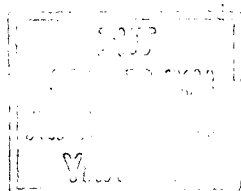


A Study of the Inquest Records of Tasmania

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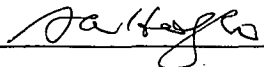
Submitted in part fulfilment of requirements for qualifying for M.A. (History).

July, 1996.



Box 112

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university and to the best of my knowledge it contains no copy or paraphrase of material already published or written by another person except where due reference is made.

Signed 

Abstract.

The inquest records of Tasmania dating from 1828 are stark revelations of human tragedy. From them it is possible to gain knowledge of the legal processes operating, vivid details of the life and times, and insight into the way in which sudden and accidental deaths were viewed by coroners and others seeking to make life in Tasmania safer for its citizens. This study samples these records, setting them in historical context and highlighting what I consider is the interesting data revealed.

Acknowledgments.

I should like to thank Professor Michael Roe for patience and good humour in his attempts to rejuvenate an old student, Dr Stefan Petrov for an introduction to the Faculty of Law Library, Gillian Winter for helpful suggestions concerning Lachlan Park, Dr Peter McCartney for a pleasant hour at the Hyperbaric unit R.H.H. and my daughter, Jane, for unflagging encouragement and a listening ear.

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Introduction.

The Supreme Court records of inquests in Tasmania as preserved in the State Archives commenced in 1828. They are available on micro-film until mid 1926 and from then until the twenty-five year withholding period are maintained in original form at the Berridale Records Department. Initially I investigated the first seven years recorded (1828-1835) with the idea of sampling similar seven year periods at thirty year intervals. Numbers precluded this approach and I was constrained to reduce the study to single year periods for the later samples.

My aims were to find what bureaucratic changes may have taken place in the interim periods, to catch glimpses of the society of the times sampled and to gauge what influences may have been exerted on subsequent happenings by the incidence of sudden and accidental death.

The records for the period 1828-35 are demonstrably incomplete and details gleaned from Statistics of Tasmania for my other samples show far from perfect correlation. It is obvious that in many cases coroners' reports did not find their way to the central records, and paradoxically, some which did made no impact on official statistics. However the numbers of sudden and accidental deaths from both sources do follow the same trends and I feel that, despite the incomplete nature of the records and the fact that my samples were comparatively small and widely spaced, my purposes were largely achieved. I have included tabulated details with my commentary on each sample and a summation for comparison at the conclusion.

The investigation revealed gradual simplification of procedures and an interesting anomaly regarding Lachlan Park Hospital records. The changes in Tasmanian society from the stark realism of the penal colony, through economic depression, gradual mechanisation of industry and transport, to the post World War II era, with its growing social consciousness, are mirrored in a very practical way in the state's inquest records.

Statistics and generalisations concerning the facts revealed in no way detract from the pathos of the situations described. The intimate details of human tragedy, particularly in the case of children's deaths, can not fail to deeply affect any reader.

Chapter 1

The British Colonial System and the Situation in the Australian Colonies from 1788.

The Legal system of the Australian Colonies, including coronial investigation, was based on the system which had grown up in Britain over the centuries preceding settlement.

The office of Coroner can be traced back at least to 1194 and had once encompassed a range of powers. "By the eighteenth century the function of the English coroner was to hold inquests into unexplained deaths and determine the ownership of treasure trove."¹ Unexplained deaths included felonious, sudden or accidental deaths and those occurring in prisons. The body of the deceased had to be on view, making it imperative for inquests to be held as soon as possible after death.

The coroner was assisted by twelve jurors who were usually tradesmen qualifying by property ownership. In 1835 qualifications included possessing a home worth not less than £30, or an income of £10 per annum or upwards. In consequence, most jurors were literate and it is rare to see a 'mark' in the records. Professionals and gentlemen were generally exempt from jury duty². Medical witness was common after 1760 and the quality of the investigations obviously improved with the addition of medical expertise. In 1836 a law was passed to pay medical witnesses and finance post mortems³. Where suspicious circumstances were found, the coroner, in conjunction with the jury, had authority to bind suspects over for trial.

The London Coronial Rolls between 1761 and 1879 have been studied by M. & G Greenwald. They give detailed accounts of official verdicts, depositions of witnesses, medical expertise (often including autopsy reports) and jury lists. The deaths can be divided into three main types:

1. Those involving illness or natural causes. These resulted in sudden or unexpected deaths and are generally recorded as due to apoplexy as a 'Visitation of God'. Specified diseases included consumption, heart disease and typhus.⁴

2. Accidental cases. The accidents covered traffic and occupational disasters, burnings and drownings and were recorded as "casual, accidental and by misfortune." Accidental deaths were viewed very seriously as they were costly and largely preventable. Juries were very displeased by negligence which often resulted in fines⁵.
3. Felonious Deaths. Suicides provided the largest group of felonious deaths. Until 1823 the law necessitated the burial of a suicide victim beneath a highway and forfeiture of all the felon's goods and chattels to the crown. To avoid this the verdict in nearly all cases was "lunatic suicide" while the victim was "deranged" or of "unsound mind". Where suicide could not be proven verdicts of "found dead" were adopted. Homicide was comparatively rare and infanticide seemed a grey area indicating a lenient attitude on the part of sympathetic juries.

Examples of interesting data from the Greenwald study include such facts as male deaths outnumbered female by 2:1, the most common accidents involved falls, traffic accidents and drownings, and occupational accidents increased dramatically with the introduction of steam power and the factory system. Women and children were most affected by accidents involving fire.

Greenwald says, "The Westminster inquest records afford a unique source of information about one urban area of England during the rapid upheaval experienced during the nineteenth century The depositions provide colour as well as valuable data concerning a wide range of social, medical and legal issues."⁶

When the Australian colonies were established governors from Phillip onwards had authority to appoint coroners. This was in contrast with the British system, where coroners were elected or appointed by local authorities, but understandable in view of the penal nature of the settlements. In the earliest years

coronial function seemed to have devolved upon the magistrates as one of their numerous duties. In 1796 it was recorded in N.S.W. that, "there being no regular coroner's inquest established in this settlement, we consider it our indispensable duty to examine the body."⁷

The early magistrates were often colourful figures and Governor Macquarie raised local ire by appointing a few emancipists such as Simeon Lord and William Redfern to this official position⁸. The varied functions are illustrated by the appointment of A.W. Humphrey in 1818 in Hobart Town to "carry out the functions of Superintendent of Police as well as coroner and chief magistrate of the town."⁹ Juries of "twelve good and lawful men were a regular and accepted feature of early coronial enquiries. They elected a foreman and their findings were engrossed on parchment and obviously signed and sealed with considerable care"¹⁰.

Changes to British law affecting coronial inquiries were quickly enacted in the colonies. The British law of 1836 regarding provision for and payment of medical officers was enacted for Van Diemen's Land by Governor Franklin in 1837¹¹. The British system of providing juries was changed slightly for the colonial situation. In 1840 Franklin authorised the summons of twelve men of the age of twenty-one years and not exceeding sixty, being free and resident within the distance of one mile from the place the inquest was to be held¹². There was no mention of property qualification nor of freedom by servitude as a bar or otherwise for jury service.

During the latter part of the nineteenth century Australian coronial juries fell into discard even though the statutory provisions for them may have been retained¹³. The coroners were also vested with the authority to investigate fires including bush fires¹⁴.

- ¹. A.C. Castles, An Australian Legal History, (Law Book Coy. Ltd. 1982), p. 69.
- ². M & G Greenwald, "Coroners' Inquests - A Source of Vital Statistics, Westminster 1761-1866," Journal of Legal Medicine, Vol. 4, No. 1, 1983, p. 55.
- ³. *ibid.*, p. 58.
- ⁴. *ibid.*, p. 63.
- ⁵. *ibid.*, p. 67.
- ⁶. *ibid.*, p. 54.
- ⁷. Judge Advocates' Reports of Coroners' Inquests, 1796 - 1820. State archives of N.S.W. as recorded by Castles p. 54.
- ⁸. Castles, Australian Legal History, p. 70.
- ⁹. Hobart Town Gazette, 24 Jan. 1818.
- ¹⁰. Castles, *op. cit.*, p. 84.
- ¹¹. The Public General Acts of Tasmania (reprint) 1837-1937, Vol. 7., p. 1.
- ¹². *ibid.*, p. 226.
- ¹³. Castles, *op. cit.*, p. 374.
- ¹⁴. Castles, *op. cit.*, p. 375.

