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**Expectations of Authorities Following Sudden Workplace Death in Queensland, Australia**

**Lynda R. Matthews, Cathryn Finney Lamb, Glenda M. Jessup, Mark Ngo & Michael Quinlan**

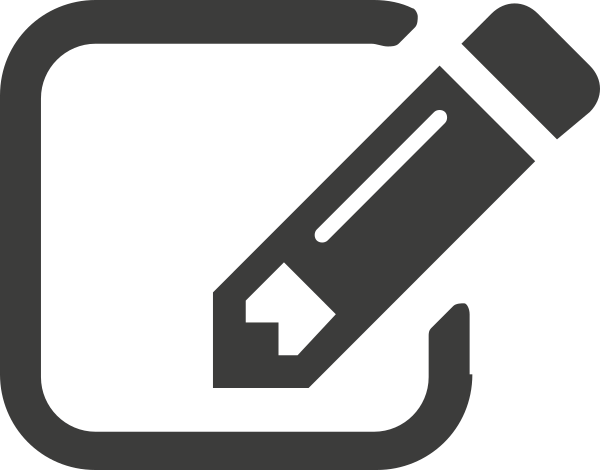
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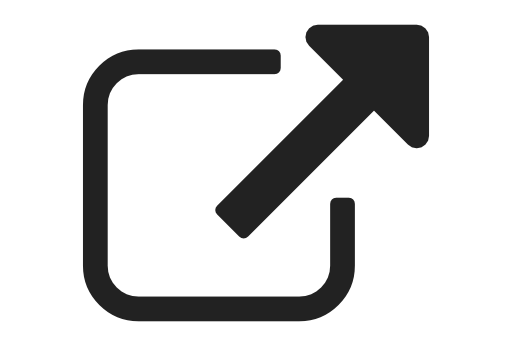
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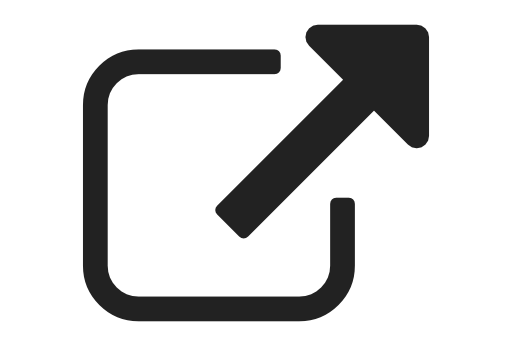
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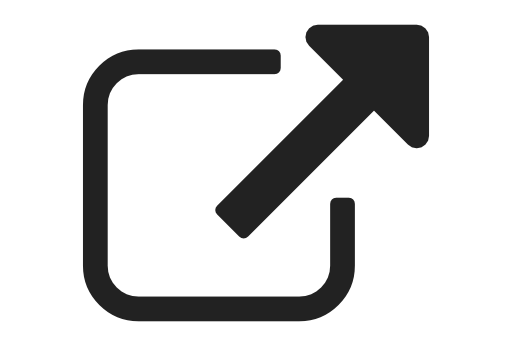


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**Family Accounts of Their Experiences and Expectations of**

**Authorities Following Sudden Workplace Death in Queensland, Australia**

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| **ABSTRACT**  Families bereaved by sudden work-related death are underrepresented in the literature therefore little is known about their engagement with the justice system. This qualitative study explored families’ experiences and expectations of authorities in the legal system following sudden workplace death. We analyzed emergent meaning from transcript data of four focus groups. Six broad themes were identified: just outcome, delivery of workplace safety, family liaison, access to information, assistance for affected people, and representation and voice. The findings provide insights into broad expectations participants had of authorities, contextualized within their experience, which can inform practical response. |

# KEYWORDS

Safety crime; industrial deaths; victimology; co- victims; OHS; white-collar crime

# Introduction

Sudden, fatal work-related injuries (workplace deaths) in wealthy countries remain a significant risk for those working in construction, road transport, manufacturing, mining, and quarrying, farming, fishing, and forestry, despite the reduced incidence over the past century of people fatally injured at work. In the 17 years to 2020, 4,136 workers died at work in Australia, and this figure excludes the far more significant number of Australians dying of occupation-related disease. In this period, the industries identified above accounted for 75% of all workplace fatalities, significantly above their representation as a proportion of the country’s workforce (Safe Work Australia, 2021a).

The pattern is similar in other countries like the USA, where there were 5,333 workplace fatalities (again excluding disease) in 2019 compared to 5,250 the previous year. Similar to Australia, workers in farming, fishing, forestry workers, road transport, and construction are among the most risk of dying on the job (Bureau of Labor Statistics, 2020). Around 90% of those killed are male, reflecting a male over-representation in the industries/occupations mentioned. However, this may change over time as the number of women working in sectors such as mining grows.

Although valuable, statistics do not capture the human tragedy that every single one of these deaths entail; a tragedy that affects their family, friends, and the community in which they lived. Several media reports of sudden work fatalities over the last few

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years illustrate the human tragedy that ensues. On 1st April 2019, just days after his 18th birthday, apprentice Christopher Cassaniti died on a large Sydney building site when a 15-meter scaffolding tower collapsed. Traumatized workmates tried to rescue Christopher, confronting police who sealed the site. After the incident, there was an outpouring of grief from Christopher’s mother and other family members. The union questioned why something like this could occur in an extensive and supposedly well- regulated workplace (ABC News Online, 2019). Eighteen months later, on the other side of the continent in Perth, a 23-year-old worker was killed, and two others injured, when a glass roof collapsed during construction at Curtin University. Concerns were raised about poor steel procurement practices, structural integrity, and design flaws (SBS News Online, 2020). Both these incidents were at large urban worksites and received considerable media coverage. However, this is not the norm for many work- related deaths, which pass primarily unreported. More typical was the death of trainee plant operator Ingrid Forshaw who died aged 30 years in a nighttime collision between a light and heavy vehicle at the Ravensworth open-cut coalmine in the Hunter Valley on 30th November 2013 (NSW Mine Safety Investigation Unit, 2015). The media made no report of the incident.

When a workplace death is the consequence of a breach of the workplace health and safety (OHS) legislation, it has generally been treated as a white-collar or corporate crime rather than a conventional or “real” crime even though jail penalties are applicable and industrial manslaughter provisions have been introduced in some jurisdictions (Clough, 2005; Croall, 2007; Dodge, 2020; Tombs, 2018; Tombs & Whyte, 2007; Whyte, 2007). OHS legislation is implemented, regulated, and enforced by the governments in each state and territory in Australia, and the Commonwealth regulates Commonwealth employees and companies self-insured under a Commonwealth scheme. Government regulatory responses determine how and why the incident occurred with a view to deciding whether laws have been breached, whether to pursue a prosecution and ways to prevent a reoccurrence (for a full account of OHS prosecution in Australia following a work- related death, see Johnstone, 2003a, 2003b). A delay of three to five years usually occurs between the work fatality and a prosecution – that is, if there is an investigation and if the breach of law is deemed prosecutable (Whyte, 2007). Prosecutions tend to result only when they are in the public interest. The strength of evidence to secure a conviction may also influence a decision to prosecute (Matthews et al., 2014). Although the regulator in each jurisdiction publishes successful prosecutions on their websites, the number of prosecutions conducted each year is not recorded publicly in Australia. Most convictions result in a relatively small fine (Tombs, 2018; Tombs & Whyte, 2007), and jail terms for those deemed culpable are extremely rare (Sarre, 2007; Tombs, 2018).

When compared to conventional crime, there is little information in the literature about victims of white-collar crimes, such as safety crimes where OHS legislation is breached (Dodge, 2020). Workers killed at work attract little publicity or research interest when compared to conventional or street crime (Croall, 2009). By its designation as a white-collar crime, the depth and extent of the serious harms caused to families by a workplace death have tended to be neglected or discounted, the lack of recognition and investigation being termed “the black box of neglect” (Dodge, 2020, p. 2). Unlike families bereaved by homicide, who are recognized as co-victims of a crime (Connolly & Gordon, 2015), families of workers killed at work are rarely considered as victims of crime even when they suffer the consequences of workplace negligence (see a detailed account in Snell, 2017; Snell & Tombs, 2011).

