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Investigation and prosecution following workplace fatalities: Responding to the needs of families

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Abstract
Every year, there are over 200 traumatic deaths at work in Australia. A government safety inspector usually investigates each incident. The investigation may lead to prosecution of the employer or another party deemed to have breached relevant legislation. However, little systematic research has examined the needs and interests of grieving families in this process. Drawing on interviews with 48 representatives of institutions that deal with deaths at work (including regulators, unions, employers, police and coronial officers), this article examines how they view the problems and experiences of families. Notwithstanding some recent improvements, findings indicate ongoing shortcomings in meeting the needs of families regarding information provision, involvement and securing justice.

JEL codes: J53, K41

Keywords
Industrial relations, safety prosecutions, traumatic workplace death, workplace health and safety

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Background

Traumatic work-related death (TWD) poses significant economic, social and human costs. In 2011, 220 Australians were fatally injured at work while in the United States the comparable figure was 4690 (US Bureau of Labor Statistics, 2013). These deaths occur over a wide range of industries although the incidence of fatal injury is conspicuously higher in road transport, construction, mining and agriculture, fishing and forestry (Jones et al., 2012; US Bureau of Labor Statistics, 2013). The number of fatal work injuries has declined over time in most Western industrialised countries (International Labour Organization, 2005). However, limitations in data collection by official work health and safety (WHS) and compensation agencies continue to result in an underestimation of the extent of TWDs in the community (Driscoll et al., 2003).

Even if the number and incidence of fatal injuries at work are declining, these deaths still represent a human tragedy that affects thousands of family members and friends. It is also a tragedy that is largely unrecognised by the broader community, apart from occasional well-publicised incidents, inquiries and media campaigns by regulators (see for example Nile, 2004). In exceptional cases where a group of workers die in the same incident, families are united in their grief, the media ensures widespread community attention and governments are under pressure to respond decisively. This occurred when 29 miners died in a methane explosion at the Pike River coal mine near Greymouth, New Zealand, in November 2010. The event led to public outrage and widespread questioning of work-safety standards in New Zealand. For their part, the families of those killed joined together and played an active role following the incident. They advocated decisive action to prevent another such incident, participated in the subsequent Royal Commission and reviewed the government's response to the Royal Commission findings.

The situation is very different when one or two workers die, which is the case in almost all incidents of TWD in developed countries, including Australia, the United States and New Zealand. In these cases, families must deal, in isolation, with the consequences, including up to six regulatory and judicial responses.[1] Of these responses, the safety investigation and prosecution processes are examined in this article.

Although there is little research on the impact of TWD on families, available studies indicate that the investigation and prosecutorial activities are important to them (Matthews et al., 2012a, 2012b). Determining the circumstances of the death helps the family to understand how their loved one died and how such events can be prevented in future. It can also identify what or who is responsible for the death, whether the law was breached and, if so, who is being held accountable. Furthermore, conviction for a breach of legislation can affect the family's decision to pursue a common law damages claim against those held responsible. Finally, research suggests families want to be kept informed of developments in the investigation process and want it to be resolved in a timely fashion (Matthews et al., 2012a, 2012b).

Under work-safety legislation in Australia and many other countries, the relevant government regulator must be notified of traumatic injury fatalities at work and other serious incidents. The government safety inspector responsible for the workplace normally carries out the initial investigation, although in some jurisdictions it may be referred to a specialist investigator or even a special investigation unit. Both the

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investigation and any subsequent prosecution before the courts can take a considerable period. Depending on the complexity of the case and the resources of the inspectorate, the investigation may take between a few months and a year or more. Judgements are made about possible breaches of the law and whether a prosecution should be pursued. Any subsequent prosecutions may not be resolved for a year or more following the investigation, depending on the backlog of judicial cases. Complex cases, those subject to appeals on technical grounds or those requiring referral to a higher court, can take even longer.