Chapter 2

Coronial Enquiries in Van Diemen's Land

1804-28

The first inquest recorded in Van Dieman's Land was held in May 1804 just three months after the settlement at Sullivan's Cove. A Frenchman named Nicholas Pirolle had died and Lieut. Governor Collins ordered Dr. Bowden to hold an inquest, as a rumor had spread that the man had been poisoned. The autopsy, conducted in Collin's presence, revealed water in the lungs, and drowning was the suggested verdict¹.

On 29 June 1804, the magistrates who had previously acted at the Port Phillip settlement were appointed for Van Diemen's Land. They were Rev. Robert Knopwood, Lieut. William Sladden R.N. and George P. Harris Esq. who acted as coroners as part of their magisterial duties².

Over the next few years accidental deaths were included in the official records, but there is no mention of inquests into these deaths. James Price, a convict mariner, was drowned on 17 February 1805, and Catherine Fox, a free female infant, died from burns on 18 June, 1805. We know no further details³.

Knopwood's diary reveals interesting details of deaths and coronial enquiries. It would appear he recorded only those inquests at which he presided or ones of particular notoriety. In 1808, he stated that Mr. Hussey, a New Norfolk settler, hung himself on 17 May, an inquest was held on 18 May and the man was buried at Sandy Bay on 19 May. Knopwood did not record the verdict or mention burial in unconsecrated ground⁴.

During 1815 the bushranging threat in Van Diemen's Land reached a peak. Historical Records of Australia lists depositions regarding outrages, captures and escapes at the time of the declaration of martial law in April. There is also a detailed account of the inquest into the death of Charles Carlisle. The verdict was recorded as "murder by James Whitehead, Peter Septon, Michael Howe, Richard Collyer, Richard McGwyre, Hugh Burn and Peter Geary, together with another man whose name is at present unknown and a Black Woman, native of this Island." Depositions included those from the surgeon, settler, prisoner and ticket-of-leave witnesses to the episode, and provide details not only of the actions involved, but of the fear and disruption caused by bush ranger attacks in rural

areas such as New Norfolk⁵. Knopwood also recorded this inquest on 25 April 1815⁶.

The incomplete nature of coronial records of this early period is best illustrated by study of the incidence of drowning accidents. Knopwood's diary mentions a total of sixty-one deaths from drowning from 1806-1837 but details only one inquest into a drowning incident - that of Captain Laughton who died getting in the anchor of the 'Hope' which was lost near the Iron Pott Island in May 1827⁷.

Marjorie Tipping in Convicts Unbound mentions that there are at least nine known drownings among the 'Calcutta' convicts. As well as individual drowning accidents there were horrific cases of multiple deaths arising from ferry boat activity on the Derwent. "Boat men, notorious for their insobriety and negligence, took many chances resulting in frequent accidents and many drownings."⁸ Knopwood reported in September 1817 that a boat coming from Kangaroo Bay with a bullock aboard was upset and three were drowned⁹. When one of James Austin's overloaded ferries capsised on the Derwent in 1818 twelve persons perished¹⁰. In September 1819 with the Derwent swollen and gale forces from the Antarctic causing boistrous stormy weather, three of Urias Allender's men drowned on a trip from Hobart Town to Clarence Plains¹¹.

The original settlements in Van Diemen's Land were sited on estuaries and exploration and subsequent settlements tended along river valleys in ribbon development. Water-born transport for population and produce was easy in the time before roads were constructed. Boatmen and passengers were obviously open to the unpredictable weather conditions particularly on open stretches such as the Derwent from Hobart Town to the eastern shore. The fact that few Englishmen had been taught to swim and that the convict population came from country areas, and big industrial cities rather than coastal areas meant they had few water skills.

Though surviving inquest records from this period are few in number it is clear from contemporary records that there were many accidental deaths from drowning and bushranger and aboriginal attacks.

¹. Surgeon's Report. H.R.A. Series III, Vol 1. p. 269. 29 May, 1804.

². Ibid. p. 272.

³. Ibid. p. 342.

⁴. Diary of the Reverend Robert Knopwood, ed. Mary Nichols, T.H.R.A., 1977. p. 158.

⁵. H.R.A. Series III, Vol. II, p. 94.

⁶. Knopwood, op. cit., p. 201.

⁷. Ibid. p. 509.

⁸. M Tipping, Convicts Unbound, (Penguin Australia, 1988.) p. 213.

⁹. Knopwood, op. cit., p. 187.

¹⁰. Hobart Town Gazette 28 Feb. 1818.

¹¹. Knopwood, op. cit., p. 314.

Chapter 3.

Coronial Enquiries in Van Diemen's Land

1828 - 1835.

Coronial Enquiries in Van Diemen's Land 1828 - 1835.

Personal Inquests

Male	49
Female	6
Child	3
Total	58

A. Natural Causes: (Termed Visitations of God) 21Diseases Mentioned

Apoplexy
Internal Disease
Ruptured Veins
Epilepsy
Suffocation
Found Dead

B. Accidental Deaths 27

Drowning	15
Traffic	5
Occupational	3
Burning	1
Others	3

C. Felonious Deaths 10

Murder	7
Gun	3
Spears	2
Pickaxe	1
Burning	1
Suicide (Lunatic)	3
Gun	1
Razor	1
Hanging	1

TOTAL 58

D. Other Categories

Prison Deaths	3
Alcohol Influenced	9
Firearms Involved	5

For the period 1828 - 1835 only fifty-eight inquests are detailed in the Supreme Court records, obviously an incomplete collection. They do not appear in chronological order and some are very difficult to decipher. The official documents recorded dates and places of the inquests, names of coroners and twelve jurors including their foreman, a short description of the incident, in some cases signed depositions of witnesses and the final verdict.

From these facts we learn much about the personnel involved and the life of the era. The coroners were men of importance in the communities represented. Thomas Anstey appears as coroner for the midlands and Charles O'Hara Booth at Port Arthur. The inquests were held in local pubs in Hobart Town and Launceston and in inns and private homes in country areas. At this stage many of the jurors and witnesses made their 'marks'. Christian and surnames of the victims are recorded but in few cases is there included any additional information such as age or whether the person was bond or free.

The gender imbalance in early Van Diemen's Land is often mentioned as a problem for society in general and the authorities in particular. In 1835 there were 3.4 men to each woman in the colony and by 1835 the ratio had dropped to 2.4:1. These figures are clearly reflected in the coronial records where of a total of fifty-eight investigations only seven involved women. The Greenwald study with its finding of 2:1 for accidental deaths would have presupposed nine female deaths in a more balanced sample for that particular category alone.

Subjects of those inquiries receiving a 'visitation of God' verdict suffered from a variety of diseases described in terms far from medically precise. There is some mention of epilepsy and apoplexy but it is clear that without marks of violence juries were content with 'natural causes'.

Over half the accidental deaths resulted from drowning and the victims were said to have 'suffocated and drowned.' There were some bathing incidents but most of these accidents occurred when boats overturned in the Derwent and North and South Esk Rivers. Thomas Simmons died when the cutter 'Dolphin'

sank in the Tamar¹ and Owen Williams when he fell from a plank placed from the wharf to a schooner in the North Esk. He was carrying potatoes at the time and was rather tipsy. His body was grappled with fish hooks². As in the earlier period the colony's water ways were a major hazard.

Early forms of the traffic accident appear in incidents involving pedestrians and horse and bullock - drawn vehicles. William Mellish died when he negligently drove a jig which collided with a bullock cart³ and there were numerous cases when men were killed by the 'wheel of a cart.'

Occupational accidents included a fall in a gravel pit resulting in the death of Patrick Mullins "prisoner in the gravel pits,"⁴ and some involving shipping in the harbour at Hobart Town. George Cooper died when he fell from the fore topsail yard of the ship 'Relia'⁵ and Charles Hill when he fell down the hatchway of the 'Lady Harewood'⁶.

Felonious deaths were recorded in greater detail than others with numerous depositions from witnesses. The first inquest in The Supreme Court Records details an incident following a burglary at the New Inn, Jericho, when Malcolm Logan was wilfully murdered by Henry Williamson. The depositions included a confession by Williamson who was committed for trial in Hobart Town⁷.

Two deaths where the victims were 'feloniously killed and murdered' by natives were subject to enquiry. In September 1829 Emma Coffin died from a mortal wound to the breast inflicted by native spears⁸. The Colonial Times gave a detailed account of this attack on the Coffin farm near Sorell. Emma's child was harassed and the hut plundered of blankets, flour, tea, sugar and clothing. "This daring instance of murder and robbery by aboriginal blacks shows how daring these wretches have become."⁹ It is interesting to ponder on this case, as Plomley records a further attack on Thomas Coffin's property near Sorell during which the owner was wounded with a spear and the house again plundered, on 16 October 1830¹⁰. Was it a particularly vulnerable or well-stocked establishment, or was there a personal vendetta involved?