In Australia, this lack of recognition by the OHS regulatory system limits families’ access to the emotional and financial support provided by victims of crime support services. Instead, the regulators have begun to offer a limited number of counseling sessions free of charge to families following the death, and to provide affected families with information about other services that can provide emotional and financial support, including workers’ compensation. Regulators publish a guide that details the legal processes that follow the death and the roles of authorities in those processes. They may also provide a liaison officer whose role it is to support families through the processes, including advise on progress with the investigation or when legal proceedings may commence (for example, SafeWork Queensland, 2019). Even with this jurisdictional arrangement, information and support provided to families varies between jurisdictions and between rural and remote locations within jurisdictions. Families’ experiences of their engagement with the legal processes following the death remain problematic (Commonwealth of Australia, 2018).

The limited available literature suggests that families bereaved by a workplace death are exposed to secondary victimization by the legal system and its authorities (Brookes, 2009; Matthews et al., 2011; Snell, 2017; Snell & Tombs, 2011). Families struggle to cope with insensitive, inefficient, and confusing interactions with the safety inspectorate as they navigate unfamiliar legal events and procedures (Brookes, 2009; Matthews, Johnstone et al., 2019; Snell & Tombs, 2011), including procedures for obtaining compensation (Shan, 2017). Consultation with families bereaved by workplace death depict the distress they experience when authorities minimize the harms done to them (Brookes, 2009). They report mental health conditions, including posttraumatic stress disorder, depression, and prolonged grief disorder, and describe physical health problems, family disruption, financial hardship, and disruption to their children’s schooling (Matthews et al., 2012; Matthews, Quinlan et al., 2019; Quinlan et al., 2015; Shan, 2017).

Despite the challenges that they face navigating the legal system and dealing with authorities, families value the investigation, prosecutorial, and coronial inquest processes because they help to determine who or what was responsible for the death, who or what can be held accountable, and actions that can prevent the incident recurring in the future (Matthews et al., 2011; Ngo et al., 2020, 2021). Victims of conventional crimes also value these processes for securing justice (Clark, 2010). However, their initial expectations that justice will be delivered changes after they experience disappointment with the system and authorities (Wemmers, 1996). This is especially so when they are not kept informed of changes to their case and if they realize that their interests have not been made a priority, their role in the investigative or legislative processes is limited, and their views on restitution are not respected (Clark, 2010; Koss, 2006; Levine, 2010; Wemmers, 2008, 2013).

Public expectations of the justice system are that professionals will (1) treat individuals fairly and with respect, regardless of age, gender, race, and wealth; (2) keep them adequately informed about case developments; (3) provide them an opportunity to voice their opinions and have their views considered; and (4) deliver just outcomes (Almond & Colover, 2010; Roberts & Hough, 2005; Stretesky et al., 2010; Tyler, 1988; Weinrath et al., 2012). These community expectations are captured in the well-known concepts of procedural, interpersonal, informational, and distributive justice (Colquitt, 2001; Greenberg, 1993; Thibaut et al., 1974). The concepts also include the essential elements noted by researchers as critical to victim satisfaction with the justice system – having a voice (Johnson, 2007; Laxminarayan et al., 2012; Tyler, 1997), being treated with respect (Bradford et al., 2009; Tyler, 1997), having access to information (Davies & Bartels, 2020; Johnson, 2007; Stretesky et al., 2010), and being compensated for loss (Hall, 2017).

Although there is developed literature on victims’ expectations and experiences of activities as they navigate the criminal justice system following a range of conventional crimes (e.g., Clark, 2010; Koster et al., 2020; Laxminarayan et al., 2013; Vinod Kumar, 2018; Wemmers, 2013), little is known of the expectations that families of workers killed at work have of authorities in the OHS legal system. Accordingly, this qualitative study explored families’ experiences and expectations of authorities following sudden workplace death in Queensland, Australia.

# Methods

## Research approach

This study utilized qualitative methods to deepen our understanding of the how families made sense of their dealings with authorities following a sudden workplace death. Qualitative research methods are valuable for providing subjective perspectives on sensitive and complex issues and experiences (Ashworth, 2003), such as those within the scope of our research. This method is recognized as well suited to bereavement or trauma-focused research and potentially beneficial to participants (Kentish-Barnes et al., 2015), despite ostensible ethical issues (Buckle et al., 2010; Rosenblatt, 1995).

## Procedure

Following approval of the study’s protocol by the University of Sydney’s Human Research Ethics Committee (#2319), the jurisdiction’s OHS regulator invited next-of-kin and family members on their database (n = 91) to participate in the study. This communication included a participant information sheet and a letter describing the study. Interested people were asked to reply to the project team directly. The regulator sent a follow-up reminder two weeks after the first communication. No financial incentives were provided to participate. There was no formal mechanism to determine that all participants had received the communication letter, and we had no method to determine why some next-of-kin and family members did not participate in the study.

Volunteering participants were provided with information about the study and proposed dates for the focus groups. Those located remotely, or interstate, were invited to use a dedicated phone line to connect to their focus group. Follow-up reminders were sent to participants the week before and the week of the focus groups. Of those invited, 28 initially agreed to participate (31%). One participant withdrew early after the first reminder advising that it was too upsetting. Three did not present despite reminders and offers of phone-in details to remaining groups; two of these participants were from interstate. They provided no reasons for not participating in the study. In total, 24 next-of-kin/family members (26%) and two family friends, who accompanied a next-of-kin as support persons, participated in the focus groups. Written consent to participate and for the group discussion to be audio- recorded was obtained prior to participation.

Focus groups were conducted in four locations of this one OHS jurisdiction: two metropolitan areas M1 (n = 8) and M2 (n = 4), and two rural areas R1 (n = 10) and R2 (n = 4) in August 2015. A basic demographic questionnaire was administered before the commencement of each focus group, which collected information about age, next-of-kin status, relationship to their deceased relative, year of death, and stage of the formal process they were currently experiencing. The focus groups were conducted by two female facilitators (first and second authors) both of whom were experienced in conducting qualitative research with vulnerable and marginalized populations, particularly people who have experienced trauma.

## Participants

A total of 26 participants (17 females, 9 males) participated in the focus groups. Twenty- four were family members of 18 deceased workers, and two were family friends who accompanied the next of kin as support persons. Family members comprised six fathers (25%, mean age = 53), six mothers (25%, mean age = 52.2), six wives (25%, mean age = 62), four siblings (17%, mean age = 38.2), one partner (4%, age = 41), and one husband (4%, age = 65). Sixteen family members (67%) identified as being next-of-kin. All traumatic injury fatalities had occurred in the jurisdiction from 2011 to 2015 and were investigated by the same regulator. Therefore, all participants were subject to the same post-death legal processes and procedures regardless of the nature of the death or industry in which it occurred. The post-death formalities that families were experiencing when the focus groups were held varied within each group.

## Data collection

In accordance with this study’s exploratory nature, participants were asked to speak about their experiences and expectations of dealing with authorities following a workplace death. The focus group guide included questions to prompt participants to talk about substantive aspects of their experience, for example, who/what sources of information or advice were, who/what provided a voice for families, or what worked well in their dealings with the OHS regulator. Participants responded with stories about their experiences, clarification questions, commentary and discussion about other participants’ experiences, and group discussion of issues salient to them. Although participants were prompted to talk about their expectations, few comments directly identified their expectations of authorities. Instead, participants spoke about their disappointments and reflected on what they thought the authorities should have done, what they thought authorities should do for families in the future, or what they wanted from authorities.

The discussion in each focus group ran for approximately 2 hours. In addition, one brief supplementary phone interview was conducted following the early exit by one participant from a focus group early in the discussion. She explained that the focus group discussion was not “very relevant” to her and that because she was in a different situation, she did not want to “be a part of it.”

