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ABSENT FIREGUARDS AND BURNT CHILDREN:
CORONERS AND THE DEVELOPMENT OF CLAUSE 15
OF THE CHILDREN ACT 1908

Vicky Holmes

Abstract
Government intrusion into the homes of the working-classes gained momentum through the late nineteenth and early twentieth century. One hitherto unexamined piece of legislation that sought to regulate behaviour was a clause in the Children Act 1908 pertaining to the use of domestic fireguards. This transpired because of the outcry of coroners who conducted inquests into the deaths of children fatally burned in their homes, supposedly a safe refuge, a space constructed as a maternal responsibility. Coroners increasingly believed such accidents were a result of either maternal carelessness or negligence, especially those involving unguarded fires and absent mothers. Yet, limited by inadequate laws and unwilling juries, the coroner could do little but admonish the mother. However, growing Government concern over the abilities of working-class mothers and the health of the nation finally brought the issue of absent fireguards and burnt children to Parliamentary debate, culminating in a provision which appeared to have been aimed more at prevention than punishment.

Keywords: childcare, Children Act 1908, children's domestic accidents, coroners, fireguards, working-class mothers

Introduction
In Ipswich, in 1896, an inquest was held on the body of Albert William Burrows, aged seven months, who died after catching fire in his home on Tanner's Lane during the temporary absence of his mother. When questioned by the coroner, Albert's mother stated that 'on the morning of the 17 April she placed the child in a nightshirt on a chair near the fire [...] put a flannel petticoat over the child's legs and went into the back yard to hang out some linen', leaving the backdoor open. The fire was unguarded. On her return to the house, she found Albert's nightshirt and petticoat 'burnt up'. Taking her son to Mr Hoyland's surgery, his burns were treated with carbolic oils. Notwithstanding this, Albert died some days later. In his summary to the jury, the coroner stated: 'the question for them was whether there had been any gross negligence [on the part of the mother], or whether it was simply an act of carelessness - The jury returned a verdict of "Accidental Death" and the mother was exonerated.'

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2 The Ipswich Journal, 2 May 1896, p.7.
However, regardless of the coroner's question as to whether Albert's death was a result of carelessness or gross negligence, the absence of adequate laws and the often frequent leniency of juries – the verdict, after all, was the jury's decision - prevented the coroner from sending mothers such as Mrs Burrows for prosecution. Just 12 years later, however, with the passing of the Children Act 1908, an unprecedented law was introduced with regards to children and fireguards in the home.

The Children Act 1908 consolidated various pieces of legislation regarding the welfare of children, in addition to, as John Clarke states, 'expand[ing] the intervention of the state into the “private” world of the family'. This Act was also the first to deal specifically with culpability regarding two particular fatal household accidents befalling young children. The first of these, section 13, regarding the overlaying of infants has had its origins and success well documented in historiography. The second provision in the Children Act 1908 concerning household accidents, section 15, is less well documented:

If any person over the age of 16 years who has the custody charge or care of any child under the age of seven years allows that child to be in any room containing an open fire grate not sufficiently protected to guard against the risk of the child being burnt or scalded, without taking reasonable precautions against that risk, and by reason thereof the child is killed or suffers serious injury, he shall on summary conviction be liable to a fine not exceeding ten pounds.

Paralleling the campaign for a law in regards to overlaying and anxieties over child welfare, coroners and others expressed increasing concern over the number of working-class children fatally burnt in their homes. They believed a fireguard would have prevented such accidents. By exploring the development of this section, this article seeks to address this historiographical lacuna. It also contributes to the debates on home safety, child welfare, and changing attitudes towards working-class mothers in the Victorian and early Edwardian era.

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The article begins by examining the changing response of the Ipswich coroner’s court towards those working-class mothers whose children, in the absence of a fireguard, had been fatally burnt. In the early Victorian period, such accidents were generally perceived as unfortunate tragedies, unless the child was illegitimate. However, from the 1860s, Ipswich coroners and coroners around the country, reflecting changing attitudes towards working-class mothers, began to perceive these accidents befalling children as a result of maternal ignorance and carelessness, and latterly negligence, despite no significant rise in the number of such accidents. Nevertheless, in spite of the increasing blame attached to mothers, inadequate laws and lenient juries rendered coroners largely powerless to refer these supposedly negligent mothers for prosecution.

One reason for choosing Ipswich, in Suffolk, as the subject of study is to remove the issue of ‘working mothers’ from the debate on childcare, focusing the discussion on gender. Much of the literature on working-class motherhood and childcare in the nineteenth century examines those areas where women went ‘out’ to work, most notably Margaret Hewitt’s *Wives and Mothers in Victorian Industry* (1958) which examines the impact of married women’s employment in mills and factories on domestic family life and Michael Anderson’s *Family Structure in Nineteenth Century Lancashire* (1971) where the textile industry took married women out of the home and into the workplace. Pamela Sharpe’s *Adapting to Capitalism: Working Women in the English Economy, 1700-1850* (1996), examines women’s employment in Essex, including those in agriculture, and discusses the concern that such work ‘indispos[ed] her for a woman’s proper duties at home’. In contrast, daily life for Ipswich’s working-class married women was centred around the home. Employment opportunities were limited for women, with the town’s economy dominated by male orientated industries. While there was a thriving stay/corset making industry employing women in the town, most of those employed in the company’s factories were young, unmarried girls. Few continued to work in the factory after marriage, instead taking intermittent and poorly paid employment in the home-based “slop” trades - dressmaking, millinery, tailoring and needlework. Only the very poorest of Ipswich’s

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8 Grace, *Rags and Bones* p.127.
women would go ‘out’ to work - charring, washing or water-cress selling in order to provide for their families.\(^9\) Therefore, in this town there was little conflict between women’s work and their domestic role as housewives and mothers. As this article shows, few of the incidences of children being burnt occurred when their mother was out working. Rather, many of these fatal accidents took place during a mother’s momentary absence, often on domestic-related errands. Thus, when comment was passed in the coroner’s court on the caring abilities of mothers, work was rarely the issue.

The article then moves on to examine issues relating to burnt children and absent fireguards on a national level, as increasing concerns over the health of the nation brought the well-being of working-class children to Government attention. After much Parliamentary debate, including worries that such legislation unfairly targeted poor mothers, section 15 of the Children Act 1908 was passed. However, as this article will demonstrate, police, magistrates, and even some coroners, were unwilling to enforce it, seeing the Act more as a preventative measure designed to encourage mothers to purchase, and use fireguards, rather than being designed to punish those mothers who had already suffered the loss of a child.

1 Historical Background

The Victorian and Edwardian eras witnessed an unparalleled level of interference – in the form of middle-class charitable work and, latterly, Government legislation – in the homes of the poor, with the aim to educate and regulate ‘careless’, ‘ignorant’, and ‘negligent’ working-class mothers in the care of their children.

During the ‘infanticide alarm’ of the 1860s, it was increasingly believed that mothers of illegitimate children were putting their children’s lives at risk, either through ignorance and carelessness or intentionally, murdering their infants to conceal their ‘fall from virtue’ or sending them to baby farmers,\(^10\) whom the middle-classes

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\(^9\) Ibid, p.128.  
believed would wilfully neglect these children and even kill them for a fee.\textsuperscript{11} Some even believed poverty would reduce some mothers to ‘subhuman levels’ – killing their own children in order to collect the burial insurance.\textsuperscript{12} The growing concern over the welfare of infants led to the formation of a number of societies, such as the Infant Life Protection Society in 1870, which campaigned for legislation for the protection of these children and, in 1872, the Infant Life Protection Act was passed, which required ‘paid carers taking in more than one infant under one year of age for longer than 24 hours [...] to register with their local authority’ and to ‘keep records and report infant deaths in their houses directly to the coroner’.\textsuperscript{13} Two years later, the Birth and Death Registration Act 1874 was also introduced, rendering those who did not register a birth within 42 days and a death within eight liable for a fine.\textsuperscript{14} Although, Hendrick states, the 1872 Act was regarded as a failure, under-enforced, with many loopholes, it does, nevertheless, show the Government taking an active role in childcare for the first time.\textsuperscript{15}

By the 1880s, it was not just the welfare of working-class infants that was of concern to the middle-classes, but the welfare of all working-class children. Concerns over child neglect amongst the working-classes led to the formation of the Society for the Prevention of Cruelty to Children, later known as the N(ational)SPCC, in various towns and cities across the country, including Ipswich. The NSPCC’s aim was ‘not to relieve parents of their domestic responsibilities, but to enforce them, by making idle, neglectful, drunken and cruel parents do their duty to their children’.\textsuperscript{16} The NSPCC considered both the mother’s and the father’s responsibility towards their children. Nevertheless, parental roles were seen as quite separate, with the mother as homemaker and the father as breadwinner. The charity campaigned for better legislation in regards to child protection, culminating in the Prevention of Cruelty to, and Protection of, Children Act 1889. This Act included a provision that would give coroners the power to refer parents to the magistrates in cases where their

\textsuperscript{16} Ibid, p.52.
negligence was proven instrumental in the child’s death.\(^{17}\) This notwithstanding, in cases of household accidents, as will be shown, coroners found themselves continually frustrated by jurors unwilling to enforce the Act.

By the 1890s, many members of the middle-class believed that, through their own ignorance, all working-class mothers, not only those who had intentionally committed neglect, were putting lives at risk. Rates of infant mortality amongst the working-classes were a constant grave concern, especially during the hot dry summers of the 1890s when infant deaths from diarrhoea dramatically increased.\(^{18}\) In Ipswich, between 1878 and 1900, summer diarrhoea was one of the greatest killers of children in the poorest areas of the town and whilst the town’s Medical Officer of Health argued sanitation would combat this problem, most officials believed these deaths to be a result of bad mothering.\(^{19}\) In 1900, the Mayor of Ipswich stated that the town’s ‘infant mortality was little less than a public scandal’, attributing ‘want of proper care on the part of parents’ as one of the causes.\(^{20}\) One of the town’s surgeons believed that a ‘large amount of infant mortality in Ipswich was caused by the action of mothers giving children [improper] food’.\(^{21}\) In other words, it was thought, if these women performed their domestic duties adequately, then disease would not be a problem.\(^{22}\) This train of thought applied to other preventable deaths.

