What good is a coroner?
The transformation of the Queensland office of coroner 1859 – 1959

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BA (Hons I)

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the degree of Doctor of Philosophy

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Statement of originality

This thesis represents my own work. This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another author except where due reference is made in the thesis itself.

______________________________
Lee Karen Butterworth
April 2012

Warning

This thesis contains language and material that may be distressing for some readers. It includes descriptions of medical procedures and decomposing bodies. The case studies cover sensitive issues. Some readers may find the content of this work disturbing or offensive. No offence or disrespect is intended towards any persons living or deceased.
Abstract

Coroners have always been associated with investigating death, but this ancient office has undergone considerable reform since its creation in the twelfth century. The role of the coroner of the twenty-first century involves investigating death, conducting autopsies, furnishing reports, issuing death certificates and if necessary, testifying in court hearings. However, the original function of the office of coroner was linked to raising revenue for the King in the form of large fines or “amercements”. By the fourteenth and fifteenth centuries the prestige and fiscal functions of the medieval coroner had diminished as a result of the increased power of justices. The gradual move away from justices’ control during the eighteenth century elevated the status of the coroner, whose role evolved into one that formed a more effective system for reporting and investigating cause of death. This in turn further legitimised the role of the office of coroner in the English legal system. It was this “modernised” institution that formed the foundation of coronial law and practice in Australia.

Queensland adopted the English common law system from New South Wales when it became a separate colony in 1859. Consequently the ancient office of coroner was also transplanted to the new colony. As a self-governing colony, Queensland could enact new coronial legislation that better suited the conditions and circumstances of the expansive area under new settlement. This thesis looks at the first one hundred years of the office of coroner in Queensland, discussing the factors that led to its transformation from 1859 to
1959. The resulting history provides a platform to examine how the institution was formed and how it evolved into the system we recognise today.

The data collected revealed a picture of a parsimonious government that marginalised the office of coroner in Queensland legislation. The government undervalued the institution of the inquest as a forum for public scrutiny and an instrument of justice and accountability.

Research data were gathered from newspaper reports, coronial legislation, parliamentary debates, parliamentary papers and archival records. Queensland State Archive records were searched widely to create a comprehensive study of the Queensland coroner. A number of case studies, extracted from the inquest data and other primary sources, are cited throughout the thesis, and expose the functional strengths and inadequacies of the office of coroner. The research method created an extensive evidential base for the contemplation and analysis of how and why the function of the Queensland coroner changed over time.

This detailed investigation of the evolution of the office of coroner in Queensland constitutes a substantive original contribution to the scholarship of Queensland history by creating an administrative and social history that fills a significant gap in the basic history
of the coroner. It also contributes to aspects of colonial legal and medical history, drawing on previously untapped sources.
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## Abbreviations

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<tr>
<td>ATSIOC</td>
<td>Aboriginal and Torres Strait Islander Overview Committee</td>
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<td>CEQ</td>
<td>The Committee of Elections and Qualifications</td>
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<td>CLO</td>
<td>Crown Law Office</td>
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<td>IFP</td>
<td>Institute of Forensic Pathology</td>
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<tr>
<td>LRC</td>
<td>Law Reform Commission</td>
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<td>NCIS</td>
<td>National Coroners Information System</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>QLD</td>
<td>Queensland</td>
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<td>QPD</td>
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<td>QSA</td>
<td>Queensland State Archives</td>
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<td>QWEL</td>
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<td>RCADC</td>
<td>Royal Commission into Aboriginal Deaths in Custody</td>
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<tr>
<td>UK</td>
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Introduction

The term “coroner” is generally associated with death. Yet Australians in contemporary society know little of the coroner’s history, function or powers. Community attention was focused on the role of the Queensland coroner following the inquest finding on the death in custody of an Aboriginal man, Mulrunji Doomadgee, on Palm Island on 19 November 2004.¹ The Palm Island Aboriginal community welcomed the finding of the Acting State Coroner, Christine Clements, that the arresting Senior Sergeant, Chris Hurley, caused the death of Mulrunji. Elation quickly turned to disbelief and anger, following the decision of Leanne Clair, the Queensland Director of Public Prosecutions, not to charge Hurley. Clair found that the admissible evidence suggested the death was a terrible accident. The public was at a loss to understand how a person can be found to cause a death, but not be indicted for the offence. The Coroners Act 2003 (Qld) states that a coroner is limited to commenting on issues linked to the death which constitute a risk to public health or safety, the administration of justice, and making recommendations to prevent similar deaths. Clements, in summing up the inquest hearing, declared that coroners must not include any statement that a person is guilty of an offence or civilly liable in their findings.²

¹ Mulrunji was arrested by Senior Sergeant Hurley and charged with the offence of public nuisance and taken into custody. Mulrunji was transported to the police station in the back of a caged van. Mulrunji was removed from the back of the van, protesting his arrest and detention, then suddenly struck Hurley on the jaw with a back handed clenched fist. Hurley responded with a blow to Mulrunji’s side and proceeded to drag him into the police station. Both men fell through the doorway and it was alleged that Hurley punched the deceased at least three times, causing potentially fatal injuries. Mulrunji was dragged into a cell and despite calls for assistance, received no medical attention from the police officers on duty at the station. Later Mulrunji was found dead in his cell (Clements 2006).

The Acting State Coroner explained the inquisitorial role of the inquest, as opposed to the adversarial function of a criminal court of law. Under the provision of Section 48 of the Coroners Act 2003 a coroner must refer information to the prosecuting authorities if it is believed an offence has been committed. In the case of a serious indictable offence, the information is to be provided to the Director of Public Prosecutions. In her closing statement Clements stated: ‘I emphasize that any decision to prosecute rests solely with other authorities’. The Queensland government, while initially advocating adherence to the “umpire’s decision”, yielded to community pressure and initiated an independent inquiry into the decision of the Director of Public Prosecutions. The inquiry overturned the findings of the Director of Public Prosecutions and found that Senior Sergeant Chris Hurley should stand trial for the manslaughter of Mulrunji. Consequently, Hurley became the first Queensland policeman for many years to face trial over an Aboriginal death in custody. The trial took place and the officer was acquitted by a Townsville jury in June 2007.

As Ian Freckelton and David Ranson state ‘misunderstanding about which deaths need to be reported to a coroner is just one of a number of misconceptions in the community about the role of coroners and coronial death investigation’. The events surrounding the Mulrunji inquest exemplify the general public’s misunderstanding and confusion over the

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3 Coroners Act 2003, Queensland Government Gazette.
5 Freckelton & Ransom (2006:161)
duties of the coroner and the function of the inquest. The research question for this thesis arose from the proceedings and outcome of the Mulrunji inquest.

This thesis is about death investigation and the role of the coroner. More specifically, it looks at the office of coroner in Queensland, discussing the factors that led to the transformation of the office. Although the coroner was also authorised to conduct inquests into fires, this study focuses primarily on inquests into death. The time period covered extends from Queensland’s separation from New South Wales in 1859 to 1960. The 100 year time span is significant because it encompasses major legislative changes to the inherited role of the coroner in Queensland. Changes to the English death investigation system at this time also influenced the transformation of Queensland coronial law. The study culminates with enactment of the Coroners Act 1958; the last amendment to coronial law in Queensland until 2003.

The office of coroner originated in England over 800 years ago and had undergone a great deal of reform at the time of its conveyance to Australia. English Law relating to coroners became part of Australian law when the colony of New South Wales was established in 1788. On separation in 1859, Queensland coronial legislation was predicated on that of New South Wales. The first significant enactment of Queensland legislation was the Inquests of Death Act of 1866 which abolished coronial juries and empowered justices of the peace to conduct inquests. The Act was brought in primarily as
part of the government’s parsimonious agenda. Full reform of the coronial law to improve the function of the coroner in the name of justice was not a priority.

It was sixty-four years before further reform of the coroner’s law was undertaken. Replacing the existing fragmented and inadequate legislation, *The Coroners Act* 1930 consolidated and simplified the law for coroners. Provisions were included to consider Queensland conditions. The role of the coroner was further transformed with the enactment of the *Coroners Act* 1958 which incorporated amendments contained in *The Coroners Act Amendment Act of 1943* and *The Coroners Act Amendment Act of 1947*. The 1958 Act stayed in force for forty-five years. It was replaced with the *Coroners Act 2003*.

**Literature Review**

The literature review discusses key works that focus on the role of the English coroner. It investigates to what extent historians and academics have written about the history of the Australian coronial institution, and how it evolved in Queensland. There is no shortage of scholarship on the history of the ancient office of the English coroner, but historians have largely neglected the coronial institution in Australia. Work dealing with the coroner in Australia generally informs readers that the ancient office was first established by the *Articles of Eyre* in 1194 and proceeds with an account of the historical development of
the office in England. In a historical sense, rarely do these works go further than informing the reader that English coronial law was adopted in the new colony of New South Wales at settlement. Current literature on the coroner, which has been generated from disciplines such as law, medicine and sociology, generally focus on the contemporary role and functions of the coroner such as the independence, jurisdiction, limits of power, and relevancy.

To understand the function of the coroner it is necessary to examine the origins of the office and how the original function has altered over time. The literature review has been divided into two sections; the first dealing with the development of the office of coroner in England, while the second section discusses the works which focus on the function of the coroner in Australia and Queensland. I have grouped the readings thematically, however the limited nature of the literature means most works are reviewed individually. Although the coroner is the common thread throughout the literature, most works reviewed explore distinct aspects of the office of coroner and only share loose connections with each other.

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First published in 1755, Richard Burn’s *Justice of the Peace and Parish Officer* was for many years the foremost authority on the law relating to justices of the peace. The duties of the coroner were incorporated within the text. In 1829, English lawyer John Jervis published the first edition of *A practical treatise on the office and duties of coroners*. Bringing together legislation, procedure, rules and practice, it is still considered the leading practitioners' text on coroners and inquests. The twelfth edition was published in 2002. Early Australian guides to the duties of magistrates, based on the English model, were John Plunkett’s *The Australian magistrate or A guide to the duties of a justice of the peace for the colony*, John Handy’s *The Queensland Magistrates Guide* and William Wilkinson’s *The Queensland Magistrate*. This body of literature encompassed the practical and legal application of coronial law, however the texts were distributed sparingly to magistrates in Queensland.

Roy Hunnisett is considered the foremost authority on the coroner’s records in the English Public Record Office. He worked primarily with medieval miscellaneous inquisitions. Discussing the medieval coroners’ various functions in separate chapters, Hunnisett provides numerous examples from primary sources. He traces the creation of the office in 1194 through to the 1500s. Originally coroners were appointed as keepers of the pleas of the crown. The main function of the coroner was to protect and raise revenue

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9 Jervis, Sir John (First Edition 1829), *A Practical treatise on the office and duties of coroners*, London: Sweet and Maxwell. (Reprinted under the title *Jervis on the office and duties of coroners: with forms and precedents*).
for the King, and it was during the mediaeval period that the coroner held the most power.

The office of coroner, according to Hunnisett, had reached its peak by the latter half of the thirteenth century. But the power of both county and borough coroners gradually declined over the fourteenth and fifteenth centuries, following the cessation of the “General Eyre”\(^\text{12}\). This coincided with the rise in importance of justices of the peace. After the abandoning of the “General Eyre”, the coroner no longer compiled formal rolls nor performed a number of duties previously linked to the coroner and sheriff. These functions had been taken over by the justices by the end of the fourteenth century.\(^\text{13}\) Although the prestige and fiscal functions of the medieval coroner had been diminished, the office continued to survive; its importance attached to the enduring power to hold and record inquests on dead bodies.\(^\text{14}\) Hunnisett’s seminal study on the origins of the English office of coroner incorporated medieval history, legal history, and a small amount of forensic medicine. Hunnisett’s text strengthened scholarship on the coroner in England and continues to provide a solid foundation for historians researching the office.


\(^{12}\) The “General Eyre” is explained in Chapter 1.
\(^{13}\) Hunnisett, The Medieval Coroner.
*Sudden and Unexplained Deaths*, covers the development of the coroners’ system in England and Wales. Harvard is critical of the methods used in investigating sudden and unexplained deaths prior to the nineteenth century. According to Harvard, for centuries coroners have ascribed some homicides as attributed to natural causes, while accidents which were in fact homicides went undetected.\(^{15}\) Kistra Kesselring argues this situation changed when medical testimony and examinations became routine by the 1800s and forensic medicine was taught at universities.\(^{16}\)

Historians, who have studied the inquest, note that juries in the past relied on lay knowledge and divine providence in reaching their verdict. The medicalisation of the inquest altered the role of the coroner. Having the authority to order post-mortem examinations and obtain medical evidence at inquests assisted the coroner with his findings. Kistra Kesselring studied the role the English coroner played in detecting ‘death disguised’ in the Early Modern period. According to Kesselring, new evidence suggests that forensic medicine was used as an investigative tool in the detection of murder earlier than originally thought. Raising revenue for the Crown was central to coroners’ duties; murder fines for those found guilty, and the forfeiture of the suicide victim’s belongings, were collected by the coroner. The coroner also confiscated the item which caused the death, the deodand.\(^{17}\)

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\(^{17}\) Kesselring, ‘Detecting “Death Disguised”’, p. 22.
If laymen sitting on the inquest jury were unable to determine the perpetrator of a murder they relied on divine intervention. Not until the late seventeenth century did the belief in divine detection of murder begin to disappear and the uses of medical evidence emerge. Like John Harvard and Ian Burney, Kesselring asserts that medico-legal practices to detect homicides were established on the Continent far earlier than in England. Kesselring goes on to argue that expert medical knowledge and the performance of autopsies were part of the system of inquiry into secret deaths in England earlier than originally recorded. She cites two cases in the 1500s of jurors calling for medical professionals to give evidence at an inquest. This claim challenges the earlier work of Harvard who argues that it was the seventeenth century before any provision existed for giving medical evidence at coroners’ inquests in England. Kesselring acknowledges that medical expertise was relied upon well before it provided any real certainty as to cause of death. She notes that it in the case of death by poison, it was not until the 1800s that reliable tests were developed.

Death by poison is the subject of Katherine Watson’s work, *Poisoned Lives: English Poisoners and their Victims*. She examines the criminal and murderous use of poison in England between 1750 and 1914, maintaining poison was difficult to detect in a body prior to 1800. She argues that as a result of suspicions of homicides due to poisoning

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going undetected, forensic tests were developed that made detection more likely.\textsuperscript{23} Watson however, fails to draw from Howard Taylor’s work on the control of the criminal justice system by financial limitation and its effect on the criminal statistics of the nineteenth and twentieth centuries in England. According to Taylor, in the 1860s English medical practitioners expressed concern about the number of undetected murders accomplished through the administering of poisons each year. He argues that growing government parsimony from the 1830s onwards meant criminal justice was subjected to budgets and rationing. Taylor concluded that it was an open secret that many murders and suspicious deaths were not investigated as the criminal justice system was severely impaired by late nineteenth century English government bureaucracy and social policy.\textsuperscript{24}

Ian Burney’s text \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}\textsuperscript{25} investigates the rise of the medical forensic expert and development of the modern inquest. Drawing on a wealth of primary data, Burney gives a comprehensive and contextual account of the development of the medical, legal and political components of the English coroner’s inquest. Medical representation at inquiries led to a new framework under which the politics of knowledge production operated. This framework was constructed on the interplay of medicine, law and public accountability and played an important role in the development of the modern state.\textsuperscript{26} The public inquiry is described by Burney as democratic politics and he maintains that ‘the inquest was a traditional

\textsuperscript{25} Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}.
\textsuperscript{26} Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 8.
bulwark by which the people could resist the ever-looming threat of abuse of authority’. \(^{27}\)

He traces the transition from the popular inquest to the expert-based inquest and looks at the circumstances requiring inquests and the conditions governing the engagement of coroners. Burney claims that the civil registration of deaths was important for the collection of vital statistics. \(^{28}\)

According to Burney, the inquest site changed from the alehouse to a complex specifically designed to accommodate post-mortem and inquests. Medical witnesses began giving evidence at inquests and juries were no longer required to view the body. \(^{29}\)

So began the transformation of the inquest based on medical evidence. Burney alludes to the threat to public accountability when he states that ‘a “decorporealized” inquest pointed unambiguously in the direction of an expert-based, efficiency-oriented system of death management. This program, however, was consistently mixed with concern for the value of the inquest as a ritual of public participation and expiration’. \(^{30}\)

The debate that continued around the modern-scientific over the traditional and popular inquest exemplifies the tension that existed between the medical and legal professions. Each professional claimed to be the best qualified to conduct an inquest. Reform of the office of coroner gradually occurred during the 1800s and early 1900s. According to Burney the \textit{1926 Coroners Amendment Act} can in one sense ‘be taken as the culmination of a century

\(^{27}\) Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 20.


of medicalizing reform, composed of provisions that cast medicine, the body, and the public in new relationships to one another’.\footnote{Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 165.}

Abolishing juries at inquests did not go uncontested. The press expressed concern over the demise of the popular inquest, hence the headline “The Coroner a Law Unto Himself. Extraordinary Powers of Exclusion”.\footnote{Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 171.} Reform of the public inquest continued; the last comprehensive parliamentary inquiry into the workings of the English inquest was the Report of the Committee on Death Certification and Coroners in 1971.\footnote{Commonly known as the Broderick Report.} The report sanctioned the utilisation of medical science at inquests. However it included proposals that the traditional public inquiry be re-endorsed.\footnote{Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 172.}

Medical science was introduced into the Australian inquest system in the mid-nineteenth century. Harold Love details the influence of specialist Melbourne pathologist, James Neild, during the 1860s and 1870s in \textit{James Edward Neild: Victorian Virtuoso}.\footnote{Love, H. (1989) \textit{James Edward Neild: Victorian Virtuoso}, Carlton: Melbourne University Press.} Love maintains that most of Neild’s professional work consisted of appearances as a medical witness and conducting post-mortems. Coroners were critical of local practitioners’ knowledge of pathology and engaged Neild to conduct autopsies when special cases were being investigated. As was the situation in England, this led to a resentment of “expertism” and a fear that a specialist forensic pathologist would become a medical
policeman, reporting on other practitioners.\footnote{Love, \textit{James Edward Neild: Victorian Virtuoso}, pp. 159-160.} Medical practitioners lobbied for the abolition of the office of coroner, claiming the police magistrates and justices of the peace were capable of investigating suspicious deaths. In addition, the legal profession felt that coroners’ duties infringed on their functions. Premier Graham Berry abolished the position of chief medical officer in 1879 and transferred the duties to police magistrates and justices of the peace. As a result, the coroners’ jurisdiction was severely curtailed.\footnote{Love, \textit{James Edward Neild: Victorian Virtuoso}, pp. 162-163, 176-183.} Continuing to lecture at the University of Melbourne, Neild remained receptive to advances in scientific medicine, but he never secured the position of coroner.\footnote{Love, \textit{James Edward Neild: Victorian Virtuoso}, p. 313.}

Focusing on the same historical period as Burney, Joan Sim and Tony Ward concentrate on the subject of deaths in custody in nineteenth-century England. The authors examine the power of coronial inquests to obtain political and legal accountability. Importantly, they argue that the populist format of the inquest provided a forum for the poor to challenge the powerful. Coroners experienced increased status when from the 1830s their investigations supplemented the duties of central government agencies. Nonetheless, a conflict existed between police magistrates and coroners concerning investigations into deaths in prisons and workhouses. Although coronial inquests were mandatory on all
prison deaths, coroners’ findings rarely criticised institutional policies. Critics argued that inquests were merely a formal process with predictable outcomes.39

Sim and Ward examine a report by a committee of Middlesex justices in 1851 who claimed that inquests were a duplication of police investigations and were therefore an unnecessary expense. The committee questioned the value of coroners’ juries and recommended that they, along with the office of coroner, be abolished. The coroners argued that their investigations should be independent of the magistrates and police. They claimed that corruption and concealment of deaths, connected to police brutality, was possible if police were the sole authority investigating sudden and suspicious deaths. Coroners were also concerned that the police magistrate would display no independence when investigating a death in a government institution.40

In 1860 a Parliamentary Select Committee on the Office of Coroner made recommendations on coroner remuneration, election and method of summoning juries. The Report proposed that inquests be held in all cases of sudden or accidental death but the legislation was not passed until 1887.41 Katherine Watson noted that the proposals from the Select Committee Report ‘became an important foundation of the Coroner’s Act 1887, establishing much of the authority and autonomy that modern coroners possess’

today.\textsuperscript{42} The recommendation calling for juries to be selected as for other courts was included in legislation passed in 1883. Sim and Ward maintain that inquests gave prisoners a voice to refute claims made by authorities. They also claimed that coroners’ juries played an important part in highlighting concerns over disciplinary procedures in prisons. Sim and Ward viewed the nineteenth century coroner’s court as a site of conflict between the legal and medical professions, the centralized state bureaucracy and those who held power in and over local communities. Evidence gathered from case studies and government reports support Sim and Ward’s argument that the benefit attached to the coroner’s court was that it afforded an opportunity for marginalised groups in Victorian society to challenge the practices of disciplinary institutions.\textsuperscript{43}

The nineteenth century role of the coroner began to change during the course of the twentieth century. Determination of cause of death was no longer the sole objective of the inquest. According to Stephen Cordner and Beatrice Loff, the value of a coroner’s inquest lies in its ability to ease public anxiety and the potential to prevent further deaths through the implementation of coroners’ recommendations. Now that the detection of homicide is the responsibility of the police, Cordner and Loff ask if the office of coroner still has a purpose. Of the five purposes for an inquest outlined by the Broderick report of 1971, the authors consider the identification and investigation of potentially preventable deaths to best meet the role of the inquest.\textsuperscript{44} The Broderick committee advocated the detection of the circumstances leading to a death, but paradoxically recommended the

\textsuperscript{44} Cordner and Loff, ‘800 years of coroners: have they a future?’, pp. 2-3.
power for a coroner to commit be abolished. Cordner and Loff argue that prohibiting a coroner from acquiring evidence of the circumstances of a death, means the death cannot be investigated properly. They suggest that the English coronial institution only appears to investigate death and claim that the English system would regain relevancy if reform was based on the Victorian Coroner’s Act of 1985 (Australia), that requires the coroner to not only ‘identify any person who has contributed to the death but also to comment and make recommendation to the Attorney-General on matters of public health and safety’.45 The authors conclude that if the present coronial system of England reacted to criticism of its lack of clear purpose by adopting a coronial system similar to that of Victoria, the present office of coroner may survive.46 Consequently, an Australian coronial system, which was adopted from England, was held up as a model for England to follow.

With regard to Australian law, the transplantation of English common law to New South Wales is the subject of Hilary Golder’s work High and Responsible Office: A History of the NSW Magistracy.47 Golder uses primary material such as court records and criminal statistics to explore the changes in the jurisdiction of the magistrate’s court. The study, which commences with the arrival of the magistracy at Sydney Cove, contains a short three page vignette on the ‘Reorganization of the Coronial System’. This piece follows the transformation of the office of coroner from settlement to enactment of the Coroner’s Act 1912 that abolished juries. Coroners, appointed by the Governor, initially conducted inquests in New South Wales until such time as the expansion of European occupation

45 Cordner and Loff, ‘800 years of coroners: have they a future?’, p. 4.
46 Cordner and Loff, ‘800 years of coroners: have they a future?’, p. 5.
placed a strain on the small number of coroners. Magistrates as early as the 1820s were authorised to conduct summary inquiries but not conduct a formal inquest. To assist with inquest duties, the *Coroners’ Act* 1901 authorised every stipendiary or police magistrate to have the powers of a coroner and provided that every coroner should be a justice of the peace.  

Ross Johnston’s 1978 work identifies a similar process in Queensland, whereby the duties of the coroner were transferred onto justices of the peace as magistrates moved away from smaller communities. Although Golder notes that New South Wales lost ‘both territory and magistrates when the separate colony of Queensland was created in 1859’, an examination of the office of coroner in the Moreton Bay settlement while under New South Wales’ government control was not included in her work.

Johnston’s work deals specifically with the application of the rule of law in the Queensland colony from 1859 to 1900. As with other literature dealing with the office of coroner in Australia, Johnson informs us that when Queensland separated from New South Wales in 1859 it carried with it the same legal system and rule of law as New South Wales. The prime concern of the new colony, according to Johnston, was ‘that at least an elementary system of justice be brought to the small, but rapidly spreading, white settlements’ and expectations of the legal system were ‘the preservation of property and

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the establishment of order’. The lower courts took up coronial jurisdiction in 1866 under *The Inquests of Deaths Act (1866)*.

As district courts spread and paid magistrates were relocated from smaller communities to the district courts, unpaid justices of the peace replaced the magistrates in the lower courts. The justices of the peace were highly criticised by the legal fraternity which was concerned about their inexperience and lack of formal instruction in legal matters. It was considered improper that unqualified justices should have the capacity to commit for trial and lay contempt charges. The largely unqualified judiciary was comprised of local officials, land owners and squatters, all of whom looked after their own interests. Claims were made that the government appointed unpaid justices as political rewards to ‘mates’ who would in turn comply with government directions; this system of justice impacted the poorer people who were at the mercy of the “magistrates of the rich”. At the beginning of the twentieth century the lower courts of Queensland still remained outside the Department of Justice regime. Although Johnson focuses on the role of the justices of the peace and the powers they possessed, there is no inquiry into their responsibilities and duties linked to conducting coronial inquests.

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54 Johnston, ‘The Growth of the Lower Courts’, pp. 15-16. It was sometime after 1909 that administration of magistrates and clerks of Petty Session passed from the Premier’s Department to the Department of Justice (Dean, G. (2008), *Here Comes the Judge: The Queensland Magistrate*, Brisbane: Department of Justice and Attorney-General, p. 35).
Mark Finnane and Jonathan Richard’s journal article ‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland’, is one of only two publications located that directly discusses the function of the inquest and its application under the rule of law in colonial Queensland.\textsuperscript{55} The authors make extensive use of archival material, inquest records in particular, to gather evidence to show that the colonial government essentially neglected or abused the rule of law when it came to coronial investigations of Aboriginal deaths, especially those perpetrated by the Native Police. They argue that the evidence suggests that while the colony appeared to operate under the rule of law, the government failed to enforce strict legal accountability for the actions of some state employees.\textsuperscript{56}

In 1866 the Queensland government passed a new inquest Act that abolished juries and allowed justices of the peace to conduct inquests, thus granting them the full power of coroners. An inquest was a public inquiry held to determine the cause of death of the deceased and to allay public anxiety over violent and unexpected deaths. According to Finnane and Richards, reports of death often did not result in an inquest and, due to the isolation of the frontier, some Native Police officers and white settlers were able to successfully conceal acts of violence and deaths against Aborigines. They claim that ‘the conditions under which a death became the subject of a coronial inquiry were mediated

\textsuperscript{55} Finnane, M. and Richards, J. (2004), “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, \textit{Australian Historical Studies}, Vol. 35, Number 123, April.

\textsuperscript{56} Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 86.
by the realities of distance, denial, cover-up and subversion of justice’. Magistrates did not always fully investigate the circumstances surrounding Aboriginal deaths. On the rare occasions when they did hold inquests into Aboriginal deaths, Native Police and other government employees called as witnesses were sometimes accused of obstructing the cause of justice. For example, the witnesses claimed to have no memory of an incident or refused to answer questions. Although inquests were held into Aboriginal deaths, no Native Police officer was ever convicted of murder, even if the evidence indicated they were culpable.

The inquest record reveals information about the actions of the Native Police and government responsibility. Between 1860 and 1897 there were more than 50 inquests into Aboriginal deaths in which police were strongly implicated or found to be formally responsible. Evidence did suggest that some inquest findings placed blame on police actions. The inquest record is unreliable as a guide to the number of Aboriginal killings as the majority remained unreported to authorities. Inquests were most likely to be held into deaths of Aborigines involved in settler society through employment. According to Finnane and Richards, the Native Police generally were not held to account because the inquest process was only loosely followed. For Finnane and Richards the colonial inquest provided an insight into the advancement of the colony and the intersection of Aborigines and white settlers, where the ‘rule of law was both agent of dispossession and

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57 Finnane and Richards, “You’ll get nothing out of it”?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 87.
58 Finnane and Richards, “You’ll get nothing out of it”?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, pp. 89-90.
59 Finnane and Richards, “You’ll get nothing out of it”?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, pp. 95-103.
its potential critic. The evidence showed that the inquest was not effective in making those responsible for acts of violence and deaths of Aborigines in colonial Queensland accountable.

Just as Finnane and Richard’s evidence was extracted from the inquest files, Simon Cooke also gathered quantitative evidence from inquests to investigate the meaning of suicide in nineteenth century colonial Victoria and the Port Phillip District. Cooke selected the inquests for his study from the index to coroner’s papers. A problem with this research method is that deaths that were most likely suicide but given verdicts to conceal the fact, such as natural causes or madness, were not included in the study.

Cooke gives a comprehensive account of the state institutions involved with an inquest, the function of the inquest and the role of the coroner. He tracks the changes to the office of coroner and the inquest process, stating that during the nineteenth century the inquest shifted from popular to institutional power. Cooke argues that the inquest institution focused more on medical and bureaucratic accuracy than popular moral judgment. His research showed that medical men dominated the coronership in Melbourne, but in rural areas inquiries were generally held by magistrates. There were only three coroners in Melbourne over a period of 59 years. Debate existed as to the legal or medical

60 Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 105
61 Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 105.
qualifications for coroners during the mid-nineteenth century in England. Cooke was not able to determine whether medical qualifications were considered relevant to the appointment of the three Melbourne coroners, as papers have not survived. Amongst his sample he only detected a few lawyers serving as coroners.  

Full coronial inquests involved empanelling a jury and having a coroner direct the proceedings. On the other hand, magisterial inquiries conducted by a police magistrate or local justice of the peace, did not require a jury. The author argues that the use of police magistrates to investigate sudden death represented the intrusion of state authority into the community. Police magistrates’ jurisdiction covered large areas, making them less familiar to the people with whom they had to deal. They would have appeared as representatives of a distant, formal institution. Deputy coroners also ran inquests when neither a coroner nor a police magistrate could hold an inquest.

Inquests were open to the public and the proceedings were regularly reported in the weekly newspapers. Suicides especially were reported in considerable detail, usually straight after the event and following the inquest. Melbourne coroners actively encouraged reporting of inquests and made available copies of depositions to journalists who appear to have had access to police reports. Many reports of inquests repeated the

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64 Cooke, ‘Secret Sorrows: A Social History of Suicide in Victoria, 1841-1921’, pp. 51-64.
depositions word for word. Press reports provide a good source of information as they usually contained details about the deceased’s life.65

According to Cooke, the use of permanent police and medical coroners at the Melbourne morgue led to a highly professional and bureaucratic medical system for the discovery and classification of suicide. This contrasted to inquests held by local justices of the police and police magistrates. Furthermore, the involvement of police at inquests led to a more formal and structured system of inquiry that was reinforced when from 1903 coroners were no longer required to summon juries.66 Cooke’s research is valuable because it produced a history of the office of coroner in Victoria during the nineteenth century, founded on primary evidence extracted from inquest records.

The works of Cooke and Love reveal important historical information about the office of coroner in Victoria. The texts supply a framework around which a history of the Queensland office of coroner may be constructed and represent a point of comparison. Moreover, these resources draw attention to the dearth of published literature dealing with the topic of the coroner in Queensland.

A more modern review of the coronial system in Queensland was undertaken by Justin Malbon, Geoff Airo-Farulla and Cate Banks.\textsuperscript{67} It should be noted that the report was written before the introduction of the \textit{Coroners Act 2003}, when the \textit{Coroners Act 1958} was still current. The authors were commissioned by the Aboriginal and Torres Strait Islander Overview Committee (ATSIOC) to examine Queensland’s failure to implement the Royal Commission into Aboriginal Deaths in Custody (RCADC) recommendations and the inadequacies of the Queensland coronial system. The report raised questions about what purpose the coronial process should serve and how it should operate. Included in the report is a proposal for a new coronial structure based on three separate pathways of action upon the reporting of a death to the coroner. The most important aspect of the new process would be the creation of the position of Registrar to liaise with the deceased’s family. Seventeen recommendations are made in the report, some of which were taken up in the \textit{Coroners Act 2003}. Overall, the recommendations are directed at making the purpose of the coronial system clearer and keeping relatives of the deceased better informed.\textsuperscript{68}

Malbon, Airo-Farulla and Banks give a brief history of the English coroners’ court noting that the nineteenth century coroners’ court claimed to have become “magistrates of the poor”.\textsuperscript{69} Following a short summary of the general function of the coroners’ court in Australia, the Queensland history of the coronial process is presented.\textsuperscript{70} This history

\textsuperscript{69} Malbon, et al., ‘Review of Queensland Coronial laws’, p. 16; as discussed above, Sim and Ward (1994) interrogate the value of the coronial institution to the lower English classes further.
amounts to a chronological outline of the coroners’ acts and amendment acts passed in Queensland, and does not discuss the intersection of the legal and medical institutions involved in the coroners’ functions, nor the political context of statutory change. Malbon et al conclude that little has changed to date in the coronial process in Queensland and it remains largely the same as in the late nineteenth century. The authors argue that the coronial process should be reformed with a view to making it more effective, efficient and fair.\(^{71}\) Although the authors maintain the coronial process in Queensland has changed little since the late nineteenth century, there is limited historical content in the review to back up such a claim.

Coming from legal and medical backgrounds, Ian Freckelton and David Ranson are well qualified to interrogate the medico-scientific and legal systems of death investigations in Australia. The vast and comprehensive text *Investigating Death and the Coroner’s Inquest*\(^{72}\) presents an overview of the historical, legal, scientific, medical and technical aspects of coroners’ investigations into death. An extensive list of sources was examined by the authors: coroners’ reports, current and historical medical and legal journals, government departmental publications, government inquiries, newspaper articles, and conference papers. They outline the history of the English office of coroner then proceed to discuss the transplantation of the English death investigation system and function of coroners to New Zealand and Australia. Freckelton and Ranson provide a concise summary of Australia’s coronial system from settlement to the twenty-first century, as

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\(^{72}\) Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*. 38
well as placing it within an international context. They include an examination of the practice, law and procedure of death investigations and inquest hearings for each of Australia’s states and territories, concentrating on aspects of jurisdiction of the coroner, the death investigation powers of the coroner, the coroner’s right to conduct autopsies and exhume bodies, and the statutory rights of appeal and reopening inquests.\(^\text{73}\)

While the text distills the technical and practical aspects of the investigation of unexplained, violent or suspicious deaths, the authors also evaluate the office of coroner. They question the limit to the coroner’s power in terms of investigations, findings and recommendations when conducting inquests. Freckelton and Ranson state that an important factor linked to the development of public policy to reduce risks to the public, has been linked to the ability of coroners to make recommendations. They contend that the institution of the coroner should continue, but conclude that it should undergo significant legal reform. They call for the professionalisation of the coroner’s office and a rise in the status of the coroner’s court.\(^\text{74}\)


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\(^\text{73}\) Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*.

\(^\text{74}\) Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*, pp. iv, 106.

towards death over the nineteenth and twentieth centuries in Australia and England. Despite the subject matter focusing on death in Australia, the role of the office of coroner does not feature anywhere in the text. John Weaver also looks at death in Australia, but his study concentrates on suicide.\textsuperscript{76} His work integrates sociological and medico-psychological insights and draws on nearly 7000 suicide inquest files from Queensland and New Zealand for the period 1900 to 1950. Through Weaver’s work it is possible to gain an understanding of how the coroner, through the inquest process, deals with an inquiry into suicide in the first half of the nineteenth century in Queensland. Importantly, Weaver also evaluates the use of historical archival data as a form of evidence, which embodies a cautionary message to researchers. He notes that the centralised state closely scrutinised judicial officers and possibly manipulated and censored their reports. Weaver maintains the issue of distortion of the public record should be kept in mind when discussing the use of evidence from inquest records.

\textbf{What the literature tells us}

The English coroner originated in the twelfth century. Initially, the coroner’s investigation of death was considered a means of issuing fines and collecting revenue for the Crown. The coroner’s ability to protect society from ‘hidden’ homicides did not gain currency until the office achieved independence from the justices of the peace and attracted a salary in place of fees for service. The move away from a revenue raising role to a position investigating death put the coroner at odds with magistrates and police in

\textsuperscript{76} Weaver, J. (2009), \textit{A Sadly Troubled History: The Meanings of Suicide in the Modern Age}, Montreal: McGill-Queen’s University Press.
England. Arguing that the coroner replicated the duties of magistrates and police, calls were made to abolish the office of coroner altogether. The office survived, and the *Coroners Act* 1887 clarified the role of the office of coroner as one that determined the circumstances and medical causes of sudden, violent and unnatural deaths. It was no longer associated with protecting the financial interests of the Crown.

The medicalisation of the inquest was more commonplace by the middle of the nineteenth century, although earlier examples of forensic evidence given at inquests have been identified. The suspicion that homicides due to administering poison were going undetected due to government parsimony, led to the increase in autopsies and forensic investigation of the dead. Medical, legal and political components constructed the modern inquest. With the view of the body no longer necessary, medical representatives at inquests transformed the public inquiry into an expert-based inquest. However, whether the decorporealised inquest was a threat to public accountability continued to be debated. Tension existed between medical and legal practitioners over who was best qualified to conduct an inquest. The same debates related to the shift from popular to medical inquiry, and whether coroners should have legal or medical qualifications were also present in Australia.

The transfer of English Common Law to New South Wales in 1788 meant the office of coroner was also established in the colony. A handful of coroners initially conducted inquests in New South Wales until the settlement spread to such an extent that the small
number of coroners could not cope with the number of inquests required. Magistrates conducted magisterial inquiries from the early nineteenth century. The *Coroners’ Act* 1901 empowered every magistrate to perform the functions of a coroner and provided that every coroner should be a justice of the peace. Magistrates were relocated from New South Wales to the newly established settlement at Moreton Bay before it gained independence in 1859 and became known as Queensland.

Full coronial inquests, when first held in Queensland, involved empanelling a jury, viewing the body and having a coroner direct the proceedings. A police officer assisted the coroner. Magistrates and justices of the peace were authorised to conduct magisterial inquiries which did not require a jury. The coroner’s court was open to the public and was central to the idea of the inquest’s purpose of public accountability. Inquest proceedings were reported in the press and it was common for coroners to provide reporters with copies of depositions.

Queensland legislation combined the role of the coroner with the duties of magistrates, which placed an additional burden on magistrates. Additionally, authorizing unqualified justices of the peace to conduct inquests attracted criticism from the legal profession. Magistrates of the lower courts in Queensland were usually squatters or influential citizens who put their own interests first. The government was accused of rewarding friends with appointments as justices to ensure their co-operation with government orders. Consequently this system of justice was criticised for placing the working class,
poor and marginalised, at the mercy of privileged magistrates. For example, magistrates did not always fully investigate the circumstances surrounding the deaths of Aborigines. Consequently, while the colony appeared to operate according to the rule of law, the government failed to demand legal accountability from public servants for their actions.

The role of the coroner in the twenty-first century has changed considerably from that of the nineteenth century coroner. But what accelerated these changes and how did the transformation take shape? The function of the office of coroner is vital to death investigation practices. The coroner’s court represents a public forum for openly enquiring into the cause of death of a deceased, as well as functioning as a catalyst of accountability. Yet the paucity of works focusing on Queensland coroners shows that they are a neglected part of the state’s history. In comparison, Simon Cooke’s work records the history and social implications of erecting Melbourne’s city morgue, and incorporates an account of the coroners who held office in Melbourne during the nineteenth century. A review of the existing scholarship has exposed the dearth of literature in relation to the history of the coroner in Queensland. Rather than claim there is a gap in the literature, I maintain that to my knowledge there is no published literature that discusses the role and transformation of the Queensland coroner. Consequently, it is obvious why a research study should be conducted into the coroner in Queensland. My research was guided by the initial question of what was the early role of the coroner in colonial Queensland? Subsequent questions were related to how the function of the coroner changed over the first one hundred years and what factors led to the transformation of the office.
Methodology and Sources

This research study focuses on the subject of death investigation and the role of the office of coroner in Queensland from 1859 to 1960. The purpose of the research was to determine the status of the Queensland office of coroner at separation, and to trace the transformation of the role of the coroner by identifying factors that instigated changes. Secondary data helped to construct the historical, legal and social context within which the coroner in England and New South Wales evolved. Nevertheless, the collection of data from primary sources was given the utmost priority in this research, as there was a paucity of published texts on the subject of the early function of the coroner in Queensland.

My research commenced with an investigation of the Queensland Parliamentary Debates to locate issues debated in relation to the office of coroner. This search steered me towards most of the case studies contained in the study. For example, in the John McCrae case study the inquest files are missing from the records at the Queensland State Archives and to date these files, along with the depositions taken at the police inquiry held by Police Magistrate Christopher Francis on 24 March 1905, have not been located. Data for this case study was gathered from selected depositions taken at the two coronial inquests read out in a 1905 sitting of the Queensland State Parliament.  

See Chapter 3, p. 177 for the John McCrae case study.
Parliamentary discussions, which centred on the draft version of a proposed Coroner’s Act, revealed the inadequacies identified in the present legislation and members’ concerns with the proposed new law. For example, when debating the proposal under the *Inquests of Death Bill* 1866 to abolish juries sitting at inquests and to empower justices of the peace to perform the functions of the coroner, William Yaldwyn, Member for Ipswich, stated:

> It was useless to talk of a coroner. What was a coroner? He was not an animal of a particular description. He was only a man like other men, and might be prepared to carry out his duties if he had the material. But in the interior, where he could not get the material, and could not get the requisite number of men to carry out an inquest, what was to be done? He could not make men, nor could he get men together. That being the case, he thought the principle of the Bill would act well, which provided that an inquest might be held by a certain number of justices without a jury at all.  

Yaldwyn was highlighting the difficulties coroners’ encountered in performing their duties. That is, a lack of fundamental administrative supplies and more importantly, an inability to gather together twelve men to make up a jury. During the same session of parliament, the Postmaster-General informed the House that the amendment of coronial law was essentially a legal matter, and should be left to the legally trained members of the House. In his opinion, medically trained members were not as qualified as legal men to draft the legislative bill. The above examples exemplify the value of the parliamentary debates in reflecting the attitudes of individual members towards the office of coroner and the proposed legislation.

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In conjunction with the Parliamentary Debates, I examined the Queensland Parliamentary Papers. The Parliamentary Papers consist of reports; returns; and statements from departments, parliamentary committees of inquiry and royal commissions which have been presented to the Parliament. Background information on the appointment of Henry Challinor as coroner to Moreton Bay, and the provision of an annual salary, was gleaned from the Report from the Committee of Elections and Qualifications (1861). In addition, this source revealed the lack of knowledge and the casual approach of government authorities vis à vis matters concerning the office of coroner. Perusal of the Queensland Parliamentary Papers allowed for a direct insight into the government apparatus. I also acquired copies of the English and Queensland Statutes relevant to the office of coroner. Not being trained in law, my interpretation of the legislation is at a rudimentary level. I summarised the salient points of the legislation for the purpose of supplying a quick reference when working on the various Coroners’ Acts. Decisions of the Supreme Court brought down in cases related to coronial inquests were accessed through the Queensland law reports.

The *Queensland Government Gazette* is a unique and useful resource for researchers in a number of fields of study. Acting as a means of communicating with public servants and the general public, the publication contains: proclamations, regulations, government notices, appointees to government positions, appointments of magistrates and police throughout the colony/state, lists of medically qualified practitioners and a range of other
entries linked to managing the colony. A valuable feature of the gazette is the inclusion of government orders which often draw attention to certain irregularities connected with public servants’ performance and responsibilities. The *Queensland Government Gazette* is a productive resource for compiling data on the intersection of the government and the role of coroner.

The police were intricately involved in the death investigation process and the *Queensland Police Gazette*, which was compiled to be distributed only amongst members of the police force, contains exclusive details and information linked to the operation of the force. Notably, new appointments and postings of police are published in the gazette. Throughout the nineteenth century the *Queensland Police Gazette* published lists of all deaths reported to the police, as well as incidences of violent crime and murder. The ‘Return of deaths reported to the police, in which Inquests have been held’ incorporates data that steers the researcher directly to inquests held on violent or suspicious deaths. The report’s nomenclature of cause of death likewise represents a valuable research tool in tracking changes to cause of death appearing on death certificates. Primary evidence was also taken from reports in Police Staff Files when investigating the death of John MacCrae. As previously stated, the inquest file was not located, however the sequence of events can be pieced together from documents contained in the Staff Files of police officers involved in the investigation and subsequent coronial inquiry.

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79 This practice ceased at the beginning of the twentieth century.
Held at the Queensland State Archives, the Queensland Blue Books give details of people employed in the Queensland Civil Service for the year of publication. After the alphabetical listing of civil servants, the larger part of this volume records appointments by department. The names of coroners appointed are listed under the Justice Department for the years 1859 to 1866, and then disappear after enactment of the *Inquest of Deaths Act of 1866*. The Blue Books also disclose the fees paid to coroners for conducting inquests and the mileage allowance for traveling away from home to hold an inquest. The legislation setting out the fees is also recorded with the entry. The Blue Books acted as a quick and convenient reference source while working at the archives. For example, when finding the signature of the magistrate holding an inquest illegible, I was able to identify the specific government official by checking the Justice Department’s list of magistrates in the district where the inquest was held.

The inquest records held at the Queensland State Archives provided the majority of the evidence for the thesis. A benefit of Queensland’s centralised jurisdiction was the preservation of records. The inquest was the crucial mechanism for establishing the identity of a corpse, and cause and manner of death. Inquest records provide a rich source of evidence for the social historian. Depositions taken from witnesses during the inquiry convey details of the deceased’s life, in conjunction with information that reflects aspects of contemporary society. While this type of research can be an emotional process, eventually the research transforms into an intellectual exercise. An inquest file generally

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80 This is because the Act empowered magistrates and justices of the peace to function as coroners in defined districts, thus doing away with the need for a full-time coroner. See *Inquests of Deaths Act of 1866*. 
contains: the name and occupation of the deceased, a physical description of the body, where it was found, who found it, the cause of death, witnesses’ depositions, a report from the attending police officer, an autopsy report if carried out, and where applicable, a chemical analysis of body tissue or organs. In cases of suicide, notes give insight into the troubled world of the deceased. Inquest records form a large archive of material related to the inquest process. A number of case studies, extracted from the inquest data and cited throughout the thesis, expose the functional strengths and inadequacies of the office of coroner. Although I managed to search four decades of inquest files, it was through the extreme generosity of a colleague Dr Jonathan Richards that I came into possession of comprehensive inquest data. Dr Richards has examined all inquest files in Record Series ID 36 from 1860 to 1960; this representing approximately 40,000 files.

Queensland State Archives holds other records pertaining to inquests and preliminary enquiries not included in the main series. These include separate sources relating to railway and mining accidents and fire inquests. The selection of records to investigate was made according to the basic research questions which related to death investigation and the development of the institution of the coroner in relation to such investigations. Working to a time frame curtailed the extent of my research involving departmental records held at the Queensland State Archives. I accessed the records of the following departments in search of information related to the office of coroner: Colonial Secretary, Police, Health and Home Affairs, Public Works, Crown Law Office, Attorney-General’s Office and the Justice Department. In conjunction with the inquest files these records proved invaluable to my research objective. I located circular memorandums and
correspondence between departments dealing with the administration and organisation of
the office of coroner. The data collected fitted together like a jigsaw, revealing a picture
of cost-conscious governments that were slow to respond when it came to issues
involving the office of coroner.81

As coronial inquiries were public inquiries, the media attended and reported on inquests.
Of course, controversial deaths or deaths linked to high profile people attracted
considerable public attention and interest. The proceedings at inquests were reported in
great detail, and the depositions of witnesses were often published word for word.
Coroners were known to provide copies of depositions to reporters. The media was also a
medium for asking questions of the government when concerns surfaced connected with
the function of the coroner. Press reports, although not free from bias, supply valuable
information when no other records can be located. For this reason, I searched newspaper
archives as part of the research process. Since beginning this research study, the National
Library of Australia has digitised an ever increasing number of Australian newspapers
from the nineteenth and early twentieth centuries. The use of the National Library’s
newspaper search engine “Trove” advanced my research on a number of fronts. The
ability to access provincial and metropolitan papers facilitated an analysis of
‘proprietorial politics’, which according to Denis Cryle, most historians fail to undertake.
Cryle argues that often the smaller short-lived journals ‘may have been more informative

81 QSA Series ID: 8433, Item ID: 290336, Administration File, Police.
and influential in their time’. Searching digital newspaper archives is quicker and far more productive than trawling through microfilm.

The greatest restriction to the research study was the limitation on time. There are thousands of records stored at the Queensland State Archives that undoubtedly contain much more information on the office of coroner. The research method concentrated on the archival records that were deemed to contain the most relevant data in relation to the office of coroner and the inquest institution. These records were searched widely to create an original and comprehensive study of the transformation of the office of coroner in Queensland. Drawing on this previously untapped resource and applying it to an unexplored topic, this thesis constitutes a substantive original contribution to the knowledge of the role of the coroner in Queensland and to the history of this under-studied aspect of the legal and justice systems in Australia.

**Chapter Outline**

This dissertation is organised chronologically. Chapter one outlines the origin and transformation of the English office of coroner and the introduction of coronial law into colonial New South Wales. Chapter two looks at the Queensland office of coroner after the colony’s separation from New South Wales, tracing the reasons for introducing *The Inquests of Death Act of 1866*. Chapter three discusses the difficulties encountered by the

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government in administering the state in the context of the role of the coroner. A number of case studies included in this chapter exemplify the major challenges confronting the government in supervising civil servants in regional areas. Chapter three examines the suicide of a young woman which instigates the introduction of *The Coroners Act of 1930*. Further reform of coronial law is examined in chapter four. This includes the Marjorie Norval case study involving the disappearance of a young public servant, which ultimately resulted in amendment to coronial legislation. The chapter ends with the enactment of *The Coroners Act of 1958*. The development of medico-legal investigations in relation to coroners’ inquests in Queensland is dealt with in chapter five. This chapter concludes with a discussion on the protracted campaign to replace the Brisbane City Morgue and the construction of the Institute of Forensic Pathology in 1960. The final chapter sums up the arguments presented in support of the thesis statement; that the Queensland government marginalised the role of the office of coroner and in most cases reform was politically motivated rather than driven by a desire to enhance the investigative powers of the coroner.
Chapter One

Investigating the Coroner

Introduction

The jurisdiction of the coroner is generally linked to investigating cause of death. Even though a fundamental function of the coronial process involves determination of the body’s identity and cause and manner of death, equally important is the contribution the coronial system makes to increased public health and safety as well as the prevention of future deaths. According to the Queensland State Coroner’s Office Annual Report, the Coroners Act 2003 significantly reformed and rectified ‘serious inadequacies’ in the previous coronial system. The Report claims the ‘new system gives greater emphasis to the prevention of avoidable deaths, focuses on the needs of bereaved families and seeks for the first time to bring case management to investigations’. This new perspective is derived from a history of identified flaws in previous coroner’s laws, especially that of 1958, in conjunction with the failure of Queensland’s coronial system, over the past 150 years, to transform itself to meet community demands for a better death investigation system.¹

In the colony of Queensland the jurisdiction of the coroner changed as the population of the new territory increased and spread. The discovery of gold and other metals during the latter half of the nineteenth century attracted large numbers of people to frontier regions

where there was little or no pastoral expansion. The maintenance of law and order at the margins of society posed a problem for government officials. The system of law applied to the newly founded British colony depended on the mode of acquisition. Territories “conquered” or “ceded” to Britain were allowed to retain their existing customary laws provided they were deemed civilised. A territory’s system of law prevailed until such time as Britain instituted a change to the English body of law.2 Alternatively, the courts defined a “settled” territory as one ‘which at the time of occupation by the British, was uninhabited or inhabited by a primitive people whose laws and customs were considered inapplicable to a civilised race’.3 The New South Wales colony was acquired as a “settled” territory; consequently the legal system transferred to the British colony in Australia was founded on the constitutional principles of English law, both statute and unenacted.4 Hence, English common law, along with coronial jurisdiction, presided over the Queensland system of death investigation at the time it seceded from New South Wales in 1859.5

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The first part of this chapter explores the origin and role of the English coroner, and then moves on to the legislative reforms it underwent before exportation to the New South Wales penal colony in 1788. Part two deals with the medicalisation of the inquest and the introduction of coronial law into colonial New South Wales.

**Origins of the Coroner**

By the time English coronial law was applied in New South Wales the function of the coroner had already experienced significant change. The word coroner is derived from the Latin ‘*custos placitorum coronae*’ meaning ‘keeper of the pleas of the Crown’. This was shortened to ‘coronarius’ or ‘coronator’, changed to the English term ‘crowner’, then to the present day title of ‘coroner’.

The elective office of coroner was established in England in September 1194. The King commissioned justices who were sent to various counties to hear cases which had been adjourned from the king’s court into the Eyre. Itinerant justices acting in this capacity were known as justices in Eyre. They carried lists of instructions which were known as the Articles of Eyre that were presented to

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8 The ancient office of justice of the peace was commonly known as magistrate (Dean, *Here Comes the Judge: The Queensland Magistrate*, p. 5).

9 Eyre meaning their journey.
jurors. Sworn jurors were required to deliver verdicts on the Articles of Eyre that covered such things as felonies, escheats,\textsuperscript{10} wardships, marriages and most importantly of all, financial improprieties of sheriffs and other royal officers.\textsuperscript{11} The Chief Justiciar\textsuperscript{12} to Richard I, Hubert Walter, in endeavouring to circumvent the authority of the sheriffs, inserted an instruction in the Articles of Eyre that the justices of Eyre were to oversee the election of three knights and one clerk from each county of the kingdom as keepers of the pleas of the Crown.\textsuperscript{13} The pleas were recorded on parchments known as the “Coroner’s Rolls”.\textsuperscript{14} The Eyres were held approximately every seven years thus making the recording and keeping of the “pleas” by the coroner of vital importance. If cases were overlooked, potential revenue to the Crown would be lost.\textsuperscript{15} Unlike the role of the coroner of the twenty-first century, the original coronial function was to protect and raise revenue for the King. Harvard states:

It would, however, be a great mistake to attribute the development of such a system to any conscious effort on the part of the administration to discourage the perpetuation of secret homicide, still less to further the arrest of the persons, if any, responsible for the death. In fact the system owed its existence entirely to the valuable incidents which had become attached to sudden deaths … The outstanding incentive to the

\textsuperscript{10} In feudal times, the reversions of real property to either the lord of the fee or the Crown where the owner died intestate without heirs or forfeiture of property upon a gross breach of the feudal bond (Butt, P. (ed.) (2004) Third Edition, Concise Australian Legal Dictionary. Chatswood: LexisNexis Butterworths, p. 154).
\textsuperscript{12} The Chief Justiciar was the chief political and judicial officer in England from the reign of William I to that of Henry III, who deputised for the king in his absence and presided over the kings’ courts (Knight, B. (2007), ‘Crown: Origins of the Office of Coroner’, Britannia History www.britannia.com/history/coroner1.html , accessed 26 December 2011).
\textsuperscript{13} Coroners had to be knights and possess a stipulated level of property wealth and an income no less than £20. By attaching prerequisites to the position (which was unpaid) it was hoped that men of wealth and status would not be enticed to defraud the Crown of revenue through embezzlement as the sheriffs had done in the past (Knight, ‘Crown: Origins of the Office of Coroner’). Within a short time four coroners were elected for each county (Maitland, The Constitutional History of England, pp. 43-44).
\textsuperscript{14} Freckelton and Ranson, Death Investigation and the Coroner’s Inquest, p. 6; Godwin, ‘End of Life: Natural or Unnatural Death Investigation and Certification’, p. 238.
inquests on sudden death in the late twelfth and early thirteenth centuries was the fine imposed by the *lex murdrorum*.\(^{16}\)

This is not to say that deaths occurring in violent or dubious circumstances were overlooked.

Although administrative and inquisitorial duties linked to raising revenue were assigned to the coroner in England, holding inquests, or *inquisitos*, upon dead bodies was also an important function of the office. The coroner however was not a judicial officer; chapter 24 of the Magna Carta stated that coroners could not hold pleas of the Crown.\(^{17}\) The process for holding inquests was set out in the ancient statute *De Officio Coronatoris*, 4 Edw. I., St. 2 enacted in 1275.\(^{18}\) The coroner was required to hold an inquest into all deaths judged unnatural, sudden or suspicious as well as any death occurring in a prison. An inquest could not be held if there was no body because the coroner was required to view the body prior to the inquest hearing. It was mandatory in late twelfth century England to summon the coroner when a suspicious death occurred. As well as serving the purpose of determining whether a death was due to violence or misadventure, the inquest also afforded another opportunity to increase the revenue of the Crown in the form of large fines or “amercements”. Failure to notify the coroner of a sudden death was a serious offence and the whole township was likely to be fined. If a deceased was buried prior to the coroner’s view of the body the coroner would order the body disinterred and

\(^{17}\) McKeough, ‘Origins of the Coronial Jurisdiction’, p. 194.
those responsible for the burial were punished, usually through “amercement”. Also, removal of the body to another county in order to avoid penalty was unlawful.\textsuperscript{19}

The body was viewed by both the coroner and the jurors prior to the commencement of the inquest. It was the coroner who held the responsibility of investigating a death in order to detect homicides. If the coroner’s jury found the evidence suggested a person or persons were involved in the death, the accused was committed to trial.\textsuperscript{20} In keeping with the fiscal role of the coroner, the primary purpose of examining the body was not to establish cause of death, but to determine and record any use of weapons that would be forfeited if a person was judged guilty of homicide by a coronial jury. This circumstance changed by the nineteenth century in England, when examining the body for marks of violence and cause of death emerged as the principal motive behind the sighting of the body. Prior to the commencement of the inquest the coroner and jury were obliged to receive “presentments of Englishry”\textsuperscript{21} in order to facilitate future allocation of “murdrum” (murder) fines or “amercements” to the Crown.\textsuperscript{22}

\textsuperscript{19} Hunnisett, \textit{The Medieval Coroner}, pp. 9-12.
\textsuperscript{20} Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 9; Hunnisett, \textit{The Medieval Coroner}, p. 19.
\textsuperscript{21} Presentment of Englishry was introduced following the Norman conquest of England in 1066. The Norman conquerors considered any body found to be that of a Norman unless it could be proven by two relatives of the deceased to be an Englishman. If Englishry was not proven then the men of the hundred incurred the “murdrum” fine of 46 marks. The townspeople also suffered the murder fine if the killer was not found. Over the following centuries the Normans integrated with the Saxons and eventually the presentment of Englishry was abandoned entirely by 1340. See Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 6-7; Hunnisett, \textit{The Medieval Coroner}, pp. 20-29; Maitland, \textit{The Constitutional History of England}, p. 46.
\textsuperscript{22} Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 6; Hunnisett, \textit{The Medieval}, pp. 20-27; Maitland, \textit{The Constitutional History of England}, p. 46.
Coroners and their juries also appraised the ‘lands and chattels’ of those judged guilty of homicide or suicide. Any assets belonging to the felon were given over to the Crown. The deodand constituted another form of raising income for the King. A deodand was any personal property that an inquest jury decided had caused a person’s death. It could be the weapon used in a homicide or suicide, or the “moving” item or animal that brought about a death by misadventure.\(^{23}\) The practice of forfeiting deodands was officially abolished in 1846.\(^{24}\) Medieval Coroners were also responsible for deliverance to the King of monies associated with treasure trove, wrecks of the sea and royal fish.\(^{25}\)

According to Hunnisett, the office of coroner reached ‘its zenith’ by 1250 but county and borough coroners began to decline in importance during the fourteenth and fifteenth centuries. Following the cessation of the “General Eyre” in favour of the Assize system, some of the coroners’ duties were duplicated by the escheator and the justice of the peace, consequently the work of the coroner decreased. Consequently coroners lost most of their powers by the end of the fifteenth century.\(^{26}\) The office of justice was first codified by statute at the commencement of the reign of King Edward III (1327-1377)


\(^{24}\) Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*, p. 21; Kesselring, ‘Detecting “Death Disguised”’, p. 22.

\(^{25}\) Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926*, p. 24; The statute De Officio Coronatoris, 4 Edw. I. st. 3 refers to the duty of the coroner to hold inquests into wrecks, royal fish and treasure trove. Royal fish are whales, porpoises and sturgeons and when caught near the British coast or cast ashore there become the property of the Crown (Knapman, P. (1993), ‘The Crowner’s quest’, *Journal of the royal Society of Medicine*, Vol. 86, p. 719).

which provided for justices to keep the peace. During King Edward’s long reign the commission of justices was increased to include hearings and determinations of felonies and trespasses against the peace. In 1361 more duties were added to the justices’ role and ‘the “keeper” was finally established in the long-lasting office of “Justice of the Peace”’.

Justices were either land owners or well-to-do merchants, whose social position and economic power meant they showed no interest in remuneration for performing their duties. Although the prestige and fiscal functions of the medieval coroner had been diminished through the increased power of the justices, the office continued to survive; its importance was attached to the enduring power to hold and record inquests on dead bodies.

Originally coroners were unpaid, and due to a lack of proper supervision following the cessation of the ‘General Eyre’, some coroners adopted corrupt practices such as claiming unauthorized remuneration. To amend this situation, parliament passed new legislation in 1487 regulating the pay and duties of coroners. They were entitled to a government paid fee of 13s. 4d (one mark) per inquest held into a homicide, and were given the right to claim four pence from the party found guilty of the homicide. The Coroners Act 1509 (1 Henry VIII c. 7) allowed for a coroner to be fined 40s for failing to inquire into a homicide, or death through misadventure. Because fines were not issued against parties involved, the coroner was not paid for conducting inquests into deaths by

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27 Dean, Here Comes the Judge: The Queensland Magistrate, p. 5.
misadventure.\textsuperscript{29} The Act gave justices of the peace authority to enquire into coronial evasion. This endorsed justices administrative powers over coroners. Following a second statute in 1510, coroners were eligible to claim payment for every suicide classed as homicide. For a verdict of \textit{felo de se}\textsuperscript{30} coroners were required to lodge records of inquisitions at meetings of the assizes in their counties. These measures were aimed at maximising profits to the Crown while also facilitating the detection of homicide.\textsuperscript{31}

Sixteenth century justices of the peace claimed that coroners should be limited solely to holding inquests into violent deaths. At the same time, justices of the peace tried to withhold coroners’ fees and also endeavoured to prevent coroners being advised of any sudden deaths. As expected, this led to ongoing conflict between the two offices. It was not until 1751 that legislation increased the payment to coroners from that awarded in 1478, allowing 20 shillings payment (plus 9 pence per mile travelled) for each duly held inquest. Then in 1860\textsuperscript{32} coroners were granted a salary and finally freed from the constraints of justices of the peace. Freckelton and Ranson argue that due to the gradual move away from justices controlling payments to coroners during the eighteenth century, the coroner’s role evolved into one that formed a more effective system for reporting and

\begin{footnotes}
\item[29] Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, pp. 11-13.
\item[30] \textit{Felo de se} was Latin for killing of oneself; self-murder. An expression used when suicide was a felony at common law, involving forfeiture of the property of the deceased person and escheat (to expire) of his or her lands. A formal finding of the inquest that the dead person had feloniously and maliciously taken his or her life when sane was required. See \textit{Butterworths Concise Australian Legal Dictionary}, general editor Peter Butt, 3rd edition, Chatswood NSW: LexisNexis.
\end{footnotes}
investigating cause of death, which in turn, resulted in a far more legitimate purpose of the coroner in the English legal system.\textsuperscript{33}

**The Nineteenth century coroner and the medicalisation of the inquest**

The nineteenth century marked the beginning of substantial changes to the office of coroner which shaped it into the institution that we recognize today. The status of the office of coroner was elevated with the provision of a salary in place of fees, while the power to order autopsies and call medical witnesses strengthened the investigative process. The advent of a death registration system increased the importance of determination of cause of death and coronial law was codified. The English coroners’ inquests became both legal and medical in nature, which achieved a greater level of professionalism. The English coronial system received into the new colony of New South Wales at settlement was also amended in accordance with the new reforms. These changes significantly affected the way in which the office developed in New South Wales and later Queensland.