## Data analysis

Immediately after the focus groups, the two facilitators shared observations about the group discussion and process and made notes. The audiotapes were transcribed by an external agency. A pseudonym and participant number were assigned to each participant. A team member listened to the audiotape and designated each comment in the transcript to a participant. The transcripts were divided into segments that marked the boundaries of discussions about substantive topics within the group, for example, a discussion of a participant’s story or an issue salient to them. Detailed analysis notes were made for each segment. These notes included data representation that highlighted the meaning of participant’s storylines and/or group discussions and a summary of meanings. Themes were then developed through an iterative process that compared and contrasted data representations within and between focus groups.

When a segment contained narrative/s, an analysis of meaning was undertaken on the participant’s story and group members’ discussion of that story. Participant stories were analyzed using narrative principles for interpreting what was “being told.” Mischler’s 1995 (as cited in Kim, 2016) adaptation of Labov and Waletzky (1967) model of analysis was used as a frame of reference. This framework identifies six components in a fully developed narrative: abstract, orientation, complicating action, evaluation, result or resolution, and coda. Kim (2016, p. 204) noted that plotline complications are not just caused by an action or “event” but also “other human issues, like anxieties, expectations, desires, wishes, failures, future developments and the like” and suggested Mischler’s framework could be extended to capture a broader range of complications in the story teller’s life. Accordingly, we adjusted Mischler’s framework to help us to explore what participant-narrators intended to communicate about a broad range of complications.

In our study, the narrative component in Mischler’s framework “complicating action” was broadened to become a new component called “plotline complication.” It was assigned the following criteria for identifying relevant data: “skeleton plot and presenting problems.*”* An additional coding category was used to capture other group members’ engagement with the participant-narrator’s story: “External engagement with or evaluation of the story.” Other group members engaged with the participant-narrator’s story in the form of a diagnostic comment, coaching about what to do, telling a contiguous story, and evaluative discussion. At times, group members offered direct comments on the original story; at other times, commentary or reflection about the experience was given indirectly through extended group discussion. This additional category enabled us to identify transcript data that could be analyzed for “meaning-making” about the participant-narrator’s experience by other group members.

After the narrative components of a story and group member engagement with it were marked in the transcript, the analysis could identify speech which signaled the meaning that a participant-narrator, and other group members, attributed to a story that was told and discussed. This was found in the “evaluation” narrative component of a story and data coded “external engagement with or evaluation of the story.”

# Results

Six emergent themes were identified from the data. These were: (a) just outcome, (b) delivery of workplace safety, (c) family liaison, (d) access to information, (e) assistance for affected people, and (f) representation and voice. These main themes comprise several sub-themes as identified in Figure 1 and presented below.

## Just outcome

Several dimensions of justice were highlighted in participant accounts of disappointed outcomes: accountability for wrongdoing, fair sentencing and law, and workplace prevention.

## Accountability for wrongdoing

Participants sought accountability for wrongdoing that had led to the loss of their loved ones. A participant (P.4.2), who engaged in advocacy with authorities to ensure the right party was held accountable, explained that what she wanted from the coronial inquest was accountability for her son’s death.

Yeah, it is hinging on accountability. It’s like that’s what you want. You just want your son’s life, accountable for that death. It’s just not right. You don’t go to work, and you’re not expected to not come home. (P.4.2)

A family group, consisting of the wife of a deceased worker and two friends who acted as her support, described an injustice they experienced when no one was held accountable for their loved one’s death. A disagreement had occurred between police and OHS officers over whether the employee or company should be held at fault. As a result, neither party was charged. Explaining the anger she felt over this injustice, a family friend (P.3.8) noted they had “had nothing:” there had been no recognition of wrongdoing from the employer, and the employee whose actions were instrumental in the family member’s death did not receive a conviction for the misconduct. Summing up how she felt, the deceased’s wife (P.3.6) said she had “lost faith in justice being served.”



**Figure 1.** Emergent themes.

In ensuant discussion about injustice, a participant in the group (P.3.1) said what families sought was “accountability with justice,” by which she explained “someone has got to be accountable” and the punishment should “be fitting the crime.*”* Other group members agreed “someone has got to be responsible” (P.3.4) and “the punishment has to fit the crime” (P.3.6). In discussing the situation in which neither the employee nor company was held to account, there was an extended discussion about the limits of employer responsibility for employee conduct.

In another discussion, a participant (P.1.3) raised the “problem” of accountability: he said the penalties companies receive are “minuscule,” which does not help prevention, and that large companies employ financial mitigation strategies to reduce the fine. During ensuant discussion, group members complained that smaller companies close up the business without paying a fine, to which he (P.1.3) replied all companies have “got an out.”

P.1.2: They don’t even pay their fines, though. Most of them don’t even pay their fine.

P.1.3: No, bigger companies do, the . . .

P.1.4: No, it’s piddling.

P.1.3: . . . smaller companies just wind up and don’t pay the fine.

P.1.4: They see it, but they don’t get accountable. They just go, oh well, belly-up. Go start again somewhere else.

P.1.2: They don’t even pay their piddly $80,000 fine.

P.1.3: That’s the smaller ones.

P.1.2: That’s exactly - but that’s - they do, they start again.

P.1.4: They don’t care.

P.1.2: I know.

P.1.3:The smaller ones, but the larger ones do the financial mitigation. That’s what I mean - they’ve all got an out.

To solve this problem, the participant (P.1.3) suggested that responsibility be directed to the company directors: if the company directors want to “let the behaviors go on” they would receive personal consequences. A group member (P.1.4) observed this would hold the directors accountable.

In holding a party to account, concern was also expressed about false blame where participants firmly believed the employers were innocent. For example, one participant (P.3.2) said she had been worried the authorities would lay fault on her neighbor for an unfortunate accident, in which there was “no blame attached.” Another participant (P.3.4) expressed relief that a family member who owned the business where the workplace death occurred, was not found at fault, or made liable for a fine.

## Fair sentencing and law

Participants expressed disappointment with lenient or unfair sentencing. In discussing “punishment that fits the crime,” a participant (P.3.1) observed a fine for unintentional death in the workplace can be up to $100,000, but that generally the fines issued are $10,000 or less. She questioned the purpose of the legislative provision if a maximum penalty is never issued and noted any perception there is “justice for the victims” was not there. A group member (P.3.8) expressed her opinion the authorities should enforce penalties “as far as they can.*”* She objected to limits in the authority OHS officers had to place a person at blame in jail. A member of the group (P.3.7) further illustrated the disproportionality of penalties for a workplace death by contrasting the high cost of compliance for small tradespeople and harsh inspections with the lenient fines big companies received in the wake of workplace death.

One participant (P.1.3) attributed unjust sentencing to an imbalance in law. In an appraisal of why justice had not been served, he said he had tried to make sense of why a company that “did what they did knowingly*”* and tried to hide it received the same fine as one that was honest. He concluded this was due to an imbalance in legal protections, explaining that “very powerful vested interests*”* have engaged in legal advocacy while no one was “fighting for the good guys” or protesting the impact of legislative change on affected people, and that laws had changed to “be completely lopsided.” Company interests were said to be about closing the repercussions financially with a plea to leniency on the basis that manslaughter had not been their intent. The participant (P.1.3) and his partner (P.1.2) were engaged in advocacy to overturn a loophole in the law. They wanted to stop companies from using a section of the Coroner’s Act as a legal ploy to avoid accountability. He (P.1.3) explained this section disallows a coronial inquest if another matter is before the court, but that after three years, the statute that enables a coronial inquest is void. At this point, families can do nothing to access the coronial inquest, which he (P.1.3) described as the “best chance” families have to find the truth.

Another participant (P.1.1) questioned the fairness of caps placed on the amount a family member can claim against a workplace death through Work Cover and insurance companies, noting the claim would be “so much higher” if you sued through the courts. He said that caps on claims render the value of a person’s life in the system “worth nothing.” In the ensuing discussion, a group member (P.1.4) objected, stating that there was “no price” that could compensate for a life lost, but another group member (P.1.3) insisted the “devalue” remained.

## Workplace prevention

Participants wanted authorities to take preventive action to save other workers’ lives. One participant (P.1.4) explained that she did not regard monetary compensation as a sufficient remittance for what a “life is worth.” Instead, she wanted the workers to “save one more life.*”* Later in this group’s discussion, a group member (P.1.2) explained that families want preventive action to stop the same incident from happening to someone else. She described this as “justice” for the loved one.

