INFORMATION NEEDS OF BEREAVED FAMILIES FOLLOWING FATAL WORK INCIDENTS

Abstract

The sudden and unexpected nature of fatal work incidents can leave family members with a strong need to know how and why the worker died. Forty Australian family members were interviewed to identify the information sought following fatal work incidents and explore the factors enhancing or impairing satisfaction with the account of the death. Findings demonstrated that employers tended to divert responsibility to the worker, to mask underlying systemic failures. Satisfaction was enhanced if family members believed a sense of justice was attained and formal investigations were able to expose the truth and those responsible for the death were identified.

Work-related fatalities are known to affect employers, colleagues, and the economy (Anderson, Schulte, Sestito, Linn, & Nguyen, 2010; Quinlan, Fitzpatrick, Matthews, Ngo, & Bohle, 2015; Vivona & Ty, 2011). In 2007, the economic cost of work-related deaths in the United States was estimated to be \$46 billion (Leigh, 2011). Such events can be traumatizing to co-workers, increasing the likelihood of resignation and impeding the overall effectiveness of organizations (Charles-Edwards, 2005; Vivona & Ty, 2011). Productivity may also be reduced as grief can impair workers' abilities to think clearly and rationally (Sunoo & Solomon, 1996; Vivona & Ty, 2011).

However, there is little knowledge about how fatal work incidents affect bereaved families (Matthews, Bohle, Quinlan, & Rawlings-Way, 2012). The manner in which an individual dies is known to have profound effects on how families cope with and adjust to the death (Armour, 2007; Rynearson, 2005). Families bereaved by sudden deaths face challenges that differ to those following anticipated deaths in that they do not have the chance to care for their family member or say goodbye (Brent, Melhem, Donohoe, & Walker, 2009; Garstang, Griffiths, & Sidebotham, 2014; Rynearson, 2005). When someone dies from a slow, progressive disease, there is an opportunity for family members to be present and care for the ill individual. They are more able to play a final role as the ill person's comforter and may accept that death will end their pain and suffering (Rynearson, 2005).

Over recent decades, there has been a shift away from the presumption that mourning requires letting go of someone who dies and movement towards recognition of the reality of living with continued bonds (Klass, Silverman and Nickman, 1996; Rosenblatt, 1983; Rothaupt & Becker, 2007). Not being able to obtain a satisfactory account of the death may lead to recurring nightmares, which disrupt sleep, diminish

quality of life, and compromise mental health (Kaltman & Bonanno, 2003; Rynearson & McCreery, 1993; Salloum, Avery, & McClain, 2001). Fantasized re-enactments of people's final moments may result if family members are only able to obtain fragmented details of how the death occurred (Lehman, Wortman, & Williams, 1987; Parkes & Weiss, 1983). These fantasized images are frequently reported by those bereaved by sudden and traumatic deaths and can cause significant distress (Kaltman & Bonanno, 2003; Rynearson & McCreery, 1993; Salloum et al., 2001).

The need to know who was responsible, why the death occurred, and the motivation for the murder are all commonly reported themes in studies involving families bereaved by homicides (Asaro & Clements, 2005; Burgess, 1975; Malone, 2007; Rynearson & McCreery, 1993). However, no study has focused specifically on families bereaved by fatal work incidents. What separates fatal work incidents from other forms of sudden death is that the environments in which they occur are governed by specific Occupational Health and Safety (OHS) or related laws (such as those dealing with mine or maritime safety). Families may, therefore, not only have a need to know how the death occurred, but also seek answers as to why the death occurred, if someone in authority at the workplace was to be blamed for the death, and whether structural or systemic failures on the part of an employer, contractor or other party led to the fatal incident (Matthews, Fitzpatrick, Bohle, & Quinlan, 2014). This information also enables preventative measures to be developed, in an attempt to ensure similar deaths do not occur in the future (Matthews, Fitzpatrick, Quinlan, Ngo, & Bohle, 2016).

The investigative processes that follows a fatal work incident has the potential to provide families with the information they seek. These formal investigations are typically performed by the police, the safety inspectorate, and the coroner (Ngo,

Matthews, Quinlan, Bohle, 2018). Transport worker deaths may be the subject of an independent investigation (for example, by the Australian Transport Safety Board or the National Transport Safety Board in the USA). In exceptional cases, such as workplace disasters, the death may become the subject of a specific government-initiated inquiry or Royal Commission. In both the latter instances, findings are generally made public with some level of community-accountability, at least in democratic countries. The findings of coronial inquests are available to members of the family and the wider public in many instances. This however does not apply to police reports, which are normally passed onto the coroner, or to safety inspectors' investigations if there is no prosecution or the employer/accused party pleads guilty where no trial is held. Even if the case proceeds to trial, court hearings may only reveal information from the investigation deemed directly relevant to the specific charges laid (Ngo et al., 2018). Employers and unions sometimes conduct investigations, but the findings of employers are seldom made available to families, or to the public (Quinlan, 2014; Quinlan, Matthews, Bohle, & Fitzpatrick, 2016).

