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# Mark Ngo1 [,](http://orcid.org/0000-0003-0377-1460) Lynda R. Matthews1, Michael Quinlan2, and Philip Bohle1

## Abstract

Fatal work incidents result in an array of government responses, and in countries such as the United Kingdom and Australia, this may include the holding of coronial inquests. A common theme from the scant literature is that family members have a strong need to know how and why their loved one died. The inquisitorial nature of inquests suggests potential in uncovering this information, although little is known about families’ experiences with these proceedings. Interviews with 40 bereaved relatives explored their views and experiences of inquests. Findings suggest that families, often frustrated with other investigative processes, want inquests to provide a better understanding of how and why the death occurred, uncover any failings/ responsibilities, and thereby move closer to a sense of justice being obtained for the deceased. Families identified problems perceived to impair the process and where improvements could be made to secure a more effective and meaningful institutional response to the fatality.

1Work and Health Research Team, Faculty of Health Sciences, The University of Sydney,

Lidcombe, Australia

2School of Management, The University of New South Wales, Kensington, Australia

Philip Bohle is now at the University of Tasmania, Hobart, Australia

Corresponding Author:

Mark Ngo, Work and Health Research Team, Faculty of Health Sciences, The University of Sydney, PO Box 170, Lidcombe, NSW 1825, Australia.

Email: mark.ngo@sydney.edu.au

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# Introduction

Serious harm arising from work, especially fatal incidents, has been the subject of considerable research and policy debate in countries such as the United Kingdom, United States, and Australia. The impact of fatal work incidents on families, while not ignored, has seldom attracted detailed attention (an exception being the families affected by the 1988 Piper Alpha oil rig disaster; see Alexander, 1990, 1991). There is a literature on responses to death, including the role of coronial inquests (Barraclough & Shepherd, 1977; Biddle, 2003), but few studies have examined the responses of families to fatal work incidents and particularly their views on subsequent institutional processes (Quinlan, Fitzpatrick, Matthews, Ngo, & Bohle, 2015). This article begins to address these knowledge gaps by (a) exploring the reasons why family members may want or not want an inquest following a fatal work incident and (b) identifying their views about the value of holding an inquest.

A common theme arising from the scant literature is that family members have a strong need to know exactly how and why the worker died (Matthews, Bohle, Quinlan, & Rawlings-Way, 2012). Rather than being able to anticipate, prepare for, and understand the course of chronic illness, individuals bereaved by sudden unexpected deaths may be left with only fragments of information about what happened to their loved ones during their final moments (Armour, 2007; Matthews et al., 2012; Rynearson, 2005). Dannemiller (2002) investigated how homicides affect the bereavement process of individuals and reported that they had a strong desire to understand and recreate the murder scene in their mind. To accomplish this goal, they sought information about various aspects of the fatality, such as the exact cause of death and a need to identify those responsible for the homicide. Culmination was reached when family members recognized that they had exhausted all possibilities with accumulating information, and they were satisfied with their understanding of the death (Dannemiller, 2002). Reaching culmination is important as it can provide families with a reprieve from their investment of copious time and energy into understanding how and why their loved one died (Dannemiller, 2002).

Neimeyer, Baldwin, and Gillies (2006) proposed that bereaved individuals create a personal and unique narrative that helps them to develop meaning in connection with the death and the life of the deceased. A critical part of the narrative is to integrate the memory of the loved one into everyday life. Meaning-making assists with this process and involves being able to understand how and why the death occurred (Neimeyer et al., 2006). Being unable to construct this narrative and make sense of the death may leave family members ruminating and fantasizing about how and why their loved one died (Lehman, Wortman, & Williams, 1987; Parkes & Weiss, 1983).

A series of investigative procedures occur following fatal work incidents that may assist with obtaining this information. In the majority of cases, the police are the first to arrive at the scene of a work fatality (Hopkins, Easson, & Harrison, 1992). They are responsible for conducting an investigation to establish whether any criminal offences were committed and ensuring the next of kin1 is notified of the death (Hopkins et al., 1992; WorkSafe QLD, 2010). Their role and specific responsibility is to prepare a report for the coroner, but they have limited capacity to provide family members with detailed information about how and why the worker died. Agencies responsible for regulating and monitoring occupational health and safety (OHS) or related laws (such as those pertaining to mines) in each jurisdiction also attend the incident scene to begin the safety investigation. The safety inspector’s role is to determine how the death occurred and whether any OHS laws were breached. If there is a breach, an application is made to the industrial court, where typically, although not in all jurisdictions, the Director of Public Prosecutions determines whether prosecution proceedings should commence. Industry-specific inspectors in mining or transport may also perform a specialized investigation (Quinlan, 2014).