P.1.2: So, it needs to be like things that are preventable, support for the families, and prevention because we all feel that we don’t want anyone else to go through what we’re going through. P.1.4: Oh, God no. You want . . .

P.1.2: We want justice, I suppose, for our loved one that’s died tragically and suddenly.

Another group member (P.1.5) said she preferred a “restorative justice approach” that focuses on “preventing further deaths*”* to litigation which could be tied up for years. In her view, unresolved litigation belies justice, providing no “satisfaction” but exacting an emotional cost.

Participants undertook advocacy to procure workplace prevention. One participant (P.1.4) confronted the company directors with responsibility for her family member’s death and demanded cooperative action for workplace safety as redress. Another participant (P.3.1) explained she wanted to prevent the same thing from happening to someone else.

P.3.1: We can’t change what’s happened to us, but if we can change it for someone else . . .

P.3.2: That’s my sentiments.

P.3.1: . . . prevent it from happening to someone else, then we’ve won.

## Delivery of workplace safety

Participant accounts about workplace safety showed they thought its effective delivery contingent on a thorough, honest investigation, timely action and policy reform, and professional performance.

## Thorough, honest investigation

An honest investigation was deemed essential for finding out what happened. A participant (P.4.3) who wanted to engage the investigation to find out what happened on the day of his family member’s death remarked that this was dependent on whether people “tell the truth.*”*

Participants advocated for a thorough investigation to ensure a good outcome in the case. For example, one participant (P.4.2) had advocated for a coronial inquest to “sort out*”* what had gone wrong with compliance and to secure workplace safety. Another participant (P.2.4) expressed an opinion that the coroner’s report should be done on its own merits, arguing that this would ensure investigative independence necessary to prevent cover-up. She argued that, in her case, the OHS report contained contradictions that covered up failings in workplace safety, and that consequently, the investigative logic of reports that relied on it went “round and round.*”* She concluded that an independent review of evidence would prevent collusion and secure an outcome that was “better” and “safer for all.”

Another participant (P.3.6) emphasized the importance of public records for a thorough inquiry. She (P.3.6) complained that the employee she held responsible for the fatal incident was involved in a similar workplace accident, but since the company did not report it, the evidence could not be used against the employee in court. She commented that companies do not report all accidents, particularly if they think an incident is minor. A friend of the family (P.3.7) expressed concern that the employee could apply for a job and repeat the offense elsewhere because there was no public record. He wanted a formal record to be made of every workplace incident so that prospective employers could consult it before taking on a new worker.

## Timely action and policy reform

Participants expressed disappointment about prolonged inaction on workplace prevention while waiting for the coroner’s inquest. One participant (P.2.1) recounted her experience of advocating for timely action, saying an authority had replied that the coroner would get to the case when he could. Rhetorically, she warned the authority this meant the incident “could happen again” and they would have done nothing to “ameliorate the risk.” Another participant (P.1.1) said the employer knew how to prevent the accident reoccurring but that immediate financial costs result in an objection, despite the potential for long-term savings. He remarked that his expectations for preventive action were disappointed because “it happens again, and again and again.”

Participants urged a common-sense approach to fix the rules. For example, one participant (P.2.4) questioned the necessity of a prolonged timeline for policy reform. She asked why timely cooperation could not occur by getting authorities together within 3–6 months to fix the rules. Another participant (P.4.4) asked why a policy that effectively eliminated risks in an adjacent sector had not been implemented nationwide.

A participant (P.1.2) commented the system did not produce preventive action in a “systematic” way. She noted that because the coroner’s recommendation is not mandatory, preventive action does not automatically occur. A member of her group (P.1.3) said employers do not respond to requests for change to a workplace practice or a coronial recommendation unless subjected to bad press. He observed the lack of preventive action while waiting for the coronial recommendation could lead to further deaths:

P.1.3: And in that three years who’s going to die in the same manner, because we’re too dumb . . .

P.1.4: To enforce that.

P.1.3: Well, to recognize what a fault is and change it.

The ensuing group discussion highlighted a conundrum – even if the company at fault makes an immediate change, other companies may retain old work practices. In conclusion, the group member (P.1.3) affirmed it “should be an industry-wide thing.”

Limits to the effectiveness of regulatory enforcement in producing changes to workplace practice were noted. For example, a participant (P.3.1) said her partner (who had been on- site on the day of their son’s accident) did not go back to work after the incident because the employers were still doing things in an unsafe way. A group member (P.3.4) expressed alarm that the site had “no workplace health and safety” despite having received a $10,000 fine.

## Professional performance and accountability

Participants expressed frustration with authorities over their performance in preventing workplace accidents and deaths. In one group, a participant (P.2.4) clarified that what she was asking from authorities was “honesty,” “respect,” and doing things in a “timely manner.” In a rhetorical exchange, she called on them to guarantee the incident would not happen again. Objecting to explanation she had received from an authority that “it’s a slow process,” she contested that workers are still “going to work at risk.” She highlighted negative emotional impacts on family members waiting for just resolution to the case. After describing how contradictions in a report had “added to” her anger a suspicion of a cover-up, she pointed out that authorities’ should “respect the workers” and do things in a timely, honest way.

A group member (P.2.1) reflected on the dilemma, how to make public servants perform. In the absence of performance standards, she said that only case advocacy can make it happen. She observed that, even then, the policy wording could take it outside of an officer’s responsibility if they are not personally inclined to help. After noting that authorities are not personally affected by workplace death, she concluded, you cannot “make public servants perform.*”*

## Family liaison

Participant accounts of case liaison showcased disappointments. In discussing these experiences, participants said they wanted to be kept “in the loop” with case progress, to receive navigation help, to receive consistent and correct messaging, and to have a timely resolution to the case.

## Being kept in the loop

Disappointment was expressed with insufficient case liaison and information. One participant (P.2.3) said she was told the contractor was likely to be charged with manslaughter; but that she did not know where the case had gone or how it was progressing. Another participant (P.4.4) observed that families “feel out of the loop” and that communication between the departments is limited.

Family members who were not next-of-kin described being kept in the loop by secondary means. A participant (P.3.1), who was not the next-of-kin because her son was married, said that they, as parents, “weren’t really kept much in the loop” for the prosecution part, except as a witness in the case and through a complicated relationship with the business owner who was the defendant – but that a coronial liaison officer had liaised with them during the inquest.

## Navigation help

Participants wanted instrumental information to help them with case engagement. This included information about what would happen in the investigation, tailored advice about what to do, and information about family rights and entitlements.

In one group, a participant (P4. 4) said he had wanted to engage the system to find answers about what happened on the day of the accident but had no information about the investigation. He said that on the day his family member died, he did not have a “clue“ about who took the body or what they were going to do it; and that since that day he has been left with no “clue” about what the authorities are doing with the investigation. He requested information about investigative roles and processes. In response, a group member (P.4.2) observed there is a disparity in families’ experiences in receiving this type of information about the investigation: she said it was “haphazard” and “nobody knows what to do.” Later in the group discussion, she described her frustration in finding this information, highlighting the absence of a “logical map” of the investigation process.

Trying to work who this person was, who that person was, how do they all fit into this, it was just ridiculous. Nobody does make a phone call. Nobody rings and says, “Oh look, we’re just going to do this, and then the investigation will head there.” There’s no logical map that they could give you, no information. (P.4.2)

Participants sought tailored advice about how to engage the case. For example, one participant (P.4.2) described a positive experience with a coronial liaison officer who stepped the family through “what could be going on” with the case and gave advice about what to do.

On the other hand, another participant (P.1.6) said they had been left “in the darkness” about how to handle the investigation. She explained they had received a letter from the OHS authority offering help, and they put their issues in writing but heard nothing back. So, when they received a letter from the coroner offering help, she said they did not realize that they should correspond with the coroner A group member (P.1.2) commented this experience was indicative – “See, no one knows. No one tells anyone anything.”