While there is limited literature documenting families' satisfaction with government initiated investigations of work-related deaths, the available evidence suggests that families are commonly dissatisfied with the information they receive (Bevan, 2005; Clarke, 2015; Nile, 2004). Further, qualitative studies examining the experiences of families bereaved by fatal work incidents suggest family members have many unanswered questions, even years after the incident (Matthews, Quinlan, Rawlings-Way, & Bohle, 2012; Snell & Tombs, 2011). These unanswered questions can complicate the grieving process. As Matthews et al. (2012) found, participants

explained that they “can’t get on with their life until they have that information... people want to know, gory or otherwise, exactly what happened” (p.45).

No study has sought to explore how the information needs of families can be better met. In the context of better managing fatal work incidents, this lack of knowledge is a notable omission. The aims of this research were therefore to identify the nature of the information sought by family members following a fatal work incident and examine the factors affecting satisfaction with the account of the death. The ways that the formal investigations by authorities enhanced or impaired satisfaction with the account of the death were also explored.

Method

Participants

Forty Australian family members bereaved by a fatal work incident were interviewed. Most were female, and either a parent or partner of the worker. Approximately one third had experienced a fatal work incident in the construction industry. Fourteen participants (35%) had had a family member die within the past five years and 22 (55%) within the last 10 years. Table 1 presents the characteristics of the 40 participants.

-Table 1 About Here-

Procedure

The research presented here was part of a larger project funded by the Australian Research Council (ARC) which aimed to examine and improve institutional responses to families’ needs following a fatal work incident. The research protocol was approved

by the University of Sydney's Human Research Ethics Committee (Project number 2012/2319). A survey was distributed to family members bereaved by work fatalities. Social media were used to assist with initiating the snowball process and outreach to families. A Facebook page was developed to assist to promote the study and tweets were sent out via the University of Sydney's Twitter account. Other recruitment techniques utilised included the development of a university web page for the study; wide promotion on radio stations across Australia; promotion of the study through press releases and articles about the study on websites including Medical Xpress and Bioportfolio; placing a newspaper advertisement; and networking with well-established industry and community support services and networks including Mates in Construction, A Miner's Promise, Workplace Tragedy Family Support, and Creative Ministries Network.

Following the completion of the survey, family members were asked if they would be interested in participating in a one-on-one interview. Consenting participants were contacted and offered the option of being interviewed at The University of Sydney or in their home. The interviews took place from September 2014 to January 2015 by a PhD-qualified researcher and were semi structured in nature. The majority of the interviews were conducted in person ($n = 26$). For those in remote locations, phone interviews were undertaken ($n = 14$).

An interview schedule was used to ensure all relevant topics were covered. It included questions to determine the nature of the information sought by family members and explore the ways that employers, co-workers, the police, coroner, and safety inspectors enhanced or impaired satisfaction with the account of the death. During the latter stages of the interview, more directive questioning ensured all items on

the schedule were addressed, including leads developed from previous interviews. Key points related to each interview schedule item were verbally summarized during and at the end of the interview, allowing the participants to confirm or clarify their responses while the interviews were still in progress.

Peer debriefing was used to improve the credibility of the findings. This process involved the interviewer discussing the contents of the interviews and emerging themes with colleagues and peers with the purpose of exploring topics that might otherwise not have been obvious (Lincoln & Guba, 1985). In particular, the debriefing sessions presented an opportunity to discuss emerging hypotheses and to add questions to the interview schedule to test and address these hypotheses.

A verbatim transcript of each audio interview was obtained and NVivo 10th Edition (QSR International Pty Ltd, 2012) was used to assist with managing the data coding process. Framework analysis (refer to Ritchie & Spencer 2002), was used to code and organize the interview data. The domains created to assist in exploring the data were (1) the nature of the information sought and (2) enhancing and impairing factors. Relevant transcript sections were coded and categorized into their corresponding domain. Four interview transcripts were analysed separately by two researchers. This process assisted in improving inter-coder reliability and ensuring emerging themes were not just the subjective views of one researcher. Coded sections were discussed in terms of why they were interpreted as being meaningful to the domain that they were sorted into and how the code was determined. Differences in coding were resolved by the researchers explaining why that specific code was assigned and mutually agreeing on the best code for that section. Once the transcripts were all

coded, the two domains were reviewed and codes were re-categorized by common themes.

