seems incongruous with the reflexive and inductive style that dominates the book. Despite this minor and perhaps unavoidable false start, the bulk of the next half a dozen chapters is captivating.

Many of the themes identified in the opening chapter are indeed captured in the stories in this book. Stories of having to adapt to new technologies, of the work–life imbalance, of work identity, and other key themes are scattered throughout the chapters. Thankfully, the authors have not attempted to force these stories together into themes. Instead, each chapter focuses upon the stories of individuals whose work has similar functionality. However, the variety and uniqueness of the voices captured in each chapter provide depth and richness equally as fascinating as the stories shared by Studs Terkel all those years ago. For example, the chapter entitled 'Helping People' is particularly powerful, capturing diverse experiences. One moment I learned about *Weihui* – a registered nurse who must manage her emotions when one of her patients dies. The next, I was introduced to *Luwigi*, a business systems manager who shared his epiphany that his staff were scared of him.

In many ways, this is a book of very personal vignettes or small case studies that could be used by those who teach classes in the sociology of work, employment studies, or human resource management at either undergraduate or graduate levels. These stories lend themselves to being unpacked and explored using a range of theoretical and conceptual lenses. This book also constitutes a time capsule snapshot of work in the early 21st century that can be contrasted with the narratives that Terkel provided 40 years ago. This would be useful to any scholar interested in exploring the changing nature and experience of work over time. Forty years from now, I hope a similarly able writing team emerges who provides the next volume of narrative work keeping this tradition alive. The concluding chapter, although a little brief, along with a brief profiling in the appendix of those whose stories were told in this book, certainly sets a framework for such a comparison down the track. A final nod to the power of narrative work is captured very effectively in the final appendix, where the two authors courageously tell their own stories.

References

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Michael Quinlan has extensive experience over 30 years in the field of work health and safety and high hazard workplaces, as a researcher and member of inquiries in mines and road transport safety. He was engaged by the New Zealand Department

of Labour to prepare background reports on mine safety for its response to the 2010 Pike River mine disaster that killed 29 miners, and in 2006, he reviewed management processes and the role of the mine inspectorate for an investigation into the Tasmanian Beaconsfield gold mine rockfall in 2006 that killed one miner and trapped two more underground for two weeks. Subsequently, he was appointed in 2013 to an Expert Reference Group to recommend enhanced regulation of mine safety in New Zealand, and was engaged in 2010 to audit the Tasmanian mines inspectorate.

It is worth recounting this depth of experience because, together with Quinlan's historical skills, it forms the basis for identifying patterns of fatality in hazardous workplaces over 200 years. Quinlan draws from detailed data on catastrophic events involving multiple fatalities in high hazard sectors – mining, oil rigs, air transport, refineries, shipping, and factories – from five Anglophone countries for 40 years. This is the period of the introduction of the Robens approach, commencing in the UK, characterized by a shift in regulatory emphasis from prescriptive standards to risk assessment and management systems, including input from employees and their representatives.

He demonstrates that recurring patterns of failure can be isolated into 10 types that provide a checklist for organizations:

- engineering design and maintenance flaws;
- failure to heed warning signs;
- flaws in risk assessment
- flaws in management systems;
- flaws in system auditing;
- economic and reward pressures compromising safety;
- failures in regulatory oversight;
- worker or supervisor concerns that were ignored; and
- deficiencies in emergency and rescue procedures.

Quinlan's analysis reveals that three or more of these pattern failures were present in all the major disasters reviewed, indicating that they interact rather than operating in isolation from each other. This explains how multiple defence barriers failed in catastrophes.

Three broad underlying risk factors contributed to the specific failures identified: economic and reward pressure, disorganization and regulatory failure, and the so-called PDR model. Economic and financial pressures impact at an organizational level through prioritizing profits and production, leading to cost-cutting in design and maintenance, incentive payment systems, lean production regimes with extended shiftwork and subcontracting, which have commonly been associated with poor safety regimes. Disorganization occurred through deficiencies in training, supervision, safety procedures and management systems, risk assessment, and communication including the ability of workers to represent their interests in the processes. Regulatory failures involved deficiencies in coverage, form, enforcement

and compliance. Each of these sets of risk factors also interacted, such that subcontracting for cost reduction is associated with disorganization and regulatory difficulties. Economic pressures also impact beyond the organization to undermine regulatory oversight.

Quinlan locates these patterns within a broader political economy that particularly impacts upon the regulatory regime. It is clear that improvements in the past century have been driven to a large extent by extension of regulatory oversight in the five countries studied, and its weakness elsewhere, in China for example, also explains the much greater rate of fatalities in mines and industry generally there. However, he notes the pressures from neoliberalism for directly reducing regulatory scope, and undermining enforcement as a result of reduced inspectorate resources. In the case of the US, such pressures have prevented the emergence of a more effective regulatory and compliance regime. In addition, at the organizational level, pressure for short-term performance from shareholders fuels many of the key risk drivers associated with disorganization and lean production and incentive schemes. Regulatory regimes ultimately need to make directors bear criminal responsibility for safety failures, but this has been difficult to achieve, and even corporate penalties are relatively mild and weakly applied.

Four other general observations arise from Quinlan's analysis. First, notwithstanding the popularity of notions of organizational safety culture among psychologists, Quinlan demonstrates clearly that this was not an explanatory factor. Workplace culture as an explanation tends to place the onus for catastrophes upon worker behaviour in terms of unsafe acts, but Quinlan shows that such acts require location within a broader environment, such as that of economic and financial pressures upon the workers.

Second, an organizational focus on lost time injuries (LTIs) bears little relevance for preventing major catastrophes. In fact, such a focus may well be counterproductive, particularly if incentives are associated with reducing LTIs, because this commonly leads to underreporting of incidents. A related point is that near misses need attention as the subject of reporting and analysis to a greater extent, because they have commonly warned of patterns of failure prior to catastrophe.

Finally, the importance of employee voice through safety committees and representatives has been a major positive factor in reducing fatalities. Unions in mining have played a key role. However, as part of the contemporary neoliberal environment, unions have declined in strength and coverage, and safety representatives have also declined in importance, undermined by regulatory reform and more direct forms of voice.

The book therefore operates at the level of a toolbox for safety professionals, as well as providing broader socioeconomic analysis. Its one drawback is a high degree of repetition due to its structure. However, this does not detract from it as a tour de force.