It is notable that two studies of work-related fatalities that occurred in New South Wales and Victoria between 1984 and 1990 (Hopkins et al., 1992; Perrone, 2000) found that not all deaths were investigated by a safety regulatory body and the extent or rigour of the investigations that did occur varied markedly in terms of identifying causation and criminal culpability. While resourcing may have been an issue, both studies identified problems of fragmentation. Incidents that entailed multi-jurisdictional coverage, such as road transport deaths, were more likely to fall between the cracks or attract less extensive investigation and prosecutorial follow-ups. Whether this problem still occurs is unclear. Nonetheless, even where a breach of legislation is identified, a decision to prosecute is not automatic but may be referred to a specialist prosecution unit in the inspectorate. The decision to prosecute is largely based on whether it is in the public interest, but this decision may also be influenced by the strength of the evidence to secure a conviction.

There is an extensive literature on incident investigation and the enforcement of WHS legislation. Leaving aside studies of workplace disasters, five broad areas of research can be identified. First, there is research on the development, testing and assessment of occupational incident models to determine causation (Hale et al., 2012; Katsakiori et al., 2010; Lundberg et al., 2009). Second, another body of research examines the role of judicial and coronial processes arising from TWD or coronial investigations and tries to determine causal patterns (Brodie et al., 2009; Bugeja et al., 2010; Hopkins et al., 1992; McCallum et al., 2012). Third, other studies examine limitations in the surveillance or investigation of TWD and their implications for understanding the prevalence and risk of TWD and identifying at-risk groups (Driscoll et al., 2003; Guthrie et al., 2009; Myers et al., 2009; Tiesman et al., 2010). Fourth, a large body of research examines WHS or mine-safety legislation, including its scope, coverage, enforcement and the role or effectiveness of inspectorates in this regard (Gray and Mendeloff, 2005; Gunningham, 2009; Gunningham and Sinclair, 2009; Walters et al., 2011). A subset of this research examines public attitudes to corporate crime and the development of specific legal provisions relating to fatal injuries at work, most commonly the offence of industrial homicide or corporate manslaughter (Almond, 2008; Tombs, 2013; Unnever et al., 2008). Fifth, a related body of research examines whether the broader political, economic and regulatory context including the presence or influence of unions, affects the incidence of fatal injuries in particular industries or jurisdictions (Loomis et al., 2009; Morantz, 2011).

Little of this research, however, makes more than passing reference to families and their needs, their involvement in the process and their experience of it. What is known about the early response to traumatic bereavement is the value of providing ongoing, accurate and timely information and the provision of both practical and social support (Dyregrov, 2006; Forbes et al., 2007; Thuen, 1997). There is also evidence that some

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aspects of information, professional contact and social support are not helpful and may be detrimental, such as the untimely withdrawal of social support or communication problems (Dyregrov et al., 2003; Ingram et al., 2001; Roberts et al., 2009). An emerging body of research has shown that institutional responses following a TWD may impose significant additional harms on the families of the deceased (Brookes, 2009; Matthews et al., 2012b). The negative consequences of long-term exposure to regulatory processes, including investigation by the WHS inspectorate and court proceedings, have been found to complicate the bereavement process and exacerbate health consequences (Matthews et al., 2012b). This research identified serious management issues that require further investigation to guide developments in policy and practice.

This article seeks to address these gaps in existing knowledge by examining the investigation and prosecution processes within the context of the management of TWD and its implications for families of deceased workers. It reports the main themes arising from systematic analysis of in-depth interviews with officials involved in formal procedures following TWD. While the research presented here is early exploratory work and therefore largely descriptive, it provides the basis for future evaluations of institutional roles and responses to TWD and their implications for families.

Aims and methods

The aim of this study was to assess how adequately the safety investigation and prosecution processes following TWD met the needs of families. The research questions underpinning the study were as follows: (1) According to officials and representatives of organisations involved in the official response to TWD, how do existing safety and prosecution processes respond to the needs of the families of people killed at work? and (2) Which areas do they identify as weaknesses, how do they explain those weaknesses and what constraints do they encounter in overcoming those weaknesses?