The other incident involving the aborigines occurred in October 1929, when John Browne was transfixed in the chest with spears and waddies on the farm of his master, George Stockell, near Brown Mountain, on the White Kangaroo River¹¹. It is easy to picture the horrific fate of this lonely stock keeper.

Plomley actually details incidents involving the deaths of eighty-two persons, landowners, servants and children, during the period 1828-31, covering the height of the Black War¹². The fact that only two inquest documents survive is clear proof of the incomplete nature of the records at this time.

An interesting inquest covered the death of Joseph Shuttleworth, a prisoner of the crown at Port Arthur in December 1835. Joseph was working on the foundations for the church, using a wheelbarrow to move overburden when he was attacked with a pointed instrument 'to wit a pick axe' and died from wounds inflicted to the head by William Riley. The inquest was held at Port Arthur, and the presiding coroner was Charles O'Hara Booth, commandant of the settlement. There were numerous depositions from witnesses and even a full account of Booth's questioning of those witnesses. Shuttleworth was found to have been wilfully murdered, and Riley committed for trial¹³. Riley, who had arrived in Van Diemen's Land in 1820 on the 'Countess of Harcourt', had originally been sentenced to transportation for seven years. He was found guilty and executed on 11 January 1836. The Colonial Times reported, "William Riley yesterday morning underwent the awful sentence of the law. This man was perhaps one of the most notorious villains that ever was transported to this colony. His police character is as black as black can be; he has been tried on capital charges three times in the colony and as to minor offences they are most numerous."¹⁴ Surely one of Arthur's incorrigibles.

The inquest records 1828-35 cover only seven murders. Return 32 of Statistics of Tasmania 1804-54 shows there were twenty-eight executions for murder during this time, a further example of the piece-meal nature of the records surviving¹⁵.

In nine cases the records mention the significance of alcohol on the accidental deaths described. John Smith, an assigned servant, rode his horse into a tree at Quamby when in a state of intoxication¹⁶ and James Shaw, a constable at Launceston who had been chasing bushrangers unsuccessfully and often drank to excess, whilst "lunatic and distracted," shot himself¹⁷.

The authorities were obviously concerned about levels of drunkenness in the colony. Return 18** of the Statistical records for the period elaborates on the "cause of death of 136 persons whose deaths were occasioned directly or indirectly by drunkenness." Males numbered 110 of the 136 and the main causes were drowning, apoplexy, excessive drinking and suicide¹⁸. Paradoxically, Return no. 22 records publicans' licenses authorised. For the year 1834, the county of Buckingham boasted 182 licensed premises and Cornwall 153, a total of 335 for a population of 37,688 persons - one for every 112 persons in the colony¹⁹. Arthur's efforts to combat immorality based on excessive drinking seemed doomed to failure in the face of the need for revenue gained from the sale of spirits.

Because ages appear rarely in the inquests, it is impossible to be precise as to the number of children involved in the study. Some deduction has isolated four cases - a fifteen year old girl died of epilepsy²⁰, a child died of suffocation due to being overlaid in bed²¹, James Burn, aged eighteen months, accidentally drowned in a tan pit²², and Silas Floranne drowned at Mount Pleasant on the Coal River after making a sort of 'raft or boat'²³. Disease, occupational hazards and the adventurous nature of children obviously played their part, then as now.

The investigation of prison deaths was mandatory. Two are recorded from 1828-35. William Payne, a prisoner in the gaol at Campbell Town, died by "Visitation by God", no details given²⁴. James Pyke, a prisoner of the crown, died at Launceston by "Visitation of God" due to sickness. The depositions raised some question as to Pyke's mistreatment while in a road gang, and gave graphic details of the crowded, unsanitary conditions in the holding cells. The coroner and jury were obviously unhappy over the incident, and noted formally that they

regretted the victim had not received medical attention sooner. One is left with the distinct feeling that a cover-up was being accepted²⁵.

The inquest records of Van Diemen's land between 1828-35, the latter part of Arthur's governorship, reflect small isolated settlements at Hobart Town, Launceston, the midlands and the Coal River Valley. The predominantly male population endured harsh living conditions, raids from aborigines and bush rangers, and was subject to accidents and violence often resulting from drunkenness. It was a basic penal colony.

- ¹. S.C. 195, No. 33.
- ². S.C. 195, No. 52.
- ³. S.C. 195, No. 31.
- ⁴. S.C. 195, No. 23.
- ⁵. S.C. 195, No. 24.
- ⁶. S.C. 195, No. 25.
- ⁷. S.C. 195, No. 1.
- ⁸. S.C. 195, No. 3.
- ⁹. Colonial Times, 25 Sept. 1829.
- ¹⁰. N.J.P. Plomley, The Aboriginal Settler Clash in Van Diemen's Land 1803 - 1831, (Victoria Museum and Art Gallery Occasional Paper, No. 6. Launceston, Tas., 1992.) p. 94.
- ¹¹. S.C. 195, No. 4.
- ¹². Plomley, op. cit., p. 68-99.
- ¹³. S.C. 195, No. 56.
- ¹⁴. Colonial Times, 21 Jan. 1836.
- ¹⁵. Statistics of Tasmania 1804 - 54, Return 32.
- ¹⁶. S.C. 195, No. 20.
- ¹⁷. S.C. 195, No. 31.
- ¹⁸. Statistics of Tasmania 1804 - 54, Return 18**.
- ¹⁹. Ibid., Return. 22.
- ²⁰. S.C. 195, No. 48.
- ²¹. S.C. 195, No. 44.
- ²². S.C. 195, No. 27.
- ²³. S.C. 195, No. 57.
- ²⁴. S.C. 195, No. 43.
- ²⁵. S.C. 195, No. 12.

Chapter 4

Coronial Enquiries in Tasmania

1858.

Coronial Enquiries in Tasmania 1858.

Personal Inquests

Male	196
Female	38
Child	31
Total	265

A. Natural Causes: 129Diseases Included

Heart
Lung
Apoplexy

B. Accidental Deaths 105

Drowning	45
Traffic	29
Occupational	13
Burning	18

C. Felonious Deaths 25

Murder	13
Manslaughter	1
Suicide (Lunatic)	11
Razor	3
Poison	4
Hanging	3
Drowning	1

TOTAL 265

D. Other Categories

Prison Deaths	4
Mental Diseases Hospital	1
Fire Investigations	3
Firearms Involved	2
Alcohol Affected	11

The most outstanding feature of the records for 1858 is the multiplicity of place names recorded, a direct reflection of the spread of settlement in the colony in the intervening years. In 1835, there were two counties, Buckingham and Cornwall. George Frankland's map of Van Diemen's Land of 1838 shows the island divided into eleven counties, but actual settlement spread very gradually. Following the loss of population to Victoria during the Gold Rush of the early 50's, the newly responsible Tasmanian government sought immigrants by liberalising land laws and, "by 1858, small-holding settlement had spread to the wet Sclerophyll forest clothing the basalt areas of the north-west and north-east, as well as the Huon, Channel and Derwent areas of the south."¹ The 1858 inquest records detail enquiries in all eleven counties and mention such remote areas as Torquay, Forth, Port Sorell, Hospital Bay, Port Esperance and Schouten Island.

Again, we see well-known names appearing on the coroners' list - George Meredith in Glamorgan, J. F. Sharland in Cumberland and William Gunn in Cornwall. Juries had decreased in number from twelve to seven men, and there is a marked decline in the number of "marks" recorded for signatures at inquests in Hobart and Launceston. Literacy was not as universal in the more remote areas. At this stage, more ages are noted, and there is sometimes mention of such personal details as "free by servitude", again more evident in country areas such as Devon. Clearly the taint of convict background was both maintained by officialdom and felt more strongly by emancipists there, than in the cities.

Inquests were still held in pubs, though some police offices and hospitals as well as private homes are mentioned. Twenty different pubs occur in the Launceston records, and eighteen in Hobart Town, their names often reflecting their position and clientele - Cascade Inn, Joiners' Arms, Ferry House Tavern and Steam Packet Hotel.

In Hobart Town, twenty-five of the seventy-eight inquests recorded were held at the Gordon Castle, whose proprietor was William Chatley. The Gordon Castle, on the corner of Argyle and Liverpool Streets, was established as early as 1835 with its licensee James Carmichael. By 1837 it

was referred to as the Gordon Castle Inn and Theatre occupied by William Chatley and from all accounts was 'a hot shop'! It was later called the Hit and Miss and finally the Carlton Club Hotel."²

It is interesting to ponder why this particular pub was used so often to investigate sudden and accidental deaths. Its site must have played a part. Normon states that "in the early days of the Rivulet row boats had no difficulty getting as far as Argyle Street and the area hummed with sailors, whalers, watermen and their ilk."³ The Gordon Castle was near the theatre, hospital, central business area and the old Wapping section of the city. However, deaths recorded there were not restricted to those who, like Thomas Breen, drowned in Constitution Dock⁴, or John Nolan who succumbed to epilepsy in a house of ill-fame⁵. They included that of Emily Grainger who died of Hydrocephalus on board the 'Culloden' on passage from Flower Pot to Hobart Town⁶, George Parker who fell from a chaise drawn by one horse near the Wheatsheaf Public House in Macquarie Street⁷, and John Smith who became lost on Mount Wellington and died of exhaustion⁸. Perhaps Algenon Burdett Jones, the officiating coroner, was a friend of Chatley, or had his office near by?