Jane Lewis notes that in response to these concerns, the late-nineteenth century witnessed ‘new efforts to regulate the behaviour of the urban working-class’. District visitors, inspectors of the NSPCC, and other public and philanthropic organisations entered their homes with the aim of bettering working-class women as mothers and housewives.\(^{23}\) Charitable organisations, a long-standing means of educating and assisting the poor, often connected to the church and run by middle-class women,

\(^{17}\) Ibid, p.54.
\(^{19}\) Grace, Rags and Bones pp.68-71.
\(^{20}\) The Ipswich Journal, 3 Feb 1900, p.2.
\(^{21}\) The Ipswich Journal, 4 Apr 1896, p.5.
became prolific in the late Victorian era.\textsuperscript{24} As well as seeking to ‘save souls’, they spent a substantial amount of time educating working-class women on matters of child-rearing and domesticity, with some also providing material, and occasionally financial, assistance. In Ipswich, where there was great concern over childhood mortality, district visitors were highly visible in the poorest areas of the town in the second half of the nineteenth century. In the district of St. Clements there were 52 district visitors assigned - 50 of whom were female – who ‘distributed groceries, meat and tea, gave out dinner and bread tickets, and arranged for coal [...] to be supplied, as well as, of course, handing out improvement tracts to ‘succour souls’’.\textsuperscript{25} Furthermore, replicating what was happening around the country, various charities and clubs were set up in Ipswich with specific purposes, such as the lying-in charity and clothing club.\textsuperscript{26} In 1888, a ‘few lady philanthropists in Ipswich’ opened a crèche in the town for ‘the careful and affectionate tending of children from six months to five years of age, when their mothers have to be employed during the day’.\textsuperscript{27} In other areas of the country, some charitable organisations ‘developed a thriving business in selling cradles made out of banana boxes’ in response to the apparent increase in deaths from overlaying.\textsuperscript{28} Others provided those who could not afford them with a fireguard; although, some cynically believed that most would pawn them rather than use them.\textsuperscript{29} Nevertheless, such charitable organisations were aware they could neither help nor reform everyone, and, as Frank Prochaska states, despite the belief that ‘law and the state were artificial contrivances, useful in punishing sinners, but incapable of redemptive action’, many called for government actions.\textsuperscript{30}

By the end of the nineteenth century, concerns about the quality of the working classes reaching adulthood intensified and the Government began to take notice. The failure of the Boer War had brought England’s military strength and the health of


\textsuperscript{25} Grace, \textit{Rags and Bones} p.229.

\textsuperscript{26} Ibid, pp.229-231.

\textsuperscript{27} The Ipswich Journal, 7 July 1888, p.5.

\textsuperscript{28} Dyhouse, ‘Working,’ p.250.

\textsuperscript{29} Second Report of the Departmental Committee Appointed to Inquire into the Law Relating to Coroners and Coroners’ Inquests, and into the Practice in Coroners’ Courts, Parliamentary Papers (PP), 1910 (5139) vol. XXI, p.43.

\textsuperscript{30} Prochaska, ‘Philanthropy,’ p.388.
the nation into question. Even though it is acknowledged now that much of the failure was due to the ‘incompetence, amateurishness and deficient education of the officer’, much of the blame rested with the common soldier and by extension his mother.31 Dwork states how recruitment statistics showed that of those who wished to serve, ‘a startling number were found physically unfit to carry a rifle, and that even amongst those who passed the recruiting officer, a large proportion were deficient in the physical stamina and the moral qualities which go to make a soldier’.32 With the unease created by the German Unification, and the declining birth rate, which symbolised future Imperial decline, the Government could no longer ignore the health of the nation and so investigations began in earnest with the 1904 Inter-departmental Committee on Physical Deterioration.33 The Government, believing that many working-class mothers were simply not up to the job, began to legislate motherhood. Working-class children were now economic and military assets and if their mothers had shown themselves to be incapable of rearing them, then the law would step in to do so.

At the start of the twentieth century the newly formed Liberal Government introduced various statutory provisions increasing the legislature’s role in childcare. These, José Harris states, may have been ‘limited and permissive in form; but in substance they consisted what many saw as an unprecedented public interference in the rights and duties of parents’.34 The Midwives Act 1902 was introduced following concerns that untrained female midwives were placing infant lives at risk and therefore these women needed to be both trained and regulated.35 The Education (Provision of Meals) Act 1906 permitted, though did not obligate, local education authorities to provide school meals in elementary schools.36 Many mothers were simply not deemed capable, either through ignorance or neglect, of feeding their children adequately. The Education (Administrative Provisions) Act 1907 established nationally the requirement on schools to medically inspect children.37 The same year the introduction of the Notification of Births Act meant that Health Visitors would be

32 Dwork, War is Good for Babies p.12.
33 Ibid, pp.18-19; Lewis, Politics of Motherhood p.15.
36 The British Medical Journal, which advocated male obstetricians, stated in 1894 the desire to control this ancient profession restricted to women: ‘That midwives exist is a fact, that they can be abolished is an impossibility; therefore we desire to educate and control them’. The British Medical Journal, 24 Nov 1894, p.1208.
38 Ibid, p.111.
notified of births and were ‘to superintend the care [children] were getting’. Then in 1908, the Children Act was passed. These Acts were all part of the Government’s ‘out-reach work’ in instructing mothers in the proper management of their children.

2. Coroners’ Inquests: Sources and Procedure
This article draws upon a range of sources including Parliamentary reports, Hansard debates, and records of the Metropolitan Police, in addition to national and local newspapers. However, the principal source utilised in this article is the provincial newspaper, The Ipswich Journal. Historians and scholars examining accidental death in the nineteenth century have generally drawn upon coroners’ inquests but, as many of the original inquest reports prior to the twentieth century have not survived, the investigators’ temporal and geographical scope is limited.

In the case of Ipswich, there are few surviving nineteenth-century inquests and amongst those there is just one inquest of a burns accident and one of a scald accident involving children in their homes. However, not all details of these coroners’ inquests are lost.

The Provincial Press
Provincial newspapers in the Victorian period eagerly reported on coroners’ inquests held in their area, especially those pertaining to violent or accidental death. Unlike the original inquests, newspapers have survived in abundance. Recent digitisation projects, such as 19th Century British Library Newspapers, have allowed historians to both search and browse large collections of national and local newspapers. The early provincial papers largely consisted of a variety of news drawn from the daily London newspapers; The Ipswich Journal, established in 1720 and published weekly, initially filled its pages with predominantly advertising and national news. Yet, as these newspapers developed, more content was increasingly devoted to local news and, by the mid-nineteenth century, some local newspapers were even ‘employing

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38 Dwork, War is Good for Babies p.131; Ross, ‘Good Mothers,’ p.183.
39 For a list on surviving inquest in England and Wales see: Gibson & Rogers, Coroners’ Records in England and Wales (Federation of Family History Societies, 1992).
40 Those documents that do survive are the minutes of the inquests for the Ipswich borough, 1889–Feb 1876, Dec 1878-Feb 1897 and Apr-Sept 1884. Suffolk Record Office, Ipswich (SROi) DG1 Minute Books of Henry Jackaman, Coroner, 1869-1884.
41 http://newspapers.bl.uk/blcs/ (accessed 19.11.2011)
42 Jeremy Black, The English Press, 1621-1861 (Sutton, 2001) p.119; Lucy Brown, Victorian News and Newspapers (Clarendon Press, 1985) p.36. However, from 1871 The Ipswich Journal began to be published twice a week. The newspaper was briefly published on a daily basis in 1886, although this was soon abandoned and the paper returned to being published on a weekly basis.
shorthand reporters to cover local events'.

Content differed little from paper to paper, covering such things as births, horse races, local celebrations of royal events, humorous incidents, ‘domestic incidents such as multiple births’, accidents, and petty crime. *The Ipswich Journal* covered all manner of local activities including church news, boat arrivals, sport, workhouse admissions, markets, corn prices and horticultural shows.

However, it was death – whether murder, suicide or accidental – that sold newspapers. Death was a staple component of the provincial press, it was common to ‘reprint the most interesting examples from the London press and add more stories of their own’, in order to shock and titillate their middle-class readership with tales and reports of unnatural deaths in the working-class districts of their town from the safety of their barricaded homes. *The Ipswich Journal* was no exception. Death and violence was a continual and predominant feature of its local news reports, covering in detail petty sessions and other criminal proceedings, fires, accidents and, most notably, coroners’ inquests.

The public nature of coroners’ inquests provided ample source material to satisfy the most sensational appetites. The coroner’s court would be crowded with bystanders and reporters, the latter supplying readers with an account of the inquests; albeit a ‘condensed version’. However, the space given to each inquest largely depended on the journalist’s perception of its particular newsworthiness. Comparing death returns for the town of Ipswich, and the surviving inquests, with *The Ipswich Journal’s* coverage, most of those omitted were inquests relating to ‘deaths from natural

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causes’; nonetheless, a substantial amount still received newspaper coverage.\textsuperscript{48} Violent death, including accidental death, unsurprisingly, received the greatest and most detailed coverage, often recounting substantial pieces of witnesses’ evidence, especially when the victim was a child. Furthermore, and crucially in regards to this article, the newspaper recorded the admonishment of mothers by the coroner at the close of the inquest.