Little is known about the nature of organisations' responses to surviving families during the investigation and prosecution processes following a TWD. For this reason, qualitative research methods were selected to obtain information about the nature of the responses (e.g. support, information and interactions) and their implications. Qualitative methods are valuable for conducting initial exploratory research into complex phenomena and for providing insights into the experiences and views of those with widely differing stakes and perspectives (Sofaer, 1999). Qualitative methods have also played a key role in applied policy research. They allow researchers to identify, examine and evaluate social and public policy issues by taking into consideration the viewpoints of those who are affected by a specific policy decision, or those thought to be a part of the problem (Walker cited in Ritchie and Spencer, 2002).

The research presented here reports the first phase of a larger study examining the consequences of TWD for families and the adequacy of institutional responses to their needs. The larger project aims to advance knowledge of how TWD and the institutional responses that follow affect families and provide guidance to improve policy interventions. The University of Sydney Human Research Ethics Committee approved the research protocol prior to the commencement of the study (Approval number 14981).

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Participants

The sample consisted of representatives of organisations and stakeholders involved in TWD in Australia. To ensure we collected optimal quality data that accounted for all aspects of the investigation and prosecution processes, representatives from the following groups were included in the sampling frame: (1) government prevention and compensation organisations, (2) employers and unions from the four industries that account for approximately 70% of all notified TWDs (road transport, construction, mining and agriculture, fishing and forestry) and (3) voluntary family support groups/services.

Interviews were sought with government agency representatives in five states but those in one (large) state declined to participate (representatives from all other types of organisations in this state agreed to participate). Those in Western Australia were not approached due to funding constraints. The four unions covering workers in road transport, construction, mining and agriculture – the Transport Workers Union (TWU), the construction and mining divisions of the Construction, Forestry, Mining and Energy Union (CFMEU) and the Australian Workers Union (AWU), which covers metalliferous mining and agriculture – were approached and all agreed to participate. Employers were approached in the four industry groups, and we obtained participants in all with the exception of mining. An interview was sought and obtained with an industry peak body (an avenue not pursued further because it became apparent peak bodies had little if any involvement in TWD). Finally, we sought interviews with several voluntary support groups and services that are generally composed of the families of deceased workers. In addition to mutual support, these bodies have advocated for investigation and prosecution processes that better meet the needs of families as well as promote more effective enforcement of work-safety legislation.

Participation by representatives from government prevention and compensation organisations extended across four jurisdictions (including both large and small states) and included a range of levels (management/policy positions, prosecutions, claims and field inspectors). For this reason, we believe findings from these organisations are relatively representative. However, as relatively few interviews were undertaken with employers, and they did not extend to all jurisdictions and industries, information from these participants may not be representative. It appears that the implications of responsibility and culpability associated with TWD for employers, particularly in road transport and mining, make discussion of the issue difficult. Similarly, separate and stringent protocols for conducting research with police in several jurisdictions prevented us from interviewing members of the police force except in one jurisdiction. However, as the role of police is largely to conduct an immediate inquiry to rule out any foul play (i.e. homicide), their views were not considered critical to the present focus on investigation and prosecution processes.

Social, cultural and institutional factors influence participants' perspectives on issues surrounding TWD, and the views and experiences of the families of deceased workers in this phase of the study are mediated through the accounts of others. However, sampling strategically across a range of organisations and stakeholders with extensive contextual and situated knowledge of the regulatory and judicial processes, but with divergent and

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Table 1. List of participants.

Sector	Representative
Government safety inspectorate (n = 11)	Senior managers, including chief inspectors, directors of policy, strategy, infrastructure, enforcement and investigations
	Senior policy, project and information officers
	Inspectors
Government compensation agency (n = 8)	Senior managers and directors, including regional managers
	Assistant directors of policy/planning and case or claims managers/coordinators (including claim agents)
Trade unions (n = 6)	State and district secretaries and presidents
	WHS officers and legal advisers
	Industry safety representatives
	Assistant secretary
Employers in construction, road transport and agriculture, fishing and forestry (n = 11)	Senior managers, CEOs, state manager and industry association director
	Safety managers, superintendents and project managers
	Site safety managers and industrial chaplains
Coroner's office (n = 4)	Coroners and senior managers coroners court and investigation units
	Coronial associates and police attached to coroner's office
Police (n = 1)	Officers in charge of crash investigations
Support and advocacy groups/ services (n = 7)	Directors and secretaries

often diametrically opposed perspectives, arguably made the sample broad enough to make meaningful comparisons in relation to our research questions.