Representatives from organizations including insurers, trade unions, and those representing bereaved families have pointed to delays and difficulties families encounter when seeking information from safety inspectors (Matthews, Fitzpatrick, Bohle, & Quinlan, 2014). Inspectors may feel constrained in terms of the information that they can provide families knowing that in doing so they may jeopardize the prosecution. Further, the adversarial nature of the prosecution hearings, which are bound by the rules of evidence, inhibits the amount of information family members are exposed to regarding how or why the death occurred (Bevan, 2005; Snell & Tombs, 2011). As a result, the safety investigation and subsequent prosecution hearing, if held, may not be the best source for families to obtain the information they seek.

Conversely, the coronial investigation is not bound so tightly by the rules of evidence and is inquisitorial in nature, meaning that the coroner may ask questions, receive evidence, or pursue lines of inquiry wider than the often-narrow terms of a prosecution under a specific provision in safety legislation (Aberdeen, 2016; Bray, 2010; Freckelton, 2010). This suggests greater potential for providing families with information regarding the worker’s death. In Australia, all unexpected or unnatural deaths, including all fatal work incidents, are reported by the police to the coroner’s office (Freckelton, 2010; Studdert & Cordner, 2010; Trabsky & Baron, 2016). The coroner’s primary role is to determine how a person died and the underlying circumstances leading to the death (Freckelton & Ranson, 2006). Although it is not the coroner’s role to apportion blame, they do have the ability to investigate why the death occurred and formulate recommendations to encourage action toward preventing future deaths from occurring in similar circumstances. This preventative role may be particularly important to family members because it can assist them to understand why the death occurred and whether structural or systemic failures contributed to it (Brodie, Bugeja, & Ibrahim, 2010). At the same time, the capacity of the coroner to assess and make effective recommendations may be influenced by their knowledge or experience of the industry in which the incident occurred and OHS more generally.

In Australia, each jurisdiction has its own Coroners Act that governs the holding of inquests. With the exception of Tasmania, inquiries are not mandatory for fatal work incidents (Matthews, Fitzpatrick, Quinlan, Ngo, & Bohle, 2016). It is the coroner’s decision as to whether an inquest is held or whether an administrative finding with a simple narrative of the cause of the death (chamber report) is all that is required (Hands, 2010). The fact-finding role of the inquest suggests those who attend may be able to obtain detailed information on how and why the worker died. The scant literature, however, provides limited evidence as to whether or not this is true.

Few studies have specifically explored families’ experiences of inquests into work fatalities. Evidence concerning other types of death, such as homicides and suicides, indicates that families are mainly dissatisfied with their inquest experiences (Barraclough & Shepherd, 1977; Biddle, 2003; Chapman, 2008; Davis, Lindsey, Seabourne, & Griffiths-Baker, 2002; Hands, 2010; Harwood, Hawton, Hope, & Jacoby, 2002; Victorian Parliament Law Reform Committee, 2006). Biddle’s (2003) findings demonstrate the potential negative impacts that attending a suicide inquest hearing may have on family members. The majority of participants reported being distressed by the lack of information and preparation offered to them prior to the hearings. Barraclough and Shepherd (1977) and Harwood et al. (2002) reported similar findings. However, family members may be more susceptible to feelings of guilt and shame when attending suicide inquests, as coroners may search for and publicly disclose indications of their loved ones’ social and personal dysfunction (Biddle, 2003).

Snell and Tombs’ (2011) interviews with six British family members bereaved by fatal work incidents found that the majority of participants were dissatisfied with theirinquest experience. Theyadvisedthatthecoroners’courts deflated their expectations and exposed them to staff who lacked compassion. Family members were left wondering about the nature and purpose of the inquest, comparing it with an adversarial forum. One participant commented: “it’s us and them” (Snell & Tombs, 2011, p. 214). Dissatisfaction with the findings from the coroner was evident: “[The verdict] accidental death doesn’t seem the right verdict really. It implied he had never worked in a safe way” (Snell & Tombs, 2011, p. 215).

With the exception of Snell and Tombs’ (2011) study, there is currently little specific evidence about bereaved families’ experiences with coronial inquests into work fatalities. To address these knowledge gaps, an exploratory study was performed, guided by three research questions:

1. What are the reasons why family members may want or not want an inquestto be held following a fatal work incident?
2. In what ways does the inquest enhance or impair the quality of the accountsof the fatality that family members receive?
3. Given responses to the previous questions, how might the coronial inquestprocess be improved to better meet family needs?