Participants coached their peers on the family’s rights and entitlements and what to do to get case justice. One participant (P.1.3) informed other group members they only had three years to take civil action and could miss the opportunity if they waited until after the coronial inquest. He also tutored them in what to do to engage authorities, informing them the coroner has powers to pursue an investigative request.

## Consistent, correct messaging

Participants expressed disappointment that they had not received consistent and correct messaging about the case and expected outcomes. In one discussion, group members discussed positive communication with a liaison officer, who had corresponded back and forth with the family by e-mail about the case. One participant (P.3.6) said that her experience of case liaison was not good: there was a discrepancy between what consecutive OHS officers had to say (she had been allocated five over time) and an inconsistency between the case outcome and what she had been led to expect. She concluded that the regulators should not change investigators because the family member gets “different messages constantly.*”* A group member (P.3.1) commented she thought this was wrong because it made it more difficult for a family member to understand and retain the information.

P.3.1: That’s wrong because the grieving person is struggling after getting their head around it all without having . . . P.3.7: That’s right.

P.3.1: . . . the wrong information. It’s hard enough to retain some of the stuff you are told because everything is a fog, as you know.

In response, a friend of the family (P.3.8) said the authorities should “make sure the information is correct*”* and not tell a family member what they “need to hear.” The group member (P.3.1) agreed there should be “no false hopes.”

Another participant (P.4.1) said she felt a “real let down” when no one contacted her to correct information she had received about how her family member died. She observed there should be a system in place to check the communications received.

## Timely case resolution

Disappointment was expressed with protracted timelines for case resolution. A participant (P.1.3) remarked he had spent longer than expected dealing for justice in the case and that they were “not even close.”

One participant (P.1.1) said the protracted timeline jeopardized emotional resolution. He had had difficulty accepting an early court decision because he expected more evidence to come to light in the coronial inquiry. Another participant (p.4.1) explained the prolonged process “brought up everything again.”

Frustration was also expressed with the open-ended timeline. A participant (P.2.1) commented there was no regulatory requirement for the inquest to finish in a specified time and that this rendered the process a “law unto itself.” She also questioned whether there were enough coroners to complete the task efficiently.

## Access to case information

Participants recounted disappointments they had had in attempting to access information about the case, including reports and evidence. They wanted the authorities to provide transparent access to information and not cover up, to recognize family members were a stakeholder in the case and to provide equitable access to reports.

## Transparent access

Participants complained of the lack of transparent access to case information. In one group, a participant (P.1.5) likened the experience of acquiring information to “a game about legal policies and technicalities,” in which the family member only knows the rules after the event. She had been blocked from gaining information access by right to information laws. She portrayed the non-release of information as a good way for the government to “hide information” and avoid accountability. Later in the discussion, a group member (P.1.3) described her experience of navigating the system to obtain information as a “Telstra [telephone company] run-around” that continues for several years. In reply, the participant (P.1.5) observed the run- around occurs because of everyone “ducking for cover” in order to avoid legal liability, commenting that this gets in the way of the case being “sorted” and of “preventing further death.” The group member (P.1.3) agreed the system reflects the legal service it provides, noting that while it is supposed to be for “justice and transparency,” it is not.

Some participants expressed a view the redaction of reports hinders the family’s ability to find the truth. One participant (P.2.1) challenged the legitimacy of withholding sensitive information to protect the family: she said it blocked “grieving” people from getting the whole story and questioned what there was “to hide.” Another participant (P1.4) said she wanted to find evidence for a specific cause but was told the family would only become “privy” to certain information in a coroner’s report.

A participant (P.3.8), who was a family friend, highlighted the impact of failure to share information on the family’s opportunity to intervene. She noted her friend had lost the chance to say goodbye to her husband because she was not told of the severity of his condition whilst he was still alive, describing subsequent communication with authorities to be “just like” that. She said OHS officers had surreptitiously pushed things “under the carpet,” and had given her friend “false information” about what she could do to obtain justice, when she “could have done more.”

## Stakeholder recognition

A view that recognition of stakeholder status should result in information access was discussed. A participant (P.2.1) argued that authorities should recognize family members as a “major stakeholder” and offer them the reports. She said that she expected to be “treated civilly” and receive information that she “might need to know” or that would help her “deal with things well or better.” She described her experience of obtaining and paying for reports through freedom of information as “demoralizing,” noting some family members do not even know how to request these reports. A group member (P.2.2) agreed, stating that as a stakeholder she should not have to “knock doors down” to obtain case reports. These participants described cultural and systemic issues that they thought undermined acknowledgment of family members and their requests. One of these participants (P.2.2) said she felt she disregarded, commenting that authorities should give more respect to the family members “left to deal with everything.” The other (P.2.1) said that the government is a bureaucracy that handles everything in terms of policies and procedures, that public servants are under-resourced and get paid regardless, and that there is “not a lot of compassion” for the family member. In contrast, compassionate acknowledgment of impacts on the family was said to be “like a breath of fresh air.”

## Equitable access

Participants expressed disappointment over inequitable access to case information. One participant (P.1.4) complained that the next-of-kin in her family “gets to know everything” while other family members “get nothing.” She had had to go to a lot of work to justify why she should “get anything.” During discussion that ensued, a member of the group (P.1.3) expressed a view that any “affected person” who needs case information should get it and that estranged parents should be liaised with “on equal terms.”

A couple (P.4.3 and P.4.2) expressed disappointment over an inequity of access to the brief of evidence between themselves and the employer being prosecuted. One of the couple (P.4.3) said that the employer “got everything,” while the family of the deceased “got nothing.” This placed the family in a disadvantaged position for case advocacy: had the employer not given them the reports, they would not have known the investigative direction or been able to question authorities on which party they were going to prosecute. The other (P.4.2) explained that official avenues through which a family can access reports would not redress this inequity: while they had received a letter inviting them to request reports, they would not have known what reports to request.

Yeah, to receive a letter from the coroner’s officer to say if you want a copy of the autopsy results, you can apply for that, and you can apply for other information. Well, that’s a hanging sentence. What other information would we be applying for because we’ve never been in this situation before, so we don’t know what we’re looking for? We don’t know what they are investigating. What information? (P.4.2)

## Assistance for affected people

Participants wanted authorities to provide instrumental and personal assistance to affected family members. They thought the authorities should honor their responsibility to assist, offer support to families living with the consequences of workplace death, and provide personal care.

## Responsibility to assist

Participants expressed disappointment when authorities attempted to minimize obligations to assist families following a workplace death. In one group discussion, a participant (P.3.8) explained, “everyone works to the book.” She said officers decline requests by indicating it requires higher clearance or falls under someone else’s area of responsibility. Another member of the group (P.3.9) said authorities attempt to get out of their obligations as cheaply as possible, describing how an authority had whittled down the family’s entitlements in a calculation of reduced assistance.

## Family support

Participants expressed disappointment over receiving little or no support particularly when they lacked capacity to meet ensuing needs. Unmet needs for counseling and emotional support featured prominently in the discussion. For example, a participant (P.3.6) said she was told there would be no counselors available in her town when she contacted authorities for help. This response conveyed to her a carelessness toward the impacts of workplace death and her request for help.

Members of this group proposed emotional counseling should be available for all family members. A participant (P.3.8) expressed anger that after the authorities did their bit for the person who died, it was “tough titties for the family.” She believed there should be more help for families not coping with the death since it’s not an “easy road.” In response to a suggestion counseling be provided for families, a group member (P.3.1) expressed surprise the government offers counseling to couples who “choose” to get married but does not offer families assistance with the aftermath of a workplace death, which they did not “choose.”

P.3.4: Find some counseling for families with young children.

P.3.1: I’m really surprised the government doesn’t do that because . . .

P3.6: For the whole family.

P.3.1: As a marriage celebrant, I know that - they put a big focus, they give out, this year $300 vouchers for people to have marriage counseling before they get married because it’s all about keeping the families together.

P3.6: Yeah.

P.3.1: Yeah, I think it’s a waste of time too, and most people do. Yet, they can’t come up with any funding for any counseling for this sort of thing. We don’t choose to be in this situation. People choose to get married. We don’t choose to be in this situation that we’re in. It’s thrust upon us and very violently, and it’s a shellshock, and you need something to get you through it.