Organisations were contacted by phone or email and provided with information about the aims of the study. Agreement was sought for their participation (or that of a nominated representative) in an interview. Follow-up requests were made to managers who had not returned phone calls or responded to emails at 2 and 4 weeks after the initial contact was made. All participants were provided with a Participant Information Statement and interview protocol prior to the interview date. Written consent was obtained prior to the interview. In total, interviews were conducted with 48 participants from organisations in five states (see Table 1).

Data collection

In accordance with the exploratory nature of this study, face-to-face, semi-structured interviews were conducted with participants by an experienced researcher. A semi-structured interview schedule was designed to obtain information regarding current

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organisational procedures and practices as well as to explore organisations' involvement with families during investigation and prosecution processes. Participants were invited to respond to a set of broad introductory questions which covered: (1) the organisation's role in TWD, (2) the nature of the support offered to partners and families, (3) the nature and timing of information provided, (4) their interactions with families and (5) the nature of the outcomes for spouse/partners and families. Specific probes to these responses facilitated further exploration of participants' responses and allowed for follow-up and clarification (Marshall and Rossman, 2010). Interviews lasted between 15 and 90 minutes and took place between August 2012 and January 2013. All interviews were audio-recorded, transcribed verbatim and de-identified.

Data analysis

A framework analysis based on the work of Ritchie et al. (2005) was used to facilitate systematic, transparent and rigorous analysis of the data. Framework analysis is a matrix-based analytic method which is used to classify and organise data according to key themes and concepts. To construct this framework, interviews were read and analysed separately by two members of the research team. This process allowed them to familiarise themselves with the data set and to identify and develop, by consensus, recurring themes and concepts. It enabled differences in interpretation or categorisation to be discussed and resolved collaboratively, helping to ensure reliability and validity (DeSantis and Ugarriza, 2000). Having constructed an initial index of categories and themes, interview data were labelled according to which part or parts of the index they applied. This analysis was done using QSR Internationals' NVivo™ software and was applied across the entire data set. Following this process, each main theme, and its associated subtopics were plotted on a separate thematic chart, and interview data from each respondent were summarised and added to the chart. Finally, to improve validity and reliability of the analysis, patterns of convergence across data sources were studied and synthesised to corroborate an overall interpretation of the data (Mays and Pope, 2000).

Results

The findings are organised under four broad themes that encapsulate organisations' views of problems encountered by families in the investigation and prosecution processes following a TWD. The themes are as follows: (1) Limited information for families: the keepers of information are constrained information providers; (2) Delayed information to families: drawn-out processes mean untimely information; (3) Lack of support for families: we are regulators and enforcers, not counsellors; and (4) Justice for families? Giving families a 'voice'.

Limited information for families: The keepers of information are constrained information providers

The centrality of information gathering to the investigation of TWD and the value of this knowledge to families of the deceased is one of the most pressing and contentious issues

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for the government safety inspectorate. In response to persistent criticism of the level of support offered to families over the course of the investigation and prosecution process, government safety inspectorates in several jurisdictions have sought to improve the level of formal procedural information provided to families. Some jurisdictions have established contact protocols for inspectors to follow. One respondent explained this process:

> One of the key roles of the manager and then the inspector who's managing the case is to keep that family informed right through this whole process so that there's no confusion or misunderstanding about the process. So that they are aware of what's happening. Maybe every couple of weeks they're contacted and advised about what's going on … We keep them informed of every process. Once the investigation is completed, the investigator and myself will go out to the family and explain the next step. (Government Safety Inspectorate 2)