Early in the nineteenth century local freeholders elected county coroners who, provided their tenure remained unblemished, retained the office for life. The coroner concentrated on ascertaining cause of death in circumstances considered suspicious, accidental, violent or unnatural. There were approximately 330 coroners for England and Wales and they

\textsuperscript{33}Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*, pp. 13-15.
held inquests into roughly 5 to 7 percent of annual deaths.\textsuperscript{34} Coroners were paid fees for holding inquests from the mid-1700s onwards. While the coroner was liable to a penalty of 40s for neglecting to carry out his duties, it was not uncommon for coroners to be accused of holding unnecessary inquests for pecuniary gain.\textsuperscript{35} The recommendations listed in an 1858 Royal Commission Report into the remuneration of coroners, as well as their duties, were included in a Bill presented to the House of Lords in 1860. Lord Chelmsford, during debate on the Bill, commented on the tenuous position of the coroner:

Coroners were in this predicament; that they were deterred from holding inquests, lest the magistrates should afterwards think they ought not to have been held. The Royal Commissioners, in their Report made in 1858, did full justice to the invidious and unjust position in which Coroners now stood, and recommended that they should be paid by salaries, and not by fees.\textsuperscript{36}

The status of the coroner improved with the passing of the \textit{County Coroners Act} of 1860, which allowed for a fixed salary to be paid. The salary was determined according to the average income from inquests held by the coroner over the previous five years. Additionally, the Act provided for magistrates of the counties, rather than freeholders, to elect coroners.\textsuperscript{37} More importantly, coroners experienced greater security as they no longer faced the threat of justices disallowing their claims for payment of fees.

The qualifications of coroners were the subject of intense debate by medical and legal professionals during the early part of the nineteenth century. On 6 August 1829 a report was submitted to the Common Council of the City of London outlining the duties of the coroner, as well as advocating that the coroner should be legally trained. The Common Council was not swayed by the recommendations contained in the report, maintaining that ‘any Gentleman of experience, respectable Character, and liberal Education, is duly qualified to fill’ the office of coroner. Nevertheless, the conflict between medical and legal practitioners gathered momentum. Thomas Wakley, surgeon and editor of The Lancet, contested the 1830 election for the East Middlesex coronership along with William Baker, a Limehouse solicitor. Gordon Glasgow maintains that the election was more about ‘medicine and politics’, claiming that ‘the issues were not confined to the merits of a medical or legal coronership but extended to politics including the sovereignty of the people, popular liberties and the open court’. Wakley sought humanitarian reform and acted in the interests of the working class and prisoners. He was critical of police magistrates, claiming they conducted superficial investigations into deaths in prisons and workhouses. Although coronial inquests were mandatory on all prison deaths, the findings were seldom critical of institutional policies. A large number of findings on cause of death were inconclusive or vague, and often cited no cause at all or such causes as visitation of God, decay of nature and dropsy. Wakley sought to extend the jurisdiction of the office of coroner in the hope of achieving political and legal accountability from

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38 Freckelton and Ranson, Death Investigation and the Coroner’s Inquest, p. 17.
government institutions as well as allowing the inquest to act as a forum for the poor to challenge the powerful.\textsuperscript{40}

Wakley wanted more thorough inquiries into workplace fatalities in the hope that accident compensation would be awarded to workers and their families. \textit{The Lancet} became his instrument of social reform.\textsuperscript{41} He waged a vigorous campaign for the East Middlesex coronership but lost to Baker. Later he was elected coroner for West Middlesex in 1839 after his opponent, a solicitor, withdrew from the contest.\textsuperscript{42} One of Wakley’s first acts as coroner was to ‘issue instructions that all deaths in custody – including workshops, asylums and police stations – were to be reported to him’.\textsuperscript{43} He was determined to investigate the reasons behind the ill-health and deaths of people confined in these institutions. Moreover, in Wakley’s opinion, only a medical coroner was qualified to carry out this work. Despite Wakley’s rigorous campaign, medical coronerships throughout the nineteenth century remained in the minority, with medical practitioners constituting only 15 per cent of the coroners for England and Wales.\textsuperscript{44}

\begin{footnotesize}
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  \item \textsuperscript{42} Glasgow, ‘The campaign for medical coroners in nineteenth-century England and its aftermath: a Lancashire focus on failure. Part II’, p. 225.
  \item \textsuperscript{44} Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 21.
\end{itemize}
\end{footnotesize}

Ian Burney explored the turbulent period in English history that witnessed the protracted debate concerning the medicalisation\footnote{Medicalisation is defined by Burney as ‘a term most often used to denote the progressive expropriation of health from the public sphere and its relocation in an exclusive professional domain’ (2000, p. 10).} of the English coroners’ inquest versus the traditional twelfth century institution that Burney claims was seen as the ‘bulwark of English liberties’.\footnote{Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 5, See also Cawthon, ‘Thomas Wakley and the Medical Coronership – Occupational Death and the Judicial Process’, pp. 191-202.} Medical testimony at inquests, based on information obtained through investigative autopsies, were conducted outside of England, well before the early nineteenth century. Krista Kesselring discusses the early modern coroner and his means of determining cause of death in cases that suggested secret slayings. She notes that medical evidence to detect hidden homicides was used on the Continent in the early 1300s, which was much earlier than in England.\footnote{Kesselring, ‘Detecting “Death Disguised”’, p. 23-24.} In support of her findings, Thomas Goodwin claims that the first written account of a post-mortem examination was that of Bartolomeo de Varignana in 1302; while Italian Giovanni Battista Morgagni was the first to correlate post-mortem pathology with clinical findings. His work \textit{De sedibus, et causis morborum per anatomem indagatis} – “Seats and causes of disease investigated by means of dissection” – is a seminal work in the field of medical history.
of anatomy” - published in 1761, marked a significant contribution to the science of pathology.49

Kesselring maintains that the first medico-legal autopsy held in England was in 1678, while the first publication on forensic medicine was released in 1634. She argues that by the end of the sixteenth century, lay jurors sitting at an inquest did avail themselves of medical knowledge when necessary.50 Helen Brock and Catherine Crawford also support the view that medico-legal post-mortems were conducted in early seventeenth-century England. Medical testimony to assist in formulating an opinion as to cause of death was a common feature of inquests held in the courts of the North American British colony of Maryland, according to Brock and Crawford. Consequently, the practice of performing autopsies for the purposes of information gathering must have been well established in England for it to be adopted by the early settlers to North America.51

That investigation of death should be organised around the evidence gathered via autopsy by an expert pathologist was the central argument of inquest reformists. Burney investigates the debate over the credibility of medical versus legal inquiry in determination of cause of death. He argues that proponents of the medicalised inquest claimed the testimony of medical witnesses was necessary at an inquest, as often no

outward signs of cause of death were visible. Further to this argument, the general practitioner was also deemed inadequate to carry out autopsies due to a perceived lack of forensic skill. In addition, the expert pathologist, unlike the general practitioner, was thought to confront the body in an objective manner and had no interest in the findings of the inquest.\textsuperscript{52}

Burney claims this friction between medical and legal practitioners persisted throughout the nineteenth century and still exists today.\textsuperscript{53} Freckelton and Ranson also assert that tensions over who should hold the office of coroner began in the nineteenth century and are present today. They compare coroners in Canada who are predominantly medical practitioners, to those in England, Australia, and New Zealand who are drawn from the legal profession. Even more complex is the situation in the United States of America that operates under a death investigation system that was originally based on the English office of coroner and has now transformed into a system based on a medical examiner. Nonetheless, a few states still retain the office of coroner.\textsuperscript{54} Overall, British legislation has not been influenced by changes in the role of the coroner in other countries.

The coroner’s purpose shifted from that of an agent raising revenue for the Crown to an instrument of democratic politics. The inquest was a forum that put the circumstances of

\textsuperscript{53} Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, p. 5.
\textsuperscript{54} Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, pp. 17, 70-75.
deaths up for public scrutiny in the name of justice and accountability. The assuaging of public anxiety over suspicious or concealed deaths through civic participation in the inquest, constituted an important part of the judicial process in late nineteenth century England.\(^{55}\) Investigative procedures by the coroner were conducted openly to manage public curiosity and concern over violent and ‘disguised’ deaths, and to maintain a check on government authority.\(^{56}\) Full medical investigation into the cause of death was necessary in the detection of homicides, particularly those linked to poisons, which were becoming easier to obtain through apothecaries open to the public. Also certain poisons were becoming more difficult to identify.\(^{57}\) However, Ian Burney argues that abolishing juries and taking away the necessity to view the body, in conjunction with the medicalisation of the inquest, meant that ‘the body [was] physically disengaged and present only in the abstracted form of a medical expert’s post-mortem report’. The inquest, therefore, was recast as a scientific event that acted as a forum for the medical expert to tell the story of the dead.\(^{58}\) The evidence of the expert pathologist assisted in accurately determining cause of death, which was not only important from a criminal justice perspective, but also a key function in the collection of the nation’s vital statistics.

In 1836 the first *Births and Deaths Registration Act* was passed in the United Kingdom. The Act required coroners to inform local registrars of deaths within eight days of an


\(^{56}\) Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926*, pp. 2-5; Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 87.


\(^{58}\) Burney, ‘Viewing Bodies: Medicine, Public Order and English Inquest Practice’, p. 36.
inquest. No burial could take place without either a signed death certificate or a coroner’s order.\textsuperscript{59} Dr William Farr, statistical superintendent at the General Register Office (GRO) relied on accurate identification of cause of death for the purpose of collecting pure statistical information. Deaths needed to be codified in detail and not merely recorded as natural causes or visitations of God. But the provisions of the 1836 \textit{Births and Deaths Registration Act} gave little priority to death certification as there was no penalty for not registering a birth or death, and this hindered the compilation of accurate statistics on causes of death. For the purpose of accurate medical certification of death, advocates of the autopsy maintained a post-mortem was necessary to discover the cause of sudden death, as in most cases no visible signs of the cause were present. However, cultural stigma attached to the dissection of bodies, made public acceptance of autopsies as common practice, difficult to accomplish. Over the course of the nineteenth century, opposition to the intervention of medical science in the inquest process meant the number of post-mortems carried out only increased slightly.\textsuperscript{60}

Successive reforms to the jurisdiction of the coroner occurred over the second half of the nineteenth century culminating in the introduction of the \textit{Coroners Act 1887}, which strengthened the coroner’s role as an investigator of the circumstances surrounding a death as well as the cause of death. Under Clause 3 of the Act the coroner was required to hold an inquest into any ‘violent or unnatural death’; or ‘sudden death’ of unknown cause; or the death of any person who died in prison; ‘or in such place or under such

\textsuperscript{59} Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, pp. 61-62; Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 15.

\textsuperscript{60} Burney, \textit{Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926}, pp. 57-65.
circumstances as to require an inquest in pursuance of any Act’. The coroner possessed the power to summon medical witnesses and order post-mortem examinations. When a coroner’s inquisition charged a person with murder, manslaughter or being an accessory to murder, the coroner was required to issue a warrant for arrest or detention of that person to await trial. The Act preserved the responsibility of the coroner to conduct an inquest into treasure-trove but repealed his duty to inquire into royal fish. Generally the Coroners Act 1887 (UK) contained provisions that were identifiable with that of late twentieth century coronial legislation.

Ultimately the most significant transformation of the role of the coroner during the nineteenth century pertained to the termination of the coroner’s function as a revenue raising administrative agent of the Crown. The value of life had eventually pervaded the moral consciousness of the government and community, resulting in a greater emphasis placed on the need to investigate sudden deaths under suspicious circumstances. As coroners began to hold more authority from the 1830s onwards, greater accountability and co-operation from government institutions ensued.

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61 The Coroners Act 1887, 50 & 51 Victoria. This Act did not apply to Scotland or Ireland.
Early twentieth century reforms to coronial legislation

A report from the Select Committee on Coroners in 1910\textsuperscript{62} recommended that:

Coroners be given power to order autopsies in cases of sudden deaths, even where there was no suspicion of death having been brought about by violence and where no inquest had yet been held. It also proposed that it be mandated that every death for which a medical certificate was not issued should be reported to the coroner, who should be encouraged to inquire further into such cases, as necessary. However, this would not need to entail an inquest.\textsuperscript{63}

A number of recommendations linked to the report were implemented through the Coroners (Amendment) Act 1926 (UK). One of the more controversial provisions of the legislation was the power given to the coroner to conduct an inquest without a body. Regardless of the criticism, the coroner’s authority to hold an inquest into the circumstances surrounding a person’s disappearance increased the investigative nature of the office, thus enhancing accountability to the public. The lay jury was marginalised to an extent as it was the coroner’s choice whether to call a jury, and the age old practice of the jury viewing the body was also left to the coroner’s discretion. Less use was made of makeshift post-mortem rooms and courts, such as the local ale house, as the body could now be moved to a place away from the coroner’s district without affecting his jurisdiction. If the coroner, during the course of an inquest, was informed that a person has been charged with the murder, manslaughter, or infanticide of the deceased, he was


\textsuperscript{63} Freckelton and Ranson, \textit{Death Investigation and the Coroner’s Inquest}, p. 22.
obliged to adjourn the inquest until the conclusion of the criminal proceedings. Medical and legal professionals came no closer to resolving who should fill the role of coroner. The Act stipulated that either could be appointed as coroner, although medical appointees must have practiced for at least five years prior to taking up the position. Additionally, if the coroner thought the sudden death might be attributed to natural causes, thus making an inquest unnecessary, he could order a post-mortem prior to deciding if a full inquest was required.⁶⁴ According to Ian Burney, this ruling meant that within a few years of the Act’s passage, the number of full inquests involving a jury had reduced significantly. He concluded that the medicalised inquest had taken precedence over civic popular participation.⁶⁵

In the same year the *Births and Deaths Registration Act 1926* (UK) strengthened the laws governing the disposal of dead bodies. The Act required a registrar’s certificate or coroner’s order to be produced before a burial or cremation could take place. Following a funeral, the Act required that a notice of disposal be sent to the Registrar. For the first time registration of stillborn babies became mandatory.⁶⁶ The jurisdiction of the coroner was consolidated with the promulgation of the *Coroners Rules 1953* (UK). The medical jurisdiction of the office gained greater currency via Section 3 of the coroners’ rules, which stated that ‘the post-mortem examination should be made, whenever practicable,

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⁶⁴ *Coroners (Amendment Act) 1926*, 16 & 17 Geo. 5, c. 59.
⁶⁶ *Births and Deaths Registration Act 1926* (UK), 16 & 17 Geo. 5, c. 48.
by a pathologist with suitable qualifications and experience and having access to laboratory facilities’. 67

By the middle of the twentieth century the office of coroner had undergone considerable transformation. Importantly, the jurisdiction of the coroner had increased which resulted in a more effective death investigation system. The evolving coronial system had been transplanted to new colonies as England extended its empire. For example, records show that an inquest was held in the colony of New Plymouth, New England (America), in 1635; 68 while in Canada the coroner’s office was established in Quebec and Montreal in 1764. 69 England’s coronial system was implemented by the penal settlement of New South Wales in 1788 and was altered accordingly to accommodate the needs and circumstances of the colony.

The New South Wales office of coroner

The office of coroner was brought to the penal settlement of New South Wales, which was founded on 26 January 1788. The settlement operated under military rule while the Colonial Office formulated a plan for civil governance. The function of the coroner was conducted by justices who were either government or military persons. Under the First Charter of Justice issued on 2 April 1787, Governor Phillip, the Lieutenant-Governor and

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67 The Coroners Rules 1953, Statutory Instruments 1953, No. 205, s. 3.
Judge Advocate were authorised to convene a Court of Criminal Jurisdiction and a Court of Civil Jurisdiction. The Governor, Lieutenant-Governor and Deputy Judge Advocate undertook the office of Justice for the New South Wales region and were invested with the same powers as English justices. With imperial authorities appreciating the difficulties of upholding the rule of law in an expanding jurisdiction based on forced convict labour, Governor Phillip was authorised to appoint additional justices. Therefore Augustus Alt, Surveyor General for the colony, became the first justice appointed in Australia without assent from London.\textsuperscript{70} Alt convened the first hearings in the colony before magistrates on 18 February 1788. Gordon Dean reports that:

the record of those proceedings shows that concepts of a fair hearing and appropriate punishments were applied. The justices acted humanely and with a deal of common sense … the foundation for an effective and sound magistracy was laid down.\textsuperscript{71}

Furthermore Castles maintains that even though magistrates, especially in rural areas, may have resorted to ‘excessive use of their powers’ that ‘notions of the “rule of law” … seem to have taken reasonable firm root in the colony from the earliest years’.\textsuperscript{72} Until such time as free settlers began to arrive in the colony only government and military officers acted as justices of the peace.

\textsuperscript{70} Dean, \textit{Here Comes the Judge: The Queensland Magistrate}, pp. 7-8; Golder, \textit{High and Responsible Office: A History of the NSW Magistracy}, pp. 2-7. The words Justice of the peace and magistrate are interchangeable.

\textsuperscript{71} Dean, \textit{Here Comes the Judge: The Queensland Magistrate}, p. 8.

While Governor Phillip was authorised to appoint coroners, the duties ascribed to the office of coroner were usually carried out by justices. The Governor and his military officers relied heavily on the diverse duties carried out by justices, especially in rural areas. Problems of distance and climate made it unrealistic for city officials to travel to isolated regions to perform administrative, judicial and legal functions. The first coroner for New South Wales, J W Lewin, was appointed Sydney coroner in 1810, and by 1821 there were five coroners serving a colony of approximately 37,000 people.\(^{73}\) The colonial method of appointing coroners was quite different to that in England, where coroners were elected by freeholders until the *Local Government Act* 1888 allowed for the appointment of coroners by the County Council.\(^{74}\) New South Wales coroners were appointed by the State. During this period, the coroner held inquests into violent and suspicious deaths to determine identity of the deceased, cause and manner of death.\(^{75}\)

In 1824 colonial authorities sent Lieutenant John Oxley north to Moreton Bay to establish a penal colony for recidivist convicts. Redcliffe Point was selected as the location on account of its isolation and the settlement began in September 1824. This site proved unsuitable for crop production, and combined with an outbreak of sickness and fear of Aboriginal attack, the settlement was closed and the inhabitants moved up-river in May 1825 to Petrie Bight. Situated on the Brisbane River, the colony had a more reliable water


\(^{74}\) The *Local Government Act*, 51 & 52 Vic., c. 41.

supply and the acute bend in the river meant escape would be more difficult.\textsuperscript{76} Settlement was prohibited within a 50 mile radius of the penal colony, which was closed officially on May 5 1839. On 10 February 1842 Governor George Gipps proclaimed the District of Moreton Bay ‘shall no longer be continued as a penal settlement, but that the same shall be open for settlers, all free persons desirous of proceeding thither’.\textsuperscript{77}

A Police Magistrate District was established and Captain John Wickham was appointed as Police Magistrate for Moreton Bay on 14 November 1842. According to John Mackenzie-Smith (2010) the town of Brisbane in 1849 was ‘a depraved, alcohol-soaked and violent backwater with too large a residue of the convict influence’.\textsuperscript{78} As police magistrate, coroner and government resident, Wickham slowly brought law and order to the town. The Court of Petty Sessions was conducted by Captain Wickham and two lay justices. Serious criminal matters that fell outside the jurisdiction of the local court continued to be heard in the Supreme Court of Sydney. Circuit court hearings of the New South Wales Supreme Court commenced in May 1850 and the \textit{Moreton Bay Supreme Court Act} of 1857 established the jurisdiction of the Supreme Court of New South Wales in the Moreton Bay district.\textsuperscript{79}

\textsuperscript{77} \textit{New South Wales Government Gazette}, 11 February, 1842.
The first statute enacted in the colony of New South Wales concerning coroners was *An Act to define the qualifications of Medical Witnesses at Coroners' Inquests and Inquiries held before Justices of the Peace in the Colony of New South Wales*.\(^{80}\) Passed in 1838, the legislation adopted provisions of the British legislation *An Act to provide for attendance of Medical Witnesses at Coroners’ Inquests and Inquiries held before Justices of the Peace*\(^{81}\) which provided for the coroner to summon a registered medical practitioner as a witness in cases where the deceased had not been attended by a medical practitioner at, or immediately before, the time of death. The New South Wales legislation allowed the Governor to appoint at least three members of the medical profession to form a Medical Board that was responsible for examining and approving the qualifications of those seeking registration as legally qualified medical practitioners. The Medical Board’s register of names of qualified medical practitioners was published annually in the Government Gazette. The *Medical Witnesses at Inquest Act 1844* provided for a Medical Board for the district of Port Phillip to be established.\(^{82}\) A further amendment act, *An Act to define the qualifications of Medical Witnesses at Coroners' Inquests* 1845 enabled members of the Apothecaries Hall, Dublin, to be legally qualified Medical Practitioners.\(^{83}\)

A notice in the New South Wales Government Gazette in 1845 defined the limits within which coroners could exercise their jurisdiction. This was in response to complaints made

\(^{80}\) *An Act to define the qualifications of Medical Witnesses at Coroners’ Inquests and Inquiries held before Justices of the Peace in the Colony of New South Wales*, (2 Vic. No. 22, 1838).

\(^{81}\) *An Act to provide for attendance of Medical Witnesses at Coroners’ Inquests and Inquiries held before Justices of the Peace*, 1838, 2 Vic. No 22.

\(^{82}\) *Medical Witnesses at Inquests Act, 1844*, 8 Victoria, No. 8.

\(^{83}\) *An act to define the qualifications of Medical Witnesses at Coroners’ Inquests*, 1845, 9 Vic. No.12.
by police magistrates and justices of the peace in relation to coroners intruding on their rights to conduct inquests. The Colonial Secretary, Edward Deas Thomson, directed that:

Some misapprehension being entertained as to the limits within which the several Coroners throughout the Colony should exercise their jurisdiction, His Excellency the Governor directs it to be notified, that in future no Coroner is to act except within the Police district in which he may reside and for which he is understood as holding his appointment. In Police Districts in which there may be not Coroners, the inquiries into the causes of any sudden deaths which may happen within the same, are to be conducted by the Police Magistrate (if there be one), or if not, by any Justice of the Peace of the District, under the powers granted by the Act of the Governor and council, 1 Victoria No.3.84

Having police magistrates and justices substitute for the coroner relieved the burden on the small number of coroners in the colony. When it came to death investigation in remote locations magisterial inquiries were more practical as assembling a jury of twelve was often a difficult task to accomplish. Such inquiries were summary in nature unless the presiding police magistrate was also commissioned as a coroner, in which case a coronial inquest was appropriate. Needless to say, confusion reigned among these government officials as to their jurisdiction and power in relation to the coronial system. Golder argues that the Coroners’ Act 1901 ‘was designed to eliminate such confusion and also to promote efficiency and economy’ 85

84 New South Wales Government Gazette, No. 22, 15 March 1845, p. 300.
85 Golder, High and Responsible Office: A History of the NSW Magistracy, pp. 117-118.
English common law was exported along with the penal system in 1788 and formed the basis of the New South Wales legal system. When Queensland separated from New South Wales in 1859, it adopted the system of courts, judicial officers, and the rules of law from the parent colony.\(^8\) The English office of coroner, being part of the common law legacy, meant Queensland inherited the legal institution of the inquest.

**Conclusion**

The ancient office of coroner began in twelfth century England as a tax-raising measure for the Crown. The holding of inquests into the causes and circumstances of unnatural, sudden, or suspicious deaths was, at that time, considered a less important function of the coroner. The majority of coroners’ powers were transferred to justices of the peace by the end of the fifteenth century, but their authority to hold and record inquests on dead bodies endured. Eighteenth century reforms to English coronial legislation lent legitimacy to the coroner’s purpose, whose principal role was to clarify the public record in relation to the causes of sudden, unnatural and violent deaths. The office of coroner became an instrument of modern politics whereby the inquest became a forum for public scrutiny of the circumstances of deaths in the name of justice and accountability.

Medical and legal practitioners argued from the early nineteenth century onwards as to who was best qualified to conduct inquests. In England while medical practitioners

\(^8\) QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office. Letter from Crown Law Office, Sydney, to Attorney-General, Queensland, 8 March 1860.
commonly acted as coroners, the office gradually became the domain of the legally qualified as the function of the inquest became inquisitorial as opposed to adversarial. Criticism of the increased medicalisation of the inquest concentrated on the diminution of public accountability, along with the hijacking of lay participation in the inquest system by government institutions of power and authority. On the other hand, supporters of expert pathology argued that specialist knowledge in classifying cause of death was a necessary part of reformative action to lend integrity to the compilation of the nation’s statistical data and improve public health. Medical testimony had become a regular feature of the inquest process by the beginning of the twentieth century.

With the adoption of the common law of England into the penal settlement of New South Wales, English coronial law formed the basis of the system of death investigation. In the beginning the colony was governed by military rule, therefore only government officials and military officers filled the role of justices of the peace. The justices held coronial inquests prior to the appointment of the first colonial coroner by Governor Phillip in 1810. It was the coroner’s duty to hold inquests into violent and suspicious deaths to determine the deceased’s identity, and cause and manner of death. In 1824 a new penal settlement was established at Moreton Bay and when the colony was opened up to free settlers in 1842, one police magistrate and two justices maintained law and order; coronial inquiries came under their jurisdiction.
The New South Wales parliament passed the colony’s first legislation relating to the jurisdiction of the coroner in 1838. It empowered coroners to summon a registered medical practitioner as a witness when necessary. Under the legislation, a Medical Board consisting of three professional medical practitioners appointed by the Governor, was authorised to examine and approve the qualifications of applicants seeking registration as legally qualified medical practitioners. Tension developed between coroners and police magistrates linked to their jurisdiction and power in relation to the coronial system. Although the practice of substituting police magistrates for coroners may have been economical, it caused confusion among the respective judicial officers. Legislation to eliminate this confusion was passed in 1901.

Queensland adopted the English common law system from New South Wales on separation in 1859. Consequently the ancient office of coroner was also transplanted to the new colony. As a self-governing colony, Queensland had the power to enact new legislation pertaining to the office of coroner which rectified previous problems, and to create an inquest system that aimed to meet the demands of the fledgling colony. The introduction of *Inquests of Death Act of 1866* extended the jurisdiction of the coroner in Queensland but neglected to consolidate coronial legislation. Chapter 2 focuses on the circumstances leading to the first reform of Queensland coronial law.
Chapter Two

The Inquests of Death Act of 1866

Introduction

The shortcomings of inherited English coronial law became apparent early in Australia’s history. Despite the New South Wales parliament’s minor reform of the time-honoured English institution, the function of the office of coroner as adopted by Queensland at separation soon proved difficult to execute in such a vast and sparsely populated territory. The limited revenue base affected government decisions when it came to administering the colony. Financial restraints compromised coronial investigations which were often haphazard and inconsistent. Although government authorities generally seemed to be responsive to enforcement of the rule of law, it was the inefficient administration and uneven application of coronial law and justice in the formative years of the Queensland colony, that undermined the role of the coroner for many decades to come.

This chapter explores the administration of the early period of Queensland settlement in the context of investigating incidents of sudden, violent or unexplained deaths. I examine the vital roles played by the Queensland government, civil servants, police and judiciary in the execution of death investigations, magisterial inquiries and inquests. Furthermore, impediments to the implementation of an effective and efficient coronial system will be discussed, revealing that the inexperienced government lacked the expertise to successfully apply coronial law to a territory where isolation, geography and climate
created many challenges. In addition, it will be argued that the colonial government’s mediocre reform of coronial law in 1866 was more about applying financial restraints than improving the coroner’s role in investigating death.

**Administering the fledgling colony**

Prior to Queensland’s separation from New South Wales, white squatters had already claimed large sections of the colony. The spread of the young colony under this “land grab” compelled the provision of a system of justice to dispense law and order to far-flung communities. New districts were proclaimed and for each district a Commissioner of Crown Lands and a site to conduct Courts of Petty Sessions were assigned. The *Offenders Punishment and Justices Summary Jurisdiction Act*, passed by the Legislative Council of New South Wales in 1832, defined the powers and authorities of the Courts of Petty Sessions and regulated the summary jurisdiction of justices of the peace.  

Criminal cases were dealt with in the Supreme Court of New South Wales, created under the *Moreton Bay Supreme Court Act* of 1857. The Act provided that two or more justices sitting together would constitute a Court of Petty Sessions. The Bench of Magistrates

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87 ‘An Act to consolidate and amend the Laws for the transportation and punishment of Offenders in New South Wales and for defining the respective powers and authorities of General Quarter Sessions and of Petty Sessions and for determining the places at which the same shall be holden and for better regulating the summary jurisdiction of Justices of the Peace and for repealing certain Laws and Ordinances relating thereto’ (*Offenders Punishment and Justices Summary Jurisdiction Act*, 3 Wm IV, No. 3, 1832); By 1860 thirteen police districts were proclaimed: Brisbane, Ipswich, Warwick, Drayton, Toowoomba, Callandoon, Dalby, Condamine, Gayndah, Maryborough, Gladstone, Rockhampton and Nanango (Johnston, ‘The Growth of the Lower Courts’, p. 14).  
consisted of unpaid justices, many of whom were squatters drawn from surrounding stations.\textsuperscript{89}

Queensland’s push for separation was spearheaded by the Moreton Bay Separation Association, which sent a succession of separation petitions to London. The majority of members were squatters or ex-squatters whose motives according to Sir William Denison, Governor-General of New South Wales:

> were entirely self-interested, and their stake in the country temporary. Graziers, squatters, were men holding, but not owning, large tracts of country. They desired riches, and were liable to leave the colony at any time. Thus, if they looked for a separate legislature, it was in the confidence that they would dominate it … and dispose of the land as they pleased.\textsuperscript{90}

Denison’s comments came on the back of a protracted legal and political debate between the British and New South Wales governments, centred on the application of the Moreton Bay District for separation. Queensland did not begin as a Crown Colony therefore England did not provide financial support. Contentious issues such as apportioning part of New South Wales’ public debt to Moreton Bay, establishing the boundary of the future colony and the formation of the new legislature demanded resolution before the letters patent were issued on 6 June 1859 designating Moreton Bay as a colony, and appointing Sir George Ferguson Bowen Governor. Initially the colonial administration consisted of three departments: Colonial Secretary’s Office (Minister Robert Herbert), Attorney-


General’s Office (Minister Ratcliffe Pring) and Treasury (Minister Robert Mackenzie). Governor Bowen ruled Queensland with these three ministers, who made up the first Executive Council, until government was formed in 1860. The legislature was to replicate that of New South Wales, formed from a House of Representatives and a Legislative Council. Between April and May 1860 the first Queensland election was held, electing 26 members from 16 electorates to form the first Legislative Assembly. The Legislative Council, or Upper House, consisted of 11 men who were appointed for terms of five years. The parliament was dominated by conservative pastoralists whose primary interests lay with ensuring the security of their pastoral leases which underpinned their wealth.

The territorial separation of Queensland carried with it the laws of New South Wales, yet the politics of law were at a raw and formative stage in 1860 and upholding the rule of law in frontier territory tested the novice parliament. Heather Douglas and Mark Finnane refer to the logistics of justice in Australian colonies when discussing the amenability of Australian Indigenous peoples to imported British criminal law. They consider ‘how the exercise of jurisdiction was constrained in colonial conditions by

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95 QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office, letter from W. E. Plunkett, Crown Law Office, Sydney, to Attorney-General, Queensland, 8 March 1860.
mundane realities of government, especially the costs of policing remote communities’. According to Douglas and Finnane court hearings were costly exercises and the ‘parsimony of a lean state in determining the conditions under which Aboriginal offences were made accountable in criminal law’, should not be overlooked. At the time of separation police, police magistrates and justices of the peace were vested with the responsibility of maintaining law and order in the Queensland colony. Michael Sturma observes that the ‘[d]ifficulties in policing the frontier were accentuated by the inhospitable climate and topography of many districts’. Furthermore he maintains that ‘the police were shaped as much by the expansion of settlement as urbanisation’. Sturma’s statements regarding the shaping of the colonial police force, along with Douglas and Finnane’s observations of a cost conscious government, equally apply to the development of the office of coroner in Queensland during the second half of the nineteenth century.

Climate, geography and long distances hindered compliance with laws pertaining to the holding of inquests. These three issues stood in great contrast between Queensland and England. The white population of Queensland was spread over an area equivalent to the size of Great Britain and Ireland combined. England was divided into boroughs to which coroners were appointed. The distance between the central jurisdiction and the

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98 Sturma, ‘Policing the Criminal Frontier in Mid-nineteenth century Australia, Britain and America’, p. 19.
99 Queensland Votes and Proceedings (1860), Statistical Register of Queensland for the Month of December.
extremities was far less an obstacle to overseeing local government. There was a thinness and fragility of local government in Queensland compared to England. In view of the size of the Queensland colony it was impractical to appoint coroners to each frontier settlement. Justices formed an integral part of the Queensland justice system and holding coronial inquests was one aspect of their judicial function. According to Hilary Golder the office of justice was the ‘lynchpin of local law, order and government’, and held the same power in Australia as in England.

The Inquests of Death Act of 1866 “officially” sanctioned a practice that had been taking place in the Queensland colony since the first settlers arrived. The Act empowered magistrates and justices of the peace to hold inquiries into deaths to supplement the work of coroners. To maintain the common law framework the Queensland government used police magistrates (later stipendiary magistrates) to perform central government tasks. Because magistrates were stationed throughout the colony it was a cost-saving measure to have them act in the place of a coroner, however they were not assigned the same powers and duties. Magistrates were not required to view the body nor summons a jury. They were also unable to commit for trial. The Governor of New South Wales had appointed three coroners to the northern colony prior to Queensland’s separation: Kearsey Cannan was appointed 15 August 1853 for the district of Brisbane, Henry Challinor was

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100 Dean, _Here Comes the Judge: The Queensland Magistrate_, p. 8; McPherson, _The reception of English law abroad_.

101 Golder, _High and Responsible Office: A History of the NSW Magistracy_, p. 3.

102 For example see QSA Series ID: 13338, Item ID: 19644, letter from acting police magistrate to Attorney-General, 22 February 1860; also QSA Series ID: 13338, Item IDs: 19644 to 19649 inclusive.

103 QSA Series ID: 13337, Item ID: 19604, Instructions to Coroners, Inwards Correspondence – Crown Law Office.
appointed 21 October 1859 for the district of Ipswich, and William Armstrong serviced the district of Drayton from February 1859. All three coroners were qualified medical practitioners. Cannan was Brisbane’s first private practitioner, and held a number of part-time positions in addition to that of coroner.\(^{104}\) He was paid a salary of £20 per annum while Challinor and Armstrong, in the absence of an annual salary, claimed fees of 20 shillings per inquest and 9 pence per mile for travelling from place of residence to the location of the inquest.\(^{105}\) Contrary to claims that no coroners existed in colonial Queensland\(^{106}\), at the end of 1860 six coroners served the 26,056 non-indigenous inhabitants of the colony.\(^{107}\)

It was difficult to establish and maintain a well-organised and professional public administration system throughout such a vast expanse of settlement. The government disseminated information to Queensland’s early civil servants via circulars or notices published in the government or police gazettes.\(^{108}\) The communication often drew attention to certain irregularities connected with the performance of their duties and responsibilities. The demands of working in remote centres were inclined to create a

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\(^{104}\) Gordon, D. (2006), 'Cannan, Kearsey (1815 - 1894)', *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, [http://adbonline.anu.edu.au/biogs/A030325b.htm](http://adbonline.anu.edu.au/biogs/A030325b.htm), accessed 30 July 2010. He held the posts of public vaccinator, medical officer to the gaol, member and later president of the Medical Board and coroner. In 1864 when a lunatic asylum was established at Woogaroo (Goodna) he was appointed its first full-time medical superintendent.\(^{105}\)

\(^{105}\) Queensland Votes and Proceedings (1859), Statistical Register of Queensland for the Month of December.\(^{106}\)

\(^{106}\) Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*, p. 36.\(^{107}\)

\(^{107}\) Queensland Votes and Proceedings (1860), Statistical Register of Queensland for the Month of December. The six coroners were: Kearsley Cannan (Brisbane); Henry Challinor (Ipswich); William Armstrong (Drayton); Samuel W. Aldred (Warwick); Elias S. Rutherford (Rockhampton); W. H. Stevenson (Gayndah); Blue Book of 1860, p. xi. In 1847 the NSW Legislative Council voted for the sum of £20 as salary for the appointment of a coroner for the Drayton district but at separation no salary was allowed for the coroner. (Moreton Bay Courier 9 October 1847).\(^{108}\)

“culture of indifference” among public servants who tended to dismiss the importance of “working to the rules” when it came to their administrative duties. The cordial relationships some police and magistrates developed with local communities also had the potential to impact upon the execution of duties.

The propensity to overlook administrative imperatives can also be attributed to the multiple positions held by public servants in regional districts which created a high and diverse workload, particularly in the area of paperwork. For example, three separate notices were published in the Queensland Government Gazette 21 July 1860 announcing the appointment of William Murphy as Chief Constable, Inspector of Slaughter Houses and Bailiff of the Court of Requests at Drayton. Following the murder of a young mother in Toowoomba in 1865 the townspeople protested over the lack of police protection, highlighting that the ‘Sub-Inspector, Mr. Foran, in addition to other duties, quite unconnected with the police, has to be present at pound sales, and was obliged to sacrifice much valuable time … on that account’. Additionally, a directive from the Colonial Secretary in October 1860 reminded Chief Constables who had been promoted to the rank of Inspector of Police in their respective districts:

that when such appointments were conferred it was not intended that the Inspectors should be relieved of the duties of ordinary Chief Constables, nor

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109 Colley, Linda (2005), ‘Traditional approaches to the merit principle in the Queensland public service from 1859 to 1959, paper presented at the 19th conference of The Association of Industrial Relations Academics of Australia and New Zealand, University of Sydney, 9-11 February. See Chapter 3 for further discussion on this topic.
112 Darling Downs Gazette, 21 June 1865.
that the fact of their being Inspectors should remove them from the absolute and undivided control of the Benches to which they belonged.\textsuperscript{113}

The first known guide to rules and regulation for police in Queensland was not published until 1869. In 1876 the \textit{Manual of Police Regulations} was published by the Queensland Police Force.\textsuperscript{114} Rural policemen were subjected to rigorous demands on their time, skills and labour. On top of their other responsibilities, police officers were called on to investigate the circumstances surrounding any violent, suspicious or unnatural death reported to them. When it was necessary to investigate a death, a great deal of time could be expended in travelling to the site, making inquiries, waiting for the coroner and giving evidence at an inquest.

Queensland common law institutions evolved in a context of the parent system which was founded on ‘cheap justice’ directed largely by the gentry. As such, the Queensland government’s parsimonious attitude originated in England. Ross Johnston writes that in the early stages of settlement unpaid justices ‘filled a need’ to reduce costs but claims that ‘[S]ometimes they were quite young (under thirty), sometimes poorly educated’ and that ‘[I]n 1861 three of the colony’s leading lawyers … doubted that these untutored people should be entrusted with such judicial functions’.\textsuperscript{115} According to Johnson, complaints were made over the appointment of justices in what was considered to be

\textsuperscript{113} \textit{Queensland Government Gazette}, No. 6, 16 October 1860.
‘political rewards’ to local squatters.\textsuperscript{116} The squatter-magistrates were also criticised for continued absenteeism that resulted in a build-up of cases waiting for a hearing. They attracted accusations of bias against the working class and incompetence based on their ignorance of the colonial statutes.\textsuperscript{117} An article in the \textit{Sydney Herald} 23 January 1841 reported on the ‘disgraceful manner’ in which the rural police carried out their duties. The paper went on to highlight the numerous letters of complaints received by the press from settlers ‘exposing glaring magisterial abuses’ as well as protesting against what they judged as the ‘marked injustice daily occurring in this department in the interior’. The paid magistrates were accused of pocketing ‘public money’ to ‘either do nothing or perform what they pretend to do, improperly’. When it came to the office of coroner, it was claimed that coroner’s inquests were ‘grossly neglected by paid magistrates’.\textsuperscript{118}

Barry Wright argues that during the nineteenth century colonial attitudes towards the law were influenced by the difficulties of accessibility to the law. He claims ‘relevant statutes and legal texts were scarce and expensive and institutional holdings limited’.\textsuperscript{119} Magistrates were guided in their duties by John Plunkett’s \textit{The Australian Magistrate} (1835) which was the first Australian practice text of its kind.\textsuperscript{120} In referring to a second and revised edition of the book by James Tegg in 1840, the \textit{Sydney Gazette and New

\textsuperscript{118} \textit{Sydney Herald}, 23 January 1841, p. 2.
South Wales Advertiser stated that ‘[t]he settler who is not a magistrate, with Mr Plunkett’s volume before him, can be at no loss to know how and in what manner he ought to proceed, where an appeal to Magisterial authority, becomes requisite’.  

William Wilkinson published an updated edition of Plunkett’s text in 1860 which was titled Plunkett’s Australian Magistrate. Wilkinson independently published The Queensland Magistrate in 1879, followed by an updated version in 1891 that incorporated recent changes of the law introduced by the Justices Act of 1886 (50 Vic, No. 17). Commenting on Wilkinson’s work, Johnston observed that ‘[A]though a succinct statement, it probably did not offer enough instruction for many of the untrained officers’. Instructions were also available from John Handy’s The Queensland Magistrates Guide published in 1869. Guides to magistrates were compendiums of the law that were relied on by lawyers, justices of the peace, magistrates and clerks of petty sessions to interpret and clarify the law. These works, which included the most recent statutory changes and decisions of the courts, were a valuable asset to magistrates in discharging their duties. However the government closely monitored the distribution of these texts as they were limited in number and costly. The Griffith government consolidated magisterial duties and common law knowledge when it passed The Justices Act of 1886.

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125 Handy, The Queensland Magistrates Guide.  
126 The Justices Act of 1886, 50 Vic., No. 17.
Queensland’s separation from New South Wales generated a high workload for public servants. The Attorney-General, Ratcliff Pring, wrote to the governor in December 1859 asking for a clerk to assist with the build-up of work attached to his office. Pring wrote ‘I beg to inform your Excellency that at present there is no person in the Crown Law Office except myself and that it is utterly impossible that I could perform the whole of the work required to be done’. In November 1862 the Executive Council approved the expenditure of £12 by the Sheriff’s office in Brisbane to acquire extra clerical assistance, as arrears had accumulated in the office ‘by reason of the great increase of work’. Full-time paid police magistrates began to take over from unpaid justices; however, as public servants they too were burdened with numerous tasks. In January 1866, Charles Gray advised the Attorney-General that ‘in many instances’ it would be impossible for him to leave his duties as police magistrate ‘for the purpose of attending to those as Coroner’. In relating his experiences as a police magistrate at Gayndah from 1888 to 1889, W. R. O. Hill lists the ‘multitude of billets’ he officially held:

‘(1) Police Magistrate; (2) Gold Warden; (3) Clerk of Petty Sessions; (4) Acting Land Commissioner; (5) Land Agent; (6) Registrar of the Small Debts Court; (7) District Registrar; (8) Registrar of Births, Deaths and Marriages; (9) Savings Bank Officer; (10) Commissioner for Affidavits; (11) Agent for the Curator of Intestate Estates; (12) Electoral Registrar; and (13) High Bailiff’.

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128 QSA Series ID: 13338, Item ID: 19646, Inwards Correspondence – Attorney-General’s Office. Letter from the Clerk of the Council to the Attorney-General, 8 November 1862.
129 QSA Series ID: 13338, Item ID: 19650, Inwards Correspondence – Attorney-General’s Office. Letter from the police magistrate, Ipswich, to the Attorney-General, Brisbane, 2 January 1866.
Hill describes his ‘office’ on the Cape River Gold Field in 1868 as ‘a bark humpy, very leaky in wet weather, and like an oven in summer, dimensions being twelve feet by ten feet’. He goes on to inform that ‘[T]his noble edifice had to serve me also as bed room, and I dined at a pub’. When he moved on to the Ravenswood Gold Fields in 1870 Hill ‘had to hold court and transact office work in a tent twelve feet by eight feet’. In the formative years of the colony, the police magistrate, who was required to pass an examination prior to appointment, operated as a vital arm of the Queensland government through his service to a colony comprising of widespread outposts.

Although published texts on the office of coroner were in circulation in the mid-nineteenth century, police magistrates and coroners still sought clarification from the Crown Law Office on legal issues relevant to their role as coroner. Elias Rutherford, coroner for Rockhampton, in a letter to the Attorney-General, acknowledged the receipt of a letter of ‘advice & notes’ for him to ‘follow when holding an inquest’. Rutherford goes on to state that he was ‘deeply grieved to think that my first attempt was so far a failure’. Henry Challinor, coroner for Ipswich, enquired of the Attorney-General if he

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131 Hill, ‘Forty-Five Years’ Experiences in North Queensland. 1861 to 1905, pp. 46-47.
132 Hill, ‘Forty-Five Years’ Experiences in North Queensland. 1861 to 1905, p. 54.
133 The Colonial Secretary, Robert Herbert, wrote to the Attorney-General, Ratcliff Pring on 18 October 1860, stating that ‘all candidates for the appointment of Police Magistrate in the Colony shall undergo Examination before they can be considered eligible for such employment, I do myself the honor to request that, calling to your assistance, the Crown Solicitor, you will be good enough to submit, for the approval of the Executive, such a plan for the examination of Candidates as may appear to you best calculated to determine their fitness for employment generally in the Public Service and especially for the appointment of Police Magistrates in the Country Districts’, QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office; Queensland Government Gazette, No 66, 3 November 1860, p. 385.
134 QSA Series ID: 7132, Books of Circulars – Colonial Secretary; Series ID: 13337, Inwards Correspondence – Crown Law Office.
was correct in empanelling a jury on a Sunday in order to view a body before decomposition set in and to determine if a post-mortem was needed. In 1865 the new coroner for Drayton wrote in a letter to the Attorney-General:

I have the honor [sic] to request that I may be informed what allowances I am authorised to pay to medical and other witnesses, persons taking up bodies etc what mileage and other fees I am entitled to receive and generally as to the duties of the Office.

I am informed that it was the practice of the late coroner in cases of sudden or violent death occurring on stations and at the places where there might be a difficulty in getting a jury, to hold a magisterial inquiry … I apprehend that I am not under any circumstances justified in going beyond the limits of the Police District of Drayton.

To familiarise themselves with the office and duties of the coroner, magistrates and coroners referred to a number of different texts, including; Burn’s Justice of the Peace and Parish Officer, A practical treatise on the office and duties of coroners by Sir John Jervis, Plunkett’s Australian Magistrate, and A treatise on the law of the Coroner.

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137 QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter from coroner for Drayton to Attorney-General, 29 August 1865.
138 Burn, ‘Coroner’.
140 QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office, letter from Colonial Secretary’s Office to the Attorney-General, 29 December 1860; QSA Series ID: 13338, Item ID: 19646, Inwards Correspondence – Attorney-General’s Office, telegram from Charles Gray, police magistrate for Ipswich to Attorney-General, 12 July 1862.
However not all officers had access to guides on the office of coroner. In 1866 the police magistrate at Maryborough reported to the Attorney-General that he had conducted his first magisterial inquiry; as he had no access to instructions to guide him, he invited the Attorney-General to point out any ‘informality’ in his proceedings.\(^{142}\)

Government officials in rural regions of Queensland were burdened with multiple administrative roles, for which, they were not always competent in performing. They relied on the provision of instructive manuals, but these were not always forthcoming. However correspondence between magistrates and the government indicates that some magistrates were striving to perform their coronial duties efficiently and that the government was achieving some success in extending its supervision over local government.

The coronial inquest

Cooke describes the late nineteenth and early twentieth century inquest as ‘both a state institution and a part of the popular response to violent death’.\(^{143}\) An inquest was an official inquiry by a court that gathered information from witnesses to assist in determining the identity of the deceased, how they died and under what circumstances the death occurred. The court hearing was open to the general public and media, although in

\(^{142}\) QSA Series ID: 13338, Item ID: 19650, Inwards Correspondence – Attorney-General’s Office, letter from police magistrate Maryborough to Attorney-General, 12 March 1866.

\(^{143}\) Cooke, ‘Secret sorrows: A social History of Suicide in Victoria, 1841-1921, p. 33.
certain circumstances the coroner could exclude individuals or the general public, and prohibit the publication of evidence.\textsuperscript{144} Nineteenth century inquests dealt with such deaths as accidental, suspicious, violent or unnatural, cause unknown or in custody. The \textit{Coroners Bail Act 1861},\textsuperscript{145} the first Queensland act relating to Coroners’ Courts, enabled juries which had delivered a verdict of manslaughter to accept bail. The \textit{Inquests on Fires Act} passed in 1863, empowered coroners to conduct inquests on fires.\textsuperscript{146} Two methods of death investigation prevailed at this time. The first was a coroner’s inquest conducted on view of the body before a jury of twelve men, or no less than five if held in a sparsely populated region. Gathering together enough citizens to form a jury was a significant problem in outer lying settlements. Henry Challinor, coroner for Ipswich, reported to the Attorney-General: ‘I have more than once been put to some inconvenience and delay in obtaining the smallest jury allowed by law. To complete the number I have had occasion to swear in the constable in attendance as a juror’.\textsuperscript{147} The coroner at Rockhampton held a magisterial inquiry in place of an inquest because there was not a ‘sufficient number present to form a jury’.\textsuperscript{148} Moves to reform the coronial law in 1866 were directed at resolving this on-going problem through discarding the need to assemble a jury for an inquest.\textsuperscript{149}


\textsuperscript{145} \textit{The Coroners Bail Act of 1861}, 25 Vic. No. 2.

\textsuperscript{146} \textit{Inquests on Fires Act} 1863, 27 Vic. No. 12.

\textsuperscript{147} QSA Series ID: 13338, Item ID: 19645, Inwards Correspondence – Attorney-General’s Office, letter from Henry Challinor, coroner for Ipswich, to the Attorney-General, 22 April 1861.

\textsuperscript{148} QSA Series ID: 13338, Item ID: 19646, Inwards Correspondence – Attorney-General, letter from William Callaghan, coroner for Rockhampton, to the Attorney-General, 30 December 1862.

\textsuperscript{149} \textit{The Inquests of Death Act of 1866}, 30 Vic., No. 3, s. 3.
Another method of investigating death was the magisterial inquiry, which was conducted by a police magistrate or justice of the peace in districts where there were no coroners or the coroner was absent. Magistrates and justices held equal power to the coroner, apart from the authority to empanel a jury and commit for trial. As they lacked the power to commit, a magistrate or justice could only recommend that police charge any person inculpated.\textsuperscript{150} Under the 1852 \textit{Acts Shortening Act} of New South Wales, police magistrates and justices were authorised to administer oaths to witnesses.\textsuperscript{151} During the course of an inquest a clerk wrote out the evidence and the deposition of each witness was read back and then signed by the coroner and the witness. The depositions, with a certificate of cause of death, were then forwarded to the Attorney General for review. At the same time a duplicate copy of the certificate was sent to the Commissioner of Police and to the Register-general. The Justice Department, often in consultation with the Commissioner of Police, determined whether any further action was necessary. The inquest file remained with the department until it was sent for storage at the State Archives.\textsuperscript{152}

The coroner held the power to order a post-mortem examination of the body and summon witnesses, including any medical professional who attended the deceased. The rapid decomposition of bodies in the hot Queensland climate hindered medical men in

\textsuperscript{150} Golder, \textit{High and Responsible Office: A History of the NSW Magistracy}, p. 118.
\textsuperscript{151} QSA Series ID: 7132, Item ID: 269825, Under Secretary, Department of Justice, to the Chairman, Bench of Magistrates, 6 May 1908 (1889 – 1939 Vol. 1), 95, Circular 2/08, legal opinion on the history of coronial jurisdiction in NSW and Qld, E. M. Lilley, ‘The King v. Thomas Smith: Opinion’; \textit{The Acts Shortening Act} (1852), 16 Vic. No. 1, Section 12.
\textsuperscript{152} Weaver, \textit{A Sadly Troubled History: The Meanings of Suicide in the Modern Age}, Press, p. 114; QSA Series ID: 36, Inquest Files. The terms “Register-General” and “Registrar-General” appeared on official Queensland Government documents. In this thesis the term “Register-General” is used, unless quoting directly from a source where “Registrar-general” is cited.
determining cause of death, therefore post-mortem examinations were conducted as soon as possible. Inquiries were generally held, and bodies buried, within twenty-four hours of death occurring. The scarcity of medical professionals in the colony meant residents of frontier settlements were happy to accept the services of non-qualified health practitioners; however qualified medical men were critical of this practice. In 1860 the acting police magistrate at Rockhampton advised the Attorney-General of ‘the necessity of putting a stop to non professional [sic] men attending patients as has been too frequent in the country districts of the colony. In 1871 Dr Kevin O’Doherty raised the matter in parliament when a non-qualified “doctor” removed the head of a deceased person for the purpose of giving evidence at the inquest. A high degree of resentment was felt towards “continental” doctors, especially those trained in Germany. Dr Wyndham


154 Patrick, R. and Patrick, H. (1989), Exiles undaunted : the Irish rebels Kevin and Eva O’Doherty, St. Lucia: University of Queensland Press. Kevin Izod O’Doherty was an Irish nationalist and medical practitioner. He was sentenced to transportation to Tasmania for treason-felony in 1849. Granted a ticket-of-leave in 1849, O’Doherty became manager of the dispensary in Hobart in November 1850 and in January 1851 was acting surgeon at St Mary’s Hospital. In June 1853 he received a conditional pardon and went to Paris. He received an unconditional pardon the next year and returned to Dublin and graduated as a fellow of the Royal College of Surgeons in June 1857. O’Doherty returned to Australia in 1860 and moved to Brisbane in 1865 where he became a leading physician. He was one of the first presidents of the Queensland Medical Society and carried out extensive honorary work at Catholic hospitals. A member for Brisbane in the Legislative Assembly in 1867-73, he had wide interests. In 1872 he was responsible for the first Health Act in Queensland and in 1875-77 gave evidence to many commissions on medical matters. In January 1868 he became one of the first trustees of the undenominational Brisbane Grammar School, but in 1874 declined to serve on the royal commission on education in protest at ‘the proposed withdrawal of aid to non-vested schools’. He was a member of the Legislative Council in 1877-85 and as an opponent of the traffic in Kanakas sponsored the bill to stop their recruitment. A leading figure in the Queensland Irish Association, he was elected president of the Irish Australian Convention held in Melbourne in 1883 (Taken from Rude, G., O’Doherty, Kevin Izod (1823-1905), Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/odoherty-kevin-izod-4319 accessed 26 December 2011).

155 QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office, letter from acting police magistrate Rockhampton to the Attorney-General, 22 February 1860.

156 QPD 1871-1872 35 Vic., pp. 293-294. For more on this case see Chapter Three.
Armstrong, took out a paid advertisement when the government proposed licensing ‘certain professionals’ in 1855. He wrote:

I beg to assert that no Act which it could pass could ever force me to associate in terms of equality, professional or otherwise, with persons who in this country lay claim to a position to which they are on no grounds entitled in their own.  

Although these “foreign” doctors were entitled to practice in the colony, they could not register as medical practitioners. A qualified medical practitioner was:

a doctor or bachelor of medicine of some university, or a physician, or surgeon, licensed or admitted as such by some university or a physician or surgeon licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland, or a member of the company of apothecaries of London, or who is, or has been a medical officer duly appointed and confirmed, of Her Majesty’s sea or land service.

Coroners were entitled to a salary of £20 per annum and fees were payable to a coroner, police magistrate or justice for holding an inquest or magisterial inquiry. They were also able to claim a mileage allowance for travelling to and from the site of the hearing. Medical practitioners were paid for holding a post-mortem and witnesses giving evidence at an inquest also were entitled to fees. Coroners and medical men frequently protested over what they considered poor remuneration for the time and effort involved in

159 An Act to provide for attendance of Medical Witnesses at Coroners’ Inquests and Inquiries held before Justices of the Peace, 1838, 2 Vic. No 22, s. 1.
performing the duties associated with coronial inquests. William Armstrong was appointed coroner for Drayton by the New South Wales government in 1859, and at that time no salary was paid to him. In February 1860 he wrote to the Queensland Attorney-General declaring that:

I … find that the duties are very onerous and sometimes absorb a good deal of time especially in this large district, where I have had to ride over 50 miles to hold an inquest, The mileage and Fee not at all compensating for trouble and loss of time.

I therefore think that I have a right to expect from the Queensland Government the usual salary given to Coroners - and unless Government will accede to my request and allow me a salary, I shall consider it my duty to send in my resignation of the office of Coroner for Darling Downs.\(^{161}\)

Referring to his position as coroner, Dr Otto Sachse maintained that he:

accepted and held the office not on account of the small renumeration [sic], attached to it, but on account of the honor [sic] it conferred on its bearer … and that I took the burden of this office on me even to the detriment of my private profession.\(^{162}\)

Further complaints from coroners were related to the length of time the government took to pay money owing for fees claimed. On an order from a justice Dr Barlow conducted an examination of remains taken from the Brisbane River on 15 November 1862. Dr Barlow wrote a letter to the Attorney-General in May 1863, stating ‘I have the honor [sic] to beg

\(^{161}\) QSA Series ID: 13338, Item ID: 19644, Inwards Correspondence – Attorney-General’s Office, letter from William Armstrong, coroner for Drayton, to the Attorney-General, 16 February 1860.

\(^{162}\) QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter Dr Otto Sachse to Attorney-General, 21 September 1865.
that you will inform me in what way I can obtain my fee of two guineas … [I] sent the usual Forms in duplicate to Mr Stephens for his signature to enable me to receive my fee but have had no communication from him since’.  

Otto Sachse, who took over from Armstrong as coroner for Drayton in 1862, enquired on 2 January 1865 about payment for an inquest held by him nine months earlier. Referring to the vouchers he stated they had been ‘forwarded in proper time’ but he had not been paid to date.  

Upon notification of a death, the police conducted an investigation to establish the identity of the deceased where possible, the date of death, profession and when and where the body was found. Statements were taken from witnesses, relatives and friends of the deceased. Police reports were commonly very superficial, often no longer than one page in length, and complied with a standard format. The wording in a large number of police reports related to deaths of babies in maternal nursing homes in early twentieth century Queensland was almost identical, thus indicating that this duty was carried out in a habitual manner. The police then forwarded the report to the coroner who initiated an inquest if necessary. The coroner could not initiate an inquest independently; he relied on information passed on to him from the police or the public. When no inquest was

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163 QSA Series ID: 13338, Item ID: 19646, Inwards Correspondence – Attorney-General’s Office, letter from Dr Barlow to Attorney-General, 5 May 1863.
164 QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter from Otto Sachse, coroner for Drayton, to the Attorney-General, 2 January 1865.
165 Freckelton and Ranson, Death Investigation and the Coroner’s Inquest, p. 36.
166 QSA Series ID: 36, Item ID: 348880 to Item ID: 349059, Inquest File.
necessary an undertaker usually took control of the body following the furnishing of a death certificate signed by a medical doctor.  

The police were charged with the responsibility of moving the body to the morgue. Should no morgue exist, which was often the case in rural towns, the body was placed in the nearest building, such as the public house or community hall. The State was reluctant to spend scarce funds on erecting morgue facilities outside of the metropolitan precinct which left many towns in outback Queensland devoid of suitable amenities for the purpose of post-mortem examinations. As late as 1933 the Chairman of the McKinlay Shire Council, Mr. W. Allison, appealed to the Department of Justice for a morgue to be built at Julia Creek. He expressed displeasure with the current situation that necessitated the storage of ‘bodies that have lain two or three days in the bush’ and the conducting of post-mortems in totally unsuitable locations. With regard to post-mortems Allison goes on to state ‘some have been done in the School of Arts & the hemorrhage [sic] getting onto the floor is most offensive & sometimes the stench is almost unbearable’. As a consequence of this practice, the School of Arts Committee banned the use of the hall for storing dead bodies. Subsequent post-mortems were held in the Shire Council’s car-shed, as well as an old hut situated on a spare allotment. The council previously had proposed to build a morgue but was informed by the Home Office that

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this was not a function of the Local Authority. Allison correctly sums up the situation in relation to the problems of a centralised government when he declares:

little bush townships are legislated for under city conditions & we had to erect a much too elaborate structure with marble slab … yet we understand a wooden bench is still used in some cities. A very simple structure with concrete floor is really all that is needed.\(^{170}\)

The government used the small number of post-mortem examinations conducted in centres with small populations to justify their reluctance to erect mortuaries.

Use of hospital mortuaries by the police department was frequently troublesome to the Department of Health and Home Affairs.\(^{171}\) The Brisbane Morgue was washed away in the 1893 flood,\(^{172}\) leaving police with no place to store bodies while identification and investigations were completed. The search for a suitable site for a new morgue was still underway in 1907 and the continued use of the Brisbane Hospital morgue triggered a letter from the Medical Superintendent complaining of the length of time drowning cases were left at the morgue. Drawing attention to the offense to nearby patients connected with the ‘intolerable stench arising from the mortuary’ as well as the distress for relatives and friends viewing a body, the superintendent requested bodies to be buried quickly as the situation was ‘becoming a most objectionable and disgusting nuisance’.\(^{173}\) Similar

\(^{170}\) Letter from W. M. Allison to John Mullar MLA, Department of Justice, Brisbane; QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland.

\(^{171}\) Administration and control of the Brisbane Morgue was transferred from the Department of Health and Home Affairs to the Department of Justice in November 1949. QSA, Series ID: 8433, Item ID: 290336, Administration File, Police.

\(^{172}\) On Friday 7 February a previous morgue located at Queens Wharf, North Quay was damaged when a serious landslip occurred in the river bank on which it stood. The government advertised for tenders to remove and re-erect the morgue on 29 May 1890. The morgue was rebuilt on the same site. For further information see QSA, Series ID: 8843, Item ID: 290336, Administration File, Police.