In order to further appeal to their readers, reporters added their own ‘descriptive gloss’, such as ‘circumstantial details’ surrounding the death, the ‘atmosphere of the courtroom’, as well as passing judgement on the ‘reputation and respectability’ of both the deceased and witnesses.\textsuperscript{49} These additional comments, not only supply extra details about the fatal event, they also drew on and contributed to public opinion with regards to circumstances in which some of these deaths occurred.\textsuperscript{50} Furthermore, Shani D’Cruze argues, ‘in choosing to report acts of everyday violence as news [...] the newspapers’ narrative invoked wider concern of perceived disorder with working-class neighbourhoods and, in doing so, spelt out the case for regulation and reform’.\textsuperscript{51} As will be discussed, the reports of coroners’ inquests in the nineteenth-century press in regards to burnt children and absent fireguards brought the issue to the attention of a wider audience, eventually gaining the support needed to legislate against such accidents.

**The Inquest**

Since 1194, the role of coroners in England has been to investigate cases of unnatural, sudden and suspicious deaths occurring within their jurisdiction.\textsuperscript{52} There were three types of coroners in the nineteenth century: county coronors, elected by freeholders; franchise coroners, appointed by estate owners, and, borough coroners, into which the Jackaman’s of Ipswich fall.\textsuperscript{53} Prior to 1835, borough coroners were


\textsuperscript{51} D’Cruze, *Everyday Violence* p.104.

\textsuperscript{52} Gibson, *Coroners’ Records* p.4.

appointed by 'charter of incorporation of the borough'. These elections, like those of county coroners, were deeply intertwined within local and national politics and, as Fisher observes, 'large sums of money could be spent on winning office.' From 1835, however, under the Municipal Corporations Act 1835, all those boroughs with quarter sessions were required to appoint 'a fit person, no being an aldermen or a councillor' to the post of coroner; although, what they considered as ’fit’ was entirely up to them. Nevertheless, this Act, Fisher states, did result in the 'loss of office for some borough coroners'.

The only real requirement for holding the prestigious post of coroner was ownership of property, as such, the financial standing of coroners must have somewhat removed them from the realities of many of those who stood before them. This requirement, however, was abolished in the Coroners Act 1887. The same Act also stated, though 'some knowledge of medical terms and the principles of criminal law are necessary [...] the chief requisites are the possession of tact, sound discretion, practical sense, sympathy, quick perception and knowledge of human nature'. Despite no medical or legal qualifications being required, great care was often taken to appoint a ‘suitable person’ and many Victorian coroners were trained solicitors, as is the case today. Once appointed, most coroners held this position for life, combining it with their work and other duties. After all, the role of coroner would typically occupy just a few hours of the week. For solicitors, Gordon Glasgow remarks, ‘the coronership afforded “an opportunity for raising both the social standing of the successful candidate and the prestige of the practice”’. In other words, it was

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57 Fisher, Object of Ambition p.6. 
58 s71 Coroners Act 1887. 
59 Barnard, Viewing the Breathless Corpse p.10; Gibson & Rogers, Coroners’ Records p.4. 
62 Bailey, This Rash Act p.38; Fisher, ‘Politics,’ p.84. 
63 Glasgow, ‘Election,’ p.80.
good for business. After their retirement or death, it was almost customary for sons to be appointed or elected as the new coroner.  

The Jackaman family held the post of coroner for the borough of Ipswich throughout the nineteenth century. After his father’s retirement, in 1823, Simon Batley Jackaman, town clerk and solicitor, was elected coroner ‘after a long and hard-fought battle’, and at some financial cost. It was not uncommon for the town clerk to act as coroner ‘by virtue of his office’. S.B. Jackaman, unhindered by the reforms of 1835, served as coroner for the town for 50 years. His obituary, in reference to his role as coroner, described him as:

a model of patience and kindness. His care in avoiding all that might wound the feelings of the bereaved people who necessarily came before him was dictated by his native benevolence of heart. No child or widow ever needed to hesitate in telling their mournful tale to him, and his kindness and consideration under painful circumstances are well remembered in many a humble home.

When S.B. Jackaman retired in 1873, aged 73 years, his son Mr Henry Mason Jackaman, already serving as deputy coroner and a solicitor, was elected coroner by the Town Council on the 17 December 1873 ‘without opposition’, seeing out this role into the twentieth century, and as will be seen, taking a tougher stance with working-class mothers when it came to the care of their children.

The notification of a death and decision to establish an inquest had long been problematic, resulting in a local variation in the number and type of inquests held. Coroners, barred from initiating their own inquiries, were reliant on the initiative and judgment of others – doctors, private citizens, and the local constabulary – to notify them of deaths they deemed worthy of an inquest. Undoubtedly, this meant a number of deaths actually warranting an inquest were missed by coroners. The Registration Act 1836, requiring all deaths to be registered with a local registrar, did improve the situation to some extent as they could then report all unnatural, sudden and suspicious deaths to the coroner. Nevertheless, some were undeniably still

63 Bailey, This Rash Act p.38.
64 The Ipswich Journal, 15 Feb 1800, p.2; The Ipswich Journal, 9 March 1875, p.3; Fisher, ‘Politics,’ p.80.
66 The Ipswich Journal, 9 March 1875, p.3.
67 Ibid; SROI DG1 Minute Book of Henry Jackaman, 1873.
68 Burney, Bodies of Evidence p 4.
The inquest of Susanna Neave, aged 65 years, reveals how a fatal household accident was almost missed by the Ipswich coroner in 1886. Early one Sunday morning, Susanna Neave was heard crying out for help and was discovered ‘on the floor in flames’ in a downstairs room. Despite medical treatment from Dr Hammond, the burns soon proved fatal. ‘Mr Neave, brother-in-law of the deceased [...] said to Dr Hammond, “I suppose there will be an inquest?” but Dr Hammond stated there would be no necessity for it’ and certified the death. William Hutchinson, registrar for the district, on ‘seeing two respectable qualified witnesses such as Mr and Mrs Neave, quite overlooked the fact that he must not register deaths where there was any suggestion of an accident or violence, and registered the death’. Had a concerned local resident not informed the coroner, no inquest would have been held. At the inquest, the coroner stated that the registrar’s oversight, in this instance, had been exceptional, and, ‘In all his experience he had found Mr Hutchinson excessively cautious in registering deaths’. Nevertheless, He should have thought it clear to anyone, especially to a medical man, that where a death had resulted from an injury that death must be fully investigated by the coroner in order to see whether it was what the law called an accident, or the result of any negligence or carelessness.70

Furthermore, absence of official guidelines meant that the criterion for establishing the necessity for an inquest was subject to each coroner’s interpretation.71 Most coroners would have relied upon John Jervis’ Office and Duties of Coroners, first published in 1829, which provided a guide on all aspects of coronership and the inquisition process for deciding whether an inquest was necessary. Towards the end of the nineteenth-century, however, the definitions of deaths necessitating an inquest was for the first time set out in the Coroners Act 1887, section 71 stated:

[If] the dead body of a person is lying within jurisdiction and there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or had died a sudden death of which the cause is unknown, or that such a person had died in prison’, then there is justification for holding an inquest.72

However, even these guidelines could be subject to interpretation; although, one could expect that in cases of fatal household accidents most coroners would deem an inquest justifiable.

70 The Ipswich Journal, 6 May 1886, p.3.
72 Thurston, Coronership p.10.
Inquests were normally held within 48 hours of death, or of the body being discovered, and at the nearest convenient place, often a public house. 73 A jury of at least 12 local men was summoned. 74 While there was no statutory qualification for jurors, they were generally tradesman, shopkeepers and artisans, and literacy was preferred, but not always possible. 75 In small communities like Ipswich, it would not have been uncommon for the jurymen to know those victims and witnesses brought before them, which, as will be discussed below, was crucial in the outcome of their verdicts.

Once the jury, witnesses, interested public viewers and members of the press were in attendance, the inquest commenced. 76 Proceedings began with both the coroner and jurymen viewing the body, which was usually brought to the site of the inquest. 77 The horrific injuries and decaying state of the corpse in burns cases must have been a shocking spectacle to those unused to such scenes, as one newspaper report recounts: ‘the poor infant was almost burnt to a cinder, presenting a most horrible spectacle; to say nothing of the agony which it must have undergone’. 78

Witness testimonies would then be heard by the court. Lay witnesses usually consisted of those present at the death, or at the incident which led to the death, or those who discovered the body, as well as anyone else who might be able to shed light upon the events preceding the death. 79 Much of the questioning of witnesses was done by the coroner, however, jurors could, and frequently did, interject. 80 Significantly, where a child had fallen victim to a household accident and the mother’s care had been brought into question, neighbours and friends would be called upon to testify to the mother’s character and her ability to care for her children.

74 Burney, *Bodies of Evidence* p.4; Gibson, *Coroners’ Records* p.4; Thurston, *Coronership* p.3.
75 Heathcote, *Viewing the Lifeless Body* p.14
76 Heathcote, *Viewing the Lifeless Body* p.5.
78 *The Ipswich Journal*, 15 March 1851, p.4.
79 Bailey, *This Rash Act* p.38; Barnard, *Viewing the Breathless Corpse* p.17; Heathcote, *Viewing the Lifeless Body* p.18
80 Burney, *Bodies of Evidence* pp.4-5.
The coroner’s court also frequently called upon medical witnesses. Coroners and jurors had been given the power, under s39 Medical Witness Act 1836, to summon medical practitioners. Doctors were, of course, recompensed for their time.\(^8\) Medical practitioners, who had attended the deceased prior to death, were called to give their account of any medical treatment they had provided and their opinion as to the cause of death.\(^8\) Other medical witnesses were also called to examine the body, which, in Ipswich, according to *The Ipswich Journal*, amounted in most cases to little more than an external examination. *Post-mortem* examinations were, at this point, still relatively infrequent.\(^8\) Nonetheless, their testimony was usually given great weight by jurors, a common statement being: ‘The Jury returned a verdict in accordance with medical evidence’.\(^8\)

After hearing all the evidence, the coroner would weigh up the evidence to the jury. How far the jury were led by the coroner at this point is debatable.\(^8\) In Conley’s work on judges and jurors in criminal courts, she argues that the level of direction given by a judge varied widely on their perception as to the abilities of jurors:

‘Justice George Bramwell believed “the less the jury have to say the better,” while his colleague Justice Samuel Martin felt that “juries almost always find a correct verdict, that they are as good a tribunal as can exist, and that they find an honest verdict on all occasions.”’\(^8\)

While in Sambrook’s work on coroners’ inquests she notes that the jury were ‘fairly independently minded’ and generally came to a conclusion of their own.\(^8\) Their decision, however, at inquests of fatal household burns suffered by working-class children was often at odds with the view of the coroner.\(^8\) Nonetheless, the verdict of the coroner’s inquest was the sole responsibility of the jurors.