Of the 265 deaths investigated in 1858, 129 were attributed to natural causes and designated to "Visitation of God" or accorded some specific medical condition. The increased medical input after Franklin's law of 1837 is reflected in more detailed reporting of medical conditions. Apoplexy still predominates, but we see mention of heart and circulation problems such as aneurism of the aorta, lung diseases and stomach and brain conditions.

The greater proportion of the accidental deaths, 42%, was attributed to drowning. Thirty-three men, six women and six children were drowned that year. They drowned in major rivers, remote flooded creeks and water holes, and from ships and fishing boats. Bridgit Ringosse drowned in a well, getting two buckets of water near Georgetown⁹. Samuel Davey fell from the steam vessel 'Tamar', and drowned in the North Esk¹⁰, and Stephen Nash succumbed when, greatly intoxicated, he went to bathe in the Derwent at Government Domain¹¹. Boats upset in the Kermandie River and near Falmouth and

accidents occurred at fords. The island's cold water ways were still a major hazard for its citizens.

Traffic accidents were next common and we learn much of the movement of people and goods from the records. Peter Kennon was killed when thrown from his horse returning from the Carrick Races¹², and Thomas Pithouse died when hit by the shaft of a dray while trying to stop a runaway horse¹³. There were accidents involving wagons with six horses, stage coaches with four horses, and chaises with two horses. There were bullock drays and carts laden with wood, grain and 'green stuff' involved in fatalities. Attention was drawn to driving conditions in the city when Harriet Horne died in a collision between two horse-drawn vehicles in the dark in Elizabeth Street¹⁴. The language used to describe the accidents is vivid, if understated, in the extreme. Silvester Sulmar died "from injuries received on the body by a heavy weight dropping upon it - to wit a dray."¹⁵

Eighteen deaths occurred from accidents involving fire with women and children often the victims. Most cooking at this time was accomplished at open fire places, or at best, wood-fired ranges, and women wore long, highly inflammable garments. Boys and girls were dressed alike until the age of two, in pinafores and petticoats, and were obviously at high risk¹⁶. Records covered incidents involving placing saucepans on open fires, lighting candles, scalding with boiling water and playing with 'firesticks'. Some burning incidents had more sinister overtones, however. Richard Evans died from burns received whilst lying in a fireplace intoxicated¹⁷, Ellen Arkwright when her clothes caught fire in the yard of the Sailor's Return¹⁸, and John Anton when his were set alight in the tap-room of the Bridgewater Hotel¹⁹.

At this time, the treatment of burns involved "pouring oil over the infected areas, dredging them with flour and poulticing. Without antibiotics and venous access to regulate fluids, regardless of treatment, few could survive."²⁰ The verdicts of 1858 record the time sufferers "laboured and languished" before death.

Accidents resulting from occupational hazards show the main thrusts of employment of the time - work on farms, forest clearing and maritime

activities. There are many instances of logging accidents in forests on the edge of settlements such as those at New Ground near Port Sorell, and Stringy Bark Forest, near Cressy. Edward Rose even died of apoplexy in a wood yard²¹. On the farms, hazards included work with horses and early machinery. Thomas -- was killed in an accident involving a threshing machine²², and Fred Randall died from injuries received whilst breaking in a horse at Brickendon²³.

In the ports, accidents were varied. Emmanuel Silva slipped and fell, dislocating his neck on a chain on the deck of the vessel 'Trade Wind', in Hobart Town harbour²⁴. Silva was "a foreigner and the unfortunate man, somewhat advanced in years, had gone to the ship to obtain employment. The mate told him he had none to give and he fell as he was leaving the vessel." The 'Trade Wind' had been quarantined earlier in the year, due to a typhoid outbreak²⁵. Henry Turner suffocated by smoke of a charcoal fire used in fumigating the hold of the 'Native Lass' at Launceston²⁶. Of particular interest is the account of the death of George Smith at Port Esperance. He succumbed to a fit of apoplexy whilst diving in a diving dress from a schooner 'Amelia Frances' but no blame was attributed to the parties attending on him²⁷. He would have worn a calico suit, heavy head piece and air would have been pumped to him manually. One wonders at the courage, or foolhardiness, of men who used such primitive equipment as was available in this era. Some accidents occurred on building sites such as the demolition of a brick wall which resulted in the death of James Goss²⁸ and the repairs to a bridge which caused Lawrence Couson to fall from a scow and drown in the Tamar²⁹.

1858 was the era before wide-spread mining activity in Tasmania but Adam Cothrill died when the roof gave way in the excavation of a gallery at Nags Pit Coal Pit at New Town³⁰. This coal seam was discovered by Zephaniah Williams in 1851 on Captain Spotswood's property and was later worked as the Triumph mine. Williams, a Welsh Chartist, had been transported for life and was involved with the discovery and mining of coal in many areas of Tasmania³¹.

It is possible to determine more accurately from these records, the causes of children's deaths. As for adults, most arose from drowning and burning, especially scalding. A number of cases of babies 'suffocating in bed' or being 'overlaid in bed' are documented. This is the grey area mentioned earlier, and one wonders at the incidence of infanticide. In the overcrowded conditions such accidents must have been common and of course nothing was known then of the modern scourge of cot death.

It is in the case of children's deaths that we find the first instances of coroners and juries making criticisms of situations and recommendations to avoid similar accidents. When Catherine Conolly died from burns received when her clothes caught fire, the verdict was accompanied by the hope "that this will be a caution to mothers leaving children to be subject to similar accidents."³² The death of James Jones was viewed more seriously. The mother was said to have neglected the child by giving it insufficient food and the verdict stated that she "feloniously, wilfully and of her malice aforethought did kill and murder."³³ Margaret was tried in the Supreme Court in April and finally acquitted. There were many witnesses, including the doctor and minister, and the case obviously involved extreme poverty in slum conditions³⁴.

Felonious deaths included thirteen cases of murder and eleven of suicide most of these again being termed 'lunatic suicide' described in various phrases such as 'temporary insanity', 'of unsound mind' and 'lunatic and distracted'. Several men cut their throats while in delirium tremors, and James Peck "feloniously wilfully and of his malice aforesaid did kill and murder himself by taking strychnine in gin."³⁵ There were several cases of 'found dead' covering suspected suicide. The coroners or recording clerks were certainly prone to using dramatic language. Dennis O'Neil died after being hit by a crowbar by Michael O'Neil, a lodging house keeper. Michael did not "have the Fear of God before his eyes" and was "moved and seduced by the instigation of the devil." - the verdict? - Murder³⁶.

Four prison deaths were recorded and, with the exception of one lunatic suicide at Bothwell, involved elderly women who died from heart failure and

dropsy by natural causes. Three fires were investigated, and in one case arson was found, as the fire was "wilfully lit with the intention of defrauding certain insurance companies."³⁷ The owner of the premises, Mr Joseph Dell, a grocer, was taken into custody to answer the charge of arson³⁸. Two investigations in 1858 arose directly from weather conditions. In October, in the Port Esperance area, four men and a woman were killed when a tree fell on a hut in which they were sheltering from a storm³⁹. In August, Jane Hughes and Charlotte Brown drowned in the flooded Humphrey's Rivulet at O'Brien's Bridge⁴⁰. The Mercury of 14 August commented vividly on the floods. " At O'Brien's Bridge the losses are greater than already noticed. The inmates of Mr Murray's extensive Starch, Candle and Vinegar Works barely escaped with their lives and all the gardens and lands fronting on Humphrey's Rivulet have been completely washed into the Derwent the bridge across the Rivulet has been built with an arch not wide enough to carry off the water."⁴¹ At the time I was researching these inquests, Humphrey's Rivulet was again in flood, causing material damage and arousing much criticism as to the adequacy of the drainage system in that area. Although it is recognised that provision can never be made to cover all natural catastrophes, it seems some 'black spots' continue to exist.