\(^{173}\) QSA, Series ID: 8433, Item ID: 290336, Administration File, Police.
issues involving police making use of hospital morgues prevailed in rural areas of Queensland.\textsuperscript{174}

Simon Cooke’s account of Victoria’s early coronial practice demonstrates a system of coronial procedure similar to Queensland, the exception being the Victorian state’s continued retention of the office of coroner from 1841 onwards.\textsuperscript{175} The Minutes of Proceedings of the Executive Council on 15 November 1865 reported that ‘the Parliament has pronounced that the Office of Coroner should be discontinued and has made no provision for the payment of such offices after the close of the current year’.\textsuperscript{176} Therefore the office of coroner disappeared from the Queensland government statistical register after 1866. Enactment of \textit{The Inquests of Death Act 1866} allowed magistrates and justices of the peace to hold inquests in place of the coroner.\textsuperscript{177}

\textbf{Death Registration and the medical expert}

The accuracy of the colony’s mortality statistics relied on coroners conducting a thorough inquest when an uncertified death was referred to them. The contribution of expert pathologists assisted coroners in determining a definitive cause of death. While the role

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\textsuperscript{174} See QSA, Series ID: 5253, Item ID: 847243, Correspondence Inwards; QSA, Series ID: 13255, Item ID: 18973, Correspondence and Reports on hospitals and public morgues in Queensland.  
\textsuperscript{176} QSA Series ID: 13338, Item ID: 19649, Inwards correspondence – Attorney-General’s Office, Minutes of Proceedings of the Executive Council, 15 November 1865.  
\textsuperscript{177} Queensland Votes and Proceedings (1867), Statistical Register of Queensland for the Month of December; \textit{The Inquests of Death Act 1866}, 30 Vic., No. 3.
\end{flushright}
of the medical forensic expert was debated back in England, it was also the subject of
discussion in the colony of Victoria. James Neild, as editor of the *Australian Medical
Journal* between 1862 and 1879 was an influential member of the Victorian medical
community. He advocated the use of forensic medicine in examinations of bodies to
determine cause of death. Neild also claimed that knowledge of medicine alone was
insufficient to instil the principles of medical jurisprudence into the post-mortem process
and was critical of local practitioners’ knowledge of pathology. The opposition of general
practitioners’ to specialist pathologists acting as medical jurists led to a call for the
abolition of the office of coroner in Victoria. It was argued that police magistrates and
justices of the peace could competently investigate suspicious deaths. The office of
coronor was retained in Victoria and ultimately became a legal not a medical
appointment.178

The mid-nineteenth century English medico-legal debate over coroner’s qualifications179
was also carried to Queensland. During parliamentary discussion on the Inquests of
Death Bill in 1866 E Barney, the Postmaster-General, informed the members of the
Legislative Council that the amendment of coronial law was essentially a legal matter,
and would therefore be more relevant to the legally trained members of the House. He
went on to add that ‘gentlemen who were conversant with the practice of medicine were
not, as a rule, acquainted with the technicalities of legal proceedings, and therefore were
not so competent as legal gentlemen to conduct inquests’.180 It was proposed that medical

179 See Chapter 1: Investigating the coroner.
evidence be sought at an inquest when deemed necessary, but fundamentally, legal practitioners were considered more suited than doctors to conducting inquests.\textsuperscript{181} This viewpoint justified the proposed amendment of the role of the coroner to authorise magistrates and justices to conduct inquests and the abolition of the office.

As early as 1867 in Queensland, directions to District Registrars stressed the importance of entering an accurate cause of death in the death register, to enable the Register-General ‘to prepare reliable tables of mortality’.\textsuperscript{182} Changes adopted in the United Kingdom in the classification of cause of death were noted by Australian statisticians who altered the Nosological Index to accommodate new discoveries of diseases by medical science. In 1885, the Victorian Government Statistician Henry Hayter, in a letter to the Brisbane Registrar General William Blakeney, commented on the need to ‘judge whether it may be desirable to adopt the English forms in their entirety or whether some changes may be necessary to render them suitable to the circumstances of this colony’.\textsuperscript{183} Despite the apparent desire of colonial statisticians to replicate the improved English codification of cause of death, Queensland coroners continued to record “natural causes” and “visitation of God” as cause of death on death certificates.\textsuperscript{184}

\textsuperscript{181} QPD 1866 29 & 30 Victoria, Vol. III, p. 84.  
\textsuperscript{182} QGG, No. 12, 8 February 1867, Vol. VIII, Regulations respecting the duties and instructions for the guidance of registrars of births, deaths, and marriages, in the colony of Queensland.  
\textsuperscript{183} QSA Series ID: 5253, Item ID: 847252, Correspondence Inwards, Letter to William Blakeney from H. Hayter, 24 June 1885.  
\textsuperscript{184} See Return of deaths reported to the police, in which Inquests have been held, since last publication, Queensland Police Gazettes, specifically Wednesday 5 January, 1870, Vol. VII, p. 99; Wednesday 4 January, 1871, Vol. VIII, p. 67.
There is no doubt that the interaction of science and justice led to an improved method of death investigation. However Simon Cooke, in researching the history of suicides in Victoria from 1841 to 1921, argues:

There was a gradual shift during the nineteenth century from popular to institutional power at the inquest. As a result, the meaning of suicide coded in the process of investigation became more about medical and bureaucratic accuracy, and less about popular moral judgement.¹⁸⁵

This move away from popular participation at the inquest was founded on the increased involvement of the state in the inquest procedure. Cooke maintains that the ‘involvement of the police in the inquest reveals how the inquest itself was being transformed into an institution of modern government’.¹⁸⁶ More recently, John Weaver comments on the high level of surveillance of judicial officers by a centralised state that possibly manipulated and censored information, when discussing the use of evidence from inquest records.¹⁸⁷

The coroner’s investigative role in relation to sudden or suspicious deaths was strengthened under the provisions of England’s *Coroners Act* 1887, which consolidated and at the same time repealed the numerous laws relating to coroners in Common Law.¹⁸⁸

By the turn of the century the inquest that functioned as a popular and transparent institution was under threat as medical investigation was taken over by the expert pathologist. Furthermore, the role of the coroner was subjected to a greater level of government interference and scrutiny, as the following evidence will show.

¹⁸⁷ Weaver, *A Sadly Troubled History: The Meanings of Suicide in the Modern Age*, p. 6.
The office of coroner: complications, inconsistency and lapses

The death of Ann Preston on 15 October 1861 at Drayton near Toowoomba triggered a dispute between the coroner and police magistrate as to who held authority to conduct an inquest into the woman’s death. The controversy was played out in the local paper and quickly degenerated into a shameful fiasco. The protagonists involved in this incident were Dr William Armstrong, who had been appointed by the New South Wales government in February 1859 as the first coroner on the Darling Downs, Prussian-born doctor Frederick Otto Sachse, the first paid medical officer at the Toowoomba Hospital and William Groom, police magistrate and Mayor of Toowoomba.

Dr Sachse was summoned around 2.00pm to the woman’s solitary hut where he found Preston lying on the floor, displaying all the symptoms of strychnine poisoning. The woman died shortly after the doctor’s arrival. A small brass box containing remnants of strychnine was removed from the hut and later produced by Sachse as evidence at the inquiry into Preston’s death. At 3.00pm the same day Dr Sachse sent a letter addressed to either the district coroner or the police magistrate, detailing the circumstances of the death. William Groom, on receipt of the letter from Constable Macdonald, directed him to inform the coroner of the death and advise that the local police magistrate was leaving for Dalby early the following morning. The following day Groom was led to believe the

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189 Dr Otto Sachse was a physician and surgeon, duly qualified and certified from the University of Berlin. He gained registration as a qualified doctor in Queensland in 1856 (French, ‘Preachers, Teachers, and Healers’, p. 215).
190 QSA Series ID: 36, Item ID: 348602, Inquest File.
coroner was out of town.\textsuperscript{191} Jane Preston, daughter of the deceased, complained to Groom that morning that no one had removed her mother’s body from the hut in order to prepare for a burial.\textsuperscript{192} Reacting to Jane’s plea as well as official complaints relating to the offensive nature of the body, Mayor Groom deemed it his duty to request Dr Sachse to hold a post mortem examination and appear before him at the Exchange Hotel to give evidence at an inquiry. Groom notified the Chief Constable of his intention to hold an enquiry into the sudden death, and directed the undertaker to prepare the body for interment. The \textit{Darling Downs Gazette}, reporting on the death of Anne Preston, stated that ‘[A]s there was no account of the Coroner, and the Police Magistrate having gone to Dalby, Mr Groom considered it to be his duty to hold a magisterial inquiry.\textsuperscript{193} Groom was acting in accordance with the New South Wales Government directive published in 1845 that confirmed the right for police magistrates or justices of the peace to hold magisterial inquiries where a police district did not have a coroner or in the absence of the coroner.\textsuperscript{194} Groom later stated:

\begin{quote}
I had no idea of interfering with the duties of the coroner whatever. I acted throughout with a due regard to my position as a magistrate of Toowoomba, with a due regard to the feelings of the relatives of the unfortunate woman, and with a due regard to the feelings of humanity.\textsuperscript{195}
\end{quote}

According to the coroner Dr Armstrong, he was first notified of Preston’s death the morning of 15 October. Armstrong directed the Chief Constable to summons a jury and he then travelled to the Exchange Hotel only to find that Groom’s magisterial inquiry was

\begin{itemize}
\item \textsuperscript{191} \textit{Darling Downs Gazette}, 24 October 1861.
\item \textsuperscript{192} QSA Series ID: 36, Item ID: 348602, Inquest File.
\item \textsuperscript{193} \textit{Darling Downs Gazette}, 17 October 1861, p. 3.
\item \textsuperscript{194} New South Wales Government Gazette, 18 March 1845, No. 22, p. 300.
\item \textsuperscript{195} Groom, W. H. in \textit{Darling Downs Gazette}, 24 October 1861.
\end{itemize}
about to begin. Dr Armstrong fervently believed that he held jurisdiction over the inquest and swiftly dispatched a note to Groom which read:

Sir

Hearing that you are about to hold an inquiry on the body of Anne Preston who died yesterday, I do myself the honour to request that you will not interfere with my duties as coroner.

W. M. Armstrong
Coroner for Darling Downs

Groom promptly replied:

I have no desire to interfere with your duties, and require no dictation nor impertinence from you as to what are mine. When called on to do so, as I was in this instance, I shall do my duty irrespective of coroners.

Groom stubbornly proceeded with his inquiry in order to ‘vindicate the rights’ of his ‘official position’. He began taking evidence from Dr Sachse and other witnesses; being a magisterial inquiry no jury was present. Sachse, having earlier performed the post mortem, handed over the stomach of the woman for analysis and declared the cause of death as an overdose of strychnine. Groom found Anne Preston had died from the effects of self-administered strychnine, ‘when labouring under temporary insanity, produced by intemperance’. Had matters rested there, the findings of the inquiry into Anne Preston’s death would have been routinely reported in the local newspaper, a death

196 Armstrong, W. ‘Letters to the Editor’, in Darling Downs Gazette, 31 October 1861, p. 3.
198 Darling Downs Gazette, 24 October 1861.
199 QSA Series ID: 36, Item ID: 348602, Inquest File.
certificate despatched to the Registrar of Births, Deaths and Marriages and the
depositions and other official documents forwarded to the Justice Department. They then
would have been filed away with hundreds of other tragic stories of death that were
common in an era that challenged settlers’ mental and physical resolve.

Armstrong however was determined to push ahead with a separate inquest and
summoned Dr Sachse in writing to make a post mortem examination and appear before
him at 2.00pm as a witness. Both inquiries were held simultaneously in the hotel with
witnesses dashing from one room to the other. Armstrong was unable to conclude the
inquest that day as Dr Sachse refused to give evidence before him, arguing that he was
already under summons from Groom and furthermore he ‘would not serve as a tool in a
proceeding which was if not contrary to law, at least against decorum’.200 Sachse claimed
he had not refused to conduct a post-mortem examination on receipt of the coroner’s
order, as he had already completed the post-mortem two hours earlier. Armstrong then
sent a telegram to the Attorney General seeking direction in the stalemate; the reply to
which advised the coroner to inform Sachse he would be subjected to a penalty of £20 if
he refused to conduct the post-mortem. Armstrong’s inquest was terminated without
medical testimony and then Armstrong caused a ‘public sensation’ by countermanding
Groom’s order for burial of the body on 16 October. Finally at 2.00pm on 17 October the
coronner made an order for burial of the body.201

200 *Darling Downs Gazette*, 31 October 1861, p. 3.
201 *Darling Downs Gazette*, 31 October 1861, p. 3.
The two doctors’ battle to demarcate their coronial jurisdiction continued in ‘Letters to the Editor’ of the *Darling Downs Gazette*. Medical officer Sachse called for the Attorney General to enquire into coroner Armstrong’s conduct, which in his opinion had given ‘serious cause for complaint in his quality as Coroner’. Armstrong also wrote to the Attorney General requesting an enquiry into his reported ‘negligence of duty’ so as to provide him an opportunity to prove the truthfulness of his statements. Armstrong’s attitude towards Groom and Sachse was evident in his statement to Pring that their actions were ‘only instigated by private pique and jealousy to interfere with me in the discharge of my public duties’. The Attorney General, Ratcliffe Pring, informed Armstrong that:

… the Government has no reason to be dissatisfied with your conduct in your official capacity as coroner, and as no charge has been made against you, I am unable to advise that the investigation you apply for should be granted.

No penalty was deemed necessary by the Attorney General in relation to Dr Sachse’s refusal to give evidence, thus ending an affair that did not reflect well on the public officials involved in the incident.

Ann Preston’s death certificate is an enigma. Information was provided by Dr Armstrong, coroner for Drayton, who stated that she died on 16 October 1861. In fact the date of Anne’s death was 15 October 1861. Furthermore Dr Sachse’s name did not appear on the

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202 Sachse, O. ‘Letters to the Editor’ in *Darling Downs Gazette*, 31 October 1861, p. 3.  
204 Pring, Ratcliffe, ‘Letters to the Editor’ in *Darling Downs Gazette*, 31 October 1861, p. 3.  
205 *Darling Downs Gazette*, 31 October 1861, p. 3.
document, yet he was the attending doctor. It is necessity to provide manner and cause of
death on the death certificate, but Armstrong only listed strychnine poisoning, failing to
record the manner of death as suicide. Some coroners did chose to omit the word
“suicide” from their findings as an act of benevolence aimed at hiding the true cause of
death or preserving the family’s right to claim on insurance. It is unlikely that
Armstrong’s omission was a deliberate oversight as the press had already revealed the
details of the case. The incomplete particulars contained on the death certificate
exemplified a failing of officers to follow guidelines when undertaking the duties of
coroner, especially during the early colonial period in Queensland. The comprehensive
study of the inquest records discloses inadequacies in the completion of ‘Certificates of
Particulars’ and ‘Death Certificates’, particularly in rural districts.

In the case of Anne Preston, the death was not registered until 1 March 1861, five months
after her suicide. There is no apparent explanation for this delay. The exact circumstances
linked to the whereabouts of the coroner remained unclear, but the intent of both
Armstrong and Groom to defend their position and exercise the power of their
jurisdiction was obvious. Groom declared that on hearing the coroner had arrived at the
hotel, and having much business to attend to, he was prepared to step aside and consent to
Armstrong conducting the inquest. However he went on to state:

Constable Macdonald brought me a letter written by Dr Armstrong … which in
the place of thanking me for what I had done, contained a deliberate insult to me

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206 See Chapter 6 for a detailed discussion on this topic.
207 Darling Downs Gazette, 17 October 1861, p. 3.
208 For example see QSA Series ID: 13381, Item ID: 19797, Letterbook - Crown Law Office, 01/09/1884 –
27/04/1886.
in my official capacity as Mayor of Toowoomba. I then deemed it my duty to proceed with the enquiry I had instituted in order to vindicate the rights of my official position.\footnote{\textit{Darling Downs Gazette}, 24 October 1861.}

It would have been prudent for Groom to transfer control of the inquest to the coroner, given that the coroner possessed greater powers of investigation and that a jury had already been assembled for the inquest.

According to the law, magisterial inquiries were to be instituted only when a coroner was not available. Believing that Armstrong was away, Groom was entitled to order an inquiry but should have respected the jurisdiction of the coroner upon his arrival. Unfortunately a power struggle and clash of individual egos overshadowed the rights and respect that should have been afforded to this unfortunate woman and her family. This case study highlights the problems associated with government officials having to operate within a large jurisdiction during the period of Queensland’s expansion. In order to perform their duties, coroners or police magistrates were often required to travel to other areas in their district, consequently leaving justices of the peace or clerks of petty sessions to act in their absence.

Dr Sachse took over from Dr Armstrong as coroner for Toowoomba on 10 October 1862, but in due course, his behaviour led to removal from the office. Controversy had a habit of following Sachse. While practicing privately in Warwick in the late 1850s, Dr Sachse
quarrelled publicly in the *Courier* with Dr Labatt, who refused to work with Sachse because his qualifications were not recognised in the British colony. Attorney-General Pring commented on the dispute, maintaining that:

It was lamentable to find that when a gentleman, who appeared in every way qualified, thought it desirable to perform an important operation for the purpose of trying to save life, he was prevented from doing so by the refusal of another medical man to consult with him, on the ground that he was not legally qualified according to the Colonial Act. The law as it stood in this colony, enabled the veriest quack or ignoramus to practise [sic] if he had only received his diploma from an English college, whilst a foreigner, however learned or talented, was looked upon with suspicion.²¹⁰

Local people were critical of Sachse’s high fees and objected to his insistence that treatment was conditional on prepayment of his fee. In 1856 Sachse gained registration as a qualified Queensland doctor and by 1858 had moved to Toowoomba. In 1859 he found himself the centre of public attention once again, following the death of a young Drayton girl from whose parents he had demanded pre-payment of £220, before commencing treatment. The girl’s parents dismissed Sachse and called in Dr Armstrong. Two months later, in December 1859, Sachse again refused to attend a patient without guarantee of payment. The injured man died and a coronial jury under William Armstrong accused him of ‘inhumanity’. Armstrong went to the press labelling Sachse ‘an amalgamation of doctor and banker’ and of following a ‘continental’ way ‘not approved of by Britishers’. The incident culminated a few days later with Sachse being shot at 3 times in a

²¹⁰ *Moreton BayCourier* 2 June 1855, p. 2.
Toowoomba Street.\textsuperscript{211} Given the past history of associations between Armstrong and Sachse, the unpleasant interaction between the two over the Preston case was predictable.

As coroner for the district of Drayton, Sachse once again came under attack for exceeding his jurisdiction while holding an inquest into the death of Margaret Curtis, who was found dead and presumed murdered, on a Toowoomba street around 8.00pm on 19 June 1865. Sachse summoned a jury to meet at the Hamburgh Hotel on 27 June where he intended to hold an inquest. The jury was sworn in and proceeded to the hospital ‘deadhouse’ to view the body. The coroner then informed the jury he had granted a request from Sub-Inspector Foran, who was to act as public prosecutor at the inquest, for permission to pursue a suspect in the murder, delaying the holding of the inquest for six days.\textsuperscript{212} By the time the inquest had resumed a man had been taken into custody in connection with Curtis’ death. Prior to the commencement of the inquest, the coroner endeavoured to extract a plea from the prisoner. In addition, Sachse attempted to nominate a foreman of the jury and in his closing address tried to coerce the jury into finding the prisoner guilty of the murder. The jury maintained their independence and delivered a verdict of ‘murder by person or persons unknown’.\textsuperscript{213}

As coroner, Sachse’s official role was to ascertain the cause of death of Margaret Curtis. The duty of a coroner dictates that he record the evidence of all witnesses summoned and

\textsuperscript{211} French, ‘Preachers, Teachers, and Healers’, pp. 215-216.
\textsuperscript{212} \textit{Darling Downs Gazette}, 24 June 1865; \textit{Brisbane Courier}, 4 July 1865, p. 3.
\textsuperscript{213} \textit{Darling Downs Gazette}, 24 June 1865.
if the jury finds a person responsible for, or in some way connected with the death, the coroner must issue a warrant for arrest or detention of that person to await trial. According to the prevailing authority on the law relating to justices of the peace, it was the role of the jury to determine the facts of the case and reach a verdict without being ‘bound by any specific or direct opinion of the coroner … But in questions of law, juries ought to ask and shew [sic] the most respectful deference to the advice and recommendation of the coroner’. At the same time, the government had offered a reward of £100 for the capture of the murderer, before legally determining that a murder in fact had been committed. The *Darling Downs Gazette* claimed that Sachse overstepped the bounds of his jurisdiction as coroner by trying to extract a plea from the prisoner, denying the jury the right to democratically elect a foreman and through his excessive direction of the jury in his summing up of evidence.

William Groom was elected as a member of the Legislative Assembly for Toowoomba in 1862. During the course of a sitting of the house in 1865, he raised the subject of the unlawful conduct of the coroner during the Curtis inquest. According to Groom, Sachse’s behaviour generated unfavourable reports in the *Darling Downs Gazette*; reports that questioned the coroner’s suitability for the office. Groom accused Dr Sachse of acting in contravention of his role as coroner concluding that as a foreigner, Mr Sachse ‘was ignorant of the nature of the English laws, and could not, therefore, be supposed to be

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214 Burn, ‘Coroner’, p. 32; *Coroners Act 1887*, 50 & 51 Victoria.
215 Burn, ‘Coroner’, p. 36.
216 *Brisbane Courier*, 1 April 1867.
217 *Darling Downs Gazette*, 24 June 1865.
qualified to conduct an inquiry in such a case’.\footnote{Groom in QPD (1865), 29 Vic., Vol. II, p. 296.} Groom asked for action to be taken to remove Sachse from the position of coroner. The Attorney-General, in reply, acknowledged existing dissatisfaction with the performance of the coroner of Toowoomba and advised of his intention to ask the government to relieve Dr Sachse of the position.\footnote{Pring, R. in QPD, (1865), Vol. II, p. 296.}

Sachse was subsequently dismissed in August 1865 from the office of coroner in a manner he described as ‘neither in accordance with my position as a professional gentleman, neither [sic] with the dignity belonging to the Office of Coroner as representative of the crown in his Court’. He was critical of Attorney-general Pring for reacting to a local newspaper report that he described as ‘a tissue of falsehoods and malicious inventions reflecting severely on myself’. Sachse closed his letter with the statement: ‘being dismissed with dishonour from my office immediately after the public remarks of the late Attorney General – unmerited and without inquiry – I regret ever to have accepted the office, and to have thrown away so much of my time’. In response to his complaint Dr Sachse was advised that his only course of action was to send a petition to the parliament.\footnote{QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter from Otto Sachse to the Attorney-general, 21 September 1865.} During August 1865, Mr J Stable was sworn in as coroner by Frederick Rawlins, the police magistrate for the district of Drayton. Stable listed the

\footnote{Groom in QPD (1865), 29 Vic., Vol. II, p. 296.}
\footnote{Pring, R. in QPD, (1865), Vol. II, p. 296.}
\footnote{QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter from Otto Sachse to the Attorney-general, 21 September 1865.
government property and papers he received from Sachse, but no formal guide to the duties of coroner was included.221

It is evident from the case studies that although Armstrong, Groom and Sachse were influential members of the Drayton community,222 they held little regard for each other and their unprofessional behaviour was a consequence of this fact. The events which transpired in relation to the Preston inquest had less to do with coronial law and more to do with petty jealousies. Admittedly a lack of legal knowledge, in conjunction with an absence of prescriptive coronial legislation, was likely to lead to confusion when a case extended beyond the usual parameters. This may have applied when Armstrong and Groom both convened an inquest at the same time. The legislation stated that in the absence of the coroner a police magistrate was authorised to perform his duties and held the same power as the coroner. It did not however cover the situation in the Preston inquest; that is the coroner arriving at the commencement of a magisterial inquiry. Legally the coroner was empowered to conduct the inquest over the police magistrate, but given the magistrate had already ordered a post-mortem and commenced the hearing it

221 QSA Series ID: 13338, Item ID: 19649, Inwards Correspondence – Attorney-General’s Office, letter from J. Stable, coroner for Drayton, to Attorney-General, 29 August 1865.
222 Henry Groom, as a state member of politics, held great political sway and was extremely successful at securing loans from the government to fulfill local needs. Originally transported to Australia for forgery at the age of 13 years, Groom also worked as a storekeeper, auctioneer, publican and newspaper proprietor. Dr Armstrong’s appointments were Government Medical Officer, Visiting Surgeon to Toowoomba Hospital, Visiting Surgeon Lunatic Reception House Toowoomba, coroner and magistrate. He was appointed Honorary Surgeon to the Drayton Benevolent Society and in August 1861 opened a private hospital in Drayton. Dr Otto Sachse was born in Prussia and obtained his medical qualifications from the Berlin University. He became the first paid medical officer at the Toowoomba Hospital in February 1861 (Waterson, D. (1968), Squatter, Selector, and Storekeeper: A History of the Darling Downs 1859-93, Sydney: Sydney University Press, pp. 225-226); Clements, J. (nd) Toowoomba General Hospital, Toowoomba Hospital Foundation, Queensland Health, pp.1-4.
would come down to a practical and ethical decision as to who held the inquest. The events connected with Preston’s inquest were connected to a power struggle between three individuals who were not prepared to allow any diminution of their power.

In the Preston case Dr Sachse was in the invidious position of receiving directions from both the coroner and police magistrate. Deeming himself under prior summons from Groom, Sachse argued that he could not comply with Armstrong’s instructions. In a practical sense, as a public servant engaged to perform a service, a rational approach to the situation would have been for Sachse to inform the coroner of the completion of the post-mortem and attend the inquest. In the Curtis case, having held the office of coroner for more than three years and conducted numerous inquests, Otto Sachse must have been conversant with the basic provisions that guided inquest procedure. Accordingly he should have known that he had acted contrary to his jurisdiction. The Attorney-General expressed regret that having been responsible for the appointment of Sachse, the doctor was found to be ‘unfit for his office’.

Dr Henry Challinor: coroner for Ipswich

Henry Challinor set up a medical practice in the Ipswich district in April of 1849 and became actively involved in the colony’s political, medical, religious and civic affairs.

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during the years of his residency at Ipswich. Dr Challinor was appointed as coroner for Ipswich by the New South Wales Governor William Denison on 24 October 1859. He was arguably the colony’s most experienced and influential coroner. Like other agents invested with the power to hold inquests, he too showed concern over issues of travelling distance and poor remuneration. A case in point was Challinor’s refusal to attend an attempted suicide victim when called upon by the chief constable of the Ipswich district. Chief constable Quinn, in a letter to police magistrate Charles Gray, recounted the order of events connected with the attempted suicide of Thomas Owen by cutting his throat with a razor. Quinn called upon Dr Challinor to attend to Owen but Challinor refused. Challinor asserted that his refusal was ‘in consequence of the Government allowing him but 1/- per mile over two miles from his … residence and that he would not go for that amount’. When informed by Quinn that his medical attention may have saved the man’s life, Challinor replied ‘I do not care I could do nothing for him until he is brought down here’. Financial concerns appear to sit at the heart of Challinor’s response to Quinn. He indicated that the death of the man was imminent therefore he would save himself the trouble of travelling to the site of the attempted suicide and wait for delivery of the deceased for the purpose of a post-mortem examination and inquest. Quinn on the other hand implied a neglect of duty on the part of Challinor.

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225 Report from the Committee of Elections and Qualifications; with Minutes of the Proceedings of the Committee, and Evidence, Election Petition; Forbes v. Challinor, Exhibit A., Legislative Assembly, Queensland, 1861.

226 QSA, Series ID: 5253, Item ID: 846730, Correspondence Inwards, Letter No. 103/1859.
Police magistrate Gray, on receipt of Quinn’s letter of complaint appealed to the Colonial Secretary for guidance on the matter. He informed Colonial Secretary Herbert:

As this is the first instance of this kind which has arisen I am rather at a loss how to act in the matter, but setting aside the inhumanity of the refusal … I think a good opportunity presents itself of at once deciding upon of what is the duty of a legally qualified medical practitioner, and especially of a Coroner in matters similar to that which I now … bring under your notice. I hope therefore that some power may be placed in my hands as Police Magistrate to call upon legally qualified medical men to visit in cases of emergency such as the present and that in so doing I may not be again placed in a false position.\textsuperscript{227}

Gray’s appeal to the Executive for direction was unproductive. Communications between the Governor, Colonial Secretary and Attorney-General focused on determining in what capacity Dr Challinor was called on and whether the government possessed the power to control his actions. Attorney-General Ratcliffe Pring advised the Colonial Secretary that ‘Dr. Challinor was not bound to attend at Moran’s, as a Coroner in as much as there was then no necessity for an inquest’ and as to his refusal to attend the wounded man as a medical practitioner, Pring was unaware that the government had any rights ‘to control his discretions on that point’.\textsuperscript{228} Ultimately, Challinor was not obliged to attend the wounded man in his capacity as coroner. His refusal to attend the victim was likely to have been related to the time involved in travelling to the location, in conjunction with the hopelessness of the situation.

\textsuperscript{227} QSA, Series ID: 5253 Item: 846730, Correspondence Inwards, Letter No. 103/1859.
\textsuperscript{228} QSA, Series ID: 5253 Item: 846730, Correspondence Inwards, Letter No. 103/1859 and 111/1859.
In a similar incident back in 1855 Henry Challinor was labelled as inhumane by Dr Frederick Cumming for not attending to a patient injured in an accident at a location approximately ten miles from Ipswich. Both doctors published letters in the *Moreton Bay Courier* defending their role in the matter. When first called on to attend the victim Challinor consented to go, but on further consideration he maintained that it was the state of the weather and the roads ‘which induced me on that occasion to decline going on a perfectly useless and to some extent hazardous journey’, preferring to leave the next morning. Refuting the charge of neglect directed towards him by Cumming, Dr Challinor stated that:

> there is an omission … that gives a different colouring to the whole affair – namely the principal reason I assigned for not going – the only reason indeed that made the other reasons reasonable – I mean the circumstances of Mrs Jubb being *dead* before the messenger was despatched for medical aid.\(^{229}\)

Challinor further justified his actions in maintaining that he had travelled through the bush at night on several occasions to attend emergency cases but stated that ‘in each of these cases I went to see a *patient* - not a *corpse*’.\(^{230}\)

The issue contested in this case was whether in fact Challinor was informed that Mrs Jubb was indeed dead; something that Cumming refuted. In further correspondence to the *Moreton Bay Courier* on 9 June 1855 Challinor wrote:

\(^{229}\) *Moreton Bay Courier*, 19 May 1855.

\(^{230}\) *Moreton Bay Courier*, 19 May 1855.
I have no objections whatever to visit a corpse when it suits my purpose, and had the night been favourable would gladly have gone to examine Mrs Jubb’s remains, knowing that Mr. Jubb would have handsomely remunerated me for the service, and that by waiting till morning I could only claim a solitary guinea for a *compulsory* ride of nine miles, and attendance at a magisterial enquiry; but a little reflection while procuring my horse, convinced me that in more senses than one I might be “penny wise and pound foolish” in yielding to the pressure of that pecuniary motive, and therefore on my return declined going.²³¹

According to Challinor his decision not to go to the Jubb residence when called on was not related to pecuniary interests. Nonetheless, what is clear from his statements is the importance of geography, climate and remuneration to men who were expected to travel long distances in the performance of their duties on behalf of the government.

The holding of two inquiries into the death of Ann Preston was not an isolated incident nor was it the first. In 1861 the Police Magistrate for Ipswich, Charles Gray, requested that Henry Challinor hold a magisterial inquiry into the death of Frederick Ware which had occurred the previous evening. According to Gray, he initially approached Dr Lucas to conduct the inquiry but as Lucas was unable to do so immediately, Challinor was engaged. At the conclusion of Challinor’s inquiry, Lucas turned up and despite being told that an inquiry had been conducted, he instituted a second inquiry. In protest over the situation Challinor then wrote to the Attorney General stating ‘[S]hould the unseemliness of holding two enquiries upon the same body without sufficient cause or circumstances connected therewith promote public comment I shall request your permission to publish

²³¹ *Moreton Bay Courier*, 9 June 1955, p. 3.
the correspondence’. It is not clear why Challinor, as coroner, was not requested to perform the inquest nor is it evident why Lucas wished to conduct a second inquiry. Apart from the evidence of competing power struggles between local identities previously discussed in this chapter, it is also conceivable that the public officials involved valued the fee connected with holding inquiries.

In January 1861, Challinor attracted the wrath of station owners in the Fassifern district due to his determination to investigate the death of three Aborigines. A coroner’s inquest was void if not conducted on a view of the body. In this case however, the bodies were in such a putrefied state when discovered, Challinor applied to the Colonial Secretary for a special commission to hold an inquest without viewing the bodies. The legal position on the matter dictated that without the special commission he could not legally hold an inquest, but a magisterial inquiry should be conducted instead. The Attorney-General ‘could not advise the Crown to issue such commission’ because as a magistrate and a coroner, Challinor was already ‘invested with the necessary power’ to hold the magisterial inquiry. By doing so a view was not necessary. The details of the killing of the Aborigines by Native Police, under the command of Lieutenant Frederick Wheeler, and the resultant findings of Dr Challinor on conclusion of the magisterial inquiry, generated intense debate in the press.

\footnote{QSA, Series ID: 36, Item ID: 348602, Inquest File.}
\footnote{QSA Series ID: 13338, Item ID: 19645, Inwards Correspondence – Attorney-General’s Office, letter from Henry Challinor, coroner for Ipswich, to the Attorney-General, 22 April 1861.}
\footnote{Cryle, The Press in Colonial Queensland: A Social and Political History 1845-1875, pp. 67-69.}
According to Wheeler he had responded to communication from Messrs Campigne, Henderson, Collins and Hardie seeking his assistance in dealing with the “blacks” who were killing stock and entering and stealing from huts on their stations. Wheeler located a group of Aborigines at the Dugandan Scrub and ‘dispersed them’.  

Francis Lucas, medical doctor, testified that after conducting an examination on three bodies in the scrub, he informed Mr Hardie, owner of Fassifern Station, that Dr Challinor would be holding an inquest into the shootings. Showing contempt for the judicial process, Hardie replied that ‘there would be no inquest held’. When advised by Edward Quinn, Chief Constable of the Ipswich Police, that an inquest would be necessary Hardie once again stated ‘that there would be no inquest there as there had been no blacks shot’. Despite Hardie’s opposition, the inquiry proceeded and taking into consideration the evidence given, the coroner found that:

The information of witnesses … will not allow me to arrive at any other finding than that the said Aboriginals were wilfully and wantonly murdered on the twenty fourth day of December last of [sic] Lieut. Wheeler and the detachment of Native Police on that day under his command; and also that John Hardie, Grazier of Fassifern was cognizant of this fact, yet endeavoured to prevent a judicial enquiry into the cause of the death of the said Aborigines by falsely asserting that no blacks had been shot on that station as had been reported.

In associated communication with the Attorney General Challinor wrote:

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235 Lieutenant Frederick Wheeler, Report from the Select Committee on the Native Police Force and the Condition of Aboriginals Generally, Queensland Legislative Assembly 1861. The word disperse became a euphemism for the killing of Aboriginal people. See Richards, J. (2008), A Secret War: A True History of Queensland’s Native Police, St Lucia: University of Queensland Press, pp. 76-81.

236 QSA Series ID: 36, Item ID: 348602, Inquest File - Evidence of Francis Lucas MD.


238 QSA Series ID: 36, Item ID: 348602, Inquest File.
As no committal can take place under this enquiry but the evidence will have to be retaken before the persons implicated I venture respectfully to request that this important case may not be left to be conducted by non professional [sic] men.\textsuperscript{239}

On receipt of the depositions Attorney-General Pring ruled that the evidence was insufficient to make a criminal charge against Wheeler and that further investigation was unnecessary unless significant evidence of a ‘direct’ nature was produced to uphold a charge of murder or manslaughter.\textsuperscript{240} The essence of the reply referred to the legal incapacity of Aboriginal people giving sworn testimony,\textsuperscript{241} which in this case resulted in a lack of credible witnesses to sustain a criminal charge against Wheeler.

As Challinor had been elected as the Member of Parliament for West Moreton in January 1861,\textsuperscript{242} he took advantage of his position to oppose the squating faction’s control of the Legislature. He also drew attention to the atrocities committed by the Native Police Force, which he encountered through his role as coroner.\textsuperscript{243} In May 1861 the government authorised a Select Committee to inquire into the Native Police Force and the condition of Aborigines generally. The Committee was immediately judged by the press as pro-squatter and incapable of impartiality. The \textit{Moreton Bay Courier} forecast that ‘it would be too much to expect, from a committee so composed, “even-handed justice”’.\textsuperscript{244}

\textsuperscript{239} Letter from H. Challinor to Attorney General, QSA, Series ID: 5253, Item ID: 846742, Correspondence Inwards, 01/01/1861-31/01/1861.
\textsuperscript{240} Letter from Attorney General to H. Challinor, QSA, Series ID: 5253, Item ID: 846742, Correspondence Inwards, 01/01/1861-31/01/1861.
\textsuperscript{241} \textit{Oaths Act Amendment} Act of 1876, 40 Vic. No. 10.
\textsuperscript{242} \textit{Moreton Bay Courier} 1861, 15 January, 17 January.
\textsuperscript{243} \textit{Courier} 3 June 1861; \textit{Moreton Bay Courier} 1861, 21 February, 27 July.
\textsuperscript{244} \textit{Moreton Bay Courier}, 7 May 1861.
Challinor was not invited to sit on the committee; he simply appeared as a witness. As foreseen by local newspapers, the inquiry turned into a white-wash orchestrated by the ‘pure merinos’ of the legislature with the purpose of maintaining an effective means of protecting their livelihoods. According to Denis Cryle, the Chairman of the Select Committee, Robert Ramsay McKenzie, ‘upheld the use of native troopers’ and ‘as a large landholder in the Burnett and Leichhardt districts, he used his influence on the Police Committee to protect his personal investments. The unprovoked “dispersal” of Aborigines was concomitant with the expanding occupation of the land by the “squattocracy”.

The Select Committee found that the Native Police were necessary for protecting property and preventing loss of life. According to the report any disciplinary problems were due to the ‘inefficiency, the indiscretion, and the intemperate habits of some of the Officers, rather than from any defect in the system itself”. The committee highlighted the difficulties of making the ‘blacks’ amenable to British Law and went on to state that it could not sanction the indiscriminate slaughter of Aborigines, as had occurred on occasions in the past. In a response to the Select Committee’s report, the Colonial Secretary advised Wheeler’s superior officer that Wheeler should be reprimanded for his

247 Report from the Select Committee on the Native Police Force and the Condition of the Aborigines Generally together with the proceedings of the Committee and minutes of evidence (1861), Brisbane: Fairfax and Belbridge, p. 2.
248 Report from the Select Committee on the Native Police Force and the Condition of the Aborigines Generally together with the proceedings of the Committee and minutes of evidence (1861), Brisbane: Fairfax and Belbridge, p. 3.
‘one or two’ indiscretions and recommended he practice ‘circumspection and humanity’ in dealing with the Aborigines in the future. Finnane and Richards note that the coroner’s inquest findings alluded to a conspiracy between Wheeler and Hardie to prevent an inquiry taking place.\footnote{Finnane and Richards, “‘You’ll get nothing out of it?’: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 23.}

The Report carefully avoided the reality of the force operating in accordance with an unstated, yet condoned, expectation among squatters that Aboriginal resistance to dispossession of their lands would be constrained via a process of ‘dispersal’. In September 1862 Wheeler and a Native Police detachment were accused of an ‘unprovoked’ attack on Aborigines at Caboolture, killing and wounding both men and women. Wheeler reportedly claimed he was following orders to disperse the ‘blacks’ wherever they congregated, and despite the matter being raised with the Attorney General in anticipation of an inquiry being instituted, nothing further happened.\footnote{\textit{Courier}, 4 October 1862, p. 2.}

Dealing with the Aboriginal population as British subjects under the rule of law had always caused the colonial and British governments discomfort. While instructions were issued from senior government officials directing colonial agents to respect Indigenous rights, historical records contain many examples of the disregard, even contempt, of this formal policy. When several Aborigines were killed under Major Thomas Mitchell’s orders in May 1836, Principal Secretary of State for the Colonies, Lord Glenelg,
expressed his approval of the suppression from publication of ‘those passages respecting the Aborigines by which the reputation of that officer might have been compromised’. Lord Glenelg was cognisant of the dilemma faced by Imperial authorities, noting that ‘if the rights of the Aborigines as British Subjects’ were to be upheld, then with regards to any deaths attributable to the ‘Queen’s Officers, or of persons acting under their Command, an Inquest should be held to ascertain the cause which lead [sic] to the Death of the deceased’. Formal acknowledgment of the authority of the law was customary in events involving atrocities committed against the Indigenous people, but in reality the unlawful killing of Aborigines continued to go unpunished. As Finnane and Richards argue, the evidence may suggest that the colony appeared to operate under the rule of law but the government failed to enforce legal accountability for actions of state employees.

Bill Thorpe argues that the pastoral occupation of Queensland which began in the 1840s triggered many violent confrontations between squatters and Aborigines across the Darling Downs and Moreton Bay districts. He maintains that following the Myall Creek massacre in 1838 many pastoralists ensured their workers controlled problematic

251 Lord Glenelg to Sir Richard Bourke, Historical Records of Australia, Series 1, Governors’ Despatches to and from England, Volume XIX, July; 1837- January, 1839, p. 47.
252 Lord Glenelg to Sir Richard Bourke, Historical Records of Australia, Series 1, Governors’ Despatches to and from England, Volume XIX, July; 1837- January, 1839, p. 48.
253 Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 86.
254 On 9 June 1838 a group of 12 men, 11 convict settlers and one free man, gathered up a group of 28 Aborigines on Henry Dangar’s Myall Creek station. The Aborigines, consisting of the elderly, women and children, were herded into the scrub and murdered, their bodies burnt in an attempt to cover up the massacre. When the manager of the station returned and discovered the bones he reported the murders to the magistrate at Mussellbrook who reported it to the Colonial Secretary, Edward Deas Thompson, who then reported the matter to George Gipps, Governor of New South Wales. The men responsible were put on
natives yet it was understood they ‘kept quiet’ about any killings. The Darling Downs region had been settled by a ‘unique and powerful squatting oligarchy which dominated every phase of human endeavour’. The Native Police in Queensland was the repressive instrument through which settlers gained and maintained possession of Indigenous lands and generally pastoralists resented formal inquiries into the deaths of Aborigines on or near their stations. Native Police officers and associated authorities at times faced accusations of obstruction of justice when a magistrate attempted to conduct a full inquiry. The failure of the rule of law to protect Aborigines was common to all of the Australian colonies. Bruce Kercher claims many white killings of blacks were ignored during European occupation. He argues that ‘a smokescreen of legal confusion and argument covered up a continuing pattern of killings’ as Aboriginal land was taken over with the expansion of settlement.

When Henry Challinor returned to Fassifern in September 1861 as a medical witness at the inquest into the death of an Aboriginal woman named ‘Boonooroo”, an incident occurred as the body was exhumed and placed at the graveside to allow for an

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258 Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 89.
examination of the wounds. The coroner, jurors, Mr Hardie and others were present. While bending over the deceased Dr Challinor was pushed forward onto the corpse when a man’s body fell heavily against him. Richard Spencer, Hardie’s superintendent had fallen onto him, ‘apparently in a fainting fit’. The Brisbane Courier reported that Spencer later apologised to the jurors then turned on Challinor stating that ‘he only wished the body had been as putrid as it could be, and that instead of falling on her as he did – the remainder of the speech being much too filthy and disgusting to appear in print’.  

Commenting on the ‘undeserved, the illegal, the coarse insult’ given to Dr Challinor at the Fassifern inquest, the Brisbane Courier accused Mr Hardie and Richard Spencer of displaying a ‘vulgar passion for mere revenge’ for the trouble Challinor had caused Hardie at the January inquest and ensuing Select Committee hearing.

As a result of his comprehensive study of the Native Police force in Queensland, Jonathan Richards argues that although coronial inquests were held into some Aboriginal deaths in frontier Queensland, a large number of Indigenous deaths went unrecorded partly due to the fact that bodies were burnt to cover up killings. According to Richards the executive council directly controlled the Native Police in Queensland but never took responsibility for frontier violence. Rarely was action taken as a result of an inquest finding against the force. Archival and historical investigations into Native Police

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260 *Courier*, 16 September 1861.  
261 *Brisbane Courier*, 16 September 1861.  
actions reveal that ‘racial violence was accepted on the Queensland frontier’ and the force ‘was a major cause of Aboriginal deaths … in colonial Queensland’.  

Inexplicably, coronial investigations were not held into two violent episodes involving the murder of white settlers by Aborigines on the colonial frontier. The murder by Aborigines of nine members of the Fraser family and two employees at Hornet Bank Station on 27 October 1857 triggered acts of revenge by armed squatters, their employees, as well as Native Police detachments. For several months following the tragedy punitive expeditions slaughtered large numbers of Aborigines throughout the area. It appears that no inquest was ever held into the deaths of the settlers due to the refusal of the police magistrate at Taroom, William Yaldwyn, to travel to Hornet Bank. Crown Lands Commissioner William Wiseman, in a report to the Governor dated 2 December 1857 stated:

I was informed by Mr Boulton, Superintendent at Euroombah, that no inquest had been held on the bodies and that no Magistrate had visited the scene of the slaughter whilst the bodies were unburied. Mr Boulton states that both himself and Mr Cardew applied to the nearest Magistrate to hold an inquest but that he declined doing anything and likewise declined to lend any assistance in burying the bodies … This will account for the fact that no inquest was held and no warrants issued immediately.

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265 QSA Series ID: 12758, Item ID: 17619, Correspondence Inwards – letters addressed to the Government Resident by the Colonial Secretary Sydney and by the Inspector-General Police, on native police matters.
Government Resident John Wickham inquired of Cardew, the owner of Euroombah Station, the name of the magistrate who refused to hold an inquest. Cardew replied, ‘I have the honour to inform you that Mr WH Yaldwyn is the gentleman alluded to by Mr Wiseman’.266 A further report by Wiseman in March 1858 informed the Governor of the deaths of a hut-keeper and shepherd on the property of William Yaldwyn. The bodies were found by Yaldwyn and numerous tracks of “blackfellows” were visible in the surrounding area. Wiseman wrote ‘I am not aware that any inquest was held on the bodies or that they were visited by a Magistrate’.267 The records indicate that no further action was taken.

In the largest single mass killing by Aborigines in Australian history, 19 Europeans including women and children were murdered at Cullin-la-Ringo on 17 October, 1861. Horatio Wills along with his family, workers and their families, had taken up land at Cull-la-Ringo near Springsure in October 1861. A party of Aborigines set up a camp near the station and little attention was paid to them. One afternoon later that month the Aborigines suddenly attacked without warning, killing Wills and eighteen other people. Thomas Wills and two stockmen who were away at the time escaped death.268 Retribution came swiftly in the form of revenge parties of squatters who were encouraged by Tom Wills to locate and disperse every black they saw. Colonial Secretary Herbert

266 John Oxley Library, Cardew, P., Letter enclosed with correspondence of John Wickham, Government Resident, to the Secretary for Lands and Public Works, dated 23 March 1858, Heritage Collection, A2.47/674.
267 QSA Series ID: 12758, Item ID: 17619, Correspondence Inwards – letters addressed to the Government Resident by the Colonial Secretary Sydney and by the Inspector-General Police, on native police matters.
wrote to the avenging squatters personally thanking them on behalf of the government for their prompt response to the call for retribution.\textsuperscript{269} An exhaustive search of the murder files, inquest records and Colonial Secretary’s correspondence at the Queensland State Archives, to date has not uncovered records of an inquest into the Cullin-la-Ringo tragedy. The fact that inquests were not conducted into the deaths of the white settlers at Hornet Bank and Cullin-la-Ringo showed a blatant disregard for the judicial process linked to coronial investigations. The response to the murders implied a collective consciousness that rejected the need to establish cause of death. As far as the settlers were concerned it was obvious that Aborigines were responsible, consequently there was an urgency to set forth on a mission of retaliation and annihilation.

Critics of the Native Police attracted few supporters in the colony, as acquisition of land by squatters was fundamental to economic development. The colonial press in Queensland, in particular the \textit{Moreton Bay Courier}, published editorial pieces encouraging the dispossession of the local Aboriginal population to facilitate the squatters’ ‘insatiable hunger for land’.\textsuperscript{270} While there were correspondents who protested against the treatment of Aborigines, as Cryle demonstrates, the local press was ‘content to act primarily as vehicles for their squatter correspondents without seriously questioning or following up the conflicting accounts which they received’.\textsuperscript{271} Resistance by the Indigenous owners of the land could not stand in the way of pastoral enterprise and had to be eliminated. Henry Challinor’s call for Indigenous justice attracted little support

\textsuperscript{269} Richards, \textit{A Secret War: A True History of Queensland’s Native Police}, p. 66.
from other parliamentary members following his election to the Legislative Assembly in January 1861.272

Challinor’s right to hold the parliamentary seat was challenged by his co-candidate George Forbes, who petitioned the Committee of Elections and Qualifications, claiming the election of Challinor for the seat of West Moreton was invalid on the grounds that he held an office of profit under the Crown at the time of the election. The focus of the Select Committee’s inquiry dealt with the technical detail of Challinor’s appointment as coroner and the provision of an annual salary. The Governor’s letter of appointment to Challinor confirming his position as coroner, which appeared as exhibit B at the inquiry, lends some understanding to the half-hearted approach of government towards coronial matters. The letter stated ‘it is presumed a gentleman performing this role would be familiar with the rules of the coroner’. This official correspondence did however confirm the legal framework under which coroners operated by advising Challinor to familiarise himself with the chapter on coroners from Burn’s Justice of the Peace and Parish Officer (1845), and the text Jervis on the Coroner (1829).273

The task of the inquiry was to determine whether Dr Challinor had been paid the £20 salary allowed for coroners in the yearly estimates. Challinor was elected as the

273 Letter to Henry Challinor from Governor of NSW, Report from the Committee of Elections and Qualifications; with Minutes of the Proceedings of the Committee, and Evidence, Election Petition; Forbes v. Challinor, Legislative Assembly, Queensland, 1861.
representative for West Moreton by a large majority of votes however his election was void if it was shown that he held an office for profit under the Crown. Appointed as coroner by the New South Wales government in 1859 prior to separation, Challinor on sworn evidence stated he had never received a salary but was entitled to claim fees and travelling expenses as set down in the letter accompanying his appointment. Facts exposed in evidence revealed that neither the Colonial Treasurer nor the Attorney-General informed Challinor of the £20 per annum salary voted for by the Legislature of Queensland. With no public document or official information provided, Challinor claimed he only became aware of the provision of a salary from the testimony of the Colonial Treasure and Attorney-General. According to Attorney General Pring he had nothing to do with Challinor’s pay as his appointment as coroner was by the New South Wales government and all he was required to do was certify the payment vouchers as correct. When asked if the fee was fixed by any statute he replied ‘I do not know exactly. I do not know that it has been fixed, but I can ascertain if the Committee desire it.’

Indeed, the government’s legal representative who authorised the vouchers to pay fees claimed by coroners and magistrates was not aware that a statute setting out fees payable to coroners existed. At that time the Statistical Register for Queensland for the month of December 1860 listed fees payable to coroners, authorised by the *Imposts Continuation Act* 1825, 6 Geo. IV., No. 20, 1 November 1825.

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274 Pring, R. in Report from the Committee of Elections and Qualifications; with Minutes of the Proceedings of the Committee, and Evidence, Election Petition; Forbes v. Challinor, Legislative Assembly, Queensland, 1861.
275 Queensland Votes and Proceedings (1860), Statistical Register of Queensland for the Month of December, p. 30.
The Committee found that at the time of the election ‘Henry Challinor was disqualified from being elected a Member of the Legislative Assembly, by reason of his holding the office of coroner for Ipswich, that being an office of profit under the Crown’ and ‘the said election was wholly void’.\textsuperscript{276} Challinor resigned as coroner for Ipswich that same day, stood unopposed for re-election in June, and was subsequently returned to parliament. This event not only exemplifies the uneven approach to government administration but is also indicative of the ad hoc way the colony was run in the early period of separation. Governing an expansive, mostly unsettled territory, populated by traditional owners of the land, created many problems for the inexperienced government. State sanctioned violence, conducted by the Queensland Native Police, underpinned much of the Aboriginal-settler relationship. Inadequate legal expertise, budgetary restraints and hostile relations between colonists and Aboriginal people, meant coronial investigations into violent, suspicious or unnatural deaths were conducted arbitrarily.

\textit{The Inquests of Death Act of 1866}\textsuperscript{277}

In the mid-nineteenth century a considerable body of legislation controlled the office of coroner. In view of the complexity of the legislation the text written by Sir John Jervis in 1829, \textit{A practical treatise on the office and duties of coroners}, was generally adopted by leading practitioners as a guide to coronial law and inquests.\textsuperscript{278} As shown earlier in this chapter a few Queensland coroners and magistrates accessed a number of works on

\textsuperscript{276} Report from the Committee of Elections and Qualifications; with Minutes of the Proceedings of the Committee, and Evidence, Election Petition; Forbes v. Challinor, Legislative Assembly, Queensland, 1861.

\textsuperscript{277} See Appendix 1.

\textsuperscript{278} Jervis, \textit{A practical treatise on the office and duties of coroners}. 140
coronial law, but it was common for officers appointed coroners to find they were expected to perform the role of coroner, despite having no instruction on coronial law and practice. Recognising a need to reform the office of coroner, the Queensland government maintained the passing of *The Inquests of Death Act of 1866* (the Act) was an attempt to meet the colony’s individual requirements for investigating death and holding inquests. In effect, the Act overlooked the obvious shortcomings of contemporary coronial law which was a need for codification of coronial legislation.

The major provision of the Act made it lawful for any justice of the peace in the absence of the coroner, or during a vacancy of that office, to hold the power and authority to perform all the duties of the coroner. The justices were obliged to hold an inquest if they received a written request by two persons. More importantly, provision three abolished the necessity of empanelling a jury for a coronial inquest. In this respect Queensland preceded New South Wales and England in electing to remove the legal obligation to hold inquests before a jury. Under provision six the coroner could order a post-mortem examination of the deceased and where considered necessary order the exhumation of the deceased. A medical practitioner could be called on to give evidence and justices were authorised to apprehend and commit for trial any person suspected or accused of causing a homicide. According to section nine a suspected or accused person who was absent during the inquest should be provided with a copy of evidence as soon as possible following their apprehension. Finally, section ten set down the fees payable to coroners, magistrates and justices for holding inquests, fees for medical witnesses and for medical practitioners holding a post-mortem. It also set down the claim for mileage for coroners,
magistrates, justices and witnesses. A notable reform of the new legislation was the introduction for the first time of a schedule of particulars to be filled out by the officer conducting the inquest.\textsuperscript{279}

The new law was intended to better suit the circumstances of the colony, with the purpose of providing greater opportunity to thoroughly investigate ‘all matters connected with death by violence’.\textsuperscript{280} During debate on the Bill the Postmaster-General, John Douglas, maintained that it was not intended to abolish the position of coroner, merely empower justices of the peace to hold inquests of death. He claimed the practice of magistrates holding inquiries in place of the coroner was common in the colony but expressed doubt as to whether ‘such inquiries were made in a completely legal manner’.\textsuperscript{281} In fact, the legal situation regarding magistrates holding inquiries was imprecise. New South Wales had never passed a special statute authorising magistrates to hold inquiries into cause of death but such an authority was implied by the Medical Witness Act (1 Vic. No. 3) to which practical effect was given by the notice that appeared in the \textit{Government Gazette} (NSW) of 18 March 1845.\textsuperscript{282} This notice instructed police magistrates or justices of the peace to conduct inquiries into ‘the causes of any sudden deaths’ in a district without a coroner.\textsuperscript{283} The authority for coroners and justices to summon legally qualified medical practitioners to appear as witnesses at inquests, as well as to order post-mortems, was...

\textsuperscript{279} QGG 1866 Vol. 7, No. 81, 28 July.  
\textsuperscript{280} QPD 1866 29 & 30 Victoria, Vol. III, p. 84.  
\textsuperscript{281} QPD 1866 29 & 30 Victoria, Vol. III, p. 84.  
\textsuperscript{282} QSA Series ID: 7132, Item ID: 269825, Under Secretary, Department of Justice, to the Chairman, Bench of Magistrates, 6 May 1908 (1889 – 1939 Vol. 1), 95, Circular 2/08, legal opinion on the history of coronial jurisdiction in NSW and Qld, E. M. Lilley, ‘The King v. Thomas Smith: Opinion’  
\textsuperscript{283} NSW \textit{Government Gazette}, No. 22, 18 March 1845, p. 300.
reinforced in the 1866 Act.284 These investigative techniques had been utilised by civil servants conducting inquests and magisterial inquiries since Queensland gained self-government.

William Yaldwyn, former police magistrate and now member for Leichhardt (Legislative Assembly), agreed that the holding of inquests should be left in the hands of justices of the peace. Moreover he left no doubt as to his opinion of the office of coroner when he declared:

   It was useless to talk of a coroner. What was a coroner? He was not an animal of a particular description. He was only a man like other men, and might be prepared to carry out his duties if he had the material. But in the interior, where he could not get the material, and could not get the requisite number of men to carry out an inquest, what was to be done?285

In Yaldwyn’s opinion any man could perform the duties of a coroner, if supplied with the necessary administrative items, and provided enough men could be gathered together to form a jury. Yet, Yaldwyn’s career itself provided evidence to show that placing the responsibility on justices or magistrates for holding inquests, was not devoid of problems. He was the police magistrate who refused the request to travel from Taroom to Hornet Bank to hold an inquest into the death of eleven settlers killed by Aborigines. Even though the government was informed of his behaviour no inquest was ever held. More importantly, no action was taken against Yaldwyn, demonstrating the powerlessness of

284 QGG No. 81, 28 July 1866.
coronial legislation if the government failed to enforce the law. Ultimately competent people were needed to act as coroners and this was something that the government could not legislate for.

The move to abolish juries was significant as it removed an ongoing obstruction to the office of coroner; namely the difficulty encountered in outer regions of gathering together the number of people required to form a jury for an inquest. It was not uncommon for coroners to act as justices of the peace and hold magisterial inquiries instead of inquests because five to twelve men could not be enlisted to form a jury. Some members of the house supported abolishing juries because they questioned the calibre of jury members and their ability to make rational judicial decisions. The fact that such doubts about the integrity of the jury would also apply to juries empanelled for criminal cases was never raised. During debate on the Inquests of Death Bill of 1866 other members expressed unease linked to a suspicion that a single individual conducting an inquiry could be influenced or exert influence over an inquiry’s findings. However during the debate it was pointed out that the open nature of the court, as well as the forthright and rapid press coverage of current events, would ensure that such a miscarriage of justice was unlikely to occur.286

The allowance of fees and travelling expenses was set out in the Act. The Colonial Treasury provided a fee of twenty-one shillings for the coroner, justice or police

magistrate holding an inquest and to any medical witness appearing at the hearing. A medical practitioner holding a post-mortem examination received a fee of forty-two shillings. The coroner, justice, police magistrate and witnesses could claim travelling expenses of sixpence per mile.\textsuperscript{287} As funds for coroners had been refused in the previous session of parliament,\textsuperscript{288} officially the office of coroner would cease to exist and the government would save the £20 salary per annum allowed for coroners. Originally the Bill made no allowance for police magistrates to claim traveling expenses because they were paid a salary, but on further consideration the members agreed that magistrates should be reimbursed for the cost incurred in travelling to attend inquests. Consequently the words ‘police magistrate’ were inserted in clause ten of the Bill.\textsuperscript{289}

An original initiative linked to the new act consisted of the introduction of a schedule to be completed and certified by the presiding official, then forwarded to the Attorney-General. The intent behind this change was the increased capacity to determine the guilt or innocence of any person connected with a violent death, through the provision of specific facts about the deceased. The schedule was predicted to prove more effective in determining criminal intent than coroners’ juries, whose verdicts were often thought to be somewhat dubious.\textsuperscript{290} Fundamentally, the coronership was changing from a system of procedural justice via a jury, to one of administrative justice by a coroner. What escaped the members’ attention was the important fact that the success of a new system based on

\textsuperscript{287} QGG 1866 Vol. 7, No. 81, 28 July, Clause 10.
\textsuperscript{288} QSA Series ID: 13338, Item ID: 19649, Inwards correspondence – Attorney-General’s Office, Minutes of Proceedings of the Executive Council, 15 November 1865.
\textsuperscript{289} QPD 1866 29 & 30 Vic., Vol. III, p. 84.
\textsuperscript{290} QPD 1866 29 & 30 Vic., Vol. III, p. 84.
this schedule depended on the coroner/magistrate/justice ensuring all facts recorded were correct and all sections were fully completed. Evidence gathered from inquest files, shows the omission of mandatory details on documents filled out by coroners and magistrates conducting inquests was problematic.

Investigating suspicious, violent or unnatural deaths was a crucial function of the justice system which was carried out by the office of coroner. A full public inquiry was fundamental to allaying community concern over threats to its safety. Coronial inquests were legally sanctioned investigations to establish cause of death and Queensland coronial legislation was originally predicated on that of New South Wales. The function of the Queensland coroner was altered by The Inquests of Death Act of 1866, but did the change of legislation enhance the jurisdiction of the coroner or dispense greater justice? Queensland Police magistrates and justices had discharged the role of the coroner since separation and the new Act confirmed the legality of this practice. Conferring all the power and authority of the coroner onto magistrates and justices paved the way for the removal of paid coroners from the civil service. As a result of this action the government saved money, while the workload of police magistrates increased. Although police magistrates were required to pass an exam based on fundamental law principals before taking up their duties, they were never given any formal instruction in preparation

for the execution of the role of coroner. This circumstance combined with the sparse supply of textual material on coronial law and coronial procedure available to magistrates, meant the introduction of the new Act did nothing to increase the efficiency of the office of coroner.

Removal of the need to convene inquests before a jury resolved the persistent problem of gathering together enough folk to make up jury numbers. Coronial inquests became administrative hearings and the certificate of particulars replaced the findings of a jury. The primary aim of the inquest was the detection of homicide and clarifying cause of death. Unlike the twenty-first century coronial inquest, at this time scant attention was paid to the prevention of deaths and improvement in safety by elected officials. Overall *The Inquests of Death Act of 1866* did little to advance the office of coroner. The government expressed no desire to simplify coronial law by codifying the jurisdiction of the coroner and the powers and obligations of the office.

**Conclusion**

Following separation Queensland rapidly developed into a diverse and expanding colony. The first government was inexperienced in ruling according to the traditional and rather complex legislative framework adopted from England. Isolation, distance and geographical features combined to challenge the government’s ability to administer the colony and maintain law and order during the first decades of independent rule. Local police magistrates and their clerks formed the link between central government and the
scattered and itinerant populations of outer districts. Magistrates’ undertakings were onerous and wide-ranging and coronial authority was added to the duties of the lower courts in 1866. Inquiries into suspicious, unnatural or violent deaths were commonly conducted by magistrates and justices of the peace if the coroner was unable to hold an inquest. The enactment of the *Inquests of Death Act 1866* formally empowered magistrates and justices to conduct inquests in place of a coroner. Having cut coroners’ funding for 1866, the government planned the demise of the office of coroner, which commanded an annual salary.

Those authorities invested with the power to administer or conduct coronial investigations possessed limited knowledge of the statutes governing the office of coroner. Coronial legislation was highly complex given that following the *Office of Coroner Act 1276*, 392 thirty-three statutes or part statutes had been passed relating to coronial law up to the time of colonial settlement. However in taking up their positions coroners were directed to specific legal texts which outlined their duties as well as the limits to their jurisdiction. Yet, it was difficult to acquire these sources. In reality not all deaths requiring an inquest were investigated due to issues of cover-up, denial or remoteness. In particular many Aboriginal deaths were not investigated because the Native Police and station owners were able to conceal acts of violence and homicide towards Aborigines due to the isolated locality within which the acts were perpetrated. The squatter dominated parliament formally respected the rights of Aborigines as

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292 *Office of Coroner Act 1276*, 4 Edw. I. c. 3.
subjects of the Crown but opposed calls for more humane treatment of the Indigenous population. Through their power they were initially able to subvert inquests into violent Aboriginal deaths at the hands of the Native Police.

