culture.

In addition to the basic survey scales, this survey included a series of NASA-specific questions. They were grouped into several thematic areas such as guiding principles for safety excellence, consistency between words and actions, cooperation and collaboration, potential inhibitors, communication, and employee connection to mission safety. All NASA-specific questions showed improvement compared to the first survey.

Results from the Stennis Space Center were very similar to those from GRC. All survey scores improved, and comments were consistent with these results.

JOHNSON SPACE CENTER RESULTS

The survey was administered at Johnson Space Center (JSC) to the Engineering Directorate and the Mission Operations Directorate (MOD). The culture change efforts had been focused on these two groups during the initial phase of the process.

All scales on the basic Safety Climate and Culture survey showed improvement for these two JSC organizational units. These results are shown in Figure 12–9 (percentile scores) and Figure 12–10 (raw scores.) The September results show significant improvement over the February results.

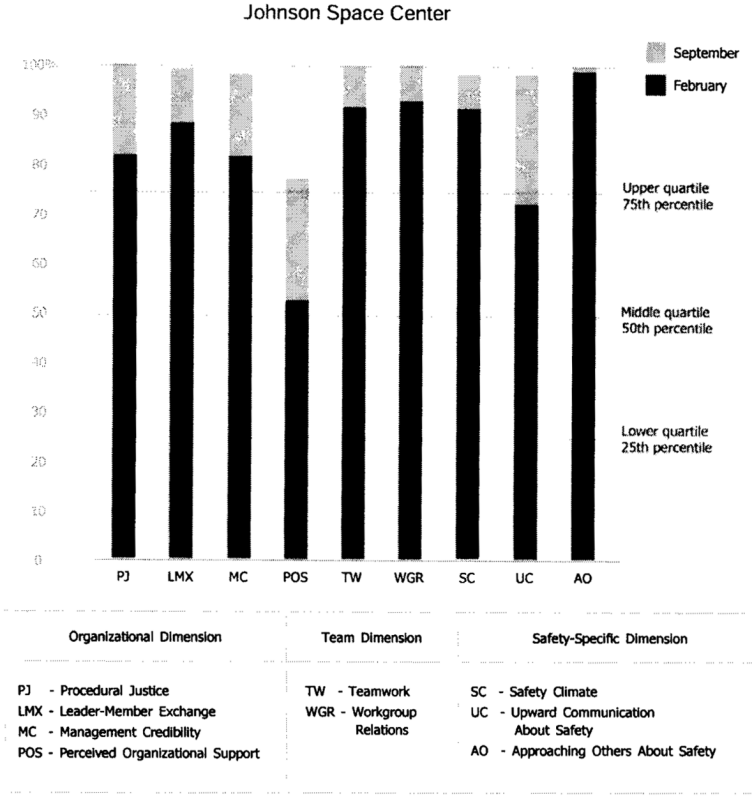


Figure 12-9. OCDI percentile scores for NASA's Johnson Space Center showing results from before and after start of intervention.

Figure 12–10 shows the comparison of these results with their confidence intervals. Where confidence intervals do not overlap, the differences are statistically significant.

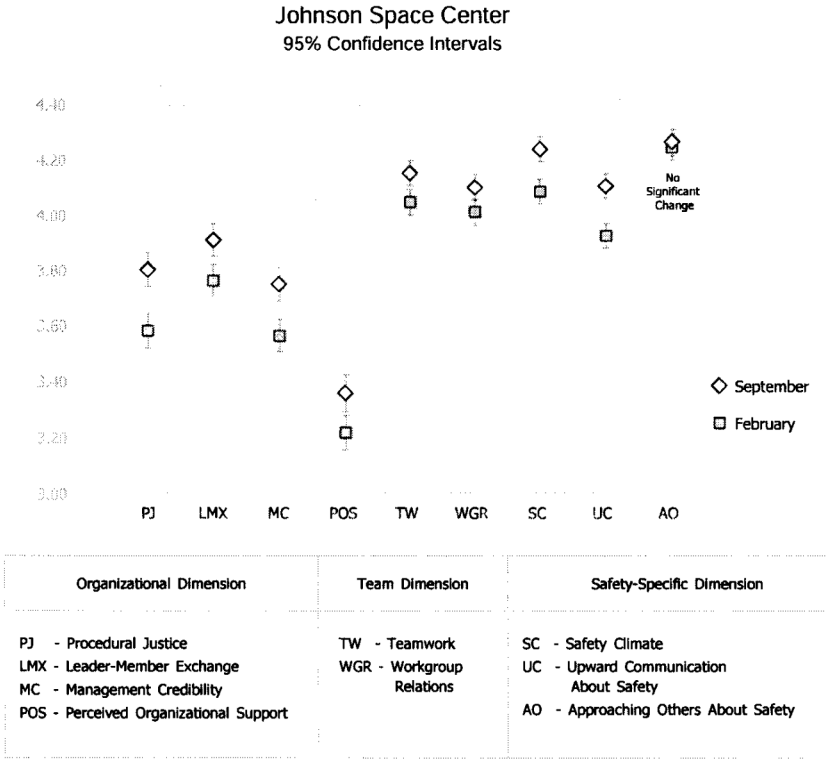


Figure 12-10. OCDI raw scores for NASA's Johnson Space Center.

Scale : 5 = Strongly agree
4 = Agree
3 = Neither agree nor disagree
2 = Disagree
1 = Strongly disagree

JSC had generally high scores on most scales prior to the culture change efforts, with most scales above the 80th percentile. In the survey conducted after the initial culture change efforts, every scale showed some level of improvement. Percentile scores were high, although raw scores still showed room for improvement.

Comparing managers' responses to non-managers' responses, we again found a greater change in survey scale results among managers than among non-managers. As noted in the discussion of GRC results, this was consistent with what we would expect.

The final question in the survey was open-ended: "What changes have you seen in NASA's culture in the last 6 months?" Among JSC managers, 52 percent of respondents provided comments, and among non-managers, 45 percent provided comments.

Among the responses provided by managers, 52 percent mentioned specific indicators of culture improvement such as seeking input from others,[3] while 7 percent indicated that they had seen no change, and 4 percent indicated that the culture had worsened.

Among non-managers, 22 percent mentioned specific indicators of culture improvement, with 22 percent indicating no change, and 3 percent indicating a worsening of culture. In addition, 13 percent indicated improvement in safety climate.

In addition to the basic survey scales, this survey included a series of NASA-specific questions. All NASA-specific questions showed improvement since the February survey.

SUMMARY

By focusing on leadership using behavior-based tools, NASA has made a strong start in its effort to change its culture. Both survey scale scores and comments indicate that the change effort at NASA has made good progress in a brief time, but that more work remains to be done. As would be expected in the early stages of a major change effort, there appears to be a segment of the population that is seeing positive change and is optimistic about the direction the organization is moving, and another segment that is skeptical and not yet seeing what its members articulate as change. However, the overall perceptions, measured by the survey scores, indicate that there is solid movement in the desired direction.

The approach taken has built ownership for the culture-change effort among the leaders of the target groups and has produced a rapid start to the longer-term job of changing the culture. Leaders have been given new tools to help them carry the change forward, and as the effort is now being expanded to the rest of the organization, NASA is on a trajectory toward an enhanced organizational culture.

Senator MURRAY. Thank you very much.

Thank you, all, for your testimony.

Mr. Frumin, I'm going to start with you—OSHA keeps justifying their lack of enforcement of existing health and safety standards by saying that the number of injuries and deaths on the job have been decreasing over the last several years, and they point to their voluntary compliance efforts as a more effective way to encourage industry to do the right thing.

Now, during my subcommittee hearing on OSHA that we held last April, we heard testimony from Dr. David Michaels of George Washington University about the serious problem of underreporting, concerning occupational injuries, diseases and deaths. According to his work, as many as two-thirds of these injuries and deaths go unreported to OSHA.