Later in the group discussion, another group member (P.3.9), who was not next-of-kin, stated the “biggest thing” is there is “nothing for the families.” After, members of the group (P.3.8 and P.3.1) reflected that he would have “known nothing” if he had not been at the worksite on the day of the accident, he (P.3.9) clarified the family would also have “got nothing” in terms of support.

A participant argued there was a need to improve the process so that it did not add to family hardship. She said it was “depleting” to tell and re-tell her story over and over again.

## Personal care

Participants expressed disappointment with system negotiations that were insensitive or impersonal. One participant (P.4.1) described how an officer had been insensitive and rude to her over eligibility for a payout. She said authorities do not understand the severity of grief and do not know how to speak sensitively and suggested better training. In response, a group member (P.4.4) observed the service is not structured for personal care. He suggested a case manager would enable family members to be “a person involved in a process.” He said the case file travels between departments, and “nothing becomes personal, and nothing becomes connected.”

Participants expressed a preference for personal forms of assistance and support. In one group discussion, a participant (P.2.1) explained help “needs to come to you.” He said that family members are unlikely to seek help because they are in a state of shock. A group member (P.2.4) agreed, saying the family member deserves to be treated “as a human being.”

You deserve a phone call and just that one person that speaks to you and treats you as a human being and talks to you because you’re not really at that time, and at that place, you’re not reading anything, and nothing’s going in anyway. (P.2.4)

These participants described the benefits of opening up a human exchange between the family member and a liaison officer, with its concomitant obligations of support. One (P.2.4) commented, “just being there is gold,” noting that it “all comes back to” the acknowledgment “every worker deserves to come home.” In response, the other participant (P.2.1) said a “personal approach” has the potential to take assistance to “the next level” and help the family “get over what they are going through.” She suggested the exchange incorporate a collaborative approach to the investigation. In that way, she said, family members can give back “gold” by assisting authorities with the investigation.

## Voice and representation

Participant accounts showed they wanted to have their voice represented and heard: they appreciated opportunities to be heard; expressed disappointment with authorities who did not defend the family’s interests in court or who limited their voice in their Victim Impact Statement; and proposed a case manager-advocate who could act on their behalf.

## Opportunity to be heard

Participants expressed satisfaction when their voice about the case had been heard. One participant (P.4.2) said she felt her voice was “respected” and “heard” by the coroner, even though it did not resolve her way entirely. Another (P.3.1) described a satisfactory outcome that had come from having a “good” coroner who took the time to understand the industry and the family’s perspective of what worked: as a result, guidance notes were produced for an industry with little guidance, despite it being “one of the most dangerous.”

Participants informally engaged authorities in case advocacy and expressed disappointment when there was no response. One of these participants (P.4.4) sought a meeting with the safety inspectorate to find out whether questions he wanted answered had been asked by the investigators but was not granted his request. He remarked that an authority’s response is contingent on whether the officer becomes sympathetic.

## Family representation in court

Participants expressed disappointment the authorities failed to represent the family’s interests in court, or act for a just outcome in the case. A family group, consisting of the wife of the deceased and two family friends who acted a support, complained that their interests were not defended in court. One family friend (P.3.8) described a conflict that had occurred between the family and defendant’s barrister in the courtroom. After the court case, she confronted the barrister who worked for the OHS regulator for “not standing up” for them. The other (P.3.7) expressed disappointment the barrister had failed to pick up inconsistencies in the defendant’s case and “never said a word.”

Participants also expressed disappointment over courtroom deals that reduced the sentencing outcome. A participant (P.1.1) said he was led to expect that the person responsible for his family member’s death would receive a sentence equivalent to manslaughter. When he arrived at court, he was informed this expectation would not be met. After describing the final sentence, he declared a government advertisement about a workers’ right to come home safely “absolute, utter rubbish,” adding the authorities “couldn’t care less.”

In discussing why neither the prosecution nor defense was going to appeal, group members suggested that the Crown Prosecutor does a deal with the defense and does not tell the family. A group member (P.1.3), whose sentencing expectations were also not met, explained the authorities negotiate a guilty plea to secure an appearance of justice in return for not “fighting hard” in court. In doing this deal, he said that government representatives “take” the resultant outcome “on behalf of everyone involved.”

P1.3: You know, and very rarely do they convict for this. Now, these people, they didn’t pull out a gun and shoot [name of son] in the head.

P1.2: They might as well have.

P1.3: They might as well have, and so, I’m going, well, you know. At that stage, I’m not even thinking about the conviction side of it. It sort of dawned on me once the penalties were handed out. When I got the inquest material - here is the agreed facts. Well, the agreed facts were done well before they got to the courtroom. They knew exactly - for a very long time what was going to happen in that courtroom, and all it is - what it is, is it’s a whole staged production where you get up, and you say this, and we won’t argue with that. So long as you concede your guilt because we don’t want it to cost a lot - we don’t want to cost a lot of money. We don’t fight it for - really hard. We just want them to say - again, appearances - that we have got a guilty verdict. If we have to bend over backward and take it on behalf of everyone involved - we will do that.

## Right to voice impact

The victim impact statement provided family members with an opportunity to voice the impact of workplace death on them. Participants expressed disappointment when this opportunity was denied or limited. For example, one participant (P.3.1) explained that the employer was “like family” to her and that it was “brutal” on them, but that she “had to say it.” A group member (P.3.8), in response, observed the victim impact statement had allowed her to release anger, hurt, and pain, to which she replied, the employer had “actually cared” and that it made “a bit of a difference.”

Later in the group discussion, the group member (P.3.8) said her friend, the wife of a deceased worker, had not had an opportunity to speak to the employee whom she held responsible. She commented her friend had “every right” to show the employee how much she had been hurt and that the employee should be able to “sit there and accept” because he had received no other consequence.

A couple (P.1.3 and P.1.2) expressed disappointment that authorities had audited and edited their victim impact statements. One of them (P.1.3) said the victim impact statement had come back with “blanked out” sections, despite every member of his family wanting “to be heard.” He described conflict with authorities over authorship rights and the editing of his statement. The other (P.1.2) explained that she did not assent to its edits, so an authority had asked her to withhold her statement so that they could progress the case, informing her it was the government’s role to prosecute, not the family’s. This had sent her the message, “your workplace impact’s really not important.” In defense, she appealed to her representation of her son.

P.1.2: So, I say to our coronial liaison officer, you know, like, he says, oh, just put them forward, and I’m saying no. It’s not what I actually - it’s not even what I want to have in there. He said, well look [name], it’s the government prosecuting. It’s not even your family. So, he’s saying to me it’s just a fellow at the end of the day. It’s the government - you as a family are really not involved. So, if you want to withhold it, and so we can just get forward this case. I’m thinking; I’m his mum. I’ve had no forthcoming information. Every bit of information we’ve had to fight for or I just [come up with] barriers. It’s been frustrating. It’s been - just the whole thing was just this ugly ball of mental - it gets to be like a mental - do you know what I mean? It’s very hard to go on with - just functioning becomes a thing, because you’re dealing with all - not only grief but also your finances and everything else, I suppose, because you’re not - I couldn’t go back to work for a while, because it was actually my workplace. So, at the end of the day, when Workplace Health and Safety say to you, well, look, you know, your workplace impact’s really not important. It’s the government prosecuting - and I think that’s my son. P.1.4: That’s what we were told.

## Case manager-advocate

Participants who described frustrated efforts to find someone with whom they could deal over case concerns suggested a case manager-advocate could act on their behalf. One participant (P.2.4) suggested a case advocate could provide a single communication conduit and speak to other authorities on the family’s behalf. She said this would ensure that family members are not “fobbed off” and that they are told the truth in a timely manner.

Another participant (P.1.1) likened the experience of finding someone with whom to deal with “walking into a maze.” He said that everyone said there was nothing they could do, or that the matter was in the hands of someone else. He asked, “Who do you deal with?” saying that he speaks to whoever is willing to talk and whilst officials get “sick and tired of you,” he had kept persisting despite its impact on his mental health. Later in the group discussion, this participant (P.1.1) suggested an advocate, who worked “for the family” by chasing down reports and holding the authorities accountable for doing the right thing, would make it easier for families. He said the problem is the deceased person is “represented by the state” and “families don’t matter.”