The effectiveness of a coronial inquest lay with the professionalism of the presiding officer which revolved around summoning witnesses, recording depositions, deliverance of findings and the accurate and full completion of official documents. A culture of inaction by the government seemed to prevail when called on to mediate complications or controversies linked to coronial inquests. Generally the role of the coroner was of minor importance to a government consisting of a powerful squatting oligarchy that closed ranks to protect their interest in the land. As shown, it was often left to the press to expose controversies involving the coroner.

The inquest institution in Queensland endured poor administration and control. The newly independent colony suffered from a shortage of experienced public servants as the best candidates remained in New South Wales. Ultimately, Queensland was “talent poor” and operated within a system lacking distinct procedural guidelines and adequate governance.
Chapter Three

Six decades without reform

Introduction

As settlement within the Queensland colony began to stretch to the far north and to the west, the demand increased for public servants to fill administrative positions throughout the settled regions. However the skilled personnel and funds available to meet this demand were scarce. Additionally, Queensland government finances were severely impacted due to the financial crisis experienced in Australia in July of 1866. The office of coroner was reformed through the introduction of The Inquests of Death Act of 1866 which transferred the duties of coroner to police magistrates and justices of the peace and effectively abolished the “paid” position of coroner. This action was designed to maximise the workload of public servants while decreasing expenditure on salaries. Although the office of coroner did not exist in the formal sense, the government and administrators continued to utilise the term coroner. For the next sixty-four years investigations into the cause of deaths considered suspicious, violent or unnatural continued to be carried out by magistrates and justices who possessed little knowledge of coronial law and the jurisdiction of the coroner when conducting inquests.

This chapter investigates the difficulties encountered by the government in endeavouring to apply coronial law in connection with deaths occurring throughout the vast expanse of
the colony. Examples taken from the correspondence received by the offices of the Colonial Secretary and Attorney-General provide numerous examples of the problems experienced by parties involved with administering and performing the duties of the office of coroner. Several case studies are used to exemplify imperfections in the death investigation system of the late nineteenth and early twentieth centuries in Queensland.

The John McCrae case study examines government interference and cover-up in relation to the inquest process. It also examines the Supreme Court and High Court legal proceedings related to a police constable’s claim of wrongful dismissal against the Police Commissioner, which flowed from the McCrae case. Politicians’ misunderstandings of The Inquests of Death Act of 1866 are demonstrated in the Simon Zieman case study. The inquests held into the deaths of Emmeline Trueman and Alice Mutlop illustrates the tendency for inquest hearings to be closed prematurely and for coroners to present findings that protect elites in the face of evidence that suggests criminal negligence.

Instead of the The Inquests of Death Act of 1866 simplifying the law for coroners and assisting those persons undertaking coronial inquests, it resulted in unqualified and inexperienced agents being allocated the role of the coroner. In an attempt to save money by curtailing public servant numbers, the Queensland government tolerated a problematic coronial system that failed in many cases to capably investigate unexplained or suspicious deaths.
The Queensland coroner after 1866

Following the introduction of *The Inquests of Death Act of 1866* the salaried position of coroner slowly disappeared.¹ This was a result of the Executive Council’s decision in late 1865 to discontinue funding for coroners’ salaries, in conjunction with the authorisation of police magistrates and justices of the peace to carry out the duties of the coroner.² Rather than representing a panacea, the introduction of *The Inquests of Death Act of 1866* caused further misunderstanding and confusion surrounding the office of coroner. As will be discussed further in the chapter, the new Act was interpreted in some circles as abolishing the coroner’s role. Although the government no longer funded a salary for coroners, it continued to meet the costs associated with the holding of coronial inquests. Despite the restructuring of the office of coroner, and the removal of the coroner from the list of civil servants, the term “coroner” continued to be used frequently by government authorities and the press. For example, the government Audit Office in a letter to the Attorney-General referred to vouchers furnished by the Attorney-general’s department authorising payment of witnesses attending ‘Coroners inquests’³ and the Executive Council continued to vote for funds to provide for ‘Coroners’ fees.⁴ Therefore the office of coroner continued to be recognised after enactment of *The Inquests of Death Act of 1866*.

¹ Following the introduction of *The Inquests of Death Act of 1866*, Hugh Massie was listed as the coroner for Brisbane in the Queensland Votes and Proceedings from 1867 to 1870. All other coroners’ positions disappeared from the civil service list.
⁴ QSA Series ID: 13337, Item ID: 19612 & 19614, Inwards Correspondence – Crown Law Office, 9 September 1875 and 16 April 1877.
Administering the expanding colony

After separation from New South Wales, the Colonial Secretary’s Office was central to the administration of Queensland and dealt with a range of functions attached to a number of departments including Police, Register-General, Immigration, Defence, Health and Education. As the Queensland colony expanded a greater administrative burden was placed on the Colonial Secretary’s Office. In 1884, Samuel Griffith, who was Premier, Colonial Secretary and Secretary for Public Instruction, supported the Officials in Parliament Bill, which proposed to have the number of government ministers increased from six to seven. In outlining the responsibilities of the Colonial Secretary’s Department, Griffith suggested that part of his workload be transferred to a new minister, created under the Officials in Parliament Bill, who could then oversee the Department of Public Instruction.\(^5\)

The difficulty of ensuring public officers were kept informed of, and followed, government directives is exemplified through the following circular dispatched in 1895 by William Parry-Okeden, Principal Under Secretary for the Colonial Secretary, to clerks of Petty Session instructing them that it has ‘come to our attention that no record is kept[,] therefore all circulars addressed to you by this office and by other departments of the Public Service are to be carefully filed and handed over to successors’.\(^6\) The increasing administrative load on the government is also reflected in an 1888 request

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from the Commissioner of Police to District Inspectors telling them to ‘be as concise as possible in their correspondence’ because ‘the work of the Head Office has increased very much’. In 1890 another Circular Memorandum ordered police officers in charge of districts to ensure that reports ‘proceed straight to the point omitting superfluous sentences … the object in view being to curtail and reduce the correspondence of the department, which is becoming exceedingly heavy’.

The Secretary for the Crown Law Office (CLO) held a powerful and responsible position. He scrutinised all inwards correspondence then decided what, if any, further action needed to be taken. The Secretary would return records to senders for the correction of irregularities however the administrative control asserted by the Crown Law Secretary over police magistrates sometimes met with objections. In 1867, John Wilkie (Secretary for the Crown Law Office), returned to William Wiseman, police magistrate for Rockhampton, inquiry depositions together with a copy of The Inquests of Death Act of 1866 with parts of section three underlined. Keane attached a note that read:

Memo for Mr Wiseman P.M.

Returned for certificate required by 30 Vic No 3

Will the Bench Rockhampton be good enough to read this Act and save the office of the Attorney General a great deal of unnecessary inconvenience and trouble.

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8 QSA Series ID: 8604, Item ID: 282299, Orders, Memoranda – Police, Circular Memorandum No. 151.
Wiseman wrote to the Attorney-General, Charles Lilley, explaining that as there was no body found a Certificate of Death could not be issued. He further stated:

I trust that in your opinion the memorandum of which a copy is annexed sent from your office to me in particular signed with the initials J. W. W. is such as I am justified in protesting against receiving … it is, I most respectfully submit, not too much for a person in my situation to expect a letter from your office in the usual courteous style in which Government letters are written …

In 1878, Henry Buttenshaw, police magistrate for Maryborough, objected to correspondence he received from the Secretary for the Crown Law Office, John Keane. Buttenshaw was informed by Keane that it was his duty to hold all inquests in his district ‘unless prevented by sufficient reasons from doing so and that the fees due to the Magistrates holding same will be withheld’, unless Buttenshaw certifies that he was prevented from holding the inquiry. In a letter to Samuel Griffith, the Attorney-General, Buttenshaw declared that he was unaware of the regulation referred to by Keane, and went on to state: ‘I must say I do not feel called upon in any way to report to Mr Keane how my time is employed, nor am I aware that he has any jurisdiction over Police or any other Magistrates’. In response, Keane informed the Attorney-General that he had never asked Buttenshaw to account for his time and in a rebuff to Buttenshaw, stated that ‘the

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tone of Mr Buttenshaw’s letter is justly uncalled for in this instance’.  

As the evidence shows, the line of authority between police magistrates and the Crown Law Office lacked clear demarcation.

The Crown Law Secretary’s administration of the department was not without fault. In July 1868 the Auditor General wrote to the Attorney-General drawing his attention to the: 

very imperfect Vouchers which are furnished by your Department in support of payments made to witnesses attending Coroners inquests. They neither shew [sic] the date when or the locality where the witnesses attended, the length of such attendance or the distance they have travelled, and finally are not discharged by the respective witnesses or certified to as correct by the Police Magistrate or other Justice of the Peace presiding at the inquiry. 

In 1875 the Secretary (CLO) wrote to David Seymour, the Commissioner of Police, informing him that in some cases the fees charged by medical men for giving evidence at inquests and ‘duly certified’ were ‘in excess of the rates fixed by the “Inquests of Death Act of 1866” or the “Medical Act of 1867”’ and in future ‘the allowances referred to are not to be exceeded … without the sanction of this office’. In reply, Seymour stated that ‘[n]o expenses incurred on a/c of inquests are paid by the Police department all such a/cs being sent direct to the Attorney General’s Office’. The Crown Law Office defended the course of action adopted on receipt of the depositions taken at the inquiry into the cause of death of William Thomson in 1886 and responded to criticism in an article in the

that commented on the uselessness of sending depositions to the Attorney-General in cases where suspicious circumstances were evident. The Attorney-General stated:

It is not true that depositions taken at Magisterial inquiries are not carefully perused in the Crown Law Office. On the contrary they are most carefully read and in many instances prosecutions are directed to be instituted and inquiries directed to be re-opened for the taking of further evidence, the Attorney general frequently employing the services and inviting the opinion of the Government Analyst and competent Medical men in cases where evidence of certain symptoms exhibited before death and other evidence has been given which have raised the smallest ground for doubt as to the cause of death.\(^\text{14}\)

The decisions made in the Queensland Crown Law Office could greatly affect the course of justice in relation to coronial inquests.

The government faced problems in administering coronial law as it was common for civil servants in outer regions to neglect important paperwork linked to death investigations. For example Certificates of Particulars were omitted,\(^\text{15}\) jurats were left out,\(^\text{16}\) depositions were not forwarded,\(^\text{17}\) and in some cases depositions were not recorded at all.\(^\text{18}\) However,

\(^{16}\) QSA Series ID: 13337, Item ID: 19609, Inwards Correspondence – Crown Law Office, 8 July 1872; QSA Series ID: 13336, Item ID: 1902, Correspondence Inwards, 9 March 1891. A jurat is the name given to the clause at the foot of an affidavit showing when, where, and before whom the actual oath was sworn.
police magistrates and justices stationed in isolated towns often found they were without supplies of stationery and official forms. Conditions could hardly have been worse for the justice at Normanton when conducting an inquest in 1887. In an appeal to the Attorney-General he requested that ‘you will overlook any shortcomings you may observe in the Depositions as my paper and writing materials were rather limited and I have neither table or stool – simply sitting on a log’.19 John Conrick, justice of the peace at Coopers Creek, advised the Secretary Crown Law Office in relation to holding an inquest: ‘I have never been furnished with any forms or information of any kind from the Crown Law Department’.20 Fred Ford justice of the peace at Boonara, 130 miles north-west of Brisbane, inquired of the Crown Law Office whom he should apply to ‘for forms of the various documents necessary to the official discharge of a magistrates duties’. He stated that:

When I required some forms of summons for Defendants, I applied to C.P.S. Gayndah, who referred me to the Gov. Printer … the Govt. Printer informed me that it was not the duty of that department to supply them – and I am quite ignorant to whom to apply.21

The Crown Law Office on receipt of Ford’s letter on 19 January 1876, asked the Under Colonial Secretary for information on supplying Ford with the required forms. The Under Colonial Secretary forwarded a memorandum to the Auditor General inquiring if he would be ‘good enough to give instructions to Mr Ford as to the manner in which he can

obtain the required forms’. The Audit Office forwarded the forms to Ford on 22 January 1876 and informed the Secretary of the Crown Law Office of their actions on 24 January 1876.22

Arguably the greatest obstruction to magistrates performing their duties was the lack of legal knowledge and formal instructions as to their duties. This was more often the case when inexperienced magistrates were sent to outback towns in Queensland in the nineteenth century. On the completion of an inquest the magistrate would write to the Attorney-General to advise that he had forwarded “under separate cover”23 depositions taken at the inquest. It was in these letters magistrates expressed their concerns regarding the application of their role as coroner. The correspondence contained in the Crown Law Office records highlighted the lack of expertise of many justices and magistrates working in country towns. Robert Johnstone, police magistrate at Winton, wrote:

I would ask that if any errors or mistakes in the mode of taking or in filling in forms should have occurred that you would please have them pointed out to me as I had nothing but “Wilkinson” as a guide and no office records to refer to and this is the first case that has come before me and I am anxious to know if I have carried it through properly.24

A justice from Chesterton, approximately 364 miles west of Brisbane, travelled 40 miles to Burenda Station to conduct his first inquiry into a supposed murder. He stated in his letter to the Attorney-General:

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23 Depositions were sent to the Attorney-General by separate mail to the associated letter. It is surmised that this was a security measure that alerted the Crown Law Office if depositions went missing.
The depositions … I inadvertently sent to Charleville, but will request the P. Magistrate there to forward them to you. Not having held (or seen held) an enquiry of this nature, I am not aware of the customary and necessary forms to be observed, but trust that the ends of justice etc. will be duly attained by the steps that I have taken in this matter.25

In 1870 Fred Ford wrote in a letter to the Attorney-General: ‘In the absence of any information to be gathered from ‘Plunket’ I have done the best in my power. It would however be much more satisfactory to Magistrates in the Bush if their duties as Coroners were defined’.26 Justice James Jeffery of the Upper Mary River informed the Attorney-General that ‘Country magistrates cannot readily refer to the acts of the Queensland parliament’ and suggested ‘that they should be supplied with a copy’.27 R. Raft of Morayfield wrote to Samuel Griffiths in 1875 stating: ‘My Dear Griffiths … Don’t you think country magistrates ought to get a few general instructions with sets of forms etc. I cannot even get a few Information, Summons and Warrant forms without paying for them’.28

Magistrates could request a guide to their duties and the law such as Wilkinson’s The Queensland Magistrate29 or Cooper’s Statutes.30 However the government strictly

27 QSA Series ID: 13337, Item ID: 19608, Inwards Correspondence – Crown Law Office, letter from James Jeffery to Attorney-General, 26 December 1871.
29 Wilkinson, The Queensland Magistrate. In February 1878 William Wilkinson wrote to the Attorney-General asking if the government would agree to print and publish 1200 copies of his new book The Australian Magistrate, as the publication was ‘prepared for the use of the legal profession and the magistrates of Queensland. The New South Wales government had assisted with the cost of publishing his
controlled the issue of these texts. In June 1883 the government printer advised the Crown Law Secretary:

Referring to your requisition re supply of one half bound unstamped copy of Coopers Statutes to Mr James Stockwell Registrar of Supreme Court Bowen. I am directed by the Under Colonial Secretary to inform you that Mr Stockwell has already received one copy of the Statutes alluded to, and Mr Gray, before approving of the same, wishes to know what the second copy is required for.\(^{31}\)

In August 1883 Charles Woodcock, the registrar and clerk of petty sessions at Maryborough, wrote to the Attorney-General requesting a second set of Coopers Statutes as both the clerk of petty sessions and the police magistrate were sharing the one copy held at the District Court. Woodcock also asked for two copies of Wilkinson’s *The Queensland Magistrate* as the one presently used was in pieces and useless. The Attorney-General only approved one copy of *The Queensland Magistrate* to be supplied to Woodcock.\(^{32}\) In October 1883 the Under Colonial Secretary denied a request from the police magistrate at Thargomindah for an extra copy of Coopers Statutes because the Bench of Magistrates had ‘been supplied with one copy of the Statutes … on 13\(^{th}\) May last’.\(^{33}\)

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last work in 1876. If the Queensland government accepted his proposal they could retain 180 copies for their own use. The cost of the proposal was taken to cabinet but did not receive approval at that time: QSA Series ID: 13337, Item ID: 19616, Inwards Correspondence – Crown Law Office, letter from William Wilkinson, District Court Sydney to Attorney-General Brisbane, 1 February 1878.


\(^{32}\) QSA Series ID: 13337, Item ID: 19627, Inwards Correspondence – Crown Law Office, letter from Charles Woodcock, Court House Maryborough to Attorney-General, 15 August 1883.

The Justice Department was still coping with incompetent management of paperwork associated with magisterial inquiries at the beginning of the twentieth century. A 1905 inquest file includes a letter from the Australian Medical Association complaining about the burial of a body without the issue of a Medical Certificate.\textsuperscript{34} In another instance, it was necessary for the Under Secretary of Justice to write twice to the clerk of petty sessions at Ipswich requesting supply of the Certificate of Particulars in connection with a magisterial inquiry held in August 1908. Upon receipt of the Certificate of Particulars it was returned to be fully completed in respect of the headings ‘Where found and when’, ‘Suggested cause of death’, ‘Person last seen in company of deceased and names of suspected persons’, ‘Accused’ and ‘Suspicious circumstances’. Half of the questions contained on the Schedule, which were designed to elicit crucial information about the death, were left unanswered.\textsuperscript{35}

In 1866, when debating \textit{The Inquests of Death Bill}, members of parliament claimed that the introduction of the Schedule, or Certificate of Particulars as it was officially named, would disclose more information than that gathered at an inquest with a jury as the Certificate required the coroner, where possible, to answer specific details connected with the death under investigation. However, the system depended on coroners fully completing the Certificate of Particulars in order to be effective but in many cases this was not happening. For example, the Certificate of Particulars connected to an inquest

\textsuperscript{34} QSA Series ID: 36, Item ID: 348938, Inquest File.
\textsuperscript{35} QSA Series ID: 36, Item ID: 348999, Inquest File.
held in January 1930 neglected to show in what manner and under what circumstances the deceased met his death. The Crown Solicitor was alerted to this administrative error but failed to take action.36

As shown, the purpose of the inquest could be jeopardised through civil servants neglecting to abide by fundamental, yet vital administrative imperatives. Furthermore, the absence of appropriate legal knowledge for country magistrates holding inquests and the difficulty in obtaining official government forms also hindered the course of justice. Archival evidence indicates that the government continued to tolerate this state of affairs into the early twentieth century. The central government of Queensland endeavoured to fund state development as cheaply as possible and as a consequence the integrity of the inquest system was compromised.

The development and accuracy of death registration

In response to a letter from the Registrar General, the Colonial Secretary dispatched a circular in July 1869 to Justices of the Peace and Police Magistrates stating:

In consequence of representations made to the Government relative to numerous instances in which Magistrates have neglected to furnish district registrars with the "information" required under the 28th section of the Act of Parliament 19th Victoria, No. 34, in cases where inquiries under "The Inquest of Deaths Act of 1866" have been held, I do myself the honor to inform you that it has been deemed advisable to frame certain Regulations, with a view to prevent, as far as possible, the

36 QSA Series ID: 36, Item ID: 349498, Inquest File.
recurrence of the omissions complained of. A copy of the Regulations is herewith subjoined, and I have to request that the same may be strictly adhered to in every case in which you may be called upon to hold an Inquest of Death.\footnote{QSA Series ID: 13337, Item ID: 19616, Inwards Correspondence – Crown Law Office, 14 July 1869.}

According to the regulations justices of the peace, or coroners, were required to attach to their vouchers for fees due a certificate from the Registrar of Deaths for the district within which the death occurred, stating that the Registrar had been notified of the death of the person mentioned in the voucher. In addition, justices of the peace or coroners were instructed to ‘furnish the District Registrar with a copy of the ‘Certificate of Particulars’, sent to the Attorney-General and Commissioner of Police’.\footnote{QSA Series ID: 13337, Item ID: 19616, Inwards Correspondence – Crown Law Office, 14 July 1869.} In 1875 the Registrar General drew the Attorney-General’s attention to a letter received by his office from the District Registrar of Births, Deaths and Marriages at St Lawrence, who reported ‘the neglect of certain justices in reporting to him cases of deaths on which enquiries have been held’.\footnote{QSA Series ID: 13337, Item ID: 19612, Inwards Correspondence – Crown Law Office, 3 March 1875.} On 8 March 1875 a circular letter was sent to all magistrates in the colony stressing the importance of reporting all deaths to the District Registrar.\footnote{QSA Series ID: 13337, Item ID: 19612, Inwards Correspondence – Crown Law Office, 3 March 1875.}

Ultimately, in 1882 the Registrar General, Henry Jordan, developed a draft form of a monthly return of all deaths reported to the Commissioner by police, which he suggested would greatly improve the death registration system. The draft of the ‘Return of deaths’ was attached to a letter sent to the Colonial Secretary in which the Registrar General raised concerns over deaths not reported for registration by police. Jordan referred to the

\footnote{QSA Series ID: 13337, Item ID: 19612, Inwards Correspondence – Crown Law Office, 3 March 1875.}
failure to hold an official magisterial enquiry into the death of a man accidentally killed at Reidsville, near Townsville. The police conducted an unofficial enquiry then sent the depositions to the Inspector of Police at Townsville. The body was buried by a police constable on the order of the Townsville police magistrate. Jordan stated that ‘[n]o certificate was sent in by the Police, and but for the application to me by his brother for a certified copy of the registration, the death would have remained unregistered’.\textsuperscript{41} As this was not the only instance in which police in country districts had neglected to report a death to the registrar after having taken possession of a body and burying it, Jordan identified a need for steps to be taken to ensure certificates were furnished for all deaths.\textsuperscript{42}

\textbf{Inquests on Fires}

The coroner’s jurisdiction also extended to investigating suspicious fires and under the \textit{Inquests on Fires Act of 1863}, the coroner could hold an inquest into a fire at his own discretion.\textsuperscript{43} Whether conducting an investigation into a death or the cause and origin of a fire, the role of the coroner varied little. A change occurred when the provision requiring a jury to sit at a death inquest was repealed through \textit{The Inquests of Death Act of 1866} \textsuperscript{44} yet it continued to be necessary for a jury to sit at fire inquiries. The law governing investigations into fires was amended fifty years later when \textit{The Insurance Act of 1916} \textsuperscript{45} came into force. This new legislation authorised the State government to ‘transact all

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\textsuperscript{\[41\]} QSA Series ID: 5253, Item ID: 847069, Correspondence – inwards, 01/01/1882 – 31/12/1882.
\textsuperscript{\[42\]} QSA Series ID: 5253, Item ID: 847069, Correspondence – inwards, 01/01/1882 – 31/12/1882.
\textsuperscript{\[43\]} \textit{Inquests on fires Act of 1863} 27 Vic. No. 12.
\textsuperscript{\[44\]} \textit{The Inquests of Death Act of 1866}, 30 Victoria, No. 3.
\textsuperscript{\[45\]} \textit{The Insurance Act of 1916}, 7 Geo. V, No. 27.
\end{flushright}
classes of insurance business’ and consequently the State Government Insurance Office came into being. The impact on the coronial system of a single clause of this Act concerning inquiries into fires was considerable. Clause 26 (1) directed a Police Magistrate or justice to hold an inquiry into the ‘origin, causes, and circumstances’ of any fire where the loss or damage of property exceeded fifty pounds.

The Fire and Accident Underwriters Association of Queensland gathered data on the causes and risks associated with fires via the attendance of a representative at court hearings. The Secretary of the Fire and Accident Underwriters Association of Queensland lodged a complaint with the Department of Justice in 1925 when Clerks of Petty Sessions consistently failed to advise him of dates of hearings into fires. This prompted the distribution of a circular to Clerks of Petty Sessions reminding them that ‘[a]s this matter is of considerable importance to members of the association all clerks of Petty Sessions will continue the practice of informing him of the date set down for hearing fires inquiries’. With inquests into fires causing losses over fifty pounds now compulsory, the number of fire inquiries held per year increased dramatically between the years of 1917 and 1930. Prior to 1917 an inquest bundle consisting of twenty-five files would commonly contain around four to five inquests into fires. During the 1920s fire inquests, in particular investigations into automobile fires, constituted well over fifty per cent of all inquests held. Although no conclusive evidence exists to explain this change in statistics,

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it is possible that inquests into deaths were sacrificed to accommodate the workload created by the large number of inquiries into fires.

_The Coroners Act of 1930_ repealed Section 26 of _The Insurance Act of 1916_, allowing the coroner the discretionary power to decide if an inquest was warranted. This removed the necessity for coroners to hold an inquest into a fire if the loss of property exceeded 50 pounds. Citizens had the right to request the holding of an inquest into the cause and origin of a fire, provided a fee of ten pounds was paid and assurance given to cover any further costs incurred during the course of the inquest.\(^{49}\) The number of inquests into fires decreased noticeably after introduction of _The Coroners Act of 1930_ and it can only be speculated that the reason for such a reduction in inquests held into fires, was due to the cost associated with the judicial proceedings.

Apparently an inadequate knowledge of the provision of Clause 26 of _The Insurance Act of 1916_ not only prevailed in regional districts, it also extended to the Crown Law Office. In 1929 Inspector George Loch of Toowoomba Police Station reported to Commissioner William Ryan on his decision to hold an inquest into a fire that he considered suspicious. This was contrary to the advice of the Police Magistrate who advised that an inquiry was unnecessary. According to Loch he instructed a Senior Sergeant to conduct a magisterial inquiry into the cause of the fire ‘in accordance with the provisions of “The Insurance Act of 1916” as the damage sustained was below £50’. In addition he claimed the Police

\(^{49}\) _The Coroners Act of 1930_, 21 Geo. 5, No.17.
Magistrate had ‘evidently lost sight of the provisions of Section 26’ of the Act.\textsuperscript{50} Commissioner Ryan forwarded the report on to the Under Secretary of Justice who furnished the following reply:

As regards the holding of Fire Inquiries the P.M. might be told that Sec.26 must be carried out in full and that the Police have their instructions and no discretion but must hold inquiries which come under that Act.\textsuperscript{51}

The Police Magistrate had correctly interpreted Section 26 of the Act. The value of the damage was less than fifty pounds consequently an inquiry was not necessary. It escaped the notice of all other parties involved in the matter, including the Justice Department, that their reading of the provision was incorrect. The Justice Department’s misinterpretation of The Insurance Act of 1916, more than ten years after enactment, raises doubts as to the department’s efficiency in administering the law throughout the colony.

\textbf{Matters of economy}

Matters of economy featured strongly during the development of the Queensland colony with all government departments encouraged to adopt frugal operative practices. According to a Justice Department report in 1894, police magistrates holding inquiries under The Inquests of Death Act of 1866 frequently incurred ‘the expenses of post-mortem examinations in cases where there was no necessity for ordering such

\begin{footnotes}
\item[50] QSA Series ID: 16865, Item ID: 316171, Correspondence– Police, Adverse decisions of magistrates.
\item[51] QSA Series ID: 16865, Item ID: 316171, Correspondence– Police, Adverse decisions of magistrates.
\end{footnotes}
examinations’. Police magistrates and justices of the peace were directed by the Colonial Secretary to ‘exercise the discretion allowed them by the Statute referred to, and by “The Medical Act of 1867”, with due regard to economy and to the circumstances attending each particular case’. Paradoxically, two years later in 1896, the Justice Department advised the Chairman of the Bench of Magistrates:

Magistrates holding inquiries have not in some cases ordered postmortem examinations in order to ascertain beyond doubt the cause of death of persons who have died suddenly from unknown causes and under somewhat mysterious circumstances … such examinations should always be made when there is the slightest suspicion that death was due to foul play.

Thus police magistrates and justices found themselves in a complex situation; left with the sole responsibility of deciding whether a post-mortem examination was required. Such inconsistent measures, founded on the cost cutting agenda of the government, ultimately adversely impacted on the quality of justice delivered at coronial inquests and the accuracy of death statistics.

The Queensland government’s rationing of funds related to the office of coroner and the detection of hidden crimes can be juxtaposed against Howard Taylor’s findings in relation to the stagnation of English crime statistics from 1857 to 1925. Taylor maintained that ‘after the 1830s growing parsimony and the large shift from higher court

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52 QSA Series ID: 7132, Item ID: 269825, Book of circulars, No. 19.
trials to summary hearings of indictable offenses provides evidence of an increasing reluctance and lack of seriousness in the prosecution of crime’. He argues that:

Because the discovery of a suspicious death and its subsequent investigation and prosecution could make a large dent in a police authority budget, it was an open secret that most murders went uninvestigated. Uncharacteristically, the Judicial Statistics admitted in 1899 that ‘Coroners juries’ return as deaths by accidents and misadventure or from natural causes many cases which are really homicides’.

According to Taylor, in the 1860s English medical practitioners expressed concern about the number of murders, accomplished through the administering of poisons, that went undetected each year. Additionally The Report from the Select Committee on Death Certification (1893-94) revealed the possible existence of commercially organised infanticide as well as serial child murderers which went undetected as no inquests were held into these suspicious deaths and the ‘coroner simply issued the normal certificate’. Post-mortems were rarely held, to save on the cost of obtaining evidence at an inquest. Coroners attempted to keep expenses down ‘because quarter sessions would disallow costs to coroners who attempted to investigate all the cases that came within their remit’. Taylor concluded that it was an open secret that many murders and suspicious deaths were not investigated as the criminal justice system was severely impaired by late nineteenth century English government bureaucracy and social policy. Taylor’s analysis of the English criminal justice system can be readily extended to the Queensland jurisdiction, given the existing evidence.

Coroners’ fees

Queensland legislation covering the payment of fees associated with conducting inquests changed a number of times between 1859 and 1900. These changes were based on attempts to reduce government spending on coronial inquests. Originally Clause 10 of The Inquests of Death Act of 1866 set down fees payable to the following parties involved in magisterial inquiries: coroner, police magistrate, justice, medical witness and medical practitioner holding a post mortem. All witnesses could claim mileage at the rate of sixpence per mile each way.\(^{57}\) One year later The Medical Act of 1867 outlined fees payable to medical practitioners, provided they were summoned by the coroner or justice to attend an inquest. Under Clause 15 of the Act, medical men were entitled to remuneration of one guinea for attendance and giving evidence and two guineas for conducting a post-mortem examination. Travel expenses were also paid at the rate of ‘one shilling each way for every mile’ if the inquest was held more than two miles from his residence.\(^{58}\)

The situation altered again with the introduction of The Public Officers Fees Act of 1884,\(^{59}\) which provided that fees received by public officers were to be paid into consolidated revenue on account of a salary being paid to these employees. The police

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\(^{57}\) *The Inquests of Death Act of 1866*, 30 Victoria, No. 3.

\(^{58}\) *Medical Act of 1867*, 31 Vic. No. 33.

\(^{59}\) *The Public Offices Fees Act of 1884*, 48 Vic., No. 5.
the Government has for some years decided that it is to be considered part of the duty of paid Police Magistrates to hold Magisterial Inquiries under the Inquests of Death Act of 1866 (30 Vic No 3), without payment of fees; and that no Police Magistrate in receipt of a salary as such has been paid for holding such inquiries.\textsuperscript{60}

The goldfield warden and justice of the peace at Maytown in North Queensland was informed by the Crown Law Office on submission of vouchers ‘that under the “Public Officers Fees Act of 1884” you are not entitled to fees for holding these inquiries’.\textsuperscript{61} Four other justices were refused payment for holding inquests under \textit{The Public Officers Fees Act of 1884} during the month of October 1884.\textsuperscript{62}

It is understandable that confusion reigned concerning claims for fees by magistrates and justices of the peace. Each new statute dealing with the fee schedule for persons participating in an inquest hearing neglected to situate the ruling within the context of existing legislation pertaining to payment of fees at inquests. Ambiguity surrounded a notice in the \textit{Queensland Police Gazette}, on 5 January 1889, advising police officers of the duties of medical officers and the fees to which they were entitled as prescribed by \textit{The Inquests of Death Act of 1866}. The fees allowed for two pound two shillings (two guineas) for a post-mortem examination and one pound one shilling (one guinea) for

\textsuperscript{60} QSA Series ID: 13381, Item ID: 19797, Letterbook – Crown Law Office, p. 35. This act was assented to 8 August 1884.


\textsuperscript{62} QSA Series ID: 13381, Item ID: 19797, Letterbook – Crown Law Office.
giving evidence. Mileage could be ‘charged either at 6d. per mile in terms of Section 10 of “The Inquests of Deaths Act,” or at 1s. per mile (after the first two miles) in terms of Section 15 of “The Medical Act of 1867”’. A medical man could claim one shilling per mile travelling expenses provided he was summoned by an authorised official to attend the deceased. The summons had to accompany his voucher in order to receive payment. At this time, the same remuneration was available to medical practitioners providing services at an inquest, whether claimed under Clause 10 of The Inquests of Death Act of 1866 or under Clause 15 of the Medical Act of 1867. The two different rates applicable to expenses travelling to inquests were also outlined in the Government Gazette notice of 1889. Consequently, legislation dealing with coronial investigations was located within three individual acts of parliament concomitantly. As the nineteenth century drew closer, Queensland was in desperate need of a cohesive legislative framework to improve the efficiency and effectiveness of the coronial system.

An Act to save money

Consolidation of Queensland’s coronial law failed to make the government’s reform agenda before the end of the century. Instead, the situation concerning inquests and the law was complicated even further when a short bill, containing only one clause, was introduced into parliament during the month of July 1893. Attorney-General Thomas Byrnes informed his fellow members of the House that the object of The Inquests of Death Act of 1866 Amendment Bill was ‘really to give the Crown Law Officers some

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63 QPG, Vol. 26, No. 1, 5 January 1889.
control over the holding of inquests … We wish to exercise control so that without any way interfering with the efficiency of the holding of inquests, they may be conducted with the utmost economy’.\textsuperscript{64} The Australian economy began to decline rapidly from the beginning of the 1890s with the reduction in wool prices and a fall in exports. Queensland in particular had been hit hard by a severe drought in 1893. Servicing the foreign debt ‘reached 40\% of export earnings’ and when British banks refused new loans to Australia, depositors began withdrawing funds. At the end of 1893 most of the banks in the country had closed, sending the economy into turmoil. Unemployment escalated, reaching ‘30 per cent of skilled labour in 1893’\textsuperscript{65} It was within this context that the government introduced the new Bill into parliament.

The Bill proposed to repeal Clause 10 of \textit{The Inquests of Death Act} of 1866 which would effectively abolish the payment of fees to justices of the peace. This decision was rationalised by the fact that justices held honorary office, therefore were not entitled to fees for their services. Police magistrates and medical practitioners would remain unaffected by the new legislation, as magistrates received salaries and were not entitled to claim fees, and medical practitioners’ fees were dealt with under the \textit{Medical Act} of 1867. The Bill also removed statutory provision for the payment of witnesses, resulting in the Crown Law Office holding the power to ‘control expenditure and to fix a scale of fees for expenses of witnesses’ that would equal those of other courts.\textsuperscript{66}

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\textsuperscript{64} QPD 1893, 57 Vic., No. 6, p. 204. \\
\textsuperscript{65} Macintyre, S. (1999), \textit{A Concise History of Australia}, Cambridge: Cambridge University Press, p. 129. \\
\textsuperscript{66} QPD (1893), 57 Vic., No. 6, p. 29.
\end{flushright}
Some opposition members expressed concern that the abolition of fees for justices and witnesses would result in a decrease in the number of inquests held. Dr William Taylor, member of the Legislative Council from 1886 to 1922, cited the increase in the number of potentially lethal medicines available, and the inadequacy of the Poisons Act, in arguing that injustices could remain undetected without full investigations of deaths. In his opinion justice took precedence over the cost of a few unnecessary inquests.\(^{67}\) William Groom, member for the Darling Downs, called the Attorney-General’s attention to the numerous complaints received regarding the ‘unsatisfactory way’ in which inquiries were held into ‘the deaths of persons in the bush’. He argued that it was difficult to obtain witnesses to appear at an inquest and the evidence given at such inquiries rarely assisted in determination of cause of death. For that reason he felt the passing of the Bill would deter witnesses even further if they were unsure of the financial recompense connected with their appearance thus leading to ‘positive injustices’\(^{68}\).

Challenging the Colonial Secretary, Thomas McIlwraith, over his claim that ‘inquests are held for which there is not the slightest necessity; and these fees are an inducement to hold inquiries for which there is no need’, James Drake, the Opposition member for Enoggera, inquired if removal of the fees would act as a deterrent to the holding of inquests. He stressed the role of the inquest as a measure ‘clearly intended to preserve life’ and suggested that an amendment to the Act should include a move:

\(^{67}\) Taylor, W., QPD (1893), 57 Vic., No. 6, p. 31.

\(^{68}\) Groom, W., QPD (1893), 57 Victoria, No. 6, p. 201.
to place all classes of alien labour in the same position as kanakas; and that is more necessary in view of the introduction of Japanese on the Northern sugar plantations. For many purposes those men are in the same position as kanakas, and the law should extend the same protection to them. In commencing a policy of economy, the Government should not do anything that may remove safeguards against any kind of violence that may result in death.  

Drake was referring to The Pacific Island Labourers Act of 1880 which was an act that provided for regulating and controlling the introduction and treatment of labourers from the Pacific Islands. Pacific Islanders, or Kanakas as they were generally called, were brought to Queensland as indentured labour to work on the cane and cotton plantations. According to Section 24 of the Act every employer was required to ‘provide his labourers with proper medicine and medical attention during disease or illness’, while Section 35 stated ‘that in the case of death a medical certificate of the cause thereof should be forwarded with the death report to the immigration officer. If no such medical certificate can be obtained an inquiry under The Inquests of Death Act of 1866 is to be held into the cause of death of such labourer or islander’. Although the introduction of the Act offered some protection for Pacific Islanders against abuse and oppression by white

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69 Drake, J., QPD (1893), 57 Vic., No. 6, p.203. Drake was a journalist, lawyer and politician. He worked for the Daily Northern Argus (Rockhampton), the Telegraph (Brisbane), the Brisbane Courier and, briefly, the Melbourne Argus. Drake was president of the Queensland Shorthand Writers’ Association, and joined the parliamentary reporting staff in 1876. He was admitted to the Bar in June 1882, and he won the Legislative Assembly seat of Enoggera in March 1888. (Gibbney, H. J. (2006), ‘Drake, James George (1850 - 1941)’, Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adbonline.anu.edu.au/biogs/A030351b.htm , accessed 31 May 2011).  

70 The Pacific Island Labourers Act of 1880, 44 Vic, No. 17.
plantation owners, many died as a result of the harsh treatment and poor conditions they were exposed to.\footnote{Scott et al., \textit{The Engine Room of Government: The Queensland Premier’s Department 1859-2001}, p. 39. See also Moore, C. (1985), \textit{Kanaka: a history of Melanesian Mackay}, Port Moresby: Institute of Papua New Guinea Studies and University of Papua New Guinea Press.}

A letter addressed to the Secretary Crown Law Office from the Colonial Secretary’s Office, dated 17 September 1886, drew the Attorney-General’s attention to breaches of \textit{The Pacific Island Labourers Act of 1880} committed by white proprietors of plantations. The letter acknowledged the receipt of the Certificates of Particulars from inquests held into the deaths of Pacific Island Labourers on Pioneer, Airdmillan and Kalamia plantations. The Attorney-General was informed that the labourers ‘had not been attended by a duly qualified medical practitioner while sick’ and consequently ‘the proprietors of those plantations have had their attention directed to the provisions of Section 24 of “The Pacific Island Laborers [sic] Act of 1880”’. The owners were also advised that ‘the employment of Mr R Stacey the Bookkeeper of Airdmillan Plantation to attend upon the sick islanders is not held to be proper medical attendance, in terms of the Act’\footnote{QSA Series ID: 13337, Item ID: 19633, Inwards Correspondence – Crown Law Office, letter from Colonial Secretary’s Office to the Secretary, Crown Law Office, 17 September.}. Again in 1887 the Government Resident on Thursday Island in the Torres Strait, when forwarding depositions taken at an inquiry held into the death of a South Seas Islander, drew the Attorney-General’s attention to the common practice of employers to ‘fail to employ medical aid for their sick colored [sic] employees, even when opportunity offers, as it did in the case’\footnote{QSA Series ID: 13337, Item ID: 19635, Inwards Correspondence – Crown Law Office, letter from Government Resident, Thursday Island to the Attorney-General, 30 April 1887.}.

Although the deaths of Pacific Islanders were well above the percentage
per one thousand than that of the white population\textsuperscript{74}, the fact that inquests were held into these deaths was an improvement on previous dealings by the colonial government with deaths of Pacific Islanders.

Even though some parliamentary members felt that abolishing fees for justices and witnesses would have a negative effect on crime prevention and achieving justice for the deceased, ultimately the government priority was saving money. On 18 August \textit{The Inquests of Death Act Amendment Act of 1893}, consisting of one clause was assented to. The clause read: ‘The tenth section of “The Inquests of Death Act of 1866” is hereby repealed’. The next amendment to coronial law occurred in 1930 under circumstances that compelled the government to undertake reformative measures.

\textbf{Justice – Not working to the letter of the law}

Meanwhile investigations into suspicious, sudden and violent deaths continued to be held in the same haphazard manner as in the past. While justices of the peace and police magistrates on occasions neglected to conduct inquests in accordance with coronial legislation, it is open to conjecture as to whether the oversights resulted from ignorance of the law or a matter of complacency. Failing to order a post-mortem when necessary, not obtaining medical evidence and not ascertaining the full facts of a death, were some of the faults found with inquests held in a colony where many settlers resided in small

towns or camps that stretched to the extreme north of the continent. On receipt of the depositions from an inquest held into a miner’s death at Wolfram Camp on 8 May 1903, which was 1420 kilometres from Brisbane, the Under Secretary Department of Justice requested that Police Commissioner Parry-Okeden determine why no police evidence was tendered at the inquiry. According to the police report, on notification of the death a constable from Thornborough police station proceeded to Wolfram Camp. On arrival he was informed by the justice of the peace that burial of the body had been ordered on account of there being no suspicious circumstances attached to the death. As he had not seen the body, the constable held an inquest on 13 May 1903 and consequently found no suspicious circumstances. The cause of death was recorded as ‘from a fit of nightmare which is suggested was due to stoppage of the circulation of the blood’. This was not an acceptable classification of cause of death, but was not questioned by relevant authorities. It is likely the justice of the peace subscribed to the “bush culture” which often tended to overlook rules and regulations emanating from the city. No direct disciplinary action was taken after the Police Commissioner sent the report to the Justice Department.

Subsequent to this event the Commissioner’s Office issued a memorandum on 16 August 1904:

The responsibility for ascertaining the cause of death rests with the Police and they are not excused if any Magistrate whom they have requested to exercise his functions, fails or neglects to do so. Their duty does not cease upon reporting the case to the Justice; they must

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76 QSA Series ID: 36, Item ID: 348912, Inquest File - Colohan P. J. to Inspector of Police Cairns.
be satisfied that all possible steps have been taken to clear up any doubt as to the cause of death.\(^{77}\)

Furthermore, the defining of jurisdiction between the police and magistrates became necessary, as the following circular from the Under Secretary, Department of Justice, in 1905 shows:

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\text{it is an error to suppose that Magistrates have a general right to control the members of the Police Force ... I need hardly point out that, in the interests of the impartial administration of the law, it is essential that Magistrates should ... refrain from any attempt to influence or direct the Police, especially in regard to matters which may subsequently come before them for judicial decision.}\(^{78}\)
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Formal rules and regulations, which governed the duties of Queensland Police, were presented in a Manual of Police Regulations, and according to Mark Finnane, most colonial police regulations were founded on the 1856 Victorian Manual.\(^{79}\) In Queensland, under Police Rule 99, police officers were presumed to have a sound knowledge of their duties but this was not always the case. Police Commissioner Parry-Okeden said in his annual report for 1897:

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\text{seeing that I have again to report that “the police have practically no book,” every man cannot “know his duty” ... it is absolutely necessary that they should be provided with a Manual which, besides the Rules and Regulations under which they serve, should contain such an outline of the law and their duties in connection therewith as would}
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\(^{77}\) QSA Series ID: 8604, Item ID: 282299, Orders, Memoranda – Police, Circular Memorandum No. 323.

\(^{78}\) QSA Series ID: 36, Item ID: 349333, Inquest File.

enable them to act “in every case” with intelligence and advantage to the State.\textsuperscript{80}

No doubt the need for the supply of updated Manuals of Police Regulations for distribution around the state would have better facilitated policing policies, yet as Finnane suggests the ‘informalities of local practice’ sometimes undermined the ‘observance of rules’.\textsuperscript{81} Accordingly, the evidence shows that the State’s police and magistrates suffered inadequate provision of instructional material in relation to their duties but at the same time they tendered to overlook well known ‘rules and regulations’.

\textbf{John McCrae Inquiry}

Inquests conducted by police magistrates or justices of the peace often lacked legitimacy and sometimes succumbed to a general complacency that tended to exist in frontier regions. As Finnane and Richards observed, ‘[t]he conditions under which a death became the subject of a coronial inquiry by a magistrate were mediated by the realities of distance, denial, cover-up and subversion of justice’.\textsuperscript{82} In the following case study, what began as a routine inquest turned into a “witch hunt” conducted by senior police officers against four constables stationed at Charters Towers. Ultimately, the officers were expelled from the force for ‘forming a combination’ and publicly criticising the actions of senior police involved in the investigation into the cause of death of John McCrae in 1897.

\begin{footnotesize}
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\item \textsuperscript{80} Report of the Commissioner of Police for the Year 1897, Queensland Legal Council Journal, 1898, Vol. 1, p. 2.
\item \textsuperscript{81} Finnane, \textit{Police and Government: Histories of Policing in Australia}, p. 152.
\item \textsuperscript{82} Finnane and Richards, “‘You’ll get nothing out of it’?: The Inquest, Police and Aboriginal Deaths in Colonial Queensland”, p. 87.
\end{itemize}
\end{footnotesize}
A culture of ineptitude and complacency had pervaded the Charters Towers police station over time and the four constables were punished for challenging the status quo by endeavouring to have McCrae’s death fully investigated in accordance with the provisions of coronial law. The evidence strongly suggests the interests of justice were not served through this inquiry due to government initiated acts of political interference, reprisal and cover up.\(^8^4\)

On 23 July 1904, the decomposed body of John McCrae, a 63 year old timber cutter, was found in a gorge approximately 300 yards from his camp at Gaines Creek, near Charters Towers. Constable George Aspinall from Charters Towers police station was ordered to view the body, inspect the site and lodge a report. As he suspected ‘foul play’ was connected with McCrae’s death, a police party led by Senior Sergeant John McGrath left for the site on 25 July 1904. The following day a search of the area was conducted by police who gave special attention to the ‘drag’, a mark on the ground extending from the camp towards the place where the body was found. McCrae’s body was taken to Charters

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\(^8^3\) QSA Series ID: 1108, Item ID: 562902, Report of Police Magistrate Christopher Francis contained in Aspinall Staff File.

\(^8^4\) Primary evidence for this case is taken from reports in Police Staff Files and debates held in Queensland State Parliament concerning the inadequacy of the inquest, along with the alleged miscarriage of justice relating to the dismissal of the constables called to give evidence at the police inquiry. The McCrae inquest files are missing from the records at the Queensland State Archives and to date these files, along with the depositions taken at the police inquiry held by Police Magistrate Christopher Francis on 24 March 1905, have not been located. The sequence of events however can be pieced together from documents contained in Police Staff Files, which include correspondence between the Commissioners of Police, the Crown Solicitor, Police Magistrate Christopher Francis, the Inspector of “E” District James Lamond and Sub-Inspector James McNamara of Charters Towers police station. Data were also gathered from selected depositions taken at the two coronial inquests which were read out in a 1905 sitting of the Queensland State Parliament.
Towers morgue where Dr. Forrest, the Government Medical Officer, conducted a post mortem examination and recorded cause of death as extensive fracture of the skull. Sub-Inspector James McNamara and Acting Sergeant John Hanly inspected the ‘drag’ on 11 August, seventeen days after the discovery of the body.\(^8^5\)

The first coronial inquest was held on 19 and 22 August 1904 at Charters Towers.\(^8^6\) McGrath, who conducted the inquiry before police magistrate Parkinson, declined to call Aspinall as a witness despite him being the first police officer on the scene. Neither was Dr Forrest called to give evidence as a medical witness despite having carried out the post-mortem and issued the death certificate.\(^8^7\) Aspinall was not summoned as a witness due to instructions issued by Sub-Inspector McNamara who said Aspinall’s ‘sensational views’ that McCrae had been murdered had ‘no foundation in fact’. McNamara also claimed that Aspinall’s evidence would be ‘contradicted by other police’ and would in no way assist the Court of Inquiry.\(^8^8\) In fact, the police magistrate, not McNamara, had the authority to determine who appeared at the inquiry as a witness. Although Police Magistrate Christopher Francis later admitted the decision made by Sub-Inspector McNamara to exclude Aspinall from the inquiry was ‘unwise’ in the face of subsequent events, he nevertheless concurred with McNamara’s judgment.\(^8^9\)

\(^{8^7}\) QPD 1905, 5 Edw. VII, Vol. 95, p. 819.
\(^{8^8}\) QSA Series ID: 1108, Item ID: 564940, McNamara to Lamond, letter dated 20 September 1904: No 359/04, Lamond Staff File.
\(^{8^9}\) QSA Series ID: 1108, Item ID: 562902, Report of Police Magistrate Christopher Francis contained in Aspinall Staff File, p. 11.
The nature of the inquest did not conform to the traditional process of conducting a full and open investigation into the death. Following the findings of cause of death as a ‘fracture of skull from fall from horse’\textsuperscript{90} the \textit{Evening Telegraph} challenged the legitimacy of the inquiry, claiming evidence suggesting McCrae had been murdered was suppressed. The paper also criticised the standard of policing in the district.\textsuperscript{91} Unhappy with the ‘farcical proceedings connected to the McCrae inquiry’, Police Commissioner Parry-Okeden informed Inspector Lamond he believed the criticism levelled at McNamara by the \textit{Evening Telegraph}’ was justified.\textsuperscript{92,93} Subsequently, Parry-Okeden called for a report from all concerned in the McCrae case. Ultimately, this case became the catalyst for exposing the dysfunctional operations of the Charters Towers police and the severe repercussions suffered by the officers who dared to challenge the status quo by attempting to make sure McCrae’s death was thoroughly investigated.

Archival records expose the disorganised and ineffectual state of the Charters Towers police station, both prior to and during the course of the McCrae inquiry. Sub-Inspector James McNamara had charge of the Charters Towers police station, but as a consequence of his ongoing ill health\textsuperscript{94} Senior Sergeant John McGrath ‘ran the show at that time’ of

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\item \textsuperscript{90} QSA Series ID: 236, Item ID: 439133, Registers of Coroners’ Inquests.
\item \textsuperscript{91} \textit{Evening Telegraph} 1 December 1904.
\item \textsuperscript{92} QSA Series ID: 1108, Item ID: 564940, Parry-Okeden to Lamond 8 December 1904, Lamond Staff File.
\item \textsuperscript{93} Additionally, the paper claimed police had gathered evidence into the death of William Rogers at Charters Towers on 7 November 1904 but did not present the evidence at the magisterial inquiry. Consequently, Parry-Okeden instructed police to give evidence at all coronial inquiries. QSA Series ID: 36 Item ID: 348924 Inquest File.
\item \textsuperscript{94} Dr Dodds had certified in December 1903 that NcNamara was suffering from ‘deficient memory’ which he did not think would improve without a ‘prolonged holiday’, and even then ‘his fitness for further service
\end{itemize}
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the inquest, according to John Burrows, Labor member for Charters Towers. Following the first McCrae inquiry, Inspector Lamond wrote to Parry-Okeden describing McNamara as a drunkard, declaring that the efforts of the police at Charters Towers had been ‘mostly directed to protect poor McNamara … and there appears to be a general mess all round’. As Inspector of “E” District, James Lamond was responsible for overseeing policing in the region; nevertheless he directed blame for the current situation towards McNamara.

Lamond was aware that officers from the Charters Towers station were expending time and energy covering for McNamara but took no action to rectify the situation. Correspondence between Lamond and Parry-Okeden suggest that their friendship may have prevented Parry-Okeden from calling Lamond to account for his negligence. An accusatory finger was promptly pointed at Lamond shortly after William Cahill became Commissioner on 1 April 1905. Cahill wrote:

Sub-Inspector McNamara appears to have been allowed to reach a condition medically certified as “imbecile”, apparently without let or hindrance from you and without information reaching this Office.

The inadequacy of the first Magisterial Inquiry held into the cause of McCrae’s death should have been easily apparent to you, who should have taken action to supply the deficiencies. Had this been done it is

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96 QSA Series ID: 1108, Item ID: 564975, Lamond to Parry-Okeden 14 December 1904, McNamara Staff File.
97 QSA Series ID: 1108, Item ID: 564975, Lamond to Parry-Okeden 9 January 1905, McNamara Staff File.
scarcely doubtful that the affair would not have assumed the dimensions subsequently reached, and much expense and trouble would have been avoided.

The Inquiry held by Mr. Francis and the long series of reports and depositions in connection with the whole case leave an impression of demoralization and dis-organisation among the Police at Charters Towers, implying a lack of proper supervision and control on your part.  

Lamond was now held accountable for his incompetent administration of police affairs in “E” District but this did not alter the unsatisfactory outcome of the McCrae inquiry.

In September, Constable Aspinall sent a report to the Commissioner claiming to have further information concerning the McCrae case. He stated ‘that the responsible officers of Police at Charters Towers were inclined not to devote much attention or inquiry to the McCrae case’. In Aspinall’s opinion, ‘the case would never have occurred’ if Sub-Inspector McNamara had been capable of carrying out his duties. On 28 October 1904, Aspinall requested a re-opening of the McCrae inquiry to allow him and other witnesses to disclose previously unheard evidence. Shortly after, Aspinall was transferred to Townsville in December 1904.

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98 QSA Series ID: 1108, Item ID: 564940, Cahill to Lamond, 5 April 1905, Lamond Staff File. In May 1905 Cahill recommended Lamond be retired early as he was ‘unfit for his position’ however Lamond was transferred to Normanton District from Townsville in June 1905 and retired in 1909.
100 QSA Series ID: 1108, Item ID: 562902, Police Service File – Aspinall G. C.

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Aspinall’s presence at the Charters Towers police station upset the general order, as is shown in Lamond’s comments to Parry-Okeden:

> Constable Aspinall is steady intelligent and knows his work but from his reports and the way he writes and speaks of McNamara Senior Sergeant McGrath and Sergeant King and also the other police there you will see that it would be impossible too (sic) keep him in Charters Towers and maintain discipline or anything like good work.\(^{103}\)

In addition, Lamond stated ‘I can not [sic] help admiring Aspinall – great big fine muscular fellow and appears to thoroughly believe he is right and if he is lying he is a past master!’\(^{104}\) Lamond seemed to consider Aspinall a competent member of the force who apparently believed his actions were commensurate with the dispensing of justice. Yet publicly Aspinall was subjected to allegations of lying and misconduct because he advocated compliance with coronial law.

Parliamentary members for Charters Towers, John Dunsford and John Burrows\(^{105}\) wrote to the Commissioner of Police on 8 December 1904, enclosing an article from the *Evening Telegraph*, and requested the re-opening of the McCrae inquiry. The Commissioner eventually ordered the holding of a second inquiry on 6 January 1905 to allow further evidence to be taken. Burrows said in parliament on 17 October 1905:

> The decisions arrived at by the magisterial inquiry were wrong. He believed McCrae was murdered. This was a case in which the

\(^{103}\) QSA Series ID: 1108, Item ID: 564940, Lamond to Parry-Okeden 14 December 1904, Lamond Staff File.
\(^{104}\) QSA Series ID: 1108, Item ID: 564975, Lamond to Parry-Okeden 14 December 1904, McNamara File.
\(^{105}\) Charters Towers was a dual representative district until 1912.
superior officers had come to a conclusion as to the manner in which this death occurred, and they did their utmost to prevent any evidence coming out in opposition to that view. ¹⁰⁶

Those who accepted McCrae’s death as an accident were never going to entertain the possibility of an alternative conclusion.

A second inquiry would give Aspinall the opportunity to publicly disclose what the Commissioner had already pre-judged as ‘uncorroborated and doubtful evidence of a sensational character’ that would fail to elicit ‘anything to prove McCrae’s death was caused by other than accidental means’. ¹⁰⁷ The serious allegations that Senior Sergeant McGrath and Sergeant King had suppressed evidence were reported by Aspinall at the new inquest. ¹⁰⁸ Aspinall stated that on his original inspection of the area where McCrae’s body was found he detected a boot track, and that the men who found the body agreed with his finding. According to Aspinall, ‘the marks on the ground were the tracks of a man who had dragged the body’ along. ¹⁰⁹ In contrast other members of the party attested to the theory that McCrae’s horse had bolted and ‘he was dragged along the ground. The marks … were horse tracks, which showed that the body had been dragged over them’. ¹¹⁰ Aspinall maintained that when McGrath inspected the track he altered it with his finger to make it appear like a horse track. Black tracker Billy Hamilton stated at the first inquiry

¹⁰⁸ Details of the second inquiry have been taken from QPD 1905, 5 Edw. VII, Vol. 95, pp. 819-833.
that he did not know what tracks they were, but subsequently said that ‘Sergeant McGrath told him to say they were horse tracks, while he himself believed they were man tracks’.  

Constable Aspinall continued his evidence at the inquest, alleging that Constable King admitted at Gaines Creek that he and Senior Sergeant McGrath knew ‘foul play’ was involved in McCrae’s death. He claimed King stated there were many similar ‘undiscovered cases’ in Queensland and there was “no hope of getting the man responsible”. Accordingly, King contended that there was no benefit in creating a ‘sensation’ and suggested the best approach would be ‘to say he was killed by a horse and thrown in there’. According to Aspinall, he then added ‘We’ve only got the black boy to square, we can easily square him’. Aspinall’s report prior to the first inquiry did not mention this conversation with King, however following his omission as a witness from the inquiry, and the sworn evidence by King and McGrath that the death was viewed as an accident, Aspinall submitted another report in September which included his claim of suppression of evidence by his superiors.

During the course of the second inquiry Aspinall’s solicitor claimed superior officers in the police force were trying to crush Aspinall. The crowd in the courtroom cheered the

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statement and the police magistrate immediately cleared the court. A justice sitting on the bench accused Parkinson, the police magistrate holding the inquiry, of siding with the police. The justice claimed that ‘if he had not been present the inquiry would have been a farce’. Parkinson, who conducted the first inquiry, upheld the finding that John McCrae died as a consequence of a fractured skull resulting from a fall from his horse.

With the second inquest completed, Christopher Francis was appointed by the Under Secretary of the Home Department to hold an inquiry into the conduct of the police in connection with the finding of the dead body of John McCrae at Gaines Creek, the magisterial inquest held into the death, and any other matters arising from these proceedings affecting the Police of “E” (Kennedy) District. Francis also investigated charges against Aspinall for insubordination, disclosing the contents of official documents and entering the office of the Queenton Police Barracks under false pretences. Inspector Lamond conducted the inquiry which was “closed” to the public and the press. Although Francis upheld the charges against Aspinall, they do not appear on Aspinall’s staff file. In fact Aspinall’s staff record contains remarks from Senior Inspectors maintaining he was a good horseman who performed his duties very

115 *Morning Post*, 23 January 1905, p. 3.
117 QSA Series ID: 236, Item ID: 439133, Registers of Coroners’ Inquests.
Yet Constable Aspinall, an experienced police officer of almost nine years, was
dismissed in April 1905 as a result of Francis’ recommendation.

The findings from the police inquiry conducted by Francis indicated he approached the
proceeding convinced of the guilt of Aspinall as well as of those officers who appeared in
support of his testimony. The charge against Senior Sergeant McGrath of altering the
track was dismissed by Francis because it was denied by McGrath, and Aspinall allegedly
could not support his story. Was McGrath deserving of the faith afforded him regarding
his truthfulness and work ethic? A number of unflattering and severe comments appeared
on McGrath’s record of service, and as a result of this, his credibility must be questioned.
Inspector FitzGerald wrote of McGrath: ‘Good bushman and horseman, but uncouth in
manner which occasionally requires checking; also apt to get careless in his office work,
but intelligent’. In 1891 Inspector Douglas commented that he found McGrath to be a
‘first class police officer’, however in 1894 Sub Inspector Urquhart found him to be ‘a
very much over-rated man … insolent and insubordinate, and untrustworthy.
Urquhart’s opinion directly contradicted that of Douglas. The next year second class Sub
Inspector William Cooper found McGrath to be a ‘fair bushman and good horseman, but
untidy in appearance, and careless in manner and office work’.

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120 QSA Series ID: 1108, Item ID: 562902, Aspinall Staff File.
121 QSA, Series ID: 1108, Item ID: 565746, Inspector FitzGerald, Record of Conduct and Service of John
McGrath, Staff File.
122 QSA Series ID: 1108, Item ID: 562902, Inspector Urquhart, Record of Conduct and Service of G.G.
Aspinall, Staff File.
123 QSA, Series ID: 1108, Item ID: 565746, Sub Inspector Cooper, Record of Conduct and Service of John
McGrath, Staff File.
Inspector Patrick Brannelly found McGrath to be ‘unreliable and untruthful’. Again Douglas stated his satisfaction with McGrath in 1898 but commented that he was ‘a very hard man to understand; his manner is boorish, but he does not intend disrespect’. McGrath had been labelled as unreliable, insubordinate, untrustworthy and untruthful, as well as criticised for his haphazard approach to administrative duties. So why did Francis accept McGrath’s word over that of Aspinall?

McGrath’s aversion to paper work and the fact that McCrae was only an elderly woodcutter might explain his hesitancy to exhaustively investigate McCrae’s death. As the following example shows, the death of an itinerant worker in Queensland’s remote areas passed with little recognition. In 1886 The Carpentaria Times questioned why a body found in the bush eight miles from Normanton, and thought to be that of a man reported missing from his camp, was not identified at the coronial inquiry. The sergeant finding his swag, and a number of men who knew the supposed deceased, were not called to give evidence or identify the body. Speculating on why nothing was done to ascertain the cause of death, the paper claimed ‘a long residence in the back blocks … induces indifference. “Oh! It is only the body of a drunken bushman; sling it into the grave and get rid of it.”‘ Similarly, the evidence gathered for this case study indicates that

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124 QSA, Series ID: 1108, Item ID: 565746, Inspector Brannelly, Record of Conduct and Service of John McGrath, Staff File.
125 QSA, Series ID: 1108, Item ID: 565746, Inspector Douglas, Record of Conduct and Service of John McGrath, Staff File.
126 Woodcutters were generally itinerant workers who occupied the lower levels of the class structure in Australia.
indifference was the foremost reason McGrath refused to further investigate McCrae’s death.