Another inspectorate has appointed designated information or liaison officers to deal with fatality cases. Their role is to keep families informed of the progress of the investigation or prosecution process:

> [The Information Officer] works in conjunction with the investigator at the investigation stage in a workplace fatality. Then with the lawyer in the conduct of the prosecution, or the legal review process, to ensure that communications are occurring in a timely manner and that communications are obviously accurate and that the families are receiving the correct information. (Government Safety Inspectorate 7)

Notwithstanding efforts by inspectorates to improve communication with families, there are barriers regarding what information can be passed onto families and when. As one respondent told us, this may be due to insufficient knowledge:

> Part of the challenge when dealing with grieving families is they want to know a whole lot of detail about how their loved one passed away. We either at that stage don't know, or don't know with enough surety, to say. (Government Safety Inspectorate 2)

However, legal concerns relating to confidentiality of the prosecution process were the main reason given for withholding information, as the following responses illustrate:

> We are obviously constrained in the amount of information we can give a family about what is happening in the investigation. By that I mean evidence. Sometimes the family members may also be potential witnesses in our proceedings, so that gives us another complexity in terms of what we can discuss. (Government Safety Inspectorate 7)

> We can't go into the causes or whether legislation's been breached or anything like that. You've got to steer clear of the sub judice and stuff. But there is some stuff that you can say. (Government Safety Inspectorate 4)

One employer saw the appointment of designated liaison officers as a way to communicate with families the reason why certain information was withheld:

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> I think people are entitled to know what happened … How did my father die? How did my son die? … The causation stuff is terribly important. Unfortunately there's legal privilege around that and even the government's investigation; they don't want to tell anybody what they have found in their inquiries. So you have this issue of timing and [the question of] can you give general information to a family? My view is you can give very general information to a family to say how the law works, who are the parties, how a prosecution would be started, under what Act it would be run, what evidence is required to prove beyond reasonable doubt it's a criminal prosecution. Families are entitled to know the process. (Employer 10)

Withholding information from families raises, in turn, a second, more problematic issue. That is, how to manage the expectations of families with regard to the availability of information about the death of their loved one:

> You learn over time and through experience that that's an important expectation that needs to be managed … Sometimes some families want a detail that means a lot to them. It might just simply be one part of our investigation but I think we've found that being very clear at the start [and saying] that we can't discuss the evidence with [them] because it may impact adversely on the process, on the case … and I can obviously only speak for myself on this [but] I think [that] whilst there's some initial frustration with that position, I find that if it is reinforced, that the families will accept that. (Government Safety Inspectorate 7)

Yet this view, and whether giving general information to a family about how the investigation and prosecution processes worked was sufficient to meet their needs, was questioned by one union respondent:

> These families, they want to know how it can be that they say goodbye to someone in the morning and they don't come back in the afternoon and that they're killed at work. I think they get very frustrated by the process. That compounds the loss. (Union 4)

Also questioned was the issue of whether designated liaison officers were capable of providing the information that these families yearned for:

> They [the government safety inspectorate] did for a time have an individual who tried to support families. I don't know that that's necessarily been very successful or they've really had the right sort of people. I don't think even when they have had that service they've actually provided the sort of information that the families want to give them some comfort. (Union 4)

The withholding of information is important because the provision of information is considered crucial to helping families cope in the aftermath of a TWD:

> One of the frustrations is that they [families] may need that information to help them heal and move and gain traction with life again … [but] we can't give it to them if we're not told. It's all about people being protective of their liabilities or potential liabilities. The truth in these matters is quickly protected. (Union 5)

Unions frequently expressed their frustration at their inability to assist families to get information, even information relating to court proceedings:

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> I've heard [of] situations where people don't even realise prosecutions have gone to court … One of the things that I think the authorities don't get is, it's not just about the money or the fine, it's actually having a process that recognises something really bad has happened and [that] we are doing the best we possibly can to get some justice at the end of the day … So if they think that they're being fobbed off or not being given information which they feel that they're entitled to, it kind of is an indication, I think, to the families that we're not really taking your situation very seriously. (Union 4)

As this point makes clear, while the provision of ongoing and accurate information to families is important, it is also imperative that this information be delivered in a timely manner. Delays in the investigation and prosecution processes, however, may complicate this process.