Methods

# Participants

The participants were 40 immediate and extended Australian family members bereaved by a fatal work incident. The majority experienced a fatal work incident in the construction (30%), transport (23%) or agriculture, and fishing and foresty (20%) industries. The mean time since the fatal work incident occurred was 9.56 years (SD ¼ 7.13, range: 2–28 years), and the majority of the participants (70%) were the worker’s next of kin. An inquest was held into the death of 12 workers (30%). Table 1 provides a summary of the demographic characteristics of the participants whose loved one’s death resulted in a coronial inquest and indicates whether they found attending the inquest valuable. One participant did not attend the inquest.

Table 1. Demographic Details of the Participants Whose Loved One’s Death Resulted in a Coronial Inquest.

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| --- | --- | --- | --- | --- | --- |
| Interviewee | Industry | Relation | Years since death | Was the inquest valuable? | Legally represented at the inquest? |
| I-01 | Agriculture | Mother | 16 | Yes |  |
| I-04 | Forestry | Sister | 14 | Yes |  |
| I-05 | Construction | Daughter | 3 | Yes |  |
| I-08 | Manufacturing | Mother | 16 | No |  |
| I-10 | Agriculture | Father | 3 | No | Yes |
| I-13 | Construction | Partner | 26 | Yes |  |
| I-16 | Construction | Sister | 15 | Yes | Yes |
| I-17 | Mining | Father | 8 | No |  |
| I-22 | Transport | Sister | 4 | Yes | Yes |
| I-28 | Manufacturing | Mother | 10 | Yes | Yes |
| I-31 | Fishing | Sister | 14 | No |  |
| I-38 | Mining | Partner | 23 | Did not attend |  |

# Procedure

The current study was part of a larger national project intended to examine and improve institutional responses to families’ needs following a fatal work incident. Its research protocol was approved by the University of Sydney’s Human Research Ethics Committee (Project number 2012/2319). As part of the larger study, a family survey was disseminated to family members bereaved by fatal work incidents. Flexible and sensitive recruitment strategies were implemented, consistent with the methods used in the Yale Bereavement Study (Michalski, Vanderwerker, & Prigerson, 2007). The process included the following: (a) advertising the study in the Australian Centre for Grief and Bereavement Journal and also at the Australian Centre for Grief and Bereavement Conference that attracts bereavement counsellors; (b) networking with wellestablished industry and community support networks including Mates in Construction, A Miner’s Promise, Workplace Tragedy Family Support, and Creative Ministries Network; (c) using Twitter and creating a Facebook page to assist in promoting the study; (d) wide promotion on radio stations across Australia; (e) promotion through press releases, and (f) articles promoting the study on websites including Medical Xpress; Construction, Forestry, Maritime, Mining, and Energy Union, Transport Workers Union; and BioPortfolio.

Prior to submitting the survey, family members were asked if they would be interested in participating in a face-to-face interview. Participants who agreed to being contacted by the researchers were provided with information about the interviews, and those who consented were provided optional times for the interview. The interviews were semistructured in nature and performed by a PhD-qualified researcher during the period September 2014 to January 2015. The majority of the interviews were conducted in person (n¼26). Phone interviews were undertaken for those in remote locations (n¼14). Consent forms were signed by participants prior to the interview commencing. If a consent form from a participant doing a phone interview was not received before the scheduled interview, verbal consent was recorded prior to the commencement of the interview.

An interview schedule was used to ensure all relevant topics were covered. This schedule included questions to identify the value of holding an inquest and explore the reasons for wanting or not wanting an inquest. For family members who attended an inquest, additional questions were asked to explore their experience of the inquest, the ability of the inquest to answer questions about how and why the worker died, and their satisfaction with the information from the inquest. During the latter stages of the interview, more directive questioning ensured all items on the schedule were addressed, including probes developed from previous interviews. Key points participants made in relation to each of the interview items were verbally summarized, allowing the participants to confirm or clarify their responses while the interviews were still in progress.

All interviews were electronically recorded, and a verbatim transcript of each interview was produced. NVivo 10th Edition (QSR International Pty Ltd, 2012) was used to assist with managing the data coding process. Framework analysis, as described by Ritchie and Spencer (2002), was used to code and organize the interview data. A working framework was initially developed based on the research aims. This framework was applied to each transcript to identify sections of data corresponding to each domain. Two domains were created to assist in (a) exploring reasons for wanting or not wanting an inquest and, for those attending an inquest, (b) identifying enhancing and impairing elements of the inquest. After all the transcripts were coded, and themes identified, a process of charting was used to map out the data and identify typologies.

