Captives of the System: The Commissioners in Lunacy as Regulators of Services for Lunatics and Idiots, 1845-1914

Thesis

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Captives of the System:
The Commissioners in Lunacy
as Regulators of Services
for Lunatics and Idiots, 1845-1914

Frank Arthur Hughes

Submitted in partial fulfilment of the degree of
Doctor of Philosophy (History of Medicine)
The Open University, January 2022
Abstract

This thesis examines in detail the work and workings of the Commissioners in Lunacy (CIL) over the period 1845 to 1914 across the whole of England and Wales. Some previous studies focused attention on the administrative structure and working of this regulator, without looking in detail at what it reported. Others have examined how it interacted with individual asylums or small groups of asylums, extrapolating the results from these samples. In most cases only the years before 1890 were examined. The results have produced a range of contradictory conclusions about the effectiveness of the CIL and there are substantial gaps in what is known about its work and working. Using a detailed analysis of the lunacy legislation and the published Annual Reports of the CIL, this study builds a more comprehensive picture of how this regulator worked and its effect on the asylum system. It offers explanations of the variation in performance previously reported. It shows that the ability of the CIL to protect detained patients from harm was affected by a combination of internal and external factors. Also highlighted is the greater protection for those detained in private asylums compared to the public asylums and between the pauper and non-pauper detainees. Whilst the CIL contributed to these discrepancies, from the way it organised its work, most of the constraints were the results of impositions over which they had little or no control. Overall, the CIL has been shown to have had an impact on the asylum system, but this was limited and, in many cases, transient. The findings show that this regulator was as much constrained and contained as the patients.
Acknowledgements:

I owe particular thanks to Drs Donna Loftus and Deborah Brunton, my supervisors throughout the long and sometimes painful journey, for their help, guidance and support. In the later stages, following the ‘escape’ of Dr Brunton to Scotland, Dr Silvia de Renzi joined them.

I would like to thank Drs Francesca Benatti and Jekaterina Rogaten for their advice on the Digital Humanities and statistical methods respectively. Any errors in interpretation or use are mine.

I owe thanks to the staff of the Shropshire, Denbighshire and Cheshire County Archives, the National Archives, and the staff of the UK Parliamentary Papers website.

Of particular importance to a part-timer not based on campus has been the Document Delivery Service of the OU Library. This service has been invaluable and all the staff very supportive.

To Richard Feynman (1918-1988), physicist and Nobel Laureate, for the idea that underpins my approach: ‘There is a pleasure in recognising old things from a new viewpoint’.

Over the years there have been many people who have influenced my thinking and ideas and contributed in a variety of ways to my approach to this research. They are too many to list and some whose names I have forgotten. To them all I express my thanks.

Last but by no means least my thanks go to Pauline Hughes who started this journey with me, tolerated all the obsessive reading and loud mutterings emanating from my hideaway but, sadly, was not able to see the arrival.
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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>BA</td>
<td>Borough Asylum(s)</td>
</tr>
<tr>
<td>CIL</td>
<td>Commissioners in Lunacy</td>
</tr>
<tr>
<td>CA</td>
<td>County Asylum(s)</td>
</tr>
<tr>
<td>CCA</td>
<td>Cheshire County Archive</td>
</tr>
<tr>
<td>CRO</td>
<td>Clwyd Records Office</td>
</tr>
<tr>
<td>IA</td>
<td>Idiot Asylum(s)</td>
</tr>
<tr>
<td>JP(s)</td>
<td>Justices of the Peace</td>
</tr>
<tr>
<td>LGB</td>
<td>Local Government Board</td>
</tr>
<tr>
<td>LL</td>
<td>Lexis®Library Archive of Legislation</td>
</tr>
<tr>
<td>MCL</td>
<td>Metropolitan Commissioners in Lunacy</td>
</tr>
<tr>
<td>MDA</td>
<td>Metropolitan District Asylum(s)</td>
</tr>
<tr>
<td>MIL</td>
<td>Military Asylum(s) for the personnel of the armed forces</td>
</tr>
<tr>
<td>MLH</td>
<td>Metropolitan Licenced House(s)</td>
</tr>
<tr>
<td>MP(s)</td>
<td>Member(s) of Parliament</td>
</tr>
<tr>
<td>NGLA</td>
<td>Northamptonshire General Lunatic Asylum</td>
</tr>
<tr>
<td>OTH</td>
<td>Other locations, including prisons, criminal asylums and military asylums, where lunatics or idiots were detained</td>
</tr>
<tr>
<td>PLB</td>
<td>Poor Law Board</td>
</tr>
<tr>
<td>PLC</td>
<td>Poor Law Commission</td>
</tr>
<tr>
<td>PLH</td>
<td>Provincial Licenced House(s)</td>
</tr>
<tr>
<td>PM</td>
<td>Post-mortem</td>
</tr>
<tr>
<td>PRI</td>
<td>The aggregated data for the Registered Hospitals, Metropolitan Licenced Houses and Provincial Licenced Houses</td>
</tr>
<tr>
<td>PSC</td>
<td>Parliamentary Select Committee</td>
</tr>
<tr>
<td>RH</td>
<td>Registered Hospital(s)</td>
</tr>
<tr>
<td>S.</td>
<td>Section of Acts of Parliament</td>
</tr>
<tr>
<td>SA</td>
<td>State Asylum(s) for the Criminally Insane</td>
</tr>
<tr>
<td>SCA</td>
<td>Shropshire County Archives</td>
</tr>
<tr>
<td>UKPP</td>
<td>United Kingdom (previously House of Commons) Parliamentary Papers Archive</td>
</tr>
</tbody>
</table>
Glossary

Alienist(s)  The title adopted by the medical staff who treated lunatics and idiots. The term psychiatrist was not widely adopted until the twentieth century.

Attendant(s)  This term was used by the CIL in two forms: For any person employed in an asylum to provide care and supervision of the patients; For male staff undertaking this work. See Nurse(s) below.

Borough Asylum  An asylum sanctioned under the terms of the County Asylums Act (1845) for the detention and treatment of lunatics and idiots and funded by a Borough.

County Asylum  An asylum sanctioned under the terms of the County Asylums Act (1845) for the detention and treatment of lunatics and idiots and funded by a county or a consortium of counties and boroughs.

Idiot(s)  The term used by alienists for those people with special educational needs or with a physical handicap present from birth.

Lunatic(s)  The term used by alienists for people with an identified mental illness that could occur at any stage in life.
Metropolitan Licenced House

Private asylums providing care for two or more fee paying patients that was licenced under the terms of the Lunacy Act (1845) and that were located within the area defined as the Metropolis, see below.

Metropolis/Metropolitan

This was the geographic area defined in the lunacy legislation as comprising of the Cities of London and Westminster, the County of Middlesex, the Borough of Southwark and the Parishes and places named within S.XIV of the Lunacy Act 1845 (8 & 9 Vict. C.100) and any place within seven miles of the Cities of London and Westminster and the Borough of Southwark.

Nurse(s):

The alternative term used for female staff employed in asylums for the care of lunatics and idiots. See Attendant(s) above.

Private Asylum(s)

Those asylums within the category of Registered Hospitals or the Metropolitan and Provincial Licenced Houses.

Professional commissioners

The three medically qualified and three legally qualified commissioners who were salaried and employed to undertake the inspection visits.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Licenced House</td>
<td>Private asylums providing care for two or more fee paying patients that was licenced under the terms of the Lunacy Act (1845) and that were located outside of the area defined as the Metropolis but within England and Wales.</td>
</tr>
<tr>
<td>Public Asylum(s)</td>
<td>Those asylums within the categories of County or Borough Asylums.</td>
</tr>
<tr>
<td>Registered Hospital</td>
<td>Institutions registered with the CIL or JPs, funded by charity and the fees from patients, their families or the Poor Law Guardians, that were either for the admission of lunatics or idiots or were a general hospital with a designated ward for this purpose.</td>
</tr>
<tr>
<td>Single Patient(s)</td>
<td>An individual who was detained in a private house under the care of a medical practitioner. These were members of wealthy families. The CIL had to be notified of all such patients.</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

From the early eighteenth century there were significant concerns about the way that some for-profit asylums that detained lunatics and idiots were being operated.¹ These concerns were related to whether admission was justified, whether the treatment and care provided was abusive and cruel, and if continued detention was required.² The following quotation, from a book written in 1837 by the experienced asylum doctor, William A. F. Browne (1805-1885), draws a vivid picture of how patients might be treated and regarded in the first decades of the nineteenth century:

[T]he lunatic might be truly said to live under a reign of terror. Immured in a wretched and comfortless prison-house, left to linger out a lifetime of misery, without any rational attempt at treatment, without employment, without a glimpse of happiness, or a hope of liberation, he was terrified or starved into submission, lashed, laughed at, despised, forgotten. The great objects were - confine, conceal. Protect society from his ferocity: protect his sensitive friends from the humiliating spectacle of such a connection. Regarded as wild beasts, all maniacs indiscriminately were treated as such;³

Attempts to protect the non-pauper patients admitted to an asylum and to regulate how these institutions operated had been made but these proved to be

¹ Throughout this thesis the Victorian terms lunatic, those people with what is now termed a mental illness, and idiot, those people now identified with a special educational need or a physical disability from birth, have been used.
ineffective. Pressure for reform mounted and in 1845, following the publication of a report on the state of asylum services throughout England and Wales, revised arrangements were implemented. To try to protect the patients within institutions, a new national inspectorate for England and Wales, the Commissioners in Lunacy, (hereafter CIL), was established under the terms of An Act for the Regulation of the Care and Treatment of Lunatics (the Lunacy Act) (1845). The CIL were charged with licencing private asylums in and around London, inspecting and monitoring all places in England and Wales where lunatics and idiots were detained, and reporting annually to the Lord Chancellor and Parliament on the state of asylum services. As part of their work they were required to visit all of the existing and new asylums for the care and treatment of pauper lunatics mandated under the terms of An Act to Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England (the County Asylums Act) (1845). The CIL had a novel position in that it was the first regulatory organisation that was required to monitor both publicly and privately funded institutions. Despite this unique arrangement the CIL has received only limited attention from historians. Those that have studied the CIL reached differing conclusions about its impact. Some, such as Leonard Smith and Nicholas Hervey, have suggested that the CIL did have some influence and could secure changes in the way asylums operated. Others, such as David Mellett, Peter Bartlett, and Elaine Murphy, concluded that the CIL had no real impact or influence and was irrelevant. This thesis seeks to

4 LL, An Act for Regulating Madhouses (1774) (14 Geo. III CAP.XLIX); UKPP, 'Report from the Committee on Madhouses in England', 1814-15 (296), (pp. i-ii); UKPP, 'Report from the Select Committee on Pauper Lunatics in the County of Middlesex and on Lunatic Asylums', 1826-27 (557), (pp. 1-8); LL, An Act to Regulate the Care and Treatment of Insane Persons in England (1828) (9 Geo. IV CAP.XLI); UKPP, 'Report from the Select Committee on Hereford Lunatic Asylum with the Minutes of Evidence, Appendix, and Index', 1839 (356), (pp. i-iv).

5 UKPP, 'Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor', 1844 (001), (pp. 204-8).

6 LL, An Act for the Regulation of the Care and Treatment of Lunatics (1845) (8 & 9 Vict. CAP.C). Separate legislation was enacted for Scotland and Ireland, and these are not considered in this thesis.

7 LL, An Act to Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England (1845) (8 & 9 Vict. CAP.CXXVI).


explain these discrepancies and attempts to provide an overall assessment of the influence of the CIL on the asylum system.

Review of the literature
Within the historiography of the development of madhouses, charitable hospitals and asylums for the treatment and care of lunatics and idiots, the CIL has rarely featured. A number of these studies focused on the years before the establishment of the CIL or only considered the early years of their work. These materials have provided useful background information for the formation of the CIL but are not of direct relevance to an examination of the work and workings of the CIL. Most of the historiography that does relate to the work and working of the CIL can be located within two general bodies of scholarship: those that reviewed the administrative working of the CIL, without looking in detail at its findings or actions; and those that studied a particular asylum or group of asylums in a geographic area and considered the impact of the CIL on those institutions. A separate and smaller body of scholarship has focused on particular patient groups, such as inappropriately detained wealthy patients and those identified as idiots, included consideration of some parts of the role of the CIL. Across these groups most of the studies related to the first twenty-years of the sixty-nine year (1845 to 1914) lifespan of the CIL. From the 1990s there was a developing literature that


13 Under the terms of the Act that disbanded the CIL the new Board of Control was appointed on 1 November 1913 but they did not take up all their duties until 1 April 1914, S.72(3) LL. An Act to Make Further and Better Provision for the Care of Feeble-Minded and other Mentally Defective Persons and to Amend the Lunacy Act (1913) (3 & 4 Geo. V CHAP. 28).
examined the role of the family in the care of lunatics and idiots.\textsuperscript{14} Given that the CIL was excluded from overseeing arrangements in domestic settings, this work has little direct relevance to this study.\textsuperscript{15} 

Administrative history, the study of how organisations were structured and developed, was a focus of research in the 1980s and this work included reviews of the CIL.\textsuperscript{16} One such study, by Mellett, examined how the CIL was organised and detailed the people appointed as commissioners.\textsuperscript{17} Mellett concluded that the CIL was an organisation that lacked power because they had to rely on persuasion and the cooperation of other agencies, such as the Home Office.\textsuperscript{18} This top-down approach, covering the period 1845 to 1890, meant that much of the detail of the CIL’s working – for example, what the CIL were finding through the inspection process and any variation between sites, was lost. It also omitted all details of the last twenty-three years of the organisation’s lifetime. In 1987, to show the impact of the CIL in more detail, Hervey used a combination of the administrative and local history approaches. He reviewed the organisational structure and manpower of both the CIL and its predecessor, the Metropolitan Commissioners in Lunacy, (hereafter MCL), before going on to examine the impact of national policies on the asylums in Kent and Sussex in the years 1845 to 1860.\textsuperscript{19} Hervey argued that the CIL were able to secure some changes but that they tended to focus attention on the attainment of ‘minimum physical conditions and basic standards of care, within a uniform administrative framework’.\textsuperscript{20} His study leaves open questions about how typical the outcomes in Kent and Sussex were compared to those from other asylums in England and Wales and between the periods before and after 1860.

Bartlett used an alternative approach to review the organisation, working and effectiveness of the CIL. In his 1999 book, \textit{The Poor Law of Lunacy}, he

\begin{itemize}
  \item[15] The relevant section only empowers the CIL to make inspections where the person providing the care obtained a financial profit from doing so, see S.CX LL, 8 & 9 Vict. CAP.C (1845).
  \item[18] Mellett, ‘Bureaucracy and Mental Illness’, (p. 244).
\end{itemize}
considered the organisation and resourcing of the CIL as part of a review of the legislation relating to the treatment of paupers within the Poor Law system. His period of study, 1834 to 1870, also encompassed the work of the CIL and its predecessor, the MCL. He argued that the work of the CIL was influenced by the Poor Law authorities and the Home Office and concluded that, as a result, it lacked the authority to secure changes in practice.\(^{21}\) This work showed the particular influence of the Poor Law authorities on the way that the CIL worked in the years before 1871. The short time-period left open the question on whether there were changes in the later years that might amend his overall conclusion about the effectiveness of the CIL.

By the 1990s and beyond more historical studies adopted a local history approach.\(^{22}\) Within the historiography of the asylum system this approach has been used to examine the history and development of particular, often but not exclusively, the better-known asylums, such as Bethlehem Hospital and Ticehurst.\(^{23}\) However, the contribution of this local approach to understanding the impact and role of the CIL can be limited, the regulator often only being mentioned in passing. As an example: Steven Cherry included twelve brief comments about the interaction between the CIL and the Visiting Committee of the Norfolk Lunatic Asylum in the part of his study that encompassed the years 1845 to 1915.\(^{24}\)

A local history approach has also been used to show how central policy was implemented locally.\(^{25}\) Comparison between the various local history studies reveal markedly different conclusions on the contribution of the CIL to the development of asylum services and the securing of compliance with the lunacy legislation. In their study of the services in Devon Bill Forsythe, Joseph Melling and Richard Adair concluded that the CIL were effective in securing change, in this

case by the building of a second asylum.\textsuperscript{26} In contrast, the conclusion reached by Hervey was that the CIL had only a limited influence and impact on the asylums in Kent and Sussex.\textsuperscript{27} Another historian, Elaine Murphy, in a study on the ability of the CIL to secure the transfer of pauper lunatics from workhouses to the asylums in East London, concluded that they were largely ineffective, having limited impact and influence.\textsuperscript{28}

Drawing conclusions about the overall impact of the CIL on the way that asylum services were provided based on small samples of asylums has some substantial drawbacks. Forsythe, Melling and Adair acknowledged this limitation in their work on asylum services in Devon. They made the point by including the comment ‘(if the Devon experience was representative)’.\textsuperscript{29} The problem of small sample size was compounded by the short time periods used in most of these studies. The consequent mixed picture of the impact of the CIL is, therefore, open to question. The inconsistencies that emerge from these studies could be the consequence of a combination of: differences in the criteria for success used and emphases on the issues being examined by the various authors; the differences in local responses to legislative requirements or recommendations for changes in practice; the CIL choosing to apply policies in different ways across England and Wales; differences in the requirements that applied between the public and the private asylums; differences in how the individual commissioners viewed and interpreted the requirements; the ability and willingness of local ratepayers or fee-paying patients to meet additional costs. To try to provide a clearer and more nuanced picture and to clarify whether this regulator was effective, a national study that covers the lifetime of the CIL and details the day-to-day working of this regulator is needed.

Apart from considering the role of a regulator, account also needs to be taken of the resources made available by government to the CIL to complete their duties. In her study of about thirty cases of alleged wrongful detention of wealthy people between c.1830 and 1900, published in 2012 as \textit{Inconvenient People}, Sarah Wise concluded that the CIL were poor at identifying such cases and had been slow at securing the release of these people.\textsuperscript{30} It was incontrovertible that any inappropriate admission, particularly where it was for the personal and/or

\begin{thebibliography}{99}
\bibitem{Forsythe} Forsythe, Melling, and Adair, ‘Politics of Lunacy’, p. 87.
\bibitem{Hervey} Hervey, ‘The Lunacy Commission Vol 1’, pp. 274-75.
\bibitem{Murphy} Murphy, ‘The Lunacy Commissioners’, (pp. 499-500).
\bibitem{Forsythe1} Forsythe, Melling, and Adair, ‘Politics of Lunacy’, p. 69.
\bibitem{Wise} Wise, \textit{Inconvenient People}, pp. 322-24 & 363-64.
\end{thebibliography}
financial benefit of another, needed to be rectified as a matter of urgency.\textsuperscript{31} However, in evaluating the CIL’s response, account has to be taken of the small number of cases, less than one a year, the problems of accurately determining if a person was a lunatic, and the limited resources of the CIL - just six professional commissioners tasked with completing all of the inspection visits throughout England and Wales.\textsuperscript{32} Given these factors, a slow response from the CIL was probably inevitable.

One study, that by William Parry-Jones, reviewed the provision in private madhouses, with particular reference being made to those in the Witney and Hook Norton areas of Oxfordshire, between 1775 and 1857. He concluded that some of the criticism of private madhouses was overstated and that the need for regulation was open to question.\textsuperscript{33} In her review of this work, Kathleen Jones wondered how typical the madhouses it focussed on.\textsuperscript{34} Further studies of the madhouses and charitable hospitals did identify that the way that individual asylums operated fell within a range, challenging the traditional view that all treated patients badly.\textsuperscript{35}

When evaluating the effectiveness of a regulator, it is essential to be clear about what it was empowered to do. In his seminal study of the development of asylum services, published in 1979 as \textit{Museums of Madness} and republished in extended format in 1993 as \textit{The Most Solitary of Afflictions}, Andrew Scull notes that the CIL had limited powers but goes on to criticise them for failing to prevent the building of ever larger asylums.\textsuperscript{36} This limitation on the power of the CIL was noted by Smith in his study of the replacement of the St Peter’s Hospital, Bristol, with a borough asylum.\textsuperscript{37} In similar vein, David Wright argued that the CIL should have done more to ensure that particular provision was made for those patients.

\textsuperscript{34} Kathleen Jones, \textit{Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s}, (London and Atlantic Highlands, NJ: The Athlone Press, 1993), p. 52.
\textsuperscript{37} Leonard D. Smith, ‘Lunatic Asylum in the Workhouse: St Peter’s Hospital, Bristol, 1698-1861’, \textit{Medical History}, 61 (2017), 225-45 (pp. 237-38).
who were neither curable nor dangerous, many of whom were diagnosed as idiots.\textsuperscript{38} These criticisms failed to recognise that the CIL had no power to require the size of a public asylum be limited or what provision was made for a particular patient group. The people with this power were the Lord Chancellor, the Home Secretary, and the Justices of the Peace, (hereafter JPs), after 1890 the County or Borough Councils replaced the JPs.\textsuperscript{39} Misconceptions about the role of the CIL did not just apply to the physical features of an asylum. In his book \textit{Proper People}, published in 2015, David Scrimgeour reported that the CIL ‘took responsibility for the management of the country’s strategy for the treatment of the insane in county asylums, private asylums, workhouses and prisons’.\textsuperscript{40} Had this been the case, the CIL would have had more control of where potentially treatable pauper lunatics were detained.\textsuperscript{41} Another comment made about regulators was that they attempted to interfere in and take over the management of the organisation being regulated, an argument made specifically about the CIL interaction with the Bethlehem Hospital.\textsuperscript{42} Such criticism is fallacious as the CIL, like all regulators, only visited infrequently and had no management control of the independent organisations that they inspected. The most that the CIL alone could do was advise and make recommendations. The power to take further action was held by senior ministers and the JPs.\textsuperscript{43}

One of the influences on the securing of consistent standards is how the individual inspectors\textbackslash commissioners interpret both what they observe and the regulations that they are applying.\textsuperscript{44} In their study of the Factory Inspectorate, Peter Bartrip and Paul Fenn compared the results between the individual inspectors and showed inter-observer variation.\textsuperscript{45} As will be seen in Chapter 3, the Annual Reports also show such variation between the findings of the professional commissioners. Consideration was given to attempting a comparison of individual

\textsuperscript{38} Wright, ‘Learning Disability’, (pp. 736-37).
\textsuperscript{39} S.II & S.XXI LL, 8 & 9 Vict. CAP.CXXVI (1845).
\textsuperscript{40} David Scrimgeour, \textit{Proper People: Early Asylum Life in the Words of Those Who Were There}, (York: Scrimgeour Yorkshire, 2015), p. 112.
\textsuperscript{43} LL, 8 & 9 Vict. CAP, C (1845).
\textsuperscript{44} Baldwin, Cave, and Lodge, \textit{Understanding Regulation}, p. 29.
commissioners informed by the biographical details to assess the impact of personal background on their reporting. As the entries on the visits to individual asylums were anonymised prior to publication of the Annual Report this work could not be progressed, making the biographical material redundant as it would have added little to that previously published by Melling and Hervey.46

The CIL was but one of the regulatory organisations established in the nineteenth century to offer protection to identified groups of the population or to seek common provision and standards across the country. Various of these organisations have been studied by historians, including the regulator of provision for lunatics in Scotland.47 Comparison of the results from these studies can offer insights into the workings of each, highlighting both common problems, such as limited resources and powers, and unique features, such as the CIL having the full members of the national board completing the inspection visits.48 Comparison between these organisations will be used to show the potential impact of these overall regulatory arrangements on the ability of the CIL to protect lunatics and idiots.

The process of regulation has been the subject of academic studies by researchers working in economics and business studies. This work has tended to


focus on the market mechanism, control of financial institutions and major development projects.\textsuperscript{49} Only relatively recently has greater attention been paid to the regulation of health services in the UK as the process of marketisation was introduced from the 1990s onwards.\textsuperscript{50} Whilst these works cannot be directly related to a historical study, there being a risk of presentism, they can offer indications of influences that might have impacted on the work of the CIL, the most obvious example being that of regulatory capture, where the regulator works for the advantage of the organisation being regulated rather than protecting the vulnerable, a risk that was noted by both Robert Peel, in 1828, and the CIL chairman, Anthony Ashley-Cooper, seventh Earl of Shaftesbury (1801-1885), (hereafter Shaftesbury), in his evidence to the Parliamentary Select Committee, (hereafter PSC), on the lunacy laws in 1877.\textsuperscript{51}

This review of the literature relating to the CIL has highlighted that the conclusions on the overall impact of this regulator were mixed. It is the purpose of this study to try to develop a more balanced perspective of the effectiveness of the CIL in protecting lunatics and idiots from harm based on a detailed examination of its role and activity over its geographical remit and lifetime. This new approach will examine the overall pattern of the issues being identified as concerns throughout England and Wales in both public and private asylums. It will also encompass as much of the working life of the CIL for which detailed information is available. This study, by adopting a broader perspective, will start to resolve the apparent discrepancies in the conclusions about the effectiveness of the CIL.


Research questions and methodology

The fundamental question being addressed in this research is whether or not the CIL were effective in protecting the patients detained in asylums from harm by seeking to ensure that the requirements of the lunacy legislation were being met. In order to address this question a new approach was needed to identify in detail the day-to-day work and working of the CIL across both its remit area (England and Wales) and over the years 1845 to 1914. Such an approach has not previously been attempted and to do so now required access to source material that provided both the necessary detail over this lengthy time period.

A range of potential source materials were reviewed. The obvious starting point were the Annual Reports of the CIL that were laid before Parliament in June of each year and then published. Whilst these reports offered both the detail on the findings from inspection visits and the coverage of the time period, they were not problem free. As with many reports, they reflected the concerns of the people completing them and they only offered the view of the Commissioners. The responses from the individual Visiting Committees, Boards of Governors and Proprietors were not included in the Annual Reports, with only a few exceptions. Those responses have not been collated in a central repository, making it necessary to visit multiple local archives to even start to review this material. To try to include a representative sample of these responses in a national study was a logistical and resource impossibility.

Commentary on the work and working of the CIL and their Annual Reports was included in both the professional journals and newspapers of the relevant period. In the professional journals the coverage could be in two forms. Firstly, the Annual Reports were summarised as in 1877. In that year the Journal of Mental Science included a review of ‘The Thirty-first Annual Report of the CIL’ (401 pages long), ‘The Nineteenth Annual Report of the General Board of Commissioners in Lunacy for Scotland’ (38 pages long) and ‘The Twenty-sixth Report on the District, 52

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53 Correspondence was included from the Visiting Committees for the Kent (Barming Heath), Middlesex (Colney Hatch) and Middlesex (Hanwell) County Asylums in UKPP, ‘The Sixteenth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1862 (417), (pp. 187-200).
54 This material is not always consistently held in the local archives. In Shropshire these materials are held as part of the records of the Annual Reports of the Medical Superintendent of the county asylum. In both the Cheshire and Clwyd archives this material was not available.
Criminal, and Private Asylums in Ireland' (115 pages long) in an 18-page article.\footnote{Anonymous, 'Part II - Reviews: The Lunacy Blue Books', Journal of Mental Science, 22 (1877), 580-98; UKPP, 'The Thirty-first Report of the Commissioners in Lunacy to the Lord Chancellor', 1877 (403), (p. 401); HMSO, 'Nineteenth Annual Report of the General Board of Commissioners in Lunacy for Scotland', 1877 (c.1785), (p. xxxviii); HMSO, 'Lunatic Asylums - Ireland: Twenty-sixth Report on the District, Criminal, and Private, Lunatic Asylums in Ireland; with Appendices', 1877 (C.1750), (p. 115).} The other form were articles on specific issues, such as the staffing of asylums.\footnote{Anonymous, 'Sisterhoods in Asylums', Journal of Mental Science, 12 (1866), 44-63; Anonymous, 'Attendants in Asylums', Journal of Mental Science, 16 (1870), 310-11.} A more general review of asylum services was published in The Lancet in 1876 under the general title of 'The Lancet Commission Reports'. Whilst these did report on the asylums visited, this was a one-off series that only showed the state of these services at the time.\footnote{Anonymous, 'Report of the Lancet Commission on Lunatic Asylums', The Lancet, 107 (1876), 329-31 (p. 329); Anonymous, 'Lancet Commission 25 March 1876', (p. 477); Anonymous, 'Lancet Commission 17 June 1876', (p. 891); Anonymous, 'Report of the Lancet Commission on Lunatic Asylums', The Lancet, 108 (1876), 17-19 (p. 17); Anonymous, 'Lancet Commission 26 August 1876', (p. 291); Anonymous, 'Lancet Commission 16 December 1876', (p. 862).} The articles in newspapers tended to focus on high profile cases of wrongful detention or incidents that involved a scandal or death.\footnote{Anonymous, 'The Fire at Southall', The Times, 30919, 7 September 1883, p. 9 [Accessed: 25 January 2019]; Anonymous, 'Terrible Fire at Colney Hatch Asylum', The Times, 36989, 28 January 1903, p. 6 [Accessed: 17 December 2019]; Anonymous, 'The Case of Lady Bulwer Lytton', The Observer, 19 July 1858, p. 7 [Accessed: 11 June 2022].} All of these potential sources failed to provide detailed reporting of the work and working of the CIL, making them of some use in relation to specific cases but of limited value in assessing the overall performance of the CIL.

A further source that was reviewed were the Minutes of the Meetings of the CIL. It was hoped that this material would show the discussion on and rationale for the decisions that were made. The minutes do indicate the effort that all of the people appointed made in addressing the workload of this regulator. However, it does not include details of the discussions held. Instead, the format adopted was of identifying the issue to be addressed and then recording the decision reached.\footnote{As an example, see the minutes for the meeting on 14 August 1845 NA, MH 50/1, Commissioners in Lunacy Minute Book Volume 1: 1845-46 p. 2.} Again, the usefulness of these materials to an analysis of the everyday work of the CIL is limited but they will be used to exemplify specific points.

Whilst these other sources are useful for the building a contextual understanding of the CIL, a study of its day-to-day working, internal operations and effectiveness in England and Wales depended on the Annual Reports. The absence of correlational sources to offer balance means that the conclusions to be drawn have to be tempered by caution. Reliance on a single main source means...
that it is unlikely that a complete picture of the work of and influences on the CIL will be generated. Separate studies will be required in the future that will take alternative perspectives, such as comparisons between the CIL and the arrangements in Scotland and/or Ireland. In order to try to control for any inbuilt biases, a methodology had to be developed that sought to balance the claimed improvements secured by this regulator with the findings reported during the inspection visits. The approach used would also take account of the findings from the earlier studies on the work of the CIL.60

In order to show the detail of the day-to-day work of the CIL and whether it was able to secure changes to protect the patients, required the identification of its duties from the lunacy and county asylum legislation of 1845, including any changes in these from later amendments, and a review of the Annual Reports to show how it undertook this work and what was achieved. The thesis demonstrates that the work of the CIL involved two linked processes: the identification of non-compliance; and the securing of compliance. As such, this study, goes on to consider what issues of noncompliance the CIL reported and how, in the process of their work, they sought to secure compliance. In so doing, it details what they were able to achieve, how they achieved this, and the factors that affected these outcomes. Included in this study for the first time in relation to the CIL is a consideration of when and how prosecution was used to protect the patients from harm and the limitations on the use of this as an enforcement tactic. Finally, as the CIL was not the only regulatory organisation established in the nineteenth century, this study makes comparisons to show if there were commonalities that affected the regulatory process in general, before making conclusions about the CIL in particular.

Capturing the work and working of the CIL across England and Wales and over the period 1845 to 1913 required a methodology that addressed both the national and local levels. Putting this national and local view together, involved a detailed reading of the relevant legislation and the reports of the CIL based on their visits, organised around the key categories of asylum and patient types. This methodology has enabled the research questions to be addressed, by following each of the elements in the process of regulation, from legislation, inspection and reporting to enforcement. Establishing the agenda of the CIL, its aims and

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60 Because it was not possible to prepare comparable material for either of the other home nation regulators, detailed comparisons have not been included. That this work might be undertaken is discussed in Chapter 7 (p. 218).
priorities, and the parameters of its role, was completed by undertaking a detailed analysis of the various Lunacy and County Asylum Acts passed between 1845 and 1913, listed at Appendix 1 (p. 223). Additionally, to show the context that shaped the development of asylum regulation, the lunacy legislation enacted between 1774 and 1845 was also briefly examined to provide the background to the formation of the CIL. The agenda of the CIL was also affected by other legislation, such as the Poor Law Amendment Act (1834), and these have also been considered.\footnote{LL, An Act for the Amendment and Better Administration of the Laws Relating to the Poor in England and Wales (1834) (4 & 5 Gulielmi IV CAP.LXXVI).} This analysis of the legislation showed that the key functions of the CIL were related to the licencing, inspecting, and monitoring of places of detention and reporting on the state of asylum services in England and Wales. It also identified that the CIL had only limited power to take independent action against individuals who infringed the law. As this thesis will argue, the examination of the functions of the CIL demonstrates that the differences in the way in which paupers and non-paupers were protected and public and private asylums were monitored went well beyond those identified by Mellett.\footnote{Mellett, 'Bureaucracy and Mental Illness', (pp. 234-35, 244).}

As already noted, the Annual Reports did offer the necessary detailed coverage but there were inherent problems with their use. Because the CIL were only infrequent visitors to asylum sites, they were dependent on the records maintained by each asylum being accurate and complete for the periods when the commissioners were not in attendance. The CIL recognised both this dependence and the impact of poor record keeping on its work. In his evidence to the PSC on Lunacy in 1859 Shaftesbury stated in relation to the use of mechanical restraint that ‘we make all enquiries that we can … but you are at the mercy of the authorities; they are bound to enter [the use of restraint] in a book, but you have no assurance that they do enter it’.\footnote{UKPP, 'Report from the Select Committee on Lunatics', 1859 Session 1 (204), (p. 26).} As was noted in the work by Jonathan Andrews, Barbara Brookes and James Dunk, and Jennifer Wallis, what was being recorded reflected the concerns of the person making that record, making inter-observer variation probable.\footnote{Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', Social History of Medicine, 11 (1998), 255-81 (pp. 258-59); Barbara Brookes and James Dunk, 'Bureaucracy, Archive Files, and the Making of Knowledge', Rethinking History, 22 (2018), 281-88 (p. 281); Jennifer Wallis, Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices, (London: Palgrave Macmillan, 2017), p. 87.} The uncertainty about the accuracy of the available
records was an inherent weakness in the process of regulation which impacts on the methodology of this study.\textsuperscript{65}

The use of the Annual Reports was also affected by the changes in way that the CIL reported their findings over time. Before 1866 the CIL only included in their published reports comments on those asylums where a particular concern was identified. After 1866 they included, as an appendix, a copy of the comments that the commissioners entered in ‘The Visitors Book’ at the end of the visit to each public asylum.\textsuperscript{66} As noted above, the responses from the Visiting Committee, the body appointed to operate the pauper asylums by the JPs, to the issues raised did not form part of the record of the visit. This form of reporting was extended to the Registered Hospitals, those charitable and privately funded institutions that admitted lunatics or idiots, from 1869. It was not until 1896 that similar reports for the licenced houses, the asylums funded by fee-paying patients, were included. Until then the CIL made entries in the main body of the report for the licenced houses where particular issues and concerns were identified or where previously identified problems were reported as having been addressed. As an example: in 1873 the CIL included reports on only 47 of the 101 licenced houses.\textsuperscript{67} This approach of selective presentation for the licenced houses and a comprehensive one for the public asylums undermines the suggestion by Smith that the CIL focussed most attention on the former.\textsuperscript{68}

A further problem with the Annual Reports was that the appendices that included the detailed reports on the site visits and the information returns are not available for the years 1910 to 1913. As a result, it was not possible to complete the detailed review of the work of the CIL in these years. Examination of the available parts of the Annual Reports for these years did not show any major change in what was previously reported and it was concluded that the lack of this data was not sufficient to undermine the methodology used.