3  **Ipswich’s Working-Class Mothers and the Ipswich Coroner’s Court**

\(^8\) Bailey, *This Rash Act* p.52. 
\(^8\) Fisher, *Object of Ambition* pp.16-17. 
\(^8\) Ibid, p.18. 
\(^8\) Ibid, pp.18-19.
\(^8\) Sambrook, ‘Unfair,’ pp.93-94.
The working-class multi-purpose urban back room or single lower room was a hub of activity, central to which was the fire grate, being most family’s only source of heat during the cold winter months, and used throughout the year for cooking, boiling the kettle, heating water for washing, and drying clothes on wet days. The fire also claimed the lives of a number of Ipswich’s young working-class children. Between 1840 and 1900 *The Ipswich Journal* reported on 62 inquests held on children mortally wounded when they or their flammable clothes caught light after coming into contact with the fire. A further 37 cases of children fatally scalded in their homes were reported during this period, most having knocked pans and kettles off the fire and onto themselves or a sibling, or having drunk from the kettle. Nearly all of these accidents involved an unguarded fire and often occurred during a mother’s absence from the home, with young children left unattended or under the supervision of an *elder* child who was usually too young to render much assistance in the event of an accident.

However, few of Ipswich’s mothers were ‘out’ at work at the time of their children’s fatal accidents. Instead, the newspaper reports reveal that most mothers had only left the home and their children briefly while they accomplished domestic-related tasks – running errands, taking their husband’s dinner, fetching water, shopping, and borrowing items from neighbouring houses. Despite these fatal accidents occurring infrequently in comparison to childhood deaths, such as diarrhoea, in a population averaging around 10,000 children, and rarely involving working mothers, they, nevertheless, increasingly evoked a strong admonishment of mothers from the coroner.

**‘Guilty of great neglect’: Single Mothers and the Coroner’s Court**

In the mid-nineteenth century, most childhood accidents were typically viewed as tragic incidents, the *married* mother receiving sympathy and understanding from both coroner and jury. In 1852 when Hepzibah Woods, aged four years, son of a mariner, was burnt to death after falling in the ‘unguarded fire’ in the absence of his mother, *The Ipswich Journal* commented: ‘The mother of the child was presented to have been very kind, and to have left the deceased but twenty minutes while she went into the Rope Walk’. Yet, by the end of the century leaving children at home for just 20 minutes had become an unacceptable practice in the eyes of the coroner – ‘almost criminal neglect’ – a point returned to later in this article. Not all mothers were treated

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89 Children refers to those aged 0-9 years.
90 *The Ipswich Journal*, 6 Nov 1852, p.2.
so compassionately in the mid-nineteenth-century coroner’s court, mothers of illegitimate children in particular were subject to opprobrium. Imbued with a sense of moral righteousness, Middle England was quick to point the finger of blame at mothers whose illegitimate children suffered fatal accidents.

Ipswich experienced some of the highest illegitimacy rates during the nineteenth century.91 In the 1850s, for example, one in 12 births in the town were recorded as illegitimate.92 The town’s high rate of illegitimacy caused great unease among town officials and the middle-class community. It is unsurprising, therefore, that mothers of illegitimate children came under the heaviest criticism in Ipswich’s coroner’s court. In the 1840s and 1850s these women were the only women deemed negligent in response to the accidents involving their children; the sole exception being one inquest in 1845 where a child was burnt to death while under the care of a servant: ‘A serious admonition was given to the servant girl for having neglected to attend to the instructions given her, to place the guard on the fire’.93 Blame for those few fatal childhood accidents that took place in the middle-class homes of Ipswich was usually targeted at servants.

In 1851, The Ipswich Journal reported on the death of an infant burnt to death while sitting in a wicker chair by the unguarded fire, her mother being temporarily absent. The parents were living together, but unmarried. Like many other instances of burns accidents involving children, the mother had only left the child for a short time; in this case while she went to a neighbour’s house to return some scissors. The mother told the coroner’s court that ‘there was a small fender only on the hearth. I have no guard to place on the fire. I think I stopped about ten minutes. I then returned home’. The jury, picked from the respectable working class and middle class men of Ipswich, were ‘unanimously of the opinion that [the mother] was guilty of great neglect in leaving the deceased as described in the evidence’. This was despite several neighbours giving testimony that she was a ‘good mother’.94 As Robert Roberts recalled in his childhood in a working-class Salford community, mothers living in

92 John Glyde, The Moral, Social and Religious Condition of Ipswich in the Middle of the Nineteenth Century (Ipswich, 1850) p.73.
93 The Ipswich Journal, 8 Feb 1845, p.2.
94 The Ipswich Journal, 15 March 1851, p.4.
‘common law’ unions were viewed differently from single mothers - ‘Strangely enough, those who dwelt together unmarried [...] came in for little criticism, though naturally everybody knew who was or who was not legitimate’.  

Similarly, in the nearby village of Bromeswell, Suffolk, in 1841, illegitimate Eliza Riches, aged two years, was left in a room by her mother who had gone to a neighbour’s house ‘to gossip’, a characteristic the middle class applied to those women who were supposedly neglecting their domestic duties. While she was gone, Eliza burnt to death. At the inquest, under the Liberty’s coroner, Mr Wood, the mother was ‘severely reprimanded [by the coroner] for her excessive carelessness’. Notably, there was a similar accident reported of another child burnt to death in that same edition of the paper, though in this instance the married mother received no admonition by the court. In Woodbridge, Suffolk, in 1859, Sarah Lawrence’s unmarried mother also left her infant unattended while she went to a neighbour’s house, and in her brief absence her child burnt to death. At the inquest, ‘The mother of [the] deceased was severely reprimanded for her neglect in leaving the deceased’.

Whilst the coroners, and even juries, perceived these fatalities involving illegitimate children as a result of unmarried mothers’ negligence, there was an absence of laws to enable coroners who so wished send these mothers for prosecution. They did, however, take the opportunity to berate these mothers not just for their supposed negligence, but the immorality of their lives. The inquests of those illegitimate children who suffered fatal accidents were reported in salacious detail in The Ipswich Journal, far more than those relating to their legitimate counterparts, and the reports show coroners’ increasing commentary on the immorality of unmarried mothers. In 1885, Mary Ann Anson Rushford, whose unmarried parents were co-habiting, caught fire and was mortally wounded while her mother was out on an errand, being gone for ‘about ten minutes’. The fire had been left unguarded. The coroner in summing up

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97 The Ipswich Journal, 16 Jan 1841, p.2.
98 Ibid.
100 John R. Gillis, For Better, For Worse. British marriages, 1600 to the Present (Oxford University Press, 1985) p.234. Town missionaries across the country took it upon themselves to encourage marriage amongst cohabitating couples. In four years, John Glyde boasts in 1850, they managed to ‘include’ 150 persons living in such unions to be ‘united in the sacred band of matrimony’. Glyde, Moral p.73.
the evidence to the Jury said they must question ‘whether the burns were a result of an accident or whether there was any gross carelessness or neglect on the part of the mother in leaving the children the way she did’. Nevertheless, with no relevant laws in place at this time, the mother could not be charged. However, the court, being also a place of moral censure, did take the opportunity to berate the couple’s immorality: ‘[The coroner] expressed great regret [at] the disgraceful condition in which they were living. […] The jury hoped the loss of the child would bring home to them the shortness of life, and would induce them at once to get married.’ The parents took little notice of the coroner’s remark, since the 1891 Census Enumerators books, six years later, show they were still unmarried and still producing illegitimate children.

‘Endeavour her to do her domestic duties’: Working-Class Mothers and the Coroner’s Court

By the late 1860s, the growing middle-class concerns over the abilities, or rather lack thereof, of working-class mothers, saw incidents hitherto perceived as tragic accidents now being attributed to a mother’s carelessness, regardless of her marital status. As the mother was responsible for the home, it was therefore her responsibility to prevent accidents occurring in that space, and in this the fireguard played a central role. Fireguards became a recurring angst at coroners’ inquests from the 1860s onwards with all working-class mothers, not just unmarried ones, being increasingly scorned for leaving their children unattended by an unguarded fire. This was also brought to attention by the Registrar General who, in 1861, commented: ‘Open fires...should be surrounded by GOOD GUARDS. This is a precaution of capital importance’.