# Results

An inquest was held into the worker’s death for 12 of the 40 (30%) participants. For the remaining 28 family members, 13 (33%) expressed a desire for an inquest to be held, 10 (25%) reported that they did not want an inquest, and 5 (13%) were unsure if they wanted an inquest.

# Families’ Views on Holding Inquests

The two key reasons for wanting an inquest were (a) the need to accumulate further information to better understand how and why the fatality occurred and (b) a sense that justice had not yet been obtained for the worker in terms of identifying any failings or parties responsible for the incident. In a sense, families saw the inquest as providing culmination, helping to bring hitherto fractured information together and providing a more holistic explanation of the death. Participants who did not want an inquest tended to have had negative experiences with the prosecution hearings, and they feared being exposed to unnecessary graphic details or additional information that would conflict with their current account of the death. These participants had reached culmination and did not see any value in further investigation.

The need to accumulate further information. Family members reported the need for additional information from multiple sources to better understand how and why the death occurred. Some were not satisfied until they recognized that they had exhausted all possibilities with accumulating information regarding the death. The holding of an inquest would allow family members to reach culmination and provide reassurance because another authority had thoroughly investigated the incident. This was particularly important if the incident was deemed an accident by the formal investigations, but family members were uncertain whether the death was indeed an accident.

I would have really liked an inquest...it would have given me peace of mind that another governing body had a look at what happened and then maybe if they deemed it still to be just an accident, that maybe I would feel a little bit more settled about it. (I-37)

Participants believed the inquest would uncover information that had not yet been presented at the prosecution hearings, which were perceived to be too technical and concerned only with the legislative breaches. Having multiple sources of information was important, and the inquest had the potential to uncover additional details through further interrogation of witnesses.

I think I could’ve made more out of answers in a coroner’s court because they would’ve gone into the whys and wherefores. ...Whereas the Industrial Court, no; there’s nothing like that. It’s just all yeah, they’ve breached Section 20, Section 21. (I-27)

However, not all participants expressed a need for an inquest. Some were satisfied with their current account of the death. They did not require additional information, particularly if they had negative experiences of the prosecution hearings and sought to move on with their lives.

So, I didn’t want any of that [inquest] because I didn’t want to be in the same room as them. I didn’t want to sit and listen to all the gory details of what had happened to him. I didn’t like the whole legal process. It didn’t seem very pleasant. Lawyers here, lawyers there - it just seemed horrible. Again, I was just trying to get on in life. I was just trying to be a - I look back and I think, I was always just trying to be a productive member of society. I was just trying to get on. (I-25)

Sense of justice not yet obtained. Some participants expressed the desire for an inquest as they were dissatisfied with the findings of the safety investigation and believed justice had yet to be attained. Families were frustrated by hearing statements that conflicted with their own understanding of the worker. They reported feeling helpless and unable to challenge the information presented during the prosecution proceedings. The coronial inquest represented a final chance to uncover the truth and set the record straight about how and why the death occurred. Participants explained that holding an inquest would increase the likelihood of identifying those responsible for the fatal incident and deliver justice.

It [an inquest] would dig into that a lot further I think. ...it would point to a lot of other people being responsible as well... The ins and outs of the whole incident. (I-29)

It’s like I said, we don’t get closure, we don’t get justice, there’s no closure. ...All they have to do is hold an inquest and it’ll be all over, but they won’t do it. (I-23)

Rather than rely on formal investigators to cross-examine key witnesses, the inquest would provide participants with an opportunity to directly question witnesses and potentially obtain answers to questions they believed were unresolved. This was important for family members who were dissatisfied with the way investigators initially interrogated key witnesses and believed justice had not been achieved for the worker.

Yes, I do [want an inquest to be held], only because then they would have been able to call [name], the responsible officer. He wouldn’t have had a choice then. They would have said, no, you need to answer some questions. (I-23)

# Factors That Enhance or Impair the Value of a Coronial Inquest

Family members who reported that the inquest was valuable (n¼11, 64%) commonly explained that it (a) uncovered underlying causes of the fatality, (b) provided firsthand access to information not available from earlier investigations, or (c) provided a sense of justice being obtained for the worker. The ability to achieve this represented a turning point for some family members. The healing process could finally begin as they had been provided with a narrative about how and why their loved one died that made sense to them and about which they did not have significant doubts.