Inclusion of the commissioners’ comments on each asylum in the Annual Reports involved a multi-stage process. It was the duty of the asylum clerk to make a true copy of the comments written into the Visitors Book and to forward this to the office of the CIL.\textsuperscript{69} On receipt in London the entry would be read at the

\begin{itemize}
\item \textsuperscript{65} Baldwin, Cave, and Lodge, \textit{Understanding Regulation}, pp. 340-41.
\item \textsuperscript{66} S.LXVI LL, 8 & 9 Vict. CAP.C (1845).
\item \textsuperscript{67} UKPP, ‘The Twenty-seventh Report of the Commissioners in Lunacy to the Lord Chancellor’, 1873 (256), (pp. 53-64).
\item \textsuperscript{68} Smith, 'The Keeper Must Himself be Kept', pp. 212, 213-14.
\item \textsuperscript{69} S.LXI LL, 8 & 9 Vict. CAP.C (1845).
\end{itemize}
next routine meeting and then copied into the draft of the Annual Report by one of the clerks. In order to check that transcription errors had not been made a sample of the entries for the Shropshire County Asylum were compared with those in the Visitors Book for this asylum. No errors were identified in the sample of the Shropshire Asylum reports from the years between 1845 and 1910 reviewed.70

Most attention has been given in this thesis to the asylums because the reporting on the other locations, such as prisons and workhouses, where lunatics and idiots were detained included insufficient detail. Outside of the asylums the largest numbers of patients were detained in workhouses, a critical element in the provision for pauper lunatics.71 Here the CIL only routinely reported the names of the sites visited and the numbers of lunatics seen at each.72 They did include in the body of the report commentary on general issues about detention in workhouses, such as the non-transfer of treatable cases, but none of the details on the physical state of the provision or the activity of the people detained.73 The reporting on Single Patients, unnamed wealthy individuals detained and treated by a doctor in a private house, was even more spartan than that for workhouses. Initially all matters relating to these patients were dealt with by the Private Committee of the CIL but this arrangement was ended in 1853 because it was found to be impracticable.74 Even when this separate arrangement was ended the CIL only reported the number of visits made.75 Also only intermittently reported

70 SCA, [X6175 A:2:2], 'The 21st-30th Annual Reports of the Medical Superintendent of the Lunatic Asylum for the County of Salop and Montgomery and for the Borough of Much Wenlock'; SCA, [X6175 A:2:3], 'The 31st-37th Annual Reports of the Medical Superintendent of the Lunatic Asylum for the County of Salop and Montgomery and for the Borough of Much Wenlock'; SCA, [X6175 A:2:4], 'The 37th-46th Annual Reports of the Medical Superintendent of the Lunatic Asylum for the County of Salop and Montgomery and for the Borough of Much Wenlock'; SCA, [X6175 A:2:5], 'The 47th-56th Annual Reports of the Medical Superintendent of the Lunatic Asylum for the County of Salop and Montgomery and for the Borough of Much Wenlock'.
72 XLVII LL, 8 & 9 Vict. CAP.CXXVI (1845). For example see: UKPP, 'The Twentieth Report of the Commissioners in Lunacy to the Lord Chancellor', 1866 (317), (pp. 93-99).
73 For examples see: UKPP, CIL, 1857 Session 2 (157), (pp. 15-18); UKPP, 'The Supplement to the Twelfth Report of the Commissioners in Lunacy to the Lord Chancellor', 1859 Session 1 (228), (p. 4); UKPP, 'The Twenty-third Report of the Commissioners in Lunacy to the Lord Chancellor', 1868-69 (321), (pp. 11-13).
74 The Private Committee comprised of the chairman, one each of the medical and barrister commissioners and the Secretary. Only the members of this committee were authorised to make visits to the Single Patients wherever they were located in England and Wales. S.LXXXIX, S.XCI & S.XCII LL, 8 & 9 Vict. CAP.C (1845). S.XXVII LL, An Act to Amend an Act Passed In the Ninth Year of Her Majesty, "for the Regulation of the Care and Treatment of Lunatics" (1853) (16 & 17 Vict. CAP. XCVI).
75 UKPP, 'The Twenty-ninth Report of the Commissioners in Lunacy to the Lord Chancellor', 1875 (337), (pp. 50-51).
were the visits made to: the asylums for the criminally insane and military personnel; the Metropolitan District Asylums, (hereafter MDA); and prisons. The lack of regular detailed reporting has precluded the inclusion of these groups in the data analysed in this thesis.

Caution also needs to be exercised in using the Annual Reports as a source on the effectiveness of the CIL for two reasons. Firstly, one of their purposes was to demonstrate that the CIL was doing its job. There is, therefore, a risk that the reports selectively presented results and comments that showed the CIL in a positive light. In the absence of other comparable sources on the state of asylums the detailed quantitative analysis of the failures of compliance from 1845 to 1910, completed to measure the effectiveness of the CIL, has been used to test the validity of the qualitative statements and claims made about the state of asylum services by the commissioners in their reports. As will be seen, some of these claims were not found to be supported by the quantitative evidence. Secondly, the incidence of failures of compliance are based on what the commissioners were able or chose to report. The actual number of infringements of the lunacy legislation may have been much higher. In later chapters the commentary on the results will show possible impacts of this factor.

The Annual Reports vary in length from about eight pages in the early years to as many as five hundred by 1910. Given this quantity of material consideration was given to using computer software to interrogate the Annual Reports, a digital humanities approach. For this method to be used the records to be analysed have to be digitised. The Annual Reports have not yet been digitised. An attempt was made to convert the downloaded web files into a usable format but this proved to be impracticable within the time and resource constraints.

76 The Criminally Insane were those people who were diagnosed as being lunatics at the time the offence was committed and were, under the terms of the M’Naghten Rules, deemed unfit to stand trial. Jon E. Roeckelein, Elsevier’s Dictionary of Psychological Theories’ (London: Elsevier Science & Technology, 2006), https://search.credoreference.com/content/entry/estpsyctheory/mcnaughton_rules_principles/0?institutionId=292, [Accessed: 26 November 2018]. The MDAs were exempt from the requirements of the lunacy legislation but still had to be visited by the CIL, S.30 LL, An Act for the Establishment in the Metropolis of Asylums for the Sick, Insane, and Other Classes of the Poor, and of Dispensaries; and for the Distribution over the Metropolis of Portions of the Charge for Poor Relief; and for Other Purposes Relating to Poor Relief in the Metropolis (1867) (30 Vict. CAP. VI).

77 Eileen Gardiner and Ronald G. Musto, The Digital Humanities: A Primer for Students and Scholars, (Cambridge: Cambridge University Press, 2015), pp. 67-82. I am grateful to Dr Francesca Benatti, Research Fellow in Digital Humanities, Faculty of Arts and Social Sciences, The Open University, for meeting with me on 18 August 2016 to discuss this approach.

78 A new version of the optical character recognition software used was issued in 2020 that can convert a standard PDF file into a searchable format. This arrived too late for use in this work.
Instead, an underlying principle of the digital humanities approach, reviewing the Annual Reports using pre-defined terms to achieve consistency, has been applied. In order to identify the search terms and test that the methodology was practicable a pilot study was completed. The Annual Report for every fifth year from 1846 to 1910 was reviewed to identify each instance where any concerns had been reported. This preliminary work confirmed that, whilst time consuming, the non-digital method could be employed to analyse each of the Annual Reports for the years 1845 to 1910. This method was found to offer an advantage over the full digital approach in that it was possible to secure a more nuanced view of changes in the way that the issues were addressed and comments phrased which highlighted the differences in reporting over time and between the individual commissioners. The detailed reading did highlight variation, but the anonymisation prevented comparison between the commissioners.\footnote{Examination of the records held in the Shropshire Archive shows that the names of the commissioners completing the inspection were recorded in the Visitors Book. For examples see SCA, [X6175:A121], 'The 1st-21st Annual Reports of the Medical Officer or Medical Superintendent of the Lunatic Asylum for the County of Salop and Montgomery and for the Borough of Much Wenlock'.}

The detailed review of all of the Annual Reports from 1845 to 1910 was completed and this identified all reported instances where the commissioners recorded noncompliance of the issues they were required to report on according to the legislation, termed collectively as the Specified Issues in this work, and those that they identified and chose to report on during their visits, collectively the Non-specified Issues, at each asylum.\footnote{The legislation of 1845 identified a total of twelve Specified Issues and the commissioners identified a further twenty-five Non-specified Issues. These are detailed in Chapter 2 (pp. 43-45).} The distinction between these groups was simply that the former had been identified in the legislation. Within these groupings, some of the issues, both Specified and Non-specified, had been concerns since the start of regulation in 1774. These are termed long-standing issues in this thesis. The others, which were added as concerns in 1845 and later, are termed contemporary issues. Each instance of noncompliance was noted on a copy of the Annual Report and then entered into a database, with a record for each asylum reported in each year. The database was interrogated to produce reports for each of the Specified and Non-specified Issues showing, by asylum and year, the reported number of failures of compliance. This information was transferred into a series of spreadsheets and used to generate the statistics reported in this thesis. The results have been used to demonstrate in detail how
the CIL monitored compliance at the England and Wales, asylum type and individual asylum levels.

Reviewing all the issues reported by the CIL suggested that there might be interdependencies and links between them, for example, whether low staffing levels led to a higher use of mechanical restraint. To test for any potential links the Spearman’s correlation coefficient ($r_s$) between each of the issues was calculated. This test shows whether the two issues were positively or negatively related and the strength of this relationship. This test has been used to highlight areas of interdependence.\(^8^1\)

The effectiveness of the CIL in protecting patients depended on both the identification of noncompliance and the securing of change so that compliance with the legislation was achieved. Having identified where an asylum was not in compliance it was the duty of the CIL to encourage that institution to implement changes. To examine the effectiveness of the CIL in undertaking this part of its work, four issues from the Annual Reports were selected for more detailed examination by using a case study approach to show how effective the CIL were in securing changes in practice and/or the environment so that compliance was achieved. The issues selected were the use of mechanical restraint and attendance at Divine Worship from the Specified Issues group and staffing levels and the numbers of PM examinations being conducted in asylums from the Non-specified Issues group.\(^8^2\) These four topics were selected because between them they show the similarities and differences between how the Specified and Non-Specified and the long-standing and contemporary issues were addressed, how the interests of influential forces acted on the work of this regulator and how the CIL used pre-existing interests to aid the achievement of their objectives. How the selected issues relate to both the domains of Specified and Non-specified and long-standing and contemporary issues is shown in Figure 1.1. The purpose of these case studies is to show if and how the powers of the CIL to secure changes in practice were constrained and where these constraints arose. The combination of the four case studies shows the detailed day-to-day working of the CIL and the

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\(^8^1\) In a positive correlation an increase in one of the pair is matched by a rise in the other. In a negative correlation a rise in one is matched by a fall in the other. A strong correlation coefficient is one where the $r_s$ value is in the range of +0.5 to +1.0 or -0.5 to -1.0. It is important to note that correlation, however strong, does not show causality. Andy Field, *Discovering Statistics Using IBM SPSS Statistics*, 4th edn (London: Sage 2000; 2014), pp. 276-78.

conditions and constraints under which it had to operate. They reveal how the CIL sought to secure changes in practice and/or the environment to protect the vulnerable patients. These cases also highlight the differences in the way that pauper and non-pauper patients were treated and protected and those between the publicly and privately funded asylums, a finding also noted by Harriet Sturdy in her study of the Scottish system of Boarding-out.  

Figure 1.1: Representation of the categorisation of the domains of the case study issues

The lunacy laws included provision for the prosecution of those individuals who failed to follow its requirements. However, this power only applied to a small number of the issues reviewed by the CIL and could not be used against an organisation, such as a county or borough authority. Included as prosecutable offences were operating an unlicenced private asylum and failing to notify the CIL of the death of a patient. Other issues, such as not having sufficient asylum places for paupers, despite this being a requirement of the County Asylums Act (1845), or not having sufficient staff, were not defined as prosecutable offences. From the perspective of the CIL, another constraint was that the decision to use prosecution was not held by them in all cases. In some instances, the prior consent of a Principal Secretary of State, the JPs or a government law officer was required.

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84 When taking legal action a named individual had to be cited as the law did not allow prosecution of organisations, this only becoming possible in the twentieth century. James Brown, 'Corporate Responsibility in the UK Construction Industry: A Study of Activities and Reporting', (unpublished doctoral thesis, University of Nottingham, 2012), p. 12.
85 S.XLIV & S.LIV respectively LL, & 9 Vict, CAP.C (1845).
86 A similar constraint also applied in Scotland, Andrews, "They're in the Trade ... of Lunacy", p. 32.
The analysis of the Annual Reports has been used to show how and when prosecution was used and the outcome of the cases that went to trial. Such a review has not previously been reported and these results show that prosecution was rarely used but when it was conviction was often the outcome. This analysis also considers the other constraints on the use of prosecution, including: the resources to take cases forward; whether reliable evidence was available; the impact of the judicial process; and the attitude of the regulator to prosecution.

Assessing effectiveness involves a measurement of performance. In the case of a regulator the ideal would be to make a comparison of the incidence of compliance and non-compliance between the periods before and after that organisation was established to identify any changes. The necessary information for this comparison is rarely available, as is the case with the CIL. Instead, evaluation of performance has been made by comparing how the reported incidence of noncompliance changed over time. This comparison needs to be treated with caution because what was reported, how it was viewed, who was making the reports and the effects of changes in local and national circumstances could independently and jointly vary over time. A simple count of whether the reported incidence of failures of compliance were increasing, stable or decreasing may not be an accurate reflection of reality as it does not allow for the significant changes in the asylum system between 1845 and 1913. Tables 1.1 and 1.2 show the increases in the numbers of asylums and patients respectively.

Table 1.1: Changes in the Numbers of Asylums by Type 1846-1909

<table>
<thead>
<tr>
<th>Asylums:</th>
<th>1846</th>
<th>1856</th>
<th>1866</th>
<th>1876</th>
<th>1886</th>
<th>1896</th>
<th>1906</th>
<th>1909</th>
</tr>
</thead>
<tbody>
<tr>
<td>#CA</td>
<td>19</td>
<td>33</td>
<td>41</td>
<td>49</td>
<td>52</td>
<td>54</td>
<td>69</td>
<td>72</td>
</tr>
<tr>
<td>#BA</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Public:</td>
<td>21</td>
<td>37</td>
<td>47</td>
<td>57</td>
<td>63</td>
<td>69</td>
<td>89</td>
<td>95</td>
</tr>
<tr>
<td>#*RH</td>
<td>12</td>
<td>31</td>
<td>16</td>
<td>17</td>
<td>22</td>
<td>23</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>#*MLH</td>
<td>49</td>
<td>31</td>
<td>40</td>
<td>39</td>
<td>34</td>
<td>23</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>#*PLH</td>
<td>96</td>
<td>82</td>
<td>61</td>
<td>62</td>
<td>62</td>
<td>47</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Private:</td>
<td>157</td>
<td>136</td>
<td>117</td>
<td>118</td>
<td>113</td>
<td>92</td>
<td>89</td>
<td>88</td>
</tr>
<tr>
<td>Totals:</td>
<td>178</td>
<td>173</td>
<td>164</td>
<td>175</td>
<td>176</td>
<td>170</td>
<td>178</td>
<td>183</td>
</tr>
</tbody>
</table>

Note: # CA = County Asylum; BA = Borough Asylum; RH = Registered Hospital; MLH = Metropolitan Licensed House; PLH = Provincial Licensed House.
* The asylums for idiots were reassigned from the MLH and PLH groups to the RH group in 1879.

Source: The Annual Reports of the CIL for the respective year.\(^{89}\)

Table 1.2: Changes in the Numbers of Patients by Asylum Type, and in Workhouses and Metropolitan District Asylums (MDAs), 1846-1909\(^{90}\)

<table>
<thead>
<tr>
<th>Asylums:</th>
<th>1846</th>
<th>1856</th>
<th>1866</th>
<th>1876</th>
<th>1886</th>
<th>1896</th>
<th>1906</th>
<th>1909</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>5173</td>
<td>13,352</td>
<td>22,515</td>
<td>31,878</td>
<td>43,843</td>
<td>57,042</td>
<td>77,429</td>
<td>83,890</td>
</tr>
<tr>
<td>BA</td>
<td>110</td>
<td>471</td>
<td>1128</td>
<td>2276</td>
<td>4296</td>
<td>6915</td>
<td>11,913</td>
<td>13,690</td>
</tr>
<tr>
<td>Public:</td>
<td>5283</td>
<td>13,823</td>
<td>23,643</td>
<td>34,154</td>
<td>48,139</td>
<td>63,957</td>
<td>89,342</td>
<td>97,580</td>
</tr>
<tr>
<td>RH</td>
<td>1135</td>
<td>1642</td>
<td>2279</td>
<td>2810</td>
<td>3233</td>
<td>4197</td>
<td>4428</td>
<td>4590</td>
</tr>
<tr>
<td>MLH</td>
<td>2850</td>
<td>2585</td>
<td>2433</td>
<td>2567</td>
<td>2063</td>
<td>1850</td>
<td>1788</td>
<td>1312</td>
</tr>
<tr>
<td>PLH</td>
<td>3876</td>
<td>2553</td>
<td>1931</td>
<td>2013</td>
<td>1805</td>
<td>1788</td>
<td>1312</td>
<td>1312</td>
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<tr>
<td>Private:</td>
<td>7861</td>
<td>6780</td>
<td>6643</td>
<td>7440</td>
<td>7674</td>
<td>8374</td>
<td>7775</td>
<td>7465</td>
</tr>
<tr>
<td>Totals:</td>
<td>13,144</td>
<td>20,603</td>
<td>30,286</td>
<td>41,594</td>
<td>55,812</td>
<td>73,331</td>
<td>97,117</td>
<td>105,045</td>
</tr>
<tr>
<td>WH:*</td>
<td>4490</td>
<td>6700</td>
<td>10,307</td>
<td>16,038</td>
<td>11,982</td>
<td>11,118</td>
<td>11,225</td>
<td>11,455</td>
</tr>
<tr>
<td>MDAs: ~</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>4519</td>
<td>5399</td>
<td>6003</td>
<td>6679</td>
<td>6941</td>
</tr>
</tbody>
</table>

Note: * WH = Workhouses.
~ The Metropolitan District Asylums (MDAs) were established in 1870 and were under the control of the Poor Law authorities for London.

To better reflect the changes to the asylum system two alternative means of measurement were piloted. The first was to calculate the rate of reporting of

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\(^{89}\) Throughout this thesis, unless otherwise stated, the data in the various tables is sourced from the Annual Reports of the CIL to the Lord Chancellor.

\(^{90}\) Patient numbers have been taken from the 1\(^{st}\) January census included in the Annual Report. A study of child insanity that used local sources reported very different patient numbers from those recorded by the CIL. Dr Steven Taylor reported that the peak patient number at the Colney Hatch Asylum between 1845 and 1907 was 3500, Steven J. Taylor, *Child Insanity in England, 1845-1907*, (London: Palgrave Macmillan, 2016), pp. 6-7. The highest CIL figure was 2584 in 1898, UKPP, ‘The Fifty-third Report of the Commissioners in Lunacy to the Lord Chancellor’, 1899 (255), (p. 180). In an interesting email exchange in June 2021 I asked for clarification of the source for his figures. Dr Taylor has, thus far, been unable to find his original source.
each issue per 1000 patients for each year and by asylum type. As all the results would be on the same basis direct comparisons between the asylum and patient types could be made. In many cases the results were less than one case per 1000 patients. With such small numbers, for example 0.02 cases per 1000 patients, there is a risk that the importance to the protection of vulnerable patients is underestimated. As an alternative, the proportion of asylums where an issue was identified was calculated for each asylum type and for each year. The resultant percentages are relatively easy to understand. Comparison between the results, when graphed, showed similar patterns for these two methods. It was decided to use the percentage method for the main presentation of results.⁹¹ Because these presentations look at the overall pattern for England and Wales there is a loss of the detail of how each individual asylum changed from year to year.

As this thesis demonstrates, the overall assessment of effectiveness of the CIL over the course of its lifetime and across England and Wales requires utilisation of both quantitative and qualitative methods to enable the presentation of a broad and contextual understanding of how this organisation worked and fitted into the asylum system. Knowing that the number of incidents of noncompliance was changing does not necessarily demonstrate the performance of the regulator. To better show the broader perspective, the analysis needs to include qualitative data. By examining the Annual Reports in detail, it has been possible to start to determine the relative power, predispositions, biases, hobby-horses and concerns of the various parties involved in the process of regulation and how these interacted. This thesis argues that it is this complex interaction that underlies the effectiveness, or lack of it, of the CIL and other regulatory organisations.

Chapter outline
The starting point for this examination of the work and workings of the CIL was an analysis of the lunacy legislation between 1845 and 1913. This has been used to identify the role of this regulator, what it was required to do, what it could choose to do and what it could not do. An analysis of the earlier legislation showed how much of its role and functions were novel and how much was legacy from earlier efforts at regulation. The results of these analyses, presented in Chapter 2, show that much of the role and duties of the CIL, as well as the constraints on what it could do, were continuations from the pre-1845 period. Whilst the issues that the

⁹¹ Where the rate highlighted a particular point, these results have also been presented.
CIL had to report on were included in the legislation of 1845, as shown in Table 2.4 (p. 47) for these Specified Issues, they did have scope to look at other matters. The list of 25 Non-specified Issues, defined in Table 2.5 (pp. 48-49), shows how the CIL used their power to consider a range of matters that could secure benefits for the people detained. The analysis also reveals how fundamental distinctions between paupers and non-paupers and public and private asylums were incorporated into the legislation. The chapter considers how the CIL sought to ensure that new asylums, both public and private, were compliant with the legislative requirements when that institution opened, also revealing how the approval process differed between the public and the private asylums. The examination of these processes shows that those patients admitted to a private asylum, including the paupers, had a higher level of protection than those detained in a public asylum. As will be seen in later chapters, this distinction between the asylum types applied to other aspects of the regulatory process.

Once an asylum opened it was the role of the CIL to confirm that it continued to be operated in accordance with the requirements of the legislation. This function was put into effect through the processes of inspection, making visits to each location where a lunatic or idiot was detained, and monitoring, receiving, analysing and collating information returns from the various asylums, Poor Law authorities and others. Chapter 3 presents the findings from the detailed analysis of the Annual Reports, showing the identified incidents of noncompliance for the various Specified and Non-specified Issues. Comparison is made between the public and the private asylums. As with the licensing\approval process, there are clear differences in the way that issues were reported and commented upon by the professional commissioners between the public and the private asylums. Examining the level of issues reported over time suggests that the CIL had only a limited impact on reducing the incidence of noncompliance, but that varied between particular issues and asylums.

Given the infrequency of visits to individual asylums by the professional commissioners, the inspection reports can only be static snapshots of a dynamic system. In order to complete an ongoing review of events in asylums the CIL collected and collated a large amount of information on patient movements through the asylum system, untoward events and accidents, and much else. This gathering of a range of information, whilst fitting the Victorian interest in statistics and the change in the role of government, was of greater importance to the work
of the CIL than has previously been suggested.\textsuperscript{92} Chapter 3 will show how the CIL utilised the returns to augment their findings from the inspection visits and to try to reduce the potential risks to the patients.

Through inspection and monitoring the CIL identified which and where asylums were operating in compliance with the legislation. Where asylums were noncompliant it was the duty of the CIL to try to secure changes that would bring the asylum into line with the law. As noted above, the issues where compliance was sought can be categorised into the domains of Specified\textbackslash Non-speficied and long standing\textbackslash contemporary, as shown in Figure 1.1 (p. 20). The purpose of Chapters 4 and 5 is to consider the techniques used by the CIL to address failures in compliance across the two domains using four case studies. Chapter 4 will examine two of the long-standing issues, the use of mechanical restraint and the staffing of asylums, and Chapter 5 two of the contemporary issues, attendance at Divine Worship and the numbers of PM examinations being completed in asylums. In each case, the origin of the concerns, the reported findings from the inspection and monitoring of the various asylums, how the CIL sought to secure change and the effectiveness of the approach used was examined. These case studies will highlight differences in approach used by the CIL between the public and private asylums and in respect of pauper and non-pauper patients. It also shows the internal and external factors that impacted on this part of the work of the CIL to protect the vulnerable patients.

The lunacy legislation identified certain actions and inactions as prosecutable offences, including operating an unlicenced private asylum, maltreating patients, failing to maintain specific records, or make specified information returns. The CIL were required to identify and report contraventions. The legislation of 1845 granted the CIL the power to initiate prosecutions in some cases, in others they had to secure permission from a senior minister first. In all cases they had to obtain funding from the Treasury. Amendments in 1889 and 1890 increased the role of the senior ministers in this process.\textsuperscript{93} The purpose of Chapter 6 is to show what was identified as a misdemeanour and the action the CIL could and could not take if an offence was confirmed. Examination of the legislation showed that most opportunities to prosecute were related to

\textsuperscript{92} Jones, Asylums and After, p. 91.
administrative failures.\textsuperscript{94} The material presented shows how prosecution was employed for various of the defined offences and makes comparisons between the public and private asylums and offences committed in non-asylum settings. Over the lifetime of the CIL the numbers of prosecutions did increase slightly but the rate of those progressed remained low when compared with the number of potential cases. Amongst the cases that were progressed to a hearing the conviction rate has been found to be high.

In the final chapter the themes explored in this thesis are brought together to address the question on the efficacy of the CIL as a regulator of asylum services. Measurement of performance is a complex issue and the chapter starts by comparing the results between a simple count of the number of incidents reported in each year, the rate of reported noncompliance per 1000 patients, and the percentage of asylums reported for noncompliance. Each of these methods of comparison generated different conclusions about the efficacy of the CIL. The chapter goes on to discuss the various factors that influenced the work and working of the CIL by facilitating or impeding its ability to secure compliance. How the CIL compares with other of the regulators established in the nineteenth century is also included, highlighting the common influences that were built into the system of regulation and over which the individual regulatory organisations had little or no control. This work confirms the general conclusion reached in the earlier studies, that the CIL was an organisation that had limited power to secure change. However, what is also shown is how, despite this inbuilt weakness, the CIL did have an impact on the asylum system that gave benefit to the detained patients. Included in this chapter is a brief discussion of how this study fits within the historiography of the CIL and what work might be undertaken to further clarify the impact of this organisation on asylum services.

\textsuperscript{94} As examples see: S.LIII, L.IV & LV LL, 8 & 9 Vict. CAP.C (1845).
Chapter 2: Duties and Development

To paraphrase the poet Maya Angelou (1928-2014), if you don’t know where the CIL came from, you cannot know where it was going. The purpose of this chapter is to outline the origins of the CIL and how its agenda was set as the preliminary to the later chapters on its regulatory activity. Regulation of asylum services did not start in 1845, the legacy of the earlier attempts to protect patients detained in asylums can be seen in the lunacy legislation of that year. It is equally true that this legacy was modified by the legislation of 1845 and later, in the light of changing ideas about the way asylum services should be provided and the role of the central government, which were also being reflected in the legislation. This process of development did not stop in 1845, and some changes continued to be made to the role and functions of the CIL in reaction to: the experience gained by the commissioners; the identification of faults and omissions in the original legislation; the increasing numbers of paupers being detained; the cost to ratepayers of providing the public asylums; and the concerns of external agents regarding the way that asylum services and regulation were operated.

This chapter, in the tradition of Mellett and Hervey, is an administrative history of the CIL, setting out its origin and agenda, but, as noted above (p. 9), without the biographies of the various commissioners. What this chapter does differently is to show how the agenda of the CIL was developed and how, within the context of the regulation process, it was implemented. This approach shows that the agenda was a complex combination of the specific, such as the issues that had to be reviewed at inspection, and the open-ended, for example the ability of the commissioners to add issues for review at inspection. The chapter will start to show how influential the founding members were in defining the agenda and working arrangements of the CIL. Adding to the complexity of the working arrangements, the CIL was part of a system in which a range of competing interests interacted including the extension of the role of central government and the retention of power by local authorities; the asylum authorities and the poor law authorities; local ratepayers and the imposed requirements that had cost

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2 LL, 8 & 9 Vict. CAP.C (1845); LL, 8 & 9 Vict. CAP.CXXVI (1845).
4 S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
implications; reformers of asylum services and opponents of change; the relatives of the detained and the various authorities. The combination of these internal and external influences imposed opportunities and constraints on the CIL and affected its impact on asylum services.

Previous work on the CIL has shown that there were differences in the protections afforded between the pauper and non-pauper patients and between the public and the private asylums. This chapter shows how deeply these distinctions were embedded. The consequence was that, overall, paupers were granted fewer protections than non-paupers and public asylums had fewer controls applied to them than the private asylums. The perceived need for greater control of private asylums was the consequence of historical concerns about how some of the madhouses and hospitals, those admitting lunatics, were operated. Despite the historical concerns about the licenced houses, much of the reporting of the CIL was focussed on the public asylums, the latter not being free from criticism.

The care of lunatics and idiots and the development of asylum regulation
As noted, the establishment of the CIL in 1845 was not the starting point of the regulation of asylum services. Nor was it the earliest step in the implementation of systems of regulation in England and Wales, having been preceded by the: MCL (1828); Anatomy Inspectorate (1832); Factory Inspectorate (1833); Poor Law Commissioners, (hereafter PLC), (1834); Mines Inspectorate; and Colonial Lands Commission (both 1842). As a consequence, the CIL carried a legacy from the earlier arrangements for asylums and, more generally, from other regulatory

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6 Mellett, ‘Bureaucracy and Mental Illness’, (pp. 243-44).


Unlike the other regulators, the CIL was distinctive in that it was required to oversee both publicly and privately funded places of detention. This section considers why regulation was deemed as necessary and how the previous arrangements fed into the agenda of the CIL.

The care of lunatics and idiots prior to the nineteenth century was seen as the responsibility of the patient’s family. Parish authorities only became involved where the patient was a danger to themselves or others or where there was no family to provide care. The concept of care by the community has been typified by the picture of the village idiot being supported by neighbours but, as suggested by Wright, there is some doubt about the reality of this solution to the care of non-dangerous idiots. For wealthy families the eighteenth century saw a gradual increase in the numbers of asylums operated on a for-profit basis which offered to discreetly house, restrain, treat and feed lunatics and idiots for a fee. At this time there were no publicly funded asylums provided for the care and treatment of pauper lunatics. A small number of these people were admitted to hospitals, such as the Bethlehem Hospital, where the fees were paid by a charity or the parish authorities. In some instances, such as at the Leicester Infirmary, charity funded care was provided for pauper lunatics. A larger number of paupers who needed detention were placed in local prisons or the few Houses of Industry or workhouses then in existence. Some were placed in those private asylums that admitted pauper patients. As Browne showed, private asylum provision for paupers was of a much lower standard than that for the non-pauper patients. The demand for support for pauper lunatics was increased by the breakdown of local support networks with the shift from a rural-agrarian to an urban-industrial society. This institutional based care of lunatics and idiots in England and Wales contrasted with the system of Boarding-out in Scotland.

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12 Andrew Scull, Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from Madhouse to Modern Medicine, (London: Thames & Hudson, 2016), pp. 133-34.
14 Browne, What Asylums Were, pp. 135-36.
Faced with increasing demand entrepreneurs invested in providing more asylum places but there were concerns about how some of these were being operated. Criticism from the early years of the eighteenth century onwards focussed on whether detention was required, the treatment given was cruel, or discharge was being delayed for non-medical reasons. This provision, based on profiting from the misfortunes of others, was viewed with suspicion by some. In the face of these concerns and criticism a PSC was established in 1763 to review the services being provided in madhouses. The PSC concluded, having reviewed four cases of admissions to such establishments in London, that all private madhouses in England and Wales should be the subject of licencing and inspection. During this review of private asylums the PSC did not examine the care of any male patients or pauper lunatics. Due to opposition from members of the House of Lords legislation implementing the recommendations of this PSC was not enacted until 1774.

This legislation, An Act for Regulating Madhouses (the Madhouses Act) (1774), required that all madhouses detaining two or more patients be licenced and subject to annual inspection. This Act established a clear distinction between pauper and non-pauper patients as the protections offered, however limited, applied only to the latter. Proprietors were not required to give notice of the admission of paupers, nor were the areas set aside for paupers subject to routine inspection. Inspection and reporting on the licenced houses, as these asylums were termed, was severely constrained. The inspectors could only visit between ‘Eight and Five in the Daytime’ and reports could not challenge the ‘Character of the House’ unless three or more of the inspectors who made the visit had confirmed the comments. Reports on the visits were not published, access being by application. A notable element of this legislation that was perpetuated was the differentiation between the arrangements for an area around London, defined as the Metropolis, and the rest of England and Wales. For the latter the County JPs

Scull, Most Solitary, p. 19.
UKPP, PSC, 1763, (p. 11).
Jones, Asylums and After, pp. 36-37.
LL, 14 Geo. III CAP.XLIX (1774).
S.XV LL, 14 Geo. III CAP.XLIX (1774).
nominated some of their number, assisted by a medical practitioner, to perform the licencing and inspection duties.25 Within the Metropolis the licencing and inspection work was undertaken by six of the Fellows of the Royal College of Physicians of London, (hereafter RCP), who were elected annually by their peers.26 In 1828 the RCP were replaced by the MCL as the regulator for the Metropolis.27

Despite the arrangements established in 1774 being found wanting by both advocates of reform of the asylum system and some proprietors of licenced houses, a number of the features it established were perpetuated in the legislation of 1845 and later.28 These included the requirement that all private asylums detaining two or more patients had to be licenced and that the licence had to be renewed annually.29 Also retained was the requirement that non-pauper patients had to be certified by a doctor before admission, with a second medical certificate being required from 1828.30 Included in the 1774 legislation was a time limit of six months to bring a case, which was extended to twelve months from 1845.31

The original focus of concerns had been on the provision of services for non-paupers, but this began to change in the early years of the nineteenth century. In 1807 the MP Charles Wynn (1775-1850) secured the establishment of a PSC to examine the provision of services for criminal lunatics and paupers.32 The outcome was An Act for the Better Care and Maintenance of Lunatics, Being Paupers or Criminals in England (the County Asylums Act) (1808) which permitted counties and boroughs to establish and fund asylums for the treatment of pauper lunatics.33 These asylums did not have to apply for a licence and nor were they subject to inspection by a regulator.34 In an updating of the lunacy laws in 1828 it was made a requirement that the Visitors, the people appointed by the JPs to visit all asylums

25 S.XXIII LL, 14 Geo. III CAP.XLIX (1774).
26 S.II LL, 14 Geo. III CAP.XLIX (1774).
27 S.II LL, 9 Geo. IV CAP.XLI (1828).
28 UKPP, PSC, 1814-15 (296), (p. 4); UKPP, PSC, 1826-27 (557), (pp. 4-7).
29 S.II LL, 14 Geo. III CAP.XLIX (1774).
34 LL, 48 Geo. III CAP.XCVI (1808).
within their jurisdiction, report on the state of the publicly funded asylums. The requirement for certification by one doctor prior to admission was extended to pauper patients in 1828, with a second medical certificate only being required from 1846.