Experts cite various reasons for underreporting—OSHA's failure to issue new regulations, employer disincentives, workers' fear of retaliation—I wanted to ask you, is underreporting a major problem, and has it undercut the data that's used by the Department?

Mr. FRUMIN. It's a huge problem, Senator Murray. It's not a new huge problem, it was a huge problem 22 years ago, today, when Labor Secretary Brock showed some of the leadership that Gerry Scannell is talking about, and authorized OSHA to levy the first egregious penalties at Union Carbide, for willfully violating their standards on injury recordkeeping. At that time, there was a fair amount of interest in improving compliance, but since then that interest has dwindled, considerably, at OSHA, and we've seen now a terrible resurgence of various ways that companies avoid, or frankly, lie in their injury-illness records, and the exposé by the *Charlotte Observer* was a terrific effort in documenting—on a very per-

[3] Only comments mentioning changes to cultural characteristics were counted. Many other comments mentioned activities undertaken during the last 6 months, such as training or meetings, but descriptors of activities—as opposed to characteristics of culture—were not counted for analysis.

sonal, individual level in a terribly abusive industry—just how widespread, systematic and reprehensible that practice is.

It needs a tremendous amount of effort, by OSHA, to fix that problem. There is no serious enforcement effort by OSHA now, to really investigate those records. It's a complicated issue—I won't say it's a simple one, but one, certainly this committee could explore in greater detail.

Senator MURRAY. Why do you think that workers and employers don't accurately report? What do you think is the incentive?

Mr. FRUMIN. Well, I think workers—given a free environment—certainly would, but they have good reasons to be fearful, often, as we've seen with workers in the industries we're in, and as the *Charlotte Observer* exposed.

But also, we have a problem with many workers' compensation laws, where the employer controls the choice of physician, so we don't have an unbiased choice by physician.

On the other hand, the employers are the ones who are responsible for these records, and as Jerry pointed out, you know, sending bad news up the pipeline is something that a lot of managers don't want—they don't want to get on the list that OSHA uses for targeting employers for enforcement, frankly, there are disincentives, in the system, for employers to report accurately. If they're going to lie and violate the law, you know, this has to be investigated and stopped.

Senator MURRAY. Ms. Morrow, you've worked for Tyson Foods for 12 years, I'm assuming you've seen injuries and accidents occur. Have you seen a change in workplace safety, in terms of employees feeling confident about reporting injuries that occur?

Ms. MORROW. No. The employees are afraid.

Senator MURRAY. Because?

Ms. MORROW. Of being retaliated against, or losing their jobs. They just don't want to complain.

Senator MURRAY. So, they just keep it quiet?

Ms. MORROW. Most of the time.

Senator MURRAY. Is there anybody talking to you about the need to report?

Ms. MORROW. Oh, they talk to me all the time. Most of the time, I'm the one that goes and reports it.

Senator MURRAY. What happens when people report?

Ms. MORROW. They just tell them anything, and they just let it go. Whatever they tell them, they just accept that, and let it go.

Senator MURRAY. Mr. Frumin, does OSHA verify injury logs at these companies?

Mr. FRUMIN. Unfortunately, the effort that OSHA once started to do widespread audits has dropped off completely, and in many States, the State plan agencies have completely dropped that effort.

In fact, we saw a really incredible response by the North Carolina Labor Commissioner to the *Charlotte Observer* articles. She, basically, blamed the workers for not reporting to her the fact that the companies were lying on their injury records. So, she was completely unsympathetic to them, and very defensive.

In fact, she said she was shocked and offended that the newspaper would even allege that employers had violated the law. She took no responsibility for this kind of enforcement effort.

Whether at the Federal or State level, we don't see the urgency that's necessary to have some confidence that even the data has some integrity to it.

Senator MURRAY. Well, I have the articles from the *Charlotte Observer*, they did some great work, really, looking into this issue. I think they revealed some eye-opening information that all of us should be aware of, and I will ask unanimous consent to put all of these articles into the record. I think that all members would do well by taking a look at them, and seeing what the challenges are out there that we're faced with, and why I think Senator Kennedy's legislation and others are so important.

Senator Isakson.

[The information previously referred to may be accessed by linking to the online address: *http://www.charlotte.com/poultry/*.]

Senator ISAKSON. Thank you, Madame Chairman.

Mr. Scannell, I think I wrote this down right, but I want to ask you—you said that compliance will not guarantee safety unless there's a culture in the company of safety, was that substantially correct?

Mr. SCANNELL. Compliance with the OSHA standards and regulations will not guarantee a safe working place. I mean, it's—you know, you have——

Senator ISAKSON. You need a culture of safety in the company.

Mr. SCANNELL. There are other hazards that may exist that there are no standards for.

Senator ISAKSON. Right.

Mr. SCANNELL. The education, and the training and education is critical. You must provide that leadership. It starts at the top, as it starts with everything in the company, and that's the CEO. Now, you say, "Well, Jerry, you know, the CEO is busy,"—if I may. I put this together when I was at Johnson & Johnson, because a President of one of the J&J companies—there were 166 companies then—was promoted to a Company Group Chairman. He called me up and he said, "What do I do? For the safety and health effort, Jerry?" I said, "You were the President of companies, you were a foreman," he was a General Manager and an Operations Vice President—he was a great manager and he knew his safety and health business in an operating company, making Tylenol. He said, "I don't know what to do in here."

It gave me an opportunity to go to the Chairman of the Board and talk to him. Here's his, Chairman of the Board's Safety Rules and responsibilities and it spells out what he does.

We started to get away from looking at the numbers, the rates, because the rates were getting so low, it's very difficult to measure any more improvement. So, we started to count the fatalities—which there weren't any—amputations, fractures, burns, and eye injuries, and started to collect those and work on reducing those. Those are very serious injuries. But, the fact is, some people can get those injuries and continue working. But I, you know, I question someone with an amputation—even if it's small—continuing on the job that they are assigned to.

Senator ISAKSON. Were you sought after by Johnson & Johnson to come be the Vice President in charge of safety?

Mr. SCANNELL. Yes.

Senator ISAKSON. Were you sought after to go to Bristol? Did they come get you? Or did you start with them?

Mr. SCANNELL. Bristol—Rohm & Haas?

Senator ISAKSON. Well, it says, "Safety Director, Bristol, PA plant, Rohm & Haas."

Mr. SCANNELL. Yes, because I was, yes.

Senator ISAKSON. You were sought by them to come, as well.

Mr. SCANNELL. I was sought, yes, I worked for Thiacall Chemical before.

Senator ISAKSON. That ties—I want to ask Mr. Bianco—Mr. Bianco, I was a salesman for 33 years, and I used to knock on an awful lot of doors. How many of your customers do you knock on their door to bring your service to them, and how many of them seek you out because they need help?

Mr. BIANCO. Very few do we go out knocking on doors, most of our clients come to us.

Senator ISAKSON. That answer—I was so interested—Mr. Scannell said that one of the big problems is not any accountability on the CEO, there's not an accountability at the top, I think that's what you said, in terms of safety.

You were sought after by two major companies to come and be Vice President of Safety, because they had a problem and you had a reputation, and your company is sought after by people, generally who have a problem or finally recognize that's the case.

Here's my question—when OSHA goes in, and if they determine there's a cultural problem, should they be able to—in other enforcements at the Federal level you have what you call "pattern of practice" where a company is found to have a pattern of practice of failing to do X, Y, or Z. There usually are legal remedies that the courts go through to make that company be more aware or more compliant. Should we give OSHA some authority to direct the CEO to address it through hiring—I know you'd love them all to hire your company, but—through either hiring or putting in a safety officer?

That's for both of you.