Ability of the inquest to uncover underlying causal factors. Participants reported that the coroner was able to uncover systemic or structural failures that had not been identified in earlier safety and police investigations. Identifying whether flaws in management systems or failures in regulatory oversight contributed to the fatality enhanced their understanding of why the fatal incident occurred.

It came out [at the inquest] that there was no regular maintenance done on the equipment so the risk management assessment according to the [Legislative Act] and all the rest of it, the risk management assessment completely and utterly forgot all plant and equipment at that [worksite]. No plant and equipment had had a risk assessment done for over five years. (I-01)

The inquest hearings were particularly valuable if the coroner scrutinized the culture or historical pattern of decisions and practices of the organization.

He [the coroner] was quite interested in the mental side of the company, what people were thinking and even the attitudes beyond and after that, to see whether or not what the company was doing was proper at the time. (I-28)

The coroner’s ability to uncover failures of the company to take action and sufficiently maintain equipment became important information. It assisted participants to understand who was ultimately responsible for the incident occurring.

In the inquest we did find out that the driver...he had told his bosses he had problems with his truck. They didn’t do [anything]... he had in 24 hours; I think five hours sleep, yep. We found that out in the inquest. (I-22)

Family members who expressed disappointment with the inquiry said that the coroner failed to extend the investigation beyond elucidating immediate events leading to the incident. Participants wanted to know in detail why the death occurred.

They weren’t interested in [why the incident occurred]. ...Cause of death? The cause of death was a bloody big truck ran over and killed him. (I-08)

It was the most bizarre thing I’ve ever been to...[the coroner] found nothing. He said, no it’s just a young girl on a vehicle. (I-10)

Firsthand access to information not available from earlier investigations. Attending the inquest hearings provided family members with an opportunity to access additional information that they did not have access to from the earlier safety or police investigations. Having firsthand access to information was important to family members, particularly those who were not the worker’s official next of kin. This also assisted with the process of reaching culmination.

Yes. Well, we didn’t know anything about the investigation until that was presented at the coroner’s inquest. So, it wasn’t - we didn’t have any of that information at all...Well, I heard the information first-hand where I hadn’t heard that information first-hand...I think just being at the inquest itself was where I got most of my information from. (I-13)

For some participants, it was not until after the inquest that they were able to trust they had finally obtained an accurate account of the death.

It wasn’t until I got the coronial inquest that the video in my head went away. I don’t know if you believe that but anyway it was nearly like dad or someone was trying to tell me something is not right. You have to find what actually happened.

(I-05)

One participant expressed amazement at the extent of the coroner’s investigation. The coroner’s ability to access information from smartphones aided with piecing together details to comprehend why the fatality occurred.

I just was blown away by how far a scope - even to the point where there were text messages on [worker’s] phone. Now for all those years nobody had bothered to look at them and yet there he was getting the police in, just like that we had them in print. So, we could show that [worker] had gone in there to work on the machine before he died. (I-28)

Participants also commented on the notable differences between the coroners’ inquests and the prosecution hearings, which lacked the human element present in the coronial inquests. Coroners were not restricted by the same principles as the safety investigations, providing a different lens for family members. This enhanced the ability to obtain a comprehensive understanding of exactly why the death occurred.

I think it’s a lot more friendlier to the families. ...The staff at the coroner’s court; I mean they’re very much into networking for families and for relatives and for friends and workmates and things like that. So therefore the family was treated, I just believe, with a little bit more respect than what the court case was. The court case was a court case and that was it...technical, everything about it. (I-01)

However, family members did not find the inquest valuable if they believed key witnesses were not summoned to court or thoroughly questioned. This limited the ability to obtain information. Further, inquest hearings that were severely delayed proved frustrating to participants as key witnesses failed to recall information.

Yeah six years after. It was very hard for the coroner because six and a half years had gone by. He’s trying to get people to answer questions or the solicitor or the lawyers representing him. When it suited them. It was just like, I don’t recall. There will be other things that you think, well if you can’t remember that being such a broad memory and this tiny detail. They were definitely playing. (I-28)

Participants suspected this was an excuse to evade answering key questions posed. Reducing delays in holding an inquest may prevent this problem from occurring.

So, all these boys, some of them still work there, knew dad for a long time, stood up and just said, I can’t remember, I can’t remember, I don’t know, I can’t remember. I’m pretty sure if you’re involved in a massively horrible event to someone who - I mean he was very close with them all, I’m pretty sure you’d remember. (I-05)

Sense of justice. Family members who found the inquest valuable commonly reported having legal representation or were able to actively participate and interrogate witnesses during the inquest.