Because of the ongoing concerns about some asylum services and the lobbying of those seeking reform, the MCL was tasked with reviewing the state of asylum services in England and Wales in 1842. The report of their findings was published in 1844 and included 25 recommendations, including the establishment of a national regulator and that all counties and boroughs be required to fund asylum places for paupers. The proposals made by the MCL formed the basis of two pieces of legislation, both enacted in 1845. The Lunacy Act (1845) had three primary functions: the establishment of the CIL and the identification of its duties, including the inspection and reporting functions, and powers; the specification of the arrangements for the certification and detention of all patients; and the arrangements for the licencing of private asylums. This Act included the schedule of inspection visits to all places where lunatics or idiots were detained. The Lunacy Act (1845) confirmed that patients could only be admitted to an asylum, public or private, if they were the subject of formal detention and the patients could not leave without being formally discharged. The second piece of legislation was the County Asylums Act (1845), which established the requirement for all counties and boroughs in England and Wales to fund asylum places for all pauper lunatics and idiots within their jurisdiction. The bulk of this Act set out the arrangements by which the publicly funded asylums were to be established. This included the arrangements for the meeting of the costs of providing and running these asylums.

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35 S.LVI LL, An Act to Amend the Laws for the Erection and Regulation of County Lunatic Asylums, and More Effectually to Provide for the Care and Maintenance of Pauper and Criminal Lunatics in England (1828) (9 Geo. IV CAP.XL).
37 LL, An Act to Amend and Continue for Three Years, and from Thence to the End of the Next Session of Parliament, the Laws Relating to Houses, Licenced by the Metropolitan Commissioners and Justice of the Peace for the Reception of Insane Persons, and for the Inspection of County Asylums and Public Hospitals for the Reception of Insane Persons (1842) (5 & 6 Vict. CAP.LXXXVII).
38 UKPP, MCL, 1844 (001), (pp. 204-8).
40 For the non-pauper patients see: S.XXI LL, 14 Geo. III CAP.XLIX (1774). S.XXX LL, 9 Geo. IV CAP.XLI (1828). S.XLV LL, 8 & 9 Vict. CAP.C (1845). For pauper patients see: LL, 9 Geo. IV CAP.XL (1828), S.LL LL, 8 & 9 Vict. CAP.CXXVI (1845). Voluntary patients, admitted as boarders, were permitted only in private asylums by S.VI LL, 16 & 17 Vict. CAP. XCVI (1853).
from a rate imposed by the relevant JPs in Quarter Session.\(^{41}\) In both acts the breaches that could be the subject of prosecution were also defined.

Whilst both these Acts contained much that was new, they also included significant continuities from the earlier legislation. These continuities included maintaining the separate arrangements for the licencing of private asylums between the Metropolis and the rest of England and Wales, the requirement that all private asylums detaining two or more lunatics or idiots had to be licenced, and that public asylums did not have to be licenced. Some of the revisions included in the Lunacy Act (1845) did facilitate the work of the CIL, such as removing the limits on the timing and length of inspection visits.\(^{42}\) Whilst the power to grant a licence was retained by the JPs, the Act established that all approved applications for asylums outside of the Metropolis be reviewed, but not amended, by the CIL.\(^{43}\) An amendment in the law in 1862 authorised the CIL to process all applications for a licence, bringing a degree of standardisation across England and Wales.\(^{44}\) The final decision on these applications remained out of the hands of the CIL.

Prior to 1845 the asylum regulators could be replaced annually, an arrangement supported by Robert Peel (1788-1850).\(^{45}\) This arrangement was not perpetuated in the Act of 1845 or the subsequent legislation. As noted by Mellett, this allowed all of the members of the CIL, including those appointed from the MCL, to serve for long periods.\(^{46}\) This arrangement suited the ideas of Shaftesbury, who wanted the CIL to be a small group that retained a perpetual nucleus which changed only slowly.\(^{47}\) However, whilst this arrangement may have suited Shaftesbury it is less clear whether it was beneficial for securing the objective of protecting the patients from harm.

The Lunacy Act (1845) substantially expanded the visiting schedule for the private asylums. The single annual visit was replaced, with the CIL having to make

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\(^{41}\) LL, 8 & 9 Vict. CAP.CXXVI (1845). Whilst the costs of buying land and constructing the asylum could be raised by a mortgage or a loan from the Consolidated Fund, the repayments all came from the rates, see S.XXXIII, S.XXIV & S.XXXV of the Act.

\(^{42}\) S.LXI, S.LXXI, S.CX & S.CXI LL, 8 & 9 Vict. CAP.C (1845).

\(^{43}\) S.XXVIII LL, 8 & 9 Vict. CAP.C (1845). The CIL processed the applications for all private asylums within the Metropolis.


\(^{45}\) S.II LL, 14 Geo. III CAP.XLIX (1774). S.II LL, 9 Geo. IV CAP.XLI (1828); Hansard, 'Lunatic Asylums', (HC Deb 19 February 1828), cc. 585.

\(^{46}\) S.II LL, 14 Geo. III CAP.XLIX (1774). The continuity was also perpetuated by the fact that the Secretary could be appointed to a vacant barrister commissioner post, eight did so, and the medical and barrister commissioners could be appointed as an Honorary Commissioner when they stood down from a paid post, nine did so. See Appendix 2 (p. 217) for details. Mellett, 'Bureaucracy and Mental Illness', (p. 229).

\(^{47}\) UKPP, PSC, 1859 Session 1 (204), (p. 94).
a minimum of four visits per calendar year to each of the licenced houses in the Metropolis and two to those elsewhere. The visiting schedule for the public asylums, registered hospitals, Single Patients, workhouses, prisons, the military asylums and those for criminal lunatics remained at one in each calendar year.\textsuperscript{48} These visits could now take place on any day, at any time of day and for an unlimited period.\textsuperscript{49} Two additional visits, made by a single commissioner, were added to the schedule for the licenced houses in 1862.\textsuperscript{50} In 1881 the CIL resolved to add an extra visit in each calendar year to the hospitals admitting lunatics, the majority of whose patients were non-paupers.\textsuperscript{51} Visits to the hospitals for idiots, where the majority of the patients were paupers, stayed at one per year.

Another significant change implemented in 1845 was the reduction in the number of people appointed to the professional and lay commissioner posts. The MCL, charged with regulating private asylums within the Metropolis, comprised of a chairman, 15 commissioners, increased to 20 in 1842 to undertake the review of all the asylums in England and Wales, and a support staff of clerks.\textsuperscript{52} For a remit that covered the whole of England and Wales the number of commissioners was reduced to 11, of whom 6 were charged with making all of the inspection visits. These eleven comprised of a chairman, three commissioners who were doctors, three who were barristers and four who were laymen, all supported by a Secretary and two clerks.\textsuperscript{53} This staffing level remained unchanged despite the increase in patients detained in asylums from 12,600 in 1845 to 105,000 in 1910.\textsuperscript{54} In Scotland the Board of Lunacy comprised of ten people responsible for supervising

\textsuperscript{49} S.LXI & S.LXII S.XCII & S.CX LL, 8 & 9 Vict. CAP.C (1845). The founding members chose not to visit on a Sunday.
\textsuperscript{50} S.29 & S.30 LL, 25 & 26 Vict. CAP.CXI (1862).
\textsuperscript{51} UKPP, 'The Thirty-fifth Report of the Commissioners in Lunacy to the Lord Chancellor', 1881 (401), (pp. 106-7).
\textsuperscript{52} S.II LL, 9 Geo. IV CAP.XLI (1828). S.II LL, 5 & 6 Vict. CAP.LXXXVII (1842).
\textsuperscript{53} S.III, S.IV, & S.XI LL, 8 & 9 Vict. CAP.C (1845). The doctors and barristers, who had to be qualified for at least five years, were paid £1500 a year (£66,200 at 2020 prices). The Secretary, also a barrister with five years’ experience, was paid an £800 (£35,300) salary. The Chairman and Lay Commissioners had no salary, but all commissioners were paid expenses. Each of the clerks were paid £200 a year (£8830). Throughout this thesis cost figures for the identified year will be followed by a figure in brackets showing that cost at 2020 prices to aid understanding of the level of spending. All 2020 prices have been calculated using the Bank of England Inflation Calculator at Anonymous, 'Inflation Calculator', Bank of England, (2017) https://www.bankofengland.co.uk/monetary-policy/inflation [Accessed 27 January 2021].
\textsuperscript{54} UKPP, 'First Report of the Commissioners in Lunacy to the Lord Chancellor', 1847 (471), (pp. 3-4); UKPP, 'The Sixty-fourth Report of the Commissioners in Lunacy to the Lord Chancellor', 1910 (204), (pp. 237, 239, 241, 245).
about 10,000 lunatics and idiots.\textsuperscript{55} Surprisingly, the legislation did not include a clause allowing an increase in the number of commissioners, despite one that allowed for an increase in the number of clerks.\textsuperscript{56} Limitation on the resourcing and powers of regulators, not restricted to the CIL, was a consequence of the context within which systems of regulation were established.\textsuperscript{57}

**The context of regulation**

The development and implementation of systems of regulation in the eighteenth and nineteenth centuries, including that for asylum services, was part of a change in the governance of the United Kingdom. The traditional focus of the central government had been on defending the realm, managing international relations, setting economic policy and enacting legislation that permitted local provision of a range of services, such as prisons and support for the poor.\textsuperscript{58} In response to the effects of the changes brought about by the agricultural and industrial revolutions, an increase in population and urbanisation, and the perceived threat of revolution spreading from North America and continental Europe, the central government became more directly involved in what and how support services were provided locally so that similar standards prevailed across the kingdom.\textsuperscript{59} As part of this attempt to secure better local provision, An Act to Provide for the Regulation of Municipal Corporations in \textit{England and Wales} (the Municipal Corporations Act) (1835) sought to make the local authorities more effective and accountable.\textsuperscript{60} This greater central intervention did not initially extend to the funding of the improved

\textsuperscript{55} Sturdy, 'Boarding-out the Insane', p. 267.
\textsuperscript{56} S.XI LL, 8 & 9 Vict. CAP.C (1845). By 1877 there were nine clerks, all 'fully employed' UKPP, PSC, 1877 (373), (p. 33).
support that was to be provided and the local ratepayers were required to meet any consequent costs.

Whilst the objective of securing improvements that would benefit the general population was laudable, the interventions by central government were not always welcomed by all. Various commentators argued that the role of central government should not be extended into matters that were regarded as being local issues requiring local solutions. In his book *Local Self-government and Centralisation*, published in 1851, the political theorist and lawyer Joshua Toulmin Smith (1816-1869) argued that centralization was fundamentally undemocratic.61

Others, such as Thomas Malthus (1766-1834), Adam Smith (1723-1790) and Alexis de Tocqueville (1806-1859), described intervention by central government as ineffective, economically harmful and counter-productive respectively.62 Whilst these commentaries showed some of the concerns about the changes, the more important and immediate response came from the ratepayers.

The ability of the ratepayers to impact on the development of regulation came from their dual and interlinked role as the enfranchised electorate and the source of funding, through the tax and rates systems, for the service being proposed. The effect of their intervention could facilitate or impede the implementation of reforms.63 Legislation proposing improved protections and provision for the more vulnerable members of society arose from the impact of lobbying. The implementation of the requirement that all counties and boroughs provide asylum treatment for pauper lunatics and idiots from 1845 is a case in point. Pressure from reformers lay behind much of the effort to implement regulation. Lobbying and public pressure was also the mechanism used to impede the implementation of reform.

Lobbying was reported to have been used to limit the resources and powers of regulators and the number of people who would be protected and supported. An effect of these limitations was to contain the financial costs of

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providing a service or operating a business in compliance with any statutory requirements. An example of how such limitations impacted on the capacity of the regulator was that of the Mines Inspectorate, where one inspector was required to visit the 400 collieries in his district, deal with about 4000 items of postage, without clerical assistance, and attend various meetings and hearings on 50 days each year.\textsuperscript{64} Limitations were also placed on the numbers of people who were included in the protective arrangements. The risks of working in a factory were not restricted to women and children but lobbying by factory owners ensured it was only these groups that were afforded protection under the terms of the Factory Acts before 1878.\textsuperscript{65} By lobbying for such restrictions potential liability was limited.

Ratepayers concerns about meeting any financial costs, which could be substantial, from the implementation of the proposals from central government was also a topic of lobbying efforts. In the case of Devon, between July 1845 and March 1909 the ratepayers spent £275,000 (£36.2 million) on the building and expansion of the county asylum.\textsuperscript{66} This total did not include the annual running costs, which in 1908 amounted to £31,740 (£3.9 million).\textsuperscript{67} Between 1834 and 1910 the ratepayers of Devon also met the costs of building nineteen workhouses, spending over £114,700 (£13.1 million).\textsuperscript{68} Given these levels of expenditure it cannot be a surprise that the ratepayers attempted to influence the scale and quality of the provision being required or suggested. Some of this resistance was ameliorated by the introduction of the grant-in-aid payment system from the mid nineteenth century, where central government made monies available from general taxation to subsidise the provision of local services.\textsuperscript{69} Such payments enabled the Home Office to improve co-ordination of prison services and the

\textsuperscript{64} Mills, \textit{Regulating Health}, p. 102.
\textsuperscript{66} UKPP, 'The Fifty-fourth Report of the Commissioners in Lunacy to the Lord Chancellor', 1900 (246), (p. 224).
\textsuperscript{67} UKPP, 'The Sixty-third Report of the Commissioners in Lunacy to the Lord Chancellor', 1909 (213), (pp. 282-83).
development of school services.\textsuperscript{70} These payments were not always seen as beneficial. The CIL argued that payments to meet the difference in cost between a workhouse and an asylum place had resulted in the blocking of asylum beds with incurable cases.\textsuperscript{71} Sturdy reported that in Scotland this payment resulted in an increased number of paupers being designated as lunatics.\textsuperscript{72}

An alternative outcome that could result from lobbying was the redirection of where the benefits of regulation accrued. Most of the regulatory activity was targeted at the relief of the threats faced by the poorest and weakest members of society. In the case of the regulation of anatomy schools the picture was less clear cut. The purpose of An Act to Regulate Schools of Anatomy (the Anatomy Act) (1832) was to ensure there was an adequate supply of corpses to meet the needs of medical education and research, thereby ending the practice of bodysnatching.\textsuperscript{73} The theft of the corpses of the recently dead had become a business enterprise that, due to the inability to pay for a mausoleum or secure burial, primarily but not exclusively affected the poor.\textsuperscript{74} The Anatomy Act permitted any person who had ‘lawful Possession’ of a corpse to grant consent for it to be donated to an anatomy school for dissection, with the school becoming responsible for meeting the costs of internment of the remains.\textsuperscript{75} This legislation was credited with markedly reducing the business of bodysnatching, although not ending it completely. Ruth Richardson reported that the corpses of paupers continued to be removed for dissection, with a weighted casket being buried to disguise the fact.\textsuperscript{76} Despite the majority of the corpses that were dissected in the anatomy schools being those of paupers, the benefits of improved medical education and knowledge accrued to those who could afford medical care.\textsuperscript{77} Evidence from the studies by Elizabeth Hurren of the anatomy schools in Oxford and Cambridge show that asylums were one of the sources of corpses for

\textsuperscript{71} UKPP, 'Special Report of the Commissioners in Lunacy to the Lord Chancellor on the Alleged Increase of Insanity', 1897 (87), (p. 23); Edward Hare, 'Was Insanity on the Increase?', The British Journal of Psychiatry, 142 (1983), 439-455 (p. 441).
\textsuperscript{72} Sturdy, 'Boarding-out the Insane', pp. 79, 87-88.
\textsuperscript{73} LL, An Act for Regulating Schools of Anatomy (1832) (2 & 3 Gulielmi IV CAP.LXXV).
\textsuperscript{75} S.VII & S.VIII LL, 2 & 3 Gulielmi IV CAP.LXXV (1832).
\textsuperscript{76} Richardson, Death, Dissection, pp. 237, 263-64.
dissection. A similar effect can be seen in the regulation of asylums that favoured the non-paupers and those admitted to private asylums.

A further concern related to the process of centralisation. In order to expand its role, central government needed an increasing amount of information about the population to be collected, collated and analysed. The outcome was that the size of the civil service was increased and there were increases in the number of enquiries by Royal Commissions and PSCs. Chris Otter noted that this enlarged information holding by central government was equated with the despotic states of Europe. This combination of local and general concerns and the effects of lobbying, both for and against reform, impacted on the work and workings of the various regulators, including the CIL.

**The duties of the CIL**

The Lunacy Act (1845) defined the primary function of the CIL as protecting the vulnerable patients from harm. The CIL was to do this by confirming whether or not the facilities used and the care provided was in compliance with the legislation. This work started with the review of the application to operate a licenced house or admit lunatics or idiots to a hospital. It also included consideration of proposals for new public asylums. After the opening of an asylum, the CIL used inspection and monitoring and the licence renewal process for licenced houses to confirm ongoing compliance. Where noncompliance was identified the CIL tried to secure change so that compliance was achieved using various tactics, including persuasion, recommending the rejection of an application, recommending the revising or revocation of an existing licence and proposing that a prosecution be initiated. Overall, the duties of the CIL, the bulk of which were completed by the chairman, the professional commissioners and the clerks, can be divided into: Licencing and approval; Inspection; Monitoring; and Administration. Using the review of the legislation to show the duties of the CIL has highlighted the

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complexity of its agenda and how the inbuilt differences between the asylum types and patient groups made the securing of consistency a difficult task.

The licencing work of the CIL differed between the licenced houses, the hospitals, and the public asylums. When applying for a licence the applicant was required to supply: architects’ drawings for the premises to be used; details of the person who was to be the medical superintendent; the numbers of patients of each gender to be admitted; whether the patients would be paupers, non-paupers or a mix of these groups; and the rules for the management of the asylum, including the numbers of staff. Prior to formal application, the CIL met with the applicant(s), usually on the proposed asylum site, for an informal discussion. Within the Metropolis the formal application was made to the CIL; all others, before 1862, were to the JPs of the relevant county. After 1862 all applications from outside of the Metropolis were processed by the CIL and then forwarded, with a recommendation, to the relevant JPs. The Annual Reports do not include any statements about the specific recommendations on individual applications.

In contrast to the licenced houses, the process of approval of the hospitals was much simpler and before 1853 did not apply to the Bethlehem Hospital, an independent charitable foundation. The medical superintendent for each hospital had to apply for registration, supplying a copy of ‘The Regulations’ which defined how patients would be managed, with a copy having to be displayed in ‘the Visitors Room’. Only from 1853 were the submitted regulations subject to review and it was not until 1889 that a hospital registration could be revoked.

Different again were the arrangements for the approval of proposals for a new county or borough asylum. Here the JPs, meeting in Quarter Sessions, were required to appoint a Visiting Committee for each asylum to prepare architects’ plans, estimates of the costs of construction and operation and regulations for the management of the asylum. Like the private asylums, informal meetings would be held with the CIL as the proposals were developed. Prior to submission, the proposals had to be approved by the relevant Quarter Sessions, later County or

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82 S.XXIV LL, 8 & 9 Vict. CAP.C (1845).
85 S.XLIII LL, 8 & 9 Vict. CAP.C (1845). S.XLXXI LL, 8 & 9 Vict. CAP.C (1845). Failure to display the Regulations was a misdemeanour punishable by a fine of up to £20 (£2490).
87 UKPP, ‘The Thirteenth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1859 Session 2 (204), (pp. 32-33).
Borough Council. The application would be received and reviewed by the CIL, with further discussions taking place as required. The CIL made a non-binding recommendation to a Principal Secretary of State, normally the Lord Chancellor or Home Secretary, on whether to approve, revise or reject the proposal. Public asylums were not licenced even though it was permissible for some non-pauper patients to be admitted. From 1889 separate facilities for non-paupers could be built on a public asylum site, but these did not have to be licenced. The CIL could, and did, recommend that proposals for pauper asylums be rejected, but the local interested parties could lobby the Home Secretary, who approved the funding of public asylums. Often this proved successful in overturning the recommendation of the CIL. Whilst the CIL had a substantive role in this approval process, as this account shows theirs was not the final voice and criticism of the way that public asylums expanded is wrongly directed against them.

In reviewing the plans for new and alterations to existing asylums the CIL was assisted by a panel of architects. These architects were also involved in the preparation of the planning guidance issued in 1847 to assist in the development of proposals. This document, later updated by the CIL, detailed the issues that would be taken into account when assessing a proposal. By publishing this guidance the CIL was doing what it could to assist localities and try to secure some standardisation across England and Wales. Because of the differences between the proposed asylum sites, it was not possible to have a national standard asylum design, although prior to 1845 Jeremy Bentham (1748-1832) did suggest that the Panopticon design might be used.

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89 S.XXVIII LL, 8 & 9 Vict. CAP.CXXVI (1845).
91 UKPP, 'The Twenty-first Report of the Commissioners in Lunacy to the Lord Chancellor', 1867 (366), (pp. 4-7).
92 Scull, Most Solitary, p. 280.
93 Scull, Most Solitary, p. 277.
94 NA MH 50/1, pp. 285-86.
95 UK Parliamentary Papers (UKPP), 'Further Report of the Commissioners in Lunacy to the Lord Chancellor', 1847-48 (858), (pp. 323-26); CIL, Suggestions and Instructions in Reference to (1) Sites: (2) Construction and Arrangement of Buildings: (3) Plans: Lunatic Asylums, (London: For Her Majesty's Stationery Office by Eyre and Spottiswoode, 1894).
Each Visiting Committee was required to submit for approval by a Principal Secretary of State a copy of the ‘Rules for the Government of Asylums’. To assist the Committees and to secure some uniformity, the Home Secretary asked the CIL to prepare a draft of these for circulation. With caveats about their lack of universal applicability, the CIL published ‘Proposed Rules for the Government of Asylums’, (hereafter the Rules), in 1847. From 1853 the CIL were granted the authority, with the prior approval of a Principal Secretary of State, to make Rules for Licensed Houses. This power was used nine times.

The licencing and application approval work of the CIL can be seen as a bureaucratic process of form filling and box ticking, but that is to misunderstand the purpose of the exercise. Under the terms of the original legislation of 1774 this accusation applied as it was not possible for the regulators to reject an application. From 1828 the law allowed the MCL\CIL or JPs to reject applications, making the process of licencing an active part of securing appropriate accommodation for patients. The CIL used this power to try to ensure that the proposals for licenced houses did address the issues of concern, any failure to do so could lead to the approval being delayed. This happened in the case of the Holloway Asylum, which had been built without consultation with the CIL. In 1877 the application for a licence was delayed because the building was not compliant with the requirements. Action to achieve compliance delayed the opening for eight years and increased the cost from £150,000 to £207,300 (£17.8 million and £27.2 million respectively).

The CIL also tried to use this approach when dealing with the proposals for new facilities and additions to existing county asylums. Here they met with mixed success. In 1865 the Visiting Committee of the Kent (Barming Heath) Asylum

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97 S.XL LL, 8 & 9 Vict. CAP.CXXVI (1845).
98 UKPP, CIL, 1847-48 (858), (pp. 46-47, 329-36).
100 S.XVII & S.XVIII LL, 9 Geo. IV CAP.XLI (1828).
submitted plans for an extension to the existing site. The CIL had concerns about the scale and plans for this extension. Following discussions, the plans were revised and subsequently approved.\(^\text{102}\) In other cases, the apparent securing of an improvement might be frustrated by their lack of enforcement powers. In 1906 the plans for the new Yorkshire (Storthes Hall) County Asylum were approved, these showing that a stand-alone chapel was to be constructed. When the asylum was built however the chapel was omitted and, despite repeated criticisms by the CIL in their Annual Reports, the Visiting Committee refused to take any action.\(^\text{103}\) Without enforcement powers the CIL could do nothing. There are no reports of the approach being applied to any of the hospitals.

Between 1845 and 1914, the balance of the licencing work changed as the numbers of private asylums fell from 157 to 88. This reduction was counterbalanced by an increase from 21 to 95 in the numbers of public asylums, with many of these sites having to apply repeatedly for the approval of extensions and alterations.\(^\text{104}\) The Annual Reports do not record the full impact of this activity on the workload of the CIL. Reviewing samples of the Minutes of the Meetings of the CIL shows that discussion of proposed changes was often on the agenda.\(^\text{105}\)

This review of the licencing-approval work of the CIL shows that they had only limited powers. Whilst they could recommend approval, amendment or rejection of an application they had little control of the final decision made by a senior minister or the JPs. Whilst the Annual Reports record when new asylum buildings were approved, they do not include details of all discussions held. It is, therefore, not possible to conclude if the CIL had a consistent impact. In addition to the legislative constraints, the power of the CIL was limited by the resistance from the Visiting Committees and proprietors. This review starts to show the limitations on the authority of the CIL, a point recognised by Shaftesbury at the time and in the work of Mellett.\(^\text{106}\)

The model adopted for the development of services to support pauper lunatics and idiots was founded on the separation of these people from the

\(^{102}\) UKPP, CIL, 1866 (317), (p. 3); UKPP, CIL, 1867 (366), (p. 4).

\(^{103}\) UKPP, ‘The Sixtieth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1906 (224), (p. 25); UKPP, CIL, 1910 (204), (p. 422).


\(^{105}\) For examples see: NA MH 50/1, pp. 285-86; NA, MH 50/12, Commissioners in Lunacy Minute Book Volume 12: 1862-64 p. 4; NA, MH 50/28, Commissioners in Lunacy Minute Book Volume 28: 1894-95 pp. 3-4.

\(^{106}\) UKPP, PSC, 1877 (373), (p. 547); Mellett, ‘Bureaucracy and Mental Illness’, (p. 244).
community in large asylums provided at public expense. Only a very small proportion of patients, notably the wealthy, were provided for on an individual basis, the Single Patients. The involvement of the CIL in the supervision of Single Patients was limited to one visit a year after notification of detention had been received, with the provider not having to be assessed prior to the patient’s detention.\footnote{107} These arrangements were in marked contrast to the more widely used and regulated system of Boarding-out in Scotland.\footnote{108}

The second and most high-profile, and most time-consuming for the six professional commissioners, element in the workload of the CIL were the inspection visits to all locations where lunatics and idiots were detained. Whilst the results of the inspection visits will be presented in the next chapter, this section explores how the CIL organised and managed the schedule of these visits. As noted above, the legislation required that all locations where a lunatic or idiot was detained had to be visited in each calendar year, with the numbers of visits varying between the locations. Whilst there was certainty about the location of asylums, hospitals and Single Patients known to the CIL, the number of visits to workhouses, prisons and newly notified Single Patients varied from year to year. This made the logistics of the visiting schedule complex. Analysis of the Annual Reports showed the increase in the numbers of visits being made, as shown in Table 2.1.

\footnote{107 S.XCI & S.XCII LL, 8 & 9 Vict. CAP.C (1845).}
\footnote{108 Sturdy and Parry-Jones, 'Boarding-out Insane Patients', pp. 88-92.}
Table 2.1: Comparison of the Numbers of Visits Made and the Mean Number of Patients Seen by Type of Site, 1848-1908

<table>
<thead>
<tr>
<th>Year</th>
<th>Public asylums</th>
<th>Private asylums</th>
<th>Other locations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sites</td>
<td>Patients</td>
<td>Sites</td>
</tr>
<tr>
<td>1848</td>
<td>22</td>
<td>301</td>
<td>397</td>
</tr>
<tr>
<td>1858</td>
<td>39</td>
<td>406</td>
<td>318</td>
</tr>
<tr>
<td>1868</td>
<td>48</td>
<td>560</td>
<td>406</td>
</tr>
<tr>
<td>1878</td>
<td>59</td>
<td>659</td>
<td>354</td>
</tr>
<tr>
<td>1888</td>
<td>66</td>
<td>783</td>
<td>326</td>
</tr>
<tr>
<td>1898</td>
<td>76</td>
<td>945</td>
<td>270</td>
</tr>
<tr>
<td>1908</td>
<td>94</td>
<td>1,021</td>
<td>258</td>
</tr>
</tbody>
</table>

Notes: Public = County and Borough Asylums.
Private = Metropolitan Licensed Houses, Provincial Licensed Houses, Registered Hospitals and Asylums for Idiots.
Others = Single Patients, Workhouses, prisons, military, and criminal asylums.

The scheduling of visits was compounded in the early years by the lack of a road and rail infrastructure that allowed ease of movement around the country. To bring some order to the visits the CIL divided England and Wales into four circuits, as shown in Table 2.2. One medical and one barrister commissioner would be allocated to visit the asylums within the Northern, Midlands or Western circuits. The Home circuit was subdivided into three districts and one of the teams allocated to each. This arrangement resulted in the distribution of asylums and patients shown in Table 2.3. Even with this arrangement the schedule of visits involved each of the medical and barrister commissioners in more than 3000 miles of travel per year. The Chairman and Lay Commissioners could and did attend some inspection visits but had no formal role.

Table 2.2: List of the Counties in Each of the Visiting Circuits

<table>
<thead>
<tr>
<th>Circuit:</th>
<th>District:</th>
<th>Counties:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>a)</td>
<td>Cumberland, Westmorland, Lancashire, Chester &amp; part of Yorkshire.</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>Northumberland, Durham and part of Yorkshire.</td>
</tr>
<tr>
<td>Midlands</td>
<td>a)</td>
<td>Anglesey, Caernarvonshire, Denbighshire, Flintshire, Merionethshire, Montgomeryshire, Derbyshire, Staffordshire, Shropshire, Warwickshire and Leicestershire.</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>Nottinghamshire, Lincolnshire, Rutland, Northamptonshire, Huntingdon, Cambridgeshire, Norfolk and Suffolk.</td>
</tr>
<tr>
<td>Western</td>
<td>a)</td>
<td>Brecknockshire, Cardiganshire, Carmarthenshire, Glamorganshire, Pembrokeshire, Radnorshire, Herefordshire, Worcestershire, Monmouth, Gloucestershire and parts of Wiltshire and Somerset.</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>Remainder of Wiltshire and Somerset, Dorset, Devon and Cornwall.</td>
</tr>
<tr>
<td>Home</td>
<td>a)</td>
<td>The Metropolis, Surrey, Kent and Sussex.</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>Hampshire, Berkshire and Oxfordshire.</td>
</tr>
<tr>
<td></td>
<td>c)</td>
<td>Buckinghamshire, Bedfordshire, Hertfordshire and Essex.</td>
</tr>
</tbody>
</table>

Source: MHI:30 Minutes of the meetings of the Commissioners in Lunacy, 26th February, 1846, pp.193-195

Table 2.3: The Numbers of Asylums and Patients in Each Circuit, 1846-1906

<table>
<thead>
<tr>
<th>Circuit:</th>
<th>1846</th>
<th>1856</th>
<th>1866</th>
<th>1876</th>
<th>1886</th>
<th>1896</th>
<th>1906</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asylums</td>
<td>36</td>
<td>36</td>
<td>29</td>
<td>34</td>
<td>33</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>Patients</td>
<td>3016</td>
<td>4381</td>
<td>6612</td>
<td>10,484</td>
<td>14,840</td>
<td>19,909</td>
<td>26,329</td>
</tr>
<tr>
<td>Midlands</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asylums</td>
<td>32</td>
<td>39</td>
<td>36</td>
<td>38</td>
<td>38</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Patients</td>
<td>1989</td>
<td>3920</td>
<td>6134</td>
<td>7874</td>
<td>10,635</td>
<td>13,061</td>
<td>17,473</td>
</tr>
<tr>
<td>Western</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asylums</td>
<td>30</td>
<td>29</td>
<td>27</td>
<td>30</td>
<td>29</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Patients</td>
<td>2264</td>
<td>3440</td>
<td>5517</td>
<td>7361</td>
<td>8996</td>
<td>12,129</td>
<td>14,635</td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asylums</td>
<td>73</td>
<td>68</td>
<td>71</td>
<td>72</td>
<td>75</td>
<td>64</td>
<td>73</td>
</tr>
<tr>
<td>Patients</td>
<td>5326</td>
<td>8848</td>
<td>12,009</td>
<td>15,861</td>
<td>21,327</td>
<td>27,218</td>
<td>38,666</td>
</tr>
</tbody>
</table>

At inspection the CIL were required by the Lunacy Act (1845) to review and report on a total of twelve issues, defined in this study as the Specified Issues. These related to the admission and care of patients and the management of the asylum system and are set out in Table 2.4 where they are defined. The relevant clauses in the Lunacy Act (1845) included a catch-all phrase that permitted the CIL
to report on any other issues they identified as concerns. The twenty-five topics they identified, listed and defined as the Non-specified Issues in Table 2.5, encompassed a wide range of matters that could affect the well-being of the vulnerable patients.