There were 265 inquests into the sudden and accidental death of individuals in 1858 far more than in any of the other years I sampled. When one considers the overall population growth, even to 1948, this fact deserves close consideration. The period following the cessation of transportation, the granting of responsible government and the discovery of gold in Victoria and New South Wales was one of economic depression. The young and able migrated to the mainland to seek their fortunes and the residue struggled to survive in the harsh economic climate. Emancipists formed a significant section of the community and prisons, hospitals, and charitable institutions were crowded. In 1857 the Examiner noted that though transportation had ceased there was "a residue of crime, disease and poverty."⁴² This social climate is reflected in the 1858 inquest records with their deaths by murder, suicide, old age and debility. Tasmania was obviously a sad state.

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- ¹. Atlas of Tasmania, ed. J.L. Davies, (Lands and Surveys Department, Hobart, 1965). pp. 43-44.
 - ². L. Norman, Pioneer Shipping of Tasmania (Walsh Hobart, 1938.) p. 89.
 - ³. Ibid, p. 89.
 - ⁴. SC 195 No 4226.
 - ⁵. SC 195 No 4225.
 - ⁶. SC 195 No 4227.
 - ⁷. SC 195 No 4337.
 - ⁸. SC 195 No 4189.
 - ⁹. SC 195 No 4201.
 - ¹⁰. SC 195 No 4157.
 - ¹¹. SC 195 No 4177.
 - ¹². SC 195 No 4211.
 - ¹³. SC 195 No 4400.
 - ¹⁴. SC 195 No 4295.
 - ¹⁵. SC 195 No 4190.
 - ¹⁶. M & G Greenwald, "Coroners' Inquests - A Source of Vital Statistics, Westminster 1761 - 1866." Journal of Legal Medicine, Vol. 4, No. 1, 1983., p. 77.
 - ¹⁷. SC 195 No 4256.
 - ¹⁸. SC 195 No 4251.
 - ¹⁹. SC 195 No 4338.
 - ²⁰. Greenwald, op. cit. p. 77.
 - ²¹. SC 195 No 4405.
 - ²². SC 195 No 4182.
 - ²³. SC 195 No 4354.
 - ²⁴. SC 195 No 4238.
 - ²⁵. Mercury 13 April, 1858.
 - ²⁶. SC 195 No 4231.
 - ²⁷. SC 195 No 4321.

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- ²⁸ SC 195 No 4394.
- ²⁹ SC 195 No 4286.
- ³⁰ SC 195 No 4208.
- ³¹ Guardian, 29 March, 1851.
Australian Dictionary of Biography Vol II. p. 601.
- ³² SC 195 No 4352.
- ³³ SC 195 No 4209.
- ³⁴ Mercury, 12 April, 1858.
- ³⁵ SC 195 No 4162.
- ³⁶ SC 195 No 4341.
- ³⁷ SC 195 No 4315.
- ³⁸ Mercury, 13 Sept., 1858.
- ³⁹ SC 195 No 4358 - 62.
- ⁴⁰ SC 195 Nos 4325 and 4328.
- ⁴¹ Mercury, 14 Aug., 1858.
- ⁴² Examiner, 10 Oct. 1857.

Chapter 5

Coronial Enquiries in Tasmania

1888.

Coronial Enquiries in Tasmania 1888.

Personal Inquests

Male	105
Female	32
Child	16
Total	153

A. Natural Causes: 62Diseases Mentioned

Heart
Lungs
Apoplexy

B. Accidental Deaths 81

Drowning	33
Traffic	18
Occupational	13
Burning	12
Poison	3
Firearms	2

C. Felonious Deaths 10

Murder	1
Manslaughter	3
Suicide	1
Lunatic Suicide	5
Shot	3
Poison	1
Hanging	2

TOTAL 153

D. Other Categories

Prison Deaths	3
Mental Diseases Hospital	1
Fire Investigations	16
Firearms Involved	5
Alcohol Affected	1

A new and brighter outlook appears twenty years later in my next sample, the 1888 inquest records. Although the population of the state had increased by 62, 000, the number of investigations into sudden and accidental deaths decreased from 265 to 153 - there was only one murder and six suicides. The new economic climate resulting from the discovery of mineral wealth and the subsequent development of railways is reflected not only in the types of incidents recorded, but directly in the numbers. X

By this stage the number of counties into which Tasmania was divided had increased to eighteen to cover the newly settled areas of the west coast and south. We see records from Montagu, West Devon, and Wellington. Investigations were still held in pubs and private homes but there is increasing mention of hospitals and police and municipal offices. The coroners were again representatives of well known and land-owning families particularly in the country areas. Names such as James Meredith at Swansea, Walter Von Stieglitz at Launceston, John Bethune at Hamilton and James Moore at New Norfolk appear on the lists. Walsh's Almanac for the year states that "Coroners are appointed by the governor and hold office during his pleasure. For every inquest the sitting coroner is paid a fee of £1 and £1 for every day after the first and also travelling expenses for each mile travelled to and from his residence. In rural areas these sums are paid by the municipal council and in all other districts paid out of the public treasury."¹

Juries were still composed of seven men and it is very rare to find a juror's 'mark' except in a remote area such as Rhyndaston and Garden Island Creek.

The number of deaths accredited to natural causes or 'Visitation of God' decreased by half, the obvious implication being that medical science and care had advanced to the stage where illnesses were better recognised and treated, if not cured, and deaths were therefore not in the sudden class covered by coronial inquiry. The records in these cases are very brief and cover mainly heart and lung conditions.

Accidental deaths are again headed by drownings, 40% of the total. There are fewer details of the circumstances of drownings at this time. They merely record the name and place such as Georges River, Tamar River or Fawkner Rivulet. One hazard that by this time in the colony's development a certain number of drowning accidents were only to be expected. Two cases were of more particular interest. In November, Shannon Horatius D'Arcy Napper drowned in the Corporation Baths at Launceston². These had been established in 1884 near the South Esk Bridge, and this was the first record I discovered of a drowning in such a man-made construction³. The Launceston Examiner of 5 November reported this inquest in detail. Napper was sixteen years old, and could not swim. There were several riders to the finding of accidental death, such as "Some competent person should always be in attendance to render assistance." The article concluded, "Safety of course rests with bathers, and this sad occurrence will convey a solemn warning. Cries for help are often raised by way of jest by bathers and they fail to attract attention when they are raised in earnest."⁴

The other drowning of note occurred in a water hole near Beaconsfield. When Henry Dalby drowned, the coroner felt the "desire to add a rider that it is desirable that persons having dangerous water holes on their land should either fill them up or protect them by fencing." We get no indication of how old Henry was, but the impression prevails of a growing inclination to protect children during this period⁵.

There were seven cases from deaths from burns recorded in 1888, with scalding, and clothes catching fire the main hazards mentioned. It is in the area of traffic and occupational hazards that we see most change. There were the usual mishaps concerning drays, carts and runaway horses, but the recent introduction of railways is clearly evident. James Charlwood was killed either by a "blow from the engine of a train or by a fall into the creek," signifying some doubt in the minds of the jury⁶. No blame is attached in any of the railway accidents.

Occupational hazards included off-loading coal from vessels in port, tree felling, and man-handling barrels on water carts. Fourteen year old Fred

Brocklehurst died from an explosion of blasting powder in the blacksmith's shop at Arrundel, No 3 Bridge, on the Derwent Valley Railway⁷. Recent mining developments are clearly mirrored. William Callaghan was drowned in the water race at the Briseis Tin Mine⁸, Thomas ---- died in an earthfall at the Golden Mine⁹, and Thomas Ryan in "a fall of earth" in a mine at Groom River¹⁰. All these incidents occurred at mines in the north east of the state, and it is here, too, that we see evidence of the presence of the Chinese miners who came to Tasmania in the 1870's and 80's - the era of alluvial tin mining¹¹. Lee Sing Lim died in an earth fall at the Garibaldi Tin Mining Company's claim at Garibaldi Creek¹², and Fong Ah Toon also died at Garibaldi Creek from natural causes¹³.

Investigations into children's deaths revealed the usual accidents involving young children - scalding, drowning in buckets, suffocation and unwitting poisoning. In an increasing number of cases, however, we see doubt in the minds of coroners and juries. When Clara Jones, an infant of three months, died of diarrhoea and convulsions, her condition was said to be "accelerated but not directly caused by want of proper food and attention."¹⁴ The Mercury of 21 April gave a graphic account of the inquest with depositions from child carers and police on what was obviously regarded as a suspicious death. The coroner complimented the police on the thoroughness of their investigations into the case, and made mention of manslaughter in his summary. The jury, however, returned a verdict of accidental death¹⁵.

On 24 March, the Mercury reported an inquest held at New Norfolk on the body of a new born male child found in bush land. The child was said to have "been mature, had lived, but died from exposure and want of attention on the part of the mother, Bridget Lapham." Bridget was later charged with concealment of birth and committed for trial in the Supreme Court. These two cases instance growing social awareness in the area of child abuse¹⁶.