Mr. BIANCO. I think the answer to that question is what OSHA can do is recognize that, you've got to go way beyond compliance with OSHA regulations in order to create a strong environment for your employees to work safely. Leadership plays, really, a very, very, key role in that. So, my thought is, if OSHA would just simply open the door, that it goes way beyond their regulations, in order to keep people safe.

If I may just talk a little bit about what we've heard here today, you know, when we think about employees, you know, the fear they have of reporting injuries, or the fear they have of bringing bad news to the boss—I look at this as cultural. I mean, I really look at this as cultural. Leadership in an organization owns the culture. They create the culture that either allows employees to feel that there's a value around safety, that the organization supports them, in general, supports their needs. And that there's a freedom, or a feeling of, you can bring bad news to the front office—it's welcomed. That's the only way we can manage risk, it's the only way we can manage exposure, by knowing what's going on.

Now, I agree there are many organizations out there today where that fear exists, but what we try to work on at BST is really the cultural aspects, not only from the CEO level, but all the way down to the most junior employee, getting everybody aligned around the fact that this is the behaviors we want, and we expect, and setting up the right supporting mechanisms for the culture to thrive.

Senator ISAKSON. Well, I know I'm beyond my time—yes? Can I let Mr. Scannell?

Mr. SCANNELL. Well, I think you could go that way, Senator, what you suggested. But I don't think it's necessary in most organizations—CEOs of big corporations, or even medium size—they know what really needs to be done. Someone has to point it out to them. The other isn't—this sounds like heresy, but you know, Eric talked about the penalty for killing a wild boar or duck on Federal—I used to get that all the time. I've had young kids come up to me and say, "My dad's life was only worth $3,000?" Look at some of the things that I did and the penalties when I was there—I stopped discounting. What are we, you know, a discount house? The penalty has got to be significant enough to being a deterrent for others, too. At times I don't think we're discounting and discounting and there's good reasons, I'm sure. But CEOs, they are very concerned about criminal activities, and anything able to reach them to bring them into the Justice Department.

I think we need to re-look at that—the old, the entire penalty system of the OSHA Act.

Senator ISAKSON. Thank you, Madame Chair.

Senator MURRAY. Senator Kennedy.

The CHAIRMAN. Thank you very much, an excellent panel.

Just continuing along on the cultural aspects of this, which I think are fair—you mentioned the culture with Paul O'Neill and ALCOA—and I'm not going to take the time, although it's interesting, whenever they had an accident in ALCOA, no matter what part of the world, within 24 hours they had done the analysis, and they had to, within 36 hours, have a series of recommendations about how they're going to deal with it. They kept driving the accidents down and down and down and down. What it does demonstrate, which all of you have said, is that when you have it at the top, and you have something that is fairly valuable and important, it goes all the way through—that's really the spirit. We could legislate a certain amount.

You've pointed out—we can only do so much if the culture and commitment isn't going to be there. I think that the comments that have been made have been excellent, the real question is, how are you going to get that culture of action, and how are you going to get that culture of leadership?

One of the ways that you're going to get it, I think, Mr. Scannell mentioned, is to raise the penalties. Hopefully you could get it because the Chamber of Commerce would go on their own and say, "This is what we need to do, this is what we have to do," but if they're not going to do it, after a period of time—and I think that time is up—we need to have the incentives built in there.

Now, what troubles me is the culture at OSHA now. It doesn't appear to me that they're using the audits the way that they used to use those audits, in order to be able to determine some of these

problems. They've been slow in developing the standards which should be. You have emphasis on compliance instead of inspectors that are over there. You haven't seen the commitment in terms of worker training.

The Administration, over the period of these last years, has reduced the support for worker training. And that, you've mentioned, is important. All of these indicators reflect, it seems to me, that what has been happening out there in the real world, is that so many of these companies get a slap on the wrist or they have their penalties reduced. In my State in Massachusetts, in 2005, two Testa Corporation workers in Lynnfield were killed, and several others injured in a crane collapse. OSHA had cited Testa for similar violations at a Boston work site the year before.

Between 2003 and 2005, three Massachusetts window washers were killed in separate incidents. The employer in both cases, UNICCO, a service company, had been repeatedly cited for safety violations. We had the Revoli Corporation in North Reading, MA, cited by OSHA for failing to provide cave-in protection for workers installing new sewer lines in Gloucester. The workers were in a 14-foot deep trench, with no means of getting out in the event of a collapse, and were just lucky they didn't get hurt. Revoli had been cited for similar violations in 2004, and again in 1999, again in 1998—and the list goes on. Yet, we're not having strong enforcement. This, I think, has been what has been enormously troublesome and bothersome to all of us.

Let me just ask Mr. Scannell—could you just comment a little bit about how you think—you move to a better culture of safety. I remember going down and visiting with Paul O'Neill and talking to him about safety—he said it was good business.

Mr. SCANNELL. That's right.

The CHAIRMAN. He said, "This thing enhanced our bottom line. This thing just made sense." He said, "The business leaders that don't do it, are missing providing responsible leadership to their stockholders, because it just made sound business sense," and he was able to demonstrate that others have done that, as well.

But we have the pressure of production on these employers, and to get that product out, to get those chickens out, at the end of the day time—to get that out. The intimidation that goes along with it—what's your recommendation on how we move to the more positive aspect and how we discourage the negative features of leadership?

Mr. SCANNELL. The emphasis on safety in the organization must be equal to emphasis on getting the chickens out. One is not over the other, and they can both be done. They just have to be willing to develop that culture in the organization.

The workers get blamed for a lot of things, and it's not the workers. The employer may not have provided the right facilities to process those chickens faster, an investment to do it better, with technology, there's ways of doing things much better today then there were years ago.

How you get that, Senator, I don't know how legislation would be crafted to all of a sudden magically we have a good safety culture in organizations. But I was looking at this, reflecting on it for

the past several weeks, and I mentioned the U.S. Chamber of Commerce—they probably wouldn't do it.

Another organization would be the Business Roundtable. I think you really have to go to the CEOs and say, "Look, there's a crisis in this country."

Now, sure the rates are going down, but I look at fatalities, and the fatalities are still pretty high, and serious injuries are high. I think if we get to, I mean, the legislation would probably be very difficult to write, and it might take years and years to get through, sir.

Somehow I would like to see the private sector—as they say, the Chamber of Commerce, the Business Roundtable, some organization like that—take it on as a challenge. I know the Business Roundtable has done this before on issues, refineries exploding—they took that issue on a long time ago and came up with some good recommendations for their companies. How you get culture in a company—a good safety culture—is very difficult. It's not a switch that you turn on, sir. I wish I could give you a better answer.

The CHAIRMAN. No, that's good, good.

My time is up, I just had a final one for Mr. Frumin about why OSHA isn't doing a better job going after repeat offenders? I mean, does it lack the necessary tools, or the necessary will?

Mr. FRUMIN. Well, probably there's a failure of will at the Administration, which we're all painfully familiar with, and it extends throughout the agency. But probably it's also the nature of the way the enforcement program was enacted in the statute, and also the way it was practiced throughout these 30-odd years, Senator.

OSHA was conceived of as an agency that would go after employers one at a time, plant by plant, establishment by establishment. In contrast, say, to other Federal agencies, or even labor standards enforcers, which look at—as Senator Isakson pointed out—patterns and practices of companies. The world has changed—these companies are huge, the ones we're talking about today are huge corporations, industry leaders.

If the agency isn't actively dealing with them at the corporate level, at the very same level that you've just been discussing with Mr. Scannell, then it's going to be ineffective—it's got to get a grip on what the corporate office is doing with regard to compliance, and what we see in these companies, at Cintas, for example, the CEO just washing his hands of responsibility here—what kind of a message does that send? When we know that these corporations—McWayne, BP, and their corporate office—are telling the plants, "Cut costs, cut costs," production, as you've said. OSHA sits by and doesn't have a remedy for that—doesn't even try to come to grips with that kind of misbehavior by corporate officials.