Results

Nature of the Information Sought

The evidence from the interviews supported the premise that the sudden and unexpected nature of a fatal work incident left many family members with a strong need to know exactly how and why the death occurred. Family members needed to know the exact sequence of events leading to the death and longed for comfort. They were consoled if they knew that their loved one endured minimal pain and suffering. Not knowing whether underlying causal factors contributed to the incident, or who was responsible and accountable for fault, reduced satisfaction with the account of why the death occurred.

Needing to know the sequence of events leading to the death. Participants advised that the sudden and unexpected nature of the fatal work incident left them needing to know the sequence of events leading to the death. Not being there to witness the fatality meant it was important to know exactly what happened and the timing of events. It was important to identify where the worker died and when, if it was in the workplace, an ambulance, or hospital, and what efforts were made to revive the worker.

...I had questions of when did he die, did he not die straight away or did he die in the ambulance? Still, I don't know. No one will tell me that. So I've got these images constantly, so 13 years or however long it's been. I-05

Not knowing exactly how the death had happened left family members pondering possible scenarios in their head.

...I mean that's very important. You need to have the facts very clear in your mind because that's the stuff you dream. Initially they gave me a very different story like when he first died, they gave me, the company and the employees told me look, this is what happened. So this is what I imagined at night time when I closed my eyes. I-28

In contrast, family members who were able to obtain adequate information no longer had to attempt to piece together exactly how the death occurred. Knowing the exact sequence of events leading to the fatality allowed them to accurately remember what happened and share this information with others. They explained the importance of being able to do this as it enabled clearer thinking and alleviated the pain and stress of not knowing.

...finally my brain stopped going errr trying all the time, every waking and non-waking hour, trying to piece these together. Finally, I could figure out how he got in there. It's like, just a little bit of information in the first four months could have just alleviated a lot of bloody stress... So after I saw the photographs and saw my husband - figured out how he could have possibly fallen in there, then it's amazing how I could think a lot clearer. Then it was like, now I can actually start to grieve. I-18

Seeking some comfort. Participants commonly reported needing to know the degree of pain and suffering endured by their loved one during their final moments. Information from witnesses and co-workers that the death was instant and knowing that they did not suffer pain was comforting.

This is the only thing that's actually stuck with me, that he said my father's injuries were so quick and severe that he would have died probably instantly, so wouldn't have suffered. So that's the only thing that I really take comfort from any of this... I-39

In contrast, not knowing whether the death was instant or hearing that it had been slow was particularly distressing.

I couldn't understand that this was an instant death that - to me, there was maybe a - because I'd heard stories and all that sort of stuff, I thought it was a slow process. So that didn't - that contributed quite a bit to the trauma and the nightmares and all that sort of stuff. I-25

In transport incidents participants commonly expressed the desire to know that the final moments before death were not of panic and fear from seeing the approaching vehicle.

Thank God, even witnesses said he didn't see it coming. It happened so quick and he was - like, [worker] was facing that way and the truck came like that. So witnesses have actually said, he didn't see it happening - wouldn't have seen it, or heard it coming... I-22

Discovering underlying causal factors. Family members reported the need for formal investigations to extend beyond describing the immediate cause of death and examine possible underlying causes of the incident. Satisfaction with the account of why the death occurred was impaired if the death was deemed “an accident” and root causes had not been determined by the formal investigations. Family members needed to know whether the incident occurred as a result of negligence, faulty equipment, or failure to maintain equipment. Some participants suspected lack of supervision or neglect contributed to the fatal incident. They were, however, frustrated that the investigations by authorities were unable to provide them answers.

...it was just deemed an accident but, to me, there's always a reason or something like, you know, you go on the wrong side of the road or you, I don't know, you go to sleep or whatever. But it's just very hard not really knowing... I just think - I mean, something caused it. I know what he was like. He was a very diligent operator. He respected what he did. He loved it and he was conscientious. I-02

Conversely, being provided information from the formal investigations that the company lacked an emergency management plan or that there were flaws in the management systems, enhanced their understanding of why their loved one died.

...through the subsequent investigations and there was a Royal Commission into (name), it came out really that the emergency management plan was not really functional. I-17

Knowing who was responsible or accountable for the incident occurring.