The number of fire investigations increased in 1888. There were inquiries into fires in barns, hotels such as the Lennox Arms at Richmond, stores and cottages. Most inquests were unable to produce evidence as to the cause of the

fires, and they were accredited to "wilful action by persons unknown." A fire in the premises of Sam Burleigh in Elizabeth Street, Hobart, was found to be due to the "thoughtless but not malicious act of throwing a wood match, not properly extinguished, on a pile of loose paper and empty cardboard boxes."¹⁷ At Redcliffe Estate, Swansea, a fire originated "from persons in a cart" but there was no evidence as to whether it was accidental or not¹⁸. The impression is gained that as the colony became more ordered, and the outlying areas better populated, investigations into fires became routine, though their findings were as vague as in the past.

The 1888 records mention only two cases in which alcohol abuse played a part. There were probably other incidences which were not noted, but significant changes to the social life of Tasmanians had occurred in the intervening years. Many of the original convict 'lags' had by this time died out. The early temperance movement had gained strength following restrictive legislation in 1854 and 1857, and many of the recent migrants, particularly in north west areas, were teetotalling members of non-conformist religious sects. Both municipal and territorial police forces had been greatly expanded and lawlessness resulting from drunkenness had decreased significantly¹⁹. The inquest records seem to provide some evidence of a more law-abiding society.

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- ¹. Walsh's Almanac 1888, p. 69.
 - ². SC 195 No. 9487.
 - ³. Walsh's Almanac, 1888, p. 221.
 - ⁴. Examiner 5 Nov. 1888.
 - ⁵. SC 195 No. 9428.
 - ⁶. SC 195 No. 9429.
 - ⁷. SC 195 No. 9368.
 - ⁸. SC 195 No. 9442.
 - ⁹. SC 195 No. 9445.
 - ¹⁰. SC 195 No. 9494.
 - ¹¹. L. Robson, History of Tasmania, Vol II (O.U.P. Melbourne 1991) p. 132.
 - ¹². SC 195 No. 9489.
 - ¹³. SC 195 No. 9457.
 - ¹⁴. SC 195 No. 9403.
 - ¹⁵. Mercury, 21 April, 1888.
 - ¹⁶. SC 195 No. 9392, Mercury 24 March, 1888.
 - ¹⁷. SC 195 No. 9454.
 - ¹⁸. SC 195 No. 9378.
 - ¹⁹. Robson, op. cit. p. 12 and 13.

Chapter 6.

Coronial Enquiries in Tasmania

1918.

Coronial Enquiries in Tasmania 1918.

Personal Inquests

Male	78
Female	25
Child	17
Total	120

A. Natural Causes: 42Diseases Mentioned

Heart
Pneumonia
Convulsions
Influenza

B. Accidental Deaths 70

Drowning	19
Traffic	12
Occupational	12
Burning	13
Firearms	7
Others	7

C. Felonious Deaths 8

Murder	2
Manslaughter	1
Suicide (Lunatic)	5
Shot	1
Razor	2
Hanging	1
Drowning	1

TOTAL 120

D. Other Categories

Prison Deaths	-
Mental Diseases Hospital	3
Fire Investigations	5
Firearms Involved	9
Alcohol Affected	1

1918, the year which marked the end of the First World War, saw a marked decline once more in the number of deaths in Tasmania investigated by coronial inquiry. This applied in all categories, natural causes, accidental and felonious. The investigations were then held almost exclusively in Police Courts and Municipal Council Chambers rather than pubs or private homes. They were conducted by coroners acting alone except in cases of fire and mining accident when juries of four or five persons were used. Some coroners were certainly long serving. Ernest Whitfield was acting in 1888 and still occupying the position in Launceston thirty years later.

Once again we see the opening up of new and isolated areas of the island reflected in the records - Grassy on King Island, Irish Town and Sisters Hills in the north-west and remote areas of the west coast. The records mention ages of victims more frequently, but certainly not universally.

Deaths by natural causes were recorded very briefly in such terms as pneumonia or 'failure of the heart's action.' The 'Visitation of God' terminology had almost disappeared with some rare occurrences from remote areas. As in 1888 increasing medical knowledge was obviously lessening the sudden and unexplained components of the investigations.

Again drownings were most numerous amongst accidental deaths but were proportionally less over all. John Llewellyn drowned in the King River at Linda¹ and Michael Whyte and Alice James at Strahan on Macquarie Harbour² - the wild waters of the west coast were beginning to exact their toll. Two more were drowned at Dover³ and there were numerous incidents in north-west coast rivers such as the Mersey.

Twelve fatal traffic accidents reflect the growth of mechanised transport with mention of cars and electric trams as well as trains and horse drawn vehicles. Alfred Smith died from head injuries received when he alighted from a moving tram car belonging to the Launceston Municipal Council which had introduced electrified tram cars in 1911⁴. Numerous accidents involved the expanded railway system. William Foster⁵ and Alfred Rodwell⁶ died in shunting mishaps

and Hubert Shepherd was hit by a runaway guard's van⁷ but no blame was accredited on any of these occasions.

Occupational accidents involved mainly logging and mining incidents. Logging resulted in fatal accidents at Pirate's Bay on the Peninsula, Branhholm on the north east coast, Irish Town on the north west and Russell in the Maydena area. The mining incidents reflected the expansion of mining activities since the rush of the 1870's and 1880's. We see accidents at the Scheelite mine at Grassy on King Island, Portland in the north east and the copper mines of the Mt. Lyell area.

These inquests were conducted by coroners with juries of four or five men, and in most cases they passed on recommendations about work practices to the appropriate authorities. When Samuel Turner fell down a pass at the Mt. Lyell mine, it was thought that "no man should be allowed to go down a pass without a rope around his body."⁸ The Mercury reported that the Chief Inspector of Mines had forwarded a telegram embodying this rider to the Secretary of Mines and "it was probable that a regulation would be framed to meet this suggestion and thus minimise the risk"⁹. James Brandum's death from injuries from a run of mullock brought the recommendation that more precaution be taken in future in removing pillars¹⁰. The Mercury report on this inquest stated that the removal of pillars had been a matter of contention between the Mines Department and the Mt. Lyell company. The inspector had been opposed to the methods used, warning the company of the dangers involved¹¹. The coroner at these two inquests was C. H. Stitz, a blacksmith, not to be confused with Robert Sticht, the Mt Lyell manager of the time. The wording on the inquest into the death of Patrick Fox at Grassy was very specific - "In our opinion the grizzly was insecurely built in as much as the bearer was hitched in soft ground and the rise should have been securely timbered to support the hitch."¹² Such detailed enquiries surely reflect the practical involvement of jurors, growing concerns for safety and the increasing power of unions in this era.

Unionism had flourished, particularly on the mining fields after the establishment of the Amalgamated Miners Union in the north in 1887¹³. Accidents such as that which occurred at Mt. Lyell in 1912, costing forty-two lives, reinforced the moves for more thorough inspection services and provision of secondary escape routes in the mines. At both government and work force levels, safety was becoming a major issue, together with compulsory unionism and wages claims¹⁴.

An interesting new category of accidental death appeared in the 1918 records - death by heart failure while under anaesthetic. Ruby Randall, aged twenty-seven, died while under anaesthetic for the removal of teeth at Hurburgh's Dental Surgery in Macquarie Street, Hobart¹⁵. The Mercury reported this inquest in great detail. There were numerous depositions, and all medical and dental staff attending were exonerated¹⁶. It was obvious that the use of anaesthetics in dentistry in Tasmania was comparatively recent, and public interest was aroused not only in the procedures, but also the danger involved.

There were only eight felonious deaths in 1918 and five of these were suicides with the usual 'lunatic' designation. Children's accidental deaths totalled seventeen, and burning and drowning still predominated in this category.

It is interesting to ponder on the reasons for the pronounced decrease in the number of inquests of all types in 1918. I feel those designated 'natural causes' could be covered by the better diagnosis and treatment of illnesses argument mentioned earlier. Accidental and felonious deaths are however, more problematic. It has long been recognised that accidental deaths occur most frequently among young males, and the fact that 13 000 young men had enlisted for overseas service during World War I must have had a direct bearing on the number of inquests recorded. Can the fact that 2 500 of these young men were killed in the various theatres of war have made the general population more sensible and careful about safety measures, and less interested in felonious acts?