So, if OSHA were focusing its efforts on looking at problems throughout a corporate structure, it would send a clear message to the CEOs that they're going to be watched, and they're going to be held accountable, and then they might want to hold the people below them accountable. But that's missing, and frankly, I think that would probably do more to change corporate culture than anything else—Jerry has pointed out that the threat of criminal prosecution is a real eye-opener, it's a wake-up call for CEOs—you've

taken that approach in Sarbanes-Oxley, I think workplace safety deserves, at least, the same.

Senator MURRAY. Thank you, Senator Kennedy. It seems to me, and Mr. Frumin kind of touched on it, that we're not dealing with small little businesses or companies that know every one of their employees. The accountability, Mr. Scannell, that you talk about is way off in Wall Street someplace.

When I grew up, my dad ran a little Five & Ten Cent Store, he knew every one of his employees, and if somebody was hurt or injured, he knew their families. Today, who knows who owns the place, and who they're even accountable to, so how do you get to that top level person? You talked about fines, is there another way that we can deal with these multinational corporations that don't even know who the Ms. Morrow's are, working on the line?

Mr. SCANNELL. Well, I think if they feel they're at risk from the standpoint of breaking a law, and the CEO being hauled up in front of the judge—that is very, very important. I've heard CEOs say, "Just make me safe. I don't want to face any legal action." I think in the environmental laws—because I get that comparison—there is a risk to some of the management, and they take it very seriously.

I'd be the last one to suggest more rules, and regulations, and laws. But, I think it needs to at least be there. Hopefully it won't be used, but be an incentive for management to do what is right.

Senator MURRAY. We have to affect the bottom line or they won't be affected?

Mr. SCANNELL. Well, the bottom line—a lot of CEOs—you'd think they'd know it. But if you just take the workers' compensation costs, and generally you multiply that by four or five, and that's what the cost is to the company—well, that isn't what it is. What you do, you take your profit margin of that company, and you apply it to it, and it triples, quadruples what it's costing the bottom line. In other words, the company has to make a bazillion widgets to offset that workers' compensation. They didn't know it.

They used, just to think, "Well, it's just the workers' compensation," and some think, "Well, the insurance company takes care of that." Well, the insurance company doesn't take care of that, you have to reimburse the insurance company.

The bottom line is, they don't realize the impact of a bad safety and health program to the bottom line. When pointed out, a lot of them really respond to that.

Mr. FRUMIN. Could I comment on that?

Senator MURRAY. Sure.

Mr. FRUMIN. Criminal prosecution is a very important tool in—many of us are in agreement that the current statute is too weak. OSHA fails to collect injury information in a consistent way throughout companies—far, far different, Senators, from what you're familiar with in the mine safety world, where virtually every injury is reported to MSHA.

OSHA knows nothing of that. They have, really, a terrible set of blinders on, just on the basic injury information, but beyond that, they don't know the lay of the land in these companies as far as where the hazards are, where the compliance is. I mean, OSHA is now struggling to keep up, Senator—as you well know, Senator

Isakson—with the challenge of fining sugar refineries and keeping them from blowing up. Yet, they don't know where they are, and they don't have, already, in hand, the kind of information that would allow them to quickly go out and do it.

We're talking the year 2008, how do they report their information on employment, race and gender hiring? It's all electronic, how do they report their environmental emissions? It's all electronic. We need a 21st century information system that puts that information in the hands of OSHA's inspectors, so that when the companies create these kinds of abuses and problems, OSHA's not starting from scratch, and asking the very criminals, "Oh, please, tell us where your hideout is." I mean, it's just absurd what OSHA had to go through in the McWayne case to uncover these kinds of abuses, and then and only then, go after them in all of these different locations—often under a different name, and OSHA didn't even know it.

So, we need an information system that supports an aggressive enforcement program underlaid by standards in the political world to go with it. Only then, I think, will CEOs begin to have the feeling that Jerry talks about, which is, unless they take preventative action, hold managers accountable, they won't be "safe" from criminal prosecution. But if we don't create a structure around them, that gives them that feeling, we're going to see the Farmers and the McWayne families and the families that run these other companies continue to just blow it off, and it's unacceptable.

Senator MURRAY. Well, we still need accurate information, which goes back to the questions I started with—if employees don't report violations, no matter what you say at the top, if it goes all the way down to Ms. Morrow's workplace, where layers and layers of superiors are in your way, and the bottom one says, "Don't you dare report this."?

Mr. FRUMIN. Well, we'll have a problem with injury reporting as long as companies create that kind of hostile environment, and that itself could be the subject of enforcement. We could improve the protections for workers who report injuries and stop some of the abuses in workers' compensation.

But that's not the only kind of information that OSHA needs, it also needs to know where the hazards are. When a company like Cintas, or Smithfield or Waste Management knows where the hazards are, and OSHA doesn't even ask them, or asks them too late, after they send inspectors to offices and to other plants, then we're missing the boat. There's other kinds of information that OSHA should be demanding of companies, that companies should know is already in OSHA's hands, so that they don't feel—in addition to the injury information—that they can hide behind, sort of, OSHA's ignorance.

Senator MURRAY. Ms. Morrow, you're on the line. What would have to change in your workplace to have people report injuries?

Ms. MORROW. What would change?

Senator MURRAY. What could be told to you, to make employees feel safe enough to report their injuries.

Ms. MORROW. That if they came forward and reported it, that nothing could happen to them, it would be OK for them to tell whatever happened.

Senator MURRAY. Would it take awhile for people to trust that, I'm assuming?

Ms. MORROW. Yes. People are so afraid.

Senator MURRAY. So, we've got a ways to go.

But we need change at the top, Mr. Scannell, that's what you're telling us, the culture has to change?

Mr. Bianco.

Mr. BIANCO. If I may, we use that word "culture" quite a bit, and I think when you think about most organizations, culture is so deep-seated, it's really hard to understand what a company's culture is. I don't think most business leaders really understand that they drive that, they own that. They can move that culture any way they want, by virtue of what they focus on. I do believe that there are a lot of organizations where the messages that come from the front office are, you know, we want to hear the good news, we don't want to hear the bad news, injury reporting may not be what they want to hear.

I've heard the whole, I mean, the whole spectrum from, "This could be a great company if we could just get our employees to do what it is we need them to do, get them to work safe, get them to follow the rules," and I don't think business leaders really understand how they drive that, how important it is that they can—you know, it's not the employee. You've got to start by looking at yourself, and I think most business leaders just don't know what that means. They don't understand how to change that.

Senator MURRAY. I think we have a safety culture at the top right now, that feels they can get away with it, so why bother?

Mr. BIANCO. The Baker Report was very interesting, at the refinery in Texas City, because we tend to get lulled by OSHA recordable rates, we tend to see very low recordable rate and we don't realize that that rate may not be reflective of the level of exposure, and we take our eye off the ball.

We think, well, gee, the rate's good, so we're OK—and we're not OK. I mean, exposure occurs every day in the work environment, and we need to have employees that recognize that, leaders that recognize that, and have the ability to stop the job and ask for help, so that that exposure level is kept under control.

Senator MURRAY. I would agree with that, but I still think we need to take away that safety net at the top. If you don't provide that leadership all the way down the line, that you're going to be held accountable.

Senator Isakson.

Senator ISAKSON. Well, a comment, and then a—well, two comments, I guess. The company that I ran for 20 years was a sales company, so your workers' compensation is not very high, but part of—I did operate two golf course communities, residential developments, I ran golf courses, which was the bane of my existence for a long time.