So, we had a lawyer - well, we’ve been very blessed with the inquest, [support group] gave us a barrister for the inquest ... it all came out in the inquest...we know now a lot of things we didn’t know before. We’re grateful... as much as it was like going through hell again, which it was, we needed to know. (I-22)

Being included in the inquest proceedings led to a stronger sense that justice had been attained for the worker. Family members were able to trust and accept the final inquest findings if they were able to voice their opinions and participate in the proceedings. The healing process could finally commence when they were able to challenge statements from others which they suspected to be false and obtain answers to the questions they had about the death.

I can’t even begin to tell you how much the healing started after the inquest. ...I represented myself. ...I wouldn’t want people to think that that’s an easy path. But it’s definitely one that I’m glad I did because I got the answers I needed. I didn’t like them but I got them. ...I had access to everything and so it was like, thank God. I could put it altogether and as much as it hurt I think that’s the turning point. The healing point is understanding what happened, putting it through your head. (I-28)

Other participants felt excluded from proceedings and unable to have their voice heard throughout the inquest. Not being able to challenge statements made by witnesses frustrated family members. This led to a feeling that justice had not been achieved for the worker, particularly if they believed the coroner failed to expose the truth, or in their opinion, the blame for the incident was being wrongly placed on the worker.

But [underground manager], when we were actually at the coroners he got up and all he was doing was covering his back. He - oh yeah [and I have]...the words that he actually come out and - they didn’t own up to what - they actually tried to put the blame on [worker] at the coroner’s. (I–17)

# Discussion

Of all the investigative processes following a fatal work incident, the coronial inquest affords the widest and potentially most holistic investigation of how and why the death occurred. This study explored three questions with regard to work fatality inquests, namely what are families’ views on holding inquests, in what ways does the inquest enhance or impair the quality of the accounts of the fatality that family members receive, and how might the inquest process be improved to better meet family needs. For most families, the coronial inquest was viewed as an opportunity to better understand how and why the fatality occurred. The inquest was also viewed as an opportunity to identify those responsible and identify measures to prevent their recurrence. These views were also shaped by their experiences with other investigative processes.

Participants explained that they relied on formal investigative processes to obtain information. However, many were disappointed with the findings from the safety investigation and prosecution. They believed that holding a coronial inquest would uncover the truth, particularly if the incident was deemed an accident, but they suspected there were underlying systemic failures that were yet to be exposed. The inquest was seen as an opportunity for witnesses to be further interrogated and provide a chance for family members to correct a public account of the death which they were dissatisfied with. If the public account differs from the understandings held by families, bereavement can be complicated by the need to set the record straight (Walter, 2005). The concept of the public account not matching an individual’s private account of the death was explored by Chapple, Ziebland, and Hawton (2012). Similar to their findings, family members in this study drew on personal knowledge of their loved one’s character to either accept or reject investigative findings. Individuals were unable to accept these findings if they conflicted with their own knowledge of their loved one.

Participants also explained that healing could not begin until they had accumulated all the information they needed regarding the death and were satisfied with their account of the fatality. It was evident that some participants had not yet reached culmination and needed an inquest to be held for this to occur. Reaching culmination and knowing exactly how and why a fatality occurs also allowed family members to create a personal narrative of the death. Constructing an accurate narrative is imperative, as it allows them to tell others exactly why their loved one died, and assists with integrating the memory of the deceased into everyday life (Neimeyer et al., 2006). This enables family members to maintain an ongoing connection with their deceased loved one.

Although early theorists such as Freud suggested maintaining emotional connections with the deceased was unhealthy, there has been a shift away from this view and greater recognition that it is healthy to maintain a connection with the deceased (Klass, Silverman, & Nickman, 1996; Rothaupt & Becker, 2007). The continuing bonds theory proposes that individuals engage in grief work to maintain an ongoing attachment with the deceased, in the absence of physical contact. Rather than removing the memory of a deceased loved one, maintaining bonds allows individuals to recognize and reflect on past relationships that can provide resources for enriched functioning in the future (Klass et al., 1996).

It is now widely accepted that, regardless of time, bereaved individuals do not wish to experience closure, as this means bringing an end to the relationship (Hogan, Morse, & Tason, 1996; Woodgate, 2006). Rather than detaching from their loved one, it is more helpful for individuals to cope with the loss by maintaining a strong bond (Woodgate, 2006). This was evident in the current study, with some family members reporting their desire for an inquest to be held years after the fatality had occurred.