Constables Sheehan, Finn, Foley and Keane appeared before police magistrate Francis to give evidence to support the claim that some officers at the Charters Towers police station were guilty of collusion, misrepresentation, and perjury in connection with the inquest into the death of John McCrae. Francis stated in his conclusion to the inquiry:

If there is one thing more than any other that became apparent … it was the existence of a combination of the kind especially prohibited by the Police Manual … In any inquiry in which any one of these men are involved the other three are ready to come forward with statements, false if necessary, to support the case of the man whose conduct happened to be in question … Aspinall has since the outset of the McCrae matter entered on a course of wholesale misrepresentation, which he has not hesitated to sustain by perjury.129

As a consequence of ‘forming a combination’ in giving evidence at the second enquiry, the careers of Constables Aspinall, Finn, Sheehan and Senior Constable Foley were abruptly terminated.

Michael Foley brought an action against the government for wrongful dismissal which led to a Queensland Supreme Court finding that Foley ‘was denied natural justice in not being allowed a hearing of charges against him’. The case subsequently went to the High

Court of Australia which upheld the decision of the Police Commissioner with regard to Foley’s dismissal. Prior to the High Court hearing, the government sought advice from the Crown Solicitor, W. Shand, who pointed out that although Foley had been investigated in relation to complaints made against him, no charges were ever laid and the evidence collected was not taken on oath. This evidence could have been used in cross-examination of Foley but the Crown Solicitor cautioned against the use of these papers. He maintained that the Commissioner may have been influenced by the content of the papers in dismissing the Plaintiff, instead of relying ‘upon the evidence taken before Mr Francis or Mr Francis’ report’. He further stated that it appeared as though the papers were ‘furnished to Mr Francis behind the Plaintiff’s back, and were the real grounds to his conclusions with reference to the Plaintiff’s character and conduct’. Furthermore Shand expressed his thoughts that ‘Other notes apparently made by Inspector Lamond also suggest a strong animus against the Plaintiff’. Finally it was recommended that the papers be kept ‘out of sight’ due to the ‘annotations’ contained on them. Finnane argues that this evidence implies that serving police officers could be denied justice when it suited their senior officers. Moreover, the legal obligation to fully investigate a suspicious death seems to have become a minor objective of the coronial inquiry.

There is little doubt that the Charters Towers police station at this time was in disarray and functioned according to its own rules, due to a lack of proper supervision from

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131 QSA Series ID: 1108, Item ID: 563446, Police Service File – Foley, M.
132 Finnane, ‘Commissioners and Minister’ in Police and Government: Histories of Policing in Australia, p. 46
superior officers. Commenting on this situation, the Cairns *Morning Post* reported that transfers in the police force were expected as a result of the McCrae inquiry at Charters Towers. If not for the protest of Constable Aspinall, John McCrae’s coronial inquiry would have been concluded without meeting the principles of coronial law; that the death was fully investigated to determine cause of death. Although Aspinall was successful in attaining a second inquiry, the hostility of the police magistrate and senior members of the Queensland police force, ensured that Aspinall’s testimony and that of the other three officers were discounted. Consequently, in spite of a second inquiry occurring, it was still doubtful that McCrae’s true cause of death was determined. Ultimately the inquest process was subjected to obstruction and diversion orchestrated by the government.

**Overlooking breaches of the Law**

The evidence given during inquests regularly revealed breaches of the law, whether unintended or deliberate, but rarely did this disclosure lead to any kind of response from the Justice Department. The following case studies show that while some offences were minor transgressions, others represented significant criminal acts that were overlooked.

**The murder of Simon Zieman**

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133 *Morning Post*, 15 February 1905, p. 3.
In 1871, Dr Kevin O’Doherty (member for North Brisbane),\(^{134}\) claimed that *The Inquests of Death Act of 1866* had added to the confusion over coronial legislation and led to a situation where death inquests were less efficient and more inclined to bring about injustices. He brought to the House’s attention a report in *The Courier* in November 1871 concerning the magisterial investigation into the murder of Simon Zieman at Gunda Gunda Creek (approximately 48 kilometers from Surat and 500 kilometers west of Brisbane).\(^{135}\) Zieman’s death appeared to be a clear case of murder when his body was found with the skull caved in and a pistol and stirrup iron lying nearby. The police called on “Dr Godfrey” to conduct a post-mortem examination at the scene of the murder on 29 November 1871. Godfrey, who declared himself a duly qualified doctor, was not registered as a legally qualified medical practitioner with the Queensland Medical Board.\(^{136}\) He immediately removed Zieman’s head and searched for traces of lead. He then removed part of the neck. Godfrey carried out a superficial examination of the remainder of the body looking for further signs of “shot”. On 30 November the body parts were placed in a tin box and taken to St George (a distance of 110 kilometers), by Godfrey and Sergeant Downie. The rest of the body was buried 200 yards from where it was found.\(^{137}\)

O’Doherty had discovered that Godfrey was not registered with the Queensland Medical Board, and yet in the presence of government officials had carved up Zieman’s body. In

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\(^{134}\) See biographical note in Chapter 2, p. 15, footnote 66.

\(^{135}\) QPD (1871-1872), 35 Vic., p. 292.

\(^{136}\) QSA, Series ID: 798, Item ID: 519907 and 519908, QPG. Godfrey was not enrolled as a registered medical practitioner in Queensland according to the Police Gazette of 1871 and 1872.

\(^{137}\) Brisbane Courier, 18 December 1971, p. 3; 27 December 1971, p. 3.
O’Doherty’s opinion, the interests of justice were not served through this mutilation and he suggested such action was only for the ‘purpose of producing sensational evidence at the trial’. Furthermore he claimed that it was as a consequence of abolishing coroners’ inquests through *The Inquests of Death Act 1866* that this situation had arisen. He maintained if a coroner’s inquiry had been held immediately and a qualified medical practitioner had examined the body and given evidence as to cause of death, there would have been no necessity for the mutilation. According to O’Doherty, any qualified medical man could have certified to the cause of death without resorting to such action. Although a medical practitioner would have been required to travel from Roma, O’Doherty considered it the government’s duty ‘to go to the utmost necessary expense in order to secure evidence that would be received in a court of law in such a case’. He maintained that the Zieman case showed that the law that abolished coroner’s inquests was detrimental to the cause of justice. Furthermore, he believed the change in the law, substituting magisterial inquiries for coroner’s inquests, was greatly disapproved of. O’Doherty thought the mutilation of Zieman’s body was unjustified and a government inquiry to investigate the matter was needed.

William Miles (member for Maranoa) also condemned the carving up of Zieman’s body. He argued that in the absence of a medical man, members of the police force could determine cause of death. Nonetheless, he went on to express his support for Godfrey as a ‘most competent medical man’. According to Miles:

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139 *QPD 1871-1872, 35 Vic.,* p. 294.
140 *QPD 1871-1872, 35 Vic.,* p. 295.
in the outlying districts of the colony, where there was not sufficient population to induce a legally qualified man to take up his residence, people were glad to obtain the services of gentlemen who were to be known as otherwise qualified. As to the change in the law ... he thought that where there was a sparse population, a magisterial inquiry was preferable to a coroner’s inquest.\textsuperscript{141}

In Colonial Secretary Herbert’s point of view, if Godfrey was not a legally qualified medical practitioner, he was unable to give evidence as to cause of death at the trial of the accused. Therefore, it would have been necessary for Godfrey to present the body part as evidence. The Colonial Secretary and Attorney-General overlooked the fact that it was illegal for a non-qualified medical person to perform such an act on a corpse. Additionally, as an unregistered medical practitioner, Godfrey’s evidence in connection with the cause of death was unacceptable.\textsuperscript{142} According to police regulations, when a qualified doctor was unavailable to perform a post-mortem, the duty to examine the body reverted to the local police.\textsuperscript{143}

In fact, the Act did not change the coroner’s authority to order post-mortem examinations or obtain evidence from a medical practitioner. Charles Lilley (Opposition leader and former Colonial Secretary and Attorney-General),\textsuperscript{144} as author of the statute, informed Dr O’Doherty that the only material alteration made by the Act was the abolition of a jury at an inquest. It also provided legal sanction for magisterial inquiries.\textsuperscript{145} The Inquests of

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\item \textsuperscript{141} QPD 1871-1872, 35 Vic., p. 293.
\item \textsuperscript{142} QPD 1871-1872, 35 Vic., pp. 293-294.
\item \textsuperscript{143} QSA Series ID: 16861, Item ID: 315992, Manual of Police Regulations.
\item \textsuperscript{144} Scott et al., The Engine Room of Government: The Queensland Premier’s Department 1859-2001, pp. 26, 32.
\item \textsuperscript{145} QPD 1871-1872 35 Vic., p. 293.
\end{itemize}
Death Act 1866 gave full coronial powers to justices and magistrates, thereby eliminating any difference between a magisterial inquiry and an inquest. The parliamentary debate over this case indicates that some government members neither possessed a full understanding of the office of coroner nor the coronial law. Even though unqualified medical persons were often consulted by residents of outback settlements, the identified breach of the law by Godfrey was overlooked by the government’s legal representatives.

Of vital importance at this time was the need to amalgamate and simplify the numerous statutes and part-statutes from both English and New South Wales coronial law which still applied to inquests. The Inquests of Death Act 1866 did not meet this demand. In the end justice was compromised by issues of ignorance of the law, acceptance of breaches of the law, along with the government’s reluctance to meet the cost of providing professional services to remote areas.

The maternal death of Emmeline Trueman

Emmeline Trueman suffered a protracted labour, the stillbirth of her child and finally death. A male midwife attended her during this time, a week in total. An inquest was held into Emmeline’s death but arguably the findings were far from satisfactory. Evidence indicating that the midwife failed to act in the best interests of the patient was dismissed by the Attorney-General. It is suggested that the inquest findings were associated with the protection of the local elite.
The member for Burnett, Francis Ivory, in July 1875, accused the Attorney-General, Samuel Griffith, of failure to prosecute an attending midwife for negligence in the death of an unborn child and its mother. When twenty year old Emmeline Trueman, pregnant with her first child, began experiencing labour pains on 9 November 1874, William Gill Bailey, an experienced midwife, was called in to attend Trueman. At Trueman’s inquest Bailey, whose father was a medical practitioner, stated his occupation as planter. At this time, he was also a member of the Queensland Legislative Assembly representing the district of Wide Bay. Despite the evidence taken at Trueman’s inquest indicating that Bailey failed in his duty of care to his patient, no further action was taken.

Maria Ridgway, a mother of seven, was also called in by the family to assist and comfort Emmeline Trueman. Although not a trained midwife, Maria had attended many women in the district during the birth of their babies. Trueman’s labour seemed to progress satisfactorily until 12 November when the contractions increased and Ridgway expressed the opinion that the baby was ready to be delivered, but might need some assistance. Bailey refrained from taking any action, as he considered assisting the birth process could injure the mother. All present noticed a slight disagreeable smell accompanying a slight discharge at the time. Bailey administered ‘small doses of tincture of opium’ for the pain.

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147 William Gill Bailey was elected 12 November 1873 and served until his retirement 17 May 1888. He acted as Government Whip in the last Samuel Griffith administration. (The Queenslander, 27 April 1889, p. 784); in 1877 he was appointed to a committee to enquire into the management of the Woogaroo Lunatic Asylum and other ‘lunatic reception houses in the colony’ and to report on the best means to improve conditions at these institutions (The Queenslander, 20 January 1877, p. 8); in 1879 he was registered as a chemist and druggist at Maryborough (The Brisbane Courier 7 July 1879, p. 3).
Mrs Trueman was left to suffer the painful labour until 14 November, despite Ridgway’s warning that both mother and baby could die if left any longer.

On the afternoon of 14 November, the pains ceased and Bailey gave Trueman ‘two doses of ergot, which were without effect’. The pains did not return. Bailey sent a message to Doctor Little in Maryborough, 26 kilometers away, at 3 am Sunday morning. Bailey asked Little to come to Tiaro to treat Mrs Trueman, but stated if Little was unable to attend, would he send short forceps and catheter. Little sent the instruments to Bailey. When Bailey applied the forceps to move the head down through the pelvis, ‘rather more than a pint of foetid [sic] liquid’ flowed out. This ominous sign caused Bailey to inform the family that he thought ‘collapse would set in after delivery’. On the direction of the relatives, he sent for Dr Little at 7 pm on Sunday evening. Little arrived at approximately 6 am Monday morning and proceeded to deliver the baby. Little stated at the inquest:

I found the head low down in the pelvis; that the bones of the child’s head had given way and were jammed together; the child was dead, and there was a very disagreeable foetid [sic] discharge; … after some time I succeeded in delivering the head, and then had great difficulty with the child’s body, as it was very much swollen; about five or ten minutes after delivery, Mrs. Trueman sank and died; … if the second stage had commenced, as stated by Mrs. Ridgway, on Thursday, I am of opinion that was the proper time to deliver her; and that if she had been delivered on that day I see no reason why her life should not have been saved.  

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148 Ergot is used to induce uterine contractions and to control bleeding after childbirth.
149 Queensland Legislative Council Journal 1875, Vol. 1, p. 578. Dr Little wrote to the Attorney-General to justify his claim for expenses to appear at the inquest. Little claimed that appearing at the enquiry was ‘to the very serious injury of my private practice’ (QSA Series ID: 13337, Item ID: 19612, Inwards Correspondence – Crown Law Office, letter from Joseph Little to Attorney-General, 11 May 1875).
Although Bailey may have been acting with good intention, Dr Little believed Mrs Trueman should have been delivered earlier by a medically qualified practitioner. A post-mortem was not carried out on the body of Emmeline Trueman, consequently the opportunity to gain valuable information that could help explain the reasons for the deaths of the mother and her baby was lost. When Mr Trueman asked for a death certificate for his wife, Dr Little advised that Bailey, who was in attendance, should issue the death certificate. Dr Little deposed at the inquest that he later discovered that Bailey was not a qualified doctor, and had been mistaken in thinking Bailey could issue the death certificate.

After reading the depositions taken at the inquest into the death of Mrs Trueman and her unborn baby, Attorney-General Griffith noted: ‘It does not appear that there was any criminal negligence on the part of any one.’ Raising the matter in parliament Ivory, moved that the papers relating to the death of Mrs Trueman be printed as he believed the Attorney-General should have prosecuted William Bailey. In the view of strong criticism of the Attorney-General in the public sphere, Ivory suggested the circumstances of the case presented a strong argument for ‘separating the functions of a political Attorney-General from the office of Prosecutor-General’.

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150 Surgeon to the police at Maryborough, Dr. John Power, also gave evidence at the inquest and fully supported Dr Little’s assessment of the circumstances of the case.
154 QPD (1875), 38 & 39 Vic., Vol. 18, p. 907. It is thought that Lyons was referring to the Crown Solicitor when using the term Prosecutor-General.
depositions. Police Magistrate George Faircloth called the Attorney-General’s attention to the reluctance of Drs Little and Power to give evidence at the inquest, describing their statements as ‘very careful and cautious’. Faircloth closed his correspondence, saying ‘I shall be glad to receive any instructions which you may be pleased to favor me with, as I am careful not to take further proceedings without it’. In his reply to Ivory, Griffith argued that ‘it was not the duty of the Attorney-General to act ex officio … his duty was to stand between the magistrate and the jury, to protect a man against being lightly sent for trial before a jury’.

Faircloth found Emmeline Trueman died of exhaustion from a prolonged labour. It appears from the evidence given at the inquest that William Bailey may have been neglectful in his treatment of Trueman, however Faircloth refrained from finding that William Bailey may have contributed to the death of Emmeline Trueman. The opportunity to commit Bailey to trial in order to defend his actions was passed over by Faircloth. Instead he chose to pass the matter over to the Attorney-General. Samuel Griffith defended his evaluation of the circumstances attached to Trueman’s death, including his resolution that no party was guilty of ‘criminal negligence’. In a case where a young woman suffered such horrendous treatment, no one wanted to attribute blame to William Bailey; not the Police Magistrate, not the doctors nor the Attorney-General. Why was this man not brought to account for the delay in treating Emmeline Trueman? Her life, if not the baby’s, might have been saved with earlier intervention. It appears that it

156 Griffith, S., QPD (1875), 38 & 39 Vic., p. 907.
was Bailey’s “position” in society and his political connections that prevented him from facing trial for contributing to the death of Emmeline Trueman.

**Alice Mutlop: death of a domestic servant**

Alice Mutlop was a young South Sea Island girl who on Christmas Eve 1899 died from venereal disease at her parents’ residence at Salt Water Creek near Mossman, North Queensland. The inquest held into Mutlop’s death left many questions unanswered. Was she the victim of sexual abuse? Was her illness detected while at her place of employment? If so, did she receive medical treatment as stipulated by law? Why was no doctor summoned to examine the body before burial? Why was a death certificate issued contrary to coronial law?

The day after Mutlop’s death the Anglican priest at Port Douglas, Benjamin Bryant, performed a burial service for Alice. When told that a doctor had not seen the body, Bryant advised Mutlop’s stepfather that ‘he ought to have a medical certificate’. A local constable confirmed he had seen the body and had obtained a justice’s order for burial. The priest performed the burial and later informed Doctor Robin that he had buried Alice Mutlop without a medical certificate. Giving evidence at the inquest, Bryant claimed he had ‘no reason whatever to believe that the deceased Alice met her death otherwise than natural causes’. A death certificate was later issued stating cause of death as venereal disease.

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157 Mossman is 70 kilometers north-west of Cairns and approximately 1800 kilometers from Brisbane.
Local justice of the peace, Richard Owen Jones, held an inquest into Alice Mutlop’s death at Mossman on 27 February 1900. At the inquest Mutlop’s mother stated:

I remember the 24th December last. My daughter Alice died on that day. She was sick seven weeks. I think she died because she got baby inside. The baby was not born before she died. Two days before she died she told me William Rutherford and James Reynolds that the baby was belong to them. I do not know if any medicine has been given to my daughter by anybody. Alice my daughter lived at Rutherford’s dairy and worked there for six months. Three weeks before she died she came home and lived with me during which time I saw her every day. She was sick all the time she was with me.

Her stepfather, Cispah, testified that Alice had told him she was pregnant and that she named William, Sidney and Archibald Rutherford, as well as James Reynolds as responsible for her condition. Cispah stated:

I said why you did not tell me before. She said I am too frightened of you and mother. She told me this one half hour before she died. Two weeks before she died she swelled all over commencing at her feet. Two days before she died flesh dropped from the knees down leaving the bone exposed.

Of the four men named as having engaged in sexual relations with Alice, only William Rutherford was called to give evidence at the inquest. He merely acknowledged that he knew the deceased but had no knowledge of what caused her death.

159 QSA Series ID: 36, Item ID: 348882, Inquest File.
160 QSA Series ID: 36, Item ID: 348882, Inquest File.
161 QSA Series ID: 36, Item ID: 348882, Inquest File.
The justice, Richard Jones, delivered a finding of venereal disease as cause of death, even though no doctor treated Alice before her death or examined her body after death. The issuing of a death certificate following her death was illegal as no doctor had examined Alice’s body before burial. As discussed earlier in this chapter, it was common practice for plantation owners to neglect sick workers, in spite of the *The Pacific Island Labourers Act of 1880* stating that employers must obtain proper medical attention for plantation workers. Jones did not determine if Alice was ill while working at the Rutherford plantation and if so, whether Alice received medical treatment in accordance with the law. Mutlop identified four men whom she believed could have been the father of her unborn child, yet only one was questioned about his relationship with the deceased. If all four men named were sexually involved with Alice, it remained unclear whether Alice was a consenting participant.

Jones, who conducted the inquiry, was a rice and sugarcane farmer and saw-miller at Mossman.\(^{162}\) The Rutherford family owned a sugarcane farm and James Reynolds’ father was a member of the Douglas Divisional Board, farmed cattle and grew maize, fruit and sugarcane. All were reputable and influential local identities. Perhaps Jones’ failure to thoroughly investigate the death of Alice Mutlop was attributable to an ignorance of coronial law. On the other hand, was he protecting his wealthy and powerful peers from

unwanted scrutiny? Ultimately, he did not adequately fulfil the purpose of the inquest, which was to identify the deceased, establish the cause and manner of death and ascertain if any person contributed to the death. The inquest file was sent to the Justice Department and routinely filed away.

**Inquest findings**

The calculation of the State’s vital statistics was a key function of the Register-General’s Department. The state was divided into registry districts, which accommodated a Registry Office staffed by the District Registrar. The District Registrar was responsible for the registration of records in his district and the transmission of all records to the Central Registry, which was located in the Register-General’s Department. The Register-General’s role was to preserve the registration records and compile and publish the annual statistics for the colony of Queensland. According to the Queensland State Archives, ‘since 1860 the chief responsibility of the office has been the registration of births, deaths and marriages’.  

The statistics related to registration of births, deaths and marriages, along with immigration numbers, provided valuable data for a young colony dependent on an increase in population for future economic growth. District Registrars experienced difficulty in acquiring information from pastoral stations and mining districts as much of the population was itinerant and communication with residents was sporadic. The

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163 QSA Agency ID: 630, Registry of Births, Deaths, and Marriages.
Register-General conceded that some births and deaths were never recorded. Improving the accuracy of Queensland death statistics was a concern of the Register-General. Prior to 1887, Queensland referred to the Nosological Index, or Classification and Tabulation of the Various Causes of Death, compiled by the Register-General’s Department of Victoria. In many cases in Queensland, inquest findings were not in accordance with this guide. Furthermore, it appears that the Queensland Register-General was not always consistent in the scrutiny of and acceptance of Death Certificates and Certificates of Particulars.

A magisterial inquiry held in Maryborough by a police magistrate in 1876, recorded the cause of death of a young woman as ‘Found Burnt’. The Maryborough Chronicle expressed dissatisfaction with the finding and called for an internal post-mortem to be conducted on the body. According to the article, from the description of the body and other evidence given at the inquest, foul play could not be ruled out. The inquest file contained a newspaper clipping with a notation in the margin (dated 21 June 1876), requiring an opinion from the attending doctor as to whether there were any suspicious circumstances attached to the case. However, no further action was taken and the Certificate of Particulars continued to show cause of death as ‘Found Burnt’. The inquiry did nothing to alleviate the public concern raised over the circumstances of the girl’s

165 Nosological Index, or Guide to the Classification and Tabulation of the Various Causes of Death; Compiled Principally for the use of the Register-General’s Department; with Instructions to Deputy Registrars, by the Register-General of Victoria, (1863), Melbourne: Government Printer.
166 QSA Series ID: 36, Item ID: 348648, Inquest File.
167 Maryborough Chronicle 10 June 1876.
death. Moreover, the deficient Certificate of Particulars was accepted by the Register-General without further comment.

Conversely, the finding in another inquiry held in 1876 did not escape the scrutiny of the Register-General. Dissatisfied with the Certificate of Death given by the doctor attending the deceased, the Register-General requested that a post-mortem be carried out on the body of a woman who died from ‘strangulation of the small intestine’. Dr O’Doherty was engaged to undertake a second examination of the body, and concurred with the previous doctor’s finding as to cause of death. The Register-General accepted the finding and the inquest was then closed.\textsuperscript{168} The previous examples illustrate the inconsistency of the Register-General’s evaluation of Death Certificates and Certificates of Particulars provided by coroners. An insufficient finding of cause of death, that attracted complaint from the public, was accepted without question. Meanwhile, a more clinical finding of cause of death, established via an internal post-mortem, prompted the Register-General to request a second post-mortem examination.

In 1887, the Queensland Registrar General’s Department published its own Nosological Index as a guide for death classification. The introduction states that ‘[t]he accompanying Index has been compiled with the object of promoting scientific accuracy in the causes of death in this colony’. Also included in the introduction were examples that illustrated the ‘manner in which certain causes of death, now often too vaguely expressed, should be

\textsuperscript{168} QSA Series ID: 36, Item ID: 348648, Inquest File.
recorded’. In the case of heart disease, it was desirable to ascertain the nature of the disease and its cause. Consequently, instead of merely recording disease of the heart as cause of death, the more specific details such as ‘Angina Pectoris’ or ‘Hypertrophy of the Heart’ were sought.\textsuperscript{169} According to the index:

> before registering deaths from violent causes, the inquiry should always be made whether they were accidental, suicidal, homicidal, and as much information as possible respecting them obtained. The nature of the injury and under what circumstances it occurred … should also be distinctly stated.\textsuperscript{170}

Despite the publication of this guide, numerous inquest findings of cause of death still failed to conform to the instructions published in the Index. In the case of the death of a young woman in 1890, the inquest hearing found that her death occurred from a heart condition which was ‘accelerated by sexual excitement’ after having connection with a man she vaguely knew. Once again the recorded cause of death did not comply with the directions of the Nosological Index, yet did not attract adverse comment from the Register-General.\textsuperscript{171} Unspecific findings as to cause of death, such as “natural causes”\textsuperscript{172} and “intemperance”\textsuperscript{173} continued to be recorded well into the twentieth century.

On 13 January 1930, an inquest was begun at Innisfail District Hospital Morgue in view of the body. The father of the deceased identified his son and stated that he had been in good health when he had last seen him. The inquest was adjourned and resumed at the

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\item \textsuperscript{169} Nosological Index, or Guide to the Classification and Tabulation of the Various Causes of Death, Compiled in, and for the use of, the Register-General’s Department of Queensland, (1887), Brisbane: Government Printer, pp. 4, 8.
\item \textsuperscript{170} Nosological Index, p. 5.
\item \textsuperscript{171} QSA Series ID: 36, Item ID: 348779, Inquest File.
\item \textsuperscript{172} QSA Series ID: 36, Item ID: 348789, Inquest File; QSA Series ID: 36, Item ID: 348790, Inquest File.
\item \textsuperscript{173} QSA Series ID: 36, Item ID: 348796, Inquest File; QSA Series ID: 36, Item ID: 348901, Inquest File.
\end{itemize}
Innisfail Court House on 20 January 1930. Albert Shersby, the Sergeant of Police at Innisfail, conducted the inquiry. He tendered the post-mortem certificate that stated drowning as the cause of death and gave evidence to the fact that no suspicious circumstances were linked to the death. The inquest was closed and the documents sent to the Crown Law Office. The following notation from the Crown Solicitor appears on the file:

This inquest is very unsatisfactory. The proceedings were held over the corpse which was identified, and a certificate showing cause of death produced. In what manner and under what circumstances deceased met his death is not shown.\(^{174}\)

The file was forwarded to the Justice Department and stamped ‘No further action’. By 1930 more than six decades had passed since the introduction of *The Inquests of Death Act of 1866*, yet as the evidence shows, it remained common for coronial inquests to be conducted in a manner that failed to fully comply with the legislative requirements of coronial law. Provision through *The Inquests of Death Act of 1866* for justices and magistrates to hold inquiries into deaths without a jury may have facilitated a more rapid and less expensive inquest system, particularly in isolated regions, but the Act was unsuccessful at improving the justice system in relation to the institution of the inquest.

**Conclusion**

The Queensland colony was expanding rapidly as new settlers arrived from New South Wales and ventured to the far north and west of Brisbane. As settled regions stretched

\(^{174}\) QSA Series ID: 36, Item ID: 349498, Inquest File.
further into the vast territory, more public servants were needed to fill administrative positions. Following the financial crisis in 1866, the Queensland government developed a stringent policy of cost cutting that adversely affected the office of coroner. In a move to save money, the government officially transferred the coroner’s duties to other public servants. Following the introduction of *The Inquests of Death Act of 1866*, the salaried position of coroner was abolished and the duties of the coroner were performed by police magistrates and justices of the peace. The term coroner continued to be applied to those holding inquests, however the formal role no longer existed. Magistrates and medical professions constantly protested over the inadequacy of the fees paid for their services related to inquest hearings. The 1890 depression led to another move by the government to reduce spending. Through enacting *The Inquests of Death Act Amendment Act of 1893*, the government was able to save money by eliminating fees for justices of the peace holding inquests and witnesses summoned to give evidence at inquests. Queensland government parsimony severely impaired the late nineteenth century coronial system.

An increasing population that was scattered over a vast untamed frontier created administrative difficulties for the Queensland government. Ministers faced obstacles in ensuring public officers were kept informed of and followed government directives. Police magistrates sent to areas on the outskirts of civilisation often suffered from a deficiency of stationery and official forms. More importantly, magistrates holding inquests did not have access to well-drafted acts or well-organised compendiums of legislation related to the function of the coroner. Many magistrates and justices in isolated towns were inclined to conduct inquests in a haphazard manner that was not in
accordance with the function of the office of coroner. The Crown Law Office regularly returned paperwork to magistrates to correct irregularities. Often the inquest finding failed to comply with the official index of classification of cause of death, which in turn had a detrimental effect on the reliability of the colony’s vital statistics. When breaches of the law were revealed during inquest hearings they tended to go unpunished. The case studies discussed in this chapter disclosed transgressions committed by police, coroners and the government in relation to the function of the coroner. Yet the Attorney-General took no action. The government’s continued acceptance of the imperfections in the coronial system compromised the legitimacy of the office of coroner.

The introduction of *The Inquests of Death Act of 1866* failed to improve the institution of the inquest because it neglected to consolidate and simplify the numerous statutes applicable to coronial inquests. Furthermore, it bestowed inexperienced police magistrates and justices of the peace with the power to act as coroners. It was not until the controversial death of Dulcie Barclay (discussed in the following chapter) that the importance of reforming the current coronial law became obvious. The introduction of the *Coroners Act of 1930* was a major amendment to the law which updated and consolidated coronial legislation with respect to inquests into deaths and fires.
Chapter Four

A young girl’s suicide changes the law

The suicide of Dulcie Barclay

The suicide of Dulcie Barclay in the chambers of a prominent young barrister on 30 August 1929, set in motion a chain of events that instigated the first reform of Queensland coronial legislation for sixty-four years. The circumstances connected with this death investigation drew attention to the inadequacy, ambiguity and misinterpretation of the fragmented coronial legislation which the legislature had failed to consolidate. These events compelled the Queensland government to introduce new coronial legislation to replace the long standing *Inquests of Death Act of 1866*. The consideration of this case in detail is significant for the role it played in prompting a changed to public policy and legislation.

Crowned Miss Queensland in 1926, Dulcie Barclay, 21, was found seriously ill in the office of Brisbane barrister Robert O’Connor, 29, with whom she had been living intermittently over the previous few months. Dulcie was transported by ambulance to the Brisbane Hospital but was pronounced dead on arrival. A post-mortem concluded she died from strychnine poisoning. Dulcie was buried at Toowong Cemetery on 2 September 1929. Police investigated her death, forwarding the report to the Department

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1 Apart from the inquest record itself, the analysis of this case has been based on reports published in the *Brisbane Courier* and *Truth* newspapers and it is acknowledged that errors in reporting and displays of bias must be taken into account when relying on these sources.

2 *The Inquests of Death Act of 1866*, 30 Victoria, No. 3.

3 QSA Series ID: 36, Item ID: 349494, Inquest File.
of Justice. Members of the general public along with the media awaited the announcement of a date of an inquiry into her death.\textsuperscript{4} The \textit{Brisbane Courier} published a brief article concerning Dulcie’s death the day after her suicide. The report stated that upon arriving at the barrister’s office at the Inns of Court, a policeman found the young woman seriously ill and called an ambulance. On searching the office he found a bottle that appeared to contain strychnine and an envelope containing letters written by the girl concerning her relationship with the barrister. According to the press report the police removed both items under the ‘strictest secrecy’ and made little information available. The barrister was reported to be away from his office at the time of the incident.\textsuperscript{5}

A far more detailed and emotive article was published in \textit{Truth} on Sunday 1 September 1929. The paper claimed a letter left by Barclay in the barrister’s office declared her love for him as well as reflecting her distress over his waning affections and the belief that he was involved with another woman.\textsuperscript{6} Three weeks before her death Dulcie had approached the \textit{Truth} and volunteered a statement concerning her relationship with O’Connor. A sworn affidavit was taken by Edgar Allan Ferguson, \textit{Truth} reporter and justice of the peace, signed by both parties and placed on file. The article, published two days after her death, recounted the ‘story of unrequited love told from the grave’.\textsuperscript{7}

\textsuperscript{4} \textit{Brisbane Courier} 1929, 17 October, p. 17; \textit{The Truth} 1929, 20 October, p. 17.
\textsuperscript{5} \textit{Brisbane Courier} 1929, 31 August, p. 17.
\textsuperscript{6} \textit{Truth} does not reveal the source of this information. The letter was in the possession of the police from the time of Barclay’s death.
\textsuperscript{7} \textit{Truth} 1929, 1 September, p. 15.
Dulcie, at the time of making her statement, was living with her widowed mother in Brisbane. In 1926, she went to Sydney for the judging of the ‘Miss Australia’ competition, after she was crowned ‘Miss Queensland’. Then she joined Fullers Musical Burlesque Theatre in Sydney, before touring North Queensland as ‘Miss Queensland’. By 1929 Barclay was living with her mother in Grey Street, South Brisbane. Apparently Dulcie first met Robert O’Connor at the Hotel Daniell8 in January 1929. A week later, following a late night outing with O’Connor to ‘The Corner House’9 at Wynnum, Dulcie was evicted from her mother’s home. The couple, at O’Connor’s suggestion, then took a place together at Milton. Although rocky, the relationship lasted until June 1929 when O’Connor left Dulcie.10

Following an interview with Dulcie’s mother, the *Truth* maintained a statement made by Mrs Barclay pointed ‘to circumstances that cry aloud … for official investigation’ and in urging for an inquiry asked ‘what caused the pretty girl to take a death-draught with such suddenness’?11 According to the paper, the number of puzzling and complicated matters attached to Dulcie’s death demonstrated the need for a public investigation. The paper highlighted the urgency for reform of the present system of death investigation and inquiries, declaring the necessity for the appointment of a coroner in all districts to

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8 The Hotel Daniell was situated close to the law courts and was frequented regularly by legal professionals.
9 ‘The Corner House’ was a restaurant but also included private function rooms. It was rumoured to operate as a brothel. Mr. Dunlop, member from Rockhampton asked the Home Secretary during question time in the Legislative Assembly ‘In view of the apparent unfavourable rumours that exist regarding a certain place called “The Corner House” on the way to Wynnum, will he make full investigation to see if this is so, and if correct will he take immediate steps to bring them within the law in the interests of those living in that important community?’ (QPD 1929, p. 1428).
10 QSA Series ID: 36, Item ID: 349494, Inquest File.
11 *Truth* 1929, 8 September, p. 15.
replace the present circumstances of police magistrates and justices of the peace holding inquiries. In addition, the paper called for an inquiry into every case of death by violence in order to satisfy a public expectation that “secret homicides” would be detected.\textsuperscript{12}

\textit{The Inquests of Death Act of 1866} did not meet the expectation that suspicious deaths would be thoroughly investigated. The Act had empowered police magistrates and justices of the peace to act as coroners, and as a cost-cutting measure the paid position of coroner was revoked. Magistrates in remote areas were required to perform many duties and taking on the role of coroner added to their workload. They had no training in coronial law or how to conduct an inquest. In most cases they carried out inquests to the extent of their knowledge. In addition, holding inquests was a time consuming exercise that took magistrates away from their other duties. Due to the demand on their time and isolated environment, magistrates sometimes failed to conduct comprehensive inquests. As we have seen, over time the coronial system proved quite inadequate and defective. The Dulcie Barclay case arose due to confusion over whether an inquest was required under the provisions of current coronial law. Neither \textit{The Inquests of Death Act of 1866} nor the New South Wales \textit{Coroners Act 1898}\textsuperscript{13} set out under what circumstances a coroner should hold an inquest. Consequently, England’s \textit{Coroners Act 1887} determined when inquests should be conducted. Provision three stated:

\begin{quote}
Where the coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or has died
\end{quote}

\textsuperscript{12} \textit{Truth} 1929, 8 September, p. 15.
\textsuperscript{13} The \textit{Coroners Act 1898}, 62 Vic. No. 8.
a sudden death of which the cause is unknown, or that such person has
died in prison, or in such place and under such circumstances as to
require an inquest in pursuance of any Act, the coroner, whether the
cause of death arose within his jurisdiction or not, shall, as soon as
practicable, issue a warrant for summoning not less than twelve nor
more than twenty-three good and lawful men to appear before him at a
specified time and place, there to inquire as jurors touching the death
of such person as aforesaid.\(^{14}\)

The Inquests of Death Act of 1866 negated the need to assemble a jury but according to
the above provision, an inquest should have been carried out because Dulcie’s death was
both violent and unnatural.

A week after Dulcie’s death, the Home Secretary JC Petersen announced that the
government intended to hold an inquiry. The *Brisbane Courier* claimed Petersen was
acting on a recommendation from the Police Commissioner to proceed with an inquiry.\(^{15}\)

On 15 September 1929 *Truth* reported that the police investigation was completed and
the report was in the hands of the Justice Department. The announcement of an inquiry
date was anticipated by the end of the week.\(^{16}\) Subsequently, on 29 September the Home
Secretary unexpectedly issued a press statement informing the public of his decision,
made after consultation with the Attorney-General, Cabinet and Commissioner of Police,
not to hold a magisterial inquiry as it was ‘neither advisable or [sic] desirable’. Petersen
also declared that magisterial inquiries were ‘only held to ascertain the cause of death and
to prosecute anyone responsible for such death’. Furthermore, he declared that as the

\(^{14}\) *The Coroners Act 1887*, 50 & 51 Vic., Part 1, provision 3(1),

\(^{15}\) *Brisbane Courier* 1929, 16 October, p. 19.

\(^{16}\) *Truth* 1929, 15 September.
evidence clearly proved Barclay’s death was a case of suicide, ‘under no circumstances could anybody be put on trial’. Why did the government change its mind and decide not to hold an inquiry into Dulcie’s suicide? Conducting an inquest would have assisted in answering some of the questions asked by the press and public organisations about her death.

The *Truth* vehemently rejected the government’s decision not to hold an inquiry, declaring the public was entitled to know the full facts of the case; facts believed to be contained in the extensive file of evidence gathered by the police. The Home Secretary was taken to task over his statement that as it was clear Dulcie had caused her own death, no person could be put on trial and therefore an inquiry was unnecessary. The *Truth* proceeded to relate the circumstances of two other coronial inquiries presently before the courts in which murder-suicide was implicated as the cause of death and asked why, in these two cases, when there was no possibility of charges being laid, it was still considered appropriate to hold inquiries into the cause of death. Similar concerns to those expressed by the *Truth* were also echoed by some members of Parliament.

The independent member for Rockhampton, Thomas Dunlop, asked the Home Secretary on 4 October 1929 why, when initially emphatic about holding an inquiry, he suddenly diverted from following the natural channels of justice, especially given the serious statements reported about the case in the *Truth*. More importantly, Dunlop asked the

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17 *Truth* 1929, 29 September, p. 1
18 *Truth* 1929, 29 September, p. 1.
Home Secretary to state why the Dulcie Barclay case should be hushed up, and to concede that his judgment was flawed and to now call for an immediate magisterial inquiry in the interests of the Queensland public. The Home Secretary informed the House that the reasons for Cabinet’s decision had already been published and the papers were available for any member to peruse.¹⁹ To date these papers have not been located at the state archives.

On 16 October the *Brisbane Courier* revealed the Home Secretary had been presented with a written request from two newspaper reporters for an inquiry to be held into the death of Dulcie Barclay, thus leaving the government no choice but to obey the law and call an inquest. Deputations from the National Council of Women and Reverends Norman Millar, Percival Watson and W. E. Hurst had called on the Home Secretary to ask for an inquest in the interests of the ‘wellbeing of the community and the safeguarding of the girlhood of the State’. The clergy had called for the banning of beauty competitions, more stringent regulations controlling the sale of poisons and reform of *The Inquests of Death Act of 1866*.²⁰ It was not until two persons in writing requested an inquiry be held, in accordance with Provision 2 of *The Inquests of Death Act of 1866*, that an inquest proceeded.²¹ Aspects of the case suggested the government was determined to ignore the overwhelming pressure from the community to call an inquiry into Dulcie’s suicide. Had it not involved a high profile member of the legal profession, the inquest would have been conducted in the same manner as past suicide inquiries and the file

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¹⁹ *QPD*, 20 George V, Vol. 153, 4 October 1929, p. 153. To date these papers have not been located.
²⁰ *Brisbane Courier*, 17 October 1929, p. 17.
²¹ QGG (1866), No. 81, 28 July.
would have joined the records of thousands of other inquests into suicides held at the Queensland State Archives.\textsuperscript{22}

Justice of the peace, Arthur Staines,\textsuperscript{23} commenced an inquiry into Barclay’s death on 17 October 1929 in response to a request in writing from two people, one of whom was Edgar Allan Ferguson, the \textit{Truth} journalist who had taken Dulcie’s statement on 8 August 1929. When the inquiry opened, Alan Mansfield\textsuperscript{24} (appearing for Robert O’Connor) objected to the holding of the inquiry as the request was not ‘bona fide’. According to Mansfield, the two persons who signed the request did so for ‘some ulterior purpose’ which, he claimed, constituted an ‘abuse of the sittings of the court’. Furthermore Mansfield requested the names, occupations and employer names of the two persons who signed the request. Staines overruled Mansfield on both points.\textsuperscript{25}

\textsuperscript{22} Queensland State Archives Series ID 236, Register of Coroners’ Inquests; Weaver, \textit{A Sadly Troubled History: The Meanings of Suicide in the Modern Age}, Weaver, J. & Wright, D. (eds) (2008), Histories of Suicide: International Perspectives on self-destruction in the Modern World, Toronto:University of Toronto Press.

\textsuperscript{23} Arthur Staines ‘joined the Public Service in Mackay in October 1894. He was transferred later to the old metropolitan Police Court in Brisbane from which he graduated to various Petty Sessions offices in the State. In 1925 he became magisterial inquiries officer in the Justice Department’. The \textit{Courier Mail}, 23 April 1941, p. 8.

\textsuperscript{24} Alan James Mansfield (1902 - 1980) was admitted to the Queensland Bar 22 July 1924 and was a struggling lawyer surviving on divorce cases at the time of this inquiry. In 1931 he secured a verdict in the favour of the defendants in a high profile case which led to a rise in prominence and a successful practice. In 1940, aged 37, he was admitted to the Supreme Court bench and in 1966 became Governor of Queensland and Chancellor of the University of Queensland (1966-76). Greenwood, J. ‘Mansfield, Sir Alan James (1902-1980)’, \textit{Australian Dictionary of Biography}, National Centre of Biography, Australian National University, \url{http://adb.anu.edu.au/biography/mansfield-sir-alan-james-11053/text19669}, accessed 26 March 2012.

\textsuperscript{25} QSA Series ID: 36, Item ID: 349494, Inquest File.
Edgar Allan Ferguson was then sworn in and began giving evidence as to the circumstances that led to the taking of Dulcie’s statement. Mansfield objected to the sworn affidavit taken by Ferguson being produced in court, on the grounds that it was irrelevant and outside the matter of the inquiry. He claimed that the inquiry was only obliged to inquire into the cause of death and not to investigate what occurred before the death. Inspector Meldon, assistant to the coroner, indicated that the document was admissible and asked for it to be tendered as evidence. Staines overruled Mansfield’s objection and the document was tendered, admitted and marked Exhibit 1. Mansfield then asked that publication of the document be prohibited but the bench overruled his request. At this stage Mansfield asked for an adjournment of the inquiry until Monday 21 October in order for an application to be made to the Supreme Court for an Order Nisi (a preliminary order to halt proceedings pending a final order of prohibition) on the ground of ‘excess of jurisdiction of the Bench in this Case’. The inquiry was adjourned until the following Monday 21 October and a prohibition was ordered on publication of the contents of Barclay’s affidavit until after the Supreme Court hearing.26 By now, Truth had already published various details of Dulcie’s statement on 1 September 1929.

Mansfield made application for an Order Nisi to Justice Macrossan. When informed that Staines had obtained authority to inquire into the cause of Dulcie’s death under Provision 1 of The Inquests of Death Act 1866, Macrossan affirmed the right of a justice of the peace to conduct an inquiry in place of a coroner. Nevertheless he ruled that ‘since the official position of coroner did not exist in Queensland’, a justice of the peace could not

26 QSA Series ID: 36, Item ID: 349494, Inquest File.
act in his place. This ruling was based on the 1908 case Regina v Thomas Smith, in which Justice Chubb stated ‘[i]n 1863 we know that inquests of death were held by a coroner with a coroner’s jury’, thus implying that in 1863 only a coroner could inquire into the cause of death of a deceased. During the course of the hearing, Justice Chubb also claimed the laws relating to inquests into deaths were baffling, declaring his knowledge in this area less than perfect.\textsuperscript{27} With reference to the Thomas Smith case Edwyn Lilley, Queens Counsel, disputed Chubb’s ruling. In 1908 he wrote:

\begin{quote}
[i]t is quite clear he was not correct, and that he overlooked or was not aware of the practice of holding them [inquests] before a Police Magistrate or Justice of the Peace … [I]t is evident that since the passing of the Act in 1863, the practice which obtained when Queensland was part of New South Wales, with respect to inquiries as to deaths, has been followed by the Magistracy of Queensland, and correctly so too … in view of the fact that the authority for holding these inquiries is so veiled in obscurity and difficult to discover, it was not possible for the Court to be properly informed of the state of the law.\textsuperscript{28}
\end{quote}

Lilley recommended amendment of the legislation by the Department of Justice. However, this recommendation was not heeded until 1930 when parliament passed The Coroners Act of 1930.\textsuperscript{29} It was obvious that the State’s highest judicial representatives found the law relating to the office of coroner complicated and ill-defined, yet less experienced police magistrates and justices of the peace were expected to carry out the duties of coroner.

\textsuperscript{27} State Law Reports Queensland (1908), 83.
\textsuperscript{28} QSA Series ID: 7131, Item ID: 269825, Book of Circulars 1889-1910.
\textsuperscript{29} The Coroners Act of 1930, 21 Geo. V, No. 17.
Macrossan also concluded that Provision 2 of the Act only provided for justices of the peace to inquire into the ‘supposed cause of death’, if requested by two people in writing. If, he said, Justice Staines proposed to hold an inquiry into the circumstances surrounding a death, he would exceed the jurisdiction of the Act. After assurance by Mansfield that Barclay’s death was undoubtedly due to self-administration of strychnine poison, the judge made an Order Nisi for prohibition directed to Arthur Staines. Macrossan called upon Staines to show cause why a writ of prohibition should not be directed to him and restrained him from proceeding further with an inquiry into the death of Dulcie Barclay.30 Justice Staines was a professional and experienced Justice of the Peace who had conducted many inquiries, including major cases such as the Walsh/Cummings murders in 1926.31 No evidence has been found to indicate that his authority and jurisdiction had ever been challenged prior to this case. Consequently, one must question the motive behind the legal proceedings resorted to by O’Connor to prevent Staines holding the inquest into Barclay’s death.

Justice Macrossan’s interpretation of The Inquests of Death Act of 1866 was flawed. Although no persons were appointed as coroners on the civil service list after the introduction of The Inquests of Death Act of 1866, it was clear the role of the coroner was not abolished under the provisions of the legislation. For example, the Statement of Expenditure in the Queensland Votes and Proceedings for the years 1896 and 1897 includes an allowance for coroners’ fees under the Department of Justice.32 Furthermore

30 Brisbane Courier 1929, 19 October, p. 18.
31 QSA Series ID: 36, Item ID: 349443, Inquest File. A police officer and his lover were found murdered in Brisbane on 23 December 1926.
the term “coroner” continued to be freely applied to the person conducting an inquest, an
acknowledgement of the continued existence of the office of coroner. Provision one of

*The Inquests of Death Act of 1866* read:

> Whenever a coroner is by law authorised or required by law to hold an
> inquest of death it shall be lawful for any justice of the peace or in the
> absence of a coroner or during a vacancy of that office to perform the
> duties and he shall have all the powers and authorities of a coroner for
> the purposes of any inquest to be taken or made by him.33

The intention of the clause was to facilitate the judicial process which was severely
hindered by issues of distance, remoteness and a shortage of funds. Attaching coronial
duties to those of police magistrates or justices saved both time and money. It would no
longer be necessary to wait for a full-time coroner to travel to the location where the
death occurred.

Reflecting on the Barclay case during a police lecture in 1938, Sub-Inspector Albert
Shersby explained that as a consequence of the Executive Council’s decision on 15
November 1865 not to renew the annual grant to the coroner,34 the duty was cast upon
justices, including the obligation to view the body. Shersby went on to state that despite
the introduction of *The Inquests of Death Act of 1866*, the office of coroner continued to
exist, adding that in Brisbane a view of the body had not been carried out prior to an
inquest for the past thirty years. Moreover, Shersby claimed as a consequence of the Full

33 QGG, No. 81, 28 July 1866.
34 QSA Series ID: 13338, Item ID: 19649, Inwards correspondence – Attorney-General’s Office, Minutes
of Proceedings of the Executive Council, 15 November 1865.
Court ruling in the Dulcie Barclay case relating to viewing the body, the *Coroners Act* 1930 was introduced.\(^{35}\)

The *Truth* reported on 20 October 1929 that the inquiry had begun ‘after having surmounted the hostility and opposition of the Premier, two Ministers individually and the whole Cabinet as a collective force’ only to be adjourned due to ‘objections raised on behalf of Mr Robert O’Connor’. According to the article an added sensation transpired when another Brisbane daily newspaper openly suggested that the efforts to hush up the inquiry might have been inspired by ‘the fear that highly placed citizens would be involved if full investigation was allowed’.\(^{36}\) In relation to *The Truth*’s claims a motion on behalf of Robert O’Connor was referred to the Full Court by Judge Macrossan for an order that Samuel McKenzie, editor of *The Truth* and John Stinson, printer and publisher of same, be committed to prison for printing and publishing in an edition of *The Truth* on 20 October 1929 several articles that were alleged to constitute a contempt of court. Macrossan found that the article was ‘calculated to interfere with the administration of justice’ and attacked ‘the character and motives of a litigant’ who was ‘prosecuting a

\(^{35}\) QSA Series ID: 16865, Item ID: 316239, Shersby, E.A. Sub-Inspector of Police, Lectures for the information of the Queensland Police Force, History of Coronial Inquiries, No. 42, 1 November 1938, p. 1. It appears that Albert Shersby himself struggled to comply with the regulations linked to holding coronial inquiries. He was criticised by the Crown Solicitor regarding the unsatisfactory way he conducted an inquest in January of 1930 at Innisfail. The identity of the deceased was not determined and ‘in what manner and under what circumstances deceased met his death’ was not recorded. QSA Series ID: 36, Item ID: 3494989, Inquest File.

\(^{36}\) *Truth* 1929, 20 October, p. 17.
legitimate claim for the protection of the Court’ and each respondent was fined £25 and ordered to meet costs.37

The Barclay inquest resumed on 21 October 1929 only to be adjourned sine die (without a day, indefinitely) by Arthur Staines pending a decision from the Full Court of the Supreme Court. Justice Macrossan had granted the Order Nisi for prohibition in this matter on 18 October 1929.38 The Supreme Court ruled the writ of prohibition against Staines absolute on 9 December 1929 ruling:

that it was immaterial whether he had received a written request to hold such inquest, since his jurisdiction arose independently of it under s. 1: that, notwithstanding the abolition of the coroner’s jury by s. 5, he had no jurisdiction to hold the inquiry except super visum corporis39: and that the applicant was entitled to prohibition.40

The affidavit tendered in evidence at the inquest was ruled inadmissible under Provision 8 of The Inquests of Death Act of 1866 which states that the evidence must be relevant to the cause of death, or the supposed cause of death. Dulcie’s affidavit, which disclosed her torrid relationship with O’Connor, was ruled extraneous to the case.41 The inquest into Dulcie Barclay’s death would not proceed. Police Commissioner Ryan waited for the decision of the Full Court before taking action. Instructions were issued on 14 January

38 QSA Series ID: 36, Item ID: 349494, Inquest File.
39 In view of the body.
1930 to all officers in charge of districts which read ‘it will be necessary for the Magistrate who is holding an Inquest of Death, in future to view the body the subject of such Inquest’.42

The full court decision prompted an attack on Queensland’s current coronial legislation by the Brisbane Courier. The newspaper argued that for the past sixty-three years all justices who conducted inquiries into death had acted illegally if they failed to first view the body. According to the paper, bodies were not usually viewed prior to inquiries conducted in Queensland. This was because most inquiries were held after burial of the body because the Queensland climate often necessitated a quick disposal due to health risks. The paper claimed The Inquests of Death Act of 1866 was loosely worded and hastily drafted, and failed to give clear directions to the justice that the body should be viewed prior to an inquiry. Attention was drawn to the fact that the Brisbane Courier had often labelled the Act as unsatisfactory and had repeatedly called for its amendment in the past. The newspaper considered it the duty of the government to promptly introduce new legislation, the framing of which should be clear and tightly worded, so that the provisions ‘will remove any suspicion that an inquiry may be blocked either by police or Ministerial influence’.43

42 QSA Series ID 15064: Item ID 87920, Circulars and Memoranda received from the Office of Commissioner of Police.
43 Brisbane Courier 1929, 10 December.
The shortcomings of *The Inquests of Death Act 1866* were similarly criticised by the *Truth*, which declared two courses of action were open to the government. These were to either amend the present Act to relieve the Inquiry Officer of the obligation of viewing the body, or ‘to adopt the sane and sensible coronial system operating in every other State in the Commonwealth, and in every British community with any pretensions [sic] to sanity and justice’.

Moreover, the *Truth* believed that the paper had become a target for abuse and vilification, much of which was alleged to have emanated from Parliament House. The same edition carried an article detailing a course of events that the *Truth* claimed was linked to a campaign waged by the government, through the police, to bring about a charge against reporter Edgar Ferguson.

The blocking of the inquiry due to the Full Court decision was not the end of the Dulcie Barclay saga. In the Supreme Court on 20 December 1929 before Justice Macrossan, Agnes Barclay, mother of Dulcie, made an injunction application through her legal representative, Mr Mansfield, to restrain Arthur Staines from proceeding with the exhumation of Dulcie’s body under Section 6 of *The Inquests of Death Act of 1866*. At the commencement of the court proceedings Mr F T Grove announced he was appearing for the ‘Magistrate’ and was swiftly reprimanded by Macrossan who informed Grove ‘he is not a Magistrate he is a Justice of the Peace’. Macrossan then went on to contradict his own direction by referring to Staines as a Magistrate throughout the remainder of the proceedings.

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44 This is a sweeping statement by *Truth* which neglected to specify any Commonwealth coronial legislation that would provide a blueprint for the reform of Queensland’s coronial law.

45 *Truth* 1929, 15 December.
Macrossan exemplified the common habit of interchanging the title of magistrate and justice of the peace when referring to officials holding inquests. It was also an example of Macrossan’s capricious rulings on matters linked to the office of coroner.

Mansfield informed the court that Inspector Meldon had in his possession a letter from Staines which stated ‘I am instructed that there should be an exhumation, and that the inquiry should continue de novo’. Justice Macrossan responded:

… I am instructed … Who by; who instructed him? … It only goes to show how little Mr. Staines knows about his powers and duties. I would like to know. I don’t suppose it matters much, from whom he got his instructions.

From a judicial point of view it was important that the origin of the instruction to Staines was determined. Provision 38 of the Cemetery Act 1865 required a directive from the Home Secretary to ‘remove any body or the remains of any body which may have been interred in any cemetery’. Consequently, it would appear that Justice Staines had sought an order from Home Secretary Petersen to exhume Dulcie’s body. However, the source of the order is not revealed in the archival records of the case. Macrossan continued:

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46 QSA Series ID 4508: Item 787426, Macrossan Court Transcripts.
47 QSA Series ID 4508: Item ID 787426, Macrossan Court Transcripts; The Brisbane Courier 1929, 21 December, p. 16; De novo: anew, beginning again.
48 QSA Series ID 4508, Item 787426, Macrossan Court Transcripts.
49 The Cemetery Act 1865, 29Vic. No. 15.
The most extraordinary feature about this alleged magisterial inquiry is that Mr. Staines thinks he is acting as a coroner under instructions from the Home Secretary or the Justice Department. He is not doing that at all. He is simply sitting there as a judicial officer, as a court of record, and it is time he knew that.\footnote{QSA Series ID 4508, Item 787426, Macrossan Court Transcripts.}

Macrossan further added that he sympathised with Staines for being misled for so many years as to the nature of his duties, and his difficulty in finding out precisely what his powers, authorities and duties were.\footnote{QSA Series ID 4508, Item 787426, Macrossan Court Transcripts.} In the past Judge Macrossan and other senior judges had misinterpreted coronial law and the jurisdiction of the coroner, showing that the ongoing confusion was a direct result of the government's neglect to reform and update this important judicial process that should satisfy demands for public accountability.

Macrossan made an order for the injunction until 10 February 1930 or further order, with costs reserved. He considered that provision of the further order would enable Staines to apply to dissolve the injunction. Macrossan thought that Staines might think it proper to allow ‘this unwholesome and unsavory incident to be buried in oblivion’.\footnote{QSA Series ID 4508, Item 787426, Macrossan Court Transcripts.} Judge Macrossan found that the order of prohibition of the Full Court had never been served on Staines and accused the prosecuting solicitor of neglect, given it had been his duty to take out an order at once and serve it on Staines. He suggested that had this been done, it may have deterred the justice from acting further.\footnote{QSA Series ID 4508, Item 787426, Macrossan Court Transcripts.} Macrossan surmised that Staines intended
to hold a new inquest under Section 2 of *The Inquests of Death Act of 1866* and the exhumation order under Section 6 was to allow him a view of the body. There is no evidence found to date to show that Arthur Staines took any further action to continue with an inquiry into the suicide of Dulcie Barclay.¹⁴ The Crown, in spite of this, forged ahead with their punitive crusade against the *Truth’s* staff members.

Following the Full Court decision on 9 December to prohibit the continuance of the inquiry into Dulcie Barclay’s death, reporter Edgar Ferguson became the focus of police attention in what the *Truth* described as ‘an example of reprehensible case-hunting’. Ferguson and other journalists at the *Truth* were on several occasions visited by Roma Street police officers endeavouring to solicit information about the Barclay affidavit. Objecting to the harassment of staff members, the paper lodged an official complaint with Police Commissioner William Ryan.²⁵ According to the *Truth*, Inspector Meldon had been provided with a copy of Barclay’s statement subsequent to her death on the understanding ‘it was to be used in the interests of justice’. The document was placed by Meldon before Staines when the Barclay inquiry began. On presentation of the same document before Justice Macrossan he indicated ‘he would make representation to the Attorney-general to have the “Truth” reporter … proceeded against’. In the paper’s opinion the police officers were instructed to ‘fish out’ information which would allow the Attorney-General or Police Department to construct a charge against Ferguson.²⁶ An entry in Judge Douglas’ notebook on Friday 22 November 1929 reads: ‘Mansfield wants

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¹⁴ *Brisbane Courier* 1930, 11 April, p. 16.
²⁵ *Truth* 1929, 15 December.
²⁶ *Truth* 1929, 15 December.
respondents sent to jail for contempt of court and for inciting the public'.

Robert O’Connor, the son of a Sub-Inspector of police at Roma Street, began his legal career under the guidance of Supreme Court Judge Hugh Macrossan. Attorney-General Neil Macgroarty, up until his election to the Legislative Assembly for the Country and Progressive National Party in May 1929, was a barrister located in the Inns of Court. O’Connor’s office was also in this building. In addition, O’Connor, Macgroarty and Hugh Macrossan were “old boys” of Nudgee College. Consequently, it is possible that the legal associates of Robert O’Connor were the driving force behind the police investigation and prosecution of the Truth’s journalists.

Edgar Ferguson first learned of possible action being taken against him through an article in the Daily Mail. A report from the Full Court concerning the taking of a statement in the Dulcie Barclay case had been received by the Attorney-General, who had referred the matter to the police. Ferguson protested against the passing of privileged information to a daily newspaper prior to the charge being laid and the police being notified. The paper intimated that either the Attorney-General or highly ranked police officers were behind this course of action. Not able to discover who disclosed the confidential material, Truth invited the government to commence an inquiry and issue a statement without

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57 QSA Series ID: 15793, Item ID: 99093, Douglas Notebook – Full Court.
59 Truth 1929, 15 December.
delay. The threatened prosecution of Ferguson was realised on 10 April 1930 when the case, the first of its kind in Queensland, commenced in the Supreme Court (Criminal Jurisdiction) before Justice Webb and a jury. Ferguson was charged with having taken a sworn affidavit that related to the relationship between two private people which ‘was not taken in any matter relating to the preservation of the peace, or the punishment of offences, or relating to any inquiry respecting sudden death’. Mr Real, for the defense, requested the withdrawal of the case arguing that no evidence of an offence being committed existed as there was no limitation placed on Ferguson, as a justice of the peace, as to the subject matter of affidavits. Judge Webb ruled that the case should be heard by a jury.

As the hearing proceeded, Mr Real informed the jury that no affidavit of any form was taken by Ferguson, adding that he would provide proof that no oath was ever taken by Miss Barclay. In giving evidence at the inquest Ferguson explained that Dulcie visited Truth on 8 August 1929 saying ‘she wanted to make a statement concerning her relations with a Brisbane man and the manner in which she had been treated.’ He stated he had not taken an oath from Barclay and also denied using the word ‘sworn’ when giving evidence at the inquiry. The defense argued the case was an insignificant indictment that

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60 Truth 1929, 15 December.
61 Brisbane Courier 1930, 11 April, p. 16.
62 Brisbane Courier 1930, 11 April, p. 16.
63 Brisbane Courier 1930, 11 April, p. 16.
would achieve nothing. The jury retired, returning two and a half hours later to deliver a
verdict of not guilty. The defendant was discharged. 64

Both the prosecution and defense in this case had access to the inquiry records which
included Dulcie Barclay’s affidavit. The main argument from the defense was that Edgar
Ferguson had not administered an oath to Dulcie when she gave her statement.
Nevertheless, the first page of the affidavit began with the following sentence; ‘I,
DULCIE ELMA BARCLAY of 52 Grey St. South Brisbane make oath and say as
follows’. The next page was headed ‘Second Sheet of Affidavit of Dulcie Elma Barclay
sworn before me this eighth day of August 1929’ and each subsequent page was headed
in the same manner. Only the page number changed. From his deposition taken at
Dulcie’s inquest Ferguson clearly stated ‘the deceased made an affidavit a sworn
affidavit’. 65 Ferguson told the prosecution that even though he signed the deposition he
had not used the word ‘sworn’ and when taking Dulcie’s statement he had not verbally
taken an oath. 66 The case for the defense seemed full of inconsistencies, yet the
prosecution refrained from exploiting the contradictions in Ferguson’s evidence. This
course of action invites speculation as to why the Crown failed to aggressively pursue the
defense during the course of the trial.

64 Brisbane Courier 1930, 11 April, p. 16.
65 QSA Series ID: 36, Item ID: 349494, Inquest File.
66 Brisbane Courier 1930, 11 April, p. 16.
The investigation into Ferguson and the rumour that a charge would be laid against him began around the time O’Connor’s order for prohibition went before the Supreme Court. At the time Ferguson’s prosecution began in the Supreme Court, the legal challenge to the holding of an inquiry into Dulcie Barclay’s death had been successful, and the inquiry was terminated. Furthermore, Staines had decided not to pursue the matter of an inquest any further. The commencement of Ferguson’s trial would resurrect the sensitive subject of Dulcie’s inquest, and potentially provoke further controversy if Ferguson was found guilty. Considering the state of affairs, presumably the government thought it in its best interests to let the issue quietly fade away.