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- ¹. SC 195 No. 13958.
 - ². SC 195 No. 13961.
 - ³. SC 195 No. 14059, 14062.
 - ⁴. SC 195 No. 13972.
 - ⁵. SC 195 No. 14049.
 - ⁶. SC 195 No. 13949.
 - ⁷. SC 195 No. 14041.
 - ⁸. SC 195 No. 13991.
 - ⁹. Mercury, 19 April, 1918.
 - ¹⁰. SC 195 No. 14015.
 - ¹¹. Mercury 22 & 23 August, 1918.
 - ¹². SC 195 No. 14039.
 - ¹³. L. Robson, History of Tasmania, Vol. II (O.U.P. Melb. 1991) p. 198.
 - ¹⁴. G. Blainey, The Peaks of Lyell, (M.U.P. 1954) p. 214.
 - ¹⁵. SC 195 No. 14060.
 - ¹⁶. Mercury, 29 Nov. 1918.

Chapter 7

Coronial Enquiries in Tasmania

1948.

Coronial Enquiries in Tasmania 1948.

Personal Inquests

Male	133
Female	53
<u>Child</u>	<u>27</u>
Total	213

A. Natural Causes:

72

Diseases Mentioned

Pneumonia
Arterio sclerosis
Heart
Epilepsy
T.B.

B. Accidental Deaths

119

Drowning	25
Traffic	47
Occupational	17
Logging	8
Earth Fall	3
Power	4
Others	2
Burning	4
Others	26

C. Felonious Deaths

21

Murder	0
Manslaughter	1
Suicide	4
Suicide (Lunatic)	16
Shot	6
Razor	3
Hanging	8
Gas	2
Drowning	1

TOTAL 213

D. Other Categories

Prison Deaths	2
Mental Diseases Hospital	63
Fire Investigations	6
Firearms Involved	9
Alcohol Affected	5

There were few changes in procedures evident in the original inquest documents I investigated for 1948. Juries were used in only two cases of accidental deaths at mining sites and inquests were held at police offices. Of the 212 personal records, seventy-two showed death from natural causes, usually heart failure or broncho-pneumonia, 119 were accidental deaths and twenty felonious.

For the first time we see traffic accidents outnumbering drownings as the main cause of accidental deaths. Vehicles mentioned included cars, lorries, motor bikes, bicycles, buses and utilities and the accidents involved drivers, passengers and pedestrians. There were numerous railway accidents particularly at level-crossings and one new category - that of air disaster. When a tiger-moth crashed at Riana on the north-west coast, Colin Cornish, the pilot, and David O'Brien, his sixteen year old passenger, were killed¹.

The traffic accidents involved speed, carelessness and the influence of alcohol. In one instance, the driver of a vehicle in Launceston was found to have feloniously killed his passenger and was committed for trial on the grounds of overcrowding in the cab of a lorry, alcohol consumption, undue speed in rain and fog and giving false report of an accident².

Occupational accidents were again headed by logging tragedies and earth falls in mines such as occurred at the Royal Tharsis mine on the west coast, and Star Hill mine at Gladstone. A new category appears here too where four deaths were recorded in connection with the widespread introduction of hydro-electricity in Tasmania. Ronald Wilby died at Burnie when a power pole collapsed³, William Martin was electrocuted at the Moonah substation⁴, and Allan Kelleher at the Austral Bronze works at Derwent Park⁵ while Maurice Hissock "succumbed to electric shock due to the poor installation of a cable" at Launceston⁶. The establishment of the isolated Hydro Electric Commission construction villages is reflected in the accounts of accidents at Tarraleah and Butler's Gorge. It is interesting to note that with the introduction of electricity the number of deaths from burns declines markedly.

Investigations into these individual accidents often raised queries and recommendations concerning work practices. When John Linnell died from injuries received in a Public Works Department accident involving explosives, the coroner reported that the "P.W.D. was remiss in not instructing its officers in the issue, handling and transport of explosives in conformity with the Explosives Act of 1916 and regulations made thereunder⁷." The Mercury commented that the coroner, Mr. Brettingham-Moore, would "make a report to the Attorney-General and no doubt action would be taken to prevent similar accidents."⁸ Apparently detonators had been carried in the glove box of a car!

The queries regarding safety measures extended to leisure activities. In January Dorothy Townson died in Cradle Mountain Lake St. Clair National Park from snake bite. The coroner, H.R. Dobbie, concluded the death was accidental and gave detailed recommendations:

1. That the venomous nature of Tasmanian snakes be made widely known.
2. That hikers who intended to traverse isolated parts be advised to carry first aid kits including some antidote to snake poison.
3. That the danger of going into the bush without wearing some cover to the legs such as putties or leggings should be emphasised⁹.

These warnings were published in The Advocate¹⁰. The previous day Alan Richmond, a local printer and scout leader, was quoted as urging the installation of telephone communication with Waldheim Chalet as the nearest phone was twenty miles away¹¹.

Another interesting feature of the 1948 records was the inclusion of four deaths of children involving anaesthetics and surgical procedures. Marion Blackwell, aged seven¹², and Mary Gregson, aged six¹³, died whilst undergoing tonsillectomies, Willis Berechree, aged four, whilst having his appendix removed¹⁴, and Graham Paynter, aged seven, under dental procedures¹⁵. Obviously what we consider routine operations were still fraught with danger even in this post-war era.

Of the twenty-one felonious deaths in this year twenty involved suicide, sixteen designated lunatic and seventeen affecting males. Of these eight persons hanged and six deaths involved firearms. In only one case was the suggestion made that war experiences may have had a bearing on the 'lunatic' designation, the victim apparently suffering from fits of depression following discharge from R.A.A.F.¹⁶. When Jan Zolobezuk, a Polish immigrant, shot himself in a single-man's hut in the H.E.C camp at Tarraleah, thoughts of war-time background must have crossed the coroner's mind¹⁷. The newly arrived workers staffing the hydro schemes had come to Tasmania to make new lives and most had war time experiences they were seeking to forget. The harsh living conditions in the highland camps must have compounded their problems.

Table 2. collates the information on suicide provided by my examples. Although the numbers involved are small, some conclusions may be drawn from my data. The designation 'lunatic' does not appear to have been used in any dramatically different way over the period studied. The incidence of suicide was relatively stable until recent times when the 1948 records show an increase to 14.3% of all accidental and felonious deaths. The number of males as opposed to females involved in suicide increased dramatically in the 1948 sample, and the use of fire-arms does not appear to have significance.

Most interest in the 1948 inquest records centres on those referring to Lachlan Park Hospital at New Norfolk. Of the seventy-two deaths from natural causes during that year, sixty-three occurred at Lachlan Park. I spent some time trying to ascertain why such deaths formed a huge proportion of total inquests in that particular year.

The establishment at New Norfolk was founded by Governor Arthur in 1827 as a general hospital and place to care for invalid convicts and lunatics. It became known as the lunatic asylum, and later the New Norfolk Hospital for the Insane, the Mental Diseases Hospital, Lachlan Park and more recently, the Royal Derwent Hospital¹⁸. Tasmanian Parliamentary Acts covering coronial inquiries always included sections to embrace the patient who died whilst in the care of mental hospitals. The 1858 Mental Hospital's Act stated, "In the

case of the death of an insane person the cause of death is to be stated and sent to the Registrar and Coroner and a special report made to the official visitors."¹⁹ The 1913 Coroner's Act required an inquest on someone who "dies while detained in any lunatic asylum."²⁰ The 1957 Coroner's Act stated that the coroner "has jurisdiction and shall enquire into deaths occurring within the mental hospital."²¹

It seems that in early years, inquests were carried out in very few cases. My 1858 study revealed William Milne had died of heart failure by visitation of God,²² and the 1888 study showed that Johanna Toms drank poison in a case of lunatic suicide²³. The 1918 study records three inquests at the Mental Diseases Hospital, two of natural causes and one of lunatic suicide. In 1924, one patient died when her dress caught fire, and another from a fractured skull, sustained from a blow from a piece of wood wielded by a fellow patient 'hopelessly insane'. In 1925 a patient died following an accident causing fracture of the femur. In all these cases, the coroner stated there had been no negligence in the care of these patients, and no blame was attached to those in authority. It seems obvious that until this stage, regardless of what the law stated, coroners actually investigated only those deaths which occurred in somewhat unusual circumstances and in which negligence may have been a contributing factor.

The change occurred in October of 1928. From 1 January until 11 October no inquests were recorded. From 12 October until 31 December in that year twelve inquests were conducted and thereafter it seems almost all deaths at the mental hospital were subject to coronial enquiry. There was no new act passed and the annual reports of the institution make no mention of the change in procedure. Apparently some local authority, either medical or judicial in function, decided it was time to abide by the letter of the established law.

Hugh Ashton Warner who had been an official visitor to the hospital for many years was coroner at the time. His findings included specific details of when the patient was admitted, summary of condition, events leading to death, cause in medical terms and names of the nursing staff in attendance at the time

of death. This information continued to be recorded by coroners in subsequent years - Gordon Matheson, George Gilmore and Colin Murdock.