Nonetheless, in the latter operation, there could have been very high risk because of the equipment that you use and things like that. We had accountability on both sides. No. 1, my manager's compensation was tied to—if we had increases in workers' compensation, and we had problems on safety, it affected the compensation of the manager.

And second, we did random drug testing on the employees. Pre-employment drug testing, is important, and I think we need to be open to that.

But I'm intrigued by—I think we ought to work on exploring something. When OSHA fines a company, the stockholders pay the fine. I mean, it comes out of the bottom line.

I think, if I'm not mistaken, in terms of major negligence cases, in terms of OSHA and worker's injuries, those go through a judicial process, I think, do they not? I mean, there's an appeal, there's a citation and then they get an appeal for judicial process?

Mr. SCANNELL. Yes.

Senator ISAKSON. If it's a judicial process and they get their day in court, maybe those negligent should be accountable to put in a workplace compliance officer, or safety officer, something like that, to bring about that culture.

We may be onto something, here, because in my experience—particularly in small businesses—every small business is attuned to safety, because they've got three, four, five employees, they lose one, they've lost 20 percent of their workforce. That's exactly right. I think most large companies are good, but there are bad actors.

Maybe if there's a new wrinkle that addresses this whole culture thing, and the pattern of practice thing, which I think is very important. If you find in your investigation that, in the culture, there's actually a pattern of practice that punishes people for reporting something, that's cultural, that's wrong—gets a manager to cover up things, that's wrong—then maybe we're onto something.

I'm willing to work with the Chairman in that vein, to see, in that aspect, if we can't do something. I'm grateful to the people that traveled all this way to come testify today, thank you.

Mr. FRUMIN. Senator, could I just reply to one part of your comment?

Senator ISAKSON. Sure.

Mr. FRUMIN. Unfortunately, I think for the size of the corporations that we're dealing with here today, the levels of penalties are really, just insignificant to them. I mean, you look at the top 20 penalties in OSHA's history, rarely do they make, or have, a material impact on the profit of those companies—huge corporations—Cintas, it was a $3 million penalty, highest ever in the services sector—it was a days' profit. They won't even pay all of that. The lawyers up at the Labor Department will want to settle that to avoid litigation. At BP, at $21 million, I mean, it's next to nothing.

That was a small fraction of just the budget cuts they impose on the Texas City plant to try to save money that led to the explosion in the first place, so I think while it's important to look at penalty issues and the impact, frankly, the question of accountability for safety and compliance at the corporate level throughout is equally, if not more, important. I'm not saying the penalty shouldn't be a lot higher, they should be. Not every company is huge, in some mid-size companies that will make a difference, but it won't get to the kinds of huge industry leaders. When the industry leaders feel that they have a way out, the message is to the rest of the industry "follow us and don't worry about it."

I would just caution you on relying on dollar signs as a measure of the severity of the penalty.

Senator ISAKSON. Well, that was my point. I made the point, the stockholder just pays the fine. I mean, it's a miniscule part of the bottom line in a major corporation. Maybe by being required to bring in a compliance officer, I—accountability is when there's a direct consequence to me for not doing my job. We have an Ethics Committee here in the Senate, we have an accountability mechanism for our activities, that was my point.

If we raise the fine on some company, tenfold, to beat our chest and think we're doing more for safety, is not nearly as important as if we're changing the culture in companies that have a bad practice, that was the point I was trying to make.

Mr. SCANNELL. May I just? One additional point, and it has nothing to do with what we have been talking about.

The Labor Department—you're going to have an opportunity—having gone through the confirmation process, you'll have an opportunity to talk to a new Secretary of Labor. I think it's important that they be questioned carefully on their position on safety and health. And, you know, they can't know everything, but be committed to it, because it starts at the top, and it starts at the top of the Labor Department.

Then you have the solicitors in there who have a major, major role in, especially in the fines and the penalties and the discounting and the negotiations and so forth. Sometimes you get the lawyers—God love them—trying to settle something, and it doesn't really come out the way we'd like to see it for the worker, or for the culture of that organization, so——

Senator MURRAY. I look forward to that opportunity to question the next Secretary.

[Laughter.]

Mr. SCANNELL. Thank you.

Senator MURRAY. Mr. Bianco, final comment?

Mr. BIANCO. I think I'd be remiss to leave here today not to mention the fact that there are many companies out there today that do get it. That really do get it, that have a value around a no-harm culture—not, the goal is zero injuries, and they work real hard at it, and they really do see the value in the people, and respect, and there's lots of mutual trust and lots of reciprocity throughout the entire organization around, you know, the goal of goal zero.

While I'm here today, I know we've talked about one side of the equation, but there are so many organizations out there that are role models for just how to make safety work, in America's businesses.

Senator MURRAY. Thank you, I think we'd all agree that there's good companies out there, and our responsibility is to make sure that all companies get to that same safety level, so thank you very much.

I want to thank all of our witnesses for your testimony. The hearing record will be held open for 10 business days for any additional questions or comments, I appreciate everybody being here.

Senator MURRAY. And with that, this subcommittee is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR OBAMA

I thank the Chair for holding this hearing and for focusing greater oversight on dangerous jobs in dangerous industries.

Since the creation of the Occupational Safety and Health Administration (OSHA), America has made significant progress in making the workplace safer. But millions of workers are still suffering injuries, work-related illnesses, or fatalities on the job every year. Unfortunately, in the face of irrefutable data, this Administration has turned its back on working families. Industry-backed appointees have weakened OSHA enforcement, eviscerated regulatory standards programs, and ignored emerging workplace hazards. By rolling back these protections, the Bush administration has needlessly put the lives of American workers at risk.

By some estimates, more than 50,000 Americans lose their lives every year due to workplace accidents or job-related illnesses. That represents more Americans than we lost in battle during the entire 16-year Vietnam War. For American workers, that's about one work-related fatality every 10 minutes; 137 working families every single day suffer a terrible tragedy, losing a father or mother, a husband or wife, a son or a daughter.

And then there are those who suffer disabling workplace injuries, or serious occupational illnesses. The Bureau of Labor Statistics estimates that in 2005 some 4.2 million workers were hurt on the job. That's 11,500 workers per day, or about 500 per hour. According to some experts, the real numbers may be much higher. American industry pays a substantial price as well: a recent study estimated that employers lose nearly $1 billion per week due to the costs of workplace injuries, illnesses and fatalities. From construction site falls to work-related cancers, from refinery explosions to utility electrocutions, from respiratory diseases to the Sago mine disaster—the toll of workplace risks remains unacceptably high.

I want to highlight some weaknesses in protection that leave workers exposed to risk and some possible solutions.

First, millions of public sector workers lack any OSHA protection at all. Many of these workers hold jobs in high-risk fields such as road and utility maintenance, corrections, health care, trash collection, transportation, and emergency services. These are some of the most dangerous jobs in the United States. But due to a gap in OSHA coverage, an estimated 8.6 million State and local government employees in 26 States and the District of Columbia are left with nowhere to turn for workplace protections.

Second, given resource limitations, OSHA is incapable of inspecting all but a tiny fraction of American workplaces each year. The agency and its 21 State counterparts have only about 2,100 inspectors. While the number of Federal and State inspectors has grown only marginally over the past three decades, the number of covered workers has grown over the same period by 55 percent. Currently, these 2,100 investigators must oversee 135 million workers at 8.9 million workplaces. As a result, in fiscal year 2006, OSHA and its related State agencies conducted a mere 96,000 inspections (down from a high of more than 126,000 in 1991), meaning that 99 percent of our workplaces were not inspected at all.

Third, it is unfortunately still true that some employers expose their workers to serious dangers in an effort to speed production or save costs. For these employers, OSHA needs a tough enforcement program with "teeth." But even when OSHA finds a bad actor, the agency's civil and criminal penalties provide little deterrent. According to the agency, in fiscal year 2006, the average penalty for a serious violation was a mere $883, only one-eighth of the statutory maximum of $7,000. For many companies, a fine of this size won't even register.