### Table 2.4: The Specified Issues

<table>
<thead>
<tr>
<th>Issue title:</th>
<th>Definition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate statutory records</td>
<td>Where the CIL reported a failure to maintain the admission records, the registers of patients or the medical records and the failure to make the required submissions.</td>
</tr>
<tr>
<td>Inappropriate admission</td>
<td>Where the CIL noted that a patient should not have been admitted or should have been transferred to another asylum/prison, including the admission of idiot children to adult wards.</td>
</tr>
<tr>
<td>Divine Worship not provided</td>
<td>Where the CIL reported that patient attendance at Divine Worship in the Anglican tradition was low.</td>
</tr>
<tr>
<td>Inadequate diet</td>
<td>Where the CIL noted that the meals provided for paupers were inadequate or where a change in the dietary was required.</td>
</tr>
<tr>
<td>Inadequate occupation</td>
<td>Where the CIL noted that the number of patients usefully employed or participating in organised recreational activities was low.</td>
</tr>
<tr>
<td>Mechanical restraint used</td>
<td>Where the CIL reported cases of the use of mechanical restraint in the treatment of any patients.</td>
</tr>
<tr>
<td>More patients than registration</td>
<td>Where the CIL reported that the number of patients admitted to a licenced house was greater than the maximum patient number specified on the licence.</td>
</tr>
<tr>
<td>JPs not visiting</td>
<td>Where the CIL reported that Members of Visiting Committees, local JPs and the Guardians were not undertaking the required visits to all asylums within their jurisdiction.</td>
</tr>
<tr>
<td>State of mind of the patients</td>
<td>The CIL were to report if any patients appeared to them not to require continued detention.</td>
</tr>
<tr>
<td>The patient classification system used</td>
<td>The CIL were to report on how patients were classified at the various asylums.</td>
</tr>
<tr>
<td>Deception of Inspectors or Visitors</td>
<td>Where the CIL reported a deliberate attempt by a proprietor or medical superintendent to mislead a commissioner.</td>
</tr>
<tr>
<td>Costs of Services</td>
<td>The CIL were to report on the weekly cost of providing services for patients.</td>
</tr>
</tbody>
</table>

**Source:** The Lunacy Act (1845).

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110 S.LXI & S.CX LL, 8 & 9 Vict. CAP.C (1845).
<table>
<thead>
<tr>
<th><strong>Issue:</strong></th>
<th><strong>Definition:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcrowding reported</td>
<td>Where the CIL reported overcrowding or where the standard of 500 cubic feet per patient was breached.</td>
</tr>
<tr>
<td>Inadequate site</td>
<td>Where the CIL noted that the space on the site was insufficient for the size of the asylum and the number of patients.</td>
</tr>
<tr>
<td>Building in poor repair</td>
<td>Where the CIL noted that the building required work to bring it up to standard or the building was in a poor state.</td>
</tr>
<tr>
<td>Insufficient staff</td>
<td>Where the CIL noted that the staffing level was less than 1 attendant\10 patients, where the staff were noted to be of poor quality or where more than 20% of the staff were replaced year.</td>
</tr>
<tr>
<td>Inadequate heating</td>
<td>Where the asylum wards and corridors were noted to be cold.</td>
</tr>
<tr>
<td>Inadequate bedding</td>
<td>Where the CIL noted that the beds and bedding were in a poor state, needed to be replaced or were insufficient.</td>
</tr>
<tr>
<td>Inadequate clothing</td>
<td>Where the CIL noted that the patients' clothes were in a poor state, needed to be replaced or were insufficient.</td>
</tr>
<tr>
<td>Inadequate ventilation</td>
<td>Where the CIL noted that the ward and other patient areas were malodorous or excessively hot.</td>
</tr>
<tr>
<td>Inadequate management</td>
<td>Where the CIL noted that the asylum was being poorly managed or where the rules issued by the CIL were not being applied.</td>
</tr>
<tr>
<td>Inadequate furnishing</td>
<td>Where the CIL noted that the accommodation lacked chairs and other furniture and furnishings.</td>
</tr>
<tr>
<td>Inadequate water supply</td>
<td>Where the CIL noted that there was insufficient water or washing facilities for ensuring that all patients could be washed and if there was insufficient water for the control of a fire.</td>
</tr>
<tr>
<td>Multiple bathing</td>
<td>Where the CIL noted that patients were required to share the same water for bathing.</td>
</tr>
<tr>
<td>Assault: Staff on patient(s)</td>
<td>Where the CIL identified that a patient had been attacked or maltreated by a member of staff.</td>
</tr>
<tr>
<td>Assault: Patient on patient</td>
<td>Where the CIL identified that a patient had been attacked or maltreated by a fellow patient.</td>
</tr>
<tr>
<td>Assault: Patient on staff/visitors</td>
<td>Where the CIL identified that a member of staff or an official visitor had been attacked by a patient.</td>
</tr>
<tr>
<td>Patient suicide</td>
<td>Where the patient died as a consequence of a self-inflicted injury.</td>
</tr>
<tr>
<td>High death rates</td>
<td>Where the CIL noted that more than 10% of the number of admissions had died in a year or where the rate was above the average for the asylum type.</td>
</tr>
<tr>
<td>Unnatural death of a patient</td>
<td>Where the CIL noted that a patient had died as a consequence of injuries sustained in an accident or assault or from choking on food.</td>
</tr>
</tbody>
</table>
Table 2.5 (Continued):

<table>
<thead>
<tr>
<th>Issue:</th>
<th>Definition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect of patient(s) and duty</td>
<td>Where the CIL identified that the actions of a member of staff, including failing to follow the Rules of the asylum, caused harm to a patient. In the later reports the CIL defined the occurrence of pressure sores as an example of neglect.</td>
</tr>
<tr>
<td>Non-statutory records not kept</td>
<td>Where the CIL identified that an asylum had failed to maintain records that were required, but not those specified within the statutes.</td>
</tr>
<tr>
<td>Outbreak of infectious disease(s)</td>
<td>Where the CIL reported that patients had been infected by a communicable disease, eg. TB.</td>
</tr>
<tr>
<td>Seclusion used</td>
<td>Where the CIL identified in a report that patients had been placed in seclusion by the staff for any period.</td>
</tr>
<tr>
<td>Post-mortem rate low</td>
<td>Where the CIL commented that the rate was low or where the rate was less than the average for the year.</td>
</tr>
<tr>
<td>Inadequate fire precautions</td>
<td>Where the CIL noted in the reports that the prevention and control of fire was not adequate.</td>
</tr>
<tr>
<td>Death of an epileptic patient at night</td>
<td>Where the CIL reported that a patient had died in the night by suffocating during a fit.</td>
</tr>
</tbody>
</table>

Source: The main text and the appendices ‘Entries by Commissioners’ of the Annual Reports of the CIL 1845-1910

The establishment of the system of publicly funded asylums for the treatment of pauper lunatics was based on the idea that such provision would result in these people being restored as contributing members of society. Given the centrality of this purpose, it stood out that in none of the lunacy legislation enacted between 1845 and 1913 were the CIL charged with making any assessment of the effectiveness of the medical treatment being provided. It is also true that the CIL did not add this topic to the list of Non-specified Issues. That there was a problem with this fundamental concept rapidly became evident as the numbers of patients being discharged remained well below the level anticipated in 1845, with far fewer than the predicted number, about 80%, achieving recovery.\(^{111}\) From 1858 the CIL published the numbers of patients being admitted, discharged and those discharged as ‘recovered’, a term not defined.\(^{112}\)

\(^{111}\) Samuel Tuke, Description of the Retreat: An Institution Near York, for Insane Persons of the Society of Friends, repr. edn (London: W. Alexander, 1813; Charleston, SC: BiblioLife Reproduction Series 2015), p. 57. In assessing this prediction it is important to note that the patient groups were very different in terms of their demographic profile and that The Retreat provided for about 100 patients and had a large staff of attendants.

\(^{112}\) UKPP, CIL, 1859 Session 2 (204), (pp. 96-109).
data reported by the CIL shows that the mean percentage of patients discharged from the public asylums was 15% of the total patient population. This compared to the 25% for the private asylums. Of those reported as ‘recovered’, these percentages were 10% for the public asylums and 11% for the private asylums. These figures show that there was a turnover of patients but this was a small proportion of the total, with an even smaller proportion deemed as having ‘recovered’. The lack of monitoring of the effectiveness of treatment was noted by the medical profession in 1870 but this did not evoke an immediate response from the CIL or Parliament. In 1877 a review of the lunacy laws was undertaken by a PSC which led to the legislation being revised in 1889. The new act did not enable or require the CIL to monitor the effectiveness of the treatment provided. How much this exclusion was influenced by the establishment of the General Medical Council, (hereafter GMC), in 1858 cannot be determined.

Analysis of the legislation has made clear that major elements of the work of the CIL were defined but there were also significant areas left unspecified. The required minimum staffing for an asylum, the amount of dormitory and day space to be provided for each patient, the rules for the management of asylums and, not least, how the CIL should organise its own work were all left to the commissioners to determine. Defining these details was made more complex by having separate requirements for the pauper and non-pauper patients. Aspects of the Lunacy Act (1845) did apply to the pauper patients, but the bulk of this legislation was only applicable to the private asylums and non-pauper patients. The separate County Asylums Act (1845) addressed the arrangements for the provision and running of the publicly funded asylums for pauper patients. This separation was maintained in all of the amending legislation enacted until 1890. In that year legislation was enacted that brought all the various lunacy laws together within An Act to Consolidate Certain of the Enactments Respecting Lunatics (the Lunacy Acts Consolidation Act) (1890). Even within this Act there were separate sections for public and private asylums and the distinctions between the pauper and non-pauper patients were maintained.

114 UKPP, PSC, 1877 (373), (pp. iii-viii): LL, 52 & 53 Vict. CHAP. 41 (1889).
The detailed review of the Annual Reports shows how the CIL translated the legislation into its day-to-day activities. This reveals how its duties, ways of working and resourcing impacted on its effectiveness. For example, the Annual Reports showed that the commissioners visited a number of the private asylums with less than fifty patients on the same day. Visits to the larger asylums took between one, for those with up to about 500 patients, and four working days, for those with more than 2000 patients. As the public asylums increased in size and number, with the number of commissioners unchanged, the mean length of visit reduced, as shown in Table 2.6. Whilst visiting a district the commissioners would also complete visits to any Single Patients, workhouses, and prisons in the locality.

Table 2.6: The Mean Number of Days per Visit by Asylum Type

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>1867</td>
<td>1.38</td>
<td>*</td>
</tr>
<tr>
<td>1877</td>
<td>1.50</td>
<td>1.06</td>
</tr>
<tr>
<td>1887</td>
<td>1.33</td>
<td>1.00</td>
</tr>
<tr>
<td>1897</td>
<td>1.34</td>
<td>0.83</td>
</tr>
<tr>
<td>1907</td>
<td>1.18</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Note: * No data in the report for 1867 to calculate this figure.

With the visiting circuits established, the CIL took the decision that a different inspection team would make the visits in each year. This arrangement was devised to prevent the commissioners becoming overfamiliar with individual proprietors, Boards of Governors, Visiting Committees or medical superintendents. This is a very early description of the concept now identified as regulatory capture. Whilst this arrangement prevented one problem, it created another. The relationship between a regulator and the organisation being regulated is based on mutual understanding, a point made by David Roberts. As will be seen, repeated changes in who was conducting the inspection precluded this development, undermining the inspection process. The CIL never revised this decision, making it a lasting legacy of Shaftesbury and the founding commissioners.

117 NA MH 50/1, pp. 193-95.
118 UKPP, PSC, 1877 (373), (p. 563).
119 Baldwin, Cave, and Lodge, Understanding Regulation, pp. 43-45.
Whilst the details of each asylum inspection varied from site to site, a finding from the pilot study, the general shape and structure of the visit followed a pattern. The commissioners would arrive unannounced and would meet with the medical superintendent, the chief attendant, the matron and the clerk. They would visit all areas of the asylum in which patients were treated so that they could review compliance with both the Specified and Non-specified Issues that were appropriate to the location. It was a requirement that the commissioners speak to all of the patients admitted to a licenced house during each visit.\textsuperscript{121} Whilst not a requirement at the public asylums, the commissioners did claim that they had seen all of the pauper patients. For example, on a one-day visit to the Suffolk County Asylum on the 17 February 1876, the commissioners reported that ‘We have…seen all the patients’, a total of 437 people.\textsuperscript{122} They also reviewed all of the various records that the legislation required to be kept on each patient. The commissioners would meet with the chairman and members of the Visiting Committee or Proprietor if these people were available. At the conclusion of the visit, they would write their findings and comments into the Visitors Book.

As part of the inspection process, the commissioners were required to assess the benefits for the pauper patients of attendance at Divine Worship and of involvement in work and recreational activities.\textsuperscript{123} Examination of the visit schedule indicates that the amount of time available to undertake this activity was very limited. There are indications in the Annual Reports that the commissioners worked up to a ten-hour day during these visits. At a visit to a 1500 patient asylum taking three working days, the various meetings and review of the records would occupy at least one of those days. This left about twenty hours for the commissioners to meet with and assess the patients, which equates to less than one minute for each. Given this timeframe any patient assessment would have been superficial at best and, as acknowledged by Mr Charles Phillips (1822-1895), a barrister commissioner in his testimony to the PSC in 1877, involved talking ‘Out of 30 to about 10’ patients.\textsuperscript{124} Claims to have even seen all patients are less than credible in an asylum with several hundreds of people in detention.

\textsuperscript{121} S.LXI required that they ‘see every Patient’ in a ‘House or Hospital’, LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{122} UKPP, CIL, 1877 (403), (p. 273).
\textsuperscript{123} S.LXI & S.CX LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{124} UKPP, PSC, 1877 (373), (p. 457).
During inspection visits it was the duty of the CIL to confirm that the proprietor for the licenced houses, the Board of Governors of the registered hospitals and the Visiting Committee of the publicly funded asylums, were operating the asylum in compliance with the legislation. The CIL had no right or responsibility to impose a specific management solution where noncompliance was identified. To demonstrate the implications of this distinction: The Lunacy Act (1845) required that all licenced houses providing care for 100 patients or more had to have ‘a Physician, Surgeon or Apothecary resident as the Superintendent or Medical Attendant’.\textsuperscript{125} This could be achieved by having one qualified person employed to be on site at all times, any absences being covered by a locum; or by employing a Superintendent and an Assistant to share the duties; or by having a rota of qualified persons who shared the residency requirement between them. The proprietor decided which to use and the CIL noted whether the requirement was met by the method adopted. From 1890 the lunacy law allowed one variation by authorising the CIL to define what equipment for mechanical restraint could be used. This change did not permit them to decide which item on the approved list was used in any particular case.\textsuperscript{126}

The inspection process was not just the collection of information by the CIL on the state of a particular asylum, it also involved feedback to the medical superintendent and the Visiting Committee or proprietor. The founding members, led by Shaftesbury, shaped this feedback process by adopting a non-confrontational style when reporting instances of noncompliance. Shaftesbury made clear in his evidence to the PSC of 1859 that this was his preference, except in the case of persistent failure of compliance. He did accept that this approach could appear to be showing leniency towards infringement of the lunacy laws.\textsuperscript{127} Whilst this non-confrontational approach may have been consistent with the personality and working style of Shaftesbury, a point noted by his biographer Georgina Battiscombe, the fact that this was his publicly stated position could have undermined the ability of the CIL to achieve its objectives.\textsuperscript{128} As this thesis highlights, the founding members of the CIL had a lasting impact on the work and working of this organisation, which, as Murphy, Mellett and Bartlett argue, limited

\textsuperscript{125} S.LVII LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{126} S.40 LL, 53 & 54 Vict. CHAP.5 (1890).
\textsuperscript{127} UKPP, PSC, 1859 Session 1 (204), (p. 34).
the effectiveness of the regulator over time. Nevertheless, it needs to be noted that in the 1870s, the CIL in general and Shaftesbury in particular garnered praise from some in the medical profession:

Nothing has impressed us more forcibly during the present enquiry, so far as it has yet been carried, than the permanent and increasing value of the service rendered to the cause of humanity, and indirectly to the interests of medical science, by the Commissioners in Lunacy.

Lord Shaftesbury has established a claim upon general gratitude, and done more than sufficient to render a life of service, otherwise so remarkable, illustrious in the annals of social reform, and in a special sense entitled to the respect of enlightened medical men.

The CIL were not the only official visitors to the asylums, a point noted by Louise Hide. The County Asylums Act (1845) required members of each Visiting Committee to make a visit at least once a quarter, recording their comments in the Visitors Book. The CIL was tasked with confirming that these visits were being made as part of their review of this record. The Visiting Committee also had to submit an Annual Report to the relevant Quarter Sessions, with a copy forwarded to the CIL. After 1889 the report was to the Asylum Committee of the County or Borough Council. The JPs appointed from their number a group of Visitors who, accompanied by a medical practitioner, would make four visits per calendar year to each of the licenced houses within their jurisdiction. The proprietor of a licenced house and the Board of Governors of hospitals were also expected to make regular visits but these were not monitored by the CIL. Shaftesbury used the visits by

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129 See footnote 11 (p. 3).
132 S.XLV LL. 8 & 9 Vict. CAP.CXXVI (1845).
133 S.LXII LL. 8 & 9 Vict. CAP.C (1845).
134 In addition, visits were also made by the Masters in Lunacy, later Chancery Visitors, to wealthy patients whose financial affairs were under the control of the Court of Chancery. These visitors were appointed by the court as a separate protective measure. S.XCV & S.XC VI LL. 8 & 9 Vict. CAP.C (1845).
others to resist the need for an increase in the number of commissioners. His argument did not allow for the fact that the non-CIL visitors had distinct purposes and agendas, most being more concerned with day-to-day operational issues than with confirming compliance with the legislation.

The third element in the workload of the CIL was of monitoring the places of detention between the inspection visits through a series of information returns. Confirming compliance from infrequent inspection visits can only ever produce a snapshot of the conditions that applied in the location on the day of that visit. Whilst compliance can be confirmed during the visit, such as use of mechanical restraint being rare, this cannot be taken to mean that it was not routinely used when the commissioners were not present. To try to fill this gap the CIL, like other regulators, received information on a range of matters that were thought to be of value. Various clauses and the Schedules to the Lunacy and County Asylum Acts defined what was required, the format in which the returns were to be made and who should make the return. The Acts also allowed the CIL to define what other information it required and the format for presentation of this material. What information was collected was also influenced from within the medical profession, with calls for all public asylums to adopt a common format. The collection, collation, analysis and reporting of this information involved the commissioners and the clerks in a considerable amount of work, reflected in the increasing size of the Annual Reports over the review period, from eight to over 500 pages.

Receiving the information returns was not an end in itself, as suggested by Mellett, but an important part of ensuring patient safety. Information was received from the asylums, including copies of certificates and detention orders, notification of the outcome of admission, notice of the death of a patient, and a census of patients remaining. They also received a list of where all pauper lunatics were placed from the Poor Law Guardians. These returns generated a large and

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135 UKPP, PSC, 1859 Session 1 (204), (p. 95); UKPP, PSC, 1877 (373), (pp. 546-47).
136 S.LIV, S.LIX, S.LX, S.LXV & S.LXVI LL, 8 & 9 Vict. CAP.C (1845). Also Schedules to LL, 8 & 9 Vict. CAP.CXXVI (1845); LL, 16 & 17 Vict. CAP. XCVI (1853); LL, An Act to Consolidate and Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England (1853) (16 & 17 Vict. CAP.XCVII); LL, 25 & 26 Vict. CAP.CXI (1862); LL, 52 & 53 Vict. CHAP. 41 (1889); LL, 53 & 54 Vict. CHAP. 5 (1890).
137 John A. Campbell, 'Uniformity in Public Asylum Reports', Journal of Mental Science, XIX (1873), 67-78 (pp. 67-69).
increasing workload, with the number of detention orders alone increasing from about 8000 in 1858 to about 26,000 in 1906. One consequence of this increase was that the number of clerks employed rose from two to nine.\textsuperscript{140} The review of the admission documentation by the CIL staff identified a large but unspecified number which were poorly or inaccurately completed, potentially invalidating the admission.\textsuperscript{141} The frequency of these errors led to the CIL securing an amendment to the law which allowed them to ask for the correction of errors by the signatory to the certificate or order.\textsuperscript{142} Whilst this pragmatic solution dealt with the problem of completion errors, the document review did not consider the accuracy of the diagnosis.

By correlating the information from the asylums with that from the Guardians the CIL was able to identify if any county or borough was not providing sufficient places for paupers. This enabled the CIL to press for additional accommodation to be provided, as they did in 1870 in relation to the County of Middlesex. In that year there were 3751 people admitted to the Hanwell and Colney Hatch asylums, with another 906 in other asylums and workhouses.\textsuperscript{143} Without this wider overview the shortage of pauper asylum accommodation could not be fully identified.

The final element in the workload of the CIL was how the organisation was managed and administered. The materials from the licencing activity, inspection visits and the information returns were the subject of a formal review by the CIL at the time of submission so that decisions could be taken on any further action that might be required. The activities of the CIL generated a large administrative workload for both the commissioners and the clerks. The Lunacy Act (1845) specified that the CIL met on the first Wednesday in February, May, July, and November to receive and decide upon applications for licences and the renewal of licences. The Act allowed other meetings to be called and required that to be quorate the meetings had to be attended by at least five of the commissioners.\textsuperscript{144} The CIL determined that these four meetings were insufficient to deal with the

\textsuperscript{140} S.XI LL, 8 & 9 Vict. CAP.C (1845); Mellett, 'Bureaucracy and Mental Illness', (p. 226).
\textsuperscript{141} For examples see: UKPP, CIL, 1847-48 (34), (p. 18); UKPP, CIL, 1866 (317), (pp. 46-48). Anne Shepherd also identified certification errors in her study of two asylums in Surrey, Shepherd, \textit{Institutionalizing the Insane}, p. 124.
\textsuperscript{142} S.XI LL, 16 & 17 Vict. CAP. XCVI (1853).
\textsuperscript{143} UKPP, 'The Twenty-fifth Report of the Commissioners in Lunacy to the Lord Chancellor', 1871 (351), (pp. 20-24).
\textsuperscript{144} S.XV & S.XVI LL, 8 & 9 Vict. CAP.C (1845).
workload as early as 15 August 1845, about eleven days after enactment of the Lunacy Act.\textsuperscript{145}

In order to deal with their work, the CIL added two sets of meetings to those required by the Lunacy Act (1845). Once a month all of the commissioners met at their London office to recommend approval or rejection of the licence applications and renewals’ make formal policy decisions, or address issues relating to general concerns. Once a week all the available commissioners met in their London office to receive and review the inspection reports and any returns from the asylums. The weekly meetings only took place if at least one each of the medical and barrister commissioners were available.\textsuperscript{146} Decisions and recommendations made at the various meetings were processed and progressed by a combination of the commissioners and the clerks. I could find no evidence that these meeting arrangements, like other aspects of the working practices of this regulator, were ever reviewed or revised between 1845 and 1914. Additional meetings, for discussing proposed changes to an asylum with the proprietor or Visiting Committee or investigating a serious complaint, were held as required, some being held in their London office and some on-site at a particular asylum.

One of the duties of the CIL was to prepare a report in January and June on the state of the asylum services and the findings from their work. The June report was laid before Parliament and published as the Annual Report.\textsuperscript{147} The published Annual Reports of the CIL comprised of two parts: A statement of the condition of asylums services in England and Wales which highlighted issues of general concern, such as the increasing numbers of pauper patients; and a series of Appendices that included the statistical returns, details of the visits to the individual asylums, reports of the investigation of incidents or reports on issues, such as staffing, that had been completed. As already noted, the amount of detail and, in particular, statistical information included increased over time.

The core statistical information reported was the routine administrative data on patient movements through the asylum system: admissions, discharges and deaths, and numbers of patients at the start and end of each reporting year. The bulk of the additional materials gave details of the patients in the form of a series of tables showing the patient numbers by diagnosis, occupation, gender,

\textsuperscript{145} The Lunacy Act (1845) enacted on 4\textsuperscript{th} August, 1845, and decision made by the CIL at a meeting on 15\textsuperscript{th} August. NA MH 50/1, pp. 7-10.
\textsuperscript{146} NA MH 50/1, pp. 7-10; UKPP, CIL, 1847-48 (858), (p. 6).
\textsuperscript{147} S.LXXXVIII LL, 8 & 9 Vict. CAP.C (1845).
age and county of origin or combinations of these. The commissioners also included information about patient deaths and the causes of these, including the numbers of PM examinations completed. Reflecting another concern about services for paupers, the reports included details of the expenditures on asylum services, but only for the public asylums and the hospitals.

The collection of large amounts of information on an asylum system, including the patient population, that cost large amounts of public money to provide is unsurprising. This was particularly the case in a period when the collection of statistics was of increasing importance within the developing system of centralised government and governance. How useful this collection of information was is debatable. From the perspective of the regulator the various returns offered an insight into what was happening between inspection visits. Knowing that people were being discharged gave an indication that treatment could be effective. Other elements in the information were of less immediate use, such as knowing the five-year average of the number of patients admitted by age group and marital status. I would argue that, whilst some of the information was not of immediate use, in a period when little was known of the causation of lunacy and idiocy, this material could have value and subsequently prove to be of importance in the treatment and/or care of lunatics.

Conclusion

This chapter focused on outlining the duties of the CIL as set in the legislation of 1845; how they were a combination of legacy and novelty; how these duties changed over time; and how the resultant workload was organised. The results offer a first comprehensive picture of the day-to-day work of the CIL as a basis for evaluating its effectiveness. The approach adopted, that of detailed analysis of the lunacy legislation and the Annual Reports, has confirmed some of the findings from earlier studies of the CIL, such as the size of the workload, but has modified others, such as the CIL’s focus on a range of physical conditions in asylums, and shown how the organisation was affected by both external and internal

149 Mellett, ‘Bureaucracy and Mental Illness’, (pp. 234-35).
150 UKPP, ‘The Fiftieth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1896 (304), (pp. 112-13).
The longer time frame taken has shown that the CIL did change over time, adjusting some of the issues being reviewed and making allowance for changes in the patient population, but that the degree of this change was limited. The combination of legacy and novelty, derived from the way that internal and external factors interacted, impacted on the ability of the CIL to influence the way that asylum services were provided.

Given the degree of overlap between the earlier legislation and that of 1845, and beyond, the impact of legacy issues on the way that the CIL was able to perform its duties has not previously been examined in detail. One example of a legacy impact was that, despite the establishment of a national regulator, the licencing of private asylums remained a local function. Even when the CIL was charged with processing all applications for a licence, they did not have the final decision for areas outside of the Metropolis. This limited the capacity of the CIL to secure greater uniformity in local provision, one of the purposes of central regulation. The decision not to grant the CIL such power was one imposed by the legislators and reflected the ongoing debate on which powers were to be exercised by central and which by local government.

Comparison between the various Acts that applied to services for lunatics and idiots has shown that the regulation system was not monolithic: it could be reformed and had some inherent flexibilities. Reforms were derived from recognition that the laws of 1845 were, in some clauses, poorly framed. They also arose from the experience of implementing the legislation, an example being when the CIL successfully lobbied for the disbandment of the Private Committee for Single Patients. The flexibilities within the legislation related to the permission granted to the CIL to identify and report on any other issues of concern not specifically included. As will be seen in Chapter 3, they used this flexibility to substantially extend the list of matters routinely reported. There was also flexibility

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152 S.XIV & S.XVII LL, 8 & 9 Vict. CAP.C (1845).
156 S.XXXVII LL, 16 & 17 Vict. CAP. XCVI (1853).
157 S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
in how the CIL chose to implement their duties. It was the determination of the commissioners that the country be divided into circuits and that there should be an annual change in which team made the visits to each circuit, the latter choice was not replicated in Scotland.\textsuperscript{158} As will be seen in the following chapters, this decision by the founding commissioners had a lasting impact on the ability of the CIL to perform its duties, an effect emphasised by the length of service of the original commissioners.

The ending of the possibility of an annual change in commissioners in 1845 had a significant impact on the working of the CIL. Whilst it did allow the development of expertise, it also slowed the introduction of new ideas and approaches. This slow turnover was compounded by the appointment of retiring medical and barrister commissioners to honorary posts, so they could continue to be involved, and by allowing the Secretary to be appointed to a vacant barrister commissioner post, as shown in list of appointments at Appendix 2 (p. 225).\textsuperscript{159} The consequence was that changes to working arrangements were limited and delayed, most often such changes were provoked by external criticism.

Some of the earlier studies focused attention on the bureaucracy of registration as a problem that had to be overcome.\textsuperscript{160} This study shows how the CIL used a bureaucratic approach to the licencing and approval of proposals to ensure that asylums would be operated in compliance with the lunacy laws and to maintain standards in order to protect the patients from harm. The ability to delay an application could be a powerful tactic in persuading a Visiting Committee or proprietor to take action to address issues of concern to the CIL. But like all potential regulatory tactics, it had to be used with care. The potency of this tactic was limited by the fact that it was not the CIL that made the final decision on an application. Their recommendations were not always accepted by the Lord Chancellor or JPs. That some Visiting Committees and proprietors did respond to the recommendations of the CIL, when they could have resisted, has to be seen as a success.

\textsuperscript{158} Andrews, \textit{"They're in the Trade ... of Lunacy"}, p. 28.
\textsuperscript{159} S.XXXIX LL, 16 & 17 Vict. CAP. XCVI (1853).
In the years after the death of Shaftesbury in 1885 the CIL did not undergo any radical changes, but a new attitude did become evident. The implementation of more detailed reporting on the licensed houses, bringing them into line with the public asylums and hospitals, being one example.\textsuperscript{161} Another was the way that the CIL brought into public debate the issue of the numbers of commissioners. Including in the published annual report commentary on their need for more staff and recording the request to the Lord Chancellor to authorise a reduction in inspection visits, was a considerable shift in position.\textsuperscript{162} That it did not lead to an increase in the number of commissioners indicates the level of resistance to change within government that had to be overcome after 40 years of Shaftesbury insisting that an increase was not required. It is open to question whether the CIL could have done more to secure changes in their resources or workload.

It is clear from the foregoing that the agenda of the CIL imposed by the legislation was both large and complex, especially given the limited number of people appointed to complete the work. Despite the limited resources, the commissioners went on to add to this workload by including a long list of problems that they chose to address, the 25 Non-specified Issues, during the inspection visits. Even in the face of an increasing workload they did not reduce the issues that they had chosen to review. As the following chapters demonstrate, the commissioners did not adopt a minimalist approach to their duties, simply doing what the legislation required of them and nothing more. They were not complacent about their activities.\textsuperscript{163} It is also becoming clear that the activities of the CIL were subjected to a number of influences, some from within the organisation and others from external agencies with which the commissioners interacted.

In the following chapters the impact of the defined agenda, the working arrangements of the organisation, the limitations imposed on the CIL, and the various internal and external influences will be examined in relation to each stage of the process of regulation. In Chapter 3 the focus will be on the work of the CIL in inspecting the locations where lunatics and idiots were detained, showing what they identified during these visits and how these findings changed over the course of the review period.

\textsuperscript{161} UKPP, CIL, 1896 (304), (pp. 405-37).
\textsuperscript{162} UKPP, 'The Fifty-eighth Report of the Commissioners in Lunacy to the Lord Chancellor', 1904 (232), (pp. 82-83); UKPP, CIL, 1906 (224), (p. 73); UKPP, 'The Sixty-first Report of the Commissioners in Lunacy to the Lord Chancellor', 1907 (225), (p. 58); UKPP, 'The Sixty-second Report of the Commissioners in Lunacy to the Lord Chancellor', 1908 (200), (p. 50).
\textsuperscript{163} Scull, Most Solitary, p. 277; Smith, 'The Keeper Must Himself be Kept', pp. 211-12.
Chapter 3: Inspection and Monitoring

This chapter uses the Annual Reports to examine in detail the inspection visits undertaken by the CIL and the issues that they focussed on, covering the whole of England and Wales, encompassing an average of 157 asylums and as much of this regulators’ lifetime as the available records allow. This approach provides the first comprehensive analysis of the work of the CIL and is used here to show how it implemented the agenda set by the legislation, how that agenda was amended and the changes in their inspection findings over time. Mellett reported that the CIL collected a large volume of statistics.\(^1\) This chapter will show how this information was used to monitor the asylums during the periods between inspection visits and how the CIL augmented their inspection findings from the various information returns.

The Lunacy Act (1845) identified twelve issues that the CIL were required to comment upon during each of their visits, the Specified Issues, listed in Table 2.4 (p. 47). These represent a very mixed group of topics that can be divided into two diverse sub-groups. The first sub-group are those that encompassed issues that had been of concern since the middle of the eighteenth century, such as inappropriate admission.\(^2\) The second included issues that were of contemporary interest or the concern of particular interest groups, such as opportunities for work and recreational activities. In addition to these Specified Issues, the legislation allowed the CIL to address other issues of concern.\(^3\) The CIL identified a total of twenty-five of these, listed at Table 2.5 (pp. 48-49). These fell into three groups: patient safety; the physical environment; and administrative matters. The inspection findings for the Specified and Non-specified Issues are presented in separate sections in this chapter and are used to compare the conditions in the public and private asylums. A more detailed examination of the processes of inspection, and the strategies to effect change is made in the following two chapters.

The detailed reading of the Annual Reports, described in the methodology section of Chapter 1, has been used to identify the entries made in respect of each

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\(^1\) Mellett, *The Prerogative of Asylumdon*, pp. 95-134.

\(^2\) In the eighteenth century wife beating fell out of favour and was replaced by the use of confinement, see Elizabeth Foyster, ‘At the Limits of Liberty: Married Women and Confinement in Eighteenth-century England’, *Continuity and Change*, 17 (2002), 39-62 (pp. 40, 45).

\(^3\) S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
asylum by the commissioners on each of the Specified and Non-specified Issues. This data was tabulated for each asylum in each year in a spreadsheet for each of the asylum types. This approach allowed the results of the inspection visits to be reviewed at the England and Wales, asylum type and individual asylum levels. The presentation in this chapter is for each of the issues, except for the use of mechanical restraint and seclusion, staffing, attendance at Divine Worship and the number of PM examinations which are reported in Chapters 4 and 5, for all asylums throughout England and Wales for the years 1860 to 1910.

Having reviewed the results from the inspection visits, the chapter will consider how the CIL used the information returns to monitor the asylums between their inspection visits. Using examples of information relating to both Specified and Non-specified Issues, the section will show how the information was collected and analysed and how it augmented the results from the inspection visits. This section will also show how the CIL used the office-based licence renewal process as a means of confirming that the licenced houses continued to be operated in compliance with the law. These various results will show the overall reported level of compliance with the legislation and how this changed over time. This chapter will reveal important variations in what was identified and reported between the individual asylums, the public and private asylum groups, the individual commissioners, and over time. These results start to show why the historiography of the CIL has resulted in different conclusions being reached about this regulator when individual asylums were examined.4

**Inspection of the Specified Issues**

Although the lunacy legislation of 1845 required the CIL to report on the twelve Specified Issues, detailed analysis of the Annual Reports undertaken here has shown for the first time that they failed to comply with this requirement. For eight of these Issues the reports did include regular commentary; for the other four the reporting was either very intermittent or non-existent. Even for the statutorily required items that were regularly reported, not all of the information was collected. Consideration will be given in this section to, first, the long-standing concerns about asylums, and then the issues added in the legislation of 1845. As will be seen, the reporting discrepancies applied equally to both these groups.