Delayed information: Drawn-out processes mean untimely information

Many of the safety regulators interviewed acknowledged the extended time taken for investigations to reach court, and some jurisdictions were actively working towards reducing this period from 2 years to 9 months. However, concern was expressed that, notwithstanding such efforts, lodging of appeals against conviction or technical appeals was becoming more common, drawing out the processes even further. Prolonged court proceedings were seen to affect families both directly and indirectly, by making it harder for government safety inspectorates to communicate with families in a supportive way:

> The single biggest point of frustration of all parties in this is the time that it takes. While an explanation can be provided at the front end that this is going to be a lengthy process, no one fully appreciates just how long that process is. So it can be up to two years before the investigation actually gets to court and then it can be, subject to the courts, another fairly long process. What adds to that and what makes it worse is if there are appeals against legal proceedings along the way. That has the potential to blow the timeframe out even further. People become incredibly frustrated about the whole process and that is really one of the most difficult issues to explain and to support people through … We're finding now that with the increase in penalties there is greater focus by lawyers, and companies are more careful about what they admit to and how they are going to proceed with cases. (Government Safety Inspectorate 2)

The length of time taken to conclude investigation and prosecution processes may also impede families' ability to grieve and begin to adapt to a life without their loved one. As a representative from a peak industry organisation explained:

> Unfortunately it's taking 18 months to get to court. By that time, the family's actually trying to move on. So there's again, another huge disconnect. So just when you've started to get the insurances, the payout on the life cover might have come through, you're moving on with your life, you then get told we're going to court now and they have to relive the horror of the incident … So there is a big issue with timing. (Employer 10)

In other situations, important information only emerges at the conclusion of the investigation. For example, one interviewee from a family support group recounted the story

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of a woman who was misled about the causes of her husband's death and only became aware of the actual causes 3 years later:

> [The government safety inspectorate] has a policy and a process that they do not allow any information to be given to the family by the inspectors or by the investigators. So up to the time of the coronial inquest which can be two or three years down the track, families are fed very little information … One woman was shocked to find out the actual nature of her husband's death because, for three years, she had thought he'd died a different way. (Support Group/Services 1)

These findings suggest inadequate and untimely provision of information to families has the potential to cause additional and significant harm beyond that already experienced as a result of the death itself. This evidence calls into question the capacity of government safety inspectorates to support families and highlights the challenges presented.

Lack of support for families: We are regulators and enforcers not counsellors

The role of the safety inspectorate was a point of contention between employer organisations, unions and family support groups and services. While most interviewees believed the regulator's approach should be supportive of families, there was disagreement about how much support could be provided without compromising its primary role of enforcing safety legislation. An employer association representative commented:

> I don't think the role of the regulator is to be counsellor. The regulator is to be the enforcer … they have no role [to offer counselling support], in my view. It's not the department's fault that someone's been killed … (Employer 10)

While the need to support families was not dismissed by representatives of government safety inspectorates, it was seen to require expertise that was challenging at an organisational and a personal level:

> For the regulator, we have the dual responsibilities of investigating and gathering evidence as to the causation, as well as endeavouring to provide some degree of support and assistance for family members … [These are] areas that require a level of expertise that is not often readily available to us. So it's difficult for agencies to, I think, manage these as effectively as we would like … We're still learning, if I can use that expression, about how to manage and deal with this in an appropriate way, given the mix of issues that we have. (Government Safety Inspectorate 2)

> From feedback to relatives and the like it's not something that I perceive we do well at all. I'm not sure that our inspectors have the necessary counselling skills to undertake that sort of role. There aren't standard procedures to do that … We're not geared well to respond to the family members who are left behind. (Government Safety Inspectorate 4)

Investigators also faced specific challenges when trying to support families. As one respondent explained, these challenges were greater in cases where the traditional family unit did not exist:

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> We have some de facto relationships; we have marriage split-ups. So we've got different family members in different groups and we've got to facilitate all those wishes of everybody that's connected with that death … There are mixed families and there are different types of relationships and there are different types of emotions running through people at this particular time. Those emotions can often extend to not wanting other people in the family to know about a particular incident or event … It's complicated where there are tensions between the de facto and other family members and so on. So it's not a straight-forward process for the investigator to connect with family members in the traditional sense, because in some cases those traditional family relationships don't exist. (Government Safety Inspectorate 2)

These difficulties and challenges highlight some of the professional, institutional and practical barriers facing government safety inspectorates when supporting families during the investigation and prosecution processes.

Justice for families? Giving families a 'voice'

The final theme concerns the extent to which families experience a sense of justice from the prosecution process when one is undertaken. The prosecution process offers families the opportunity to present a Victim Impact Statement (VIS) that documents the personal impact of the death on them. This document can be tabled as a written submission or tendered as evidence and read out in court. The VIS is seen by the formal parties involved in the prosecution as giving families a 'voice':

> It can be quite therapeutic for them. It's their chance to have a voice in the prosecution. I think, for some families, they feel like they're just in the background and don't have a say. It was their family member and they sort of don't really get a chance to express what this means to them. (Government Safety Inspectorate 7)

Those working closely with families of deceased workers questioned the value of a VIS, especially its capacity to provide a definitive account of trauma, grief and loss and other consequences. It is often very difficult for families to quantify and articulate the full range of social, physical, financial and emotional effects of the death. Furthermore, because the document can be considered by the judge or magistrate during sentencing, its use is predominantly adversarial and, therefore, overlooks the needs of families (Brookes, 2009). This issue, and the penalties imposed, was raised by a senior executive from a government safety inspectorate who advised families on what to expect from the prosecution process:

> When I talk to people, I always say, it's not about the penalty; it's about just getting a conviction and then trying to move on. If they worry about the actual penalty from the court, it's only going to frustrate them more. It's about getting that conviction and getting the employer or whatever to, at the end, stand up and say, 'look, I'm sorry'. What most families are looking for is an employer to say that they're sorry about this accident. (Government Safety Inspectorate 2)

Another important outcome of the investigation and prosecution processes was the potential for prevention – the capacity to learn from fatalities and make changes to occupational practice and systems to ensure that similar incidents did not occur in the future.

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For families, knowing that the death of their loved one was not in vain and measures would be implemented to reduce the risk of other workers suffering a similar fate was a powerful force for action. Several union representatives noted that many spouses had become tireless advocates for improved safety and associated social changes:

> There's some families and their partners who'll continue to work with us over time on various campaigns, trying to get the message to politicians … [They] get stuck in with us and try and make change. (Union 1)

The ongoing, tireless commitment of some family members to improving WHS legislation and practice raises additional questions about the capacity of investigation and prosecution processes to deliver justice to families of deceased workers.

Discussion and conclusion

This study examined the views of representatives of institutions and other stakeholder organisations about the problems experienced by families during the safety investigation and prosecution processes following a TWD. The themes drawn from in-depth interviews reflect problems of reconciling competing demands between institutions' roles and responsibilities to the legal system and their implied moral responsibility to the victims of TWD, including surviving families. Findings suggest that despite measures by authorities to reform processes, the challenges for families remain significant.

Families' needs and experiences were widely acknowledged by the participants; all were aware that the families of workers who died generally had a keen interest in the investigation and prosecution processes. They were particularly aware that families wanted timely information about the circumstances of the death and to be kept informed about the progress of the investigation and subsequent court proceedings, including the option of making a VIS. Securing justice and ensuring that similar events did not recur were also issues that representatives from government safety inspectorates, unions and other institutions reported. Finally, it was recognised that within the constraints of a rigorous investigation, families wanted these matters resolved as quickly as possible.