Participants commonly reported a need to identify who or what was responsible for the incident occurring. Being able to apportion blame to another worker or person, the employer/contractor, or the organization enhanced their understanding of why the fatality occurred. However, the majority of participants reported being unable to obtain this information.

I think the fact that there was no-one to grab hold of and say you did this, people just had to kind of blame something or somebody... someone must have to be in trouble for this. I-33

Participants reflected on their private knowledge of the worker. When they knew that the worker was vastly experienced in their job or was always conscious of safety, they questioned why the incident occurred in the first place.

He was a very safety conscious worker and experienced worker. How that could have happened we still don't really know. I-15

Understanding why the death occurred was further complicated if participants believed blame was wrongly attributed to the worker.

So there are things that come out [of the common law hearing] like well he had something wrong with his eyes or we heard this and we heard - so they'll do

everything they can to discredit [worker] as a means of eliminating their responsibility. I think that that - personally that was a really, really difficult thing to have to contend with. I-38

However, others accepted that the fatality was indeed an accident and no one was to be blamed. The differences in families' responses may reflect the contrasting circumstances in which the fatalities occurred. While it was difficult to accept, these family members came to terms with the fact that no one was at fault and the death was an accident.

It was just really more of an accident than somebody had done something wrong. I guess a lot of these families there is probably blame that can go somewhere, we found that hard. You couldn't really blame anybody... Nobody had done anything wrong, it just happened. It was just a faulty [piece of equipment]. I-16

Impairing and Enhancing Factors

Perceiving the formal investigations to be poorly conducted, receiving conflicting information regarding the death, having limited sources of information, and encountering legal barriers impaired satisfaction with the account of the death. In contrast, believing a sense of justice had been attained for their loved one and having first-hand access to information enhanced satisfaction.

Dissatisfaction with the rigour of the formal investigations. A poor initial investigation, particularly by the police, at the scene of the incident had detrimental consequences for subsequent investigations.

Yeah but from day one there was no step because the police officer was just - I'll be honest - was useless, absolutely useless. Wasn't even a detective we've since found out. He was a trainee detective but he was the only one out there on that day... So [the senior sergeant] has now done a second report on it. Basically that report was finished, done and delivered with the same sort of thing. He said to me, I'm sorry that I've had to do the report. He said, I looked at it and I looked at it from a father's point of view and thought, this is just not right. He said, I'll never ever get the proper answers. He said, I wish I didn't have to do it, I wish I had it from the start. He said it would have been a different outcome. I-10

Concern was raised about the attitudes some police had regarding work fatalities.

...I think that the police just went there and they just thought - I don't know whether that's normal, but they just think it's a workplace accident and don't worry. They may have left it to [agency], I don't know, but they didn't have any report on the fact that - of them going and signing something afterwards and taking any witnesses that may have seen where they went or that sort of thing, there wasn't anything of that done, the people would have seen. I-14

In fishing-related fatalities particularly, some participants were dissatisfied with the manner in which the police conducted investigations. They believed that incident scenes were insufficiently cordoned off and that minimal investigation was undertaken. When participants believed professionals failed to properly conduct the investigation, some took it upon themselves to investigate how and why their loved one died. This was noticeable among family members who had experience working in or vast knowledge of the worker's industry and how hazardous incidents could occur.

Now first of all it's in the trial, the police attended the boat when it got into shore- they never cordoned it off as a crime scene. Every other place where someone dies it's cordoned off as a crime scene, not in this case. I-23

Some participants were frustrated that workplace deaths were not treated as a homicide investigation. They believed they would never be able to understand how and why the death occurred because the police failed to treat the work incident as a potential homicide during the initial investigation.

I think every death should be considered a homicide until proven differently because at the end of the day, how do they know? Once it's established that it might be a thing, they've already contaminated the scene, the guy can get off. Every death should be considered, in a workplace situation, a homicide. That's what I reckon, because they get off too easy. I-04

Another participant expressed disappointment with safety inspectors who appeared to consider that further investigation was beyond their scope and would lead to unnecessary work. This participant needed to know whether failures or decisions made at managerial level contributed to the fatality.

[the government safety agency's] only focus is the safety side and so if there's drugs for example involved, they go well that's not our problem. Yet nobody thinks to say but why are the drugs there? What impact does that make? Should we be looking at implementing mandatory drug testing on everybody around that workplace when that death happened? Who has control of that workplace at the time? So there's some really important questions that I think families have a right to ask and yet the position of the legal side of it is well, but that's not our issue. Our issue is to find the defendant guilty of unsafe work practices and we've got enough here to do that. We don't need any more. We don't need any more work, so to speak. I-28

Receiving conflicting or limited sources of information. Receiving conflicting information reduced satisfaction with the account of the death. It left participants pondering whether there was more to the fatality and if those responsible were attempting to cover-up the truth. If things did not “add up”, they were left wondering exactly what had happened.