In 1948 Lachlan Park recorded sixty-three deaths, twenty-one males and twenty-two females, all from natural causes, mostly from bronchial-pneumonia and arteriosclerosis. Most patients were quite elderly and some had been resident at the hospital for over thirty years.

Table 3. shows official statistics and Supreme Court Inquest numbers of deaths at the mental diseases hospital for the years which I sampled and studied in detail. Considering the nature of the population involved, these figures are in no way remarkable. The interest lies in the bureaucratic process involved.

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- ¹. SC. 195, Nos 19801, 19805.
 - ². SC. 195, No 19735.
 - ³. SC. 195, No 19714.
 - ⁴. SC. 195, No 19831.
 - ⁵. SC. 195, No 19815.
 - ⁶. SC. 195, No 19751.
 - ⁷. SC. 195, No 19871.
 - ⁸. Mercury, 1 Dec. 1948.
 - ⁹. SC. 195, No 19689.
 - ¹⁰. Advocate, 13 Jan. 1948.
 - ¹¹. Advocate, 12 Jan. 1948.
 - ¹². SC. 195, No 19699.
 - ¹³. SC. 195, No 19827.
 - ¹⁴. SC. 195, No 19895.
 - ¹⁵. SC. 195, No 19840.
 - ¹⁶. SC. 195, No 19744.
 - ¹⁷. SC. 195, No 19769.
 - ¹⁸. R.W. Gowlland, Troubled Asylum. History of the Royal Derwent Hospital (New Norfolk Tas. 1981.)
 - ¹⁹. Tasmanian Statutes 1826 - 1959 (Reprint) Vol. 4., p. 93.
 - ²⁰. Ibid. p. 713.
 - ²¹. Ibid. p. 903.
 - ²². SC. 195, No 4364.
 - ²³. SC. 195, No 9355.

Conclusion.

The main impression gained from the study of the inquest records of Tasmania is of increasing awareness of the watch-dog role of investigating authorities. Coroners from 1858 onwards made recommendations concerning safety measures with the aim of reducing the incidence of sudden and accidental death. Combined with individual awareness and increased union activity in the twentieth century, these have led to educational initiatives and dramatic changes imposed on work practices. In the industrial sphere financial outlays on clothing, equipment and protective structures are now mandatory. Innovations such as pedestrian crossings, lights, safety gadgets and increased police activity are tackling, not altogether successfully, the increasing incidence of traffic accidents. Recognition of the danger of drowning in Tasmanian waters has resulted in the work of the Royal Life Saving Society, the 'Learn to Swim' campaigns introduced to Tasmanian schools in the 1950's and current advertising to combat carelessness in boating practices. The watch-dog role has widened in recent years as we now see constant measures to combat child abuse, domestic violence, deaths in custody and lately firearms. Investigations into deaths whilst undergoing medical procedures have highlighted public awareness of accountability and led to the increased litigation which is so much part of the modern world. It seems we need the cold, hard facts as revealed in coronial inquiries to force action towards solving social dilemmas, whether by legislation or increased provision of emergency services. Paradoxically, tragic deaths do seem to contribute to social betterment.

Appendix.

Table 1. Comparison of Deaths by Drowning and Traffic Accident.

Table 2. Suicide in the Tasmanian Inquest records.

Table 3. Inquest Records for Lachlan Park Hospital, New Norfolk.

Table 4. Summation Sheet for All Samples 1828 - 1948.

Comparison of Deaths by Drowning and Traffic Accident.
(Expressed as % of Accidental Deaths).

	Drownings	Traffic-Accidents
1828 - 35	55	15
1858	42	28
1888	40	22
1918	27	17
1948	21	40

Suicide in Inquest Records.

	1828-35	1858	1888	1918	1948
Total Recorded	3	11	6	5	20
Designated Suicide	-	3	1	-	4
Designated Lunatic Suicide	3	8	5	5	16
Male	3	9	3	3	17
Female	-	2	3	2	3
Hanging	1	3	2	1	8
Shooting	1	-	3	1	8
Razor	1	3	-	2	3
Drowning	-	1	-	1	1
Poison	-	4	1	-	-
Gas	-	-	-	-	2
% of Shooting	33	0	50	20	40
% of Suicide in Accidental & Felonious Deaths	8.1	8.4	6.5	6.4	14.3

Mental Diseases Hospital - New Norfolk.

	Statistics of Tasmania - Deaths Recorded	S.C. 195 - Inquest Records
1858	7	1
1888	17	1
1918	0	3
1923	35	0
1924	30	2
1925	33	2
1926	44	0
1927	34	2
1928	37	12
1929	39	39
1938	48	39
1948	65	63

Tasmanian Inquest Records
1828 - 1948.

	1828	- 1835	1858	1888	1918	1948
<u>Total Population</u>	18128	40172	84080	146149	202843	275142
<u>Total Deaths</u>	250	525	1562	2036	1802	2528
<u>Number of Personal Inquests Recorded</u>		58	265	153	120	213
<u>Verdicts of:-</u>						
<u>Natural Causes</u>		21	129	62	42	72
<u>Accidental Deaths</u>		27	105	81	70	119
Drowning		15	45	33	19	25
Burning		1	18	12	13	4
Traffic		5	29	18	12	47
Occupational		3	13	13	12	17
Others		3	-	5	14	26
<u>Felonious</u>		10	25	10	8	21
Murder		7	13	1	2	0
Manslaughter		-	1	3	1	1
Suicide		3	11	6	5	20
<u>Prison Deaths</u>		3	4	3	-	2
<u>Mental Diseases Hospital Deaths</u>		-	1	1	3	63
<u>Fire Investigations</u>		-	3	16	5	6
<u>Firearms Mentioned</u>		5	2	5	9	9
<u>Alcohol Infected</u>		9	11	2	1	5

Statistics of Tasmania
S.C. 195 Inquest Record.

Bibliography.

Primary Sources.

Supreme Court Records of Inquests in Tasmania S.C.195., Archives of Tasmania.

Historical Records of Australia; Series III, Vols. I & II, Sydney, 1921.

Public General Acts of Tasmania 1826-1936 Reprint. Chronological Table of Acts. Vol. 7, Tasmanian Government Printer.

Statistics of Tasmania.

Diary of The Reverend Robert Knopwood, ed. Mary Nichols, T.H.R.A. 1977.

Journal of Charles O'Hara Booth, ed. Dora Heard, T.H.R.A. Hobart, 1981.

Secondary Materials.

Atlas of Tasmania, ed. J.L Davies, Lands and Surveys Department, Hobart, 1965.

Walsh's Almanacs.

Australian Dictionary of Biography, ed. D Pyke, Vols. I & II, M.U.P. 1966.

G. Blainey, The Peaks of Lyell, M.U.P., 1954.

P. Bolger, Hobart Town. A.N.U. Canberra, 1973.

A.C. Castles, An Australian Legal History. Law Book Coy. Ltd., 1982.

R.P. Davis, The Tasmanian Gallows, Cat and Fiddle Press, Hobart, 1974.

R.W. Gowlland, Troubled Asylum - History of the Royal Derwent Hospital. New Norfolk, Tas., 1981.

G.J.R. Hinge, Industrial Awakening. A.N.U. Canberra, 1979.

L. Norman, Pioneer Shipping of Tasmania. Walsh, Hobart, 1938.

D. O'May, Ferries of the Derwent. Hobart, 1988.

N.J.P. Plomley, The Tasmanian Aborigines. The Plomley Foundation, Foot and Playsted, Launceston, 1993.

L. Robson, A History of Tasmania, Vol. II. O.U.P. Melbourne, 1991.

L. Robson, A Short History of Tasmania, O.U.P. Melbourne, 1985.

L. Ryan, The Aboriginal Tasmanians. (2nd Ed.) Allen & Unwin, St Leonards, N.S.W., 1996.

M. Tipping, Convicts Unbound, Penguin, Australia, 1988.

W.A. Townsley, Tasmania - from Colony to Statehood 1803-1945. St. David's Park Publishing, Hobart, 1991.

Wapping History Group, Down Wapping. Blubber Head Press, Hobart, 1988.

M & G Greenwald, "Coroners' Inquests - A Source of Vital Statistics, Westminster 1761-1866" Journal of Legal Medicine, Vol. 4, No. 1, 1983.

E. O'Brien, "Two years Hard Labour: Post War Immigrants with the Hydro Electric Commission" T.H.R.A. Vol. 41, No. 1, 1994.

N.J.P. Plomley, "The Aboriginal-Settler clash in Van Diemen's Land 1803-1831". Victoria Museum and Art Gallery Occasional Paper, No 6, Launceston, Tas., 1992.