**Why was the Barclay inquest adjourned and never reopened?**

There was no doubt that under the existing law an inquiry should have been held into Dulcie Barclay’s death. Why then did the Attorney-General, after consulting with the Police Commissioner announce that an inquiry was being held, and then decide against it after meeting with cabinet? Each of the central characters involved in this case were powerful and influential people who were connected with each other in some way. Consequently, it seems that people in “high places” pressured the government into blocking the inquest for the purpose of protecting reputations. An investigation into the death of Dulcie Barclay would have proceeded unimpeded had she not become romantically involved with Robert O’Connor. Dulcie Barclay’s inquest was subjected to a united undertaking of interference from the executive government, police and judiciary, with the intent of covering up indiscretions and illegal behaviour in order to protect “mates”.

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The furore and subsequent legal maneuvering after Dulcie Barclay’s tragic death left the government with little alternative but to reform the current coronial law in Queensland, *The Inquests of Death Act of 1866*. As the Barclay case illustrated, there was a need for the jurisdiction and function of the coroner to be clearly and precisely defined in the legislation. This is because politicians did not place enough importance on the role of the coroner as an instrument of justice, nor did they fully grasp the complexities linked to existing coronial laws.

**Coroners Act of 1930**

The *Coroners Act of 1930* was a major amendment to the law with respect to death investigations and the coroner’s inquest. It was not until the controversial death of Dulcie Barclay in August 1929 that the government finally acknowledged the need to formulate new legislation governing the office of coroner. Attorney-General Macgroarty introduced the Coroners Bill in August 1930 to update the law relating to the holding of inquests into death and inquests concerning fires, as a result of ‘the fuss and litigation which ensued with respect to the holding of an inquiry into a certain death last year’. 67 William Forgan Smith, Labor leader of the opposition and member for Mackay, maintained the law should be clarified to put beyond doubt ‘the conditions under which a coroner shall carry out the purpose of his office’. He concluded that such a measure would remove public

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suspicion that an inquiry could be quashed by the State if desired.\textsuperscript{68} John Mullan,\textsuperscript{69} Labor member for Flinders and Attorney-General in the previous government, claimed the present government would have continued to hold inquests of death under the present law, had the Barclay case not transpired. Furthermore, although the Supreme Court ruled a view of the body must take place, Mullan argued that the existing Act did not state viewing the body was necessary, adding that the matter had never before been raised in Queensland. Consequently, the challenge to Arthur Staines’ judicial course of action was uncharacteristic and encouraged speculation as to the motivation behind such legal proceedings. Mullen alleged that Staines, in applying to have the body exhumed, was attempting to meet his legal obligation to view the body, yet the Attorney-General did nothing to assist him.\textsuperscript{70} It had evolved that the coroner’s primary function was investigating suspicious deaths and detecting homicides, and the general the public needed to be satisfied that the inquest system was thorough, open and accountable.

A mixture of English statutes and common law informed Queensland coronial practice. Nonetheless, the codification of coronial legislation would assist the function of the office of coroner. The coronial laws of other Commonwealth countries were taken into consideration by the architects of the Coroner’s Bill, seeking to clarify coroners’ powers and obligations. Clause 5 (1) outlined the circumstances under which a coroner had

\textsuperscript{68} Forgan Smith, W., QPD (1930), 21 Geo. V, Vol. 155, p. 500.
\textsuperscript{69} John Mullan was a miners’ union organiser in 1905 and 1906, secretary of the Amalgamated Workers’ Association (later Amalgamated Workers’ Union) in 1912 and 1913, and Attorney-General (12/11/1920 to 21/05/1929 and 17/06/1932 to 14/11/1940). Although not a lawyer, ‘he had a personal library on legal subjects and was well respected by lawyers and officials of the Justice Department for his common-sense analysis of the advice he received’. Guvatt, J.(2006), Mullan, John (1871-1941), Australian Dictionary of Biography, National Centre of Biography, Australian National University, \url{http://adb.anu.edu.au/biography/mullan-john-7677} , accessed 14 July 2011.
\textsuperscript{70} Mullan, J., QPD (1930), 21 Geo. V, Vol. 155, p. 572.
jurisdiction to inquire into the manner and cause of death, but a paragraph dealing with suicide was omitted from the list.\textsuperscript{71} Edward Hanlon, Labor member for Ithaca, argued that cases of suicide should be fully investigated and moved that in Clause 5 (1) paragraph (d) the words ‘including circumstances apparently disclosing suicide’ be inserted.\textsuperscript{72} In reply, Attorney-General Macgroarty declared the amendment foolish, declaring that ‘in any suicide an inquiry must be held’ and in any case inquests into suicide would be held under paragraphs (a), (b), (c) and (d) of the clause. Macgroarty qualified his standpoint:

If a person is “killed,” then he or she can kill himself. That is suicide. If a person “is found drowned,” then that person can drown himself or herself. That is suicide. If a person “dies a sudden death of which the cause is unknown” or “dies under any suspicious or unusual circumstances” – and it is unusual for a person to kill himself or herself – then I am quite confident that under this clause an inquiry can be conducted into such death.\textsuperscript{73}

The new clause went a long way to formalising the law governing coroners’ jurisdiction but it still lacked clarity in the area of looking into suicides. The Attorney-General’s rejection of the amendment suggests he failed to comprehend the reasons for reforming the law. Importantly, the reasons he gave for not specifically including suicide in the clause were perplexing. The ambiguity in the law related to when inquiries into suicide should be held, that led to the farcical actions of the government in handling the inquiry into Barclay’s suicide, still remained.

\textsuperscript{71} The Coroners Act of 1930, 21 Geo. V, No. 17.
\textsuperscript{73} Macgroarty, N., QPD (1930), 21 Geo. V, Vol. 155, pp. 1317-1318.
Confusion existed over the legal obligation to hold an inquest when a person disappeared in circumstances that indicated death was almost a certainty, but no body was recovered. Two sailors on the fishing cutter “Maggie Lander” were drowned near Fitzroy Island in 1882. An inquiry into the cause of the accident was held in Cairns by the police magistrate and the depositions forwarded to the Justice Department. A few days later, the police magistrate asked the Colonial Secretary whether a magisterial enquiry should be held ‘if the bodies were not recovered’.\textsuperscript{74} Legally an inquest could not be held in these circumstances as it was impossible to view the bodies. Although the Coroner’s Bill removed the obligation of the coroner to view the body, the Attorney-General explained that when no body was found, irrespective of the situation surrounding the disappearance, an inquest could not be held because it could never be certain that death had taken place.\textsuperscript{75} The position on this matter remained unclear and for this reason it would have been expedient for the new act to qualify the legal position, if either part of or no body was found following a disappearance. This would assist coroners the performance of their duties.

\textit{The Coroners Act of 1930} provided for the Governor in Council to appoint ‘any person, being a justice of the peace’ as a coroner or deputy coroner for Brisbane. Under the new legislation, police magistrates held the power to act as coroners in districts holding courts of petty sessions and when they were unavailable the following public servants could

\textsuperscript{74} QSA Series ID: 5253, Item ID: 847068, Correspondence Inwards, 01/01/1882-31/12/1882.
hold inquests: Acting Police Magistrate, Clerk of Petty Sessions, and Acting Clerk of Petty Sessions.\textsuperscript{76} A justice of the peace could hold an inquest if requested to do so by the above mentioned officers, although the services of justices were required less frequently with the placement of magistrates in most districts. Viewing of the body was no longer considered necessary unless ordered by the Minister, who also held the authority to order an exhumation of a body.\textsuperscript{77} Mullan commented on the Minister possessing sole power to order an exhumation. He stated:

\begin{quote}
I say it is a most dangerous power, as was shown last year, for any Minister to have, whatever his party may be, because it allows him to interfere with the administration of justice … the less the Attorney General has to do with the court and the judicial functions of the court the better for the government.\textsuperscript{78}
\end{quote}

Both Mullan and Morgan Smith reminded the House of what they alleged were ‘extraordinary’ efforts by the Crown to prevent the holding of the Barclay inquest.\textsuperscript{79}

Worthwhile reforms to Queensland coronial legislation were accomplished with the introduction of \textit{The Coroners Act of 1930}. The more clearly defined jurisdiction of the coroner resulted from removal of the provision that two people could secure an inquest through a request in writing. The power to summon witnesses and issue fines for nonattendance at inquests was retained, as was the authority of the coroner to order a post-mortem. Medical testimony could be taken when deemed necessary to confirm cause of death. Fees for witnesses were to be paid for each day’s attendance at an inquest and

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\textsuperscript{76} \textit{The Coroners Act of 1930}, 21 Geo. V, No. 17, S. 4.  \\
\textsuperscript{77} \textit{The Coroners Act of 1930}, 21 Geo. V, No. 17, S. 9 & 11.  \\
\textsuperscript{78} Mullan, J., QPD (1930), 21 Geo. V, Vol. 155, pp. 572-573.  \\
\end{flushleft}
for travelling expenses. The rate of payment was equal to that allowed to witnesses for the Crown appearing in the Supreme Court. The *Inquests on Fires Act of 1863* and section 26 of *The Insurance Act of 1916* were repealed under the act and new provisions for inquiring into the cause and origin of any fire gave the coroner the discretion to hold an inquiry. Insurance companies or private citizens requesting the holding of an inquiry were required to bear the cost of the inquiry and any associated expenses.\(^80\) This led to a large reduction in the number of inquests held into fires during the 1930s.

A valued tradition of the inquest institution is the public accountability associated with its function. This principle came under threat when it was proposed that coroners be given the discretion to exclude the public and press from courts in ‘the interests of public morality’. With the press viewed as the guardian of people’s rights, the proposal to prohibit their presence at inquests met with resistance from opposition member Edward Hanlon. In the event of a closed inquiry taking place, Hanlon considered it essential that the press retained the right to be present in the courts. He argued that as representatives of the public in such circumstances, the press was responsible for maintaining the open character of the inquest system. An amendment preventing coroners from excluding ‘representatives of newspapers’ from the court, but allowing coroners the power to prohibit the publication of any details of the proceedings, was put forward by Hanlon and passed.\(^81\)

\(^{80}\) *The Coroners Act of 1930*, 21 Geo. V, No. 17

The removal of coroners’ power to commit for trial attracted vigorous criticism from only one member. John Mullan strongly believed the coroner should have the right to commit a person for trial in the same way coroners did in New South Wales and Victoria. When asked why the Queensland coroner was not granted the same power, the Attorney-General advised that he thought it unwise to give such power to a justice of the peace or clerk of petty sessions. Mullan remarked that justices of the peace presently possessed the right of committal on offences and argued there was no valid reason why the right to commit in his role as a coroner should be revoked. Of primary concern to Mullan was the waste of time and money in holding a coroner’s inquest, forwarding the papers to the Attorney-General for perusal and if it was decided a person should be prosecuted, the proceedings of the coroner’s court were duplicated in the criminal court. Since he was advocating a strategy for saving money therefore he found the hesitancy of the government to adopt a measure which would reduce expenditure of the Justice Department uncharacteristic.\(^{82}\)

Ultimately, an amendment by Mullan to provide the coroner with the power of committal was rejected by the Attorney-General. His foremost reason for not accepting the amendment was based on the fact that hearsay evidence was permitted at inquests and this evidence when passed onto the Crown Law authorities was examined in order to determine whether any person should stand trial. Additionally, unlike the Crown Law Office, the coroner was unable to charge a person with any offense. He could only comment on the case and report any suspicious circumstances he uncovered during the

course of the inquiry. According to Macgroarty, the interests of justice were best served by leaving the power of committal with Crown Law.\(^8\) The Coroners Act of 1930 became law on 23 October 1930.

**Conclusion**

For more than six decades the Queensland Government oversaw a complex coronial system that depended on regional magistrates to act as ex officio coroners. Depending on the experience and reliability of magistrates, the standard of coronial inquest and interpretation of coronial law varied throughout the State. Establishing and overseeing uniform rules of conduct remained an intractable problem for centralisation. However, with the death of Dulcie Barclay the government could no longer ignore the need for the jurisdiction and function of the coroner to be clearly and precisely defined in coronial legislation. The protagonists in this episode demonstrated the prevalence of ignorance associated with the workings of the office of coroner in Queensland. It was the inadequacies and ambiguity of *The Inquests of Death Act of 1866* and other contemporary coronial legislation, that led to government interference in the duties of the coroner engaged in the Dulcie Barclay death investigation.

The introduction of the *1930 Coroners Act* was a major amendment to the law which updated coronial legislation with respect to inquests into deaths and fires. Codification of the law represented a long over-due reform. Abolishing the necessity to view the body

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and withdrawal of the coroner’s power to commit for trial significantly changed the legislation. However, matters of jurisdiction of the coroner continued to trigger public debate and the controversial disappearance of a young public servant led to an early amendment to the act, within five years of enactment of The Coroners Act of 1930.
Chapter Five

Coroners Act 1958

Introduction

When *The Coroners Act of 1930* became law in Queensland, a complex array of existing coronial legislation was repealed. The 1930 Act consolidated and simplified the law related to the powers and duties of coroners. Yet within the next five years considerable criticism of the Act had emerged. In chapter four, I argued that the introduction of the 1930 Act was in response to the extraordinary course of events linked to the inquiry into the death of Dulcie Barclay. The government did not initiate *The Coroners Act of 1930* from a desire to introduce positive and progressive reform of coronial law. The extension of the coroner’s jurisdiction to facilitate the detection of homicides and prevent future deaths, was far from a motivating factor. In the mind of the public and the government, the role of the coroner remained linked to exposure of crime and criminal prosecution. Although the *Coroners Act of 1958* acknowledged the slowly emerging practice of coroners appending recommendations to their findings, there was no legislative power attached to the implementation of coroners’ recommendations.

This chapter, in examining the social and political history of Queensland between 1930 and 1958, sets up the context within which changes to the coronial law took place. I discuss calls to extend the jurisdiction of the office of coroner and investigate the mysterious disappearance of public servant Marjorie Norval in 1938. I argue that the Queensland
parliament enacted *The Coroners Act Amendment Act of 1943*, which legalised the holding of an inquest into a person’s disappearance, in order to address the rumours and accusations raised regarding her fate. I also contend that *The Coroners Act Amendment Act of 1947*, further expanded the jurisdiction of the coroner established through the 1943 Act, to facilitate a more comprehensive inquest process. A desire to merge the three acts into one concise coronial law was the impetus for passing the *Coroners Act of 1958*. The research shows that important changes to coronial legislation between 1930 and 1958 only came about because of public criticism, largely through the media, of the law as it stood, and of events that showed up a failure or inadequacy in the system.

**Economic, political and social upheavals**

Several disruptive phenomena transpired in Queensland between 1930 and 1958 that placed the State government under considerable pressure financially and administratively. Of great consequence was the change of government immediately prior to and towards the end of the “Great Depression”. In 1929, Arthur Moore’s Country and Progressive National Party defeated the Labor government, led by William McCormack, which had dominated politics in Queensland since 1915. Control of the State was handed over to the newly elected and inexperienced Moore administration at the beginning of the Great Depression. According to Brian Costar “[t]he hard reality of governing during a period of economic stagnation determined that the government would behave differently from what had been anticipated”\(^{84}\) by supporters. A large proportion of the population suffered under Country

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and Progressive National Party policies that increased working hours, reduced the basic wage, and removed fifty percent of the workforce from the protection of the Industrial Court. Furthermore, the government reduced salaries in the public service and all government departments ‘were encouraged to limit their expenditure’.\textsuperscript{85} As Costar emphasises, ‘[t]he depression of the 1930s destroyed every Australian government that was unfortunate enough to encounter it’.\textsuperscript{86} Labor, led by William Forgan Smith, won the 1932 election and set about restoring measures withdrawn by the previous government, reviving industry and reducing unemployment.\textsuperscript{87}

The Forgan Smith government raised taxes to fund unemployment relief programs on public works projects.\textsuperscript{88} Appointed as Home Secretary in 1932 and Minister for Health and Home Affairs in 1935, Edward Hanlon set about reorganising the independent health and hospital services in the state, assisted by Dr Raphael Cilento, who took up the position of Director-General of Health and Medical Services in 1934. Hanlon established Queensland’s free public hospital system and expanded the institution’s array of medical services.\textsuperscript{89} In spite of the government’s reformist activity in the health sector, pathology

\textsuperscript{85} Scott et al., \textit{The Engine Room of Government: The Queensland Premier’s Department 1859-2001}, St. pp. 96-97.
\textsuperscript{88} This building program included Brisbane’s Storey Bridge; the Somerset Dam; the Hornibrook Highway; the University of Queensland Campus at St Lucia; government offices; schools and colleges; court houses and police stations; hospitals and asylums; and gaols. An area of government that underwent a major transition in the mid 1930s was health and welfare.
services and the city morgue held a low priority. Government pathologists performed post-mortems in a facility that was unhygienic and grossly inadequate. Despite their complaints, the government only carried out minor alterations to the morgue in 1931. Funds were not allocated for structural renovations to the city morgue until 1943. This upgrade, in conjunction with another in 1956, did little to improve the appalling conditions at the city morgue. In both cases, the renovations carried out were far from satisfactory, and were complained of by the Director-General of Health and Medical Services, Dr John Tonge, throughout the 1950s.90

In the wake of the depression, Queensland faced a new challenge when Australia entered World War Two in 1939.91 Confronted with the growing prospect of war, the Commonwealth Government set up a National Council (consisting of the Prime Minister and State Premiers) at a conference held on 31 March 1939, to devise plans whereby each state government would co-operate with Federal authorities in giving priority to public works linked to military and civil defence. At the conference, all States received a copy of the current Commonwealth War Book ‘as a “master reference” to the action that would be required on the outbreak of war’.92 The War Book detailed the formation of a Central Executive Medical Committee to co-ordinate the provision and distribution of medical personnel, hospital accommodation and medical equipment to meet military and civil

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90 For further reading on the history of Brisbane’s city morgue see Chapter 6 of this thesis.
community needs. The National Security Act became law in September 1939 and through the authority of this Act, Commonwealth Executive rule increased in two ways. First, the Commonwealth had the power to make laws in areas that the Constitution did not allow; and second, it could override parliament because the government had the power to make laws that only needed the signature of a handful of ministers and the Governor-General. The laws and regulations linked to the increase of Commonwealth powers affected all areas of people’s lives. They also impacted upon the jurisdiction of the coroner.

In order to assist medical officers performing autopsies in the field, regulation number 37 of the National Security Act gave a ‘qualified commissioned medical officer of the armed forces power to perform a post-mortem examination on request by a coroner of any state or territory, and to sign any necessary certificate of death’. This removed the obligation to convey bodies to the city morgue for autopsies.

The Queensland government had developed wartime plans just prior to the outbreak of World War Two, and when the Public Safety Act 1940 came into effect in December 1941

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94 Some of the major rules and regulations were: the reduction of the Christmas-New Year Period to three days; the restriction of weekday sporting events; blackouts and brownouts in cities and coastal areas; daylight saving; increased call-ups of the Militia; the issue of personal identity cards; increased enlistment of women into the auxiliary forces; regulations allowing strikers to be drafted into the Army or into the Army Labour Corps; the fixing of profit margins in industry; restrictions on the costs allowed for building or renovations; the setting of some women’s pay rates at near-male level; internment of members of the Australia First organisation; controls on the cost of dresses; the rationing of clothing, footwear, tea, butter and sugar; the banning of the Communist Party, and the Australia First movement for opposition to the war; The formation of the Women’s Land Army; the pegging of prices; and the prosecution of about 1000 conscientious objectors and the imprisonment of some. (Lewis, R. (2001), ‘The Home Front – World War 2’, http://www.anzacday.org.au/history/ww2/homefront/controls.html, accessed 3 June 2010). For an insight into the social dislocation and government interference in the lives of Melbourne families during World War II, see Darian-Smith, K. (2009), On the Home Front: Melbourne in Wartime 1935-1945, Melbourne: Melbourne University Press.
(five days after the Pearl Harbour attack), the Premier was authorised to create a Council of Public Safety. The Public Safety Act authorised the Council to govern without consulting parliament and, if necessary, to amend the Queensland Constitution. In relation to this legislation, Kay Saunders contends that Queensland did not relinquish its autonomy to the National Security Act of 1939, but passed its own emergency legislation that exposed the people of the state to two levels of ‘totalitarian executive government’ for the duration of the war. The acquisition of government land and premises came under the regulations of the Public Safety Act 1940; legislation which was based on similar laws in New Zealand, Great Britain and Victoria. In mid 1942, Dr Johnson of the Civil Defence Organisation, along with Inspector Harold of the Police Department, set out to secure buildings suitable for fitting out as emergency morgues should Queensland come under enemy attack and suffer a high number of casualties. Two buildings had already been secured for this purpose, the store of John Lysaght (Aust) Pty Ltd in Ann Street and the Temperance Hall, Nile Street South Brisbane. Plans were drawn up for the conversion of these two buildings into temporary morgues. In addition, the ‘Ipswich Road Workshops’ manufactured 1000 coffins in standard and larger sizes, in preparation for handling a large number of bodies if required.

In May 1942, the Queensland government submitted an order drafted under regulation 35A of the National Security (General) Regulations, to the Commonwealth Department of Home Security, for consideration as a measure of ‘disaster management’. The order made it compulsory for all persons to wear identification discs. The Prime Minister, John Curtin, opposed the draft order due to the high cost of materials and labour and the lack of submissions from other states. Although the order was not promulgated, the Queensland government arranged for the Government Printer to provide to citizens on request, an identification disc bearing name and address, for the cost of 3d. per disc. The government felt that if the civilian population wore identification tags, this would speed up the identification process in the event of mass casualties resulting from wartime activity.\footnote{QSA Series ID: 6717, Item ID: 267156, Papers relating to the Second World War, defence, documents from Agent-General, disposal of dead bodies, Bundle No 193.} It is unknown how many adults purchased the discs, but the Queensland government issued approximately 100,000 children with identity discs in preparation for emergency evacuation.\footnote{Three forms of identification tags for children are on display in the MacArthur Museum. (MacArthur Museum Brisbane, A Story of Brisbane at War, From the Collection, http://www.mmb.org.au/Pages/Collections.html , accessed 15 January 2012).}

Regulation 37 of the National Security (General) Regulations was repealed and replaced with a regulation that defined more specifically the directions for the disposal of dead bodies. Sub-regulation (1) of regulation 37, stated that if any police officer in charge of a police station, any member of the police force holding the position of sergeant or higher, or any commissioned officer of the Armed Forces conclude that a dead body is that of a person ‘who has died in consequence of war operations, that officer or member may,
subject to such restrictions and conditions as are imposed by order of a Minister, give such
directions for the disposal of the body as the officer or member thinks fit’. In contrast, sub-
regulation (2) only allowed for a commissioned officer of the ‘Armed Forces’ to dispose of
the body of a member of the forces, ‘whose death occurred, while on duty, from accidental
or natural causes’. The laws relating to coroners or the registration of deaths did not apply
to any body dealt with under sub-regulations (1) and (2), but ‘a Minister may by order
make provision for securing’ the identity of any person, where possible, dealt with under
the previous sub-regulations. The Register-General was then furnished with this
information. Any commissioned medical officer of the Armed Forces who was a
qualified medical practitioner was authorised to perform a post-mortem on the body of any
person, ‘if requested to do so by any coroner or deputy coroner of the State or Territory.’
In addition, the medical officer could sign a certificate of death for any member of the
armed forces who died while on service, and the certificate carried the legal weight of one
signed by a qualified medical practitioner. The National Security Act of 1939 had a
substantial impact on the Queensland office of coroner, in that it over-rote the local law
related to inquests and death registration.

Evidence shows that reform of colonial law was a low priority to the Queensland
government. Key events often drove government policy, which in the case of the office of
coroner, was more reactive than planned and developed. It was government reaction to the
events surrounding Dulcie Barclay’s death, that resulted in enactment of The Coroners Act
of 1930. Likewise, as will be discussed later in this chapter, it was public protest and

102 QSA Series ID: 6717, Item ID: 267156, Papers relating to the Second World War.

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controversy linked to the mysterious disappearance of Marjorie Norval, amplified through the media, that generated government action to amend coronial legislation in 1943.

**Outcomes of The Coroners Act of 1930**

The press and the Brisbane coroner found fault with two sections of the 1930 Act; the delay in holding inquests and the loss of the coroner’s power to commit for trial. A report in the *Courier Mail* in August 1934, highlighted the state of affairs in Queensland where police investigating violent or suspicious deaths decided whether to initiate a coronial inquiry or not. The article drew attention to subsection two of section five of *The Coroners Act of 1930*, which required all coroners to ‘inquire forthwith into the manner and cause of any death occurring under the circumstances as set forth in sub-section one of this section’. However, an ongoing complication of the inquest process was the delay caused while waiting for the Police Department to send investigative reports on deaths to the coroner. The coroner could not commence an inquiry until he received the police report. A review conducted by the *Courier Mail* of fatalities and inquests held over previous months exposed a number of cases in Brisbane where long delays in investigating deaths had ‘cruelly prolonged the distress of relatives’. The paper questioned the efficiency of the Queensland Police in taking so long to produce reports for the coroner. In addition, the present city coroner, Mr J Leahy, also filled the role of police magistrate and magistrate of the children’s courts. The *Courier Mail* suggested that the appointment of a full-time

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103 *Courier Mail* 9 August 1934, p. 12.
104 *Courier Mail* 17 May 1933, p. 10.
In response to the Courier Mail’s article, Attorney-General John Mullan, requested reports from the Police Department and the Justice Department, to assist with identifying areas where delays in holding inquests might be prevented or addressed. The subsequent reports declared delays unavoidable due to factors such as the time required to locate witnesses, make inquiries and gather evidence from witnesses. Mullan also added that when the coroner was required to perform “special duties” elsewhere, a deputy coroner took over his coronial functions, in addition to performing his duties as acting police magistrate and clerk of petty sessions. Despite this, Mullan assured the Courier Mail that the Department of Justice and the Police ‘would continue to arrange for the hearing of inquests without avoidable delays and without inconvenience and hardship to witnesses’. The Courier Mail declared the explanation of “unavoidable circumstances” as totally unacceptable as a reason for delays, and continued to maintain that a far more plausible explanation for inquest delays was the fact that both the coroner and deputy coroner were obliged to perform numerous additional duties. A suitable resolution to the problem continued to evade Attorney-General Mullan.

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105 Courier Mail 9 August 1934, p. 12.
106 Courier Mail 11 August 1934, p. 17.
107 Courier Mail 13 August 1934, p. 10.
In 1939, the city coroner Mr Leahy complained about the delay by police in submitting files for transfer to the coroner, prompting the Police Department to generate another report on the subject. Following this report the Police Commissioner despatched a memorandum to police in charge of police stations situated within the jurisdiction of the Brisbane City Coroner, setting out instructions for creating a ‘uniform system’ in handling files on deaths that were forwarded to the coroner. If possible, only one member of the force should investigate the circumstances surrounding a death, obtain statements and attend the post mortem. This procedure limited to one the number of police required to give evidence at an inquest. The memorandum instructed police officers to find out whether witnesses intended to leave the district in the near future, and if so, take their evidence prior to departure. Consequently, if the coroner called for their evidence at the inquest, it was available. All officers investigating a death were instructed to submit their reports ‘without undue delay’, and all files transferred to the city coroner were to be treated ‘as urgent correspondence’. In order to expedite the holding of inquests, the Commissioner encouraged reform of the law relating to the office of coroner. He thought that empowering coroners to initiate and control investigations into deaths and inquiries into fires was a progressive move. Ultimately, little was achieved in the way of accelerating the process of police inquiring into and reporting to the coroner on ‘notifiable’ deaths. Twenty years later, numerous cases of inquests held long after a death

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108 QSA Series ID: 16865, Item ID: 316239, Police Correspondence, memorandum from Commissioner of Police, Cecil James Carroll, to Inspectors in Charge of Brisbane, Fortitude Valley, South Coast and Ipswich Districts, and of the Traffic and C.I. Branches, Brisbane, and to the Members of the Force in charge of Stations situated within the area over which the jurisdiction of the City Coroner, Brisbane extends, 9 August 1939.
occurred were still being reported. The length of time taken for police to send reports to
the coroner still caused delays to inquest hearings.  

The removal of the coroner’s committal power in *The Coroners Act of 1930* had attracted
criticism throughout the 1930s. Arguments over the need for the coroner to retain such
power continued up to the drafting of *The Coroners Act Amendment Act of 1943*. Mr J
Leahy, who replaced William Harris as Brisbane City coroner in July 1933, wasted little
time before criticising coronial legislation that stopped coroners from exercising the right
to commit a person to face trial. Leahy made the following remarks when addressing the
annual meeting of the Queensland Justices’ Association in December 1933:

> Queensland Coroners have no power after hearing the evidence at inquests
to commit a person for trial if the evidence disclosed a prima facie case
against such person under the criminal law. It seems out of keeping with
the traditions of British courts that a coroner in this State is called upon by
law to inquire into the manner and cause of death yet, [sic] is not required
to find any verdict or to express any opinion upon the evidence given on
the hearing. The law seeks to clothe him with the powers, authority and
jurisdiction of a police magistrate under the Justices Act in relation to the
holding of any inquest, but when the penetrating winds of scrutiny begin
to assail him he finds that his pseudo-important garment is in places very
thin.

Leahy further claimed that extending committal powers to the coroner would lead to a
reduction in waiting time and a decrease in expenses, due to the elimination of the need for

110 *Courier Mail*, 15 December 1933, p. 22; *Truth*, 17 December 1933, p. 2.
a committal hearing. The evidence taken at an inquest was enough to send a person to trial according to Leahy.

Leahy objected to the provision in *The Coroners Act 1930* that required the holding of an inquest if the deceased had not visited a doctor in the three months prior to death. He argued that the coroner should have the discretion to decide if a post-mortem and inquest were necessary when elderly people, not previously seen by a doctor, died from natural or obvious causes.\(^{111}\) The adoption of Leahy’s proposal might have prevented the distress connected with the funeral of a retired Brisbane schoolteacher, Miss Georgina Shepherd. The last minute postponement of the funeral, due to a legal complication linked to *The Coroners Act 1930*, illustrated Leahy’s argument. Miss Shepherd died suddenly in a nursing home. Diagnosed with a terminal brain tumour nine months prior to her death, no doctor had attended Shepherd since that time. A doctor issued a death certificate, but just as the funeral was about to get underway, it was found that the death certificate did not conform to provision [5](1) (j) of the coroners’ Act. The provision stated that the coroner must ‘inquire into the manner and cause of the death of any person who: Dies, not having been attended by a medical practitioner at any period within three months prior to his death’.\(^{112}\) The postponement of the funeral until a police report was completed, thus allowing for the issue of the death certificate, caused great distress to Shepherd’s family.

\(^{111}\) *Courier Mail*, 15 December 1933, p. 22; *Truth*, 17 December 1933, p. 2.
\(^{112}\) *The Coroners Act of 1930*, 21 Geo. 5, No. 17, 5(1) (j).
and friends. Regardless of Leahy’s call for removal of this section of the coroner’s act, it was retained in *The Coroners Act Amendment Act of 1943*.

*The Coroners Act of 1930* prevented the holding of an inquest without a body; even when the circumstances of the disappearance indicated that the person was dead. In 1936, a press report hinted at a change of coronial law governing inquests without a body. Under the headline ‘No Body, No Inquest’, the *Courier Mail* wrote that according to the deputy coroner Mr Hickey, ‘the rule may be modified, and an inquest held, if there is sufficient evidence to show that the death actually occurred’. His comments were in response to a Sydney report that the New South Wales parliament were considering amending their coroner’s act to enable an inquest to be held on any part of the human body. The ruling of Justice Rogers in the case commonly referred to as the “Shark Arm Case” prompted the New South Wales government’s decision. As reported by the *Sydney Morning Herald*:

> His Honor held that no separate member of the human body could be termed "a body" for the purpose of an inquest. He then restrained the City Coroner (Mr. Oram) from proceeding with the inquest into the alleged death of James Smith, on the ground that no proper basis existed for an inquest.

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113 *Argus*, 13 January 1936, p. 8.
114 *Courier Mail*, 8 September 1936.
115 On 17 April 1935, an angler hooked a small shark off the coast of Coogee Beach. A four-metre tiger shark swallowed the smaller shark resulting in the capture of the larger shark. The tiger shark went on public display at the Coogee Aquarium Baths. On 25 August 1935, in front of spectators, the shark vomited up the tattooed forearm of a man. A medical examination of the arm revealed it had been cut from the body with a knife or sharp object. The distinctive tattoo on the arm in conjunction with the matching of fingerprints, allowed police to determine that the arm belonged to a petty criminal Jim Smith. The police commenced a murder investigation and arrested an associate of Smith, Patrick Brady, for his murder. An inquest commenced on 12 June 1935 at the City Coroner’s Court led by Mr Oram. Brady’s lawyer, Clive Evatt, claimed that an arm did not constitute a whole body and therefore it was possible Smith was still alive. Brady applied to the court to stop the inquest through his lawyer. (Castles, A. (1995) *The shark arm murders: the thrilling true story of a tiger shark and a tattooed arm*, Kent Town S.A.: Wakefield Press).
In his judgment his Honor pointed out that the history of coroners’ inquests showed that the view of a body had always been essential to the holding of an inquest. No body identified as that of James Smith had been found, and it followed, his Honor held, that the whole body of James Smith had not been viewed by the coroner; but an arm which had been found in extraordinary circumstances had been produced to him.\textsuperscript{116}

In spite of the earlier prediction, Queensland law vis à vis conducting an inquest without a body remained unchanged. In 1939, \textit{Truth} published an article arguing for a change of Queensland legislation governing the holding of inquests. It maintained coroners should have the power to render verdicts, commit for trial and hold inquests without a body. Referring to the case of Marjorie Norval, \textit{Truth} claimed the holding of an inquest at the time of her disappearance would have revealed additional information and the standard of police investigation would have been more transparent.\textsuperscript{117} Overall, the 1930s debate demonstrates a general desire for codification of the law on coronial practice. Amendment to the coroner’s law in Queensland regarding inquests without a body, did not occur until 1943, however archival records show that prior to this amendment, inquests were often held on the presumption that a person had died, yet the body had not been found.\textsuperscript{118}

\begin{footnotes}
\item[116] \textit{Sydney Morning Herald}, 7 September 1936, p. 11.
\item[117] \textit{Truth}, 16 July 1939.
\item[118] QSA Series ID: 36, Item ID: 348955, Inquest No. 328 (1906) – disappeared while shooting goats at Percy Island, north east of Rockhampton; QSA Series ID: 36, Item ID: 349119, Inquest No. 242 (1913) – man disappeared at Port Douglas, suspected crocodile attack; QSA Series ID: 36, Item ID: 349478, Inquest No. 97(1929) – fisherman disappeared at Second Beach near Cairns, thought to have fallen overboard from his motor boat; QSA Series ID: 36, Item ID: 349491 Inquest File – Old Japanese man living alone on Tully river disappeared; QSA Series ID: 36, Item ID: 349559, Inquest File – man fell off launch “Burrum” near Bundaberg, body not found; QSA Series ID: 36, Item ID: 349601, Inquest File – man disappeared in surf at Main Beach, Southport and his body was not found.
\end{footnotes}
The Disappearance of Marjorie Norval

On 19 November 1938 Marjorie Norval, social secretary to Mrs Forgan Smith, wife of the then Premier Mr William Forgan Smith, disappeared without a trace after a friend picked her up from the Albert Hotel and dropped her off about 7pm at Brisbane’s Central Railway Station. An intense search for Norval, conducted by police from all Australian States as well as New Zealand, failed to find any trace of the woman.\textsuperscript{119} The government offer of a £500 reward for information concerning her disappearance\textsuperscript{120} was the second largest reward offered since 1917.\textsuperscript{121} Norval was never found and during the years following her disappearance, rumours continued to circular as to her fate. On 24 September 1942 Frank Barnes,\textsuperscript{122} the outspoken Member for Bundaberg, asked Edward Hanlon (the Minister for Health and Home Affairs) for the names of the detectives working on the investigation into Marjorie Norval’s disappearance. Barnes also asked Hanlon to confirm or dispel the rumour that Marjorie Norval had gone to California. In reply, Hanlon avoided directly answering Barnes’ questions.\textsuperscript{123} Then on 15 January 1943, William Power (Member for Baroona) asked Hanlon if he was aware of the claims made by Barnes about the missing woman, and if so, had Hanlon taken action to extract the information from Barnes. The Minister informed the House that the Commissioner of Police instructed Barnes on several occasions to liaise with the police.\textsuperscript{119} The Royal Australian Air Force assisted in the search for Marjorie Norval by conducting an air search of coastal areas. They requested a police officer to accompany them, as it was an official police search. Constable George Young, a member of the Brisbane Water Police, accompanied the crew of the Sea Gall on 28 November 1938. During the search along the Logan River the plane hit power lines and crashed, killing all four men on board. (QSA Series ID: 36, Item ID: 349651, Inquest File).\textsuperscript{120} QPD (1942-43), 6 & 7 Geo. VI, Vol. 179, p. 314.\textsuperscript{121} Courier Mail, 1 December 1938, p. 2. In 1917, a reward of £1000 was offered for information leading to the conviction of the person or persons who caused an explosion on the steamer Cumberland (Sydney Morning Herald, 13 July 1917, p. 6).\textsuperscript{122} John Francis Barnes (1904-1952) was known as Frank Barnes. He was the independent member for Bundaberg. (Costar, B. Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adbonline.anu.edu.au/biogs/A130141b.htm, accessed 5 May 2008).\textsuperscript{123} QPD (1942-43), 6 & 7 Geo. VI, Vol. 179, p. 314.
occasions to reveal all the information he had concerning the case, but Barnes had refused to comply.\textsuperscript{124} Instead, according to Hanlon, Barnes had indulged in ‘writing slanderous and evasive letters to the Commissioner of Police’ relating to the disappearance of Norval. Hanlon reminded Barnes of his duty to disclose any information he possessed to the police in order to assist them in solving a ‘suspected serious crime’.\textsuperscript{125}

Barnes, who admitted possessing undisclosed evidence, was defiant towards police when ordered to hand over information. Finally, during a parliamentary session on 31 March 1943, Barnes informed Hanlon that he had agreed to hand over to the Commissioner of Police, all the information sought on the Marjorie Norval case. Barnes stated that he would do so on the condition that the Minister answered two questions in connection with the investigating detectives. Although Hanlon claimed to have responded to these questions during a previous session of parliament, that was not the case. For a second time, he focused attention on Barnes’ recalcitrant behaviour and ignored the questions.\textsuperscript{126} Eventually, on 6 April 1943, Hanlon responded to Barnes’ request, stating that it was not common practice to disclose the names of individual police officers participating in investigations.\textsuperscript{127} A week later Attorney-General David Gledson introduced the \textit{Coroners Act Amendment Bill} and while outlining the principles of the Bill, Barnes interjected, declaring ‘[w]hy not call it straightout the Frank Barnes Bill’? The \textit{Truth} and the \textit{Courier Mail} published details of the Bill, almost word for word, prior to its introduction to the House. This led to allegations that a government member had supplied the press with a

\textsuperscript{124} QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1475.
\textsuperscript{125} Hanlon, E., QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1475.
\textsuperscript{126} QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1605.
\textsuperscript{127} QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1665.
copy of the Bill. Both the Attorney-General and the Commissioner of Police denied leaking the information to the press. Barnes was not convinced, declaring that it was probable that ‘some of the caucus rats gave the information to “Truth”’ and that ‘there seemed to be some motive behind it’. As far as Barnes was concerned, his badgering of government ministers eventually forced them into taking action. Barnes maintained that the amendment of The Coroners Act of 1930, permitting a coroner to inquire into a person’s disappearance, was directly linked to the Marjorie Norval case. He also claimed the government made the provision retrospective in order to make him give evidence.

Frank Barnes, standing as an independent candidate, won the Bundaberg seat from the Australian Labor Party in 1941. He had worked as a commercial traveller selling wine and spirits before 1937, when he took over the licence of the Commercial Hotel in Bundaberg. He was a self-professed opponent of police and political corruption, and in his maiden parliamentary speech on 2 September 1941, Barnes expressed his opposition to the Forgan Smith government. Prone to extravagant behaviour to attract attention both within and outside parliament, Barnes was a constant irritation to the government. His actions eventually resulted in his suspension from the House on eight occasions. Barnes endeavoured to embarrass the government and to cast suspicion on the activities of certain

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131 QPD (1941), 5 Geo. VI, Vol. 178. p. 149.
government ministers connected with the Marjorie Norval affair. The Norval murder files are held at the Queensland State Archives and are thought to contain the inquest record. There is a one hundred year restriction on access, therefore Barnes’ claim of government involvement in the disappearance of Norval (as well as a government led vendetta conducted against him) cannot be confirmed.

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The Coroners Act Amendment Act of 1943

The jurisdiction of the coroner in Queensland rarely gained the attention of the State government. When problems arose the government response was more often than not reactive rather than proactive. The introduction of the first major law related to the office of coroner in Queensland, The Coroners Act of 1930, followed the extraordinary events associated with the termination of the inquest into the suicide of Dulcie Barclay. Likewise, it was the speculation and rumour circulating about the fate of Marjorie Norval, spearheaded by Frank Barnes, that initiated amendment of the 1930 Act. It was Barnes’ persistent questioning of the government on details of the case, in conjunction with the publication of his allegations linked to the missing woman, that triggered an amendment to The Coroners Act of 1930.

133 Dr “Jappy” Ross was allegedly a well-known abortionist in Brisbane. Ross was supposedly closely linked to some government members and rumours circulated that Marjorie Norval was pregnant to Forgan Smith and had died when undergoing an abortion conducted by Dr Ross. Dr Ross was convicted of conducting an illegal abortion in December 1953, and sentenced to four years jail. The Criminal Court of Appeal quashed the conviction in March 1954. (Townsville Daily Bulletin, 27 March 1954, p. 2).

134 An application (made via a Queensland State Archive’s form) to access the Marjorie Norval murder files was lodged with the Police Department in January 2010. The application, along with two follow-up phone inquiries, failed to achieve any response.
Four principal amendments were contained in *The Coroners Act Amendment Act of 1943*. In the wake of condemnation of its earlier removal, the Act reinstated a coroner’s power to apprehend and commit for trial any person ‘suspected or accused’ of wilful murder, murder or manslaughter, if justified by the evidence. Following the Attorney-General’s second reading of the Coroners Act Amendment Bill, debate concentrated on the provision giving the coroner committal power. This provision brought Queensland into line with coronial legislation in New South Wales, South Australia, Victoria and England. The member for Hamilton, Bruce Pie (Independent Democrat), argued that clause 5 of the Bill allowed the coroner to decide the guilt of a person before he or she had been tried in the magistrates court. The leader of the Opposition, Frank Nicklin defended this provision, maintaining that a duplication of proceedings would be avoided because the coroner could send a person straight to the Criminal Court to stand trial. He claimed that ‘the coroner commits him for trial but does not find him guilty’. The Attorney-General confirmed that all the evidence goes before the Crown Prosecutor to determine if a trial takes place, and that no coroner has to the power to record a conviction. Pie then moved on to the matter of the right of an accused to be present during the inquest, in order to hear evidence given against him.

Pie objected to the retention of section 13 (3) of *The Coroners Act of 1930* without amendment. Section 13 read:

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135 *The Coroners Act Amendment Act of 1943; 7 Geo. VI, No. 8, S. 7.*
136 Coroners Act 1912 (NSW), S. 6; Coroners Act 1935 (SA), S. 22 (2) & S. 19 (b) (iii); Coroners Act 1928 (Vic), S. 11 & S. 12; Coroners (Amendment) Act 1926 (UK), S. 25.
137 QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, pp. 1809 - 1810.
Provided that if the coroner shall consider an person whether subpoenaed as a witness or not has any particular interest in the proceedings, or if the coroner shall consider the conduct or act of any such person was in any material way relevant to the subject matter of the inquest, he may permit such person to be present in such room or place: and in such case such person shall be entitled to be represented by counsel or solicitor and to examine and cross-examine witnesses in relation to the subject matter of such inquest.\textsuperscript{138}

Pie considered if a person could be committed for trial by a coroner, than that person had the right to hear the allegations made against him or her and have legal representation. He wanted the section amended through the substitution of the word ‘may’ with the word ‘shall’. Ted Hanlon, Secretary for health and Home Affairs, informed the house that when a coroner becomes aware that a person may be ‘implicated in the death of a deceased’ then it is the coroner’s duty to allow him to be represented by counsel. The members passed clause 5 and Pie’s amendment was ruled out of order as it sought to ‘amend the principal Act in a particular not covered by [the] Bill’.\textsuperscript{139}

The amendment giving coroners the discretion to dispense with an inquest met with some degree of protest. The long held dependence on the coroner’s inquest to satisfy public concern over the cause of any unexplained death came under threat with amendment of The Coroners Act Amendment Act of 1943 that gave coroners the discretion to dispense with an inquest. A new subsection inserted into section five of the Act read:

\begin{enumerate}
\item \textit{The Coroners Act of 1930}, 21 Geo. V, No. 17.
\item QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1838.
\end{enumerate}
Notwithstanding anything to the contrary contained in subsection two of this section where after considering any information as to any death in respect of which an inquest is, by subsection two aforesaid required to be held, the coroner considers that no good purpose will be served by the holding of an inquest, he shall forward to the Minister a certificate in the form of the Fifth Schedule or to the like effect, and stating the reason for coming to that decision. A copy of such certificate shall be sent by the coroner to the Commissioner of Police and the Registrar-General.  

In 1950, Rockhampton’s local newspaper the *Morning Bulletin* published an article that raised questions about the jurisdiction of the coroner under the 1943 legislation. The article focused on the change in coronial law that gave coroners the power to dispense with holding an inquest. It recounted the circumstances related to two men found shot dead at their Clermont camp in 1946 as well as the death of a Rockhampton woman from a gunshot to the head in 1950. In both cases, the coroner announced that there would be no inquest held. The *Morning Bulletin* claimed that it was due to their efforts in making representation to the Attorney-General and the coroner that inquests were subsequently held into these deaths.

Referring to the inquest held into the woman’s death at Rockhampton the article stated that:

> In all, this case - into which there was to have been no inquest - dragged on for over six months … An inquest held immediately after the event would have had before it all witnesses, with their evidence fresh in their minds.

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140 *The Coroners Act Amendment Act of 1943*, 7 Geo. VI, No. 8, S. 5, sub-section [2A.] (1.)

Commenting on the changes brought about through the introduction of *The Coroners Act Amendment Act of 1943* the *Morning Bulletin* wrote:

We believe that the Coroner’s Act as amended makes possible such amazing happenings as are revealed herein, together with others where inquests that were mandatory under the unamended Act may have been suppressed under the amended Act. We also believe that the law in this regard, as it now stands, is based upon the erroneous premise that it is now officials, and not the public conscience, who are to be satisfied that proper inquiries be made into all cases of violent death. We believe, too, that the Coroner’s Act today starts Queenslanders on the way to an ultimate Police State.\(^{142}\)

The *Morning Bulletin* argued that the changes to the coroner’s act dispensed with one of the most valued functions of the office of coroner – public accountability. In the paper’s view, there was a lack of transparency in a system that empowered government officials to determine when to hold an inquest. However, coroners were accountable for their actions as the decision not to hold an inquest required the Minister’s approval.

Coroners forwarded their findings and depositions taken at inquests to the Minister for Justice. The Crown Solicitor determined if further action was necessary. This process placed a great deal of responsibility on the government’s legal representative and as evidence already presented in this study has shown, the Crown Solicitor did not in all cases act in the interest of delivering justice to the deceased. Allowing the coroner to deliver his finding in the coroner’s court and introducing the right of relatives to request an inquest, would have contributed to the perception of transparency and public accountability.

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\(^{142}\) *Morning Bulletin*, 12 June 1951, p. 4.
In a move aimed at reducing the waiting time for inquests, the 1943 amendment provided for every stipendiary magistrate to act as a coroner either within or outside his own district.\textsuperscript{143} The \textit{Justices Acts Amendment Act of 1941} altered the title of magistrates from “police magistrates” to “stipendiary magistrates”,\textsuperscript{144} hence in \textit{The Coroners Act Amendment Act of 1943} all references to police magistrates were to be read as “stipendiary magistrates”. On an administrative level, the Act amended the title of the form “Certificate of Particulars Inquest of Death” to that of “The Coroner’s Inquisition”. Two new headings were included on the document: “Name of suspected person” and “Accused”.\textsuperscript{145}

In another principal amendment to the Act, a coroner was authorised to hold inquiries into persons missing for twelve months or more. He also acquired the power to compel any person or persons who may have information related to an inquiry, to attend the inquiry and give evidence.\textsuperscript{146} Additionally, \textit{The Coroners Act Amendment Act of 1943} allowed the coroner to hold an inquest without a body. The legislation made provision for holding an inquiry into a person’s disappearance once the missing person’s report had been on file for twelve months or more. Section [6C] (2), of the Act gave the coroner the power to compel any person claiming to possess information pertaining to a missing person, to attend an inquest and give evidence.\textsuperscript{147} \textit{The Coroners Act Amendment Act of 1943} amended section 15 of \textit{The Coroners Act of 1930} to state that any person who refused a second time to give

\textsuperscript{143} \textit{The Coroners Act Amendment Act of 1943}, 7 Geo. VI, No. 8, S. 3.
\textsuperscript{144} \textit{Justices Acts Amendment Act of 1941}, 5 Geo. VI, No. 9, S. 4 (2).
\textsuperscript{145} \textit{The Coroners Act Amendment Act of 1943}, 7 Geo. VI, No. 8, S. 13.
\textsuperscript{146} \textit{The Coroners Act Amendment Act of 1943}, 7 Geo. VI, No. 8, S. 8.
\textsuperscript{147} \textit{The Coroners Act Amendment Act of 1943}, 7 Geo. VI, No. 8, S. [6C] (2).
evidence at an inquiry, may be sent to prison on order of the coroner. The person remained in prison until he agreed to be re-examined and to answer questions asked of him.\textsuperscript{148} The introduction of this section was interpreted as a measure to force Frank Barnes to disclose what he claimed to know about the disappearance of Marjorie Norval. Frank Nicklin stated that the provisions dealing with persons who alleged to possess information about missing persons were quite drastic, and he hoped they would ‘not be used for the purpose of instituting a vendetta against any particular person’.\textsuperscript{149} The events that unfolded during the inquest held into the disappearance of Marjorie Norval show that Nicklin’s concerns were justified.

**The Inquest**

The *Coroners Act Amendment Act of 1943* came into effect on 22 April 1943. The inquest into the disappearance of Marjorie Norval began a short time later on 19 May 1943. The rapid commencement of the inquest suggests that the amendment to *The Coroners Act of 1930* was to allow an inquest into her suspected death to proceed. It seemed the government thought that conducting an inquest into Norval’s mysterious disappearance, was a strategy for confronting the accusations and gossip circulating about Marjorie’s fate. The inquest, which began on 19 May 1943,\textsuperscript{150} was the first held in Queensland into the circumstances surrounding a missing person. Frank Barnes appeared before the coroner’s court on 24 May 1943 but refused to disclose the names of the informants who had told

\textsuperscript{149} QPD (1942-43), 6 & 7 Geo. VI, Vol. 180, p. 1809.
\textsuperscript{150} Clem Lack in *Three Decades of Queensland political history 1929-1960* gives an account of this saga but incorrectly gives 28 April 1943 as the commencement date of the inquest.
him that Marjorie Norval was alive and living overseas. Consequently, coroner Leahy fined Barnes £10 for refusing to give evidence. When Barnes reappeared at the inquiry on 30 November, he again refused to disclose his sources. He claimed that the ‘new Act introduced by the Government … was brought in to get Frank Barnes and not to find Marjorie Norval’. As far as he was concerned, ‘[t]he inquiry from the start had been actuated by political spleen and by no good motive’. The coroner sent Barnes to jail ‘until such time as he agreed to give the information required’.

Barnes left Boggo Road Gaol on 2 June 1943, to appear again as a witness at the inquest. He told the coroner that he was ready to disclose the names of the two informants. He then testified detective Tom Smith and Citizen Harry Jones were his sources, and declared (on oath) that he was not falsely using the names Smith and Jones. Barnes told the Crown Prosecutor, Mr J A Sheehy, that detective Smith said ‘Norval had been shanghaied to California’, and the Police Commissioner (Mr Carroll) went to California after that to ‘handle the blackmail for Forgan Smith’. When Sheehy reminded Barnes that he had previously failed to disclose this piece of information, Barnes said ‘Yes, you cannot think of everything at once’. Coroner Leahy advised he needed more time to consider whether Barnes had met his obligation to give truthful evidence, and ordered Barnes to return to Boggo Road Gaol until the resumption of the hearing on the following day.

151 Courier Mail, 1 June 1943, p. 4.
152 Courier Mail, 1 June 1943, p. 4.
153 Courier Mail, 2 June 1943, p. 4.
154 Courier Mail, 2 June 1943, p. 4.
155 Courier Mail, 2 June 1943, p. 4.
156 Courier Mail, 2 June 1943, p. 4.
discharged Barnes from custody on 2 June 1943, following his third appearance at the inquest.\textsuperscript{157}

What happened to Marjorie Norval still remains a mystery. The inquiry gathered a great deal of circumstantial and hearsay evidence. Witnesses included the former premier Mr Forgan Smith, his wife, the Police Commissioner, four doctors, an assistant under secretary, a Parliamentary draughtsman, Marjorie’s mother and two sisters, and several of her friends. The hearing set a new Queensland record for the length of an inquiry as well as the number of witnesses called.\textsuperscript{158} Coroner Leahy had little concrete evidence to assist him in determining his finding. Norval, who had told several different stories as to why she was going away, took only a pair of pyjamas and a kimono with her. She was also rumoured to be pregnant, and had withdrawn 30 pounds from her bank account. From this evidence, the coroner decided that ‘on the night Norval disappeared, she went to the premises of an abortionist from which she never emerged alive’.\textsuperscript{159} On 29 July 1943, Lewis Barnes (independent member for Cairns and brother of Frank Barnes) put the following question to the Attorney-General:

\begin{quote}
In view of District Coroner Leahy’s finding, namely, that Miss Marjorie Norval went to the house of an abortionist and never returned, will he obtain from him the name and address of the abortionist and inform the House accordingly?\textsuperscript{160}
\end{quote}

\begin{flushleft}
\textsuperscript{157} Cour\textit{ier Mail}, 2 June 1943, p. 4.  \\
\textsuperscript{158} Cour\textit{ier Mail}, 5 June 1943, p. 6.  \\
\textsuperscript{159} Cour\textit{ier Mail}, 5 June 1943, p. 6.  \\
\textsuperscript{160} QPD (1943), 7 Geo. VI, p. 15.
\end{flushleft}
Attorney-General Gledson replied that ‘[t]he name of the abortionist or address is unknown to me or to Mr Leahy. As far as I know it might be T. Smith or Citizen Jones’. Gledson emulated the behaviour of Frank Barnes in relation to the coroner’s efforts to extract the names of his informants at the inquiry.

The restriction of access placed on the murder file of Norval prohibits public scrutiny of the records until November 2038. This rule of prohibition greatly hinders examination of all aspects of this case, particularly the inquest process. Press reports and parliamentary debates are the only sources available to researchers. Until further information surfaces, suspicion about the involvement of government ministers in the disappearance of Marjorie Norval, as alluded to by Barnes, is likely to persist. Government members needed to quieten the outspoken Frank Barnes and took the opportunity presented by this case to take revenge on Barnes for his public attacks on the Forgan Smith administration. Because of this case, the government passed *The Coroners Act Amendment Act of 1943*, which amended coronial law to allow coroners to hold an inquest without a body. The coroner also regained the power to commit individuals for trial. it could be argued that this amendment was about political expediency motivated by criticism by the city coroner and the press.

**The Coroners Act Amendment Act of 1947**

161 QPD (1943), 7 Geo. VI, p. 15.
Three years after the government passed *The Coroners Act Amendment Act of 1943*, it passed a second amendment to *The Coroners Act 1930*. Under existing law, the coroner had no power to reopen an inquest if new evidence became available. Attorney-General David Gledson asserted that ‘some cases have arisen that could very well have been reopened in the public interests [sic] and that some inquiries have not been held that might have been held in the interests of the public’.¹⁶³ Gledson held the view that if fresh evidence surfaced in relation to a closed inquest, the Government was obliged to dispel any doubt and suspicion connected to the case. Accordingly, to address these concerns, he initiated the *Coroners Acts Amendment Bill* in 1947. Evidence taken at an inquest is inadmissible at any resulting legal action, because the coroner’s court is a court of record and the rules of evidence do not apply to inquest hearings. On this subject, Thomas Hiley (Queensland People’s Party member for Logan), stated during debate on the Bill:

I have some doubt as to the real purpose that coronial practice has served in our system of judicial practice. I have further doubt as to whether we can forever permit that system to continue with no real laws of evidence governing the practice of those courts. Whatever doubt I may have under those two headings, however, I recognise that whilst we retain coroners [sic] courts it is essential that this Bill be introduced.¹⁶⁴

Hiley’s remarks showed that reservations over the contribution the office of coroner made to the justice system continued to exist.

The Coroners Act Amendment Act of 1947, assented to on 24 November 1947, was a short act that contained one principle. It gave the coroner ‘power to hold an inquest where one has not been held or to reopen an inquest’ closed by him, without direction from the Attorney-General. The Minister gained the power to reopen an inquest, while the Commissioner of Police and Inspectors of Police could ask a coroner to hold or reopen an inquest. Furthermore, a direct relative of the deceased could call on a coroner to conduct an inquest or reopen an inquest. The Act removed any time limit on the reopening of inquests.

It is reasonable to assume that the motivation behind reform of the coroner’s law was the expansion of the jurisdiction of the coroner to establish a more effective death investigation process. It was necessary for coroners to read The Coroners Act of 1930 with The Coroners Act Amendment Act of 1943 and The Coroners Act Amendment Act of 1947.\textsuperscript{165} The three acts combined became the Principal Act under the collective title of The Coroners Acts of 1930 to 1947.\textsuperscript{166} It was imperative that coronial officers were familiar with and functioned according to the provisions of all three acts. A decade later, enactment of The Coroners Act of 1958 overcame this complex administrative undertaking.

\textit{The Coroners Act of 1958}

Although exaggerating the weakness in Queensland’s coronial system, in 1952 the Courier Mail questioned the jurisdiction of the coroner. The paper stated that in its present form:

\begin{footnotesize}
\begin{itemize}
\item[165] The Coroners Act Amendment Act of 1947, 11 Geo VI, No. 34.
\item[166] The Coroners Act Amendment Act of 1947, 11 Geo VI, No. 34, S. 1.
\end{itemize}
\end{footnotesize}
The coronial system in this State seems pointless. Coroners hear evidence but seldom make findings. They do not exercise their powers of committal for trial. They content themselves with sending along papers to the Justice Department. And Queenslanders accept this because they have never known a real coronial system. They have never had the benefit of the advice or warning that coroners in the full sense are able to give to individuals and to a community.

The article acknowledged that allowing the coroner to dispense with the holding of an inquest was a means of reducing demands on the court, but it also claimed that leaving it to the Crown Law Office to examine the papers and take action where it saw fit, might lead to abuse and suppression of unlawful activity. In addition, the Courier Mail asked ‘why is it that the Queensland coroner cannot deliver a finding in court when other countries allow this practice’? It went on to compare Queensland’s coronial system with those of New South Wales, Victoria and South Australia, which allowed coroners to deliver their findings in court, and ‘make useful comments from the bench on sudden death as a guide to the public’. 167 The article concluded with the following assessment of the Queensland government:

IN all administration in Queensland — not only in relation to the courts— there is a political tendency to regard every existing system as perfect, and to defend it against scrutiny. Any suggestion for improvement is resisted, often resented.

But the test of good government is a Cabinet's willingness to order changes for the public good. Here in the coronial system is one of the most pressing needs for court reform. 168

The Queensland government had disregarded periodic calls for further reform of coronial law since enactment of The Coroners Act of 1930. In due course, the Gair government

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167 Brisbane Courier, 7 November 1952, p. 2.
168 Brisbane Courier, 7 November 1952, p. 2.
commenced the process of reform, which the newly elected Nicklin government completed in 1958 with the passing of a new coroner’s act.

The Coroners Act of 1958 enacted a number of coronial reform measures in Queensland, thus supplying the office of coroner with a more comprehensive Act to replace existing coronial legislation. In introducing the Coroner’s Bill in September 1958, the Minister for Justice, Alan Munro, explained the need to amend the law relating to coroners to draw together the 1943 and 1947 Amendment Acts and The Coroners Act of 1930. In 1957, the previous Gair government appointed a Chief Stipendiary Magistrate and the Crown Solicitor to review The Coroners Act of 1930 and the amending legislation. The officers conferred with Doctors John Tonge and Justin O’Reilly from the Laboratory of Microbiology and Pathology, Mr T Scott the Register-General, and Inspector Frederick Palethorpe, representing the Commissioner of Police. According to the Minister, the 1958 Coroners Bill incorporated recommendations made by the review panel as well as reforms included in England’s Coroners Rules 1953.169 The Coroners Act 1887170 and The Coroners (Amendment) Act 1926171 formed the basis for the Coroners Rules 1953, which codified practice and laid down standards of procedure and conduct for coroners. The Coroners Act of 1958 was less definitive than Section 3 of the Coroners Rules 1953, which stated that ‘the post-mortem examination should be made, whenever practicable, by a pathologist with suitable qualifications and experience and having access to

170 The Coroners Act 1887, 50 & 51 Vic., C. 71.
171 The Coroners (Amendment) Act 1926, 16 & 17 Geo. 5 c. 59.
laboratory facilities’.\textsuperscript{172} Up to this point, the State government apparatus had shown little regard for the imperatives of providing well-resourced facilities for medical laboratory scientists. John Tonge, Director of the Laboratory of Microbiology and Pathology from 1948 to 1979, commented in his memoirs that ‘the first decade of my work was in cramped and under-resourced facilities at the Alice St morgue and the William St laboratory’.\textsuperscript{173}

According to the Minister, the aim of the Bill was to draft legislation to suit the conditions, ‘disclosed by experience’, of the ‘vast and relatively unsettled territory’ of Queensland.\textsuperscript{174} This declaration suggested that after almost one hundred years of independent state rule, Queensland administrators were still dealing with a largely undeveloped region, with a population scattered between towns separated by long distances. Consequently, appointing a number of officials with the jurisdiction, power, function and authority to act as coroners was as an appropriate course of action in the eyes of the government.

Aspects of the 1958 Act were drawn from other Acts consisting of *The Coroners Act* 1887 (Imperial); *The Coroners (Amendment) Act* 1926 (Imperial); *The Medical Act of 1939* (Queensland); the *Coroners Act* 1935-1952 (South Australia); the *Coroners Act* 1957 (Tasmania); and the *Coroners Act* 1951 (New Zealand). Under Section 7 of the

\textsuperscript{172} The Coroners Rules 1953, Statutory Instruments 1953, No. 205, S. 3.
\textsuperscript{173} Tonge J. (2009), *Just keep your knife sharp: Memoirs of John Tnge as told to Anne Chamberlain*, July, pp. 86, 89, 92.
\textsuperscript{174} QPD (1958-59), 7 & 8 Eliz. II, Vol. 221, p. 320.
Coroners Act of 1958 the ambiguous description of the manner of death, ‘is killed’, contained in The Coroners Act of 1930, was replaced with ‘has died either a violent or unnatural death (but so that the meanings of the terms “violent” and “unnatural” shall not be affected by anything contained in the subparagraphs following)’. Following the death of Dulcie Barclay, parts of the debate on the Coroners Bill of 1930 had centred on whether in Clause 5 (1) (d) the words ‘including circumstances apparently disclosing suicide’ should be inserted. The Attorney-General at that time, Neil Macgroarty, rejected this move, giving a pedantic explanation of why inquests into suicide would be held under specific paragraphs of Clause 5 as they stood. In his opinion ‘if a person is “killed,” then he or she can kill himself’ therefore an inquiry could be held into a case of suicide. He also maintained that if a person died under any suspicious or unusual circumstances an inquest would be held and as it was ‘unusual for a person to kill himself or herself’, suicide would come under this category and an inquest would be held. The inclusion of the new sub-section of Section 7 in the Coroners Act of 1958 provided a more clearly defined category, that of ‘violent or unnatural’, under which suicide would be included.