Notwithstanding this homily, one Saturday afternoon in February 1865, three-year-old Henry Taylor was burnt to death at his home in Morfey’s Court, Ipswich. His (married) mother had made up a fire in her bedroom in the morning, ‘while she used the lower room for the purpose of drying some clothes’. She then went into town, leaving her nine year old daughter whom ‘she considered quite equal to the charge of taking care of her brother’, in loco parentis. However, on her return home, she found her son had been severely burnt. It was supposed that he had gone too close to the fire. There

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101 The Ipswich Journal, 8 Jan 1885, p.2.
102 Ibid.
103 TNA RG12/1469/79 Census Enumerators Book, Ipswich, 1891.
was ‘no fire-guard’. Henry died that following Wednesday and an inquest was held the same day, where ‘the coroner, at the request of the Jury, reprimanded the mother for leaving such young children with a fire in the room and advised her to be more careful in future’.105 Two years later, the married mother of Arthur Suckling temporarily left her children home alone while taking her husband, a platelayer, his lunch. In this brief absence Arthur, aged four years, caught light after playing with the unguarded fire, resulting in fatal wounds. The surgeon who had attended Arthur commented at the inquest that the house was in a ‘shocking state of filth’ and that the child had not been properly cared for. It was perceived, therefore, that the mother was clearly not embracing her role as homemaker and mother. The coroner hoped that the death of her child would ‘endeavour her to do her domestic duties’.106 These two inquests reflect the increasing sense of blame attributed to all working-class mothers for the well-being of their children and the care of their home.

Yet was it really the mother’s fault for not owning a fireguard? While many of the inquests state that there was not a fireguard present, they do not query why this was the case. An Ipswich inquest in 1849 gives some insight into a possible reason why so few homes boasted fireguards. After his son had been fatally burnt, the father stated at the inquest that his wife had suggested purchasing a fireguard on several occasions, but he believed it to be an ‘unnecessary expense. He should now, however, adopt the suggestion’.107 Fireguards were certainly an expensive purchase for the working-class household. An advertisement in The Ipswich Journal, in 1876, by a local manufacturer, shows the price of fireguards ranging from 11s.6d. to 26s.6d.108 This leads us to question whether the coroner’s court was justified in blaming the mother in every instance for a missing fireguard. If her husband did not allow her the money for one or the family simply lacked the finances, obtaining one may have been almost impossible. Yet little blame was ever laid on the husband in these circumstances.

Mothers were repeatedly warned by the coroner to procure a fireguard, the implicit warning being that if a similar accident recurred, the jury might not be so lenient. Nevertheless, as with single mothers, the coroner was largely limited to berating married mothers for their lack of precautions regarding their children’s safety. The

105 The Ipswich Journal, 4 Feb 1865, p.6.
106 The Ipswich Journal, 13 Apr 1867, p.5.
108 The Ipswich Journal, 9 Dec 1876, p.4.
Offences Against Person Act 1861, which covered offences relating to ‘intentional’ bodily harm, could not be easily applied by the coroners’ courts in the case of such accidents, as it was simply too difficult for the court to establish intent. Problems with medical evidence also hindered coroners, as illustrated in 1876, when Annie Meadows, an illegitimate child aged three years, was fatally scalded after upsetting a kettle of hot water in the presence of her mother. Instead of immediately calling for medical assistance, her mother applied yeast, potato and snowy water to the wound. The mother then went to the local herbalist who provided her with some ointment. Several days after the fateful incident, with the child’s health deteriorating, the mother was advised by the herbalist to seek professional medical aid. However, the child died before medical aid arrived. At the inquest a post mortem examination was held to determine whether the child would have lived if proper medical assistance had been immediately called for. The surgeon stated that the wounds had become gangrenous and that if the proper medical treatment had initially been sought, the child would have “probably” survived. Even though the coroner believed the mother and the herbalist ‘guilty of great neglect’, there was insufficient medical evidence for a charge of neglect to be sustained. All the coroner could do was simply warn the mother and the herbalist ‘to be more careful in future’, for ‘on a future occasion they might have to answer for such neglect to another jury’.109

However, with the emergence of the NSPCC and the passing of the Prevention of Cruelty to, and Protection of, Children Act 1889, the coroner was apparently placed in a stronger position to punish these ‘so called’ negligent mothers. However, legislation notwithstanding, coroners still found themselves continually hindered, both by the ambiguities and inadequacies of law and the leniency of jurors more familiar with the circumstances of working-class life.

‘Had it not been for the leniency of the jury’: Jurors’ Attitudes to the Burnt Children and Absent Fireguards

The Ipswich Journal refers to a number of cases where the coroner suggests to the jurors the possibility of bringing a verdict of neglect in cases of fatal household accidents. To some extent, the coroners were simply summarising the case to the jury but it is obvious in some cases that a harsher verdict was being called for and they were exasperated by juries’ responses.

109 The Ipswich Journal, 1 Jan 1876, p.5; The Ipswich Journal, 4 Jan 1876, p.2.
Newspaper reports of the inquests held on children in Ipswich who suffered fatal household accidents indicate that the parents were never charged with neglect. Cases brought before the Ipswich magistrate that are reported in The Ipswich Journal, generally involved sustained parental neglect on the body of the child, such as malnutrition and physical abuse. With accidents it was more difficult to determine guilt where the parent had been attentive to the child’s bodily needs. Furthermore, the jury were probably more sympathetic to those parents who had lost their children in tragic circumstances rather than through perceived neglect, especially when a verdict of neglect could mean being tried for manslaughter for which the penalty was a maximum sentence of life imprisonment. This problem is highlighted by a later Parliamentary discussion on legislation dealing with infant suffocation:

In England and Wales in 1906, there were 1,453 inquests on infants suffocated, and only one verdict of manslaughter was returned by a coroner’s jury. The ‘present law’ was inadequate, because where it is applied at all was too harsh, and the juries would not permit persons to be tried for manslaughter on this charge, nor would the juries in the Assize Courts condemn them.

This was particularly problematic in small communities and towns, like Ipswich, since it would have been difficult for jurors to bring judgment against a mother they may have known. The jury would instead resort to offering advice and hope that the tragedy would encourage the bereaved to better themselves as parents, even going against coroners’ and expert witnesses’ recommendations of a harsher verdict.

In 1897, The Ipswich Journal reported on an ‘IPSWICH BURNING FATALITY – PARENTS CENSURED’, Annie Alcock, aged six years, had died in Ipswich hospital whilst being treated for burns. The child’s mother, who had previously been cautioned by the NSPCC inspector for leaving her children at home without any proper care, had gone out to do some washing, leaving her nine-year-old daughter, who should have otherwise been at school, in charge. It was certainly not uncommon for parents to keep their children, especially daughters, away from school to care for younger children while their mothers worked or when help was needed at home, this practice continued in spite of the Education Act 1876 which made it compulsory for those aged five to ten years to attend school. While Mrs Alcock claimed ‘she could not remember having been cautioned by the Inspector’, the father ‘admitted hearing

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[110] s5 Offences Against the Person Act 1861.
[him] caution his wife about leaving the children'. During her mother’s absence, Annie reached for a buttonhook on the mantelpiece, catching her pinafore alight. The fire had been left unguarded. At the inquest, the coroner, highlighting the inadequacies of the law to penalise such parents, stated

There was no doubt that there had been neglect in this case, but the question was whether it was culpable neglect. There are no definitions of culpable neglect in the law books, but his definition of such neglect was that it was such neglect that no ordinarily intelligent and reasonable person would be guilty of; then, if committed it constituted culpable neglect.

He goes on to state, however, that ‘It is for the jury to say whether the mother’s conduct had been criminal or not’:

The Jury returned a verdict that the child died from shock to the system, the result of burns, and although they did not consider the mother’s neglect to be of a criminal character, they desired the coroner to censure both parents, which he did, and informed them that they might congratulate themselves that they had had a very narrow escape of being sent for trial for the manslaughter of the child. [In his opinion,] the jury had taken a lenient view of the circumstances.\(^\text{113}\)

In 1900, *The Ipswich Journal* reported on a ‘CHILD BURNT TO DEATH AT IPSWICH – DISTRESSING CASE’. Elizabeth Wesley’s married mother, an outworker for the local staymaking factory, had briefly gone to the factory to deliver her work, leaving her young children alone at home, as she stated, for less than 25 minutes. During her absence, three year old Elizabeth caught light and was fatally injured. The mother, in her defence, stated, ‘She had frequently left them before. She thought it was a dangerous practice, but she had no one to leave them with’. The newspaper records how,

The Coroner, in summing up, said the question for the Jury to decide was whether there was any need for the mother to be away so long and whether she was away so long as she stated. He commented strongly upon the very dangerous practice on the part of parents of leaving young children alone in a house with a fire. It might be called almost criminal neglect on their part not to provide someone to look after them. Notably, there was a fixed fireguard on the grate, although Police Constable Woodward, who had inspected the guard after the accident, remarked to the court that there ‘was sufficient space between the bars of the guard for a child to put its arm through’. No charges were pursued, as the jury deemed the incident to be accidental and recommended that ‘a piece of galvanised wire

\(^{113}\) *The Ipswich Journal*, 3 Dec 1897, p.5.
Even the most cautious of mothers could not guarantee a safe home for their children and were subject to reproach in the coroner’s court. In 1900, Jesse Maude Clover, wife of a sawyer, was required to go on an errand. After securing the guard in front of the fire, she went to a neighbour’s house to ask them to watch over her children while she was gone. In that brief absence, one of her children managed to put its arm through the guard and catch fire, mortally wounding itself. The coroner suggested that ‘the mother ought to get a guard through which [the child] could not thrust its arms’, deeming her still responsible for the accident despite all the precautions she took.  

Three years previously, Bertie Green, aged two years, was also burnt to death in the absence of his mother who had gone to purchase some sweets for her children: ‘The supposition [was] that prompted by infantile curiosity he raised himself on the guard in front of the fire to reach something from the mantelshelf, lost his balance, and fell forward into the fire’. This was not the first occasion Bertie had attempted to reach for items on the mantelpiece, his mother told the court that ‘she had seen [Bertie] draw a chair up to the fireguard and take matches and other items on various occasions. [Bertie’s] clothes, which would easily take fire, were burnt to shreds. The fireguard had three bars all around’. This led the coroner to comment that, in this case, the mother should have known it was necessary to ‘take extraordinary precautions’ and ‘asked the jury to consider whether there was any culpability on the part of the mother, or any want of precaution on her part’. In their summary, the jury stated: ‘it is most desirable, in the interests of society, that guards for fires should be constructed with top and bottom bars only, and vertical uprights, instead of horizontal bars, thus preventing children from getting on to the guard and thus reaching the mantelpiece’. The jury then went on to say, they ‘hope[d] that the mother would not be indiscreet enough to leave so young a child on a future occasion’.