# Discussion and conclusion

This study explored family experiences and expectations of the formalities that followed a workplace fatality. The emergent themes highlight the salience to participants of six broad expectations of authorities: just outcome, delivery of workplace safety, family liaison, access to case information, assistance for affected people, and voice and representation. These themes depict expectational meanings conveyed in participant accounts of their experiences and expectations in dealing with authorities following workplace death in one jurisdiction in Australia. Expectational meaning was derived from stories of their experience, and discussion of their own and others’ experiences, in which they reflected upon what they thought authorities should have done, what authorities should do in the future, or what they wanted from authorities. In addition, accounts of disappointing experiences indirectly display expectations about what authorities should have done. As such, thematic representations provide insight into the nature of expectations held by participants in this study.

Participant expectation for just outcome incorporated dimensions in case justice and workplace prevention. Expectation for case justice focused on accountability for wrongdoing, whereby an individual or agency at fault is held publicly responsible and receives due consequence, and on fair sentencing and law. Disappointment was expressed with lenient or unfair sentencing. Light penalties may not reflect the seriousness of a breach to workplace health and safety or act as a sufficient deterrent to further noncompliance. They risk treating an incident of noncompliance as an unfortunate incident rather than penalizing an employee or company that was corporately at fault (see, also, Matthews, Johnstone et al., 2019). In the same manner, when participants firmly believed that employers did not cause the death, they held concerns about false blame by authorities. Elements of the justice being sought were truth and retribution, and absence of negative consequence employers did not deserve.

Holder (2018) suggests that expectations for just outcomes in victims of crime are linked to outcomes that they perceive as fair to the victim, the offender, and the broader community. As experienced by participants in this study, victims of other crimes may get the guilty verdict they want from the justice system but may be disappointed or dissatisfied when a sentence that is less than they expected is handed down, for example, a good behavior bond rather than a jail sentence or mandatory rehabilitation (Holder, 2018; Wood et al., 2015).

Workplace prevention was also viewed as a form of justice for the death of loved ones. It recognized the worth of a worker’s life and what went wrong. Like family responses to loss as victims of other crimes (Kilpatrick et al., 2007), families in this study wanted something to come out of the tragic loss to prevent the same incident from happening to someone else. This need heightened the importance of successfully delivering workplace safety, and some participants engaged in case advocacy to ensure it occurred. Several elements of effective workplace prevention were identified – a thorough, honest investigation, timely action and reform, and professional performance and accountability. Honesty and investigative thoroughness were regarded as critical ingredients for investigations that find the truth. Concerns over professional performance in delivering an honest investigation following a workplace death have been reported earlier in the literature (Brookes, 2009; Snell & Tombs, 2011) and appear to remain a concern for other victims, including those of homicide (Reed et al., 2020) and sexual assault (Hohl & Stanko, 2015).

The central role of the public coronial inquiry in ensuring timely action and policy reform was recognized. This reflects the coroner’s role, which is to investigate why the death occurred and formulate recommendations to encourage action toward preventing future deaths in similar circumstances (Walter et al., 2012). However, only a small percentage of workplace deaths result in a public hearing in Australia (Walter et al., 2012). Findings in this study highlight limits to the coronial inquiry’s capacity to produce timely workplace reform and concerns that delay waiting for the coronial inquiry leaves workers at risk. Since the coroner’s recommendation is the only formal mechanism for producing sector-wide reform, immediate workplace safety responses rely on industrial and workplace safety leaders communicating safety solutions across the sector. Ongoing initiatives to encourage companies to place greater value on workers’ lives and their right to come home than on the costs of work health and safety, would be helpful. In this study, calls were made for additional measures of professional accountability to be introduced to improve performance in delivering workplace prevention in a timely, honest way.

Participant expectation for case liaison and information reflected family members’ need for instrumental information to help them engage with the investigation and case information. Participants not only expressed interest in basic case updates and information, but in navigational help. They argued they should receive case evidence and reports based on claims for transparency, stakeholder recognition and equitable access. Equity in information access was argued not only on a needs-to-know basis but also on the basis it affords family members equality of opportunity in advocating for a just outcome in the case.

Information about processes that occur following a workplace death is complex and authorities admit legal privilege limits the information they can provide families about the investigation (Matthews et al., 2014, 2016). Nevertheless, receiving adequate and timely information about processes and case updates is a common cause of dissatisfaction in victims of crime, and most studies exploring victims’ experiences of the criminal justice system report this finding (e.g., Connolly & Gordon, 2015; Laxminarayan et al., 2013; ten Boom & Kuijpers, 2012). Stretesky et al. (2010), who interviewed co-victims of homicide, suggest that families need this information to actively engage with the investigation process and other formal procedures that follow the death. Families also need to understand the communications given by authorities. As an example, for victims of sexual assault there is evidence a significant gap exists between the information authorities think they provide to victims and what victims recall receiving (Davies & Bartels, 2020). Some participants in this study discussed a need for a case manager or case advocate to act on their behalf in communications with authorities and to help families navigate the legalities, a suggestion endorsed by several authors in the victimology literature (e.g., Gaines & Wells, 2015; Madoc-Jones et al., 2015; Reed et al., 2020)

Refusal to release reports and the redaction of information through information laws raised questions about transparency and accountability. Policies and legislative instruments provide reasons for refusing document access. For example, Section 55 of the Coroner’s Act (District Court of Queensland, 2003) provides that a coroner may refuse release if a document contains defamatory information, unsubstantiated allegations of criminal conduct, or information that could prejudice the coroner’s investigation, and may delay a document’s release if the information it contains is likely to prevent fair trial. These reasons relate to a foundational principle in upholding justice: fairness of procedural process. The Best Practice Review (WorkSafe Queensland, 2017) explains that under the Right to Information Act 2009 (Qld) authorities are required to apply a public interest test that weighs up factors favoring disclosure and non-disclosure, and considers the potential harms of disclosure. It explains that under the same Act, agencies are required to uphold obligations to protect personal information. Nevertheless, access to information on OHS issues by all parties will contribute to better OHS outcomes. The Best Practice Review (WorkSafe Queensland, 2017) identified room for improvement in the transparent release of information.

The findings underline the importance of making family members aware that information about expected case outcomes, regarding conviction, sentencing or fines, is not definitive. This could be done by explaining the evolving nature of legal decision-making and factors that influence it so that family members have realistic expectation of what the justice system can deliver (Wemmers & Cyr, 2016). If this is not understood, the family’s hopes about what will happen in the judicial process may be falsely raised (see also for homicide Englebrecht et al., 2014). Law reform action has underscored the need for victims to have realistic expectations about what the criminal justice system can deliver (Victorian Law Reform Commission, 2016). Stress and confusion about the justice process has been reported previously as having the potential to re-traumatize co-victims of homicide and victims of other crimes (Englebrecht et al., 2014; Gekoski et al., 2013; Wemmers, 2013).

Families’ expectation for assistance appeared to derive from a sense of what was owed them to redress personal costs stemming from workplace death. These families wanted authorities to provide assistance in dealing with the consequences of workplace death and to ameliorate personal hardship without making it worse. Findings demonstrate that family members valued personal forms of service interaction that display care about the impact of the workplace death and service interaction on the person and recognize an obligation to assist. Insensitivity was attributed to impersonal forms of service provision. The need for assistance and experiences of insensitivity, however, appears to be a shared experience amongst victims of crime, including sexual assault, domestic violence, and of particular relevance to this study, co-victims of homicide (Clark, 2010; Connolly & Gordon, 2015; Laxminarayan et al., 2012; Robinson & Stroshine, 2005; Wemmers, 2013).

Insight into the possible genesis of insensitive interactions by authorities with families’ who experience a workplace death is provided by Reed et al. (2020). They note co-victims of homicide and detectives who investigate the case, despite having the same goal of solving the crime, bring different expectations to post-death processes. Families are relegated to a passive and dependent role in the criminal justice system and rely on detectives to solve the crime. Their experience is of emotion, loss, and high stress. Conversely, detectives need to be emotionally detached to do their job well and deliver the evidence that will underpin prosecution. It is this detachment that families seem to perceive as an uncaring approach by detectives and for them to have “little compassion for the family and their ongoing suffering” (p 554).