He said, I gave her mouth to mouth and all this sort of stuff and that's what we've been told. In court it was a completely different story; he said he never touched her. I don't know why; just different stories. The shoe thing came out and they

said we were going to get her shoes. The coroner said she had boots on but they said - so it's all wishy-washy. I-10

For some participants, the magistrates' or coroners' reports conflicted with the accounts of the deaths provided to them by employers and colleagues.

I got home after it was handed down. I read the finding and the Judge had, Magistrate had actually written down a part of what he was described. I read it and I went, hang on, no that didn't happen. That's not right. Because it said that he was left spinning on the machine. But I was told that he was thrown clear even before anybody got to him. So in my mind I was imagining him on the ground. The reality is he was tangled on this thing. His body was wrapped around it. I said that's a completely different version of things. I-28

The nature of some sudden work fatalities resulted in few witnesses at the scene of the incident. This impaired the ability of family members to obtain the information they needed. In transport incidents, particularly those occurring during the night, there were usually no witnesses nor even any remaining evidence at the scene of the fatality. This made it difficult for families to obtain answers to the questions they had regarding how or why the death occurred.

He stopped at [town] which I think was like 40 minutes down the road so it wouldn't have been fatigue. I just don't believe that - not that that's really been said but why was he slumped over the wheel, like if he was asleep? I just don't

believe that at that time of the day after a break that would have happened but something made him so I have no real kind of answers or closure around what happened. I-02

Police and safety inspectors not being able to contact and interrogate key witnesses also impaired the ability to obtain answers. Participants believed some key witnesses were never questioned satisfactorily by investigators following the death. It became problematic for families to obtain the information they needed when witnesses refused to be interviewed or departed the country shortly following the incident.

One of the main reasons was because [loved one] was run over by an excavator, the excavator driver was [age] years old and he was just on a working visa from [country]. There were rumours that he had his dog in the cabin and there was something else that he was not - that was a bit dodgy. Soon after the accident he went home to [country] so he didn't really get - nobody really questioned him at all of exactly what happened. I-15

Families needed to reach out to co-workers. As the last people to see their loved one alive, co-workers became key stakeholders in providing answers to the questions they had. However, it was common for employers to prevent this exchange of information. Participants believed that being given the opportunity to talk with co-workers would assist them to understand the attitudes and culture of the workplace and provide answers as to how or why the incident occurred.

That was a big part of it. You have to understand how it happened. You have to understand why it happened. But for me the big part is to understand the people that he worked with. Their attitudes were - I always wondered what are they thinking? How are they? They're the people that you feel closest to because they were the last ones to see him as a conscious mind. I only saw him once he was in an induced coma. He couldn't talk to me about it. I really desperately needed to reach out to them but they shut the doors. So it was really hard to understand. I-

28

Barriers to obtaining answers appeared when co-workers failed to disclose information for fear of losing their jobs, or provided misleading information in the hope of maintaining their employment.

People are too scared to talk because you don't want to lose your jobs. I-24

... a lot of them will just lie if they want to keep their jobs... I-07

Encountering legal barriers to obtaining information. Legal barriers were a major impairing factor affecting the ability to obtain answers. In particular, access to information and investigation reports from the coroner and safety inspectorate were restricted and not released to those not officially listed as the worker's next of kin (the person's closest living relative).

...I rang the coroner at one stage, to see what was going on with the coroner's report, and he wouldn't - well, they wouldn't talk to me, because my daughter-in-

law hadn't given me permission to do it. Now, I can understand that; that they just can't give out information over the phone. But there must be some way. I mean, he's my son, and there must be some way that I could have been given information as well... maybe there should be provision for next of kin, closest family member, or whatever. But it should be broadened up... I-29

This was a problem which frustrated parents, especially if their child had only been with their partner for a short time.

They said, well we need authority from the boyfriend. My partner said, well what's the boyfriend got to do with it? They said, well he's the next of kin. I said, how is he the next of kin? They went, I don't know, it's on the report that he's the next of kin. The police have given him the next of kin. I go, she's been with him for three months and now this kid of 18 or whatever is the next of kin? You've got to be joking. I-10

Having a poor relationship with the listed next of kin further restricted the flow of information. This left some participants feeling insignificant, cast aside, and unfairly excluded from information because they were not the official next of kin.