Frustration with jurors and the perception that working-class mothers were careless and negligent in the care of their children was not confined to the Ipswich coroner. In Pamela Sambrook’s research on community responses to sudden deaths of children in Staffordshire in the mid-nineteenth century, she argues that ‘occasionally, [juries]

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114 *The Ipswich Journal*, 13 Jan 1900, p.8.
115 *The Ipswich Journal*, 17 Feb 1900, p.5.
brought in a more lenient verdict than the higher-status coroner would have done'.\textsuperscript{117} Sambrook illustrates this in the inquests of Edward Walker, where the coroner stated ‘‘This case was one of gross negligence on the part of the mother, in leaving the child from seven in the morning to two in the day, and again to seven at night. I quite expected the jury to have returned a verdict of manslaughter’’.\textsuperscript{118} Working mothers, Sambrook notes, were especially subject to sharp rebuke from the coroner.\textsuperscript{119}

Similarly, Siân Pooley’s article on childcare, neglect and parental authority in the late nineteenth century, referring to a young child fatally burnt in the absence of his working mother reported in the local Burnley press, suggests the coroner was ‘pressing to interpret the tragedy as the result of parental neglect’. Further remarking, that while ‘the parents and neighbours were clearly shocked by this domestic tragedy, they all maintained that the parents were in no way negligent to leave the children alone in the house […] Instead [such] incidents were interpreted as family tragedies, but ones that were an unavoidable part of accepted childcare practices’.\textsuperscript{120}

By 1880, some coroners were pushing for legislation in response to those deaths from burns and other household accidents. For example, The Times reported on an inquest held in Paddington on a five year old child, the son of a labourer, burnt to death in the temporary absence of his mother who was in the next room, where the coroner concluded, ‘he thought a small penalty should be imposed on parents who did not take the precaution of providing a fireguard for the protection of their children’s lives’.\textsuperscript{121} While toward the end of the century, Mrs Greenwood, Sanitary Inspector for the Corporation of Sheffield was advising mothers on the importance of using fireguards, even distributing a leaflet, entitled ‘On the Care of Infants and Children’, which contained an image of a recommended guard.\textsuperscript{122}

Coroners’ pressure upon working-class mothers in regards to the care of their children further increased towards the end of the century. Mothers were no longer just expected to use a fireguard during their absence, but were now expected to

\textsuperscript{117} Sambrook, ‘Unfair,’ pp.93-94.
\textsuperscript{118} Ibid, p.94.
\textsuperscript{119} Ibid, p.94.
\textsuperscript{121} The Times, 5 March 1880, p.10.
provide suitable childcare even in the shortest of absences. A young child watching over still younger children was also no longer tolerated by the coroner’s court. Whilst the Prevention of Cruelty to Children Act 1889 may have been a turning point in child welfare, it did not prove to be so in the case of household accidents. Jurors were either unwilling or unable to enforce the legislation, much to the dismay of coroners. However, the court still took the opportunity to severely reprimand the mother for neglecting her domestic responsibilities, with little consideration for the circumstances of the accidents. Although men were not immune from criticism by the court, the responsibility for the accident fell upon the mother, as she was responsible for the domestic space. By the end of the century, coroners across the country had become exasperated by the working-class mother’s inability, either through carelessness or negligence, to keep her child out of harm’s way, and began to voice the need for action to force these women to fulfil their domestic duties. As one Government minister latterly stated, ‘Coroners had protested and cried aloud in vain, as they had no power to enforce anything, nor has any other person’, but events of the last decade of the nineteenth-century thrust motherhood to the forefront of politics and finally gave coroners the opportunity to bring the issue of absent fireguards and burnt children to Government attention.

4 Legislating Motherhood: Burnt Children, Absent Fireguards and Government Intervention

Heightening Government concern over the abilities of working-class mothers to protect and care for their children finally brought the issue of burnt children and unprotected fires to Government attention at the turn of the century. In 1901, following the coroner for the City of Nottingham drawing Government attention to the frequency of fatal burns in his jurisdiction, the Home Office began to investigate incidents of these accidents. Gathering reports from 200 coroners, they found ‘in the years 1899 and 1900 coroners held 1,684 inquests on the bodies of children whose death had resulted from burning, and that [in] 1,425 of these cases the evidence showed that the fire by which the burning was caused had been unprotected by a guard’. This resulted in a circular being produced and distributed to shopkeepers and Police Stations, warning parents and guardians of the danger of not owning a fireguard. It stated:

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123 HC Deb (4th series) 12 Oct 1908 vol. 194 c.145.
125 TNA MEPO 2/582. Deaths from fire – children: precautions, 1901.

47
DEATHS OF CHILDREN FROM BURNING.

TO PARENT AND GUARDIANS.

Attention is drawn to the frequency with which the death of children is caused owing to their clothes talking fire at unprotected fire grates. During the years 1899 and 1900, Inquests were held on the bodies of 1684 YOUNG CHILDREN whose death had resulted from burning and in 1425 of these cases the fire by which the burning was caused was unprotected by a guard.

With a view to prevent such deplorable loss of life it is suggested to Parents and Guardians, who have care of children, that it is very desirable that efficient fire guards should be provided, in order to render it impossible for Children to obtain access to the fire grates.\(^\text{126}\)

However, the ineffectualness of such circulars is illustrated in the Report of the Inter-Department Committee on the Physical Deterioration and the Judicial Statistics 1904. That year 988 inquests were held on people who died as a result of ‘burns at unprotected grates or stoves’ and a further 131 from scalds, many of whom were undoubtedly children.\(^\text{127}\) Mrs Greenwood, Sanitary Inspector, reported to the Inter-Department Committee on the Physical Deterioration that she had tried in vain to educate Sheffield’s working-class mothers on the importance of using fireguards and, while people generally resent such instructions, ‘she had never known [a fireguard] bought as the result of the warning, and thought they could only be brought into use by the inclusion of provisions in the building bye-laws’.\(^\text{128}\) Mrs Greenwood’s innovative solution was not realised in building bye-laws but the Children Act 1908.

The Children’s Bill Debate

In the House of Commons debate on the Children’s Bill, on 10th February 1908, the then Under-Secretary of State for the Home Department, Mr Herbert Samuel, proposed to the House that a clause be included that imposed a penalty on those whose children under their care died as a result of ‘burns and scalds owing to their being left in rooms with unguarded fires [...] except where it can be shown that reasonable precautions were taken’.\(^\text{129}\) This particular part of the Children’s Bill had been drafted under the collaboration of, what Samuel states were, ‘responsible

\(^{126}\) TNA MEPO 2/582. Deaths from fire – children: precautions, 1901.
\(^{127}\) Judicial statistics, England and Wales, 1904, PP, 1906 (2871, 2945) vol. CXXXV, pp.130-134.
\(^{129}\) HC Deb (4th series) 10 Feb 1908 vol. 183 c.1434.
authorities who had first claim to speak on the subject', including the Coroners' Society.\textsuperscript{130}

One of the most vocal members of the House in support of Clause 15 was Mr Thomas Bramson, coroner of Portsmouth and a Liberal Member of Parliament. Bramson stated that he, in his role as coroner, had 'held inquiries concerning hundreds of cases of death by burning, and his heart bled of seeing the horrible spectacles brought before him. His experience was similar to that of every coroner in the United Kingdom'.\textsuperscript{131} Further stating, ‘the clause came before the House with the approval and sympathy of every coroner’.\textsuperscript{132} Samuel also proclaimed to the House, that 'the coroners of the country were continually drawing attention to this matter.' He quoted expression of opinion on this subject from the coroners of West Bromwich, Manchester, Liverpool and Dublin'.\textsuperscript{133} Mr Walsh, Member of Parliament for Ince, also stated that the coroner for North-West Lancashire had 'urged upon Parliament the necessity for legislation' of this kind.\textsuperscript{134} Donald Maclean, Liberal Member of Parliament for Bath, also in support of the clause, gave the example of a mother of drunken habits allowing two or three young children to play about in a house, with the result that some of them having gone too near the fire an accident occurred. The mother had placed herself in such a condition that she was unable to safeguard her children. She was prosecuted, but a conviction was not obtained. If the provisions of the Bill had been in force, she would have been properly punished.\textsuperscript{135}

They, along with several other Members of Parliament, concluded that such a clause would be preventative and dramatically reduce the '1,600 deaths every year, and serious injuries to many more children from this cause', as it brings to the attention of parents their responsibilities towards keeping their children safe from fire.\textsuperscript{136} Samuel argued, for every person brought into Court under this clause there would be at least ten other parents who would be saved the agony of losing their children. One case brought into Court, even if no penalty was inflicted, would be the means of bringing to the attention of thousands of persons in that particular district the fact that the law required the taking of proper precautions.\textsuperscript{137}