Disappointment was expressed over procedures that limited the family members’ right to voice impact through the victim impact statement. Victim impact statements allow family members to voice the human impact of workplace death and have a sense of participating in the justice process. Having their information edited by authorities was frustrating and disappointing. Yet, editing statements is a common practice in criminal courts (with inconsistencies in editing rationale), to which victims of other crimes, including homicide, sexual and physical assault, and domestic violence, have strongly objected (Englebrecht & Chavez, 2014; Tait, 2015). Authorities rarely advise families or victims that the victim impact statement has a legal purpose as a statement to be considered during sentencing, or that its purpose is not primarily personal expression of voice (Booth, 2005; Miller, 2014). Lack of information about the purpose of the statement and the power of authorities to edit the statement diminish the family’s sense of justice. As Malone (2007, p. 52) has explained about co-victims of homicide in negotiating the criminal justice system, “the needs and instinctive responses of family and friends are repeatedly overruled by the demands of the machinery of investigation and prosecution.”

Some of the participants in this study knew the person who was being investigated for a workplace death or held accountable for it. Unfortunately, our methodology does not allow us to make inferences about the effect of having a close relationship with the person who might or has been held responsible on family expectations of authorities. Nevertheless, the family homicide and interpersonal violence literature provide insight into the victim- offender relationship (McQuade, 2014). For example, victims who know their offender tend to have different expectations of the authorities and the legal process than victims who do not: they expect they will influence the justice process and have a say in sentencing because the information they have can assist authorities in making informed decisions (Wemmers & Cyr, 2016). Some need to repair relationships with the offender and with the community (whom they believe should condemn the offense), and some seek protection and safety, rather than retaliation or retribution, as an outcome of their engagement with the justice system (ten Boom & Kuijpers, 2012; Van der Aa & Groenen, 2010). Research specific to workplace death would clarify this aspect of the expectations literature.

As identified in earlier sections of this discussion, many of the general expectations depicted in this study have been described previously by co-victims of homicide and victims of other crimes. Several systematic reviews have also captured the extensive literature on this topic for a range of other conventional crimes (Connolly & Gordon, 2015; Koster et al., 2016; Laxminarayan et al., 2013; ten Boom & Kuijpers, 2012). The consistency of findings from this study with those reported in the existing victims of crime literature point to a disjunction between expectations held by families and victims of the authorities and what authorities and criminal justice system can offer them.

Much of the existing literature points to ways to improve procedural justice and victims’ satisfaction with their experience of the system (e.g., Elliott et al., 2012; Laxminarayan et al., 2013; Lorenz, 2017; Vinod Kumar, 2018; Wemmers, 2008). Some have looked at using a trauma-informed lens, rather than a procedural justice perspective, to improve authorities responses to victims (Rich, 2019). There is also literature reporting the use of legal representation of victims in the criminal trial process, not ordinarily provided in adversarial systems, as a way to improve victims’ participation in the process and increase compliance with their rights (e.g., Braun, 2014; Davis et al., 2012; Elbers et al., 2020); although this approach is only developing in Australia (Kirchengast, 2021; O’Connell, 2020). Few studies report a practical response to the experiences and expectations voiced by victims or co- victims in their journey for justice.

Since this study, legal reforms in the jurisdiction where the study was conducted have attempted to address shortcomings in OHS legislation. The Work Health and Safety and Other Legislation Amendment Act 2017 (Queensland Government, 2017) incorporated a new offense for industrial manslaughter into the Work Health and Safety Act 2011 (Queensland), the Electrical Safety Act 2002 (Queensland), and Safety in Recreational Water Activities Act 2011 (Queensland). These amendments were based on recommendation 46 from the Best Practice Review (WorkSafe Queensland, 2017), which were designed to “send a clear message to PCBU’s [person conducting a business or undertaking] about the standard of safety required and the expectation on senior management to proactively manage health and safety risks” (p 113). The Work Health and Safety and Other Legislation Amendment Act 2017 (Queensland Government, 2017) also banned company directors from taking out insurance to cover the cost of penalties, in accord with recommendation 47 of the Best Practice Review (Queensland Government, 2017).

The Work Health and Safety Act 2011 has also been amended to include a mechanism to promote productive communication between affected family and OHS authorities – the Consultative Committee for Work-Related Fatalities and Serious Incidents (Queensland Government, 2020). The Committee comprises affected family members who are appointed by the Minister to provide advice and recommendations on the information and support required by families following severe injuries and deaths. Initiatives such as this, and those mentioned above, will improve the authority’s capacity to better meet community expectations of justice.

The Australian Commonwealth Government has taken action through a Senate Inquiry into the framework surrounding the prevention, investigation, and prosecution of industrial deaths in Australia (Commonwealth of Australia, 2018). Eleven of the 34 recommendations from the inquiry directly addressed families’ needs following a workplace death. Most recommendations were actioned by the government and incorporated in the Federal Government’s OHS statutory body’s 2019–2020 operational plan (Safe Work Australia, 2019).

Work subsequently undertaken by SafeWork Australia in response to the Senate Inquiry delivered a set of nine national principles to guide and support families following an industrial death (see, Safe Work Australia, 2021b). These principles provide a national framework to guide OHS authorities and associated agencies to implement family-centered policies and practices. Still, their uptake, compliance, and enforcement are delegated to state and territory governments. They are yet to be actioned, enforced, and evaluated in all jurisdictions in Australia.

Research that evaluates the effect of implementing recommendations from the National Inquiry on families’ experience and satisfaction with the OHS legal processes, both at jurisdiction and national levels, is needed. Solutions to enhance families’ experiences of procedures they navigate and the interactions they encounter, and to improve satisfaction with case outcomes could also be explored in Australian jurisdictions and internationally. For example, some have suggested authorities who integrate elements from procedural and distributive justice theory into their practice build trust, promote process inclusion, and produce better criminal justice experiences for victims and authorities (Ballucci & Drakes, 2021). Others have applied a therapeutic jurisprudence approach to identify elements that harm or promote the psychological well-being of victims who use the legal system (Wemmers, 2008, 2013). Another avenue for inquiry could evaluate alternative legal responses to workplace fatalities that aim to uphold victims’ rights and reduce secondary victimization. Restorative justice is one such alternative (Brookes, 2009). Finally, COVID- 19 safety protocols have significantly impacted the ways of working, focusing on the increased use of technology for communications. Research exploring the impact of COVID-19 safety protocols on family and their subsequent satisfaction with authorities’ communication, provision of information, duration of procedures, and the holding of public coronial inquiries would help identify the efficiencies and frustrations of the protocols offered.

The limitations of this study should be noted. Rather than describe a range of substantive experiences or views, this focus group study depicts expectational meaning conveyed through participants’ accounts of their experiences and expectations of authorities following a workplace death. Since individual and collective meaning-making occurred through the storytelling and discussion, it cannot be claimed all participants shared the expectational meanings depicted in this study. Families who had positive experiences with the system may have been less likely to participate in the study. Their accounts of experience and expectations dealing with authorities may convey expectational meanings not captured in these themes.

The results from this study contribute to the existing literature in several ways. They provide insight into the nature of expectations of authorities that exist within this group of families, which may help inform practical responses in similar service settings. A deepened professional understanding of the nature of expectations within this family group could lead to other improvements, most notably in professional conduct and interpersonal care throughout the legal process. The findings add to the literature reporting families’ expectations and experiences navigating the legal processes following a traumatic work-related fatality and, in doing so, increase the visibility of this under-represented group in the victimology literature and the white-collar and corporate crime literature.

Workplace incidents continue to claim workers’ lives every day (Bureau of Labor Statistics, 2020). Families of people killed on the job will continue to engage with authorities of the criminal justice system to search for justice. Insights from this research may help authorities understand how to better prepare families for their experience with investigation proceedings and identify ways they can better respond to family and community expectations.

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