The thing is - because [worker's partner] was his next of kin. That's probably like the thing that grated us all, that she was next of kin and when she turned nasty, we weren't really entitled to a whole lot. I understand that she'd given the coroner or

the morgue or whatever it was... permission for my family to access those documents and be kept informed. I-03

For some families, this restriction of information resulted in fractured relationships.

If they [the authorities] had done that [contacted family members] I don't think in all honesty half of what happened would have happened... Had we had an equal share in the information, if we had been equally treated with the information I don't think that our family would have fractured. I think that we would have stuck together because we would have felt equally important and not against each other... I honestly believe that it was that which was the catalyst to our family completing fracturing... I-33

Censored reports also hindered the account of the death. Participants suspected that this was due to employers or other parties attempting to mask their own failings. These censored reports often led to more unanswered questions and impaired their understanding of why the fatality occurred.

...there was a third party which blocked my request. So now I have the report but it's partial. So there's lots of bits that are blacked out... half of the questions they wouldn't answer. Because they couldn't under some - yeah, a section of the Mining Act or something. So I guess - I understand why they can't but I don't understand why they would say that I could ask any questions as well. So I do

feel like I got information but I do want to know more and I still do have questions about it. I-37

A sense that justice was attained for their loved one. In contrast to the struggles encountered by many, and although few participants seemed to experience this, those satisfied with their account of the death commonly reported a sense of justice being attained. This occurred if participants believed a rigorous investigation had been performed; if they felt included, were provided a voice or given a chance to provide input throughout the investigative process; if they perceived the truth to have been exposed; and if those responsible for the death were identified and made accountable. Having access to information from industry specific and specialist investigative bodies, particularly the crash investigation police in the transport industry, also enhanced satisfaction.

Yeah I went down - it happened in [month]. In the January I went down and actually met the forensic - the crash investigation officer that was conducting the case and I actually met him and went through the scene with him. I-20

Family members needed to know that the public account of the death closely matched their own understanding of the worker. Participants reported that employers tried to shift the blame onto the worker in an attempt to mask their own failings. Claims from employers or co-workers that the worker was intoxicated at the time of the incident conflicted with their own knowledge of the worker. A sense of justice was

obtained when family members received forensic reports which cleared these accusations.

I've got the forensic report. He was not drunk. See, they tell you all these lies. I-04

First-hand access to information. Having first-hand access to information or being able to visit the incident scene also enhanced families' satisfaction. The ability to visit and visualise the incident scene assisted with understanding what may have occurred and how their loved one died.

I suppose going to the scene was the most helpful and seeing the pictures and stuff like that. I-20

Unions also played a role, obtaining clearance and organizing the opportunity for family members to visit the incident site.

So, the union have been quite good... he was excellent. He got clearance for me, took me in there... I'm very glad I did it, yes, because I felt like, okay, now I can picture where it actually happened... I-21

The ability to obtain witness statements from the police provided important information for family members.

At some point [the police] they obviously gave me all the witness statements and all the things like how fast he was going and his whole trip record for the whole day of speeds and all that sort of stuff. I-06

The ability to meet and converse with witnesses, colleagues, and co-workers also enhanced satisfaction. Witnesses were able to provide family members with important information, such as the last words spoken by their loved one before their death.

I think the turning point for that was those guys giving me the information because they felt up until that day that they couldn't speak to us, that the company may sack them for giving us information. I-26

Discussion

Following a fatal work incident, family members needed to obtain detailed information from witnesses or from the formal investigative processes. Investigations by police, safety regulators and coroners played an important role in enhancing families' satisfaction with their account of the death, particularly if participants believed a rigorous investigation had been performed, if they perceived the truth to have been exposed, if they were provided a voice throughout the investigative process, and if those responsible for the death were identified and made accountable.

Employers and co-workers also played an integral role. As the final people to see the worker alive, workmates became valuable sources for information. However, the majority of family members reported negative experiences with employers and co-

workers. These may be explained by the tendency for some organizations to divert responsibility to the worker, and their supposed failings, to mask any underlying systemic or structural failures (Hood, 1991; Perrow, 1984; Sinclair & Haines, 1993). Such unhelpful experiences may also reflect fears any statement made might subsequently become part of legal proceedings. Sinclair and Haines (1993) discussed how fear of civil liability prompted organizations to avoid responding to work fatalities in a manner which might be interpreted by investigators and the public as accepting responsibility.