Respondents also acknowledged the frustration and suffering caused by delays in the process and limited information. They described measures undertaken to address these issues, including protocols issued to inspectors, the appointment of liaison officers and the option for VIS in court proceedings. Nevertheless, some measures had proved ineffective, and achieving all the intended outcomes simultaneously was difficult. Unions, support groups and services were critical of the degree of contact, delays and outcomes in terms of prosecution, conviction and penalties. Inspectorates felt constrained regarding the amount of information they could release while an investigation was still in progress without jeopardising a prosecution. Inspectorates also pointed to delays arising from the obstructive role played by law firms in some cases – a point also raised by other parties, including unions, support groups and even one employer.

The investigation and prosecution processes following a TWD are influenced by various interest groups, each with its own set of priorities. Families, even with the assistance of unions and support groups, are relatively isolated and not the most influential parties.

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Investigations and prosecutions by an inspectorate are legal processes, shaped by legal rules that pursue broad social objectives rather than the immediate needs of the family involved. However, it is neither unique nor contrary to wider social objectives for families as victims of a corporate crime to seek justice for TWD (Almond, 2008). As this study has clearly illustrated, the families face obstacles that have the potential to place their well-being at risk (Herman, 2003). In fact, many families describe the legal process as 'yet another painful event in an already traumatic bereavement' (Biddle, 2003: 1041). Given the frequency with which families seek justice for TWD, a key question is why the process continues to give them little recognition. Some suggest that surviving families are excluded from significant consideration because they are not viewed as real victims of crime (Tombs and Williams, 2008; Whyte, 2007) – a notion that stems from corporate offences being subject to health and safety regulation by state agencies rather than criminal policing (Hawkins, 2002). This lack of recognition results in families experiencing what is termed 'double victimisation' – once from the offence and then again from the official response to it (Shover et al., 1994; Snell and Tombs, 2011).

The problems reported in this study parallel those reported in the relatively limited literature on sudden death investigations and therapeutic jurisprudence, in particular concerning the coronial investigation (Biddle, 2003; Freckelton, 2007). In describing the therapeutic jurisprudence perspective, Wexler (1997) states,

> The law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures, and the roles of legal actors (such as lawyers, judges, and often therapists) constitute social forces that, like it or not, often produce therapeutic or antitherapeutic consequences. (p. 233)

What therapeutic jurisprudence has emphasised for families engaging in the coronial investigations are the counter-therapeutic consequences of limited information and low-level participation by families, leading to exclusion and alienation (Tyler, 1992), delays in convening and completing investigations that impact families' health (Freckelton, 2007) and poorly conducted inquests that further traumatise or disrupt families' ability to grieve (Biddle, 2003). The parallels between these observations and our findings are striking.

Just as therapeutic jurisprudence can emphasise the negative implications of families' involvement in legal processes, it can also identify requirements for positive, therapeutic outcomes (Freckelton, 2007). These findings suggest that authorities should take further measures to improve information flow to families, including explaining the investigation and prosecution process. Regulatory agencies should be resourced to prosecute all cases in which death results from serious breaches of safety legislation. Families should also be given support to prepare VIS and be encouraged to express all issues they believe are relevant. Providing more recognition and assistance to support groups would also be beneficial. Finally, worker health and safety representatives could be empowered and trained to obtain and convey information about the circumstances of a fatality to families.

To our knowledge, this study is the first systematic exploration of this significant topic and the findings require testing, evaluation and extension. Although this study concerned only the perspectives of organisations involved in the process, a later stage

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involves surveying family members about regulatory responses to TWD. Further research on how the experiences of Australian families compare to those in other countries is also warranted. Such research will progressively enhance understanding of institutional responses to TWD and implications for families.

From a labour-relations perspective, this article highlights how the physical, psychosocial, organisational and regulatory context of work affect not only workers, but their families and wider community – and that these effects can carry over long after a worker has died. The broader consequences of the adverse health and safety effects of work warrant greater recognition not only within the field of WHS but also in industrial relations.

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1. These include (1) police investigation, (2) workers' compensation claim, (3) government safety investigation, (4) prosecution, (5) common law claim and (6) coronial investigation.

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