Under the OSH Act, the crime of willfully causing the death of a worker is treated as a misdemeanor, with a maximum sentence of 6 months. There is no criminal penalty at all for employers who willfully cause permanent injuries. Moreover, when OSHA finds an imminent danger at a workplace, it has no authority to shut down the hazardous work, process, or machine, but instead must first obtain a court order, which can take days.

Fourth, OSHA is able to regulate only a small number of the many hazards workers face on the job. For example, OSHA currently regulates hundreds of dangerous workplace chemicals through a series of badly outdated Permissible Exposure Limits (PELs), many of which were issued in 1971 based on science as old as the 1940s and 1950s. OSHA's 1989 effort to update these standards was overturned by the courts even though for nearly all of the affected chemicals there was no debate over the need for increased protection.

Even worse, the Bush administration has all but shut down the agency's rulemaking function, withdrawing at least 24 critical safety and health standards from the agency's regulatory agenda. This action has left millions of affected workers with no protection against serious hazards such as glycol ethers, tuberculosis, and metalworking fluids. Many hardworking Americans have suffered workplace injuries, illnesses, and fatalities that could have been avoided had these OSHA and MSHA standards been issued.

In the face of this Administration's abdication of responsibility, it is clear that Congress must play a greater role in improving workplace health and safety.

OSHA must be reinvigorated so that it can fulfill its role in spearheading reductions in workplace fatalities, injuries, and illnesses. Public servants committed to the agency's mission of advancing worker safety and health must have the power to lead OSHA. In addition, we must fund the agency at higher levels to enable OSHA inspectors to reach more of the most dangerous workplaces. These new resources would also allow OSHA to build productive relationships and partnerships with business, labor, and nonprofit organizations that can reduce injuries and fatalities. Rebuilding the leadership and strengthening the funding of these agencies represents the bedrock for a sound workplace health and safety policy.

In addition to increasing the enforcement staff to facilitate more inspections of dangerous workplaces, OSHA needs better and more strategic enforcement tools to deter noncompliance among those employers who disregard worker protection in favor of production speed or profit.

OSHA can and should also improve how it targets inspections, so that its investigations focus on the employers and industries that pose the greatest risks to workers. It can also adapt its policies to make sure that employers do not avoid health and safety responsibilities by outsourcing work through subcontracting or misclassification of employees. OSHA enforcement should send a clear message to companies and their subcontractors about their fundamental responsibility to provide a safe workplace.

With regard to penalty policies, OSHA must increase the penalties for noncompliance, particularly in the case of serious, repeat, and egregious violations, for example, by overhauling the methods for calculating civil penalties. The bottom line is that when an employer exposes workers to serious hazards, it should pay meaningful fines.

I would also support legislation to strengthen OSHA's enforcement program. First, the agency's "egregious penalty" policy allows OSHA to penalize the very worst employers with meaningful fines that can run as high as millions of dollars, but the policy is perpetually challenged by employers. The policy should be codified to end these challenges. Second, the OSH Act must be amended to strengthen criminal penalties—to enable the Department of Justice to prosecute a felony when an employer willfully causes death or serious bodily injury to a worker. Some of these changes are included in S. 1244, the Protecting America's Workers Act, a bill now pending before this committee. Third, OSHA inspectors should have imminent danger tag-out authority like their counterparts at MSHA; this valuable tool can save lives by allowing an inspector to shut down operations that pose a substantial and immediate risk of harm.

However, even with greater resources and a strong, targeted enforcement program, OSHA will never be able to inspect every hazardous workplace. For that reason, we must use all available tools to get employers and workers to find and fix hazards before a worker is hurt or killed. OSHA should expand the use of safety and health programs so that all employers with hazardous workplaces take a systematic approach to injury and illness prevention, with the help and participation of their employees. The evidence is strong that such programs save lives, and in many cases save money.

In many ways, workers are the front line of safety enforcement. Since close to 20 percent of inspections arise from complaints, OSHA should encourage exercise of employee rights in workplaces where workers face significant risks but may be reluctant to use them. It can do so through improved outreach to workers via labor unions, worker centers, not-for-profit organizations, and community groups as well as outreach by OSHA itself. The Department of Labor should develop a "one stop" complaint process so workers unfamiliar with the Department's different agencies and procedures can easily enforce their rights. It must also ensure that workers are not discriminated against for exercise of those rights.

Legislation is also needed to extend the coverage of the OSH Act to the estimated 8.6 million State and local government employees who presently lack any OSHA protection. These hard-working public servants deserve protection from the hazards they face every

day in serving their communities. Notably, the proposed Protecting America's Workers Act, which I have cosponsored, would effectuate this change.

OSHA must also reestablish strong regulatory programs to promulgate standards that protect American workers. Standards must be prioritized to address the most serious hazards that affect the most workers. In addition, new approaches must be explored to expand the reach of these regulatory programs. For example, in recent years representatives of labor, industry and professional safety and health organizations have worked together to develop a new advisory committee approach to updating OSHA's Permissible Exposure Limits based on NIOSH recommendations and the best, most current science. Similarly, negotiated, multiparty rulemaking holds promise as a collaborative regulatory approach where the affected parties are small in number and work closely with OSHA to satisfy the statutory criteria for safety and health standards. Last, OSHA must ensure that those rules already on the books—many of which are now decades old—are updated in the most effective manner.

The major features for a policy to improve workplace health and safety are clear. In fact, many of these changes do not require major legislation, but do require agency leadership and focus. Right now, that leadership is lacking, so I applaud the subcommittee for shining a spotlight on these problems.

Thank you.

PREPARED STATEMENT OF THE UNIFORM AND TEXTILE SERVICE ASSOCIATION

The Uniform & Textile Service Association (UTSA) appreciates the opportunity to submit this statement for the record regarding the subcommittee's hearing held on April 1, 2008 entitled "*Serious OSHA Violations: Strategies for Breaking Dangerous Patterns*."

UTSA is an international, not-for-profit, trade association representing over 40 textile supply and service companies with over 2,500 production facilities, depots, and branches all across the United States and Canada many of which are small businesses. Companies in the industrial laundry industry provide and maintain, clean employee uniforms, protective outerwear, linens, patient gowns, towels, reusable shop towels and floor mats, and employ more than 135,000 Americans.

The Association and its members wholeheartedly support the assertion, made at the hearing that safer workplaces result from a corporate culture that embraces safety at all levels, especially one in which senior management adopts safety as a core value of their organization. Countless corporate mission statements tout safety as a "priority," but in our view, priorities can change; values do not. Therefore in UTSA's view, safety is more than a priority—*it is a core value, a value that should be integrated into the culture, communications and business operations of all of our members*.

Toward that end, the Uniform and Textile Service Association, in cooperation with the Textile Rental Services Association, is spearheading a long-term, multi-faceted effort to transform our industry's facilities into models of world-class safety. This new effort, which is also sponsored by the Western Textile Services Association, the Independent Textile Rental Association, UniLink and the CSC Network will be known as the Laundry Safety ESP (Effective Solutions + Prevention) program.

The goal of Laundry Safety ESP is to reduce workplace injuries and illnesses within the laundry industry, and it has been crafted to involve every plant and service center in the uniform, textile rental, healthcare and hospitality laundering business. The program will facilitate more than just compliance with Federal, State, and local requirements, but will provide a road map for the achievement of world-class safety programs and processes at every applicable industry location.

As a part of Laundry Safety ESP's launch, the industry has declared May 2008 as the first annual Laundry Safety Awareness Month. Each year in May, participating companies will conduct a series of interactive safety review programs that enhance existing compliance training programs and focus attention on specific sub-

jects that have been identified by a panel of industry safety professionals as among some of the most critical safety topics facing our industry and its workers.