From a restorative justice perspective, families may benefit from being provided an opportunity to engage with the employers and co-workers to exchange information in a mediated discussion (Braithwaite, 2002; Gunningham, 2007). Providing opportunities for dialogue among those affected by the fatality encourages collaboration and reintegration rather than coercion and isolation (Brookes, 2008). Restorative justice processes are designed to enable participants to discuss in the presence of a mediator: (1) what happened and why; (2) how individuals were affected; and (3) plans to meet the needs of those affected, including the identification of strategies to prevent similar incidents from occurring in the future (Brookes, 2008).

The coronial inquest may be a more fitting venue for this to occur than a prosecution. King (2008) suggests that these dialogues be mediated by the coroner as their role is to ascertain what happened and to prevent similar incidents from occurring. Such meetings have the capacity to assist all parties with coming to an agreed account of exactly how and why the death occurred. However, a core element of restorative justice requires an offender to take responsibility for their actions. In the context of fatal work incidents, this may prove challenging if issues of accountability and blame are still

disputed (Brookes, 2008; King, 2008). Policy makers should consider whether, and in what ways, restorative justice systems could be better implemented to enhance families' satisfaction with their account of how and why their loved one died.

When employers and co-workers failed to disclose information, family members relied primarily on the formal investigations. However, the majority of participants expressed dissatisfaction with the formal investigative processes, perceiving them as being poorly conducted. Participants were frustrated that the death had been treated by the police as an accident rather than a potential criminal offence. Incident scenes were inadequately cordoned off and key witnesses were not interviewed. These findings raise concerns regarding the attitudes some police may have towards fatal work incidents and questions as to whether they are being provided with adequate resources and training to investigate these fatalities. It is important that the police treat fatal work incidents as potential criminal offences by rigorously documenting the incident scene and interrogating all available witnesses.

Snell and Tombs (2011) suggested that police perceptions of what constitutes “real crimes” may influence the performance of their investigations. It is possible that police viewing a fatal work incident as an accident may spend less time and energy and fewer resources documenting the incident scene and interrogating witnesses. Fatal work incident scenes raise complex questions. Where police are simply securing the scene and ruling out the more general types of criminal homicide (like murder by a spouse) before a dedicated safety inspector arrives this may not be so pressing an issue. However, even here more training and protocols may be valuable to ensure information is duly recorded and documented. Where a safety inspector cannot reach the scene

promptly or does not take a key role (as in many road transport incidents) the situation is more challenging.

Currently, there is a growing body of literature regarding the use of body camera systems on police (Cubitt, Lesic, Myers, & Corry, 2016; Elliott & Kurtenbach, 2015; Jennings, Fridell, & Lynch, 2014; Sousa, Coldren, Rodriguez, & Braga, 2016; Taylor, 2016) and it is generating pressure for greater utilisation of this innovative technology (Ariel, Farrar, & Sutherland, 2015). Its use could assist in addressing the concerns reported by family members of the poor initial investigation of the incident scene. Body cameras may capture images and details that can become important sources of information for subsequent investigations. Whether this innovative technology can be incorporated to improve the initial investigations into fatal work incidents is worth exploring. However, technology is unlikely to reveal work organization issues and therefore its contribution is limited to specific aspects of the investigation.

Family members also perceived the investigations by the safety inspectorate to be poorly conducted and lacking rigour. In particular, they were dissatisfied if investigations concluded that the fatality was an accident when they suspected structural or systemic failures were not identified. Some inspectors were criticized for being insensitive and lacking awareness regarding the information needs of families. When prosecution hearings were held, they were often perceived as being too technical and focusing only on the legislative breaches. Attending these hearings also proved difficult for some family members, as defending parties often sought to place blame on the deceased worker. Similarly, prosecution and criminal proceedings for homicide cases are known to not only obstruct information being provided to family members, but also

negatively affect the memories of those who died (Riches, 1998; Stretesky, Shelley, Hogan, & Unnithan, 2010).

Legal barriers were a commonly reported hindrance in accessing information. For example, some parents explained that they needed formal permission from the next of kin to obtain documents from the coroners' courts. Participants suggested that the safety inspectorates and coroners' courts broaden information provision beyond the listed next of kin. It was evident that parents had a strong need for detailed information on how their child died. Understandably, the strong bond between parents and their children, through years of nurturing and protection, can lead to a need for detailed information (Bowlby, 1969). Although participants valued the information provided by the coronial investigation, access was restricted for some family members, especially those who were not the listed next of kin.