Only minor changes to the provisions governing inquests into fires were introduced under Section 8 of the Act. The most significant change was the increase in the cost to a person requesting the holding of an inquiry into a fire rising from £10 to $50. The only other notable amendment was the addition of the words ‘whereby the life of man or beast has

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175 The Coroners Act of 1958, Eliz. 2, No. 32, S7 (1) (a) (i).
177 Macgroarty, N., QPD (1930), 21 Geo. V, Vol. 155, pp. 1317-
178 This is the decimal currency reference substituted pursuant to S. 7 of the Decimal Currency Act of 1965.
been lost or endangered" to extend the coroner’s jurisdiction to inquire into a fire.\textsuperscript{179} The purpose of the inquest was to establish that the person had in fact died; the identity of the deceased person; when, where and how he came by his death; any person or persons to be charged in relation to the death; and any particulars required for the purpose of the registration of death.\textsuperscript{180} This more clearly delineated the coroner’s jurisdiction. More importantly for some, \textit{The Coroners Act of 1958} retained the coroner’s authority to commit a person for trial. Conflicting views on the coroner’s power to commit continue to this day.

During the course of debate on the Bill, the leader of the Labor opposition, John Duggan, recommended that magistrates entrusted with the duty of holding coronial inquests should hold legal qualifications at some stage in the future. This suggestion was agreed to by the Attorney-General William Power, who expressed the opinion that having magistrates trained in law was a progressive step, and advocated legally trained magistrates, as they became available, replacing present magistrates.\textsuperscript{181} Although magistrates dispensed justice without holding formal legal qualifications, the role they played was crucial to the administration of justice throughout the vast region of Queensland. The transformation of the magistracy from persons trained within the public service to legally qualified practitioners was slow. It was not until 1971 that changes to

\textsuperscript{179} \textit{The Coroners Act of 1958}, Eliz. 2, No. 32, S8 (1) (iii).
\textsuperscript{180} \textit{The Coroners Act of 1958}, Eliz. 2, No. 32, S24.
the Public Service Regulations required new appointees to the magistracy to possess formal legal qualifications.\textsuperscript{182}

Parts of the \textit{Coroners Act} 1958 were considered worthy of adoption by others. In 1975, the New South Wales Law Reform Commission submitted a report reviewing the \textit{Coroners Act} 1960 (NSW). The report recommended changes to the jurisdiction, practices and procedures of the coroner and the office, that would further assist in meeting community needs. Contained within the report were recommendations for adopting some aspects of the Queensland Act, that represented areas of the New South Wales Act in need of reform. The recommendations were:

(a) Section 52 (it is a crime to publish in a newspaper any question to a witness that the coroner disallowed or ordered not to be published);

(b) Section 29 (the coroner holds the right to fix the time of commencement and place of an inquest and to notify relevant persons of the holding of the inquest);

(c) Section 9 (investing coroners with jurisdiction to deal with cases where a body is destroyed or is irrecoverable);

(d) Section 16 (the coroner has the power to dispense with an inquest).\textsuperscript{183}

Overall, the coronial legislation of each Australian State varied little by the end of the 1950s. Queensland’s coronial legislation differed because it was the only state to allow a

\textsuperscript{182} Dean, \textit{Here Comes the Judge: The Queensland Magistrate}, p. 36.
coroner to conduct an inquest without the material presence of a body, while in South Australia the coroner did not have the power of committal.\textsuperscript{184}

The outstanding issue in relation to reform of Queensland’s coronial law was the formal recognition of coroner’s recommendations. They were occasionally appended to coroners’ findings in the 1930s, but began to appear more often in findings from the 1950s onwards. Queensland coroners appended recommendations to inquest findings through a desire to move beyond the traditional role of fact finding, into the realm of preventative action. Recommendations were aimed at improving public health and safety, as well as establishing safer working environments. However, the \textit{Coroners Act of 1958} placed little importance on coronial recommendations, and in most cases, the government paid little attention to them.

**Coroners’ Riders or Recommendations**

The making of riders has long been a function of coroners, however the Queensland government viewed coroner’s recommendations as subordinate to the finding of the cause of a person’s death and determination of any person who may be criminally responsible.\textsuperscript{185} Appending riders to coronial findings was becoming more frequent during the 1950s, and \textit{The Coroners Act of 1958} included a section dealing with recommendations made by coroners. This was the first time the subject was incorporated

\textsuperscript{184} \textit{Coroners Act Amendment Act 1952}, No 53, Section 20 (b).

\textsuperscript{185} It was only with the introduction of the \textit{Coroners Act 2003}, S. 46, that any recognition of the coroner’s prerogative to make recommendations was incorporated into the legislation.
in Queensland coronial legislation. Section 43(5) stipulated that the coroner was unable to express any opinion on any matter outside the scope of the inquest except in a rider concerned with preventing similar deaths. The rider was not classified as part of the coroner’s finding but was included if the coroner thought it necessary. Furthermore, no finding could be ‘framed in such a way as to appear to determine any question of civil liability or as to suggest that any particular person [was] found guilty of any indictable or simple offence.\footnote{Coroners’ riders had a long history of bearing little consequence in relation to the overall purpose of the inquest. John Jervis made the following comment on the significance of recommendations or riders:}

\begin{quote}
The addition is no part of the verdict, but is mere surplusage. A recommendation is no part of the verdict and the coroner may refrain from recording it, or, he may allow it to be written in the margin of the inquisition, of which it is not part.\footnote{Jervis, J. (1946), p. 110, cited in Boronia Halstead (1995), ‘Australian Deaths in Custody: No 10 Coroners’ Recommendations and the Prevention of Deaths in Custody’, Australian Institute of Criminology, \url{http://www.aic.gov.au/documents/4/D/F/%7B4DFAD9F6-CD7B-4A56-8512-828A37EDBD1F%7Ddic10.pdf}, accessed 7 March 2010.}
\end{quote}

Research for this study showed that recommendations from coroners at the conclusion of an inquest hearing did not begin to appear with any regularity until the 1950s.\footnote{QSA Series ID: 36, Inquest Files (1950 – 1959).} Prior to this, coroners and magistrates only intermittently attached riders to their findings. When they did, their suggestions met with little compliance from the authorities involved.
In the late nineteenth century, warnings in relation to medicines given to children began to appear. In 1879, Surgeon William Little claimed that the frequent use of “Infants Preservative” to soothe children and to stop them crying was responsible for a large number of infant deaths. Dr Bancroft also reported to the Brisbane Board of Health in 1881, that he saw ‘many children brought to death’s door from their parents dosing them with a powerful powder of mercury’. When, in 1896, a medical practitioner found that the dose of “Infant’s Preservative” administered to a child caused her death, the police magistrate holding the inquest wrote on the file that the government should ‘look into’ the easy access to such a dangerous medicine. The papers from the coronial inquest, sent to the Justice Department, were subsequently marked ‘Away’, suggesting no further action was taken. No other inquest in the data examined contained a coroner’s rider warning of the dangers linked to the use of proprietary medicine. Previous research undertaken by this author showed that although reports on the harmful contents of proprietary medicine had been published in medical literature, the warnings were consistently ignored by government health authorities, and infants continued to die unnecessarily.

Despite a lack of formal recognition of their recommendations, some coroners did propose means of providing better protection of the public prior to the 1950s. When in

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191 QSA Series ID: 36, Item ID: 348844, Inquest File.
1925 a woman fell in the Brisbane River at North Quay and drowned while intoxicated, the coroner conducting the inquest into her cause of death recommended the construction of a railing to prevent accidents of a similar kind.\textsuperscript{193} In 1934 a coroner suggested the Main Roads Department erect warning signs on a piece of roadway near Warwick where a commercial traveller died in a car crash.\textsuperscript{194} In the case of a Japanese diver dying of paralysis in 1940, the coroner recommended that owners of pearling luggers pay more attention to the amount of time divers spent below water.\textsuperscript{195} In the 1950s, coroners began making recommendations more frequently in areas such as road safety; better worksite practices; easy access to poisons; water and boat safety; prevention of train accidents and improved hospital drug regimes.

The appearance of increased recommendations attached to inquest findings indicated a slowly emerging public health and safety focus within the inquest system. However, this did not mean the government acted upon the recommendations. To date, the legislative system does not compel consideration of, public reporting of and response to coronial recommendations.\textsuperscript{196} Evidence from a national study into the implementation of coroners’ recommendations identified the ad hoc nature of agency responses to recommendations and ‘recurring instances where coronial recommendations had not been

\textsuperscript{193} QSA Series ID: 36, Item ID: 349403, Inquest File.  
\textsuperscript{194} QSA Series ID: 36, Item ID: 349576, Inquest File.  
\textsuperscript{195} QSA Series ID: 36, Item ID: 349680, Inquest File.  
\textsuperscript{196} In 2008 the Queensland State Coroners Office conducted the state’s first research into the Queensland Government’s response to coronial recommendations handed down between 1 January 2008 and 31 December 2008 . The Justice Department published the results in 2009. The Queensland Government response to coronial recommendations 2008,  
communicated or had been miscommunicated, or were lost within bureaucratic processes’. Investigating the follow-up rate of recommendations made by Queensland coroners would represent a valuable and worthwhile research project.

**Coroners’ Findings**

Coroners also took into account the protection of the character of the deceased when bringing down their findings. When a Maleny dairy farmer died in 1943, the cause of death entered on The Certificate of Particulars – Inquest of Death read ‘laceration of rectum’ and ‘general peritonitis’. The post-mortem determined that this certainly was the cause of death, but the coroner’s acceptance of the manner in which the farmer sustained his injury must place a question mark over the credibility of some coronial findings. The farmer left his house at around 6.00am on the morning of 7 March 1943 to carry out the milking of his dairy cows. His wife and three sons arrived at the milking yard at approximately 6.20am, bringing with them tea and toast for the farmer. He stopped milking when they arrived, had the tea and toast, then resumed milking. At about 7.45am the farmer complained of pains in the stomach and at about 8.30am lay down on the floor of the dairy, telling his wife he thought he was suffering from gastric trouble.

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198 In July 2000 the National Coroners Information System (NCIS), was established. ‘It is a national internet based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (January 2001 for Queensland) is stored within the system, providing a valuable hazard identification and death prevention tool for coroners and research agencies’. As the evidence of Watterson et al shows, this system has had little effect on the response of state and territory governments to coronial recommendations. (National Coroners Information System, Victorian Institute of Forensic Medicine, [http://www.ncis.org.au/web_pages/historical_background.htm](http://www.ncis.org.au/web_pages/historical_background.htm), accessed 5 February 2012).
199 QSA Series ID: 36, Item ID: 349725, Inquest File.
The pains worsened and he returned to the house accompanied by the youngest son at approximately 8.45am. Shortly afterwards the farmer’s wife arrived at the house to find him writhing in pain and it was at this stage he informed his wife that ‘the bull had got him’. Explaining further, the farmer said ‘[t]he young bull jumped on my back and his penus [sic] went into my back passage’.

Giving evidence at the inquest into the farmer’s death, his wife deposed that:

My husband had previously informed me that there was a cow in season and he had put her in the bull yard with the old bull. The young bull was in another yard and from what my husband told me it would appear that as he was going out of the yard in which the old bull and the cow were he turned to shut the gate and the young bull evidently tried to jump the gate. He failed to get over the gate and slid down on to my husband’s back. The weight of the bull evidently caused my husband to bend over and as he did so his penus [sic] entered his back passage. My husband told me that he felt the bull’s front feet slide over his shoulders. I did not see any marks on my husband’s shoulder but he complained of a sore shoulder.

She then sent her son to ring for the doctor who arrived at 9.45am. On the doctor’s instructions, the farmer went by ambulance to the Brisbane General Hospital where he died the next day, following an operation to repair the tear in his rectum. At the inquest held by Angus Ole, the doctor stated that the farmer had told him the ‘younger bull’s penis had entered his rectum’, adding ‘I examined the deceased but there was no evidence of any external injury to the anus but from signs I diagnosed the presence of

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200 QSA Series ID: 36, Item ID: 349725, Inquest File.
201 QSA Series ID: 36, Item ID: 349725, Inquest File.
developing peritonitis’. The doctor observed a rip in the seam of the trousers, over the anal area, two to three inches long. Hence, the medical practitioner declared it possible for the injuries to occur in the manner described to him by the deceased. He further maintained that if a stick had been inserted into the back passage there would have been external signs of injury, and according to the doctor, there were no signs of the deceased having passed any blood. The doctor, who knew the deceased, maintained he was a ‘well respected citizen’ and ‘of good character’ and that nothing the deceased told him ‘would suggest that he gave the bull any encouragement or assistance’.

Dr Edward Derrick, the Director of The Laboratory of Microbiology and Pathology conducted the post-mortem examination and found no external signs of violence on the body. He accepted that the internal injuries were consistent with ‘a bull’s penis having entered the deceased’s anus and rectum’ but asserted that ‘some instrument entering the anus’ could also have caused them. Although he considered it possible that the farmer received his injuries in the way described, he had never ‘heard of an incident like that before’ and thought it ‘very exceptional’. The only other witnesses at the inquest were a police constable from Landsborough and another from Fortitude Valley Police Station. As there were no witnesses to the “attack”, the account given by the farmer and the

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203 QSA Series ID: 36, Item ID: 349725, Inquest File.
204 Dr Edward Derrick’s appointment as Director of The Laboratory of Microbiology and Pathology in 1935 heralded the beginning of a long and distinguished career as a research scientist and administrator with the Queensland Department of Health and Home Affairs. See Chapter 7 of this thesis.
doctors’ testimonies were all that the coroner had available to determine the manner and cause of death.\textsuperscript{205}

Dr Carol Petherick, Principal Scientist (\textit{Animal Behaviour} and Welfare) with the Queensland Department of Primary Industries and Fisheries, believes that the findings were consistent with some instrument entering the anus, but if it was a bull’s penis she asks:

(1) why didn’t the farmer mention the incident straight away (2) why were there no external injuries from being mounted and penetrated by a 300+ kg bull (3) why did the trousers not prevent intromission (4) why was the peritonitis apparently advanced?\textsuperscript{206}

According to Petherick, the inquest did not determine conclusively that the bull’s penis caused the injury, nor whether the incident took place on the day in question. She doubts the farmer sustained the injury in the manner described and suspects the finding was part of an attempt to protect his reputation.\textsuperscript{207} Dr John Tonge replaced Dr Derrick as Director of The Laboratory of Microbiology and Pathology in 1946. In 2010, when questioned about the content of the post-mortem report on the farmer, Dr Tonge claimed that he too had never come across a case like this during his career. He expressed the opinion that more signs of violence, and the loss of blood, would have been present if the injuries were inflicted in the manner described. He also maintained that peritonitis would not

\textsuperscript{205} QSA Series ID: 36, Item ID: 349725, Inquest File.  
\textsuperscript{206} Personal communication with Dr Carol Petherick, Principal Scientist (\textit{Animal Behaviour} and Welfare), Queensland Department of Primary Industries and Fisheries, 16 February, 2009.  
\textsuperscript{207} Dr Carol Petherick, 16 February 2009.
have set in so quickly. Dr Tonge did not speculate on how the injuries may have occurred.208

The facts of this case cast doubt on the farmer’s explanation as to how he encountered his injuries, yet the coroner had to accept the findings of the medical witnesses and investigating police officers, in determining cause of death. The possible alternatives, that the farmer participated in consensual homosexual sex or was the victim of male on male rape, would have been shameful and humiliating for the family. For that reason, it is possible the farmer covered up the true cause of his injuries and that his wife, local doctor and the coroner accepted his version of events. If this was the case, the coroner recorded the correct medical cause of death, but failed to determine the correct manner of death. Moreover, the law overlooked a criminal offence. It seems that the finding of the coroner as accepted in order to preserve a local person’s reputation.

John Weaver speculates that occasionally coroners ‘gave the benefit of the doubt’ in their inquest findings and recorded some suicides as accidents to save the deceased family from undue trauma.209 Research undertaken by Weaver of suicide cases in Queensland between 1890 and 1940 and specifically for Brisbane from 1942 to 1950, showed that just over 10 per cent of inquests wrongly recorded deaths as accidental, when they were

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208 Dr John Tonge, 20 April 2010.
more likely to have been a case of suicide. A coroner holding an inquest in a small country town where the deceased was well known, would overlook evidence that might suggest suicide, in order to deliver a cause of death that would not tarnish the person’s reputation.  

210 There was a stigma associated with suicide that is still prevalent within society today.  

211 In addition, the deliberate taking of one’s own life was a crime in Queensland, and remained so until 1976.  

212 Furthermore, most life insurance policies carried a suicide clause that stated if the person covered by the policy died through suicide, beneficiaries were not paid.  

213 Coroners were mindful of this situation when delivering their findings, especially if a finding of suicide left a surviving partner and/or children without financial support.  

214 In view of Weaver’s conclusions, readers of inquest records must main mindful of the presence of ‘errors and deception’ in coroners’ findings.

Conclusion

The Conservative and Labor governments that ruled Queensland between enactment of

_The Coroners Act of 1930_ and _The Coroners Act of 1958_ experienced the Great

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210 Weaver, A Sadly Troubled History: The Meanings of Suicide in the Modern Age, pp. 53, 114.
214 QSA Series ID: 36, Inquest Records.

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Depression, World War II, industrial strikes and political disunity. These events caused economic hardship, social disorder and political instability within the state. Furthermore, scarce government funds were stretched to the limit forcing the introduction of harsh cost saving measures by the government. Consequently, the sub-standard conditions experienced by government pathologists, and reform of coronial law, constituted a low priority on the government agenda.

Changes to the legislation dealing with the jurisdiction and practice of coroners, were mostly initiated in response to unfavourable public and press comment, rather than a desire to detect “hidden homicides” and account for all suspicious, violent and unnatural deaths. Introduction of *The Coroners Act Amendment Act of 1943* was related to the speculation and innuendo openly expressed over the disappearance and suspected death of a young woman. It was not initiated through a desire for reform of coronial legislation. Ultimately, the Act extended the coroner’s jurisdiction and reinstated the coroner’s power of committal. The Brisbane coroner, in conjunction with the local press, had been quite vocal in their protest over the removal of the coroner’s right to commit to trial, following enactment of *The Coroners Act of 1930*. Giving coroners the power to dispense with an inquest remained a contentious issue, but nonetheless was retained in the 1947 and 1958 legislation. Although *The Coroners Act Amendment Act of 1947* only contained a solitary clause, it represented a significant change to the law, in that it allowed a coroner to hold an inquest when he had previously deemed one unnecessary, or to reopen an inquest if
additional evidence became available. This again expanded the role of the coroner when investigating deaths that came under his jurisdiction.

A driving factor behind enactment of *The Coroners Act of 1958* was the consolidation of previous coronial legislation in order to simplify and clarify coronial law. The legislation was more prescriptive than in the past, with provisions outlining procedures to follow for all parties involved in the investigative process. To determine the identity of a deceased person, as well as the cause and manner of death, remained the most important purpose of the coroner’s inquest. Although *The Coroners Act of 1958* broadened the scope of the office of coroner, the Act failed to capitalise on the potential for coroners’ recommendations to advance community health and safety, by attaching greater importance to coronial recommendations.
Chapter Six

Post-Mortems and Coroners’ Inquests

Introduction

At the beginning of the twentieth century, post-mortem examinations were generally carried out in the local morgue. If country towns were fortunate enough to have a mortuary, it was often little more than a single room building with sub-standard facilities. Post-mortems were conducted by general practitioners, who had no special training in pathology. Morgues in rural areas still lacked many basic facilities at the end of the 1950s. The four morgues that served Brisbane prior to construction of the Institute of Forensic Pathology (IFP) in 1960 were rudimentary structures that were criticised for deficiencies in standards of operation. In 1931, Brisbane pathologist Dr James Duhig first complained of the appalling conditions at the city morgue. When Dr John Tonge was appointed Director of the State Laboratory of Microbiology and Pathology in 1948, he continued fighting for better facilities until the battle culminated with the opening of the Institute of Forensic Pathology in 1961. The IFP represented the first facility in Queensland to support effectively a forensic pathological service, as well as operating as a teaching and research centre.

Condemnation of the city morgue had generated little reaction from the State government until unfavourable publicity in the 1950s forced them to take steps to improve conditions. Although the government was aware of the valuable contribution forensic pathology made to the inquest system, cost continued to remain the deciding factor when it came to issues
associated with the Queensland office of coroner. In this chapter I discuss the government’s piecemeal attempts to improve the city morgue in response to protests over its substandard and unhygienic facilities. I argue that Queensland government parsimony outweighed consideration for the rights of the deceased and the advancement of medico-legal coronial investigations.

**The rise of forensic medicine**

Today forensic medicine plays a vital role in coroners’ investigations into causes of death. Forensic medicine is the specialty that applies medical knowledge to questions of civil and criminal law. A forensic autopsy combines post-mortem findings with the results of other specialist investigations, including histology and toxicology,¹ to answer questions relating to a death.² Writing on the historical development of medico-legal pathology in England and its close links with the office of coroner, Arthur Mant maintains that advancements in toxicology have led to the detection of drugs and poisons in such low concentrations that it would have been impossible to detect their presence in the past.³ A forensic pathologist, on order of the coroner, performs an autopsy on a deceased person, reports on the findings and when required gives evidence at the inquest hearing. David Ranson emphasises the importance of a post-mortem examination, when stating that ‘[t]he autopsy is central to death investigation. Many coronial jurisdictions

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¹ Histology is the microscopic study of body tissue; and toxicology is the measurement of poisons or toxic substances in the body, and the probable effect of those chemicals on the person.
rely almost entirely on the medical death investigation to the exclusion of the other investigative processes that might be of value’. 4

Examining the dead to make determinations regarding the cause and manner of death has a long history. The Chinese as far back as 3000 BCE and the Egyptians in the seventeenth century BCE employed forensic techniques when conducting autopsies. The Chinese manual, *His Yuan Lu* (1236 CE), outlined procedures for the medical examiner to abide by when examining a dead body. It also described ways to interpret signs on the post-mortem body. 5 The practice of forensic pathologists carrying out post-mortem examinations began in early nineteenth century England. Ian Burney concluded that the English *1926 Coroners Amendment Act* represented ‘the culmination of a century of medicalizing reform’ which finally involved specialist pathologists in the inquest process, resulting in an expert-based, efficiency-oriented system of death investigation. 6 The *Coroners Rules of 1953*, stipulating that post-mortem examinations when possible should be conducted by trained pathologists, embedded the medico-legal death investigation system in coronial practice. 7

Forensic medicine practised by specialist pathologists was part of the inquest process in Victoria, Australia, from the 1860s onwards. 8 At this time, protests by Victorian medical

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practitioners against expert pathologists performing autopsies, mirrored those opposed to inquest reforms in England. According to Burney, medical practitioners claimed that through knowing the medical history of a patient the doctor would investigate certain things that an expert, engaged to provide ‘empirical pathological evidence’, may not think to explore. Nevertheless, as Andrew Brown-May and Simon Cooke state, at the end of the nineteenth century in Melbourne, the importance of the post-mortem had grown, and the morgue had become ‘the institutional home of the Coroner, and a site for forensic expertise’.

Morgue facilities and post-mortems in Queensland rural regions

The Queensland office of coroner and the Brisbane City Morgue were administered by the Department of Justice. The Department of Health and Home Affairs controlled all other morgues in Queensland, as most were situated in hospital grounds. In 1949 the Brisbane morgue was also transferred to the jurisdiction of Health and Home Affairs. Early Queensland morgues in rural areas were rudimentary structures, constructed according to a standard works department plan. They consisted of nothing more than a small wooden structure of one room containing a table on which post-mortems were carried out. Figure 1 shows the plan for the Geraldton “Dead House” and Figure 2 shows the plan for the Maryborough “Dead House”. Both plans were drawn up in 1886 and were typical of the

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10 Burney, Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926, p. 133.
12 Geraldton is a small town near Innisfail, Queensland.
design of late nineteenth century morgues in rural Queensland. Maryborough, being a larger town than Geraldton, was supplied with a mortuary that was slightly bigger and included the benefit of drainage for waste materials.

Figure 1: Geraldton Dead House 1886

Source: QSA Series ID 1162, Item ID: 583923, Architectural Drawings of Public Buildings
When a town had no morgue bodies were stored, and post-mortems were carried out, in any available building.¹³ For example, the Government Medical Officer at Nambour in 1931 objected to having to conduct post-mortems in the prison cells attached to the police station. In his opinion it was ‘undesirable to have live human beings living and sleeping in a room in which a post-mortem has been held’.¹⁴ In 1933, a corpse was placed under the hospital building in Tully, North Queensland, because the building that had served as a

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¹³ See Chapter 2, p. 22.
¹⁴ QSA Series ID: 13255, Item ID: 18974, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Dr Roberts to the 1/C Sergeant, Nambour Police Station, 25 June 1931.
morgue had been condemned and not replaced. Apart from the lack of concern over the obvious health risks related to this practice, the deceased was treated with a total lack of respect.

Archival records show that in the absence of a public morgue, hospital morgues were regularly used by police to store bodies awaiting identification and post-mortem examinations. This practice caused discord between hospital boards and the Justice Department, which administered public morgues up to 1949. After this the responsibility was handed over to the Department of Health and Home Affairs. In a letter dated 20 January 1937, Dr Harper, Medical Superintendent at Mossman Hospital, expressed to the Mossman Hospitals Board his dissatisfaction with the police placing bodies in an advanced state of decomposition in the hospital morgue. He explained that the ‘objectionable odour arising from the body could be detected in the Hospital kitchen’ and that the corpse attracted ‘millions of blow-flies’ that then ‘migrated to the Hospital kitchen and to the wards’. In conclusion he wrote:

I consider it a disgraceful state of affairs that such conditions should exist in these enlightened times. I .. ask the Board to communicate with the proper authorities, recommending that the Justice Department be asked to provide its own mortuary elsewhere …

15 QSA Series ID: 13255, Item ID: 18974, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Cardwell Hospitals Board to Cardwell Shire Council, 16 October 1933.
16 QSA Series ID: 5253, Item ID: 847243, Correspondence Inwards – Colonial Secretary, 1887; Medical Officer’s report on the morgue at St George Hospital to the Balonne Hospitals Board, February 1932; Townsville Hospitals Board to the Under Secretary, Department of Justice, May 1946.
17 QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Dr H Harper, Medical Superintendent, Mossman Hospital to Mossman Hospitals Board, 20 January 1937.
The Hospital Board sent a letter dated 23 January 1937 to the Under Secretary, Department of Health and Home Affairs, asking that the practice of police using the hospital morgue be discontinued. The Board’s letter, along with that of Dr Harper, was also sent to the Justice Department. The Board secretary wrote again on 16 August 1937 requesting this matter receive attention.\footnote{QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Mossman Hospitals Board to Under Secretary, Department of Health and Home Affairs, 16 August 1937.}

Dr Raphael Cilento,\footnote{Sir Raphael Cilento had worked as a medical officer for tropical hygiene with the Commonwealth Department of Health in Townsville, Queensland, prior to appointment as the director of the Australian Institute of Tropical Medicine in 1922. Following time spent in New Guinea he published \textit{The White Man in the Tropics} (1925) which reported the results of his research into the “white man’s” ability to survive in a tropical environment. In 1934 he was appointed as the first state Director-General of Health and Medical Services in Queensland. (Finnane, M., ‘Cilento, Sir Raphael West (Ray) (1893-1985)’, Australian Dictionary of Biography, National Centre of Biography, Australian National University, \url{http://adb.anu.edu.au/biography/cilento-sir-raphael-west-ray-12319}, accessed 27 March 2012).} Director-General of Health and Medical Services, was consulted by the Department of Health and Home Affairs on the matter. On 7 October 1937 Cilento wrote:

The complaint made by Dr Harper with regards to post-mortems of grossly decomposed bodies and the danger of contamination by flies, is a legitimate one. In many outpost towns, accordingly, arrangements are made that the doctor should perform the post-mortem on the spot where the body is discovered or, alternatively, that the body should be brought to some retired place close to the township and that the post-mortem should be carried out within a tent erected for the purpose. I have personally carried out many post-mortems under these conditions without ever finding any difficulty that could not be met adequately both medically and in a legal sense.\footnote{QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Dr Raphael Cilento, Director-General of Health and Home Affairs, to the Under Secretary, Department of Justice, 7 October 1937.}
Considering his research into the effect of climate on the spread of disease, Dr Cilento’s complacency towards the problems experienced by Dr Harper at Mossman Hospital, seemed out of character. The Department of Health and Home Affairs was slow to respond to the Mossman Hospital Board’s request, which indicated that the state of affairs at the hospital morgue was not considered critical. According to a Public Works report supplied to the Department of Justice, Mossman was still waiting for the provision of a public morgue in 1939.  

Later, on 28 August 1937 Dr Harper requested that the Department of Justice pay the hospital wardsman one guinea (£1.1/-) for assisting him to perform autopsies ordered by the police or the coroner. This work was not part of the wardsman’s hospital duties but was considered essential by Dr Harper when conducting post-mortems. According to Harper the assistant prepared the body for autopsy and afterwards for burial, in addition to cleaning down the morgue. If the Justice Department did not agree to this payment, Harper asked that he be supplied with an assistant to aid him with future cases. In his October letter, Dr Cilento advised that the Hospital Employees’ Award made no provision ‘for the payment of any fees for preparing the body for a post-mortem examination, nor for any other work in connection therewith’. The Department of Justice paid 10/- for the morgue to be cleaned following an autopsy and this amount was ‘in consonance with the Asylum Employees’ Award which allowed a fee of 10s/- to employees performing post-mortem work’. Cilento went on to declare:

21 QSA Series ID: 13255, Item ID: 18974, Correspondence and reports on hospitals and public morgues in Queensland, report from the Department of Works to the Department of Justice, 3 May 1939.
22 QSA Series ID: 13255, Item ID: 18973, Correspondence and reports on hospitals and public morgues in Queensland, Letter from Dr Harper to Officer in Charge, Mossman Police Station, 28 August, 1937.
I cannot agree with Dr. Harper that assistance in the actual performance of the post-mortem is required. I have personally done several hundred post-mortems without ever requiring lay assistance and have found such assistance to be a hindrance ... All that is, therefore, done by the assistant is the cleaning of the morgue.  

Cilento oversaw the centralisation of control over all State health services which ultimately put him at odds with individual members of the medical profession. His response to the issues raised by Dr Harper seemed to reflect his belief that he set the benchmark for all medical practices carried out in Queensland; he was not at all flexible. The claim for payment for an assistant to Dr Harper was disallowed and it was noted on the side of the document that approval would create a ‘dangerous precedent’. This notation reflected the on-going concern about the prospect of increased costs to the department and disregarded the potential improvement in efficiency of post-mortem examinations.

Julia Creek was more fortunate than other outback towns when it came to the provision of a morgue. Approval for the erection of a morgue was given in 1934 after Attorney-General John Mullan, MLA for the Flinders electorate (which included Julia Creek), made personal representation to the Minister for Works on behalf of the town council. A

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23 QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland, letter from Dr Raphael Cilento, Director-General of Health and Home Affairs, to the Under Secretary, Department of Justice, 7 October 1937.


25 Julia Creek, 1840 kilometres north-west of Brisbane, became a major transport hub for freight and passengers with the extension of the railway line from Richmond in 1908. The major industries in the area were beef, wool and mining. Eckford, S., Julia Creek, Faculty of Medicine, Health and Molecular Sciences, James Cook University, http://www.micrrh.jcu.edu.au/Our-Region/julia-creek.html, accessed 4 March 2012.
Department of Works letter informing the Attorney-General of approval for the morgue stated:

The building is designed to suit the requirements of small townships, and is a modification of the standard type Morgue.

Construction –
Concrete floor;
Galvanized corrugated iron walls (no lining);
Galvanized corrugated iron roof;
Asbestos-cement ceiling;
500 gallon tank.

The fittings to be provided are a lead covered mortuary table and a lavatory basin.

It seems that Mullan’s influence generated a favourable decision from the Department of Works. According to the plan medical practitioners performing post-mortems in the 12 feet by 9 foot 6 inch room, were working in an environment that contained asbestos and lead. The health risks associated with exposure to asbestos and lead were identified prior to this time.26 27

26 QSA Series ID: 13255, Item ID: 18973, Correspondence and Reports on Hospitals and Public Morgues in Queensland, Letter from Department of Works to John Mullan, Attorney-General, 30 November 1934; Plan of Morgue Standard Type, Department of Works, 10 February 1932.
27 By the early 1900s doctors in Europe knew asbestos workers were dying from respiratory ailments. There was a considerable amount of scientific knowledge accumulated about asbestos related diseases by the 1930s. (History of Asbestos, Asbestos disease Advisory Service of Australia, http://www.asbestosdiseases.org.au/asbestosinfo/historyasbestos.htm, accessed 4 March 2012. Occupational lead poisoning was detected in workers at Mt Isa Mines in 1931and led to a government inquiry in 1933, therefore the danger of exposure to lead was known when the plans for the Julia Creek
The facilities provided in Queensland morgues had improved little by 1938 as this report to the Police Commissioner on the morgue at Boonah discloses:

The morgue at Boonah is situated at the Boonah General Hospital and Dr. Yeates, who is in charge there, is not satisfied with the facilities for holding post-mortems. The building is 18 feet by 12 feet, wooden walls and galvanised iron roof. The floor is of wood and there are two windows and one door. The table used for the examinations is of wood and not drained with the result that fluids from the bodies under examination run on to the floor and the person making the examination has to walk in this fluid when moving about the table. There is no water laid on and any water used has to be carried in buckets. There is no electric light and if an examination is made at night somebody assisting the doctor has to hold a hurricane light, which is not very suitable. There are no instruments at the morgue; any instruments used are supplied by the doctor.\(^{28}\)

Yet conditions in Queensland appear little different from those in England at this time. The description of post-World War II mortuaries in local parishes in England, as described by Arthur Mant, forensic pathologist at Guy’s Hospital, showed conditions in Queensland morgues were almost identical. Mant wrote:

> The mortuaries were often provided with only a body slab which post-mortem examinations had to be performed; the lighting was usually very substandard, water was often heated in a bucket or urn by the mortuary attendant, and heating was provided by oil stoves, gas or electric fires. If there were a hard frost the pipes would freeze, and water for all purposes had to be carried in by buckets. The pathologist had to come equipped with instruments, bottles, bacterial swabs and preserving fluids …\(^{29}\)

\(^{28}\) QSA Series ID: 13255, Item ID: 18974, Correspondence and reports on hospitals and public morgues in Queensland, report from Inspector's Office Ipswich to Commissioner of Police, 12 December 1938.

By the mid-twentieth century, in both England and Australia, the post-mortem had evolved into one of the most important functions of the morgue. In spite of this, morgue designs and facilities were still woefully inadequate for the task.

Research for this thesis has revealed the extent to which cost factors have influenced decisions made by the State government, and compromised the health and welfare of Queensland citizens. For example, in May 1961, the Cloncurry Hospital Board wrote to the Department of Health and Home Affairs requesting permission to ‘borrow by debentures, a loan of £720, from the Bank of New South Wales, Cloncurry’ for the purpose of purchasing a freezer unit for the morgue. The repayments on the loan were to be funded from the hospital’s canteen profits over the following three years. The government denied the request for the following reason:

Approval has previously been refused the Board for the provision of refrigeration in the Cloncurry morgue as it was considered the expense would not be warranted for a hospital of this size where only a limited number of autopsies would be performed. An approval in this case would have a far reaching effect in so far as other hospitals of this size are concerned.\(^{30}\)

What the government implied in their response was that if one country town was provided with refrigeration facilities for their morgue, other country towns would expect equal services. The government, with its parsimonious attitude, could not let this situation develop and consequently denied the Cloncurry Hospitals Board request. The State

\(^{30}\) QSA Series ID: 8400, Item ID: 280670, Special Batches.
government’s decision in 1961 to deny the Cloncurry Hospital’s request to install refrigeration to the morgue was inconsistent with its resolution to build the Brisbane Institute of Forensic Pathology in 1959. It appeared that as far as the government was concerned, inadequate facilities and unhygienic conditions were acceptable in rural areas because only a few post-mortems were performed yearly. Due to limited resources, those citizens unfortunate enough to die in country areas did not have their cause of death investigated as thoroughly as their city counterpart. As a result, not all inquests were effective agents of accountability and failed to meet their legal obligations under the legislation.

**Early Brisbane City Morgues**

Brisbane’s first public morgue was built in the grounds of the Brisbane General Hospital in 1863.\(^{31}\) Sharing the morgue with the hospital was problematic and eventually a new city morgue was built in 1877 at North Quay behind the museum on William Street.\(^{32}\) The first census, taken in 1861, measured the population of Queensland as 30,059 non-indigenous persons. Two-thirds of this population lived in areas outside of Brisbane, Ipswich, Toowoomba and Warwick.\(^{33}\) Queensland, like Victoria, experienced a large increase in population when gold was discovered in the 1860s and 1870s. Brown-May and Cooke note that the discovery of gold in Victoria in 1851 led to the tripling of Melbourne’s population and subsequently a dramatic increase in the number of deaths. The Melbourne City

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\(^{31}\) *Courier* 18 October 1862, p. 2, 5 September 1863, p. 3.

\(^{32}\) *Queenslander*, 14 July 1877.

Council called for the provision of a morgue which Brown-May and Cooke maintain was partly in response to the need for identifying ‘the deceased in a society of immigrant strangers, and partly a requirement of the climate’. They show that Melbourne’s first central morgue was constructed in the late 1850s and by the 1890s the morgue ‘had become the main site of coronial inquests’. In contrast, a Brisbane morgue was never the site of a coronial inquest; the judicial and medical sites of death investigation always remained separate.

A large landslide in February 1890 severely damaged the morgue and on 29 May 1890 the government advertised for tenders to remove and re-erect the morgue. Once again the morgue was situated on the river bank near Queen’s Wharf, but was swept away during the 1893 Brisbane flood. The Government Architect, A B Brady, suggested the new morgue be built on a pontoon moored to the riverbank as he considered a morgue should be isolated but in easy reach of the river. He had drawn up plans for a new brick morgue, 22 feet by 32 feet, with four tables, wall vents, a lantern light and ridge vent. When no decision on the morgue was forthcoming from the government, he then suggested building the morgue in the railway yards in Countess Street. Following a review of the expenditure on the previous two morgues, erection of a new morgue was postponed. As an alternative, the Brisbane Hospital morgue was utilised as a public morgue, and became the joint property of the hospital committee and the government.

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35 QSA Series ID: 8843, Item ID: 290336, Police Station Files.
36 Brisbane Courier, 30 August 1910, p. 4.
Medical Superintendent of the hospital, J B McLean, complained about the use of the mortuary by police. In 1905 a general renovation of the hospital mortuary was carried out in response to McLean’s objection to the hospital’s exposure to the stench emanating from fly blown, decomposing bodies stored in the mortuary by police. At the time, health standards were also compromised by the discharge of untreated waste from the morgue straight into Breakfast Creek.\(^{37}\) The neglect of standards of hygiene in the colony was blamed for the spread of diseases such as smallpox, typhoid fever and the plague. In an effort to stem the spread of these diseases the government had enacted three major health acts in the late nineteenth century. Additionally, in a move to further improve the standard of health in the state, the Queensland State Health Department was established under the 1900 *Health Act*.\(^{38}\) Despite the new legislation, the Brisbane Hospital morgue was allowed to continue with a practice that posed a serious risk to public health. In 1907 the government began searching for a suitable site to build a new city morgue.\(^{39}\) It was not until 1910 that the new public morgue was erected in Brisbane at a cost of £855.10.00\(^{40}\). It was later moved in 1927 to a less prominent site further down the river at the end of Alice Street.\(^{41}\)

\(^{37}\) Watson, D., Architect, Department of Public Works, Brisbane, email communication 12 April 2010.  
\(^{39}\) QSA Series ID: 8843, Item ID: 290336, Police Station Files.  
\(^{40}\) QSA Series ID: 13255, Item ID: 18974, Correspondence and Reports on Hospitals and Public Morgues in Queensland.  
The morgue is the white building in the foreground on the edge of the river. Source: Gregory, H. (2007) *Brisbane then and now*, Wingfield S. Aust: Cameron House.

**The Development of Forensic Medicine in Death Investigations in Queensland**

When a violent, suspicious or unnatural death occurs, a number of agents are involved in the pre-inquest investigation. The police, medical practitioners, pathologists, and experts in specific fields usually produced reports for the coroner. The use of forensic medicine became a valuable aid to the office of coroner. Yet the efficiency of post-mortem examinations in Queensland was compromised by the appalling conditions under which government pathologists were expected to work.

Dr James Duhig established Queensland’s first pathology laboratory at the Mater Misericordiae Hospital in 1920, then founded the Pathology Department at the Brisbane General Hospital in 1924. He set up the Red Cross Blood Bank in Queensland and was
professor of pathology at the University of Queensland from 1938 to 1947.\textsuperscript{42} As Acting Government Pathologist in the year 1931, he wrote to the Home Secretary suggesting ways of dealing with the storage of unidentified bodies in the morgue, and the importance of carrying out pathological tests at post-mortems. With respect to post-mortem examinations he stated that prior to taking on his current position:

there were no records kept beyond the three or so lines on the Death Certificate. Strictly speaking, there should be a book of forms which would enable the pathologist to set out all the information he obtains … In the meantime, I use a ledger knowing that the cost of printing the book I would like would be too great at present.\textsuperscript{43}

Dr Duhig, writing at the beginning of the Great Depression in Australia, was aware that attempts to reduce expenditure were of vital importance. The 1931 Premiers’ Plan implemented by the Moore government, ‘called for a 20% reduction in government expenditure, increases in commonwealth taxes, and lower interest rates’.\textsuperscript{44} Was the paucity of post-mortem records due to government restrictions on printing expenditure or was it that the data gathered was not valued? It is plausible that both considerations were applicable to the situation.

Duhig also noted that a conflict seemed to exist between the Acts under which the Coroner and the Registrar operated. While the Registrar required that deaths be registered within

\textsuperscript{42} James Vincent Duhig was the nephew of Brisbane’s Archbishop James Duhig. See Leggett, C. A. C., Australian Dictionary of Biography, National Centre of Biography, Australian National University, \url{http://adb.anu.edu.au/biography/duhig-james-vincent-6035}, accessed 10 March 2010.

\textsuperscript{43} QSA Series ID: 16865, Item ID: 316239, Correspondence Police, Post Mortems (and Coroners Inquests), Letter from Dr J V Duhig to the Home Secretary, 16 February 1931.

\textsuperscript{44} Scott et al., \textit{The Engine Room of Government: The Queensland Premier’s Department 1859-2001}, p. 97.
thirty days, in certain circumstances inquests ran longer than thirty days and in some cases were not held for a number of months. Therefore the coroner was prevented from determining cause of death within the required timeframe. Delays in the holding of inquests were a recurring problem in Queensland which consistently attracted the attention of the press during the 1930s. Although the Attorney-General and Police Commissioner ordered reports on the reasons for such delays, very little was achieved in reducing the long waiting period prior to the holding of an inquest.

On the subject of identification of bodies, Dr Duhig suggested a statutory period be determined within which identification must be made. A decomposing body should either be embalmed or removed to some alternative place of storage, as it was unreasonable to expect members of the public and the police force to tolerate the stench. Duhig had mentioned the possibility of embalming the bodies awaiting identification but this solution was considered too expensive. Instead, an alternative was to temporarily preserve fresh bodies via:

- the use of formalin injected into the body through the use of an embalming syringe and needle;
- and in the case of bodies in a state of putrefaction [sic], they could be covered with Cellulose Wadding soaked in lysol, which would absorb foreign matter and keep down the smell.
The Brisbane morgue keeper was already using Formalin and Lysol to help control offensive odours, but could see a benefit in the use of the cellulose wadding soaked in Lysol.\(^{48}\) Duhig also recommended giving a pathologist the right to suspend the rule prohibiting the removal of bodies after 6pm in circumstances where decomposition was well advanced. This would allow for removal of the body from the morgue directly following the autopsy and in cases of emergency, permit the burial outside normal burial hours. Furthermore, he argued that when the position of Government Pathologist was created, it should be ruled that ‘when deemed necessary by some competent authority, tissues or organs of deceased persons should be sent to the Pathologist for Microscopic or other examination’. He then went on to point out that there were no facilities at the present morgue for microscopic or bacteriological work. Maintaining that ‘the day has gone by when accurate judgments can be formed by naked eye examinations alone’, Duhig called for the government to assist the Brisbane and South Coast Hospital Boards to ‘build a proper mortuary at the Hospital and so enable its officer to do the most efficient work there’.\(^{49}\)

Dr Duhig concerned himself with implementing a new system for death investigations in Queensland. He called for police to become better acquainted with pathological details when making their inquiries. He offered to write his reports in simple language, setting out all the details connected with the death. The doctor felt the report could then take the place of a pathologist appearing as a witness at the inquest, thus avoiding the information having

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\(^{49}\) QSA Series ID: 16865, Item ID: 316239, Correspondence Police, Post Mortems (and Coroners Inquests), Letter from Dr J. V. Duhig to the Home Secretary, 16 February 1931.
to be extracted by counsel. Duhig’s suggestion of a simplified medical report met with the Police Commissioner’s approval, however the Commissioner still maintained that a medical practitioner was always required to appear at an inquest. This was because questions asked by counsel could never be predicted.

The city coroner (W Harris Esq. PM) had been furnished with a copy of Duhig’s letter to the Home Secretary, but offered no comment. Acting Sergeant Norton interviewed Dr Duhig regarding the matters raised in his letter and reported to the Home Secretary. According to Norton, Duhig proposed removing a putrefied body to a shed placed at a distance from the morgue itself. This would avoid the need to suspend the rule prohibiting the removal of bodies after 6pm. His recommendation that the city morgue be moved to the Brisbane Hospital, where a laboratory existed for carrying out pathological examinations and tests, was deemed impractical. The hospital was considered too far away for members of the public to travel for identification purposes. Additionally, the present site of the morgue was considered more suitable for the removal of drowning cases from the river by water police. The correspondence shows that locating the public morgue on the river was an important factor in choosing a location, due to the difficulties of removing bodies from the water to the morgue, while at the same time maintaining the privacy and dignity of the deceased. Freckelton and Ranson claimed that mortuaries built in Melbourne Victoria during the nineteenth century were situated beside water to allow ‘autopsy waste and fluids

50 QSA Series ID: 16865, Item ID: 316239, Correspondence Police, Post Mortems (and Coroners Inquests), Letter from Dr J V Duhig to the Home Secretary, 16 February 1931.
52 QSA Series ID: 16865, Item ID: 318879, Correspondence, Police.
to be carried away by the tides’. The evidence shows that this method of disposing of waste was not an issue when choosing a location for the Brisbane City Morgue. Although waste material from the Brisbane General Hospital, which included the morgue, was discharged into Breakfast Creek in the first decade of the 1900s, the city morgue (erected in 1910) disposed of waste via a drain that emptied into a sump. While the Brisbane morgue did not deposit autopsy waste and fluids into the Brisbane River, the preferred location of the morgue was alongside a water source. From 1877 until 1992 the Brisbane City Morgue occupied five different sites, all of which were on the Brisbane River. This was because the riverside location of the morgue met the requirement of close proximity to the city and ease of access for the Water Police.

Dr Duhig maintained that retention of the morgue at its present site meant the government would have to provide adequate facilities to allow him to carry out his work. He stated to Norton that:

he wished to stress on [sic] the advantages of pathology as by its means in the event of a prosecution, the defending Counsel would not be able to break down the testimony of the Pathologist giving evidence, as he might be able to do with a Medical man who was giving his opinion formed by the naked eye examination alone.

Duhig’s statement shows he was well aware of the value of specialist pathological investigation, over the traditional examination, when it came to investigating death. In a

53 Freckelton and Ranson, *Death Investigation and the Coroner’s Inquest*, p. 39.
54 Watson, D., Architect, Department of Public Works, Brisbane, email communication 12 April 2010.
In the legal sense, he emphasised the importance of the level of knowledge provided by a pathologist at an inquest. Dr Duhig was not the first pathologist to promote the value of forensic medicine in determining the cause of death. James Neild, a specialist forensic pathologist in Victoria during the late 1800s, claimed that knowledge of medicine alone was insufficient to instill the principles of medical jurisprudence. He advocated the inclusion of forensic medicine in the post-mortem procedure.\textsuperscript{56} Likewise, Kesselring and Burney identified the increasing use of forensic medicine in England from the mid-nineteenth century onwards.\textsuperscript{57}

The Alice Street Morgue

The building utilised as the Brisbane morgue in the 1930s was originally built at North Quay in 1910 to replace the morgue washed away in the 1893 flood. The morgue was then moved in 1927 to a site on the river at the end of Alice Street, and was commonly known as the Alice Street Morgue.\textsuperscript{58} The morgue was a rectangular shaped timber framed building clad with galvanised iron, divided into three sections. The first section consisted of a vestibule and office. The central section contained a table with a metal cover to which was attached a funnel running up to the roof. Post mortems were carried out here, however the morgue keeper also stored decomposed bodies under the cover. The end room, labelled the “post mortem room”, held the “fresh” bodies. Members of the public taken to the city morgue to identify a body had no choice but to pass through the middle room, which often


held the unbearable stench of a putrid body. According to Acting Sergeant Norton, as many as five bodies could be lying in the morgue at one time, necessitating the placement of two bodies on the one table. He had witnessed a doctor holding a post mortem with another body lying alongside on the operating table. The building of another room eighteen feet by twelve feet, beside but apart from the main building, was recommended by Norton in order to greatly improve conditions at the morgue.59

The links between the police and health departments is apparent from the pattern of communication followed in this matter. Inspector Meldon forwarded to the Commissioner of Police the report of Acting Sergeant Norton, along with his own report containing recommendations that an additional room be erected at the city morgue. The extra room was to accommodate bodies awaiting identification. Meldon also suggested facilities be provided for Dr Duhig, as well as the supply of a stock of cellulose wadding for the morgue keeper.60 Architectural plans from 1931 show that only minor alterations were made to the morgue. They consisted of new basins, a new shelf and connection of power for a heater, and the replacement of the existing post mortem table with a new revolving table.61 Little attention was paid to the urgency of the situation at the city morgue and it was not until 1943 that the government undertook structural alterations to improve conditions at the morgue. Regrettably, these improvements were a long way short of Dr Duhig’s proposal in 1931. Duhig’s call to introduce a modernised program associated with

60 QSA Series ID: 16865, Item ID: 316239, Correspondence Police, Post Mortems (and Coroners Inquests), Report of Inspector Meldon, Roma Street Police Station.
61 QSA Series ID: 16433, Item ID: 101441, Brisbane Morgue Alterations, Additions and Refrigeration.
“scientific medicine”, a valuable investigative tool in the detection of murder, was disregarded.

Figure 4: Proposed alteration to Brisbane Morgue (1931)

Source: QSA Series ID: 8400, Item ID: 280668, Morgues Brisbane

Without the benefit of refrigeration, the storage of bodies in the hot climate had always posed a great problem for government health officials. The government seemed reluctant to meet the expense of refrigeration at the city morgue. Dr Raphael Cilento, Director General of the Department of Health and Home Affairs, advised the Under Secretary Department of Justice in February 1940 of a discussion held with Commander Rhodes, District Naval Officer for Queensland, who requested the removal of the city morgue to another more
suitable site, due to the objectionable odours emanating from the building. The matter had only recently become an issue because of the increased use of the Naval Depot next door under active service conditions. The government refused to relocate the morgue and was reluctant to meet the expense of refrigeration. Alternatively, they investigated the possibility of installing refrigeration chambers.

Plans in the archival file, drawn up by Waugh and Josephson Limited, refrigeration engineers of South Brisbane, show an insulated chest to accommodate four bodies. The dimensions of the chamber were six feet six inches high, seven feet six inches wide and eight feet long. The outside and inside of the chamber was constructed of timber with granulated cork between each layer. The chamber was zinc lined. A cooling coil ran lengthways down the middle, dividing the container in two, which allowed the storage of two bodies on either side, one above the other in separate compartments. A hinged door on the side opened to allow a body to be slid in on a nickel plated stretcher on rollers. The cost of production was not included with the plans and there is no indication that the refrigerated chambers were ever introduced.⁶²

Cilento commented that the naval officer did not mention the cost of the morgue’s removal, but suggested that the officer could make representation to the Department of Defence ‘with a view to money for refrigeration space being provided as a military

⁶² QSA Series ID: 16433, Item ID: 101441, Brisbane Morgue Alterations, Additions and Refrigeration.
necessity’ as there was no money available in State funds. Cilento maintained that the objectionable odours were only present when decomposed bodies were held in the building, adding that this was an infrequent occurrence; at other times the smell was barely detectable apart from inside the morgue. According to Cilento, in the future, when a decomposed body arrived at the morgue every effort would be made to have a post-mortem performed at once. If necessary he would approve the holding of a post-mortem outside the usual hours, provided the coroner consented to the procedure as he was required to view the body beforehand. The government seemed to be moving towards a more forensically based autopsy as evidenced by Cilento’s reference to the establishment of a fully equipped Medical-Legal Institute ‘pending a determination as to the housing of the Department of Microbiology and Pathology in a contemplated extension of the Department of Health and Home Affairs’.  

The Laboratory of Microbiology and Pathology began as a Stock Institute in Turbot Street (1893) under the directorship of Charles Pound. In 1899 the scope of the laboratory extended to the fight against human disease and the name was changed to the Bacteriological Institute and the laboratory was transferred to the suburb of Normanby. Pound was appointed government bacteriologist. In 1910 the institute was split into the Laboratory of Microbiology and Pathology under Dr John Harris, attached to the Department of Health, and the Stock Institute under Pound, attached to the Department of Agriculture and Stock. Ultimately the Laboratory of Microbiology and Pathology was

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63 QSA Series ID: 16433, Item ID: 101441, Brisbane Morgue Alterations, Additions and Refrigeration.
64 QSA Series ID: 16433, Item ID: 101441, Brisbane Morgue Alterations, Additions and Refrigeration.
incorporated into the Department of Health and Home Affairs in William Street in 1935, with Edward Derrick as medical director. Derrick left the Laboratory of Microbiology and Pathology in 1946 to establish the Queensland Institute of Medical Research in a fibro-cement hut in Victoria Park.\textsuperscript{66}

**Extensions to the Morgue**

In 1943, the government moved to extend the Alice Street morgue and improve overall conditions. In July of that year the Department of Justice informed the Medical Superintendent of the Brisbane and South Coast Hospitals Board that structural alterations were to be carried out on the city morgue. For that reason, the mortuary belonging to funeral directors Cannon and Cripps, Grenier Street Fortitude Valley, was rented for a period of approximately three months to accommodate the needs of the public mortuary. Alterations to the morgue consisted of a galvanised iron, timber framed post mortem room erected on the side of the present structure and extending the existing post mortem room. Most importantly, a refrigeration room was installed along with exhaust vents in the roof to aid ventilation. Other improvements included provision of hot water to the shower, additions to the electricity supply as well as extra mortuary tables and trolleys.\textsuperscript{67} The renovations carried out at the city morgue still only met minimum requirements. Australia’s participation in the Second World War had entered its fourth year and although the government was well aware of the urgent need to improve conditions at the morgue,

\textsuperscript{67} QSA Series ID: 8843, Item ID: 290336, Police Station Files.
the high cost of the State’s involvement in the war, and the uncertainly of the length of the war, resulted in stop gap measures being employed to reduce costs.

A new timber pontoon connected with the Alice Street Morgue was built on the riverbank in 1950. The water police requested retention of the pontoon at the city morgue jetty in August 1956, claiming it was the only convenient place for the landing of deceased persons recovered from the city reaches of the Brisbane River. The wharf at the Department of Harbours and Marine was too high and the pontoon used by the public ferry was too open to public gaze. Both were therefore unsuitable for the operational transfer of a body from the Water Police craft to an undertaker’s vehicle for transportation to the morgue. As the correspondence shows, Queensland police displayed a strong preference for a river landing attached to the public morgue. The Minister for Health and Home Affairs announced in May 1959 that no ‘river landing’ would be provided at the new morgue as the Water Police Station jetty would be used to land bodies recovered from the river.

Shortly after the Minister’s announcement, a deputation from the Queensland Police Union visited the Commissioner of Police, Frank Bischof, to discuss the practicality of providing a jetty at the site of the proposed new morgue. They advised that there was ‘no jetty of any description at the Water Police Station’ and suggested that the existing pontoon and landing stage at the present morgue be moved to the site of the new morgue. This would involve extending the landing stage to cross the mudbank at the site, but it was considered

68 QSA Series ID: 8843, Item ID: 290336, Police Station Files.
69 QSA Series ID: 16865, Item ID: 318879, Correspondence, police.
the expense attached to such an exercise would be manageable. The reason given for maintaining a river landing related to the difficulty of handling bodies in a state of decomposition. It was also claimed that:

the recovery and transport of bodies so recovered attract large numbers of morbid spectators and it is felt that facilities should be provided so that the task could be carried out with dignity and respect to both the deceased and relatives … a most disagreeable task could be carried out without exposing the activities of the Water Police to the morbid gaze of sightseers.70

It was customary for any Queensland morgue situated on a riverbank to have a pontoon and landing-stage attached.

**The Institute of Forensic Pathology**

The Department of Justice transferred control of the morgue to the Department of Health and Home Affairs in November 1949. The mid 1950s heralded the commencement of planning by the Department of Health and Home Affairs for construction of a new public morgue in Brisbane, which would also operate as a teaching facility. The use of expert scientific examination to establish cause of death of a deceased person had been part of the coronial inquest process in Australia, although not consistently, since the late nineteenth century. In the latter years of the nineteenth century James Neild, a specialist pathologist from Melbourne, Victoria, regularly appeared as a witness at inquests and held post mortems at the request of the city coroner. Critical of the lack of pathological training of

70 QSA Series ID: 16865, Item ID: 318879, Correspondence, police, letter from Queensland Police Union to the Commissioner of Police, 22 June 1959.
general practitioners, the coroner engaged Neild to carry out autopsies when investigating suspicious deaths.\footnote{Love, \textit{James Edward Neild: Victorian Virtuoso}, p. 159.} Although Dr Duhig stressed the need for expert pathological examinations in the post-mortem procedure, Queensland authorities were extremely slow to employ the measures he recommended.

The most unsatisfactory state of the city morgue was brought to the attention of the Director-General of Health and Medical Services in September 1955 by Dr John Tonge. He advised of the urgent need to erect a new morgue on another site, but in the meantime, alterations to the current morgue were necessary to enable work in the building to continue. On reading a Public Works Department report that indicated the cost of renovations would be quite high, Dr Tonge maintained that the building would continue to remain quite inadequate even after the temporary alterations were completed. According to Dr Tonge the building was far too small for the ever increasing demand made on it, the layout was flawed and it would be impossible to ‘eliminate either the noise or dirt which comes from the adjacent sand and gravel depot’, while ‘[t]he present autopsy tables have been condemned as unhygienic and quite unsuitable’.\footnote{QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Letter from Dr Tonge, Director, Laboratory of Micro-Biology and Pathology to the Director General of Health and Medical Services, 9 December 1955.} A further report from the Architectural and Estimating Branch of the Department of Public Works fully supported Dr Tonge’s evaluation of the current state of the morgue. In the report it was suggested that ‘serious
consideration be given to obtaining a more suitable building and position for the City Morgue’ before approval was sought for the proposed renovations.\footnote{QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Report of D. Mercer, Architectural and Estimating Branch, Department of Public Works to the Chief Architect and Chief Quantity Surveyor, Department of Public Works, 14 December 1955.}

Bacteriological analysis was becoming an increasingly important part of the autopsy procedure, especially in the investigation of the deaths of newborn infants. However Dr Tonge considered it ‘well nigh impossible to make bacteriological cultures due to the prevailing conditions’ at the morgue. In his opinion, a new site for the city morgue should be obtained as soon as possible, and he recommended the Geological Survey Bulk Store in William Street for conversion to a morgue. This site was dismissed as unsuitable in March 1956 because it was too close to government offices and Parliament House. In contrast to the thoughts of others, especially the Water Police and the Queensland Union of Police Employees, Dr Tonge did not consider it necessary for the city morgue to be situated on the river bank.\footnote{QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Letter from Dr Tonge, Director, Laboratory of Micro-Biology and Pathology to the Director General of Health and Medical Services, 9 December 1955; Note on memorandum to Under Secretary the Department of Public Works form R. Fryberg, Director General of Health and Home Affairs, 12 March 1956.}

Complaints about the unsatisfactory state of the Alice Street Morgue were steadily increasing and in January 1956 the Brisbane Chamber of Commerce wrote to the Department of Health and Home Affairs to advise them of the city funeral director’s ‘concern at the un-hygienic conditions at the Brisbane Morgue’.\footnote{QSA Series ID: 8843, Item ID: 290336, Police Station Files.} Eventually, when an
incident occurred at the morgue that affected a member of parliament, the government reacted quickly to the related criticism. Alexander Dewar, MLA for Chermside, visited the city morgue in June 1956 to identify the body of his mother, who had been struck and killed by a motor vehicle at six o’clock that evening. Dewar was appalled at the ‘state of affairs’ he encountered when taken by police to the morgue at ten o’clock at night. He was so disgusted he raised the matter four months later in parliament. Having to leave his mother’s body at the morgue over the weekend in order for an autopsy to be performed on Monday morning caused great distress to Dewar. He proclaimed:

This is wrong in any community that calls itself Christian. I will not rest until something is done about it. It simply means that if a person is unfortunate enough to lose his life on a Saturday nobody is interested in the body until Monday morning.\(^{76}\)

In response to Dewar’s complaints, relevant authorities ordered a review of the duties of police at the city morgue, particularly on those occasions when the morgue attendant was off duty.\(^{77}\)

Dewar was escorted to the city morgue by Constable Squassoni. Upon arrival he took Dewar straight into the refrigeration room. From a refrigerated cabinet Squassoni pulled out (to a distance of approximately one foot) the tray on which Mrs Elizabeth Dewar had

\(^{76}\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Extract from Hansard attached to letter from Mr H Noble, Minister for Health and Home Affairs to Mr A Jones, Minister for Labour and Industry

\(^{77}\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Minister of Health and Home Affairs to the Minister of Labour and Industry, 6 November 1956.
been placed. Dewar then identified his mother’s body. Having been advised by Constable Squassoni and the funeral director at Alex Gow Funerals that the body could not be removed until a post mortem examination had been made, Dewar then phoned the coroner to request an emergency autopsy. The coroner informed him that under the coroner’s act a post-mortem examination would have to be completed before permission was given to move the body. Dewar was led to believe that a government doctor was the only person authorised to carry out an autopsy, yet Section 11 sub-section (1) of The Coroners Acts, 1930 to 1943 provides that:

The Minister or a coroner may in his discretion order a post-mortem examination of any deceased person for the purpose of an inquest, and the Minister may order the body of any deceased person to be exhumed, and for that purpose the coroner may, with such assistants as he may require, enter and break open any ground, cemetery, or place for the purpose aforesaid.

while sub-section (2) reads:

Where the Minister or a coroner orders a post-mortem examination as aforesaid, it shall be lawful for any member of the Police Force on production of such order –

(a) To enter in or upon any premises and take possession of the body;
(b) To have such body conveyed to the morgue or other suitable place for the conduct of such post-mortem examination;

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80 Coroners Acts, 1930 to 1943, 7 Geo. VI, No. 8.
(c) To arrange with a medical practitioner to perform such post-mortem examination.\(^81\)

While the Act did not specify a particular medical officer to conduct the post-mortem, it was usual for pathologists attached to the Laboratory of Micro-Biology and Pathology to conduct post-mortems at the city morgue.\(^82\)

Dr Derrick was appointed Director of the Laboratory of Microbiology and Pathology in 1936, and according to Dr Tonge the government instructed Derrick to carry out all post-mortems for the State to justify his nine hundred pound annual salary. Dr Tonge stressed that in spite of the second rate conditions he and Derrick worked under, from that time onwards, post-mortems were exhaustive and record-keeping were meticulous. He claimed that up to 1936 general practitioners, who held no special training and no interest in the work, conducted post-mortems. Tonge maintained ‘[t]hey were only interested in the fees’.\(^83\) After 1936, no private practitioner or doctor working for the General Hospital had ever applied to hold a post-mortem examination.\(^84\) Responding to Dewar’s criticism, Dr Tonge advised the Director General of Health and Medical Services that a medical officer from the Laboratory of Micro-Biology and Pathology was available at any time of the week or week-end to carry out post-mortem examinations. Consequently, there should be no necessity to call upon a doctor from the General Hospital or private practice to carry out

\(^{81}\) *Coroners Acts*, 1930 to 1943, 7 Geo. VI, No. 8.