\textsuperscript{130} HC Deb (4th series) 24 March 1908 vol. 186 c.1292.  
\textsuperscript{131} HC Deb (4th series) 12 Oct 1908 vol. 194 c.143.  
\textsuperscript{132} HC Deb (4th series) 12 Oct 1908 vol. 194 c.143.  
\textsuperscript{133} HC Deb (4th series) 12 Oct 1908 vol. 194 c.136.  
\textsuperscript{134} HC Deb (4th series) 12 Oct 1908 vol. 194 c.145.  
\textsuperscript{135} HC Deb (4th series) 1 Apr 1908 vol. 187 c.578.  
\textsuperscript{136} HC Deb (4th series) 24 March 1908 vol. 186 cc.1251-300; HC Deb (4th series) 1 Apr 1908 vol. 187 cc.560-590; HC Deb (4th series) 12 Oct 1908 vol. 194 cc.41-160.  
\textsuperscript{137} HC Deb (4th series) 12 Oct 1908 vol. 194 cc.137-138.
Aware of the unprecedented nature of this legislation, by intruding into people’s homes, the Lord Advocate, Mr Thomas Shaw, stated that while it ‘appears at first a strong interference with the liberty of the subject’, it was, nevertheless, in his opinion, necessary that all children should have ‘the protection of protected fires in the room in which they are left by the parent or guardian’.138

Not everyone supported the inclusion of clause 15. In particular Mr Rawlinson, Member of Parliament for Cambridge University, Mr Rees, Liberal Member of Parliament for Montgomery, and Thomas Cochrane, Unionist Member for Ayrshire, who, as well as highlighting the problematic wording of the clause as to what consisted ‘reasonable precautions’, all vehemently opposed the clause, arguing it unfairly targeted working-class mothers for whom the loss of a child was punishment enough.139 Rawlinson believed such a clause to be ‘contrary to most of the ordinary principles of legislation’ and ‘wrong in principle and wrong in desirability’.140 To haul a parent before a magistrate and fine them after the death of their child was, they stated, ‘objectionable’, imposing a fine which many would struggle to afford.141 They further argued that the clause did not take into consideration the realities of everyday life of the poor. Rees questioned ‘What would a poor woman do who only had one room and three children? [...] Was it an offence for her to allow them to remain in the only room she had?’142 George Wyndham, Conservative Member of Parliament for Dover, also added:

The difficulties in the homes of the poor arose from the distraction caused by other duties than the constant care of the children by the mothers [...] and if any failed through negligence it might be because this clause added to the stock of distractions that they might be haled up before a Court of Justice and have a black mark put against their name of having been guilty of the manslaughter of their child [...] 999 out of 1,000 parents were not callous, but simply distracted by the cares of home.143

Much of the opposition to the clause questioned how a poor mother was meant to afford a decent fireguard. A good fireguard, one Member of Parliament stated, cost ‘£2 or £3’ and the cheap fireguard bought for 1s, popular amongst the working-class, was completely inadequate in protecting children from the fire; as Rawlinson

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138 HC Deb (4th series) 24 March 1908 vol. 186 cc.125.
139 HC Deb (4th series) 24 March 1908 vol. 186 cc.1251-130; HC Deb (4th series) 12 Oct 1908 vol. 194 cc.41-160.
140 HC Deb (4th series) 12 Oct 1908 vol. 194 cc.133-134.
141 HC Deb (4th series) 1 Apr 1908 vol. 187 cc.560-90; HC Deb (4th series) 12 Oct 1908 vol. 194 cc.41-160.
142 HC Deb (4th series) 12 Oct 1908 vol. 194 c.148.
143 HC Deb (4th series) 12 Oct 1908 vol. 194 cc.142-143.
remarked: ‘He was no expert on fireguards, but he knew that a 1s fireguard would not last very long in a house full of children’.\footnote{144}{HC Deb (4th series) 12 Oct 1908 vol. 194 c.150.}

Furthermore, Rees objected to the claim that ‘all coroners were in favour of the Bill and quoted from a letter to The Times from the coroner of Surrey to the contrary effect’.\footnote{145}{HC Deb (4th series) 12 Oct 1908 vol. 194 cc.147-148.} The letter, written by George Perceval Wyatt, H.M. Coroner for the Counties of Surrey and London and the Duchy of Lancaster, mostly details Wyatt’s opposition to the clause proposed about overlaying, but also remarks on the problems he sees in clause 15. Observing the practicalities of everyday working-class domestic life, he further comments, if ‘a mother was cooking, she would have to put all the children under seven years of age out of the room to comply with the Act’, adding ‘it must be borne in mind that the only fire is generally an ordinary register grate, and it is almost impossible to devise a fireguard that would enable cooking operations to be carried on and perfect protection maintained at the same time’.\footnote{146}{The Times, 18 Apr 1908, p. 5.} Wyatt concludes, ‘to make every mother in the country liable to a Police Court prosecution for trying to do the best in her power for her children by keeping them warm [...]appears to be manufacturing criminals on an enormous scale’.\footnote{147}{Ibid.} Wyatt, however, was one of few coroners opposed to the clause, as highlighted in Maclean’s comment to the House, that ‘The Society of Coroners had considered the matter and [had actually] given their adhesion to a much more drastic amendment of the law than proposed by the Bill’.\footnote{148}{HC Deb (4th series) 1 Apr 1908 vol. 187 c.578.}

In his final appeal, Rawlinson ‘asked the House to hesitate before they added another senseless crime to those with which the courts had now to deal. He attached great importance to this as, in his opinion, this was an extremely dangerous clause’.\footnote{149}{HC Deb (4th series) 12 Oct 1908 vol. 194 c.150.} Nevertheless, despite the reservations of some ministers, coroners’ and other supporters’ voices were the ones that were heard by the Members of Parliament; the Bill received overwhelming support when put to the vote, with 177 Ayes and 30 Noes.\footnote{150}{HC Deb (4th series) 12 Oct 1908 vol. 194 cc.150-151.}

As a consequence of the Act, public notices were circulated to inform parents of the new legislation. These stated:
Among other provisions of the Children Act, Parents or other persons having the charge of Children are made liable to fines or other penalties for (1) Leaving a child under the age of seven in a room without a fireguard, or without taking other precautions, if the child is burned to death or seriously injured.\footnote{151} Nonetheless, the law still had to actually be enforced and the realities of working-class life did not change simply because of a piece of legislation.

**Section 15: Success or Failure?**

Reports of the Commissioner of Police of the Metropolis show that between April 1909 - when the law came into force - to the end of 1912, 25 persons were convicted under section 15.\footnote{152} However, in March 1911, an investigation held by the Commissioner of the Metropolitan Police into the number of proceedings which had been taken for offences against section 15 reveals that from April 1909 to that date a total of 20 cases had so far been taken to court. Of these, only six resulted in a conviction, while five resulted in bail and another nine cases were dismissed, with a further one case pending. Listing several cases in detail, the investigation shows that both police and magistrates were generally sympathetic to the situation of those working-class mothers brought before them.

On 28 December, 1910, in Greenwich, Martha Matilda Waller left her home a little before 1pm for ‘the purpose of taking her husband’s dinner’, leaving her three young children in the kitchen ‘with a fire in the grate’. The fire was unguarded. On her way home, three hours later, Martha was informed that her youngest child had been taken to hospital with severe burns. The child died a month later from ‘Syncope due to pneumonia accelerated by burns’. Martha was informed by Police Constable Everitt that she could be summoned under section 15, to which she replied ‘I hope they won’t summon me after my sad loss’. In his report to the Greenwich Police Court, Everitt, sympathetic to the mother’s situation wrote ‘It is quite clear that the mother has committed an offence in leaving the children in this way; but they were otherwise well cared for and her absence was for the purpose of taking her husband’s dinner’. Thus, she had not strayed from her domestic role as mother and housewife. He

\footnote{151} TNA MEPO 2/1138. Records of the Metropolitan Police Office, Correspondence and Papers on the Children Act 1908, Public notices from 1909 making people aware of the terms of the Children Act,1907 - 1909.
further added, ‘having regard to the punishment the woman must have suffered by the loss of her child I respectfully recommend no action’.

Despite the recommendation of Police Constable Everitt, Martha was summoned to Greenwich Police Court on the 18th February 1911. The magistrate, A.E. Gill, made clear to Martha that ‘according to the act of Parliament [she had] committed a serious offence, for which [she was] liable to a heavy penalty’. Nevertheless, he then went on to state ‘I don’t think any useful purpose would be served by imposing a fine. I must take into consideration the loss of your child, and other distressing circumstances’. He bound the mother to ‘the sum of £5 to come up for judgment if called upon within six months and revoked her bail fee of £2. ¹⁵³

Meanwhile, in East Wickham Market, Kent, Grace Cuthbert was to the Dartford Petty Sessions on the 3rd March 1911 after her two-year-old son was mortally burnt after being left at home with inadequate supervision and an unprotected fire burning in the grate, while she went 50 yards down the road to the shops. Police Inspector Powell noted at the proceedings that Grace’s husband, a mechanical engineer, was away working in Chile and kept his wife ‘well supplied with money’. He then goes on to state that since the accident, the defendant had purchased a fireguard, but ‘there was no reason why she should not have done so before the accident’. Nevertheless, the Bench concluded that while it was ‘a very proper prosecution’, ‘the defendant had already suffered such a severe punishment’ at the loss of her child and ‘that they (the Bench) did not propose to add to that punishment’. Case dismissed. ¹⁵⁴

Many cases were not even brought to the magistrates’ attention. The investigation issued by the Commissioner of the Metropolitan Police shows that a further 25 cases brought to that force’s attention in this period only resulted in a caution or in no action taken; although, their justification for these decisions are not recorded. ¹⁵⁵ Even coroners, many of whom were supportive of legislation in regards to child safety, seemed, in some cases, reluctant to refer mothers for prosecution. In November 1910, The Times reported on the inquest of a child named Perkins, ‘who was burnt to death through lighting a piece of paper at an unprotected kitchen range’. A compassionate coroner, Mr Troutbeck, ‘said it was extremely difficult to enforce the

¹⁵³ TNA MEPO 2/1450. Records of the Metropolitan Police Office, Correspondence and Papers, Children’s Act 1908: Child burned to death through no fireguard, 1909-1911.
¹⁵⁵ Ibid.
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Act, as they could not treat as criminal a parent whose chief crime was being poor and, instead of referring the parents for prosecution, provided them a fireguard funded 'out of the poor-box'.\footnote{The Times, 24 Nov 1910, p.13.}