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4 See literature review (p. 3-9).
Because of the concerns about the way that private asylums had been operated, it was the duty of the CIL to confirm that all such institutions detaining two or more lunatics or idiots were licenced. How they dealt with those that were not licenced is addressed in Chapter 6. During the inspection visits the CIL had to confirm that the licence was properly displayed, with no failures to do so being reported. They also had to confirm that the number and mix of patients, by gender and pauper/non-pauper designation, did not exceed the numbers on the licence. The CIL reported seven cases of such a failure between 1845 and 1910 and dealt with them by allowing the proprietor to discharge or transfer the extra patients. No legal proceedings were instituted. This approach was low key and reflected both the non-confrontational preference of Shaftesbury, and the similar approach used by other nineteenth-century regulators to address noncompliance.

The wrongful detention of people, in particular, wealthy women, had been a fundamental concern about asylum services that had prompted the implementation of regulation in 1774. Because of ongoing concerns in the Victorian period about unwarranted incarceration, the legislation of 1845 required that the CIL confirm that admission was and continued to be appropriate and justified. This they did through inspection and monitoring, the latter being discussed below. As part of the inspection the CIL was charged with reviewing all the certificates and detention orders for patients admitted since the last visit. They also had to review the Admission Book, Patients Book, Medical Visitation Book and Medical Case Book, in order to confirm that all of the required records on each patient were properly maintained. In this study these various documents have been defined as the Statutory Records. Analysis of the Annual Reports showed that a substantial minority (20%) of public asylums consistently failed to maintain all of these records, with a peak of nearly 40% doing so in 1896, as shown in Figure 3.1. This issue was reported less often in the private asylums, although the proportion did approximate to that of the pauper asylums in the years after 1896. Part of the lower incidence at

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6 UKPP, PSC, 1859 Session 1 (204), (p. 34); UKPP, PSC, 1877 (373), (p. 547); Bartrip and Fenn, ‘The Evolution of Regulatory Style’, (pp. 204-6).
8 S.LXV LL, 8 & 9 Vict. CAP.C (1845).
the private asylums was probably related to the much smaller numbers of patients, which reduced the number of records to be maintained. Part also appears to be due to the reporting practices of the CIL. The increased number of reports after 1896, when more detailed reporting on all private asylums was introduced, suggests that in the earlier years there had been some under reporting.

![Figure 3.1: Comparison Between the Percentage of Public and Private Asylums Reported for Inadequate Statutory Records, 1860-1910](image)

Source: The Annual Reports of the CIL to the Lord Chancellor 1860 to 1910.10

The fear of wrongful incarceration, along with burial, was a powerful concern in the nineteenth century.11 This fear was fed by the considerable uncertainty as to what constituted lunacy or idiocy and how these conditions were diagnosed. These uncertainties made wrongful incarceration a real risk. To try to identify cases, during the visits the commissioners were required to speak to each of the patients admitted to a licenced house, but not other locations, to ascertain if continued detention was required.12 Given the brevity of the visits it is unlikely that these contacts were meaningful. In her study of the wrongful incarceration of the wealthy, Wise reported on 30 cases in the period 1830 to 1901.13 An analysis of the Annual Reports showed a very small and uncertain number of cases, with these being reported to rather than identified by the commissioners. That these cases were identified from external reports raises serious questions about the accuracy of assessment by the commissioners and suggests that some may have been overlooked. However, analysis of the Annual Reports does not support the suggestion by Peter McCandless that the CIL was antagonistic to the possibility of

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10 Throughout this thesis all of the graphs are based on data from the Annual Reports of the CIL unless otherwise stated.
11 Mangham, 'Buried Alive', (p. 13).
12 S.LXI, S.LXVIII & S.LXXVI LL, 8 & 9 Vict. CAP.C (1845).
13 Wise, Inconvenient People, pp. 401-8.
wrongful detention.\textsuperscript{14} Rather, the CIL focussed on those patients who were being admitted to asylums that could not provide appropriate care. As an example, during visits to the Norfolk County Asylum and the Northampton County Asylum in 1885 the commissioners noted that idiot children had been admitted to adult wards, alongside manic and disturbed patients.\textsuperscript{15} Table 3.1 shows the numbers of cases of wrongful admission in selected years. Whilst the number of these admissions is small, those who were identified as being wrongly placed were increasing.

Table 3.1: Comparison Between the Instances of Wrongful Admission to Asylums by Type Reported by the CIL, 1858-1908

<table>
<thead>
<tr>
<th></th>
<th>1858</th>
<th>1868</th>
<th>1878</th>
<th>1888</th>
<th>1898</th>
<th>1908</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not insane</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Wrongly placed</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>

The CIL identified three groups of patients who were detained in the wrong institutions. The most frequently commented upon, but whose numbers were not reported, were the pauper lunatics detained in workhouses who the CIL thought should be in an asylum. Comments on these cases formed a regular element in the Annual Reports.\textsuperscript{16} The persistence of these reports shows that the CIL had little impact on resolving this problem and overcoming the resistance of the Poor Law authorities to transfer potentially treatable paupers to asylums. Even the payment of a subsidy of four shillings per patient per week, to offset the additional costs of an asylum placement, did not resolve this problem.\textsuperscript{17} When transfer of incurable patients to workhouses was attempted this could result in the patient being transferred back, as in the case of the Hereford County Asylum in 1896.\textsuperscript{18} The second largest group, considerably smaller than the first, were the children diagnosed as idiots who were admitted to adult wards in the County Asylums. Here the CIL advocated for specialist facilities to be provided within the existing asylum, if there were a sufficient number of cases, or for the child to be transferred to an

\textsuperscript{14} McCandless, 'Dangerous to Themselves and Others', (p. 88).
\textsuperscript{15} UKPP, CIL, 1886 (196), (pp. 212, 213).
\textsuperscript{16} Commentary on these cases and the debates with the Poor Law authorities was an element in the main text of the Annual Reports throughout the review period. For example see: UKPP, CIL, 1866 (317), (pp. 18-20); UKPP, CIL, 1909 (213), (pp. 68-69). There were also tensions between the CIL and the prison authorities about where criminals who suffered from lunacy should be detained. See Catherine Cox, "]Unfit for Reform or Punishment": Mental Disorder and Discipline in Liverpool Borough Prison in the Late Nineteenth Century', Social History, 44 (2019), 173-201 (pp. 185-86).
\textsuperscript{17} UKPP, CIL, 1897 (87), (p. 23).
\textsuperscript{18} UKPP, CIL, 1897 (279), (p. 259).
asylum for idiots, of which there were a small number.\textsuperscript{19} The third and smallest group were those patients whose care needs could not be properly met in the asylum in which they were detained. In many of these instances this problem resulted in the patient being mechanically restrained or secluded for long periods. One such case was that of a Mrs H at the Castleton Lodge Licenced House, Yorkshire. The high use of restraint was identified during an inspection in 1854. The recommendation of the CIL for Mrs H to be transferred was adopted and in the Annual Report of 1855 the CIL recorded that following transfer Mrs H was much improved and restraint discontinued.\textsuperscript{20} The incorrect placement of patients was more frequently reported in relation to the public than the private asylums, as shown in Figure 3.2, but in both cases the overall proportions were low. The reason for the spike in reported cases at the public asylums in 1884 cannot be ascertained from the Annual Report.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.2.png}
\caption{Figure 3.2: Comparison Between the Percentage of Public and Private Asylums Reported for Inappropriate Admissions, 1860-1910}
\end{figure}

It is possible that the number of inappropriate admissions of paupers was an underestimate due to two linked factors that combined with the problems of diagnosing lunacy. The first of these was the limited and declining amount of time available for assessing pauper patients in public asylums during the inspection visits, as shown in Table 2.6 (p. 51). The other was that, given the CIL were not empowered to discharge a wrongfully admitted pauper patient, it is open to

\textsuperscript{19} UKPP, CIL, 1886 (196), (pp. 212, 213, 242). Separate facilities were to be provided under the terms of LL, An Act for Giving Facilities for the Care, Education, and Training of Idiots and Imbeciles (1886) (49 Vict. Ch.25). There were ten designated Idiot Asylums by 1910.

\textsuperscript{20} UKPP, CIL, 1854 (339), (p. 42); UKPP, ‘The Ninth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1854-55 (240), (pp. 26-27).
question how much effort they put in to looking for such cases.\textsuperscript{21} The schedule for the inspection visits was already long and time-consuming, even without this task.

The failure of JPs to make visits to the asylums within their jurisdiction, first identified in the evidence to the PSC on Lunacy of 1814, was an issue that the MCL noted in their report of 1844.\textsuperscript{22} The CIL were required to include an assessment of whether these visits were being made at each inspection.\textsuperscript{23} Over the years 1845 to 1910 commentary on whether these visits were being made was included each year in an average of only four of the records of site visits, with the majority of these referring to the public asylums. The failure to include these reports in each instance was not the subject of any commentary. An issue that was unreported was any instance of a proprietor attempting to deceive a commissioner. This lack could be from the deception having been successful and unidentified. Whilst the identification of an attempted deception could be an indication of efficiency, the reporting of such an attempt might undermine the credibility of the CIL by showing others potential organisational weaknesses.\textsuperscript{24} Again, the lack of reporting was not subject to comment.

The second sub-group of the Specified Issues were those that were introduced in 1845. The achievement of a higher cure rate, by the use of moral therapy, was central to the decision to require all counties and boroughs to provide treatment for pauper lunatics. Despite this, the CIL were not charged with reviewing the results of the treatment provided. Instead, they were required to report on three of the elements of the treatment regime: attendance at and the benefits for the patients of work, recreational activities and Divine Worship (the latter is discussed in Chapter 4). For both work and recreational activities, a distinction was drawn between the pauper and non-pauper patients. For paupers, the expectation was that they would undertake work and participate in the recreational activities provided for them.\textsuperscript{25} The interest in how people used their time in asylums was part of a wider concern in Victorian and Edwardian society

\textsuperscript{21} S.LXVI, S.LXVII & S.LXVIII LL, 8 & 9 Vict. CAP.C (1845). S.LXV & S.LXXI LL, 8 & 9 Vict. CAP.CXXVI (1845). Pauper patients who asked the commissioners to be discharged were referred to the Visiting Committee, for example see: UKPP, CIL, 1886 (196), (p. 143).
\textsuperscript{22} UKPP, PSC, 1814-15 (296), (p. 4); UKPP, PSC, 1826-27 (557), (pp. 6, 7); UKPP, PSC, 1839 (356), (p. iii); UKPP, MCL, 1844 (001), (p. 51); Smith, 'The Keeper Must Himself be Kept', pp. 202, 208.
\textsuperscript{23} S.LXII LL, 8 & 9 Vict. CAP.C (1845). S.XLV LL, 8 & 9 Vict. CAP.CXXVI (1845).
\textsuperscript{24} Baldwin, Cave, and Lodge, \textit{Understanding Regulation}, p. 71.
\textsuperscript{25} For examples see: UKPP, CIL, 1881 (401), (pp. 303-4); UKPP, CIL, 1887 (200), (p. 325).
about malingering, the deliberate avoidance of work. In the case of the lunatics and idiots the application of the designation of malingerer was complicated by the need to distinguish between those deliberately avoiding work and those whose mental and/or physical condition precluded them from participating in work or recreational activities. In contrast, the non-paupers, who paid for their own treatment, were not expected to work and their recreational activities could be self-organised. Examples of the latter were reported by the CIL in 1896, when they noted that ‘a considerable number’ of the non-pauper patients at the Newlands Asylum, London, ‘have frequent carriage exercise’, whilst those at The Briars asylum, Isle of Wight, were enjoying their ‘afternoon siesta’. Overtly the employment of pauper patients was a fundamental element in the treatment regime. However, having patients undertake a range of duties, from cleaning the wards to working on the asylum farm or in the workshops, also had a financial benefit for the asylums.

The review of the Annual Reports showed that if less than about 40% of pauper patients undertook work or attended the organised recreational activities the CIL commented on the fact. Why this particular figure was used is not explained, but the consistency with which it was used suggests it was a target figure adopted by them. The work the patients undertook was gendered, with the women being employed in domestic duties and the men in more physical labour on the asylum estate. Waltraud Ernst, in the introduction to *Work, Psychiatry and Society* argues that different values were ascribed to the work being undertaken, with the production of foodstuffs and goods (men’s work) being given a higher value than domestic duties (women’s work). Hide has noted that this division started to change in the early twentieth century at some asylums in London. Whilst employment was recognised as one element in the moral therapy regime of trying to re-establish acceptable behaviour by persuasion, its secondary role of

27 UKPP, CIL, 1896 (304), (pp. 411, 417).
28 For examples see: UKPP, CIL, 1862 (417), (pp. 104, 106).
contributing to the reduction in the operating costs of the pauper asylums was sometimes noted.\textsuperscript{31} The recognition of the issue of cost savings can be seen from an incident at the Bristol Borough Asylum in 1888. During the inspection the patients informed the commissioners that they had ‘refused to work’ because their tobacco allowance had been stopped. The CIL thought stopping this allowance was a ‘short-sighted policy’ that would lead to increased costs as additional and higher paid staff would ‘have to be engaged’.\textsuperscript{32} The place of employment in the moral therapy regime of pauper patients appears, from the reports of the CIL, to have been more than just part of their treatment. This distinction can also be seen in a comparison between the work of middle-class patients at the Bethlehem Hospital (reading, writing and drawing) and paupers in county asylums (manual labour) completed by Nancy Chaney.\textsuperscript{33} For the non-pauper patients the commissioners did not report on how or if they undertook work within the asylum. The absence of reporting on those patients who paid for their care suggests that the CIL thought it inappropriate for these people to undertake work. This differentiation between the patient groups adds weight to the argument that the work paupers undertook was not solely therapeutic.\textsuperscript{34}

Reports on work and recreational activities showed a marked difference between the public and the private asylums, as shown in Figure 3.3. Before 1900 a substantial minority, about 40% on average, of the public asylums were shown to be failing to get enough pauper patients involved in work and recreational activities. The marked reduction in noncompliance after 1900 suggests that the CIL had been able to secure changes. However, analysis of the reports showed a change in policy that influenced what was reported. From 1900 the CIL made allowance for the increasing number of incurable patients who did not have the physical and/or mental capacity to participate in work or recreational pursuits. Whilst the purpose of work was as an element in the securing of a cure, the comments made by the CIL in their Annual Reports suggest that concern about the low rate of employment was strongly associated with the benefits that accrued to the asylum. Insufficient working patients both led to increases in ‘the cost of maintenance’ and the amount

\textsuperscript{32} UKPP, CIL, 1887 (200), (p. 294).
\textsuperscript{33} Chaney, 'Useful Members of Society', pp. 278-79.
\textsuperscript{34} Ernst, 'Work, Psychiatry and Society', p. 8.
of ‘menial duties’ that had to be performed by attendants.\textsuperscript{35} At the private asylums the commentary on the lack of occupation and recreational activities were only applied to the pauper patients, even then infrequently.

One aspect of the topic of work and recreational activities that went unreported by the CIL was that of the effects on and benefits for individual patients.\textsuperscript{36} The problem for the commissioners was how to identify in any individual what benefits might have accrued from participation in these activities. In the face of this difficulty, the CIL ignored the topic. The lack of reporting went unremarked, making this another example of how this regulator could adjust its defined agenda.

A second contemporary Specified Issue related to the mental and bodily state of the pauper patient on admission and the diet during detention of the pauper patients.\textsuperscript{37} There was recognition of a link between an improved diet and the relief of lunacy.\textsuperscript{38} The CIL was authorised to require changes to the diet of pauper patients.\textsuperscript{39} The grant of this power was probably linked to the scandal about the misuse of resources and the savings made on the feeding of the paupers at the Andover Workhouse.\textsuperscript{40} Changes in diet did have a cost consequence that had to be met by the local ratepayers. The financial reports for the public asylums show that, on average, it cost about £13 per year (£1600) to feed each patient out of a

\textsuperscript{35} UKPP, CIL, 1904 (232), (p. 316).
\textsuperscript{36} S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{37} S.CXI LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{38} UKPP, MCL, 1844 (001), (pp. 118-19); Tuke, Description of the Retreat, pp. 123-26; John A. Campbell, ‘On the Appetite in Insanity’, Journal of Mental Science, 32 (1886), 193-200 (pp. 193, 194-95).
\textsuperscript{39} S.LXXII LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{40} S.LXXXII LL, 8 & 9 Vict. CAP.C (1845); UKPP, ‘Report from the Select Committee on Andover Union; Together with the Minutes of Evidence, Appendix and Index’, 1846 (663-I)(663-II), (pp. vi-vii).
total cost of £28 per year (£3500). With about 46% of the cost being on food, this budget element was a target for savings, as attempted by the Buckinghamshire County Asylum Visiting Committee. The provision of a good diet could contribute to securing an improvement in the condition of the patient, a change that might enable that person to be discharged. However, the number of patients who might have benefitted to this extent was not known. Given the uncertainty of the potential benefit the Visiting Committees continued to seek savings, including from the budget for food, contributing to the impression that cost reduction was a higher priority than effective treatment.

In order to identify the diet being provided to the pauper patients at the public asylums the CIL requested the weekly menu from each institution, a similar request was not made to any of the private asylums that admitted pauper patients. The results of this survey, published in the Fourth Annual Report in 1854, showed that male and female patients had separate menus, with the portions for the women being smaller. This survey was not repeated nor ever extended to the private asylums. During the inspection visits the CIL monitored the meals provided and were present when these were served. They reported a total of 393 failures to provide an adequate diet, 337 at the public asylums. Only six asylums were reported more than ten times. In the majority of cases the food provided to pauper patients was reported as adequate by the commissioners. The lack of detail in the Annual Reports means that it is not possible to determine whether the diet was nutritionally adequate or if it was being used as a means of covert patient control. Scull suggested that by keeping the pauper patients underfed the staff could better exercise control of unwanted behaviours.

There were two of the contemporary Specified Issues that the CIL did not fully report during each visit. The first was information on the costs of all asylum services. Instead, they only published the accounts of the public asylums and the Registered Hospitals. Unlike the PLC, the CIL did not attempt to secure a standard

41 UKPP, CIL, 1881 (401), (p. 102). The cost figures are the mean for all public asylums.
44 UKPP, CIL, 1854 (339), (pp. 77-115).
45 For examples see: UKPP, ‘The Thirty-second Report of the Commissioners in Lunacy to the Lord Chancellor’, 1878 (337), (pp. 290, 293).
46 These were the county asylums for Oxford (14), Durham (12), Kent (Barming Heath) (11), Somerset (Wells) (11), Suffolk (11) and Wiltshire (11).
47 Scull, Most Solitary, p. 291.
accounting system within all the public asylums.\textsuperscript{48} The absence of this information in respect of the licenced houses was not explained but may have been affected by the concept in the Victorian period that the accounts of private businesses were, where they existed, strictly confidential.\textsuperscript{49} The other issue where reporting was very limited related to the system of patient classification used at individual asylums. Occasionally a listing of the proportion of admissions in each diagnostic group was recorded.\textsuperscript{50} These failures of compliance by the CIL went without comment, suggesting they were uncontroversial at the time or that the senior ministers were complacent about the matter.

This review of the Specified Issues has highlighted that the CIL only identified a minority of both the public and private asylums failing to achieve compliance of the six issues included here between 1845 and 1910. Four issues were only partially or not reported on by the CIL, either from a combination of an inability to make a report, as on the benefits of work and recreational activities, or a positive decision not to do so, the accounts for private asylums being an example. These outcomes show that whilst the agenda of the CIL was set by the legislation, they did use the leeway, available from some of the phrasing used by the drafters (such as ‘shall consider the Observations made in the Visitors Book by the Visitors appointed by the Justices’ where the meaning of ‘consider’ was not defined), that was available to make some changes.\textsuperscript{51} This leeway was needed because, as the results of the analysis of the Annual Reports show, some issues, such as non-Visiting by JPs, reflected historical rather than existing problems.\textsuperscript{52} Leeway was also needed because some information, such as the benefits to individual patients of work and recreational activities, were not available for reporting. In the years before 1896, public asylums were frequently reported as being noncompliant.

\textsuperscript{48} Verna Care, ‘The Significance of a “Correct and Uniform System of Accounts” to the Administration of the Poor Law Amendment Act, 1834’, \textit{Accounting History Review}, 21 (2011), 121-142 (p. 136).
\textsuperscript{50} See for example: UKPP, ‘The Thirty-fourth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1880 (321), (pp. 36-37); UKPP, ‘The Thirty-ninth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1884-85 (285), (pp. 48-49).
\textsuperscript{51} S.LXI LL, 8 & 9 Vict. CAP.C (1845). In this context ‘consider’ could mean anything from reading the entry to detailed discussion at a meeting of the CIL.
\textsuperscript{52} MacDonagh, ‘Nineteenth-Century Revolution in Government’, (pp. 58-61); Baldwin, Cave, and Lodge, \textit{Handbook of Regulation}, p. 7.
that year the gap between the two groups of asylums narrows. The more detailed reporting on private asylums, matching that at the public asylums, partly explains this shift. This outcome also suggests that the reports of the level of noncompliance for the private asylums before 1896 were an underestimate.

**Inspection of the Non-specified Issues**

No predetermined list of topics to be examined during an inspection can ever be fully comprehensive. To cover this contingency, the legislation included a catch-all phrase that allowed the commissioners to determine issues that they considered to be matters of concern, both long-standing and emergent.\(^53\) Analysis of the Annual Reports showed that twenty-five Non-specified Issues were identified, the vast majority in the years before 1850. As will be seen, the list of Non-specified Issues was amended, with some being adjusted and others added in the light of experience and in response to pressure and criticism. Of the total, thirteen related to patient safety, ten to the physical environment, and the remainder to administrative matters. Two of the twenty-five, staffing and the numbers of PM examinations, are to be reviewed and discussed in Chapters 4 and 5 respectively. Also discussed in Chapter 4 will be the use of seclusion, as this was closely linked by the medical practitioners and the CIL to the use of mechanical restraint.\(^54\)

Within the patient safety group, the commissioners identified three forms of assault by staff on a patient, by a patient on another patient, and by a patient on staff. The total reported number of each are shown in Table 3.2. Given the large numbers of patients detained in asylums over the review period, about 105,000 in 1910 alone, this was a low rate. In all three forms of assault, the major problem faced by the CIL was in securing evidence that an incident had happened and who was responsible. Because of this problem the number of cases reported by the CIL is very likely to have been an underestimate, particularly for the first two groups in Table 3.2. A strong positive correlation was found between each of the forms of assault and reported overcrowding in the public asylums, \(r_s = +0.7\). This link was not found in the results for the private asylums.

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\(^{53}\) S.LXIV & S.CX for the private and public asylums respectively LL, 8 & 9 Vict. CAP.C (1845).

\(^{54}\) UKPP, CIL, 1854 (339), (pp. 40-43, 123-209); UKPP, CIL, 1880 (321), (p. 182). S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
Table 3.2: Comparison Between the Reported Numbers of Each Form of Assault by Asylum Type, 1860-1910

<table>
<thead>
<tr>
<th>Assault Type:</th>
<th>Public:</th>
<th>Private:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff on patient</td>
<td>425</td>
<td>107</td>
</tr>
<tr>
<td>Patient on patient</td>
<td>528</td>
<td>34</td>
</tr>
<tr>
<td>Patient on staff/visitor</td>
<td>219</td>
<td>23</td>
</tr>
</tbody>
</table>

Because the CIL recognised that patients were 'so much in the hands of attendants, that it is of the utmost importance to punish proved assaults, as a warning to others', they paid particular attention to the assaults by staff on patients. The distribution of the identified cases, as shown in Figure 3.4, shows that, whilst they were more common in the public than the private asylums, such cases occurred in a minority of sites. Within the public asylums group, the six with the highest numbers of reports accounted for seventy-seven of the incidents that were reported. The pattern of these assaults showed a gentle upward trend throughout the review period, with a sharp upturn between 1896 and 1905. This peak coincided with the Boer Wars, when some asylums, notably in locations with military connections (such as Hampshire, Devon, and Yorkshire), had problems in retaining and recruiting male attendants because they had been called or recalled to the colours. Amongst the private asylums group the incidence of these assaults was generally low, being reported at less than 5% of the sites. Examination of the data for the licenced houses showed that the highest number of reports related to two of the largest private asylums for paupers in the Metropolis (Camberwell House and Peckham House) and to an asylum in Wiltshire that provided care for highly complex cases, many of whom were paupers (Fisherton House).

55 UKPP, CIL, 1884 (280), (p. 326).
56 The asylums and reported incidents were Kent (Barming Heath) and Birmingham (Winson Green) 15 each, Durham 14, Cheshire (Parkside) 12, Hampshire 11, Shropshire 10.
57 UKPP, CIL, 1900 (246), (p. 50).
There were two major problems with the identification and investigation of an assault by a member of staff. Firstly, that of securing reliable evidence from the victim and any witnesses that an assault had taken place and, secondly, if the assailant was prosecuted, whether the court would accept evidence from people detained in a lunatic asylum.\textsuperscript{58} On the issue of the credibility of lunatics as witnesses, the CIL erred on the side of caution, noting in their report of 1874 that they had to make allowance for the untrustworthiness of evidence from patients.\textsuperscript{59} Nor could all the evidence from staff be relied upon as in some instances people made statements to protect their colleagues from prosecution or reported injuries from an assault as the result of an accident.\textsuperscript{60} A member of staff assaulting the patient was classified in the lunacy laws as a prosecutable offence and the outcome of the cases reported by the CIL will be examined in Chapter 6.

Patient on patient assaults were equally problematic to identify. Whilst such an assault was not an offence under the lunacy laws, a patient could be prosecuted under the criminal law when the assault resulted in serious injury or death. At the trial the patient would usually be deemed unfit to plead and the court would order that the offender be transferred to an asylum for the criminally insane.\textsuperscript{61} Analysis of the Annual Reports showed that patient on patient assaults were reported in a minority of public asylums, less than 20%, in the years up to

\textsuperscript{58} For instances where there was a lack of credible witnesses see: UKPP, CIL, 1878 (337), (pp. 143, 249-50).
\textsuperscript{60} UKPP, CIL, 1878 (337), (pp. 188-89); UKPP, CIL, 1900 (246), (p. 304); UKPP, ‘The Twenty-sixth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1872 (279), (p. 68).
1905. After that date the proportion increased sharply to about 40% of sites. The reason for this upsurge cannot be identified from the Reports but increased overcrowding may have been a contributory factor. At the private asylums, where overcrowding was not a major issue, the rate was very low.

The other form of assault by patients, those on staff or visitors, was used by the CIL to emphasise the risks of working in asylums and the need for good pay, conditions and pensions. They also noted the risk faced by themselves, citing the assaults on the barrister commissioners Robert Lutwidge (1802-1873), in 1873, and George Urmson (1851-1907), in 1901. Both occurred during inspection visits and Mr Lutwidge died from the injury he sustained. Between 1870, when the CIL started reporting these cases, and 1910 there was a total of 242 reports, of which 219 related to the public asylums. The rate varied from year to year but there was a definite upward trend. A similar but much smaller increase occurred at the private asylums.

Harm could also come to a patient if staff were negligent in performing their duties, leaving suicidal patients unsupervised or not properly securing razors or drugs being examples. From about 1870 the CIL also noted when staff failed to prevent patients from developing a pressure sore as a form of neglect. Because neglect was a prosecutable offence, the CIL were careful to take account in their investigations of the Rules and working practices of the institution in recognition that these may have contributed to the incident. Most instances of neglect that were reported related to accidents where a patient was injured. One example was the case of patient W.J. at the Cambridgeshire County Asylum in 1876 who, whilst being bathed by an unnamed attendant, had fallen and sustained injuries from which he died. The neglect arose because the attendant failed to promptly report the accident to a medical officer. Depending on the seriousness of the harm caused the CIL made recommendations on any disciplinary or other action that

63 UKPP, CIL, 1874 (284), (p. 1); UKPP, 'The Fifty-fifth Report of the Commissioners in Lunacy to the Lord Chancellor', 1901 (245), (p. 13).
64 A pressure sore is an area of damage to the skin and underlying tissue caused by unrelieved direct pressure. These sores can be prevented by regular turning from side to side or, if capable, getting the patient stand so that the pressure is relieved. Jane Mallett and Lisa Dougherty, eds., The Royal Marsden Hospital Manual of Clinical Nursing Procedures, 5th edn (Oxford: Blackwell Scientific, 1992; 2000), p. 690; UKPP, CIL, 1870 (340), (p. 182).
65 S.LVI & S.LXXVII LL, 8 & 9 Vict. CAP.C (1845). Separate clauses for private and public asylums respectively. The prosecutions for this offence will be discussed in Chapter 6.
66 UKPP, CIL, 1877 (403), (p. 180).
they thought should be taken by the Visiting Committee or proprietor, including prosecution.67

The reported incidence of neglect of duty or patients shows that cases were more common in the public than the private asylums, as shown in Figure 3.5. The results for the public asylums showed a general upward trend in cases until 1900. The spike in reports in 1899 coincides with a loss of male staff to the military for the Boer Wars. After 1902 there was a gradual decline in reported incidents. Most of the instances of neglect occurred in the larger county asylums, a result that supports the suggestion by Smith, that that these cases were contributed to by a lack of supervision.68 In the private asylums neglect of the patients and of duty was a very infrequently reported event.

Some of the Non-specified Issues added to the list of items reviewed during the inspection visits reflected the concerns of individual members of the CIL. The death of epileptic patients was a particular concern of Shaftesbury, whose son Maurice was epileptic.69 Prior to the establishment of the CIL, epileptic patients were placed randomly in the dormitories or in single rooms at night. To try to reduce the number of these deaths, from the late 1850s the CIL advocated for these patients to be brought together in a designated ward area so they could be closely supervised.70 Examination of the Annual Reports shows that of the 606

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67 For examples see UKPP, CIL, 1877 (403), (pp. 178, 184); UKPP, CIL, 1884-85 (285), (pp. 241, 235).
69 Battiscombe, Shaftesbury: A Biography p. 204. Maurice, who was admitted to an asylum in Switzerland, died following an epileptic fit in 1855.
70 UKPP, CIL, 1859 Session 2 (204), (pp. 63-67).
patients with epilepsy that were reported to have died from suffocation during a fit 580 occurred in the public asylums, with the vast majority of these reported in the years before 1880, as shown in Figure 3.6. In the years after 1875, the CIL claimed that the fall in reported cases was because most asylums had adopted their recommendation. The fact that it took nine years for the reported rate to start to fall shows how long it could take for the Visiting Committees to secure consent from the JPs to make changes. In this case the results show that the CIL were able to influence the asylum system and reduce the risk of harm coming to the patients who had epilepsy.

Another issue reviewed at inspection, that reflected the nineteenth-century focus on insanitary conditions, was that of multiple patients being bathed in the same water. Between 1866 and 1878 the Annual Reports noted examples of where up to six patients were using the same bath water. This problem was identified in up to 45% of the public asylums, as shown in Figure 3.7. The problem was reported as the consequence of a combination of insufficient bathrooms, poor water supply, lack of hot water, and an inability to quickly dispose of waste water. Given that the numbers of patients in public asylums continued to increase and the building of new facilities did not keep pace with this change, such an instant resolution was impossible. A detailed examination of the pattern of reporting suggested that the sharing of bath water was the particular concern of one

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**Figure 3.6: Comparison Between the Percentage of Public and Private Asylums Reported for Deaths of Epileptic Patients at Night, 1860-1910**

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72 For examples see: UKPP, CIL, 1867 (366), (pp. 116, 129, 133); UKPP, CIL, 1868-69 (321), (p. 145).
commissioner who managed to persuade his colleagues to also report on this topic during his tenure. Examination of the changes to the membership of the CIL showed that Dr James Wilkes (1811-1894), medical commissioner between 1856 and 1878, was the only person who served exclusively in the relevant period.\footnote{Between 1866 and 1878 the commissioners appointed were Drs James Wilkes, Robert Nairne and John Cleaton. Those who ceased to be commissioners were Dr Wilkes and Messer’s William Campbell, John Foster, Greville Howard and Robert Lutwidge.}

The second cluster of issues of concern that the CIL reviewed at inspection related to the size, layout, services and upkeep of the asylum buildings, the physical environment. None of the Specified Issues related directly to this topic. Identification of failures of compliance relating to the physical environment was easier to establish than, say, if a patient had been assaulted. Physical faults, such as a broken window, were obvious. Whilst all plans for new asylums and adaptations to existing sites had to be reviewed by the CIL, this did not empower the commissioners to require that the buildings be kept in a good and suitable condition. The cost of any recommended maintenance work had to be met by the ratepayers, for the public asylums, or the fee payers, for the private asylums. Such recommendations could provoke debate between the CIL and the Visiting Committee or proprietor.

The MCL, in their report of 1844, recognised that the physical scale of an asylum needed to be controlled to allow the full benefits of moral therapy to be achieved. They sought to limit the maximum size of a public asylum providing active treatment to 250 patients.\footnote{UKPP, MCL, 1844 (001), (p. 204).} The legislators did not adopt this recommendation, in 1845 or later. The only consideration of the issue of the size of

\begin{figure}
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\includegraphics[width=\textwidth]{figure3.7}
\caption{Comparison Between the Percentage of Public and Private Asylums Reported for Multiple Bathing of Patients, 1860-1910}
\end{figure}
public asylums was to grant the Lord Chancellor power to issue an order for additional accommodation to be provided if the local need for places was not being met. The problem of asylum size was exacerbated by the failure to achieve a high rate of cure, which resulted in large numbers of incurable patients being detained. The County Asylums Act (1845) empowered, but did not require, counties to provide separate facilities for these patients. No consideration was given to the use of non-asylum placements, such as the Boarding-out arrangement used in Scotland for incurable patients.

Without a specified maximum number of places being defined it was left to the CIL to establish a space standard to try to limit patient numbers and prevent overcrowding. In their advice to architects, issued in 1847, they stated that a minimum of about ‘576 cubical feet’ of dormitory space per patient was needed. The amount of day space was not specified in 1847 but in later guidance, issued after 1887, the CIL requirement was for ‘40 feet superficial’ per patient. By 1889 the dormitory space had been rounded up to six hundred ‘cubical feet’. The CIL used their guidance to assess if the public asylums were overcrowded, with the suggestion of overcrowding often being challenged by the Visiting Committees. In 1883 the CIL listed fifteen public asylums where there was insufficient accommodation. Rather than build new accommodation, the county authorities either sent patients to asylums outside the county, the response in Middlesex, or only admitted new inmates when an existing patient was discharged or died, as they did in Devon. Admission to another county’s asylum increased expenditure as the receiving asylum charge was higher for these patients. At the Cambridgeshire County Asylum in 1865 the charge for an imported patient was £34 a year, compared to the £23 for a county resident, (£4240 and £2955 respectively).