\(^{82}\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane.

\(^{83}\) Personal communication with Dr John Tonge, 15 April 2010.

\(^{84}\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane.
Tonge also pointed out that post-mortems only took place on the week-ends in an emergency, because calling in the morgue keeper was costly.  

Subsequent to Dewar raising the matter in parliament, Sub-Inspector Diflo of Roma Street Police Station was instructed to investigate and report on the procedure followed in the Brisbane Police District in relation to the viewing of dead bodies and attending post mortems. Reporting on conditions at the morgue Diflo explained that:

the refrigerator was built to accommodate nine bodies in tiers of three, but same is an antiquated affair, dirty, blood stained, and in my opinion should be condemmed, and if Mr. Dewer, M.L.A., for Chermside was unfortunate enough to see inside the refrigerator, he has just cause for complaint, as the stench alone is putrid.

The Police Commissioner decided that the problems at the morgue lay with the lack of facilities rather than with police procedures associated with the viewing of bodies and the holding of post-mortems. He noted that Inspector Palethorpe of Police Headquarters had recently visited the public morgue in Melbourne and submitted a very favourable report on the building itself and the facilities provided. Furthermore, Palethorpe reported that post mortem examinations were not conducted at the Melbourne Morgue over the weekend. For a second time, the Commissioner concluded that there was an ‘urgent need for

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85 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Dr Tonge, Laboratory of Microbiology and Pathology to the Director General of Health and Medical Services, 5 February 1957.
improvement and modernisation of facilities at the City Morgue’ and recommended that ‘the facilities for persons waiting to view bodies and for storage and viewing of bodies be modernised’. As a result of Dewar’s emotional presentation to the House, the Health and Home Affairs Minister acknowledged that the need for a new morgue was critical. Subsequently moves were made to decide on a site for a new morgue and an order was issued for plans to be drawn up.

A new site for the Morgue and the 1956 alterations

Just prior to Dewar’s complaint, a site situated in the Domain, which formed part of the Brisbane Botanical Gardens, was submitted by Dr Tonge in August 1956 as a suitable location for the new morgue. The advantage of the site according to Tonge was its relative isolation and the close proximity to the medical offices of the laboratory. The land was owned by the Brisbane City Council, so he suggested approaching the council to enquire whether they would agree to the site being excised from the Domain for the purpose of ‘setting it aside as a site for a morgue’. The matter was then referred to the Public Service Commissioner for investigation and recommendation of a site.

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89 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Letter from John Herbert, Liberal Member for Sherwood to Mr D Home, 8 June 1959.
90 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum to the Under Secretary, Department of Public Works from the Under Secretary, Department of Health and Home Affairs, 2 August 1956.
When advised by a representative of the Public Service Commissioners Department that the Under Secretary of the Public Works Department had ‘strongly urged’ that the morgue be placed at the Brisbane General Hospital, Dr Tonge wrote to the Director General of Health and Medical Services advising of his rejection of the location. He listed his objections to building the morgue in the grounds of the hospital as follows:

- it is placed at a long distance from the State Health Laboratory and would entail considerable inconvenience for the pathologists concerned in travelling to and from there, often several times a day. In addition numerous specimens have to be conveyed from the Morgue to the Health Laboratory for further investigation and often specimens for bacteriological examination require rapid transport. … It would seem also that the City Morgue should be placed in a more central situation with more ready access to the Water Police.91

Tonge’s correspondence points to the link between the river, the morgue and the medical laboratory. A morgue located on the riverbank assisted the Water Police when retrieving bodies from the river, while a central city site facilitated the swift dispatch of fresh medical specimens from the morgue to the health laboratory. The Public Service Commissioner’s Department recommended that the land ‘known as “The “Domain” be selected as a site for the new City Morgue’ and that ‘as a preliminary to the taking of the above action, the Brisbane City Council be advised of the government’s decision to excise an area from the Botanic Garden Reserve’. The government did not need approval from the council to acquire the land. Under the provisions of the Land Acts, an Order in Council to alter the

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91 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum to the Director General of Health and Medical Services from Dr Tonge, Director of the Laboratory of Micro-Biology and Pathology, 20 November 1956.
boundaries of the Botanic Gardens’ reserve to exclude the part of the land required for the new morgue was sufficient.\(^{92}\)

In the meantime, repairs and additions to the Alice Street Morgue, which were approved in February 1956, were completed in September at a cost of £1,456. The plans below, showing the floor plan of the morgue prior to and following completion of the renovations, indicate that facilities at the city morgue remained extremely rudimentary.

Figure 5: Floor layout of city morgue prior to September 1956

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\(^{92}\) Other sites considered included land adjacent to the Primary Correspondence School in College Road, land facing Turbot Street between Jacob’s Ladder and Albert Street, the Old Masonic Building in Alice Street, the Brisbane General Hospital, land at Kangaroo Point and the Geological Bulk Store in William Street. QSA Series ID: 8400, Item ID: 280668, Morgues Brisbane, Report from the Public Service Commissioner to the Secretary for Public Works, Housing and Immigration, 8 February 1957.
Figure 6: Floor layout of city morgue after September 1956

Source: QSA Series ID: 8400, Item ID 280668, Morgues Brisbane

Figure 7: Alice Street Morgue (1955) prior to 1956 alterations

Source: John Oxley Library, State Library of Queensland, Image number 34355.
A skillion roof was added to the side of the building to provide cover for loading and unloading bodies. The main entrance was sealed and moved to the side of the lobby under the roof so that visitors entering the lobby did not look directly at the swing doors leading into the refrigerator lobby. A nine foot opening between the refrigerator lobby and the post-mortem room was closed off by sliding doors making it impossible to see into the post-mortem room if the swing doors were open. Recommendations to build a waiting room and viewing room onto the front of the morgue were not taken up. The proposed plans for alterations to the morgue displayed the notation ‘[p]resent refrigeration system condemned as too small and not up to requirements mechanically’. The refrigeration system installed during extensions to the morgue in 1943 was no longer coping with the...

demands made on it, but the government was not inclined to upgrade the facility. Despite
the renovations, the Wavell Heights Branch of the Queensland Labor Party wrote to the
Minister for Health and Home Affairs on 28 October 1956, requesting that a new building
replace the current overtaxed morgue.\(^9^4\) The Minister replied, informing them that the work
was only a temporary measure while the process of planning for the erection of the
urgently needed new morgue continued.\(^9^5\)

Following Cabinet approval of a site for the new morgue, Dr M J O’Reilly Deputy Director
of the Brisbane Laboratory of Micro-Biology and Pathology, accompanied the Chief
Engineer of the Department of Public Works, Mr E G Carlisle, on a three day visit to
inspect the Melbourne Morgue in March 1957. The new two-story brick building,
completed in 1953, was hailed as one of the most modern mortuaries in the world.\(^9^6\) The
Chief Medical Officer of the Melbourne Coroner’s Department, Dr K M Bowden, assisted
with the inspection of the morgue. On his return Dr O’Reilly, in consultation with Dr
Tonge, recommended that a number of features of the Melbourne Morgue be incorporated
in the design of the new Brisbane morgue. O’Reilly stated that:

> in planning for the new Brisbane Morgue, we should make adequate
allowance for the inevitable increase of work during the coming years and
also be equipped to handle any major disaster such as a plane or train
crash … it is most desirable to arrange it so that it could be expanded at
some time in the future should the need arise.\(^9^7\)

\(^9^4\) QSA Series ID: 8843, Item ID: 290336, Police Station Files.
\(^9^5\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Under Secretary, Department of
Public Works to the Under Secretary, Department of Health and Home Affairs, 29 February 1956.
\(^9^6\) *Mail*, 27 January 1951, p. 44.
\(^9^7\) QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Report of Dr O’Reilly, Deputy Director of,
12 April 1957.
Tonge and O’Reilly had previously encountered the difficulties of storing a large number of bodies when a plane crashed on the beach at Bilinga, on Queensland’s Gold Coast, in 1949. Twenty-one bodies were transported to the Brisbane morgue and because of a shortage of refrigerated storage, they were kept in the yard between the morgue and the corrugated fence. A common practice at the morgue was storing two bodies, top and tail, on each of the nine trays in the refrigerator according to Dr Tonge.⁹⁸

Figure 9: Inside the Brisbane City Morgue following 1956 alterations

At the Melbourne Morgue the handling of bodies was reduced to a minimum because bodies were stored on individual trolleys in a large single refrigerated room, unlike the conventional compartment refrigerator in use at the Brisbane morgue. Furthermore,

⁹⁸ Personal communication with Dr John Tonge, 15 April 2010. Dr Tonge spoke of the ‘appalling’ morgue attendant in the 1940s who had a habit of storing his bottles of beer in the armpit of the dead bodies in the refrigerator.
cleaning one large room as opposed to individual small compartments improved health standards. O’Reilly recommended inclusion of a room to deep freeze bodies for a few hours prior to autopsy. The adoption of this practice at the Melbourne Morgue showed that it reduced the odour emitted during autopsy and preserved the body for a greater length of time.99

Referring to the Melbourne Morgue’s provision of a viewing room for relatives of the deceased, O’Reilly concluded that ‘[t]he room itself is rather austere and chilling and probably something more dignified and sympathetic should be aimed at’.100 His consideration of the feelings of the deceased’s family was an issue rarely taken into account by the government in relation to the remodeling of the old morgue. Earlier police department recommendations to include a separate waiting room and viewing room for visitors to the Brisbane morgue were ignored. The disregard for persistent complaints over the substandard conditions of the morgue in conjunction with the paltry attempts to improve conditions exemplified the government’s failure to prioritise the function of the coroner.

O’Reilly also recommended that a rotating autopsy table be incorporated in the Brisbane facility. Including a gallery meant medical students could attend lectures and witness dissection demonstrations. However, unlike the Melbourne example which conducted all

99 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Report of Dr O’Reilly, Deputy Director of the Laboratory of Micro-Biology and Pathology, 12 April 1957.
100 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Report of Dr O’Reilly, Deputy Director of the Laboratory of Micro-Biology and Pathology, 12 April 1957.
autopsies in the one area, Dr O’Reilly considered a small autopsy room was desirable in order to allow routine work to proceed without the distraction of students. He was of the opinion that ‘ultra-violet lamps provide the only safe and efficient method of regularly decontaminating rooms’ and recommended their installation in the autopsy room. On the subject of x-ray equipment, O’Reilly maintained that radiology was used often in forensic pathology and ‘has been of vital importance in detecting bullets and other foreign material in bodies … and would recommend that facilities for the type of radiology required be installed in the new morgue’. Both O’Reilly and Carlisle agreed that air-conditioning was an essential item considering the sub-tropical climate of Brisbane.\textsuperscript{101} When the plans were drawn up it was obvious that O’Reilly’s report to the Minister for Health and Home Affairs, the Director-General of Health and Medical Services and Dr Tonge, following his visit to the Melbourne morgue, influenced the design of the new Brisbane mortuary.\textsuperscript{102}

\textsuperscript{101} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Report of Dr O’Reilly, Deputy Director of the Laboratory of Micro-Biology and Pathology, 12 April 1957; Report of Mr E Carlisle, Chief Engineer, Department of Public Works, 3 April 1957.

\textsuperscript{102} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Letter from Mr C McCathie, Minister for Public Works to Mr W Moore, Minister for Health and Home Affairs, 4 April 1957.
Progress towards replacement of the old Alice Street Morgue stalled when the Queensland Labor Party lost the state election on 3 August 1957. Premier Vincent Gair had withstood a number of crises throughout 1955 and 1956 related to power struggles within the party. He was expelled from the Labor Party in April 1957 ‘after its central executive charged him with failing to follow the Party’s 1956 convention decision to support three weeks annual leave’. When Queensland Australian Labor Party parliamentarians combined with the Opposition to block Supply, Gair called a state election which the Country and Liberal Parties won. Frank Nicklin became Premier and the long reign of Labor in Queensland
came to an end.\textsuperscript{103} Since Dewar had raised the matter in parliament beforehand, the new state government was aware of the existing crisis attached to conditions at the City Morgue and upheld actions undertaken by the former government, to acquire a site and build a new morgue. The Under Secretary of the Department of Public Works recommended to the Minister of Public Works that the previous government’s choice to locate the new morgue on the Domain site be re-affirmed, as it met the requirements of: (a) convenient location to the Department of Health and Home Affairs and Government Analyst; (b) some degree of privacy; (c) reasonably easy access for members of the public; (d) reasonable location in relation to the river; and (e) as far as possible, the location should be away from established residential, commercial and industrial areas.\textsuperscript{104}

After sparse renovations to the old morgue were undertaken in 1956, Dr Tonge still judged the facilities as unsatisfactory. He warned of the extreme age of the refrigerator, as well as the inadequacy of the refrigeration accommodation especially during long weekends when over-crowding often occurred and in cases where bodies of paupers or unidentified persons had to be kept for long periods. According to Tonge low temperature chambers were required for storage of decomposed bodies, the odours from which were ‘repellant [sic] and nauseating for those within the building’.\textsuperscript{105} The urgent need for an updated city morgue was reinforced when during a long weekend in May 1958, the refrigerator at the


\textsuperscript{104} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from D Longland, Under Secretary, Department of Public Works to the Minister of Public Works, 20 August 1957.

\textsuperscript{105} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Dr Tonge, Director of the Laboratory of Micro-Biology and Pathology to Director General of Health and Medical Services, 3 February 1956.
morgue ceased to function. As a result all the bodies stored in the building began decomposing. Additionally, on the Saturday morning ‘a decomposed body from the river was placed in the refrigerator and the odours from this permeated the whole cabinet, extended out into the building, and surrounding courtyard’.\textsuperscript{106}

This ‘mechanical breakdown at the Morgue’ resulted in a ‘distressing experience’ for the relatives of a deceased man stored at the morgue over the long weekend.\textsuperscript{107} The father of Mr Stanley Abbott had been taken to the morgue on the Friday and as a result of the decomposition which took place over the weekend, the body of Mr Abbott’s father could not be viewed by relatives at the funeral. Abbott and his sister visited Dr Tonge to inform him of their traumatic visit to the city morgue and to complain about the existing conditions. Tonge left no doubt about his feelings on the matter when he wrote to the Director General of Health and Medical Services the same day declaring that:

\begin{quote}
The disgraceful conditions at the Morgue have been pointed out repeatedly and it is an appalling state of affairs when members of the Public are exposed to them when called upon to view bodies. The conditions are utterly disgusting for those called upon to work in the building. It has also been pointed out that the refrigeration system is antiquated and inadequate and mechanical faults may well occur at any time in a unit which is over 20 years old.

The Government’s decision to build a new Morgue was naturally very pleasing to us but I am extremely concerned that no progress whatever has been made towards the design let alone the erection of this building.\textsuperscript{108}
\end{quote}

\textsuperscript{106} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from Dr Tonge, Laboratory of Micro-Biology and Pathology to the Director General of Health and Medical Services, 7 May 1958.
\textsuperscript{107} \textit{Truth} 11 May 1958.
\textsuperscript{108} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from Dr Tonge, Laboratory of Micro-Biology and Pathology to the Director General of Health and Medical Services, 7 May 1958.
A letter was then sent by Abbott to Dr Noble, the Health and Home Affairs Minister, informing him that the condition of the city morgue was appalling and as the Minister was ‘in charge’ Abbott was referring the matter to him. Abbott went on to maintain that ‘[m]y three brothers and myself [sic] carried his coffin a short distance and the vapour around the box was disgraceful. The smell was even coming through the box’. He also stated that [f]rom what I have been told this occurrence is entirely due to the poor state of the refrigeration. Well Sir, I only hope something is done for the benefit of the public to come’. 109

Noble responded, acknowledging the inadequacy of the present morgue and informing Abbott that, on taking over the Health and Home Affairs portfolio, he ‘initiated action with a view to replacing the present building’ and plans had been prepared for the provision of a new morgue. In the meantime he would take steps to ‘see whether a temporary improvement’ could be made at the present morgue. 110 Noble then sent a memo to the Commissioner of Police instructing him to effect an immediate improvement in arrangements for relatives to view deceased persons at the city morgue. The Minister requested two police officers attend the morgue on weekends and that for viewing purposes, the deceased be placed on a trolley and covered with a sheet up to the neck. Relatives were not to be taken to view the body in the refrigeration cabinet. Sensitive to

109 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Stanley Abbott to Dr Noble, Minister for Health and Home Affairs, 8 May 1958.
110 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter to Mr S Abbott from Dr Noble, Minister, Department of Health and Home Affairs, 14 May 1958.
cost issues, the Minister confirmed that the Department of Health and Home Affairs was prepared to meet the cost of any overtime payments incurred through this arrangement.\textsuperscript{111}

This case displayed close similarities to that of the Dewar case in 1956 which prompted a call for official reports on the procedure followed by police officers for preparing bodies for viewing by relatives. Both the Labor and Liberal and Country Party governments had formally recognised the compelling need to improve conditions at the city morgue, but in reality the importance of correctly storing bodies for the purpose of post mortem examination, as part of a coroner’s investigation into cause of death, continued to be neglected. After Abbott and his sister related their story to \textit{Truth}, the paper referred their complaint to Mr K McCormack, the Under Secretary of the Department of Health and Home Affairs, who responded that the ‘building of the new Morgue had been undertaken by the Government as a priority job, and the work should be begun [sic] any day now’.\textsuperscript{112} This was misleading as correspondence shows that Cabinet did not make a final decision on where to build the morgue until May 1959, therefore McCormack’s statement was far from correct and more than likely made to deflect further criticism.

\textsuperscript{111} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from K McCormack, Under Secretary, Department of Health and Home Affairs to the Commissioner of Police, Frank Bischof, 15 May 1958.

\textsuperscript{112} \textit{Truth} 11 May 1958.
Morgue Site Protests and the Stigma of the Coroner’s Office

The Department of Public Works was ready to call tenders for the erection of the new morgue by April 1959 and on 26 May 1959 Cabinet voted to proceed with construction of the public morgue on the Domain site which had been excised for that purpose by the Gair Labor Government. The Fabian Society of Queensland had already protested against building a new morgue on the Domain on the grounds that it would ‘postpone the opening of the domain for the expression of free speech’. Local newspapers opposed the site with the *Courier Mail* accusing the Nicklin government of making a decision that was ‘obnoxious to Brisbane people, who will have to accept it’.

A repugnance for the office of coroner as illustrated by the directive of Mr L Monaghan, coroner for Brisbane in 1956, that should police need to call him at his private hotel, ‘he should be asked for personally and not referred to as Coroner’. The coroner and the morgue were associated with death, and society’s attitude towards death had changed over time. During the Victorian era, the washing, laying out and dressing of the body was performed at the home of the deceased. The service was also conducted at the home and was followed by a funeral procession and burial. Mortuaries and funeral parlours did not exist. But by the end of the nineteenth century preparation of the body for burial was being

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113 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from D Longland, Under Secretary, Department of Public Works to the Minister of Public Works, 18 March 1959.
116 *Courier Mail* 4 June 1959.
increasingly handled by professional funeral firms. This disengagement from the traditional practice of keeping the body at home, meant people were not use to seeing dead bodies and increasingly a tendency to avoid connection with the corporeal aspect of death permeated society. Griffin and Tobin maintain that:

this fear pushes us to seek to avoid death, almost at all costs and on all occasions, even when death might be appropriate. Fear drives our desire to remove the dying and the aged from our proximity so that we are “protected” from death.118

Pat Jalland also argues that Australians developed a tendency in the early twentieth century to avoid the subject of death and minimise grief.119 That similar sentiments towards death still prevailed in the 1950s were reflected in such comments as ‘why insist on putting it in a place where it will have to take its grim traffic close to a public park’120 and ‘there is no doubt that a Morgue, however well planned, is a most unsuitable institution to be placed in the area’ of the Domain’.121 In fact, people were opposed to the institution of the morgue itself and did not want it built on such a prominent location as the Domain.

The Lord Mayor Thomas Groom claimed the State Government decision had been ‘bludgeoned through in the face of opposition by the council and all sections of the community’.122 Furthermore, throughout 1959 the Premier received correspondence from community and political groups requesting that the government reconsider its choice of site.

118 Griffin and Tobin, In the Midst of Life: The Australian Response to Death, pp.5, 8, 23.
120 Courier Mail, 27 May 1959.
122 Courier Mail 8 June 1959.
for the new morgue. The Queensland Women’s Electoral League (QWEL) wrote to Dr Noble, the Minister for Health and Home Affairs, stating:

we regret to hear that a group of intelligent men can find no other site more suitable for this purpose … we are aware of the responsibility of the Liberal Party, which had always had our support, and we should much appreciate the privilege of an interview with you to give you our expressed views of our members.123

The QWEL hinted at the political power they wielded by making thinly veiled threats when responding to Noble’s denial of their request to meet a deputation. The League wrote:

We had hoped to see the Liberal-Country Party Government in office again next year and our members who campaign would prefer to have some answers to the awkward questions asked … The fact that the Gair Government approved this site is surely not relevant … Could you tell us what were the other sites considered, and their disadvantages?124

The government replied, firmly stating the intention to proceed with the proposal of the chosen site. The QWEL accepted the decision.

At the same time the Town and Country Planning Association also asked the Minister to meet a deputation of executive officers from the Council to discuss their ‘proposal that the Brisbane Domain be handed back to the people intact for the purpose of meetings and

123 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Queensland Women’s Electoral League to Dr H Noble, Minister for Health and Home Affairs, 28 May 1959.
124 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Queensland Women’s Electoral League to Dr H Noble, Minister for Health and Home Affairs, 17 June 1959.
to which he responded informing them there would be no ‘good purpose’ served by meeting to discuss the matter. The political risk attached to the choice of site was patently obvious. A constituent wrote to the Member for Sherwood, Mr John Herbert, declaring:

What has happened to the Liberal-Country Party? Has the Queensland coalition become a dictatorship such as the Federal Government has? While I am not particularly a Reggie Groom follower, I uphold his attitude towards the building of the Morgue in the present suggested site. If your Government goes ahead with its present plan, I am afraid you will lose a lot more votes. I personally have lost faith in Jim Killen and the Federal Liberal Party, and it looks as though it won’t be long before we’ll feel that we made a mistake putting Mr. Nicklin and Party in after all. Hands off the Domain.

Fundamentally, the vital function of providing a clean environment in which autopsies were carried out to ensure that an accurate cause of death was determined, was lost to the general community. Instead the new morgue was classified as a ‘waste of money’ at the extravagant cost of £100,000.

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125 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from the Labor Council of Queensland to Dr H Noble, Minister for Health and Home Affairs, 28 May 1959.
126 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Dr H Noble, Minister for Health and Home Affairs to the Labor Council of Queensland, 9 June 1959.
127 QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from Mr Doug Home to Mr John Herbert, Member for Sherwood.
128 *Courier Mail* 4 June 1959.
Construction of the city morgue went ahead at the Domain, with Dr Tonge overseeing the purchase of necessary equipment and furnishings. Cost was always a consideration therefore to justify his request for specific equipment Tonge claimed that:

For the adequate investigation of sudden death, particularly deaths in infants and young children, bacteriological investigation or examination of post mortem material is essential … In many cases the diagnosis as to the cause of death cannot be determined without the histological examination of many tissues collected at the autopsy … As mentioned
before the facilities in the Laboratory of Micro-Biology and Pathology are not sufficient to do this work.\textsuperscript{129}

He gave an assurance that any serviceable equipment from the present morgue would be transferred to the Institute but emphasised the importance of providing the extra equipment in order for the Institute to function at maximum efficiency.\textsuperscript{130}

The Queensland Funeral Director’s Association asked that the word ‘morgue’ be replaced with ‘Hall of Mortuary Science’ when naming the new establishment,\textsuperscript{131} however it was officially named the Institute of Forensic Pathology, and was handed over to the Department of Health and Home Affairs on Wednesday 21 December 1960.\textsuperscript{132}

\textsuperscript{129} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from Director General to Under Secretary, Department of Health and Home Affairs, 18 July 1960.
\textsuperscript{130} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, Memorandum from Director General to Under Secretary, Department of Health and Home Affairs, 18 July 1960.
\textsuperscript{131} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, letter from the Brisbane Chamber of Commerce to the Under Secretary, Department of Health and Home Affairs, 5 April 1960.
\textsuperscript{132} QSA Series ID: 8400, Item ID: 280668, Morgues: Brisbane, memorandum from the Deputy Director of the Laboratory of Micro-Biology and Pathology to the Director-General of Health and Medical Services, 19 December 1960.
Conclusion

Although the forensic autopsy was not a new investigative practice in the determination of cause of death, the first signs of the acceptance of forensic medicine in England emerged in the early to mid-nineteenth century. By the early 1900s scientific medicine had developed into a vital component of the death investigation system. The advanced investigative methods employed led to greater accuracy in determining cause of death. The medicalisation of the inquest process, which consisted of a post-mortem examination carried out by a specialist pathologist, originated in Australia from the 1860s. Melbourne coroners engaged the services of forensic pathologist, James Neild, and by the end of the nineteenth century the purpose built Melbourne Morgue had become the institutional home of the coroner and a site for carrying out forensic post-mortems. In Queensland the post-
mortem was carried out at the morgue and the court building housed the office of coroner. The two institutions were always separate.

Efficient post-mortems were difficult to conduct in outback regions of Queensland. Many towns did not have morgues and were forced to make do with storing bodies and carrying out autopsies in public buildings. Morgues erected by the government often lacked adequate facilities to carry out these tasks efficiently. Generally, government authorities were dismissive of complaints related to the unhygienic conditions and sub-standard facilities of morgues in rural areas. The cost factor influenced decisions made regarding the quality of services provided at the post-mortem site. Additionally, the value of the post-mortem as an investigative tool in the detection of cause of death was diminished, because general practitioners conducting autopsies lacked specialist forensic training. The founding in 1935 of the Laboratory of Microbiology and Pathology headed by Dr Edward Derrick, heralded the beginning of an efficient forensic medical service. The standard of autopsies improved, despite the cramped and under-resourced facilities at the morgue and the William Street laboratory,

The Brisbane city morgue, erected in 1910 at North Quay, was moved further down the river to Alice Street in 1927. The morgue was an institution neglected by government departments intent on ignoring numerous protests over the unfit state of the building, and its inability to function proficiently. Minor improvements in 1931 preceded structural renovations in 1943 and 1956, but pathologists still judged the facilities as sub-standard.
The press regularly published articles calling attention to the abhorrent state of the morgue, but it was not until a parliamentarian personally encountered the ghastly conditions of the institution and demanded its replacement, that the State government listened. In 1956 the government moved to acquire a site and had plans drawn up for a new city morgue. The choice of the Domain as the location for the morgue, attracted vocal criticism from the community. Protestors expressed their displeasure with and sensitivity to the placement of the morgue in a public space so close to the city gardens. This rejection of the site exhibited the modern tendency to fear and avoid the reality of death. Construction of the public morgue on the Domain site went ahead regardless of the objections.

Medical jurisprudence became a valuable tool for the institution of coronership. It represented an improved means of achieving legal justice for the dead. Unfortunately, the parsimonious policy of the Queensland government impeded the advancement of forensic medicine for more than thirty years. Completed in 1961, the Institute of Forensic Pathology was a modern, well equipped medical institution that contributed to the expansion of scientific knowledge in Australia and provided forensic scientific services for the office of coroner. The medical component of the inquest became more technical, with law and medicine combining to extend the jurisdiction of the coroner to investigate death.
Chapter Seven

Conclusion

The Queensland office of coroner has grown in capacity since its adoption from New South Wales in 1859. Unlike the role of the coroner in the twenty-first century, the original function of the coroner – as it emerged in 1194 - focused on raising money for the Crown through fines and taxes. With the rise in importance of justices of the peace, the power of the office of coroner declined over the fourteenth and fifteenth centuries, until eighteenth century reforms confined the coroner’s principal role to determining cause of death for the public record. But the reforms did little to clarify the role of the coroner whose functions were by now embedded in a host of regulations in different Acts. In the nineteenth century the English Coroners Act of 1887 repealed thirty-three Acts, statutes or part of statutes, to codify the law. It also removed the protection of the financial interests of the Crown from the role of the coroner, rendering the name of this office passé.

English Common Law formed the foundation of Australian law and as a consequence English Coronial law informed the office of coroner and the inquest process in Australia from the beginning. The legislation pertaining to coroners in England was always somewhat ill-suited to colonial conditions because of remoteness, sparse settlement, and skills shortage. Within a short time, minor adjustments to coronial legislation by the New South Wales parliament, led to tension and confusion between coroners and police magistrates, relating to their coronial jurisdiction and power. The New South Wales Coroners Act 1898 attempted to deal with these inconsistencies. Consolidating the earlier statutes, it dealt with the attendance of medical witnesses at inquests and inquiries, and the general power and authority of coroners.
In 1859, Queensland inherited its coronial office from New South Wales, and its shortcomings soon became apparent, because in the new colony colonial conditions were exacerbated: isolation, distance and the hot climate challenged the inexperienced government’s ability to administer the colony and maintain law and order. Magistrates stationed in outback towns and far-flung settlements populated by unruly settlers, carried out multifarious tasks on instruction from the central government in Brisbane. Police magistrates could hold coronial inquiries but not inquests. The Inquests of Death Act of 1866 dispensed with juries and coroner’s duties were given to police magistrates and justices of the peace. The cash-poor government considered it an economically sound decision to erode the office of coroner, which commanded an annual salary of £20. Subsequently, the official position of office of coroner disappeared, but the term coroner continued to be applied to those holding inquests. Ultimately, the new law served the government’s interest in saving time and money but in no way facilitated the delivery of an efficient, effective and cohesive inquest system. It was another 64 years before further reform of the office of coroner took place.

Throughout the latter part of the nineteenth century, public servants authorised to hold inquests were limited by a lack of training and knowledge of the statutes governing the office of coroner. Specific legal texts covering the jurisdiction of the coroner were jealously guarded by a bureaucracy that felt it necessary to limit and control such resources. This lack of legal knowledge, in conjunction with the indifferent approach to rules typical of the “bush culture”, meant not all deaths requiring an inquest were investigated. The squatter dominated parliament was able to subvert inquests into violent Aboriginal deaths at the hands of Native Police and when inquests were held the letter of the law was not necessarily followed. Many
Aboriginal deaths were not investigated so that the Native Police and station owners were able to conceal homicide and acts of violence towards Aborigines, sheltered by cover up, denial and remoteness.

Inquests in Queensland were poorly administered and controlled. Administering such a vast territory proved difficult for the government with regards to distributing directives and policing compliance with orders. Instead, a culture of inaction by the government seemed to prevail when called on to mediate on complications or controversies linked to coronial inquests. The new colony was hindered from the beginning by a scarcity of experienced public servants operating within a system lacking distinct procedural guidelines and adequate governance. When breaches of the law were revealed during inquest hearings, they often went unpunished. The government’s continued acceptance of the imperfections in the coronial system meant the legitimacy of the office of coroner was compromised.

While medical practitioners originally acted as coroners, the office gradually became the domain of the legally qualified as the function of the inquest became inquisitorial. Medical testimony became part of the medicalisation of the inquest process by the beginning of the twentieth century. This led to greater accuracy in determining cause of death, thus improving the gathering of statistical and health data. The progress in forensic investigative methods gave invaluable assistance to the coroner in bringing down his findings. The coroner operated at the interface between law and medicine. The Brisbane City Morgue was erected in 1910 and not replaced until 1961 as the government disregarded complaints lodged by pathologists over the unsanitary conditions there. Cost always seemed to outweigh the potential benefits gained from forensic investigations into deaths. Motivated by public exposure and complaints
about the dire conditions of the public morgue, the government finally replaced the Brisbane City Morgue. When it was completed in 1961, the Institute of Forensic Pathology was a modern, well equipped medical institution that expanded scientific knowledge and provided forensic scientific services for the office of coroner.

Evidence from the Crown Solicitor’s correspondence indicated that magistrates and medical professions regularly complained of the inadequacy of fees paid for their services related to inquest hearings. Ignoring their protests, the government passed *The Inquests of Death Act Amendment Act of 1893* to reduce spending. This Act enabled the government to save money by eliminating fees for justices of the peace holding inquests, and for witnesses appearing at inquests. Holding inquests was considered part of the duties of the salaried police magistrates. In due course, the Queensland government’s parsimony severely impaired the late nineteenth century coronial system.

The office of coroner relied heavily on the police to advise of any suspicious, violent or unnatural deaths and to carry out initial investigations into a fatality. It was on account of this information that a coroner would decide if an inquest was necessary. Depositions taken at an inquest were forwarded to the Crown Law Office for assessment by the Attorney-General. Research for this study identified transgressions committed by police, coroners and the government in relation to the function of the coroner in the late nineteenth and early twentieth centuries. The coronial legislation was inadequate, ambiguous and complex, creating an environment that fostered errors and misconduct. *The Inquests of Death Act of 1866* did nothing to improve the justice system in relation to the institution of the inquest. This is because politicians did not place enough importance on the role of the coroner as an
instrument of justice, nor did they fully grasp the complexities linked to existing coronial laws.

It was due to public pressure that the powers of the coroners were again expanded in the twentieth century. Ultimately, the sensation surrounding the Dulcie Barclay inquest represented the culmination of more than six decades of a flawed justice system governing investigations into violent and suspicious deaths in Queensland. The government finally acknowledged the need to formulate new legislation governing the office of coroner. The 1930 Coroners Act was a major amendment that consolidated coronial law relating to death investigations and the coroner’s inquest. Just thirteen years later this Act was amended as a consequence of another controversial incident involving a young woman. The mysterious disappearance of Marjorie Norval in 1938 attracted unfavourable public and press comment. This prompted the government to introduce The Coroners Act Amendment Act of 1943, authorising coroners to conduct inquiries into missing persons. This Act also restored the coroner’s power of committal. The Coroners Act Amendment Act of 1947 gave the coroner the additional power to hold an inquest or to reopen an inquest if additional evidence became available.

The Coroners Act of 1958 consolidated and simplified previous coronial legislation and lent the investigative role of the coroner independence and substance. Being more prescriptive than previous legislation, it contained detailed provisions for procedures that all parties involved in the investigative process could follow. The central objective was still to determine a deceased identity and cause and manner of death. The Coroners Act of 1958 broadened the scope of the office of coroner, but continued to discount the benefits that could
be derived from adopting the recommendations made by coroners in their findings that appeared with increasing frequency.

My study of the office of coroner over a one hundred year period shows that the Queensland government gave a low priority to the institution of the office of coroner and the inquest as a forum for public scrutiny in the name of justice and accountability. Furthermore, they also appeared ready to subvert the function of coronial law when it threatened their interests (or those close to them). During the first seventy years following Queensland’s separation from New South Wales, the government neglected to transform coronial law to meet community demands for a better death investigation system. The government’s primary concern was reducing expenses, so that the office of coroner became redundant and the government created a substandard coronial system that failed in many cases to thoroughly investigate unexplained or suspicious deaths.

This arbitrary application of the complicated coroner’s law continued until unfavourable press and public protest drew attention to the need to consolidate and simplify coronial law. The Barclay case exemplified the political nature of the office of the coroner and the threat to its independence. Although *The 1930 Coroners Act* consolidated the law, further transformation of the office of coroner took place with enactment of *The Coroners Act Amendment Act of 1943*. Enactment of this legislation was also of a political nature, as it was introduced in response to the controversy arising over the disappearance of the social secretary of the Premier’s wife. Although the government amended *The Coroners Act Amendment Act of 1947* and *The Coroners Act of 1958* out of a desire to update and extend the jurisdiction of the coroner, a vital component of the role of the coroner continued to be
overlooked. This was the opportunity for the government to advance the health and safety of the community through implementation of the coroner’s recommendations.

This thesis is the first history of the coroner in Queensland from which the disciplines of law, medicine, history and sociology may benefit. It has not exhausted the thousands of files in the Queensland State Archives yet to be investigated, which would no doubt contain further material relating to the office of coroner in Queensland. Therefore further research may uncover more cogent data. In the meantime, this detailed history of the evolution of the office of coroner in Queensland provides an insight into the intersection between legal, medical and political institutions, drawing on previously unpublished sources.

The depositions taken from witnesses at inquests give us a rare opportunity to learn about the lives of ordinary people which contributes to a social history of Queensland. This history of the transformation of the office of coroner in Queensland, based on primary data, forms an original and significant contribution to our knowledge of Queensland history and to the history of this often neglected aspect of the legal and justice systems in Australia.
Appendices

Appendix 1: The Inquests of Death Act of 1866

INQUESTS.

An Act to Abolish Coroners’ Juries and to Empower Justices of the Peace to hold Inquests of Death.

Whereas it is expedient to make further provisions for the holding of inquests of death, Be it therefore enacted by the Queen’s Most Excellent Majesty by and with the advice and consent of the Legislative Council and Legislative Assembly of Queensland in Parliament assembled and by the authority of the same as follows—

1. Whosoever a coroner is by law authorised or required to hold an inquest of death it shall be lawful for any justice of the peace in the absence of the coroner or during a vacancy of that office to perform the duties and he shall have all the powers and authorities of a coroner for the purposes of any inquest to be taken or made by him.

2. All justices of the peace are hereby required to hold such inquests if thenceunto requested by any two persons in writing.

3. No jury shall be summoned for any inquest of death by a coroner or justice of the peace but such coroner or justice shall return the depositions to the Attorney-General with a certificate of the supposed cause of death appended thereto in the form in the schedule to this Act and shall at the same time send a duplicate of such certificate to the Commissioner of Police or head of the police department for the time being.

4. Such certificate shall not have the force or effect of a verdict.

5. All the powers and authorities of justices out of sessions under an Act passed in the eleventh and twelfth years of the reign of Her present Majesty chapter forty-two intituled “An Act to Facilitate the Performance of the Duties of Justices of the Peace out of Sessions within England and Wales with respect to Persons charged with Indictable Offences” may be exercised by such coroner or justice whilst holding an inquest of death but nothing herein contained shall prevent or limit the exercise by either of them of any of the duties powers or authorities now lawfully exercised by coroners and not repugnant to the provisions of this Act.

6. Such coroner or justice may in his discretion order a post-mortem examination of any deceased person for the purpose of an inquest and upon reasonable cause being shown may order the body of any deceased person to be exhumed and where information has been taken upon oath may enter and break open any ground cemetery or place for the purpose aforesaid.

7. Whenever a justice of the peace or coroner shall hold an inquest he shall if there be any reasonable doubt as to the cause of death and it be possible to obtain such testimony take the testimony of a medical practitioner thereon.

8. It shall be lawful for any coroner or justice by whom an inquest of death shall be held to cause to be apprehended and to commit for trial any person suspected or accused of having caused such
such death by homicide. Provided that whenever it can be done the evidence shall be given and all proceedings incidental to commitment or trial shall be taken in the presence of the accused.

9. Whenever the evidence has been taken in the absence of the person suspected or accused he shall immediately after his apprehension or so soon thereafter as conveniently may be receive a copy of the evidence taken as aforesaid from the Attorney-General or other person having the custody thereof.

10. There shall be paid out of the Colonial Treasury for each Inquest to the coroner police magistrate or justice holding such inquest a fee of twenty-one shillings to each medical witness a fee of twenty-one shillings to each medical practitioner holding a post mortem examination a fee of forty-two shillings to the coroner police magistrate justice and medical witnesses mileage at the rate of sixpence per mile each way and other witnesses at the like rate of mileage.

11. This Act shall be styled and may be cited as "The Inquests Short title.

of Death Act of 1890."

SCHEDULE.

I hereby certify that on the day of 18 I held an inquest of death at in the police district of and that the following particulars were then disclosed—

1. Name of deceased (if known)
2. Profession or calling
3. Height color of hair peculiar clothing and any other means of identity
4. Where found and when
5. Date of death
6. Supposed cause of death
7. Person last seen in company of deceased and names of suspected persons
8. Accused
9. Names and residences and callings of witnesses
10. Suspicious circumstances

(Signature)

Coroner or Justice.

An Act to Provide for the Distribution of the Estates of Insolvent Debtors amongst their Creditors and their Release from their Debts and for the Punishment of Fraudulent Debtors and for other purposes.

[THIRD JUARE, 1874.]

WHEREAS it is expedient to amend the law relating to Insolvency Present, and to fraudulent debtors Be it enacted by the Queen's Most Excellent Majesty by and with the advice and consent of the Legislative Council and Legislative Assembly of Queensland in Parliament assembled and by the authority of the same as follows—

1. This Act is divided into twelve parts that is to say—

Part I.—Preliminary—Sections 2 to 7.
Part II.—Constitution and Powers of Court and Practice—Sections 8 to 39.
Appendix 2: The Coroners Act of 1930, p. 1

THE CORONERS ACT OF 1930.
(31 Geo. V. No. 17.)
AS AMENDED BY
Regulation published in Gazette of April 14, 1934.

An Act to Consolidate and Amend the Law relating to the Holding of Inquests of Death and Inquests concerning Fires.

[Assented to 23rd October, 1930.]

1. Short title and commencement.—This Act may be cited as “The Coroners Act of 1930,” and shall come into operation on a date to be proclaimed by the Governor in Council by proclamation published in the Gazette.

This Act came into operation on January 1, 1931, by virtue of a Proclamation published in a Gazette of December 20, 1930.

2. Repeal. First Schedule.—Without prejudice to the provisions of the Acts Shortening Acts, the several Acts set forth in the First Schedule to this Act are repealed.

For the Acts Shortening Acts, see the Title Acts.

3. Interpretation.—In this Act, unless the context otherwise indicates or requires, the following terms have the meanings respectively assigned to them, that is to say:
- ”District” —A petty sessions district constituted under “The Justices Acts, 1886 to 1929,” or any Act amending the same;
- ”Justices Acts” — “The Justices Acts, 1886 to 1929,” or any Act amending the same;
- ”Minister” — The Attorney-General or other Minister of the Crown for the time being administering this Act;
- ”Person” includes any corporation, company, society, or association, public authority, partnership, or firm, or any body of persons corporate or unincorporate;
- ”Prescribed” — Prescribed by this Act;
- ”This Act” — This Act and all Orders in Council, Regulations, and Rules of Court made thereunder.
- ”District” — Petty sessions districts are constituted under The Justices Act of 1886, ss. 10, 15, etc.

4. (1.) Appointment of coroners.—Subject as hereinafter provided, the following officers shall be and are hereby declared to be coroners for the State of Queensland, namely:
- (a) Every police magistrate or an officer acting as police magistrate, by virtue of his office as police magistrate or acting police magistrate, and in and for the district containing the place for the holding of courts of petty sessions at which place such police magistrate or acting police magistrate is stationed;
Coroners Act of 1930.

ss. 4, 5.

(b) Every officer of the Public Service appointed pursuant to the provisions of "The Public Service Acts, 1923 to 1924," who is a justice of the peace, and who is clerk of petty sessions or acting clerk of petty sessions of the court in respect of a place appointed for the holding of courts of petty sessions (but to which place no police magistrate or acting police magistrate has been appointed) by virtue of his office as clerk of petty sessions or acting clerk of petty sessions, and in and for the district containing the place for the holding of courts of petty sessions at which such clerk of petty sessions or acting clerk of petty sessions is stationed:

Provided always that if at any time it is not possible for such police magistrate or acting police magistrate or clerk of petty sessions or acting clerk of petty sessions, as the case may be, to exercise the jurisdiction, powers, and authority of a coroner under this Act, such police magistrate or acting police magistrate or clerk of petty sessions or acting clerk of petty sessions, as the case may be, is hereby authorized and empowered to request any justice of the peace to act as a coroner, and to hold the inquest as specified in such request, and the jurisdiction, powers, and authority of a coroner and the provisions of this Act relating to coroners shall extend and apply with respect to such justice of the peace, who shall be and is hereby declared to be a coroner in regard to such inquest as specified in such request accordingly.

(2.) (a) Coroner may be appointed for the City of Brisbane.—Notwithstanding anything hereinbefore contained it shall be lawful for the Governor in Council to appoint any person, being a justice of the peace, to be the coroner stationed at the City of Brisbane as defined by "The City of Brisbane Act of 1924," and in like manner to appoint any person being a justice of the peace to be the deputy coroner stationed at the said City of Brisbane, and the jurisdiction, powers, and authority of a coroner and the provisions of this Act relating to coroners shall extend and apply with respect to any such coroner or deputy coroner so appointed accordingly.

(b) Provision may be extended to other cities or towns.—The provisions of this subsection may be extended by the Governor in Council by Order in Council to any other city or town in the State, to the intent that a coroner and/or deputy coroner may be appointed in like manner for such city or town.

(c) Salary.—The Governor in Council may prescribe the salary to be payable to any coroner or deputy coroner appointed pursuant to the provisions of this subsection.

A regulation of June 8, 1933, published in a Gazette of June 10, 1933, empowers the Governor in Council to appoint coroners for districts where there is none or office.

For The Public Service Acts, 1923 to 1924, see the title PUBLIC SERVICE.

For the boundaries of the City of Brisbane, see The City of Brisbane Act of 1924, s. 4 and First Schedule, title BRISBANE in the Volume containing Local, Personal and Private Acts.

5. (1.) Jurisdiction of coroners. Inquests on death.—Every coroner shall have jurisdiction throughout Queensland to inquire into the manner and cause of the death of any person who—

(a) is killed; or

(b) is found drowned; or

(c) dies a sudden death of which the cause is unknown; or

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6.  [Vol. IV-

(d) Dies under any suspicious or unusual circumstances; or
(e) Dies while under an anaesthetic in the course of a medical,
surgical, or dental operation or operation of a like nature; or
(f) Dies, but no certificate of a medical practitioner has been
given as to the cause of death; or
(g) Dies within a year and a day from the date of any accident
where the cause of death is directly attributable to such
accident; or
(h) Dies under such circumstances that, in the opinion of the
Minister, the cause of death and the circumstances of such
death should be more clearly and definitely ascertained; or
(i) Dies in any prison hospital, hospital for the insane, or any
institution, under such circumstances as to require an inquest
in pursuance of this Act or any other Act;
(j) Dies, not having been attended by a medical practitioner at
any period within three months prior to his death.

(2.) Duty of coroner to inquire into manner and cause of death.—
It shall be the duty of every coroner to inquire forthwith into the
manner and cause of any death occurring under the circumstances as set
forth in subsection one of this section in the district for which he
is coroner by virtue of this Act:

Provided that no inquest shall be held after the expiration of twelve
months from the date of death, or after the expiration of twelve months
from the date of the finding of the dead body, unless the Minister
otherwise orders.

(3.) Medical practitioner.—Subject to this Act a medical prac-
titioner shall not, unless with the consent of the coroner, give a medical
certificate as to the cause of death in respect of any death which occurs
under the circumstances referred to in paragraph (a), (b), (c), (e), or
(f) of subsection one.

Any medical practitioner offending against the provisions of this
subsection shall be liable to a penalty not exceeding two hundred pounds,
to be recovered in a summary way by complaint under the Justices
Acts.

As to the duty of the coroner to inform the district registrar of the finding
of a dead body and of the inquest to be held thereon and to furnish other
necessary particulars, see The Registration of Births Deaths and Marriages
Act of 1855, s. 28, title STATISTICS.

For history of the coronial office, see Halsbury's Laws of England (2nd

6. (1.) Coroner to examine on oath.—The coroner holding any
inquest shall examine on oath all persons who are summoned to give
evidence at such inquest.

(2.) Depositions to be in writing.—The coroner shall reduce to
writing the evidence given before him, and the deposition of each witness
so taken shall be read over to the witness and shall be signed by him
and the coroner.

(3.) Coroner to return depositions to Minister.—The coroner shall
forward the depositions to the Minister with a certificate of the supposed
cause of death appended thereto in the form of the Second Schedule to
this Act, and shall at the same time send a duplicate of such certificate
to the Commissioner of Police and to the Registrar-General.

The form printed in the Second Schedule was substituted for that originally
contained therein by regulation of April 13, 1924, under power conferred by
s. 18, post.
Coroners Act of 1930.

7. (1) Inquests on fires.—Every coroner shall have jurisdiction to inquire and shall inquire into—

The cause and origin of any fire whereby any property of any kind whatsoever is destroyed or damaged—

(a) If he is of opinion that such an inquiry ought to be held; or

(b) If the Minister directs him to hold an inquiry.

(2) The coroner shall examine on oath, touching the cause and origin of the fire concerned, all persons who are summoned to give evidence at such inquest.

(3) The coroner shall reduce to writing the evidence given before him, and the deposition of each witness so taken shall be read over by the witness and be signed by him and the coroner.

(4) Third Schedule.—The coroner shall forward the depositions to the Minister, with a certificate of the supposed cause of the fire appended thereto in the form of the Third Schedule to this Act, and shall at the same time send a duplicate of such certificate to the Commissioner of Police.

(5) Request for inquest.—Notwithstanding anything herein contained, an inquest concerning the cause and origin of a fire shall be held at the request of any person upon payment by him to the coroner of the sum of ten pounds or such sum as may be prescribed, and at the same time on giving an undertaking to pay such further costs which may be entailed in the holding of such inquiry, the amount of which costs shall be as certified by the coroner holding the inquiry. Any such further costs so certified may be recovered by the Crown in any court of competent jurisdiction.

Any such sum so paid or recovered shall be paid into and shall form part of the Consolidated Revenue.

[6) This subsection repealed s. 26 of The Insurance Act of 1916, title Insurance.]

8. Inquest to be before a coroner only.—Any inquest concerning a death or a fire shall be held by a coroner sitting alone, and, notwithstanding any provision in any law to the contrary, shall be held without a jury.

9. View of body not necessary.—Unless a view is ordered by the Minister, it shall not be necessary for the coroner on any inquest of death to view the body of the deceased unless the coroner deems it advisable to do so:

Provided always that the coroner shall forthwith notify the Minister of his intention not to view the body.

The provision of this section mark a radical change in the law. Under the Inquests of Deaths Act of 1868 it was held that, notwithstanding the abolition of the coroner’s jury by s. 6 thereof, the coroner had no jurisdiction to hold an inquest except super corpus (D. v. Stones, Ex parte O’Connor, [1930] 2 R. Qd. 142; 24 Q.J.P.R. 19).
10. Meaning of view.—For the purposes of this Act a view of the body shall mean and include any view by the coroner of such body, whether such view shall take place before burial, or whether such view shall take place by exhumation after burial.

11. Post-mortem examination may be ordered and bodies examined.—The Minister or a coroner may in his discretion order a post-mortem examination of any deceased person for the purpose of an inquest, and the Minister may order the body of any deceased person to be exhumed, and for that purpose the coroner may, with such assistants as he may require, enter and break open any ground, cemetery, or place for the purpose aforesaid.

12. Medical testimony to be taken when practicable.—Whenever a coroner shall hold an inquest he shall, if there be any reasonable doubt as to the cause of death and it be possible to obtain such testimony, take the testimony of a medical practitioner thereon.

13. (1.) Further powers of coroners.—In addition to the powers, authorities, and jurisdiction of a coroner under this Act, every coroner shall, subject to this Act, have generally the powers and authorities and jurisdiction of a police magistrate under the Justices Acts in relation to the holding of any inquest under this Act.

(2.) Open court.—Without limiting the generality of such provisions, it is hereby declared that the room or place in which a coroner conducts an inquest shall be deemed an open and public court to which all persons may have access so far as the same can conveniently contain them.

(3.) Witnesses to be excluded except when giving evidence and after having given evidence.—No witness shall be permitted to be present in the room or place in which the coroner is conducting the inquest except when such witness is giving his evidence and after he has given his evidence at such inquest:

Provided that if the coroner shall consider any person whether subscribing as a witness or not as any particular interest in the proceedings, or if the coroner shall consider the conduct or act of any such person was in any material way relevant to the subject matter of the inquest, he may permit such person to be present in such room or place; and in such case such person shall be entitled to be represented by counsel or solicitor and to examine and cross-examine witnesses in relation to the subject matter of such inquest.

(4.) Power of exclusion.—In any case in which in the opinion of the coroner the interests of public morality require that any persons should be excluded from the room or place in which the coroner is conducting the inquest the coroner may exclude such persons therefrom accordingly; but such power shall not be exercised for the purpose of excluding any counsel or solicitor:

Provided further that the coroner shall not under the provisions of this subsection exclude representatives of newspapers from such room or place; but the coroner shall in any case have power and authority to make an order forbidding the publication of any report or account of the evidence, or other proceedings therein, either so to the whole or portion thereof, and the breach of any such order, or any colourable or attempted evasion thereof, shall be an offence under this Act, and shall
render the offender liable on conviction to a penalty not exceeding two hundred pounds, to be recovered in a summary way by complaint under the Justices Acts.

(5.) Summons. Fourth Schedule.—Without in any way limiting the operation of the above provision, every coroner shall have full power and authority to issue a summons in the form in the Fourth Schedule or to the like effect, to any person whose evidence he may deem necessary to obtain, to attend the inquest at the time and place named in the summons and then and there to give evidence and be examined; and the coroner, either in the summons or by an order in writing, may require any person to produce at the inquest any books, documents, or writings or any other thing whatever in his custody, possession, or control which the coroner thinks ought to be produced.

Warrant.—Moreover, if any person summoned as a witness neglects or refuses to appear at the time and place appointed by the summons and no just cause is offered to the satisfaction of the coroner for such neglect or refusal, then (after proof upon oath that the summons was duly served upon such person) such coroner may issue his warrant to bring and have such person at the time and place to be therein mentioned before him to testify as aforesaid, and the provisions of the Justices Acts relating to the enforcement of warrants shall, mutatis mutandis, apply and be extended for the purpose of the enforcement of such warrants accordingly.

A person present at the inquest who, in the opinion of the coroner, has a particular interest in the proceedings and whose conduct or act is, in the coroner's opinion, relevant to the inquest, may, if not represented by counsel or solicitor, be represented, with the coroner's permission, by some other person, who in that capacity is entitled to examine and cross-examine witnesses (see regulation of March 25, 1885, published in a Gazette of March 25, 1885).

As to the powers of a police magistrate, see The Justices Act of 1885, s. 96, etc.

As to the power of exclusion in the interests of public morality, cf. the similar provision in s. 70 of the same Act.

Enforcement of warrants for attendance of witnesses is provided for by The Justices Act of 1885, ss. 78-81, etc.

16. Adjournment.—When it becomes necessary or advisable to defer the holding of an inquest, the coroner may adjourn such hearing to the same or some other place, for such period as the coroner in his discretion deems reasonable, and such inquest may be conducted by the same or such other coroner as shall be acting at the time or place appointed for continuing the conduct of such inquest.

15. (1.) Penalty on witness neglecting to attend, &c.—When any person who has been summoned to attend any inquest—

(a) Fails without reasonable excuse to appear at the inquest; or
(b) Refuses without reasonable cause to give evidence at the inquest; or
(c) When required by the coroner, either in the summons or by order in writing as aforesaid, fails or refuses without reasonable excuse to produce at the inquest any books, documents, or writings or any other thing whatever in his custody, possession, or control which the coroner thinks ought to be produced,

the coroner may impose on such person a penalty not exceeding twenty pounds.
(2.) Nemo tenetur se ipsum accusare.—Nothing hereinbefore contained shall render any person compellable to answer any question tending to incriminate himself or herself.

(3.) Further offences.—If any person—
(a) Insults the coroner during the holding of any inquest;
(b) Willfully interrupts the proceedings at any inquest;
(c) Obtains or assaults any persons in attendance at any inquest;
(d) Refuses or neglects to obey any lawful order of the coroner,
the coroner may impose on such person a penalty not exceeding twenty pounds.


16. (1.) Witnesses’ expenses.—Every person duly summoned as a witness at an inquest shall, for every day during which he is required to attend and actually attends at such inquest, be entitled to receive such compensation for such attendance and for travelling expenses as may be prescribed:

Provided that, unless otherwise prescribed, the amount of compensation shall be computed at rates in no case exceeding the rates for the time being allowed to witnesses for the Crown and to interpreters respectively in criminal cases in the Supreme Court, taking into consideration in regard to witnesses the different rates payable in the case of different classes of witness:

(2.) Statement of accounts.—Any coroner by whom any inquest is held shall state in an abstract the names of all witnesses examined at the inquest, and shall annex thereto an account of all sums of money liable to be paid and the person to whom such payment shall be made on account of the inquest, and an account of the number of days during which the inquest or any adjournment thereof continued, and shall sign and forthwith transmit the abstracts and accounts to the Minister accordingly.

Witnesses and interpreters attending inquests of death or inquests on fires (other than sergeants, acting sergeants and constables of police and prisoners), if resident more than two miles from the Court, are entitled to a refund of the amount of their fares both ways, or, if transport by railway, coach or steamer is not available, to mileage at the rate of sixpence for every mile after the first two miles actually travelled in going to and returning from the Court (see regulation of Oct. 23, 1931, published in the Gazette of Oct. 26, 1931).

17. Power of coroner on default of payment of fine.—(1.) On default in payment of any fine imposed under this Act, the coroner may make out and sign a certificate stating—

(a) The name, residence, and occupation of the person so making default;
(b) The amount of the fine imposed; and
(c) The cause of the fine;

and transmit the said certificate to the clerk of petty sessions at the nearest place appointed for holding courts of petty sessions.
Coroners Act of 1930.  

(2.) In every case in which a certificate has been transmitted to a clerk of petty sessions in pursuance of this section, the payment of the fine shall be enforced as if such fine had been part of the fines imposed by justices sitting in petty sessions at such place appointed for the holding of courts of petty sessions.

18. (1.) Regulations.—The Governor in Council may from time to time make regulations providing for all or any purposes, whether general or to meet particular cases, that may be convenient for the administration of this Act or that may be necessary or expedient to carry out the objects and purposes of this Act.

Without limiting the generality of the foregoing provision, such regulations may be made—

(a) For the conduct of and procedure relating to inquests;
(b) For altering any of the forms set out in the Schedules to this Act, and prescribing other and additional forms; and
(c) Prescribing allowances to witnesses and interpreters attending inquests; and
(d) Generally as to any matters necessary or convenient to be prescribed for carrying out or giving effect to the provisions of this Act.

(2.) Effect of Orders in Council and regulations.—All Orders in Council and regulations shall be published in the Gazette, and thereupon shall have the same force and effect as if they were embraced in and formed part of this Act, and shall be judicially noticed, and shall not be questioned in any proceedings whatever.

(3.) To be laid before Parliament.—Copies of such Orders in Council and regulations shall be laid before Parliament within fourteen sitting days after such publication if Parliament is in session, or, if not, then within fourteen days after the commencement of the next session.

Regulations under this Act have been published in Gazette of October 24, 1931 (travelling expenses of witnesses), March 25, 1933 (representation at inquests of certain persons not represented by counsel or solicitor), and June 10, 1933 (appointment of coroners for certain districts).

A form was substituted for that originally contained in the Second Schedule by regulation published in Gazette of April 14, 1934.

As to the effect of provisions similar to those of the second subsection, see Preliminary Notes to title ACTS.

[19. This section amended ss. 28, 29 of The Registration of Births, Deaths and Marriages Act of 1855, title STATUTES.]

FIRST SCHEDULE.
The Acts mentioned in this Schedule are repealed by s. 2, exte.

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<th>Title</th>
<th>Extent of Repeal</th>
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Scha. II, III.

Justices.

Second Schedule.

This Schedule was substituted for the original Second Schedule by Regulation published in Gazette of April 14, 1894, made under s. 28 (1) (b), ante.

For application of this Schedule, see s. 6 (3), ante.

"The Coroner's Act of 1890."

Certificate of Particulars—Inquiry of Death.

I hereby certify that on the day of , 19 , I held an Inquiry of Death at , in the district of , and that the following particulars were then disclosed:

Name of deceased:

Protection or calling:

Condition of life [married, single, widower, or widower, or child]:

Age:

Place of residence:

Place of birth:

If unidentified, state description:

Where found, and when:

Date of death:

Cause of death:

Names of suspected persons:

Names, residences, and callings of witnesses:

Suspicious circumstances:

Coroner.

Note.—One copy of this certificate must be attached to the Report of Death Depositions and forwarded to the Attorney-General, and a duplicate must be sent to the Commissioner of Police. A copy must also be forwarded, together with the death certificate, to the Register of Births, Deaths, and Marriages of the District within which the death took place.

Third Schedule.

For application of this Schedule, see s. 7 (4), ante. For power to amend same, see s. 18 (1) (b), ante.

"The Coroner's Act of 1890."

Certificate of Particulars—Inquiry of Fire.

I hereby certify that on the day of , 19 , I held an Inquiry on a Fire at , in the district of , and that the following particulars were then disclosed:

Description of property:

Where situated:

Date of fire:

Supposed cause of fire:

Names, residences, and callings of witnesses:

Suspicious circumstances:

Coroner.

Note.—One copy of this certificate must be attached to the Report of Fire Depositions and forwarded to the Attorney-General, and a duplicate must be sent to the Commissioner of Police.
Coroners Act of 1930.

FOURTH SCHEDULE.

For application of this Schedule, see s. 18 (5), note. For power to amend same, see s. 18 (1) (b), note.

"The Coroners Act of 1930."

SUMMONS TO A WITNESS.

Queensland to wit:

To

These are in His Majesty's name to require and command you of

of

to appear before me, the undersigned, one of the Coroners for

Queensland, at

in the said State, on the

data

at

o'clock in the

noon, then and there on His Majesty's behalf to testify what you shall know concerning

(an also to bring the following books, documents, and other things:

or such of them as are in

your possession or control).

Dated at

this

data

, 19

Corner.

* The death of

, or a certain fire which occurred at

, as the case may be.
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