Many magistrates were equally aware of the difficulties mothers in poor circumstances faced in affording a fireguard. In April 1911 The Times reported on a case held at the Old Street Police Courts, where 'a married woman named HARRISON [had been] summoned under the Children Act for failing to provide a fireguard, with the result that her child, three years of age was burnt and eventually died from the injuries'. The witnessing Police Officer remarked, it was nearly always women summoned in these cases, because they were responsible for the home and their child’s safety. However, in a remarkable move by the magistrate, Mr Cluer, stated to the court that: ‘it was the husband who was responsible for the non-provision of the fireguard. He would never impose a penalty on the woman in such a case [...] the husband is responsible. He earns the money and provides the home’. After agreeing to have his name substituted for that of his wife’s on the summons, the husband was then questioned by Mr Cluer as to why no fireguard was present at the time of the accident, to which the husband replied: ‘he did not believe in fireguards at all. Women only made clothes-horses of them, and that was far more dangerous than having no guard at all. He thought he had been punished enough by the loss of his child’. ‘A fine of 5s was [then] imposed on the husband’.\footnote{The Times, 21 Apr 1911, p.4.} Mr Cluer also took the opportunity of this case to voice criticisms of section 15:

The proper thing would be for the people who make these Acts to provide fireguards for poor people at the public expense. Poor people at times can hardly provide themselves with food, and if they buy a fireguard, of necessity they buy one of the cheapest kind they can. That complies with the Act but does not prevent accidents, as children can lean over these trumpery guards and so set their clothes alight with impunity.\footnote{Ibid.}

The Penny Illustrated Paper took a similar stance, reporting on 18 February 1911 a case held at Tower Bridge Court where a wife and her husband were summoned ‘for not having a fireguard “whereby their daughter, age three, was burnt to death”’. The constable, giving evidence, stated how the father had been ‘out of work for a long time, and could not afford to buy a fireguard’ and, at the time of the fatal incident, he was out looking for work, while his wife ‘was earning a few coppers by washing for some neighbours’. The magistrates dismissed the case and ‘urged them to get a
fireguard at once’ to avoid a repeat of such an accident. The paper concluded with the remark: ‘We should like to know how the unfortunate individuals propose to get a fireguard without money. Helpful proceedings these.’\textsuperscript{159} The following week, the paper reported on how they had ‘received from [readers] postal orders for 10s. for the benefit of the husband and wife [...] summoned for not having a fireguard. The gift is acknowledged on behalf of the poverty-stricken couple with many grateful thanks’.\textsuperscript{160}

A month later, \textit{The Penny Illustrated Paper} returned to the topic of absent fireguards and burnt children. Reporting on an inquest held on ‘a child burnt to death through an absence of a fireguard’ at South Norwood, the newspaper criticised one coroner’s ignorance of the realities of working-class life following remarks that ‘a fireguard could be purchased for a shilling’ and that the parents should be sent before the police courts under the Children Act 1908. ‘A correspondent [stated that] the lowest price at which he could buy one was 4s.6d.’ and that poverty had prevented the parents in question from purchasing a fireguard. The article then criticises section 15, remarking ‘It certainly seems that if the regulation – a wise one in its way – regarding fireguards is to be carried out, some provision will have to be made by the Government for supplying these articles at a much more moderate price than they can be purchased for at present’.\textsuperscript{161}

The reluctance of many coroners and Police officers to refer mothers to the magistrates under section 15, as well as magistrate’s unwillingness to convict many of those brought before them, does not necessarily mean that the legislation was not a success. One Government minister had previously stated in the discussion pertaining to the provision that ‘It seemed to him that this clause would do good if it developed a higher sense of parental responsibility’.\textsuperscript{162} Coroners, interviewed by the Select Committee on the Law relating to Coroners, praised the new statute. Mr Frederick Joseph Waldo, coroner of London City and Southwark, stated in February 1909, how he thought ‘the Children Act [...] to provide against an insufficient guard, is a very good thing’, adding ‘I believe the Act will be the means of saving a number of lives’.\textsuperscript{163} Under the same Select Committee the following year, the coroner of Nottingham, Mr Charles Lambert Rothera, when asked ‘Do you think this new

\textsuperscript{159} \textit{The Penny Illustrated Paper}, 18 Feb 1911, p.196.
\textsuperscript{160} \textit{The Penny Illustrated Paper}, 25 Feb 1911, p.252.
\textsuperscript{161} \textit{The Penny Illustrated Paper}, 25 March 1911, p.371.
\textsuperscript{162} HC Deb (4th series) 12 Oct 1908 vol. 194 c.145.
\textsuperscript{163} \textit{First Report of the Departmental Committee appointed to inquire into the Law relating to Coroners and Coroners’ Inquests, and the Practice in Coroners’ Courts}, PP, 1909 (4782) vol. XV, p.80.
legislation has had much effect in diminishing fatalities?’, responded ‘I think that the
attention that has been drawn to the subject by the legislation must have been
effective from the reduction in the number of cases I have had this year [...] And I
believe that there has been a considerable extension in the use of fireguards.’ 164

Leonard A. Parry, Assistant Surgeon to the Children’s Hospital in Brighton also
remarked that, ‘since the passing of the Children Act [...] an enormous number of
mothers have been buying fire-guards’, further noting, when asked if he thought
mothers were using them as well, ‘I do not believe they will go to the expense of
buying them without using them. We are dealing with people whose incomes are
reckoned in shillings. They are not going to spend three or four or five shillings on a
fireguard as an ornament’. 165 Although, Parry himself is critical of section 15, arguing
that it ‘only punishes the parent if a child is burned to death or burned seriously; it
does not do anything in the way of prevention, except the moral influence of the fear
of a fine’ he goes on to suggest an alternative solution of legislation regarding ‘fixed
fireguards’.166 Parry, like many others, believed that more could still be done via
legislation to protect children from the dangers of fire. With the issue of fireguards
diminishing after the passing of the Children Act 1908, another issue was soon raised
in its place, this time not focusing on the role of mothers and absent fireguards, but
the responsibility of manufacturers and traders of flammable flannelette for burns
accidents amongst poor children. 167

It certainly would initially appear that section 15 of the Children Act 1908 proved an
effective deterrent, as children’s fatalities from burns and scalds declined in the early-
twentieth century. However, as the twentieth century progressed, this law largely
became obsolete. While the fire grate had been both a source of heat and a means
of cooking for most working-class housewives throughout the nineteenth century, by

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164 Second Report of the Departmental Committee Appointed to Inquire into the Law Relating
to Coroners and Coroners’ Inquests, and into the Practice in Coroners’ Courts, PP, 1910
(5139) vol. XXI, p.173.
165 Second Report of the Departmental Committee Appointed to Inquire into the Law Relating
to Coroners and Coroners’ Inquests, and into the Practice in Coroners’ Courts, PP, 1910
(5139) vol. XXI, p.43.
166 Ibid, p.41.
167 For more information on the debate regarding the dangers of flannelette, see: Report of an
inquiry into the question of the Danger arising from the Use of Flannelette for Articles of
Clothing’, PP, 1910 (5376) vol. XXI; Misdescription of fabrics. A Bill to Prevent the
Misdescription of Fabrics, PP, 1913 (286) vol. IV; as well as the various aforementioned
Reports of the Departmental Committee Appointed to Inquire into the Law Relating to
Coroners and Coroners’ Inquests, and into the Practice in Coroners’ Courts and The Times,
22 Apr 1913, p.22; The Times, 27 June 1913, p.50.
the turn of the century the dependency on the fire declined as new technologies, such as gas cookers, were introduced into the home and cooking moved out of the multifunctional backroom and into the separate kitchen. In addition, through successive Education Acts, children were now spending increasingly more time away from the hazards of the home; unlike previous generations, they were in school where they were being educated not just in ‘mere ABC instruction’ but in matters of home safety. Furthermore, as the years unfolded, fashions and materials used in children’s clothing became less flammable. It is assuredly the combination and the interplay of these factors rather than simply the introduction of legislation which culminated in the declining rate of burns and scalds accidents in the home.

Conclusion
Negative perceptions of working-class motherhood and coroners’ frustrations at the inadequacy of the laws to prosecute these supposedly negligent mothers are evident to anyone reading the newspaper reports pertaining to coroners’ courts in the period under discussion. In the first half of the nineteenth century, most fatal burns and scalds accidents involving absent mothers and non-existent fireguards were, on the whole, perceived as tragic accidents – unless the mother happened to be unmarried. By the late 1860s, however, married mothers were being increasingly blamed for the accidents that befell their children at home. If a child were burnt to death, then it was the mother who was blamed for not having procured a fireguard, rather than the father who, as the wage-earner, would in most homes have had the ultimate veto on such a purchase. Nevertheless, in the absence of adequate legislation there was little coroners could do apart from berate the mother for being careless in her domestic duties. Towards the end of the century, the attitude of the coroners, including the then Ipswich coroner, hardened in regard to working-class mothers – most were no longer just seen as being simply careless, but instead in many cases considered negligent in their duties if this resulted in her child’s death. Now if jurors brought in a verdict of negligence, the mother could be potentially charged under the Prevention of Cruelty to Children Act 1889. However, to many coroners’ dismay, juries were often unwilling or unable to send mothers for prosecution, even in cases where the coroner was adamant that the accident had been a direct result of the mother’s neglect. Tiring of this impasse, many coroners advocated the need for legislation to

169 Hair, ‘Death,’ p.20.
force the working-class mother to adhere to her role in keeping the home a safe space. By the end of the nineteenth century, heightened government concern over child welfare and the health of the nation, set the stage for a more aggressive stance towards mothers who were perceived as incompetent, eventually resulting in the ‘preventative’ provision of section 15 of the Children Act 1908.