Pregnant Workers & Return-to-Work: Unique Hazards and Protections Fatality File

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What Happened

In an eight-month period from May to December 1981, five of seven pregnancies among employees of the Immunology Branch at the Centers for Disease Control in Atlanta — or among spouses of male employees in the same department — ended in spontaneous first-trimester abortions. The concentration of losses within a single workplace triggered a formal NIOSH Health Hazard Evaluation. Investigators found that of more than 180 chemicals in use at the laboratory, 39 were identified as known mutagens, teratogens, or embryotoxins. Workers had been routinely handling these substances with no reproductive hazard assessment, no targeted exposure controls for workers of reproductive age, and no communication about the reproductive risks those chemicals carried.

What Went Wrong

The chemicals were already classified as hazardous to reproduction. What was missing was a workplace system to translate that knowledge into protection — flagging reproductive toxins specifically, controlling exposures for workers who were or could become pregnant, and informing workers of the risks they faced daily. Standard occupational exposure limits are developed for normal adult non-pregnant workers and do not account for effects on a developing fetus. None of that was communicated. Workers made no informed decisions because they were given no information on which to base them.

The Bottom Line

Five pregnancies ended in one department in eight months. The hazard was already known. The gap between what was known about those chemicals and what was communicated to the workers who handled them was the gap in which five pregnancies were lost. Identifying reproductive hazards, communicating them clearly, and providing accommodations are not optional — they are the controls that protect workers and the lives they are carrying.

Source: https://www.cdc.gov/