Findings from our study can also be viewed through the lens of the Two-Track Model of Bereavement (Rubin, 1999). Families who were not satisfied with the information they were given about the death of their relative became preoccupied with the loss and their relationship with the deceased. This led to fractured familial relationships and somatic concerns. Conversely, family members who were satisfied with their account of the death reported being able to accurately share this information with others and memorialize their relative in meaningful ways. Using this model helps us to understand the reasons why providing families with information is central to (1) their biopsychosocial well-being and (2) their attachments to the deceased and the living.

Being exploratory in nature this research had limitations that should be considered when interpreting the findings. The interviews were conducted in English,

which resulted in the sample being biased towards participants proficient in English. It is possible that a significant proportion of workers' families were not able to participate. Compared to workers born in Australia, immigrants tend to work in jobs with higher fatality and injury rates (Davila, Mora, & Gonzalez, 2011; Hersch & Viscusi, 2010; Toscano, 2016). Our evidence is also confined to Australia and further research is needed to see how comparable the findings are with the experiences of families in other countries. Funding should also be sought for translators to ensure accessibility of participants of non-English speaking backgrounds to the research.

The sampling in the current study was biased by self-selection of the participants. It is possible that the family members willing to participate in the research were less satisfied with their experiences following the fatality and more keen to voice their dissatisfaction with the investigative processes. Nevertheless, this research has identified key issues that warrant attention and further examination, particularly by formal investigators of fatal work incidents.

Conclusion

This study identified the information needs of family members and examined the factors affecting satisfaction with the account of the death. The ways that the investigations by the police, safety inspectorates, and the coroner's office enhanced or impaired satisfaction with the account of the death were also explored. It was important to discuss all three authorities because they have different roles and are governed by different bodies of law and protocols. This means that while more generic studies of institutional responses to death are of value there is a need to recognize the distinctive aspects of work-related death when compared to homicides or a non-work-related road

death fatality. Further, depending on the industry or circumstances one or more of these processes may not occur and even if all do, the key question is whether, independently or in combination, they address the information needs of bereaved families.

Using evidence from detailed interviews with family members the findings identified that the sudden and unexpected nature of a fatal work incident left many family members with a strong need to know exactly how and why the death occurred. Family members needed to know the exact sequence of events leading to the death and whether their loved one endured minimal pain and suffering. Not knowing whether there were underlying causal factors that contributed to the incident or who was responsible and accountable reduced satisfaction with the account of why the death occurred.

Co-workers, employers, the police, safety inspectors, and coronial staff played important roles in enhancing or impairing understanding of how and why the death occurred. Perceiving the formal investigations to be poorly conducted, receiving conflicting information regarding the death, having limited sources of information, and encountering legal barriers impaired satisfaction with the account of the death. In contrast, satisfaction was enhanced if they obtained first-hand information (from witnesses, co-workers, or the ability to visit the incident scene), and if they believed a sense of justice was attained (where formal investigations were able to expose the truth and those responsible for the death were identified and made accountable).

The study highlighted the importance of the police treating fatal work incidents as potential criminal offences rather than accidents. Poor initial police investigations, where incident scenes were inadequately cordoned off and key witnesses were not interviewed, had detrimental consequences for subsequent investigations. Further,

investigative bodies such as the coroners' court and safety inspectorate should provide family members, particularly parents who are not the next of kin, with updates and timely written advice regarding the outcome of investigations. Findings from this paper not only inform future research, but also offers policy guidance on this important but neglected subject.

Table 1. Interview Participant Characteristics Grouped by Next of Kin Status

Characteristic	n	(%)	Next of Kin			
			Yes	(%)	No	(%)
Gender						
Female	36	(90)	25	(70)	11	(30)
Male	4	(10)	3	(75)	1	(25)
Relationship						
Partner/Spouse	18	(45)	16	(89)	2	(11)
Parent	11	(28)	10	(91)	1	(9)
Sibling	7	(18)	0	(0)	7	(100)
Child	4	(10)	2	(50)	2	(50)
Jurisdiction in which death occurred						
South Australia	13	(33)	7	(54)	6	(46)
Victoria	10	(25)	6	(60)	4	(40)
New South Wales	8	(20)	6	(75)	2	(25)
Western Australia	6	(15)	6	(100)	0	(0)
Queensland	2	(5)	2	(100)	0	(0)
Australian Capital Territory	1	(3)	1	(100)	0	(0)
Industry						
Construction	12	(30)	7	(58)	5	(42)
Transport	9	(23)	6	(67)	3	(33)
Agriculture, forestry or fishing	8	(20)	5	(63)	3	(37)
Mining	6	(15)	6	(100)	0	(0)
Manufacturing	5	(13)	4	(80)	1	(20)

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