Laundry Safety ESP will help laundries go beyond basic OSHA compliance by incorporating interactive safety review, internal inspections, employee awareness, safety-related employee activities and general employee involvement in safety issues.

Through Laundry Safety ESP the industry will demonstrate the strength of its existing programs, enhance them, and develop additional industry-wide procedures to achieve significantly lower accident levels.

Key Elements of Laundry Safety ESP include:

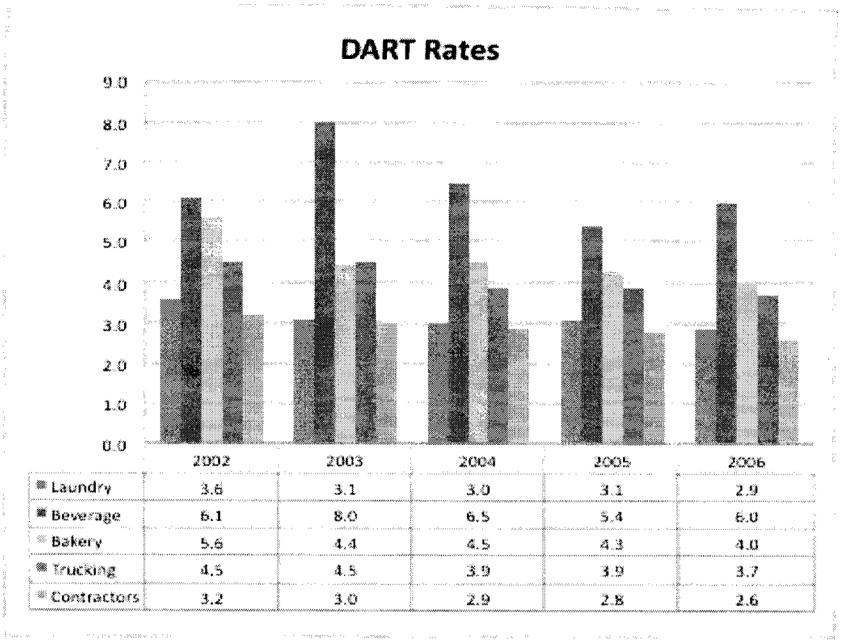
- An annual industry-wide Safety Awareness Month focusing week-by-week on four specific safety topics;
- Annual collection and compilation of injury and illness data, and reporting of accident prevention practices;
- A research component that will help identify why laundry workplace accidents occur;
- An annual Safety Summit to foster discussion on a variety of health and safety topics;
- Industry-specific health and safety campaigns;
- Annual awards to recognize plants with exemplary safety records;
- A Health and Safety Committee which will oversee all aspects of Laundry Safety ESP.

UTSA is proud of its members' historic safety record, yet we recognize that the industry must continuously improve in order to achieve an accident-free workplace—this is why Laundry Safety ESP was developed. UTSA is confident that Laundry Safety ESP will significantly reduce injuries and illnesses across the entire industry, which in turn, will lead to world-class safety records. *In the laundry industry safety is much more than a priority—it is a core value*.

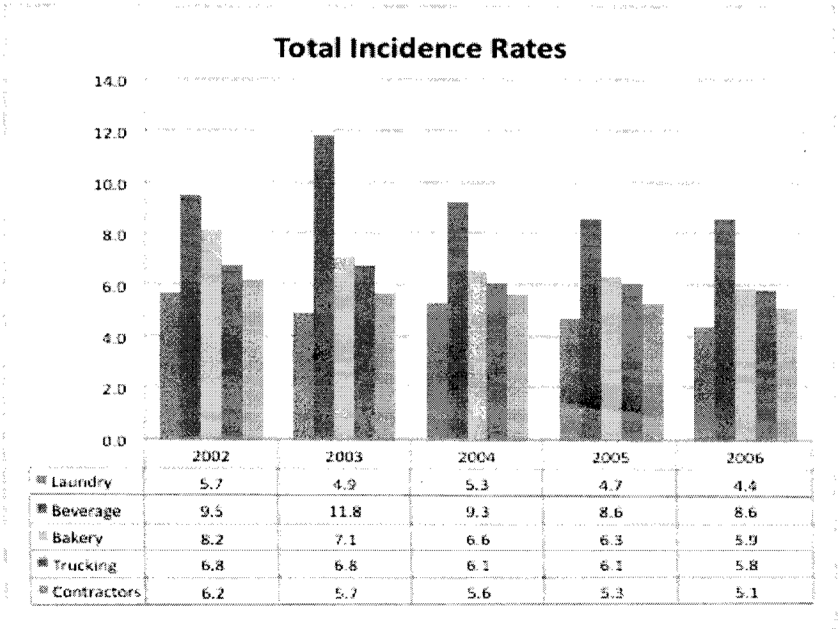
The Uniform & Textile Service Association appreciates the opportunity to submit this statement for the subcommittee's consideration. If you have any questions please contact Tony Wagner, UTSA's Director, Environment & Government Affairs at 703-247-2608 or wagner@UTSA.com.

ATTACHMENTS

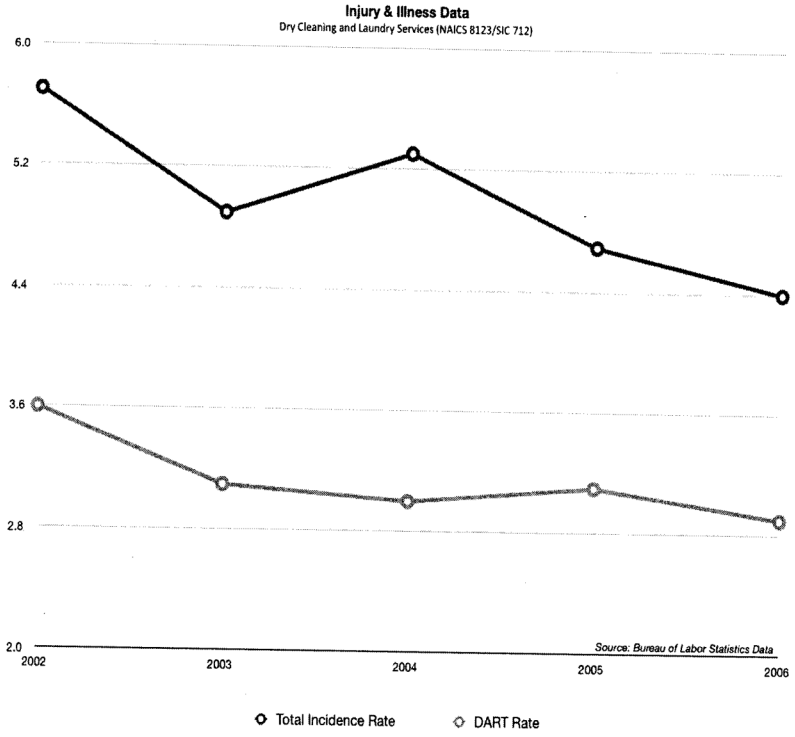
Two charts and one graph are attached which show the rates of injury and illness as well as days away, restricted or transferred (as reported by the Bureau of Labor Statistics). As the data indicate, not only has the laundry industry's injury and illness record improved over the past few years, but our members' companies have had a better history of employee safety than those in similar industries. While the trend is favorable for our industry's employees, UTSA is taking steps to do better; that is the reason why we are implementing Laundry Safety ESP.