Family members reported many benefits from attending a coronial inquest. The coronial investigations were more useful and closely aligned with their need for information than safety investigations and prosecutions. The coroner provided a different lens for family members. Understandably, investigations by safety inspectorates pursue broad social objectives and are shaped by legal rules rather than the immediate needs of the family involved (Matthews et al., 2014). Unlike the adversarial prosecution hearing, the inquest allowed some family members an opportunity to express their opinion on how and why they believe the worker died. Lippel (2007) has highlighted the importance of providing victims an opportunity to “have their day in court,” as it can assist them with regaining “some dignity and lost self-esteem,” through having a person of authority hear their story (p. 438). The ability that a coronial inquiry provided for families to actively participate, or be legally represented, enhanced their satisfaction with the account of the death by providing a greater sense of justice being obtained.

Increasingly, coroners are drawing on the principles of therapeutic jurisprudence to optimize their potential in delivering therapeutic outcomes to bereaved families (Bray, 2010; Freckelton, 2007; King, 2008; Wexler, 2011). Freckelton (2007) explains that “therapeutic jurisprudence highlights the potential for investigations taking place in the shadow of the law and for legal hearings to have counter-therapeutic as well as pro-therapeutic outcomes” (p. 6). Findings from the current study demonstrate that the capacity of the coroners to deliver therapeutic outcomes may be improved by allowing family members to actively participate and question witnesses during the inquest, as well as having the opportunity to express their opinions on how and why they believed the fatality occurred.

Family members were dissatisfied with the final inquest findings if the coroner deemed the fatality to be an accident and did not identify the root causes of the incident. Participants expressed the need for coroners to scrutinize the culture of the organization and to examine whether flaws in management systems or failures in regulatory oversights contributed to the fatality. Employers are often legally represented at inquests, effectively making the organizational armory more impenetrable and less accountable to the public (Sinclair & Haines, 1993). In contrast, families with no legal representation often become vulnerable in inquest proceedings as they are unable to challenge statements from others, which they suspect to be false. Examining the operation and mentality of organizations and understanding the overall culture of an organization is imperative to understanding why fatal incidents occur (Hopkins, 2006). Analyses of the extent to which the reports from coronial investigations identify root causes or systemic failures as contributors to fatal work incidents conclude that coroners do not always extend their investigation beyond the immediate cause of death to examine possible systemic failures (Cooke & Lingard, 2011; Hopkins et al., 1992). The present findings reinforce earlier research on the coronial system and fatal work incidents which, while identifying positive changes, highlights significant limitations in both resourcing and the practices and expertise of coroners (Matthews et al., 2016).

Although it is acknowledged that the legislation and protocols that may limit families’ abilities to obtain information exist for a purpose, investigative systems are not impervious to change. This is evident in recent coronial law and policy reforms across several coronial jurisdictions in Australia (Federation of Community Legal Centres Victoria, 2013; Bray & Martin, 2016). Researchers have also recognized that coroners are steadily severing their partnership with criminal law and emerging as investigators with great potential to meet the information needs of bereaved families (Aberdeen, 2016; Baker, 2016; Gregory, 2014; Trabsky & Baron, 2016).

Various coronial jurisdictions in Australia have recently undergone reforms and amended their Coroners’ Acts to better meet the needs of families. In 2013, Victoria developed the Coroners Prevention Unit to enhance the level of resources and support provided to coroners. The creation of the Coroners Prevention Unit marked an important step in supporting coroners and enhancing their ability to identify underlying causal factors. Victorian coroners have also begun clustering similar cases to increase the likelihood of detecting underlying causation (Matthews et al., 2016; Victorian Parliament Law Reform Committee, 2006). Allowing some coroners to specialize in investigating fatal work incidents may also enable them to more confidently identify structural or systemic failures.

The Queensland government has recently reviewed and amended its Coroners Act, with the aim of making better use of its resources and reducing delays in commencing investigations that require the urgent attention of coroners (Aberdeen, 2016; Barnes, Kirkegaard, & Carpenter, 2014). In relation to fatal work incidents, coroners in Queensland are no longer restricted to holding an inquest after all relevant prosecutions are finalized. The findings from this study support this amendment. Inquests could not commence until the completion of the safety prosecution and, for the majority of participants, did not occur until at least three years after the fatality. When key witnesses were called to the stand and questioned by the coroner, some failed to recall information. Family members suspected this was an excuse to evade answering certain questions that may have shed light on how and why the death occurred. The ability to obtain information may be greatly improved for families if these changes are implemented in all jurisdictions. Indeed, there may be an argument for accelerating the coronial timeline, as the wider scope of this process may uncover otherwise unknown information or issues relevant to an investigation or prosecution decision by safety inspectorates. This potential synergy would not compromise the latter because the laying of charges would still need to meet the rules of evidence governing this procedure.