The absence of a defined maximum number of patients resulted in the public asylums rapidly becoming overcrowded. Over the review period the proportion so reported was in the range of 40% to 80% of sites, as shown in Figure

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75 S.VIII LL, 8 & 9 Vict. CAP.CXXVI (1845). For an example of its use see UKPP, CIL, 1867 (366), (p. 12).
76 LL, 8 & 9 Vict. CAP.CXXVI (1845); Sturdy, ‘Boarding-out the Insane’, pp. 78, 198-201.
77 UKPP, CIL, 1847-48 (858), (p. 324); CIL, Suggestions and Instructions, p. 7. This revised guidance was issued by the CIL between 1887 and 1911 and was more detailed than the first version from 1847.
78 UKPP, CIL, 1889 (207), (p. 214).
79 UKPP, ‘The Thirty-Seventh Report of the Commissioners in Lunacy to the Lord Chancellor’, 1883 (262), (pp. 70-77).
80 UKPP, CIL, 1866 (317), (p. 69).
3.8. This is very clear evidence that the building programme failed to keep pace with the demand for places. These results contrast with those for the private asylums, where overcrowding was a rare but not unknown finding, with those admitting pauper patients being more frequently identified.\textsuperscript{81} The consistency of the reporting of overcrowding shows how limited the influence of the CIL was over such a fundamental issue. It also clearly demonstrates the reluctance of senior government ministers to use their power to require that additional accommodation be provided.\textsuperscript{82} However, the persistence of the CIL in reporting overcrowding undermines the view expressed by Scull that they were complacent about the issue.\textsuperscript{83}

![Figure 3.8: Comparison Between the Percentage of Public and Private Asylums Reported for Being Overcrowded, 1860-1910](image)

The shortage of publicly funded asylum places was contributed to by the failure of senior ministers to enforce the requirement for such provision contained in the County Asylums Act (1845). This legislation required that all counties and boroughs without an asylum should have started the process of either building, individually or in combination with other counties, or purchasing places for their pauper lunatics by 1848. In the absence of action having been taken by a county or borough a Principal Secretary of State could order the JPs to either build an asylum or purchase places at asylums outside of the county.\textsuperscript{84} When the lunacy laws were revised in 1853 those counties and boroughs that had not started to make this provision were given a year to do so.\textsuperscript{85} Despite this requirement not all

\textsuperscript{81} For examples see reports on Plympton House and Vernon House from 1861 in UKPP, ‘The Fifteenth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1861 (314), (p. 41).

\textsuperscript{82} S.VIII LL, 8 & 9 Vict. CAP.CXXVI (1845).

\textsuperscript{83} Scull, Most Solitary, p. 277.

\textsuperscript{84} S.II LL, 8 & 9 Vict. CAP.CXXVI (1845).

\textsuperscript{85} S.X LL, 16 & 17 Vict. CAP.XCVII (1853).
boroughs took action. The CIL reports show this problem persisted until the early years of the twentieth century. Not all commentators acknowledged that provision was delayed. In 1886 the Hon Frederick Lygon 6th Earl Beauchamp (1830-1891) maintained that ‘He was not aware that there had been any hesitation on the part of the Local Authorities in providing the necessary accommodation’. Whilst the CIL pressed for more accommodation, the local ratepayers resisted. Ministerial support for the CIL was not forthcoming in the face of opposition from the ratepayers.

Because the physical conditions in which the patients were detained were easy issues to assess, the commissioners, as noted by Hervey, did focus on the topic. Observing peeling paintwork and broken windows during an inspection visit led to the commissioners noting the need for repair work and a schedule of planned maintenance. Analysis of the Annual Reports showed that the rate of reporting was higher at the public than the private asylums but that the pattern of these incidents of noncompliance were similar, as shown in Figure 3.9. Over the course of the review period between 25% and 82% of public asylums were identified as needing to take action to improve the state of repair in order to ensure that a suitable environment was available for the patients. The general trend until 1900 shows an increase in reported problems. After 1900 there was a sharp reduction but by 1908 this downward trend had been reversed. At individual public asylums the problem of poor repair was one that recurred. For example, the commissioners noted this problem in every year except two between 1876 and 1910 at the Cambridgeshire County Asylum. In the private asylums the percentage of sites reported was lower, being between 0% and 40%. The results for the private sites that catered for paupers showed the same trend pattern as the public asylums. The least reported sites were the smaller asylums for private patients. As with the building programme, these results show that the CIL had little ability to effect change on repair work, or even maintain a steady state, a consequence of their lack of control of financial resources.

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86 UKPP, CIL, 1901 (245), (p. 44); UKPP, ‘The Fifty-seventh Report of the Commissioners in Lunacy to the Lord Chancellor’, 1903 (231), (pp. 47-49).
87 Hansard, ‘Lunacy Acts Amendment Bill (No. 12) Second Reading’, (HL Deb 1 March 1886), cc. c1499.
89 For examples see: UKPP, CIL, 1867 (366), (pp. 119, 122, 129, 137-38).
90 Hide, 'From Asylum to Mental Hospital', p. 58.
Problems with overcrowding and the heating, ventilation and water supply of buildings were emphasised as contributory factors in another issue that was identified by the CIL, the incidence and prevalence of outbreaks of infectious diseases, such as tuberculosis, within the asylums. Before about 1860 the concern was that patients were being infected by a member of staff or visitor bringing a disease into the asylum, such as Asiatic Cholera in the 1850s. After 1860 the focus of the CIL shifted to those diseases that were prevalent within the asylum, but not all of which were also prevalent in the local community. From 1901 the CIL included in the main text a listing of the various infectious diseases reported and which asylums were affected. In response to the increased numbers of cases the CIL advocated the provision of isolation facilities, describing them as an ‘absolutely necessary adjunct to every lunatic Asylum’. This need for an isolation facility was only applied in relation to the county and borough asylum sites and the idiot asylums.

The increased incidence of infectious diseases reported by the CIL in the public asylums is shown in Figure 3.10. It is clear that this topic attracted an increasing amount of attention from the CIL and they highlighted in the Annual Reports when individual public asylums failed to provide an isolation ward.

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91 UKPP, ‘The Report of the Commissioners in Lunacy to the Lord Chancellor’, 1850 (735), (pp. 29-49); UKPP, CIL, 1854 (339), (pp. 67-68).
92 The first general section was in UKPP, CIL, 1901 (245), (pp. 16-19). By 1903 this had expanded further: UKPP, CIL, 1903 (231), (pp. 19-30). This extensive presentation was retained in the subsequent years.
93 UKPP, CIL, 1898 (259), (p. 352).
pace of providing new isolation facilities, like other new buildings, was not fast. Aside from providing an isolation ward, the CIL encouraged the Visiting Committee to reduce overcrowding, ensure that buildings were adequately ventilated and heated, that the water supply and drainage were adequate and that a good diet was provided. Together these measures aimed to reduce the incidence and effects of the infectious diseases, protect the patients, and reduce the risk for the staff. In the private asylums the highest number of reports was amongst the Idiot Asylums, where the population included a large number of children who were susceptible to the various infections of childhood, and the larger asylums for paupers, such as Bethnal House. Given that the majority of fee-paying patients were accommodated in single rooms, the issue of isolating patients was less of a problem.

Figure 3.10: Comparison Between the Percentage of Private and Public Asylums Reported for a High Incidence of Infectious Diseases, 1860-1910

Another issue related to the physical environment and the protection of patients that became a matter of importance was that of ensuring that the asylum had adequate fire prevention and fire-fighting arrangements in place. The isolated location of many asylums meant that in the event of a fire the initial response had to come from the staff, with support from the fire services only available later. Initially the CIL paid little attention to the issue of fire prevention, their guidance to architects only mentioning the need for stone staircases and fire-proof store-rooms for flammable materials. This changed in 1883 when the CIL were criticised by an inquest jury after a fire at the Southall Park Asylum, London, led to the deaths of five people.

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95 UKPP, CIL, 1847-48 (858), (pp. 324-25).
96 UKPP, CIL, 1884 (280), (pp. 96-98).
Following this incident, the CIL reported regularly on this issue, noting when it thought that the arrangements for dealing with a fire were inadequate. They also issued guidance to all asylums on fire prevention and precautions that included a recommendation to have fire patrols and a 'mechanical means of testing [the] vigilance’ of these. During inspection visits to the public asylums the commissioners would conduct a fire drill. The proportion of public asylums reported as having inadequate arrangements rose sharply from a small minority (10%) in 1872 to a large majority (75%) by 1885, as shown in Figure 3.11. The marked reduction in reports after 1885 indicates that the CIL gave the issue less attention as the Visiting Committees had responded. A fire at the London (Colney Hatch) Asylum in 1903, which resulted in the death of fifty-one female patients, stimulated renewed interest and an upsurge in reports. At the private asylums the increase in the numbers of reports was more gradual, with most being related to the Idiot Asylums. Whilst the achievement of a safer environment demonstrates that the CIL could be effective, the fact that it was a response to external criticism suggests that its ability to take the initiative in securing change was limited.

The layout of buildings and where patients were placed in them could have an impact on the numbers of suicides. Suicide was a topic that attracted

97 For examples see UKPP, CIL, 1870 (340), (pp. 139, 191); UKPP, CIL, 1872 (279), (p. 184); UKPP, 'The Thirty-third Report of the Commissioners in Lunacy to the Lord Chancellor', 1878-79 (342), (p. 53).
98 UKPP, CIL, 1884 (280), (p. 382). Checks of the apparatus for testing ‘vigilance’ were carried out, see UKPP, CIL, 1886 (196), (p. 294). These checks were not routinely reported.
100 UKPP, CIL, 1903 (231), (pp. 15-17).
much attention in the nineteenth century in part because of the numbers of cases and the fear that suicide reflected the negative impact on society of urban industrialisation and the social disruption this could cause.\textsuperscript{101} Concern about the negative impact resulted in suicide, attempted suicide and assisting a person to commit suicide being made criminal offences.\textsuperscript{102} Suicide (self-murder) was regarded as an abnormal act, one that ‘The ordinary Englishman cannot be convinced that a sane man can kill himself’, that was linked to insanity.\textsuperscript{103} The degree of horror at suicide can be seen from the victims exclusion from burial on consecrated ground, a post-mortem punishment.\textsuperscript{104} Despite this attitude of horror towards suicide, inquest juries were reluctant to criminalise the dead, choosing instead to determine that death occurred whilst the balance of the persons’ mind was temporarily impaired.\textsuperscript{105} People who attempted suicide were routinely detained in an asylum, so long as the attempt was identified as such. As with other aspects of the asylum service, the wealthy were less likely to be reported as suicidal and those that were may have been treated more discretely at home by their doctor.\textsuperscript{106}

The concern about the link between suicide and lunacy was reflected in the evidence of Dr Wilkes to the PSC of 1877. His opinion was that the majority of the 1600 people in the population who committed suicide in 1875 were insane and that they ‘died for want of proper care’.\textsuperscript{107} The potential to commit suicide was identified in a significant number of people being admitted to asylums. In his evidence to the PSC of 1877, Shaftesbury reported that 6096 suicidal patients were admitted, about 14% of the patient population in that year.\textsuperscript{108} When account is taken of the numbers of patients and deaths in asylums, the number that committed suicide whilst detained was small, as shown in Table 3.3.

\textsuperscript{103} George H. Savage, 'Constant Watching of Suicidal Cases', \textit{Journal of Mental Science}, 30 (1884), 17-19 (p. 17).
\textsuperscript{105} Bailey, \textit{"This Rash Act"}, pp. 65-72.
\textsuperscript{106} Anderson, \textit{Suicide}, pp. 386-87.
\textsuperscript{107} UKPP, PSC, 1877 (373), (p. 42).
\textsuperscript{108} UKPP, PSC, 1877 (373), (p. 534). What was meant by suicidal was not defined and how it was used could vary. Some might apply the term to anyone who spoke of thinking about ending their life, others only when a serious attempt had been made that involved physical injury.
Table 3.3:  Comparison Between the Numbers of Patients, Deaths, and Suicides at Public and Private Asylums, 1875-1905

<table>
<thead>
<tr>
<th></th>
<th>1875</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>32,529</td>
<td>40,088</td>
<td>47,749</td>
<td>52,937</td>
<td>61,908</td>
<td>74,004</td>
<td>87,091</td>
</tr>
<tr>
<td>Deaths</td>
<td>3789</td>
<td>3873</td>
<td>4726</td>
<td>5659</td>
<td>6517</td>
<td>7766</td>
<td>8892</td>
</tr>
<tr>
<td>Suicides</td>
<td>11</td>
<td>12</td>
<td>9</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Private</td>
<td>7729</td>
<td>7383</td>
<td>7493</td>
<td>8156</td>
<td>8103</td>
<td>7957</td>
<td>7878</td>
</tr>
<tr>
<td>Deaths</td>
<td>721</td>
<td>546</td>
<td>532</td>
<td>682</td>
<td>642</td>
<td>545</td>
<td>548</td>
</tr>
<tr>
<td>Suicides</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

To try to reduce this number further, the CIL advocated close observation of all those people admitted with a history of suicidal thoughts and behaviour. This involved the medical staff in providing written instructions for the attendants to follow for each patient. It also required that all the at-risk patients slept in a designated ward area within each gender division.\(^{109}\) Where patients committed suicide the CIL would review the supervision arrangements. If an attendant was found to have failed to provide the correct level of supervision, then a recommendation of dismissal or even prosecution might be made.\(^{110}\) Failure by a doctor to provide adequate written instructions prompted criticism but did not lead to a recommendation of dismissal or prosecution.\(^{111}\) The CIL reported that their recommendations for close supervision, where followed, had been effective in reducing the proportion, if not the total number, of suicides in the public asylums. In 1862 there had been twelve suicides amongst the 25,799 patients (1 per 2150). In 1892 there were fifteen amongst the 71,878 patients (1 per 4792).\(^{112}\)

The last group of Non-specified Issues are those that addressed how the asylum was being administered, topics that were infrequently reported by the CIL. Criticism was levelled when the CIL considered that too many male staff had access to the keys to the female division, because of the risk of inappropriate behaviour.\(^{113}\) Negative commentary was also made if an allowance to support patients during a trial of discharge was not paid.\(^{114}\) The failure of an asylum to

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\(^{109}\) UKPP, CIL, 1859 Session 2 (204), (p. 65); UKPP, CIL, 1872 (279), (pp. 70-71); UKPP, CIL, 1878 (337), (p. 40). In the same areas as the epileptic patients.

\(^{110}\) For example see: UKPP, CIL, 1870 (340), (pp. 22-23).

\(^{111}\) For example see: UKPP, CIL, 1870 (340), (pp. 14-15).


\(^{113}\) For example see: UKPP, CIL, 1886 (196), (p. 217); UKPP, CIL, 1887 (200), (p. 287).

\(^{114}\) UKPP, CIL, 1893-94 (242), (p. 156); UKPP, 'The Forty-sixth Report of the Commissioners in Lunacy to the Lord Chancellor', 1892 (320), (p. 171).
complete documentation recommended by the commissioners, such as displaying a copy of the bathing procedure in each bathroom, also led to criticism of the management being recorded.\textsuperscript{115} The vast majority of the critical comments, 343 of the 425 reports, related to the public asylums. Whilst these issues seem trivial, they could have serious consequences. Failure to follow the bathing procedure could result in a patient’s death from scalding.\textsuperscript{116}

As part of the review of the Annual Reports the correlation between the various issues was calculated to identify any possible connections, for example: low staffing and increased patient maltreatment. Some of these links are to be expected, such as that between overcrowding and a high incidence of infectious disease ($r_s=+0.8$). Other expected links, such as between low staffing and an increased incidence of patient-on-patient assaults due to poor supervision, were not found. Still others, such as between the low attendance at Divine Worship and a high incidence of infectious disease ($r_s=+0.7$), appear to be spurious. The full results for all correlations between $+0.5$ and $+1.0$ and $-0.5$ and $-1.0$ are shown in Appendix 3 (p. 227). Underlying the failures of compliance for both Specified and Non-specified Issues was the level of resourcing of the asylums, particularly in the case of those that were publicly funded.

**Monitoring of the asylums**

As noted in Chapter 2, the intermittent visits of the CIL to the various locations where lunatics and idiots were detained could only ever produce a snapshot of the state of the patients and of these locations. To augment the information gathered at inspection and to help to fill in any information gaps, the CIL collected, collated, and analysed statistical data reported by each asylum and by the Poor Law authorities. Much of the material that had to be supplied was specified in the lunacy legislation. The legislation did allow the CIL to add to the information that asylums had to provide.\textsuperscript{117} The commissioners used the returns to show how the asylum system was functioning and changing over time, and issues that should or could be followed up at the next inspection visit. Using examples, this section will

\textsuperscript{115} UKPP, CIL, 1892 (320), (p. 149); UKPP, CIL, 1897 (279), (p. 246).

\textsuperscript{116} For example see: UKPP, CIL, 1871 (351), (p. 35).

\textsuperscript{117} S.LIV, S.LIX, S.LX, S.LXV & S.LXVI LL, 8 & 9 Vict. CAP. C (1845). Also Schedules to LL, 8 & 9 Vict. CAP. CXXVI (1845); LL, 16 & 17 Vict. CAP. XCVI (1853); LL, 16 & 17 Vict. CAP. XCVII (1853); LL, 25 & 26 Vict. CAP. CXI (1862); LL, 52 & 53 Vict. CHAP. 41 (1889); LL, 53 & 54 Vict. CHAP. 5 (1890).
show how the collection of data was an important element in the identification of noncompliance with the legislative requirements.

In addition to reviewing all of the documentation for each patient admitted since the last visit, the CIL routinely received copies of the certificates and detention order for each patient admitted to an asylum, as well as those for the Single Patients.\(^{118}\) These documents were reviewed to confirm that they had been fully and properly completed, thereby ensuring that the detention was legally justified. This activity was part of the process of ensuring that inappropriate admission was not occurring. It must be stressed that this work did not involve review of the diagnosis, so its role in protecting the patients from inappropriate admission was limited.

Given the numbers of admissions, particularly to the public asylums, this generated a large volume of documents to be processed. In reporting on these records, the CIL throughout its lifetime reported that they had identified numerous errors but failed to specify the number.\(^{119}\) After 1853 the CIL was authorised to return any faulty documents to the person who completed it so that the record could be corrected.\(^{120}\) The number of documents returned for correction was not reported by the CIL.

Section XXVII of the County Asylums Act (1845), by authorising the building of separate accommodation for incurable patients, makes clear that the purpose of admission to an asylum was to achieve a cure.\(^{121}\) As noted in Chapter 2 (p. 49), the CIL were not required and did not choose to report on the benefits of the moral therapy, treatment that sought a cure through compassionate care in a clean and ordered environment. They did include, from 1858 onwards, the numbers of patients discharged as ‘recovered’, separately from the number discharged, in the statistics for each asylum.\(^{122}\) The CIL did not routinely comment on or discuss the treatments used in asylums. In some reports they noted the use of drug treatments, such as ‘Morphia … has largely been tried in the treatment of patients, and has been found to be of great value in cases of recurrent mania’.\(^{123}\) They did, in 1855, try to challenge the use of enforced bathing in both the criminal

\(^{118}\) S.XLV, S.XL VIII & S.XC LL, 8 & 9 Vict. CAP.C (1845).

\(^{119}\) UKPP, CIL, 1847-48 (858), (p. 18); UKPP, CIL, 1866 (317), (pp. 46-48).

\(^{120}\) S.XI LL, 16 & 17 Vict. CAP. XCVI (1853).

\(^{121}\) S.XXXVII LL, 8 & 9 Vict. CAP.CXXVI (1845).

\(^{122}\) UKPP, CIL, 1859 Session 2 (204), (pp. 96-109).

\(^{123}\) For example: UKPP, CIL, 1877 (403), (p. 214).
court and at a GMC professional conduct hearing.\textsuperscript{124} The details of this case are given in Chapter 4 (p. 107).

Whilst it was the duty of the CIL to monitor all locations where lunatics or idiots were detained, the requirements for detention documentation were not identical across these sites. Those people detained in workhouses, whether in the general population or on a dedicated infirmary ward, were not required to be certified prior to detention.\textsuperscript{125} Such a requirement only came into force if an individual were to be transferred to an asylum.\textsuperscript{126} Also exempt from the need for a detention order or certification were those pauper lunatics and idiots admitted to a Metropolitan District Asylum, a point noted with concern by the CIL.\textsuperscript{127} The legislation that underpinned these alternate locations effectively constrained the ability of the CIL to undertake its duties.

As a Specified Issue, notification of all admissions was a piece of information that would inevitably have been used in monitoring the asylums. The monitoring of deaths, other than as a simple count of a patient movement through the asylum system, was a topic the CIL chose to review as part of two of the Non-specified Issues. The first of these was in monitoring the death rate at each asylum, a high death rate being an indicator of maltreatment or a systemic problem, akin to that at the Andover Workhouse. When reporting the death rate the CIL used a different denominator, the number of patients, than for other rate calculations, which used the number of admissions. The result was that the death rate was substantially reduced.\textsuperscript{128} For example, at the Bedford (Three Counties) Asylum in 1865 the rate was reported as 12% of patients, as opposed to 40% of admissions.\textsuperscript{129} Where the death rate was greater than 10% of patients the CIL noted this in the Annual Report. The results show that from 1870 to 1910 between 30% and 60% of public asylums were reported as having high death rates, as shown in Figure 3.12. Over the same period less than 10% of private asylums were ever reported, this despite the fact that in the asylums with less than twenty

\textsuperscript{124} UKPP, CIL, 1857 Session 2 (157), (pp. 24-40).
\textsuperscript{125} For lunatics detained in prison the crucial factor was when they were diagnosed. If they were already prisoners then they remained in prison without a detention order. If they were diagnosed as lunatics prior to trial, they would be detained by order of the court as a criminal lunatic.
\textsuperscript{126} LL, 4 & 5 Gulielmi IV CAP.LXXVI (1834).
\textsuperscript{127} S.21 & S.30 LL, 30 Vict. CAP.VI (1867); UKPP, CIL, 1884 (280), (p. 324).
\textsuperscript{129} UKPP, CIL, 1866 (317), (p. 52).
patients only two deaths in a year would have reached the high death rate criterion. The CIL took no specific action relating to this issue.

The CIL also used the death notification data to monitor the incidence of accidents and untoward events that resulted in the death of a patient. Included in this group are those who suffered a fall or choked whilst eating. The CIL recorded a total of 1084 instances of unnatural death over the course of the review period, with 949 of these at the public asylums. Many of these cases were the subject of an inquest as well as investigation by the commissioners.\textsuperscript{130} A substantial minority, 20\% to 40\% per year, of the Public Asylums were reported as having a high rate of unnatural deaths, as shown in Figure 3.13. At the private asylums these events were rare, apart from an occasional spike, as in 1879 and 1906. The reports on these events were included to try to encourage the various asylums to adopt working arrangements that reduced the risk of harm coming to the patients. The persistence of these events shows that this approach had only a limited impact. In many cases the events leading up to an injury varied, making the applicability of the suggested solution of less value. The limited readership of the Annual Reports also contributed to the lack of impact of this intervention.

\textsuperscript{130} For examples see: UKPP, CIL, 1874 (284), (pp. 138-39); UKPP, ‘The Forty-eighth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1894 (172), (pp. 183, 190).
The majority of the information collected by the CIL applied to all of the asylums. However, in the case of the licenced houses the CIL had an additional monitoring opportunity. As part of the licence renewal process the proprietor had to supply a list of the names of each patient, whether they were paupers or non-paupers and the gender of each. 131 Failure to provide this information was a prosecutable offence. 132 This arrangement gave the CIL and the JPs the opportunity to confirm that these premises were continuing to be operated in compliance with the legislation and the conditions of the Licence. Between 1845 and 1910 the CIL reported on one licenced house that was not in compliance with its licence conditions. This exception was when a suicidal patient was admitted to the Elm House Asylum, London, the admission of such patients was not permitted by a condition imposed on the licence. The acting medical superintendent was admonished by the CIL and the patient transferred to another asylum. No further action was taken. 133

The impact of inspection and monitoring
Detailed examination of the Annual Reports has created a much clearer picture of the work and workings of the CIL across its remit area and over time. This has highlighted how large and complex this workload was and that the CIL did not adopt a minimalist approach to their work, ‘just what the legislation specified’, although they did not routinely report fully on all of the Specified Issues. The persistence with which they addressed the various issues of concern very strongly

131 S.XXIV LL, 8 & 9 Vict. CAP.C (1845).
132 S.XXIX LL, 8 & 9 Vict. CAP.C (1845).
133 UKPP, CIL, 1878 (337), (pp. 71-73).
suggests that this was not a complacent organisation. The results also indicate that whilst the CIL adopted, out of necessity, a bureaucratic approach, they did adapt the issues they examined over time.

The analysis used also clearly demonstrates the impact of the way they worked on their ability to meet their objective of protecting patients from harm, through the identification and reporting of noncompliance. The establishment of the four visiting circuits maximised the efficient use of the teams of commissioners so that, in most years, all of the required visits were completed. This achievement did come at the cost of some shortening of the length of inspection visits, as shown in Table 2.6 (p. 51), as their workload increased over the course of the nineteenth century. The decision, never reported as having been reviewed, by the founding members of the CIL to make an annual change in which commissioner team made the visits to each circuit has been shown to have been counterproductive. The consequence was considerable variation between years in the issues addressed, which can be seen in Figures 3.14 to 3.17. These show the annual incidence of reported non-compliance for the Specified Issues (SPI) and Non-specified Issues (NSI) at four County asylums between 1860 and 1910. These sites, Devon, Kent (Barming Heath), Shropshire and Yorkshire (Wakefield) County Asylums, represent each of the four inspection circuits. Together they show that the pattern of variation occurred throughout England and Wales. This variation made it very difficult for the Visiting Committee, Board of Governors or proprietor to know what to respond to as a priority, undermining the ability of the CIL to secure compliance and protect the patients.

![Figure 3.14: Reported Incidents of Noncompliance by Issue Group at Devon County Asylum, 1860-1910](image-url)
The use of a national regulator to identify the level of compliance was an attempt to secure common standards of provision across England and Wales. Attainment of such standards could be extremely difficult because of local differences that had to be taken into account. The CIL guidance to architects specified that the ideal asylum site was one that provided ‘not less than one acre
per ten patients’, that was away from ‘nuisances’, ‘such as steam engines’, and that had an ‘ample supply of running water’. Whilst this was attainable in county settings, such provision was rarely possible for a Borough Asylum. Similar constraints also applied to the issues reviewed at inspection, and included the ability and willingness of the ratepayers to meet the costs of provision and compliance. These constraints on securing common standards were then compounded by the variations between the individual commissioners on the comments made about issues of concern and the priority attributed to their correction.

The inability to secure common standards across the country was also affected by the differences built into the legislation in relation to the public and private asylums and between the pauper and non-pauper patients. The requirement for private asylums to be licenced gave the CIL a means of influencing the proprietors to ensure that compliance was achieved, a power that was unavailable in their dealings with the Visiting Committees for the public asylums. Before 1896 the reporting on the licenced houses differed from that of the publicly funded asylums, a finding not previously reported. This has created the impression that the licenced houses were better at achieving compliance. After 1896 the differences between the two groups narrowed, suggesting that either there had been some under reporting of noncompliance at the licenced houses between 1845 and 1896 or that there was a deterioration in compliance from 1896 onwards. At the publicly funded asylums the identification of noncompliance was affected by: having only one visit in each calendar year by the CIL; the ever-increasing size of these institutions as the patient numbers rose; and the failure to increase the numbers of professional commissioners completing the inspections, despite the increase in work. These constraints made the identification of some forms of noncompliance, such as abuse or neglect of patients, less likely. The potential result was that the attention of the commissioners was drawn towards those issues of concern that were obvious or easy to identify, particularly those relating to the physical condition of the asylum.

Comparison between the graphs of the individual issues of concern, both Specified and Non-specified, shows a mixed picture of noncompliance over the years 1860 to 1910. For some issues, such as the failure to complete statutory records, the numbers of inappropriate admissions and unnatural deaths, the results

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134 CIL, *Suggestions and Instructions*, pp. 3-4.
show very little change between 1860 and 1910. Over the same period there were falls in the reporting of low levels of patient involvement in work and recreational activities, deaths at night of epileptic patients and the same bath water being used for multiple patients. Issues where increasing noncompliance was reported included overcrowding at the public asylums, the incidence of infectious diseases and assaults by staff on patients. This mixed picture suggests that the CIL did have some impact on the asylum system, but this was not consistent between the issues or over time. The areas where increases were reported were those that involved the greatest cost to correct, such as the resolution of overcrowding by the building of new wards. Whilst this pattern of results suggests that the CIL had only limited impact, what cannot be known is what the state of asylum services in England and Wales would have been had the CIL not been established.

The lunacy legislation also set requirements for the CIL to meet, these being achievement of all of the required visits in each calendar year and reporting on the Specified Issues at each inspection visit. Unlike the asylums, the failure of the CIL to meet these requirements went uncommented on by any Lord Chancellor or Principal Secretary of State. In most years the CIL did make all of the required visits, the exceptions being in 1907 and 1908 when they requested and secured consent from the Lord Chancellor to reduce the visiting schedule. As noted, the CIL did not routinely report on all twelve of the Specified Issues. The absence of reporting was less of a feature of the way that the CIL addressed the Non-specified Issues. Except for the two issues which were of particular interest to individual commissioners, multiple patients being bathed in the same water and, to a lesser extent, the deaths of epileptics, the other twenty-three issues were consistently included in the Annual Reports. Overall, the thirty-one items that were regularly reported on by the CIL shows that the commissioners did attempt a comprehensive review of each asylum. However, from a practical perspective, it is debatable if this very broad-brush approach was realistic. It is possible that had they focussed on a more limited range of topics they might have achieved greater consistency between the inspection teams, and enabled the Visiting Committee, Board of Governors and proprietor to be clearer about what changes needed to be made and the priority order of these. As the asylums responded and corrected the identified noncompliance, the list of issues could be revised and other, previously lower priority, concerns addressed.

135 UKPP, CIL, 1907 (225), (p. 58); UKPP, CIL, 1908 (200), (p. 50).
The inability of any regulator to be in all locations all of the time meant that there was an information gap that needed to be filled regarding what was happening when the regulator was not on site. Part of this gap was filled by the information that the asylums were required to supply. The collection, collation, analysis and publication of such information, therefore, formed a basic element of the process of regulation and was not a bureaucratic end in itself. In the case of the CIL, the analysis of the Annual Reports makes clear that the information returns were used to augment the findings from the inspection visits. Some of the material gathered was of limited use – for example the numbers of patients admitted with specific diagnoses appears to have made little obvious contribution to the care and protection of patients. The CIL also used the information from these returns to press for improvements, such as more patient accommodation or better working conditions and terms for the staff. However, as a source these returns were open to question. The CIL was dependent on the asylums for making the returns and supplying accurate information, an issue that features in both the securing of compliance and the use of prosecution by the CIL, discussed in the next three chapters.
Chapter 4: Securing Compliance of Long-standing Issues

The analysis of the Annual Reports in the last chapter showed the level of and changes in noncompliance with the lunacy legislation over time reported by the CIL. In this and the following chapter analysis of the Annual Reports will be used to show how the CIL tried to secure compliance, thereby fulfilling its primary role of protecting the patients from cruelty, neglect, inappropriate detention and other forms of harm. Within asylums harm may have been the result of: action or inaction by one or more persons; the way the asylum was operated; the physical environment in which the lunatic or idiot was detained; or any combination of these. These circumstances, individually or together, produced varying risks of harm to patients. The potential of this risk could be open to challenge, making the securing of compliance a complex process. This and the following chapter will consider: the methods of securing change available and those used by the CIL; whether the selected methods were effective; and the factors that affected the securing of compliance so that the patients were protected from harm. As shown in Chapter 3, both the Specified and Non-specified Issues can be grouped based on whether they were concerns that had been addressed prior to passing of the lunacy legislation in 1845 or incorporated from that year onwards. To allow comparison between the long-standing and contemporary and the Specified and Non-specified Issues, one of the issues from each of the domains shown in Figure 1.1 (p. 20) were selected as a case study for closer examination. This chapter will consider the long-standing issues and Chapter 5 the contemporary issues. The case studies, using a combination of quantitative and qualitative data, will show whether the CIL was able to secure compliance and what factors were influential in each case.

To examine how the CIL sought to address long-standing issues this chapter reviews the use of mechanical restraint (Specified Issue) and the staffing of asylums (Non-specified Issue). Confinement and restraint of dangerous lunatics had been the mainstay of treatment since the fifteenth century, and probably earlier, these methods being used to limit the ability of the person to exhibit unwanted or unacceptable behaviours.1 The continued use of mechanical restraint

in the early nineteenth century was questioned within the medical profession. Also contested at this time was moral therapy, the alternative system of treatment based on the use of kindness and respect to persuade the patient to change their behaviour. Whilst not banning the use of mechanical restraint the legislation of 1845 established a requirement that the CIL monitor its use. The case study shows how the CIL monitored the use of mechanical restraint, in its various forms, and the related action of secluding patients. It reveals how the conflicting views of the medical profession hampered the ability of the CIL to secure minimisation of the use of restraint. Also shown is the effect of the move by the medical profession to use drugs to control patient behaviour and how this impacted on the use of restraint and seclusion.

The second case study, which examines the staffing of asylums, also highlights the need for the CIL to negotiate with competing local interests. Working as an attendant in a public or private asylum was not a popular job and all asylums suffered from the problem of recruiting and retaining a sufficient number of staff with appropriate skills. The lack of attendants with these skills placed the patient at risk of harm and the CIL focused much attention on the issue. They also, to a lesser extent, reviewed the employment of doctors, particularly at the public asylums where the increase in size led to larger clinical and administrative workloads. Whilst there were differences in view of how the numbers and quality of staff was to be maintained, the CIL faced little opposition from the medical profession on the issue of staffing. The main opposition came from the people who ultimately had to meet the costs of employing more staff, the ratepayers, and their representatives, and the fee-paying patients.

Following on from Chapter 3, the case studies will show that the securing of compliance differed between the public and the private asylums, the former being the subject of greater criticism. They will also show clearly how the securing of compliance differed when dealing with the pauper and non-pauper patients, whether in the public or the private asylums. This pattern of differentiation, first

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2 Samuel Hadwen, 'Mr Hadwen on the Restraint of Lunatics', The Lancet, 2 (1840), 904-7 (pp. 904-5); John Conolly, Treatment of the Insane Without Mechanical Restraint, repr. edn (London: Smith, Elder & Co., 1856; Dawsons of Pall Mall 1973), pp. 28-34.
3 Tuke, Description of the Retreat, pp. 57-58; Scull, Most Solitary, pp. 379-80.
4 S.LXI, S.LXII, S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).
shown in relation to the basic legislation and the legacy from the eighteenth century, permeated the process of regulation. The case studies also show the complex network of interests that the CIL had to negotiate when they attempted to secure changes in practice and/or the physical environment within an asylum, with the impact of financial costs being of particular importance. The balance between the level of protection and any consequent costs was recognised and acknowledged by the CIL and there is evidence to suggest that they tempered their activities and recommendations to reflect the economic realities. This chapter will start by detailing the potential methods of securing compliance that were available to regulators in the nineteenth century and those that the CIL used.