	2002	2003	2004	2005	2006
Laundry	3.6	3.1	3.0	3.1	2.9
Beverage	6.1	8.0	6.5	5.4	6.0
Bakery	5.6	4.4	4.5	4.3	4.0
Trucking	4.5	4.5	3.9	3.9	3.7
Contractors	3.2	3.0	2.9	2.8	2.6



	2002	2003	2004	2005	2006
Laundry	5.7	4.9	5.3	4.7	4.4
Beverage	9.5	11.8	9.3	8.6	8.6
Bakery	8.2	7.1	6.6	6.3	5.9
Trucking	6.8	6.8	6.1	6.1	5.8
Contractors	6.2	5.7	5.6	5.3	5.1



SMITHFIELD FOODS, INC.,
SMITHFIELD, VA 23430,
April 7, 2008.

Hon. PATTY MURRAY, *Chair,*
Subcommittee on Employment and Workplace Safety,
U.S. Senate,
Washington, DC 20510.

Hon. JOHNNY ISAKSON, *Ranking Member,*
Subcommittee on Employment and Workplace Safety,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN MURRAY AND RANKING MEMBER ISAKSON: I understand that your subcommittee held a hearing on April 1 regarding OSHA violations and that a witness included a Smithfield Foods plant among a group of facilities that he asserted had in some way failed to provide a safe environment for workers. The committee may not have been aware that the witness represents an organization that has long been hostile to Smithfield. Smithfield did not have an opportunity to respond at the hearing, so I write to set the record straight on this issue.

At Smithfield Foods, our employees are our most valuable asset, which is why senior management has consistently made on-the-job safety a top priority. We strongly believe in rigorous safety standards. Our policy is not simply to meet State and Federal standards, but to exceed them. We have set the standard in the meat and livestock industry for keeping workers safe and healthy on the job.

Smithfield has developed a unique Employee Injury Prevention Management System (EIPMS) that is deployed at all locations throughout our company. The EIPMS is based on the Occupational Health and Safety Assessment System (OHSAS) 18001 guideline and is designed to involve all employees, from management down, in

maintaining a safe working environment. This program requires each of our facilities to establish and maintain a management system that ensures compliance with all local, State and Federal regulatory statutes, general industry-accepted safe work practices and other standards including company-specific requirements. Because we have a wide range of operations, from farms to packing plants to office buildings, each location's EIPMS is unique; however, all plans include performance goals and measurements, hazard identification and risk assessment, safety and awareness training and clearly defined roles and responsibilities. In addition, each location must develop an internal audit of its Health and Safety program and is subject to external auditing by Smithfield Foods corporate or a select third party auditing firm.

Recent statistics demonstrate that our EIPMS is working. We have seen a substantial reduction in occupational injury and illness rates for our organization. Our Calendar Year 2007 injury and illness stats indicate a 26 percent decrease in the Total OSHA Incident Recordable (TIR) Rate, a 29 percent decrease in the Days Away, Restricted, Transferred (DART) Rate and a 14 percent decrease in our Days Away (DAW) Rate. Previous years' data shows that we are at or below the national average in these categories.

The witness before your committee referred specifically to our Smithfield Packing Co. plant in Tar Heel, NC. He cited selected events, none of them recent, to suggest that the Tar Heel plant is unsafe. In fact, Tar Heel's safety record is strong. Our data show a downward trend at this location in line with reductions at the rest of our company. In 2007, the Tar Heel plant's injury and illness rates were reduced by an average of 9 percent, with a Total Recordable Rate of 6.9, a DART Rate of 6.0 and a DAW Rate of 0.9. The Tar Heel plant is the largest pork processing plant in the world, a crown jewel of the Smithfield family. We have gone to great lengths to ensure the safety and well-being of our workforce there. In addition to our standard safety programs, we operate an on-site Family Medical Center open to all Tar Heel employees and their families. The facility offers primary care, laboratory, X-ray and pharmacy services 6 days a week for the low cost of $10 per visit.

Health and safety is not just a priority for Smithfield Foods, it is a core value of our business, which is why we feel the need to defend our record when it is attacked by groups who have little incentive to speak objectively about our company. We have made a commitment to being an industry leader in this area. If you fairly examine our full record and our practices I am confident you will agree that we are achieving that goal.

I welcome any questions that you may have.

Sincerely,

DENNIS H. TREACY,
Vice President, Environmental and Corporate Affairs.

TEXTILE RENTAL SERVICES ASSOCIATION OF AMERICA (TRSA),
ALEXANDRIA, VA 22314,
April 15, 2008.

Hon. PATTY MURRAY, *Chairman,*
Employment and Workforce Safety Subcommittee,
Committee on Health, Education, Labor, and Pensions,
U.S. States Senate,
Washington, DC 20510.

DEAR MADAM CHAIRMAN: On behalf of the Textile Rental Services Association of America (TRSA), I would appreciate your placing this correspondence in the record for the April 1 Employment and Workforce Safety Subcommittee hearing titled "Serious OSHA Violations: Strategies for Breaking Dangerous Patterns." TRSA has a long commitment to helping our industry be safe, so I welcome the opportunity to let you and members of the subcommittee know about TRSA's historical and continuing efforts relating to this goal.

Founded in 1912, TRSA is the world's largest textile service industry association, representing more than 1,000 industrial laundry facilities in 24 countries. The membership of TRSA represents a cross-section of the industry, including some of the world's largest textile service companies, along with numerous mid-size and one-plant operations. Our membership includes companies currently doing business in commercial laundering and rental services to commercial, industrial and institutional accounts, as well as firms selling services, equipment and supplies to commercial launderers and linen rental companies.

TRSA's mission is to advance the professionalism of its members and promote their success through government advocacy, education, marketing and businesses

enhancing services. TRSA is committed to addressing the changing needs of the industry, and our members, while striving to surpass industry standards by uniting members through a progressive organization.

TRSA has always believed that educating its membership on the importance of a safe workplace and instilling a commitment to safety principles is an essential part of its core mission. Throughout its history, TRSA has developed resources and programs to improve the knowledge of its members on the most up-to-date practices to make our workplaces safer.

Together with our sister association, Uniform & Textile Service Association (UTSA), TRSA established the Production Management Institute (PMI) in 1990. A strong and ongoing program, PMI is designed to educate plant managers and supervisors on state-of-the-art plant operations, including leadership and supervisory skills. From the beginning, safety has been a key component of PMI, and it will be a major focus at the upcoming PMI session in May.

In addition, during the February TRSA Tech/Plant Summit of industry executives, I announced the TRSA Safety Initiative. The TRSA Safety Initiative is a comprehensive program that was conceived to help the textile service industry improve workplace safety. It encompasses four key areas: to **educate** TRSA members on how to improve safety; to **serve** the TRSA membership by assisting individual members on how to enhance the safety of their facilities; to **track** the progress of safety improvements through the collection and analysis of data; and to **represent** to the public and government bodies the industry's commitment to safe facilities. One aspect of the Safety Initiative, **SafetyESP** (Safety Enhancement Stewardship Program), is being administered in cooperation with UTSA and will focus on tracking industry progress on safety improvement through data collection and analysis.

TRSA—and its members—understand the importance of a safe workplace and we are committed to making the working environments of our membership among the safest in the world. We have been in contact with OSHA to make sure that the lead Federal agency on safety is aware of our Safety Initiative and we have asked the agency to provide constructive criticism and other input that will make the TRSA Safety Initiative even more effective.

My staff and I would appreciate the opportunity to meet with you and/or your staff for a dialogue similar to our recent discussions with OSHA. We also plan to meet with other subcommittee members and their staffs as well.

Thank you for the opportunity to let us share what TRSA has done, and is doing, to improve safety in the textile services industry. If you have any questions or would like additional information, please contact me or TRSA's Director of Government Affairs Larry Fineran. Both of us can be reached at (703) 519–0029 or through e-mail at rcocivera@trsa.org or lfineran@trsa.org.

Sincerely,

ROGER COCIVERA,
President, Textile Rental Services Association of America.

[Whereupon, at 11:27 a.m. the hearing was adjourned.]

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