Future research may benefit from exploring the views of coroners about their decisions to hold work fatality inquests and their perceptions of the adequacy of the support, training, and resources they are provided. This knowledge would enable the findings from this research to be more accurately and effectively translated into practice. It should be noted that, in this study, an inquest was held for only 12 participants, and their experiences are unlikely to be representative of the wider population of those attending work fatality inquests. It may also be of value to explore the experiences of non-English-speaking families, as they may experience additional communication barriers and difficulties understanding information presented at inquests. Not having an interpreter to translate the information presented at inquests has been found to frustrate family members because they cannot fully comprehend what is happening in the hearing (Chapman, 2008).

# Conclusion

This study found that some families viewed the coronial inquest as the single most important in terms of understanding how and why a worker died. Attending an inquest allowed them to hear information firsthand and provided an opportunity to question witnesses and challenge statements that conflicted with their own knowledge of the worker. When coroners decided against holding an inquest, most family members expressed the desire for one to be held, as it would allow peace of mind that another governing body had thoroughly investigated the death and ensure all possibilities of accumulating information had been exhausted.

Participants drew on personal knowledge of their loved one’s character to either accept or reject investigative findings. They were able to accept the findings if it did not conflict with their own private knowledge of their loved one. Family members were dissatisfied with investigative findings if fatalities were deemed to be accidents and root causes of incidents were not identified. Coronial investigations that scrutinized the culture of the organization and examined whether flaws in management systems or failures in regulatory oversights contributed to the fatality assisted family members with understanding why the fatality occurred. This information enabled the healing process to begin as family members sensed that justice had finally been achieved for their loved one.

Key factors requiring the attention of coroners and policy makers were also identified. These include greater consideration being given to holding work fatality inquests, ensuring family members are represented throughout the inquest and are able to express their views on how and why the worker died, extending coronial investigations beyond the immediate cause of death to identify underlying causal factors, and reducing delays in holding inquests. One option to increase understanding of underlying causes is the clustering of similar cases into an inquest. Another option is the allocation of specialized coroners to work-related cases so they can buildup background knowledge of OHS, including regulatory requirements that might inform their findings and recommendations. Finally, an option for reducing delays would be allowing the coronial inquest to occur before, or concurrent to, the prosecution investigation.

Exploring the views of coroners about their decisions to hold work fatality inquests, and the adequacy of the support, training, and resources provided to them, will enable the findings from this research to be more effectively translated into improved practice. Parallel research on the views and experiences of bereaved family members from other countries would also be valuable in furthering the debate both at an academic and policy level.

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Note

1. The next of kin is defined as the person’s closest living relative.

## ORCID iD

Mark Ngo <http://orcid.org/0000-0003-0377-1460>

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## Author Biographies

Mark Ngo, PhD, is from the Work and Health Research Team in the Faculty of Health Sciences at the University of Sydney Australia, where he also teaches Mental Health Rehabilitation, PTSD, and Criminal Rehabilitation. In addition to being a practicing radiographer, he is a teaching associate at the Department of Medical Imaging and Radiation Sciences at Monash University Australia. His research focuses on improving support for families bereaved by fatal work incidents and reducing occupational burnout and work-related musculoskeletal injuries among radiographers.

Lynda R. Matthews, PhD, is an associate professor in the Work and Health Research Team in the Faculty of Health Sciences at the University of Sydney Australia and an honorary senior fellow in the Department of Psychiatry at the University of Melbourne Australia. Her primary research focus is mental health, rehabilitation and work. Current research includes the consequences of traumatic workplace death for next-of-kin and families; rehabilitation of posttraumatic mental health conditions in high risk occupations; and improving men’s use of employee mental health support programs.

Michael Quinlan, BEc (hons) PhD is emeritus professor in industrial relations at the School of Management University of New South Wales and a visiting professor at the Business School at Middlesex University, London. In addition to workplace death his major research interest is organisational and regulatory aspects of occupational health and safety. In 2014 he published Ten Pathways to Death and Disaster: Learning from Fatal Incidents in Mines and other High Hazard Workplaces, Federation Press, Sydney.

Philip Bohle, PhD, is a professor at the University of Tasmania and honorary professor in the Work and Health Research Team in the Faculty of Health Sciences at the University of Sydney Australia. For more than 20 years, his research has concentrated principally on occupational health. His key research interests currently include working hours, work-life conflict and health; the impact of workplace death on victims’ families; ageing, employment and occupational health and safety; and the health and safety of precarious workers.