The methods of securing compliance

Nineteenth-century regulators had available a number of techniques, that varied in both severity and appropriateness, to try to secure compliance. The work of Bartrip and Fenn showed that how compliance was secured underwent evolution in the nineteenth century. In selecting the method to be used the regulator had to apply both judgement and discretion. There were circumstances where immediate and severe action was the required and appropriate response, such as where a patient was being maltreated. A draconian response to a failure to make a required information return, even when this was defined as a misdemeanour, could be seen as disproportionate if it were a first offence. A reaction perceived as too draconian could, in the worst case, result in the disbandment of the regulator, as Sir Edwin Chadwick (1800-1890) found to his cost, when the PLC was replaced in 1847. Judgement and discretion were also needed when making the decision not to take action. Allowing repeated failure to go unpunished would result in the credibility of the regulator and the process of regulation being undermined. The decision to use any of the means of securing compliance was also affected by the views and ideas of the people employed as regulators. In the case of the CIL, it was the strong view of Shaftesbury, uncontested publicly by his colleagues, that the way to proceed was by a form of persuasion.

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7 Bartrip and Fenn, 'The Evolution of Regulatory Style', (pp. 204-6).
10 Bartrip and Fenn, 'The Evolution of Regulatory Style', (pp. 204-5).
11 UKPP, PSC, 1859 Session 1 (204), (p. 34); UKPP, PSC, 1877 (373), (p. 547).
In the nineteenth century there were five possible routes that could lead to the achievement of compliance, presented here in order of increasing severity. Not all were available to the CIL or usable in all of the locations which they were required to visit. The simplest and most frequently used by the CIL and other regulators was persuasion, a technique that could take different forms. At its simplest, it involved a private conversation with the Visiting Committee, Board of Governors or proprietor. If this failed, then formal correspondence could be used. If this did not produce a response, the request for action could be published in the Annual Report, an early attempt at naming and shaming.

Where persuasion did not produce a response, the CIL progressed to formal contact with the licencing authority. In the case of the licenced houses the CIL would write to either the Lord Chancellor, in the case of asylums in the Metropolis, or the chairman of Quarter Sessions, for others. In this letter they could recommend that the licence be revised, not renewed or revoked. None of these outcomes was certain as the decision was not for the CIL to make, but the threat alone could be effective. This form of intervention was not available for the unlicenced public asylums, reducing the protection for the patients detained in these facilities.

An alternative approach, that was available for a short period in the nineteenth century was by giving the regulator the power to issue a notice requiring action to be taken. This power was granted to the Factory Inspectorate in 1833 and was found to be an effective means of securing improved safety for women and children in the regulated factories. When the Factory Act was reformed in 1844 this power was revoked. It is interesting to note that one of the opponents of this method of securing compliance was Shaftesbury, the chairman of the MCL from 1834 and of the CIL from 1845 to 1885.

Another mechanism for securing compliance was for the regulated organisation to have to have in place rules that determined how the business or institution was run. In the case of the asylum system the Visiting Committees, Boards of Governors and proprietors had to prepare and submit such rules for

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13 S.XVII LL, 8 & 9 Vict. CAP.C (1845).
14 S.IV LL, 8 & 9 Vict. CAP.CXXVI (1845).
15 S.XVIII LL, 3 & 4 Gulielmi IV CAP.CIII (1833).
16 S.XVIII LL, 3 & 4 Gulielmi IV CAP.CIII (1833).
17 S.II LL, 7 & 8 Vict. CAP.XV (1844).
review by the CIL and approval by a Principal Secretary of State.\textsuperscript{18} From 1853 the CIL was authorised to ‘make Rules’ for the Licenced Houses, but for no other asylums. However, the legislation required that the Rules proposed by the CIL had to be approved by a Principal Secretary of State before publication.\textsuperscript{19} The rule making power only allowed the CIL to define what was required to be done, not how, limiting them to confirming whether the method adopted met the requirement. Extension of this power to the public asylums and registered hospitals was never enacted. From 1889 the CIL were mandated to issue a list of means of mechanically restraining patients that could be used in asylums. This power did not allow them to specify which item on the list was to be used in any particular case.\textsuperscript{20}

In the face of persistent noncompliance, severe danger to patients or blatant disregard for the law, such as operating an unlicenced private asylum, the sanction of prosecution was available. However, its use was restricted in two ways. Firstly, prosecution could only be used for the failures in compliance that were defined in the lunacy laws as misdemeanours. This was only a subset of the issues that the CIL reviewed at inspection. Secondly, the CIL could not initiate a prosecution without consent from a senior minister or a law officer and were required to have started the prosecution within twelve months of the prosecutable offence having been committed.\textsuperscript{21} The offences defined in the lunacy laws and details of the cases taken to trial will be discussed in Chapter 6. The conditions and constraints that applied to all methods for securing compliance were not unique to the CIL. The other regulatory organisations established at this time were subject to similar restrictions.\textsuperscript{22}

Case Study 1: The use of mechanical restraint
A fundamental concern about the care of lunatics in asylums was about the risk that these vulnerable people might be maltreated whilst being detained. This risk was compounded by the fact that much of the treatment of lunacy and idiocy prior to the nineteenth century was based on preventing unwanted and unacceptable

\textsuperscript{18} S.XLII. 8 & 9 Vict. CAP.C (1845). S.XL. 8 & 9 Vict. CAP.CXXVI (1845). At the request of the Home Secretary the CIL issued a draft set of ‘Proposed General Rules’ in 1847, see UKPP, CIL, 1847-48 (858), (pp. 46-47, 329-336).
\textsuperscript{19} S.XXI. 16 & 17 Vict. CAP. XCVI (1853).
\textsuperscript{20} S.45. 52 & 53 Vict. CHAP. 41 (1889).
\textsuperscript{21} S.CV. 8 & 9 Vict. CAP.C (1845).
\textsuperscript{22} Bartrip, ‘British Government Inspection’, (pp. 616-18); Bartrip, ‘State Intervention’, (p. 67); MacDonagh, Early Victorian, pp. 80-82; Mills, Regulating Health, pp. 2-3.
behaviours, often by means of mechanical restraint. Chaining a person to a bed or wall for long periods as a treatment could easily appear to be or become abusive control. In the late eighteenth century, the failure of these methods to achieve a cure was challenged. In Paris Dr Phillippe Pinel (1745-1826) developed moral therapy as an alternative approach based on securing changes in behaviour by the use of kindness and encouragement. Within this new treatment the use of mechanical restraint was reduced to a last resort method of controlling unwanted behaviour, but importantly it was not prohibited. Proponents of moral therapy, such as the Tuke family who operated the York Retreat, an asylum for Quakers who were diagnosed as lunatics, argued that use of this treatment resulted in a much higher cure rate, over 80%. Whilst moral therapy was gradually adopted for the treatment of lunatics, divisions remained within the medical profession on whether limitations should be placed on the use of mechanical restraint. Opposition to limitations on the use of mechanical restraint also came from practitioners in other countries. Mechanical restraint continued to be widely used in the USA and proponents of non-restraint criticised.

When challenged at the PSC evidence collecting session in 1815 about his use of restraint in the case of William Norris, a patient at the Bethlehem Hospital who had been chained to a wall for fourteen years, Dr Thomas Monro (1759-1833), physician to the hospital, spelled out the dichotomy between care and cost by stating that the inability of the paupers to pay for attendants meant that chains were ‘the only means of restraining them’. He also noted that he rarely restrained his private patients. Another supporter of the use of restraint, Dr Samuel Hadwen, argued that proper ‘use of restraint, judiciously and humanely employed, are not ignominious manacles and fetters, as the vain claimants of a pseudo-humanity love to represent’. Opponents of moral therapy also argued

26 Tuke, *Description of the Retreat*, pp. 139-159, 163-164; UKPP, PSC, 1814-15 (296), (p. 113).
29 UKPP, PSC, 1814-15 (296), (pp. 12, 95).
that the use of rewards to encourage the adoption of acceptable behaviours and the withholding of these for noncompliance was, if less blatantly, as coercive as the use of restraints.31

Initially in England and Wales the use of the moral therapy approach had been limited to the smaller private asylums, such as the Quaker Retreat at York. Therefore, there were doubts about whether a system of non-restraint could be used in the larger public asylums in the treatment of pauper patients. The experience at the Lincoln Lunatic Asylum and the Middlesex (Hanwell) Asylum, the latter caring for about 900 patients in the late 1830s, demonstrated that the treatment could be used.32 But there was a cost implication, as additional attendants had to be employed. The Middlesex JPs accepted this increase in cost in respect of the Hanwell Asylum.33

The divide in medical opinion was recorded in the MCL report of 1844. The MCL, who had supported the use of non-restraint in the Metropolitan Licensed Houses, made no specific recommendation on limiting the use of mechanical restraint.34 In the Lunacy Act (1845), and all subsequent legislation, the CIL were required, in the private asylums, to monitor: ‘if any Patient is under Restraint, and why’ and ‘whether there has been adopted any System of Non-coercion, and, if so, the Results thereof’.35 In contrast, for the public asylums the requirement was for the commissioners to report on: ‘whether any System of Coercion is in practice therein, and the Results thereof’.36 The reason the drafters of the legislation included this distinction between the asylum types is unknown, but it is to the credit of the CIL that they did not implement the distinction in their reporting. In fact, they went beyond the simple issue of mechanical restraint and noted where other means of confining or limiting the movement of patients were being employed.

In response to the ongoing debate over the use of mechanical restraint and seclusion, the CIL conducted a one-off survey in 1854 of the opinions and practices of all asylum medical superintendents. The results from this survey

31 Scull, Most Solitary, pp. 379-80.
33 Akihito Suzuki, ‘The Politics and Ideology of Non-restraint: the Case of the Hanwell Asylum’, Medical History, 9 (1995), 1-17 (pp. 5-9). Part of the action of JPs was to amend the governance arrangements, a change that led to the Medical Superintendent, Sir William Ellis (1780-1839), to resign and be replaced by Dr John Conolly.
34 UKPP, MCL, 1844 (001), (pp. 137-59).
36 S.CX LL, 8 & 9 Vict. CAP.C (1845). Italics added.
showed that amongst the respondents both mechanical restraint and seclusion were more likely to be used at the private asylums, as shown in Table 4.1. The results from this survey, published as an Appendix to the Eighth Annual Report, does not make clear if it was just the pauper patients who were being mechanically restrained and/or secluded in the private asylums. Using the responses obtained the CIL concluded, noting the effect of cost, that it:

may fairly be deduced from a careful examination of information thus collected, we feel ourselves fully warranted in stating that the disuse of instrumental restraint, as unnecessary and injurious to patients, is practically the rule in nearly all Public Institutions in the kingdom, and generally also in the best conducted Private Asylums… For ourselves, we have long been convinced, and have steadily acted on this conviction, that the possibility of dispensing with mechanical coercion in the management of the insane is … a mere question of expense.

Table 4.1: Responses of the Medical Superintendents on the Use of Mechanical Restraint and Seclusion as at 1854 by Asylum Type

<table>
<thead>
<tr>
<th>Asylum Type (No.):</th>
<th>Mechanical Restraint</th>
<th>Seclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Used:</td>
<td>Not used:</td>
</tr>
<tr>
<td>Public (37)</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Private (144)</td>
<td>55</td>
<td>35</td>
</tr>
</tbody>
</table>

Where mechanical restraint was not used there remained the problem of how to manage those patients who, being either very excited and/or aggressive, presented a danger to themselves or others. The widely adopted alternative was to place the individual into seclusion. Instead of being chained these people were confined within a closed room, creating a version of solitary confinement that could be seen as only marginally less restrictive than mechanical restraint. In their report of 1844, the MCL made the point that the use of seclusion alone was not always effective in reducing the excitement or aggression of patients. They

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37 UKPP, CIL, 1854 (339), (pp. 123-209).
38 UKPP, CIL, 1854 (339), (p. 42).
39 Topp, 'Single Rooms', (p. 767).
40 UKPP, MCL, 1844 (001), (pp. 147-49, 157).
advised that seclusion should only be for short periods, under the direct control of
a doctor and that all use was recorded.\textsuperscript{41} This recommendation was not included
in the legislation of 1845. The CIL included the use of seclusion as one of the
Non-specified Issues, reporting the results alongside those for the use of
mechanical restraint.

Whilst the monitoring of the use of mechanical restraint, but not seclusion,
was a requirement, the Annual Reports noted that other methods of limiting patient
movement to induce calm were not. These methods included placing the patient in
a bath or shower for varying periods of time, using the straight-jacket, or tightly
wrapping them in either wet or dry blankets, all of which would now be recognised
as forms of restraint but which the CIL reported separately.\textsuperscript{42} It was believed that
using baths, showers or wet blankets would cool the fevered brain of the lunatic.\textsuperscript{43}
There were concerns amongst the medical profession as to the efficacy of forced
bathing and showers and these treatments were not without their problems.\textsuperscript{44} In
1857 the CIL reported on the case of Daniel Doolley, a 65-year-old patient, who
collapsed and died shortly after being placed in a shower for thirty minutes on the
instructions of Dr Charles Snape, medical superintendent of the male department
of the Surrey (Wandsworth) County Asylum. The CIL sought to challenge this
practice and recommended that Snape be prosecuted for manslaughter and that
the case be considered by the Disciplinary Committee of the recently established
GMC. These recommendations were approved. Both hearings resulted in Snape
being acquitted. Following these hearings, the CIL issued suggested regulations
for the use of therapeutic bathing.\textsuperscript{45} No further comments were made about
therapeutic bathing in the Annual Reports or on the adoption of the draft
regulations.

Over the course of the nineteenth century clinical practice in relation to the
management of aggressive and manic patients changed as doctors attempted
to use a variety of drugs to control patient behaviour. These agents included
opium, morphine, choral hydrate, bromide and digitalis, and the effects of these
were mixed. Some, such as morphine and chloral hydrate, were found to be

\textsuperscript{41} UKPP, MCL, 1844 (001), (p. 146).
\textsuperscript{42} For examples see UKPP, CIL, 1872 (279), (p. 159); UKPP, CIL, 1874 (284), (p. 218).
\textsuperscript{43} From the mid-nineteenth century the use of showers was more for cleanliness than therapy.
Stephanie C. Cox, Clare Hocking, and Deborah Payne, ‘Showers: From a Violent Treatment to an
\textsuperscript{44} Forbes Winslow, ‘Prolonged Shower-baths in the Treatment of the Insane’, \textit{Journal of
Psychological Medicine and Mental Pathology}, 10 (1857), 1-28 (p. 27).
\textsuperscript{45} UKPP, CIL, 1857 Session 2 (157), (pp. 24-40).
effective in sedating the patients.\textsuperscript{46} Others, such as digitalis, were found to have an initial benefit but prolonged use could produce serious side effects, such as hallucinations and confusion.\textsuperscript{47} Again, medical opinion was divided, with some arguing that sedative drugs were a safe and effective treatment, usable as an alternative to restraint and seclusion.\textsuperscript{48} Others, more cautiously, advised that it be made a requirement for all drug use to be recorded.\textsuperscript{49} Governments did not respond to this advice by amending the legislation and the CIL did not add the use of drug therapies to the list of Non-specified Issues.

Before 1889, little attention had been paid by governments to the reported use of mechanical restraint, other than noting the report from the CIL that there had been a reduction.\textsuperscript{50} When the lunacy law was revised in 1889 the new Act included a clause that defined the appropriate uses of mechanical restraint as being to prevent a patient harming themselves or others, and to aid healing following a medical or surgical treatment.\textsuperscript{51} The new law required that all uses of mechanical restraint had to be certified by a medical officer, a full record kept and the method of restraint limited to one that had been approved by the CIL.\textsuperscript{52} The CIL were concerned that having this list would indicate their approval of the wider use of mechanical restraint and seclusion, and this led to its publication being delayed until 1895.\textsuperscript{53}

In his evidence to the PSC on lunatics in 1859 Shaftesbury stated that the absence of use of mechanical restraint was ‘the established rule’ and that more than two or three cases of it being used ‘would be sufficient to condemn any asylum in the estimation of the Commissioners’.\textsuperscript{54} By 1882 the CIL felt able to state that: ‘The general abolition of instrumental or mechanical restraint in all English Asylums, Hospitals and Licenced Houses, renders unnecessary any

\begin{thebibliography}{99}
\bibitem{47} Digitalis is derived from the foxglove plant and has a strong effect on the heart, causing the pulse rate to fall. \url{https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4984589/} [Accessed 24 April 2019].
\bibitem{49} UKPP, PSC, 1877 (373), (p. 405).
\bibitem{50} UKPP, PSC, 1859 Session 1 (204), (pp. 64, 158); UKPP, PSC, 1877 (373), (p. 40).
\bibitem{52} S.45 LL, 52 & 53 Vict. CHAP. 41 (1889). No controls were placed on the use of seclusion or sedation.
\bibitem{53} UKPP, CIL, 1890 (274), (p. 358). The circular included a general statement on what constituted means of mechanical restraint and not an itemised list. UKPP, CIL, 1895 (311), (pp. 403-4).
\bibitem{54} UKPP, PSC, 1859 Session 1 (204), (p. 64).
\end{thebibliography}
remarks on a “system of non-coercion”\textsuperscript{55}. The following section presents the results from the analysis of the Annual Reports, which shows a rather different picture.

**Results from the inspections – mechanical restraint**

Detailed analysis of the Annual Reports shows that the claimed abolition had not occurred. Between 1845 and 1910 the CIL recorded a total of 1500 instances of mechanical restraint being used and 1809 uses of seclusion. The CIL did not consistently record the number of individual patients being restrained or secluded. The results do show that there was a higher reported incidence of the use of both at the public asylums, 1033 of the instances of mechanical restraint and 1323 of those of seclusion. The change from the results of the 1854 survey is, probably, explained by the increasing numbers of patients being admitted to the public asylums, making the use of both more probable.

This analysis of the Annual Reports shows that the use of mechanical restraint was not unusual or rare throughout the review period, undermining Shaftesbury’s *ex cathedra* comments on the subject. Figure 4.1 shows that the proportion of public asylums reported as using mechanical restraint rose from about 20% to about 60% between 1869 and 1892. After 1893 there was a marked and fairly rapid decline before the proportion levelled off at about 20% of these sites, a substantial minority. At the private asylums the proportion remained fairly stable before 1900 but then showed a small uplift, with a substantial minority (20%) of these institutions being reported. The use of mechanical restraint may have reduced from the pre-1845 level but there are no figures available to make this comparison. The use of seclusion, as shown in Figure 4.2, was, prior to 1872, used in a large majority (80%) of the public asylums. After this there was a gradual decline until about 1890, when the usage levelled off to between 20% and 30% of asylums, still a substantial minority. At the private asylums the rate was generally low (about 10%) but increased after 1894, when more detailed reporting was implemented, to about 20% of sites. The absence of information from before 1845 means that the impact of the CIL on these asylums cannot be fully assessed.

\textsuperscript{55} UKPP, ‘The Thirty-sixth Report of the Commissioners in Lunacy to the Lord Chancellor’, 1882 (357), (p. 91).
When account is taken of the much larger number of patients admitted to the public asylums, the pattern of use of both mechanical restraint and seclusion changes markedly. Calculation of the reported use of these techniques per 1000 patients showed that both were more frequently used in the private than the public asylums, as shown in Figures 4.3 and 4.4. These results more closely match those from the survey of 1854. For both techniques, there was an upward trend in usage at the private asylums and a gentle downward trend at the public asylums. The peaks in usage were, overall, higher in the private than the public asylums. If the use of restraint and seclusion in private asylums was linked to the ability to pay for additional staff, as suggested by Monro in 1814, the marked reduction in the number of these asylums that admitted these patients should have led to a lower rate of usage.\textsuperscript{56} Between 1849 and 1909 the number of private asylums admitting

\textsuperscript{56} UKPP, PSC, 1814-15 (296), (p. 12).
pauper patients reduced from thirty-nine to eight.\textsuperscript{57} The explanation for the increase in reported use cannot be identified from the Annual Reports.

Where the reports included details of the actual number of patients being restrained or secluded this was found to be low, with the average being less than ten people from each gender.\textsuperscript{58} The largest number of cases in a single year, forty-nine, was reported at the Earlswood Asylum for Idiots.\textsuperscript{59} The number of cases, when reported, did not receive particular attention or comment. Instead, the CIL focussed on cases where very long periods of restraint or seclusion were used. As one exceptional but not unique example; during the visit to the Surrey (Wandsworth) County Asylum on the 14\textsuperscript{th} March 1885 they found that:

\textsuperscript{57} UKPP, ‘Fourth Annual Report of the Commissioners in Lunacy to the Lord Chancellor’, 1850 (291), (pp. 18-23); UKPP, CIL, 1910 (204), (pp. 238-44).
\textsuperscript{58} For examples see UKPP, CIL, 1867 (366), (pp. 180, 195, 200); UKPP, CIL, 1896 (304), (pp. 243, 254, 310).
\textsuperscript{59} UKPP, CIL, 1896 (304), (p. 396).
Since the last visit [3 April 1884] 12 men and 19 women have been thus treated [restrained], the former for a total of 20,630 hours and the latter were for 20,958 hours … One female patient has also worn a “restraint dress” for 8064 hours, owing to destructive habits. We do not express any opinion on the necessity for the use of so much restraint, beyond remarking that it is much in excess of what we usually find employed in the present day.\(^\text{60}\)

The reporting by the CIL on the use of restraint has to be treated with a degree of caution as there was variation in what was recorded between asylums and these recordings were not always accurate. There were cases where during the inspection visit patients were found in restraints or seclusion for which a record did not exist.\(^\text{61}\) There was also some confusion over what constituted restraint and seclusion. During the visit to the Gloucestershire County Asylum on the 7 June 1867 the commissioners found a male epileptic patient locked in a padded room. This asylum did not count this as seclusion.\(^\text{62}\) Given that the recordings of the use of restraint and seclusion was how the CIL monitored the use of these techniques, these inaccuracies further undermined the claim that mechanical restraint was not being used. The reporting was also affected by differences in the way that the individual commissioners assessed, recorded and commented on the use of mechanical restraint and seclusion. In the report for 1873 this was demonstrated by the entries relating to the Middlesex (Colney Hatch) County Asylum and the Surrey (Wandsworth) County Asylum respectively:

[On the use mechanical restraint, after noting a specific patient the commissioners reported] ten other cases of restraint on the men’s side, one having had his arms fastened, and the remainder having worn “gloves” altogether on 253 occasions. Such an amount of instrumental coercion is without precedent in any other English asylum at the present day, and we hope

\(^{60}\) UKPP, CIL, 1886 (196), (p. 235).
\(^{61}\) For examples see UKPP, CIL, 1867 (366), (p. 18); UKPP, CIL, 1873 (256), (pp. 54, 134).
that some less objectionable mode of dealing with violent and destructive propensities will be adopted.  

During the same period it appears by the medical journal that 33 males and 12 females had their hands restrained by gloves for destructive propensities.  

This variation between the individual commissioners was compounded by the decision of the CIL to implement an annual change in which team was making visits to each of the circuits. The impact of this decision can be seen from the results of the visits to the Surrey (Wandsworth) County Asylum in 1879 and 1880. At the visit in 1879, the visiting commissioners noted that the use of restraint was ‘rather numerous’ with twelve men and eighteen women recorded as having been restrained. In 1880, when sixteen men and thirty-three women were reported as having been restrained, there was no comment about the frequency of use. Such variation in how an issue was addressed made it very difficult for the CIL to present a consistent view and for the institution being regulated to know how and when to respond.

Unlike the use of mechanical restraint, there was no requirement for the use of drugs as a chemical restraint to be recorded or monitored. The CIL did not routinely report its use, but they did on occasion include instances of the use of drugs. One such report related to the visit to the Gloucester County Asylum on the 21 November 1876:

Morphia by subcutaneous injection has been largely tried in the treatment of patients, and has been found to be of great value in cases of recurrent mania, and mania with paroxysmal outbreaks, but of no avail in acute mania. Eighteen men and 19 women are registered as at present taking medication. [Total of 317 men and 352 women were detained at time of the inspection visit.]  

63 UKPP, CIL, 1873 (256), (p. 178).
64 UKPP, CIL, 1873 (256), (p. 206).
65 UKPP, CIL, 1880 (321), (p. 297).
66 UKPP, CIL, 1881 (401), (p. 302).
67 UKPP, CIL, 1877 (403), (p. 214). A subcutaneous injection is into the fat below the skin, as opposed to one into the muscle or a vein.
The reports on the use of drugs confirm they were being used on only small numbers of patients but my analysis of the financial information showed there was a substantial increase in spending on medicines at the pauper asylums. The Reports included an appendix that showed the average cost\patient\week for a range of elements of the budget, including medicines. From this data it has been possible to calculate the annual spending on medicines for all public asylums, as shown in Table 4.2. This calculation showed that between 1866 and 1906 the number of patients nearly quadrupled, whilst spending on medicines increased six-fold. Given the level of increase in spending it seems likely that the reported use of drugs was an underestimate. A survey of therapeutic drug use in asylums was undertaken in 1881 which showed that there was no consensus within the medical profession. This lack of consensus can be seen in the variation in spending at individual asylums. Between 1870 and 1906 spending at the Yorkshire (Wakefield) Asylum fell from £399 (£48,570) to £240 (£29,210), whilst at the Northumberland Asylum it rose from £81 (£9860) to £257 (£31,280). Over the same period the numbers of patients at the Yorkshire (Wakefield) Asylum rose from 1414 to 1970 and those at Northumberland Asylum from 376 to 792. It is notable that as the overall spending on drugs rose the use of mechanical restraint and seclusion fell, a change over which the CIL had little or no control or influence.

Table 4.2: Comparison Between the Numbers of Patients and the Spending on Medicines at Public Asylums, 1866-1906

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
<th>Cost\Year</th>
<th>Patient\Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1866</td>
<td>23,643</td>
<td>£112,983 (£13.7m)</td>
<td>£4.78 (£609)</td>
</tr>
<tr>
<td>1876</td>
<td>34,153</td>
<td>£189,316 (£22.3m)</td>
<td>£5.54 (£708)</td>
</tr>
<tr>
<td>1886</td>
<td>48,130</td>
<td>£289,383 (£38.5m)</td>
<td>£6.20 (£797)</td>
</tr>
<tr>
<td>1896</td>
<td>63,962</td>
<td>£441,264 (£60.0m)</td>
<td>£6.90 (£952)</td>
</tr>
<tr>
<td>1906</td>
<td>89,342</td>
<td>£712,659 (£88.6m)</td>
<td>£7.98 (£995)</td>
</tr>
</tbody>
</table>

68 There is no comparable financial information for the private asylums, including the hospitals.
69 Harvey B. Wilbur, 'Chemical Restraint in the Management of the Insane', Archives of Medicine, 6 (1881), 271-92 (pp. 277-78); Robert Gray, 'Medical Men, Industrial Labour and the State in Britain, 1830-50', Social History, 16 (1991), 19-43 (pp. 19-20).
70 UKPP, CIL, 1871 (351), (pp. 258, 260); UKPP, CIL, 1906 (224), (p. 238). The inflation rate between 1870 and 1906 was -0.1%.
71 UKPP, CIL, 1871 (351), (p. 112); UKPP, CIL, 1910 (204), (pp. 234, 236).
72 UKPP, CIL, 1867 (366), (pp. 80, 94-97); UKPP, CIL, 1877 (403), (pp. 146, 326-29); UKPP, CIL, 1887 (200), (pp. 124, 304-7); UKPP, CIL, 1897 (279), (pp. 156, 198-203); UKPP, CIL, 1907 (225), (pp. 192, 228-33).
The analysis of the Annual Reports shows that mechanical restraint continued to be used routinely in both public and private asylums, contradicting the statement made by Shaftesbury. The absence of a count of the numbers of patients being restrained makes it impossible to determine if an absolute reduction in use had taken place. The results also showed that seclusion remained a routine part of the treatment regime. Whilst there were reductions in the proportions of asylums where use was reported this occurred at the same time as there was an overall increase in the use of sedation. This wider use of drugs in the management of the unwanted behaviours of lunatics and idiots reflected how the asylum service was being medicalised in the late nineteenth and early twentieth centuries.

**Action taken by the CIL – mechanical restraint**

That the monitoring of the use of mechanical restraint was identified as a Specified Issue in the legislation indicates that the CIL was expected to take action on this long-standing concern. However, the legislation of 1845 did not grant the CIL any powers to limit its use or to define when it should be used. It was not until 1889 that the legislation defined its usage and allowed the CIL to specify the permitted methods of restraint. The excessive or inappropriate use of mechanical restraint was not identified as a misdemeanour, preventing the use of prosecution. If maltreatment or neglect could be evidenced then the CIL could recommend prosecution under the terms of the Lunacy Act (1845). If such evidence could not be found, the CIL were left with trying persuasion to secure changes in practice.

The most frequently reported means of persuasion was that of commentary by the commissioners recorded in the Visitors Book. With some variation, these entries included the numbers of uses, the method used, the length of use for all recorded cases, and, if available, the reason(s) for use. Where this was known, the commissioners would indicate if the use of restraint had changed. This information was taken from the patient records contained in the registers. During a visit to the Middlesex (Colney Hatch) Asylum on 22 June 1872 the commissioners noted that eleven patients were being mechanically restrained for a period 'without precedent in any other English asylum at the present day'. At the next visit, 6 May 1873, it was noted that a substantial reduction had taken

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73 S.45 LL, 52 & 53 Vict. CHAP. 41 (1889).
74 S.LVI LL, 52 & 53 Vict. CAP.C (1845).
75 UKPP, CIL, 1873 (256), (p. 178).
place but it is uncertain whether the comment caused the change.\textsuperscript{76} Negative comments by the commissioners did not always lead to changes in practice, as shown by the reports on the visits to the Surrey (Wandsworth) Asylum in May 1875 and September 1876. In both the commissioners noted a high use of both restraint and seclusion.\textsuperscript{77} In the majority of the reports the CIL made no specific comment or requirement for action.\textsuperscript{78} As such, the reduction in the use of mechanical restraint over the review period cannot be definitively linked to the activity of and responses to the CIL.

Unless the patient was being restrained or secluded during the inspection visit, the CIL had to rely on the records maintained by the asylum. These were not always either accurate or reliable.\textsuperscript{79} Part of the problem, contributed to by the drafters of the legislation, was the lack of a definition of what constituted seclusion. This oversight was not corrected in any of the legislative changes and it was not until 1900 that the CIL promulgated the following definition, which ignored what happened at night:

By seclusion shall be understood the enforced isolation of a patient by day, between the hours of 7a.m. and 7p.m., by the closing, by any means whatsoever, of the door of the room in which the patient is.\textsuperscript{80}

Where, in the view of the CIL, an excessive amount of restraint or seclusion was being used or where the records of use were persistently incomplete a letter of admonishment was sent to the Visiting Committee or proprietor.\textsuperscript{81} Continued failure to take action by a proprietor could, rarely, result in the CIL recommending that the licence be modified so that only patients unlikely to need restraint were admitted. Such a recommendation was made in respect of

\textsuperscript{76} UKPP, CIL, 1874 (284), (pp. 186-87).
\textsuperscript{77} UKPP, 'The Thirtieth Report of the Commissioners in Lunacy to the Lord Chancellor', 1876 (383), (p. 229); UKPP, CIL, 1877 (403), (p. 277).
\textsuperscript{78} For examples see: UKPP, 'The Eighteenth Report of the Commissioners in Lunacy to the Lord Chancellor', 1864 (389), (pp. 12, 67); UKPP, CIL, 1877 (403), (p. 321); UKPP, CIL, 1886 (196), (pp. 228, 248).
\textsuperscript{79} For examples see: UKPP, 'The Tenth Report of the Commissioners in Lunacy to the Lord Chancellor', 1856 (258), (pp. 18-19, 20); UKPP, 'The Fourteenth Report of the Commissioners in Lunacy to the Lord Chancellor', 1860 (338), (p. 62); UKPP, CIL, 1871 (351), (p. 140); UKPP, CIL, 1910 (204), (p. 476).
\textsuperscript{80} UKPP, CIL, 1900 (246), (p. 12).
\textsuperscript{81} UKPP, 'The Seventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor', 1852-53 (285), (p. 21).
each of Barr House, London House and Upper Mall House. Even more infrequently, the CIL proposed, as in the case of Kingsdown House, that the licence be revoked. Without explanation, the JPs did not adopt this recommendation, a clear demonstration of an external limitation on the ability of the CIL to protect the patients. A threat to revoke or amend the licence was not available in the case of the public asylums.

One of the possible causes of the excessive use of restraint and/or seclusion was when an asylum could not fully or properly meet the care needs of a patient. The CIL recognised that this problem could arise when there were insufficient staff available. Because of the possible link between the use of restraint and/or seclusion and staffing numbers a correlation test was completed, but this showed no strong association between these issues in either the public or the private asylums. The CIL also considered if the excessive use of restraint could arise from who controlled the means of restraint. It had been the long-standing opinion of the CIL that the equipment used to restrain a patient be under the direct control of the medical staff, preferably the medical superintendent. They also recommended that both restraint and seclusion only be used on the written instructions of a medical officer. The lunacy legislation of 1845 did not include any section that specified the control of these techniques, this only being incorporated into the lunacy legislation in 1889. It was from then that the CIL were granted the power to define what particular instruments of mechanical restraint were appropriate for use in asylums, making the use of a non-approved method a misdemeanour. Because they feared that such a list was seen as indicating approval of the use of mechanical restraint, the CIL were reluctant to publish this document, only doing so in 1895. When the commissioners found equipment that was not on the approved list being used, they took no action beyond reporting the fact.

Whilst the statements of the CIL present a position of opposition to the use of mechanical restraint, the analysis of the Annual Reports has shown that they

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82 UKPP, CIL, 1862 (417), (p. 35); UKPP, CIL, 1867-68 (332), (pp. 17, 18).
83 UKPP, CIL, 1856 (258), (p. 20).
84 For examples see: UKPP, CIL, 1873 (256), (p. 23); UKPP, CIL, 1870 (340), (p. 154); UKPP, CIL, 1861 (314), (pp. 39-40); UKPP, CIL, 1886 (196), (p. 66).
85 UKPP, CIL, 1854 (339), (p. 43); UKPP, CIL, 1872 (279), (p. 201).
86 S.45 LL, 52 & 53 Vict, CHAP. 41 (1889).
87 S.45 LL, 52 & 53 Vict, CHAP. 41 (1889).
88 UKPP, CIL, 1895 (311), (pp. 403-4).
89 For example see UKPP, CIL, 1898 (259), (p. 373).
adopted a more pragmatic approach, more closely approximating to the general view within the medical profession, when dealing with the various asylums. This finding confirms the results reported by both Andrews and Tomes.\textsuperscript{90} During the visit to the Derbyshire County Asylum on 5 June 1876 the commissioners recorded that ‘Seclusion and restraint must occasionally be adopted’.\textsuperscript{91} Where attempts were made to modify the use of restraint the comments of the CIL encouraged this change in practice:

\begin{quote}
We are glad to be able to report that the patient who was continually under restraint has for the past month only been restrained at night, and for the last week the restraint has been entirely discontinued, with, as far as we can see, no ill results.\textsuperscript{92}
\end{quote}

This less absolutist position, likely contributed to by having no real power to require changes in practice, sought to ensure that mechanical restraint was used only for the exceptional cases. Achievement of this target was hampered by the absence of any published definition of what exceptional meant. Achieving a reduction could require more staff, incurring additional costs. The willingness and ability to meet these costs varied and the CIL had to rely on the cooperation of the medical superintendent, Visiting Committee, Board of Governors or proprietor. Variation in response was inevitable. This link to local cooperation can be seen in the case of Norwich Borough Asylum. Here high use had been a concern until September 1874, when a new medical superintendent was appointed. Following this change the CIL were able to report that there had been a marked reduction in the use of mechanical restraint.\textsuperscript{93} Given this dependence on the local response it is difficult to attribute responsibility for success or failure in securing change to the CIL alone.

In the case of mechanical restraint and seclusion the results show different patterns of use between the public and the private asylums. At both the public and private asylums there was an overall reduction in the proportion reported as using these methods of behaviour control. At the private asylums the proportion reported

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{90} Jonathan Andrews, 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry: Part 2', \textit{History of Psychiatry}, 8 (1997), 333-60 (pp. 342-44); Tomes, 'The Great Restraint Controversy', p. 199.
\item \textsuperscript{91} UKPP, CIL, 1877 (403), (p. 198).
\item \textsuperscript{92} UKPP, CIL, 1896 (304), (p. 433).
\item \textsuperscript{93} UKPP, CIL, 1876 (383), (p. 271).
\end{itemize}
\end{footnotesize}
as using mechanical restraint and seclusion in the control of patient behaviour was consistently lower than that at the public asylums. Whether this result was linked to the differences in reporting practice is uncertain, but the rise in reported use after more detailed reports started to be published does suggest that prior to 1896 there was some underreporting. This mixed pattern indicates that the CIL, despite their public advocacy of the use of non-restraint methods, had only limited influence. This limitation was the consequence of a combination of a lack of enforcement powers, variation in response from the asylum authorities, variation in how individual commissioners addressed these issues, and the annual change in which of the commissioners were making the visits. Analysis of the financial reports for the public asylums suggests that there was an increase in spending on drugs as the use of mechanical restraint declined. These changes in expenditure were not universal, emphasising that the policy on the use of restraint, seclusion and sedation was determined locally. The statements by Shaftesbury, about the abolition of the use of mechanical restraint and the effect of the condemnation of the CIL (p. 109), were undermined by the details reported by the commissioners.

Case Study 2: Staffing of asylums
Both those seeking reform of asylum services and the CIL recognised that the number and quality of the staff was an essential element in ensuring the safety of patients, hence the attention paid to the issue by the commissioners and its selection as a case study. This case study examines how the CIL sought to ensure that asylums were adequately staffed. This element of their work involved consideration of: the number of people employed; the knowledge, skills, and attitudes, termed here as quality, needed by the people employed; and the pay and conditions of service. The CIL focused most attention on the attendants, the largest single group of employees.94 The need for an adequate number of staff of the right quality was well understood at the time. Also understood was that staff shortages could affect the way patients were treated and the outcome of that treatment.95 However, securing sufficient capable staff had a cost implication.

In their report on the state of asylum services in England and Wales the MCL had noted the need for an increased number of well qualified attendants

94 Unless specified, the term attendant has been used to mean both men and women employed to provide care to the patients.
95 UKPP, PSC, 1814-15 (296), (pp. 26, 60, 78); UKPP, PSC, 1826-27 (557), (pp. 4, 21, 28); Conolly, The Construction, p. 83; Conolly, Treatment of the Insane, p. 99.
when non-restraint was adopted. They stated that the larger asylums had ‘sometimes great difficulty in finding good attendants’. Despite this recognition the MCL made no recommendation on the attendant to patient ratio in asylums. No minimum staffing levels were defined in law and it was left to the CIL to address the issue. This they did by recommending in the Rules published in 1847, that there should be ‘not less than one attendant for every twenty-five [or twenty] patients who are tranquil or convalescent; one attendant for every fifteen [or twelve] patients who are dirty, violent, or refractory, or dangerous to themselves or others’. They also stated that one attendant should sleep in each dormitory or in an adjacent room so as to be able to monitor the patients at night. In 1890 the CIL issued an updated version of the Rules, ‘RULES made by the Commissioners in Lunacy with the Approval of the Lord Chancellor’, which again did not include a statement on minimum staffing. No reason for these omissions was given in the Annual Reports. In 1893 the CIL suggested that ‘One attendant to 10 patients is a barely sufficient proportion to meet all requirements in an urban Asylum’. The Annual Reports do not explain why this distinction between urban and other asylums was drawn.

Some staff appointments were specified in the legislation. At the private asylums it was a requirement that a doctor be appointed as the medical superintendent, where the proprietor was medically qualified he could undertake this role. At the public asylums the required appointments were the medical superintendent, chaplain and clerk. There is a reference in the legislation of 1845 to the ‘Matron and other Officers and Servants’. Details of the roles of these posts, and of other staff, were included in the Rules (1847).

The only clause in the legislation of 1845 that related to the quality and behaviour of the staff was one that made the abuse, maltreatment or wilful neglect of a patient by an employee a prosecutable offence. This clause was included in both the Lunacy Act

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96 UKPP, MCL, 1844 (001), (pp. 24-25). In the smaller private asylums much of the care could be undertaken by a medically qualified or asylum experienced proprietor, Smith, ‘Behind Closed Doors’, (p. 305).
97 UKPP, CIL, 1847-48 (858), (pp. 334-35). The numbers in square brackets are as shown in the original and are not explained if, when or how they applied.
98 UKPP, CIL, 1890 (274), (pp. 340-57).
99 UKPP, CIL, 1893-94 (242), (p. 278). The term ‘urban’ was not explained and was not used at any other time.
100 S.XXIV & S.XLIII LL, 8 & 9 Vict. CAP.C (1845).
101 These appointments are in the order shown in S.XLII LL, 8 & 9 Vict. CAP.CXXVI (1845).
102 S.XLIII LL, 8 & 9 Vict. CAP.CXXVI (1845).
103 UKPP, CIL, 1847-48 (858), (pp. 329-36).
and the County Asylums Act. The legislation also drew a distinction between the asylum types on the monitoring of staff numbers. At the public asylums the numbers were to be checked at each visit. At the private asylums this was not a requirement. Again, the reason for this distinction was not explained. In monitoring both the number and quality of attendants at all asylums the CIL went beyond what was required by the Act, a further demonstration of the effort they expended and the importance they placed on staffing as a means of ensuring the safety of the patients.

Whilst the number of medical staff was not specified in any of the lunacy legislation, the frequency of their visits to private asylums was. A private asylum with more than one hundred patients had to have a medical officer resident at all times. A doctor had to make a daily visit where the private asylum had between fifty and one hundred patients. In those with less than fifty patients the doctor had to visit at least twice a week. The Lunacy Act (1845) granted the CIL the power to require an increase in the number of visits for the last group, up to a maximum of once a day. Whilst the County Asylums Act (1845) did not specify a schedule for the medical visits it did require that each week the Medical Officer complete a record on the condition of all patients admitted to the asylum. Failure to maintain this record could result in the individual doctor being fined up to twenty pounds (£2486), a substantial sum.

The quality of the attendants working in asylums had been an issue of concern since early in the nineteenth century. Exactly what was meant by high quality attendants was not defined and a range of criteria had been identified. Dr John Conolly (1794-1866), the well-known alienist, emphasised that the good attendants were those who could lead the patients through the strict routine of their day. John Sheehan, in his study of the attendants employed at the Yorkshire (Wakefield) County Asylum, also identified obedience to the rules of the asylum as an important factor. Also seen as being of importance was the physical size and strength of the attendants. Smith noted that male attendants were commonly ex-

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105 S.CX LL, 8 & 9 Vict. CAP.C (1845).
106 S.LXIV LL, 8 & 9 Vict. CAP.C (1845).
107 S.LVII LL, 8 & 9 Vict. CAP.C (1845). The medical officer could be any ‘Physician, Surgeon or Apothecary’
108 S.LXXIV LL, 8 & 9 Vict. CAP.CXXVI (1845). There are no reports of this fine being imposed.
109 UKPP, PSC, 1807 (39), (p. 21); UKPP, PSC, 1814-15 (296), (pp. 12, 19, 26, 44).
110 Conolly, The Construction, pp. 87-105.
military personnel and that the nurses had worked in domestic service.\textsuperscript{112} In a circular dated 31 March 1859 the CIL sought to offer the following guidance which distinguished between the needs of pauper and non-pauper patients:

The particular qualifications for Attendants, in addition to moral character, patience and good temper, and cleanly and orderly habits, depend upon the classes and stations in life of the patients under their care.

As respects Pauper Patients, the Attendants should be capable of directing and promoting their occupations and amusements, of reading to them, and of instructing them in their various trades and employments.

Qualifications of a higher order, and a superior degree of education, are required in Attendants for Private Patients, to whom they are … companions.

In order to ensure the service of good and efficient Attendants, and to prevent a frequent change of such persons, it is indispensable that they should be adequately paid.\textsuperscript{113}

An anonymous article published in 1866 in the \textit{Journal of Mental Science}, acknowledged the low quality of asylum attendants, describing ‘the mass as coarse, harsh, passionate, indifferent, untrustworthy, intemperate; as having no higher conception of their office than as that of gaoler’. The author went on to contend that the solution was not to increase the pay of these staff, as this had been found to be ineffective, suggesting instead, as was the case in many European asylums, that the number of women employed to care for male patients be increased.\textsuperscript{114}

Ten years later and writing in the same journal, Dr, later Sir, Thomas Clouston (1840-1915), Physician-Superintendent at the Royal Edinburgh Asylum, identified that there was approximately one attendant to every twelve patients at

\textsuperscript{112} Smith, ‘Behind Closed Doors’, (pp. 306-7).
\textsuperscript{113} UKPP, CIL, 1859 Session 2 (204), (p. 114).
\textsuperscript{114} Anonymous, ‘Sisterhoods’, (pp. 44, 47, 62).
the asylums in Great Britain, and that there was a small nucleus of long-serving staff and a much larger group of short-term employees. He argued that it was vital to ensure that the long-servers were retained and identified an eight-point plan, which included good pay, a pension, decent living conditions and opportunities for promotion, to achieve this.\textsuperscript{115} As the CIL implemented its agenda these ideas were under discussion and, as will be seen, improvement to the terms and conditions of attendants was supported by the commissioners and was a focus of attention during inspection visits.\textsuperscript{116}

\textbf{Results from the inspections - staffing}

Because of their direct interaction with patients, their central role in the implementation and effectiveness of moral therapy and their numbers and consequent costs, the CIL focused most attention on the attendants. They reported on the number of staff, their quality and whether the turnover rate was high. Despite the recognition that insufficient medical staff could cause harm to the patients, the CIL paid less attention to the doctors.\textsuperscript{117} Other staff, such as the chaplains, clerks and artisans, only received attention when they attracted praise or, more often, criticism from the commissioners.\textsuperscript{118} The deployment of staff was influenced by the concern of the CIL that contact between men and women in asylums, whether staff, patients or visitors, be limited.\textsuperscript{119}

Reporting on the numbers of attendants differed between the public and private asylums, with reports on staff shortages being more frequent at the former. Between 1860 and 1890 the proportion of public asylums reported for staff shortages rose from a substantial minority (20\%) to the vast majority (90\%), as shown in Figure 4.5. After 1900 there was a marked drop in reports, which reversed in 1905. Detailed examination of the results showed eight public asylums were reported for low staffing for more than thirty-five of the years between 1845

\textsuperscript{115} Thomas S. Clouston, 'On the Question of Getting, Training, and Retaining the Services of Good Asylum Attendants', \textit{Journal of Mental Science}, XXII (1876), 381-88 (pp. 381-82, 387-88).
\textsuperscript{116} UKPP, CIL, 1892 (320), (p. 46).
\textsuperscript{118} The artisans included the joiners, handymen and other male staff employed in non-direct care roles in the asylum.
\textsuperscript{119} UKPP, CIL, 1847-48 (858), (pp. 324, 334); UKPP, CIL, 1890-91 (286), (p. 139).
and 1910. These results contrast with those for the private asylums where, aside from the period between 1899 and 1902, the rate was well below 20%, as shown in Figure 4.5. The highest numbers of reports in this group related to those sites that provided care for pauper patients but the instances were much lower, the most frequently reported being St Luke’s Hospital (16), Hoxton House (14) and Fisherton House (14). The CIL reported that the shortage of staff in all asylums in the years 1899 to 1903 was the consequence of how:

The war, prosperity of trade, and the high rate of wages in other employments, have, during the past year, added to the difficulty experienced in some Asylums, in securing and retaining the services of suitable persons as attendants.

The financial data for the public asylums and the mental hospitals, aside from showing how much more was spent on staff at the latter, as shown in Table 4.3, highlights that expenditure on staff rose as patient numbers increased. At the public asylums there was an increase in spending on staff from 22% to 30% of the total cost. At the mental hospitals, where the increase in patient numbers was much smaller, the rise was from 20% to 24%. The rate of inflation between 1866 and 1906 is shown to have been -0.1% on the Bank of England inflation calculator,

![Figure 4.5: Comparison Between the Percentage of Public and Private Asylums Reported for Inadequate Staffing, 1860-1910](image)

The highest numbers of reports were at: Denbigh (42); Oxfordshire (39); Devon, Surrey (Brookwood) and Worcestershire (Powick) (36 in each); Gloucester, Lancashire (Rainhill) and Nottinghamshire (35 in each). These reports were not always consecutive entries.

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120 The highest numbers of reports were at: Denbigh (42); Oxfordshire (39); Devon, Surrey (Brookwood) and Worcestershire (Powick) (36 in each); Gloucester, Lancashire (Rainhill) and Nottinghamshire (35 in each). These reports were not always consecutive entries.
121 UKPP, CIL, 1901 (245), (p. 16).
122 The CIL did not report the financial data by site prior to 1866 and never reported this information for any of the Metropolitan or Provincial Licenced Houses. The changes in patient numbers are shown in Table 1.2 (p. 22).
making the increase a rise in real spending and not just the impact of inflation. The changes in staff costs recorded could be the result of increasing staff numbers, of improving pay and conditions (to encourage retention), or, after 1853, of the payment of a pension to staff aged over fifty who had been continuously employed for more than twenty years.123 Despite receiving the lists of all staff employed at each asylum the CIL did not produce a report of staffing numbers by site.

Table 4.3: Comparison Between the Average Total Costs (All) and Staff Costs (Staff) per Patient per Year at Public Asylums (Public) and Registered Hospitals (Hosp.), 1866-1906

<table>
<thead>
<tr>
<th>Asylum</th>
<th>1866 All</th>
<th>1866 Staff</th>
<th>1876 All</th>
<th>1876 Staff</th>
<th>1886 All</th>
<th>1886 Staff</th>
<th>1896 All</th>
<th>1896 Staff</th>
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</tr>
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<tbody>
<tr>
<td>Public</td>
<td>£50</td>
<td>£11</td>
<td>£57</td>
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<td>£47</td>
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<td>£47</td>
<td>£14</td>
<td>£55</td>
<td>£16</td>
</tr>
<tr>
<td>Hosp.</td>
<td>£72</td>
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<td>£89</td>
<td>£17</td>
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<td>£16</td>
<td>£101</td>
<td>£23</td>
<td>£119</td>
<td>£28</td>
</tr>
</tbody>
</table>

Commentary on the quality of the asylum staff related mainly to the attendants, with the CIL noting how the attendants interacted with the patients, if and how they followed the rules of the asylum and the demeanour, age and maturity of these staff.124 An example of the impact of the quality, which included the skills, aptitudes and attitudes of the staff, on patients was reported in 1848. During a visit to Vernon House Asylum, Glamorganshire, the CIL noted that none of the attendants could speak Welsh. The majority of the eighty-six pauper patients were reported as speaking only imperfect English.125 No comment was made about the language skills of the medical staff.126

Prior to 1860 the CIL reported on the numbers of staff, with very few comments about their quality.127 Between 1861 and 1901 the trend seen was of an increasing number of reports relating to the quality of staff at the public asylums, as shown in Figure 4.6. Around the turn of the century there was a spike in these reports, which coincided with the years when there were problems with the

123 S.LVII LL, 16 & 17 Vict. CAP.XCVII (1853). S.12 LL, 25 & 26 Vict. CAP.CXI (1862). This provision only applied to the public asylums.
124 UKPP, CIL, 1870 (340), (pp. 77-78).
125 UKPP, CIL, 1847-48 (858), (p. 105). A feature of dementia is that as the disease progresses the patient reverts to their mother tongue, "Losing your English: "Reverting" to your mother tongue as dementia progresses" Alzheimer's Society (alzheimers.org.uk) [Accessed 17 June 2021].
126 In the Rules the CIL did suggest that in asylums admitting large numbers of Welsh patients that 'the Chaplain...[and that] a fair proportion of attendants of each sex [be] acquainted with the Welsh language...[and able to] communicate [the patient's] wishes to the medical and other authorities', UKPP, CIL, 1847-48 (858), (p. 333).
127 UKPP, CIL, 1859 Session 2 (204), (pp. 38-39).
recruitment of attendants due to the effects of the Boer War and competition for labour from other sectors of the economy.\textsuperscript{128} By 1906 the proportion of asylums reported for low staff quality had reduced to about the pre-war level. Reports of low-quality staff being employed at the private asylums were much fewer throughout the review period. There were small spikes in reports in 1881 and 1901, the former was not explained but the latter was attributed by the CIL to the effects of the Boer War.

As an adjunct to their site visits the CIL monitored the numbers of attendants who were dismissed. Following the unexplained failure to secure the conviction of an attendant for maltreating a patient, the CIL advised the Visiting Committees to keep a record of all staff who had been dismissed.\textsuperscript{129} Asylums were reluctant to do so and the CIL secured an amendment to the lunacy laws in 1853 that made the reporting of these cases a requirement.\textsuperscript{130} The CIL maintained a register of these notifications which could be accessed by any Visiting Committee or proprietor, so that a person previously dismissed could be prevented from securing employment elsewhere. There are no reports as to how frequently or even if this resource was used.\textsuperscript{131} Before 1890 the CIL only reported the dismissal of a member of staff where that person was prosecuted, giving the impression this

\textsuperscript{128} One of the sources of male attendants was the military. After serving a number remained on the reserve list and were called back to the colours. Whilst the conflict lasted this source of recruits was reduced, leading to staff shortages in some, but not all, asylums.

\textsuperscript{129} UKPP, CIL, 1870 (340), (p. 72).

\textsuperscript{130} UKPP, CIL, 1847-48 (858), (p. 332); UKPP, CIL, 1850 (291), (p. 10). S.LVI LL, 16 & 17 Vict. CAP. XCVII (1853). A similar clause was included in the legislation relating to registered hospitals and licenced houses, see S.XXVI LL, 16 & 17 Vict. CAP. XCVI (1853). Failure to comply with this requirement was itself a misdemeanour punishable by a fine.

\textsuperscript{131} In Scotland this listing of staff dismissed was also reported to have been bypassed, Andrews, “They’re in the Trade ... of Lunacy”, p. 55.
was an unusual event. From 1890 they included cases not involving prosecution, which, by 1906, showed that 130 people had been dismissed.¹³² That the numbers of cases were affected by under reporting was recognised and noted by the CIL:

As a general rule, only the most flagrant cases of dismissal of attendants are reported to this office; and no doubt many are either allowed to resign, or are discharged without notice being sent.¹³³

The ability of the Visiting Committees to ensure that there was an adequate number of good quality attendants on duty was affected by the fact that the majority of people employed stayed in post for only a short period of time. The high turnover of attendants got progressively worse over the course of the nineteenth century, with the proportion of asylums affected rising from a substantial minority (20%) to a peak of the majority (70%) in 1901, as shown in Figure 4.7. In the private asylums the CIL reported that this issue was also a problem, particularly in those that admitted pauper patients.¹³⁴ Having a large number of attendants remaining in post for only a short period undermined the achievement of sufficient numbers. It also increased the likelihood that those staff lacked experience in caring for the patients. The CIL identified three main causes for the high turnover rate, these being low pay, poor working and living conditions and the people employed not being suitable for the work.

¹³² These figures are from a count of the cases noted in the individual entries for asylums in Appendices C, E & I of UKPP, CIL, 1906 (224), (pp. 281-425, 428-48, 458-93).
¹³³ UKPP, CIL, 1872 (279), (p. 67). There is no evidence of any prosecutions being initiated for a failure to supply this information.
¹³⁴ UKPP, CIL, 1867-68 (332), (p. 8).
The CIL noted that the turnover rate for female nurses was higher than that for the male attendants and attributed this to the women leaving to have children. Another factor, not commented upon by the CIL, was the substantial pay differential between male attendants and female nurses for doing the same work, despite an early attempt to correct this problem by Sir Alexander Morison (1779-1866). In their Report of 1881 the CIL noted that at the Wiltshire County Asylum the pay for male attendants started at £20 and rose incrementally to £35 per year (£2487-£4352). The equivalent pay for female nurses was a scale of £16 up to a maximum of £23 per annum (£1990-£2860). Because of their shorter length of service the majority of the nurses were at the lower end of the pay scale. Whilst this pay was modest, attendants and nurses were provided with free accommodation and meals, equating to that provided for the patients. The lack of commentary on the pay differential probably reflects the attitude in this period to the place of women in society and at work.

The reporting of medical staffing differed from that relating to the attendants. Whilst the CIL were concerned about the number of doctors employed, particularly where this impacted on the ability of the medical superintendent to

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136 UKPP, CIL, 1881 (401), (p. 312). This pay differential was maintained for all grades of care staff, including the head male attendant and matron grades.
supervise the patients and complete his administrative duties, they rarely commented on the quality of the people employed in these posts. An insufficient number of doctors was most frequently reported at the public asylums. In June 1878 the CIL noted that the size of the Devon County Asylum now required the appointment of a second medical assistant to enable the medical superintendent ‘without undue strain’ to efficiently administer the institution.\textsuperscript{139} Aside from a peak of ten in 1891, there were no more than two or three reports on insufficient medical staff in any year. At the private asylums these shortages were a very infrequent finding.\textsuperscript{140} Inadequate medical staffing could have serious consequences. In January 1876 the medical superintendent of Wonford House Asylum, Exeter, was unwell but no locum cover had been arranged. As a consequence, the treatment of a patient, Mr RHC, for bronchopneumonia was delayed, a factor that contributed to his death.\textsuperscript{141}

Unlike with the attendants, commentary on the quality of the medical superintendents tended to be positive and complimentary. The work of medical staff would be noted, such as upon the retirement due to ill health of Dr T. Seymour, senior assistant medical officer of the Norfolk County Asylum in 1882.\textsuperscript{142} Similar commentary was not made about non-medical staff. An exception was the negative report on the work of Mr G. L. Millard, a surgeon appointed as the medical superintendent of the Haverfordwest Borough Asylum. He had been in post for an unspecified period before the MCL first visited in 1842. In their report of 1844, he was criticised for failing to perform his duties.\textsuperscript{143} The CIL also criticised both his qualification to hold the post and his work and in 1857 they wrote to the Secretary of State asking that he intervene with the Visiting Committee to replace Mr Millard ‘with some person properly qualified’. A new appointment was made, but only after twelve years of intermittent negative commentary.\textsuperscript{144} This reluctance by the CIL to criticise the medical staff, even when patient safety was thought to be compromised, was in contrast to the reaction to other staff. It is possible that the CIL were less willing to publicly criticise men of high social standing, except in very extreme circumstances.

\textsuperscript{139} UKPP, CIL, 1878-79 (342), (p. 220).
\textsuperscript{140} UKPP, CIL, 1890-91 (286), (p. 246).
\textsuperscript{141} UKPP, CIL, 1876 (383), (pp. 46-47).
\textsuperscript{142} UKPP, CIL, 1883 (262), (p. 251). Similar comments were not made about non-medical staff.
\textsuperscript{143} UKPP, MCL, 1844 (001), (pp. 46-52).
\textsuperscript{144} UKPP, CIL, 1847-48 (858), (pp. 93-95); UKPP, CIL, 1857-58 (340), (pp. 10-11).
Because medical staff retention was high the CIL paid little attention to the pay and conditions of these staff, with only the occasional report on the salary of the medical superintendent. In his history of the Norfolk County Asylum, Cherry reported that the total salary for the medical superintendent in 1903 was £1100 (£136,800). The salary for junior and senior medical officers in the same year was £160 and £250 respectively (£19,900 and £31,000).¹⁴⁵ All the doctors were provided with on-site accommodation, with that for the medical superintendent coming at high cost (see below, p. 132). The turnover rate amongst the medical staff varied with the grade of the doctor. Once appointed to a medical superintendent post the doctors tended to remain for long periods, unless there was a significant disagreement with the Visiting Committee or proprietor or for reasons of health. In the assistant posts there was an inevitable higher rate of turnover as these doctors moved to gain experience, to secure a more senior appointment or to leave the asylum service.

**Action taken by the CIL - staffing**

Despite the recognition of the importance of having a sufficient number of suitable staff, the lunacy legislation did not specify a minimum staffing level or grant the CIL any enforcement powers in respect of staffing. This lack of power left the CIL with little choice but to try to establish a dialogue with the Visiting Committees and the proprietors to secure recommended changes. They usually started this dialogue by offering general comments on their findings, with examples of this approach being: ‘the bad class of attendants employed’ at Peckham House Asylum, London, or ‘Some of the Nurses and Attendants also are young and inexperienced’, a comment made about the staff of the Oxford and Berkshire County Asylum.¹⁴⁶ The benefit of such vague comments from the CIL was questionable as they offered little assistance to the Visiting Committee or proprietor on the action to be taken. Where this approach failed to be effective the CIL adopted a progressively more overtly critical tone of reporting.

This progressive public commentary started with the identification of a staffing shortage as a factual and non-critical statement. An example of this came from the visit to the Cheshire (Chester) Asylum on 3 August 1867. Here the commissioners reported that ‘The staff of female attendants is now two short of the

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¹⁴⁵ Cherry, *Mental Health Care* p. 121.
¹⁴⁶ UKPP, CIL, 1860 (338), (p. 38); UKPP, CIL, 1862 (417), (p. 156).
usual number, and we understand that some difficulty has been found in securing
the services of suitable persons’. In some cases, such as the Cumberland and
Westmorland Asylum, this approach appears to have been effective as the
shortage noted in 1882 was not mentioned in the following year, but this lack of
reporting may have been due to the change in the team making the visit. Where
statements of fact were not effective the CIL made increasingly direct comments.
This can be seen in the case of the Devon County Asylum between 1881 and
1884, with the commentary going from identifying the staff to patient ratio of one to
fifteen ‘being insufficient’ to ‘No increase in staff has been made’. Despite these
comments the Visiting Committee took no action. There was a similar lack of
response to a recommendation for the employment of an additional doctor to the
Cambridgeshire County Asylum between 1867 and 1874.

Not all of the solutions to resolve non-compliance of staffing issues were
found to be acceptable by the CIL, as was made clear in the feedback on
inspection visits. In response to the CIL recommendation that attendants be
employed just to supervise the epileptic and suicidal patients at night, some
asylums used patients as assistant attendants instead. The opinion of the CIL on
this practice was clear from their comment on a visit to the Lancashire (Rainhill)
Asylum in September 1871:

[W]e regret still to have to observe that the second night watch
in each division is supplied by a male and female patient
respectively. We do not think that for a continuance of such
important services should be so supplied; … we think that each
division should have two paid night attendants.

The setting of the level of remuneration for staff employed in asylums was
a matter that was determined by the relevant Visiting Committee, proprietor or
Board of Governors. Because the CIL had no role in the setting of the budget, or
the rates to fund the public asylums, they only rarely commented on the salaries

147 UKPP, CIL, 1867-68 (332), (p. 134).
148 UKPP, CIL, 1883 (262), (p. 181); UKPP, CIL, 1884 (280), (p. 182).
149 UKPP, CIL, 1881 (401), (p. 211); UKPP, CIL, 1882 (357), (p. 248); UKPP, CIL, 1884 (280), (p.
188).
150 UKPP, CIL, 1867-68 (332), (p. 180); UKPP, CIL, 1868-69 (321), (p. 146); UKPP, CIL, 1870
(340), (p. 121); UKPP, CIL, 1873 (256), (p. 126); UKPP, CIL, 1874 (284), (p. 28).
151 UKPP, CIL, 1872 (279), (p. 152).
paid at the individual public asylums because of the need to take local conditions into account. One intervention on this subject came in 1879 when they set out suggested pay scales.\textsuperscript{152} The CIL proposed that the minimum starting salary for a male attendant be £30 (£3800), that for a female attendant was to be £20 (£2500). A male attendant in charge of a ward should be paid £40 (£5000). No mention was made of the salary for a female attendant in charge of a ward.\textsuperscript{153} There were no reports to indicate if this proposal was ever implemented.

The CIL had more to say on the means of encouraging both recruitment and retention. They supported proposals from asylums to build designated staff accommodation and for the payment of pensions.\textsuperscript{154} The medical superintendent had always been provided with on-site accommodation for use by him and his family. In some instances, this took the form of a set of rooms within the main building, in others a detached house was provided, some at significant cost. At the Devon County Asylum such new accommodation was provided in 1901 at a cost of £2431 (£306,000).\textsuperscript{155} Each member of the junior medical staff, whose accommodation was normally within the division for which they were responsible, were provided with a smaller set of rooms. When first established, the county asylums did not provide separate accommodation for the attendants, these employees having to use side rooms and beds on the wards. In order to improve retention some asylums started to build separate accommodation for attendants, thereby allowing more patients to be admitted to the wards. An example of such an investment was the nurse’s home built at the Lancashire (Rainhill) Asylum in 1895 at a cost of £5500 (£740,000) to the ratepayers.\textsuperscript{156} At the turn of the twentieth century on-site accommodation started to be provided for the married male attendants. This housing, such as that at the Berkshire County Asylum, was in the form of a short terrace of cottages, with each cottage costing about £250 (£30,800) to build. This accommodation was noted by the CIL to be ‘one important means of promoting long service and contentment among the staff that married men should be able to obtain suitable accommodation for their families in close proximity to the asylum’.\textsuperscript{157} Much of this investment in working conditions occurred at the turn of

\textsuperscript{152} UKPP, CIL, 1852-53 (285), (p. 115).
\textsuperscript{153} UKPP, CIL, 1880 (321), (pp. 433-435). Smith reported that there was a pay differential between the county asylums and the madhouses, Smith, ‘Behind Closed Doors’, (p. 311).
\textsuperscript{154} UKPP, CIL, 1890-91 (286), (pp. 7-9); UKPP, CIL, 1900 (246), (pp. 38-40, 209).
\textsuperscript{155} UKPP, CIL, 1901 (245), (p. 24).
\textsuperscript{156} UKPP, CIL, 1895 (311), (p. 83). The number of staff to be accommodated was not reported.
\textsuperscript{157} UKPP, CIL, 1907 (225), (p. 31).
the twentieth century when pay and conditions were improving in other sectors of the economy, affecting the ability to recruit staff, and in response to the unionisation of the asylum workforce, which was commencing.\textsuperscript{158} It became a matter of self-interest for employers to pay attention to these issues.

The CIL also used its advisory role to support and publicise innovations that they thought should be adopted more widely. One of these was the attempt to raise the quality of the medical staff and attendants through the implementation of training schemes. Such training was initiated by individual medical superintendents responding to a particular local need. An early example was a series of lectures delivered by Sir Alexander Morison at the Surrey (Wandsworth) County Asylum in 1843.\textsuperscript{159} The result of these local initiatives was that training, if any, varied from site to site, being dependent on what each employer considered appropriate and affordable.\textsuperscript{160} This piecemeal approach prompted an anonymous asylum chaplain, writing in 1870 in the \textit{Journal of Mental Science}, to propose that a standardised training for attendants be implemented.\textsuperscript{161} This proposal was taken up by the Medico-Psychological Association, (hereafter MPA), the professional association of asylum medical staff, when they established a committee to prepare a scheme of training. The proposed scheme was published in 1885 as the \textit{Handbook for the Instruction of Attendants of the Insane}.\textsuperscript{162} This was gradually adopted as the standard training for asylum attendants. Even with the use of the \textit{Handbook} as guidance, the standard of training remained variable and this impacted on the attempt to include asylum attendants on the proposed register for nurses at the turn of the twentieth century.\textsuperscript{163} Alongside training for attendants, the MPA also lobbied for training in the treatment of lunatics to be added to the medical school syllabus. The development of training for doctors was part of the wider professionalization of the medical profession taking place in the nineteenth and

\textsuperscript{158} UKPP, CIL, 1901 (245), (p. 16); Anonymous, 'Mental Hospital and Institutional Workers Union', \textit{Wikipedia}, (nd); https://www.wikiwand.com/en/Mental_Hospital_and_Institutional_Workers%27_Union [Accessed 24 May 2022].
\textsuperscript{159} Alexander Walk, 'The History of Mental Nursing: The Presidential Address at the One Hundred and Twentieth Annual Meeting of the Royal Medico-Psychological Association', \textit{Journal of Mental Science}, 107 (1961), 1-17 (p. 8).
\textsuperscript{160} UKPP, CIL, 1895 (311), (pp. 262, 289).
\textsuperscript{161} Anonymous, 'Attendants in Asylums', (p. 310).
\textsuperscript{163} Mrs. Ethel Bedford Fenwick, 'Editorial: Mental Nurses', \textit{The Nursing Record and The Hospital World}, VXII (1896), 429-31 (p. 430).
early twentieth centuries, to which the CIL added its voice. In respect of staff training it is clear that the CIL were not instigators of this development but supported these independent initiatives.

The results of this case study show that the issue of the staffing of asylums proved to be one that the CIL had limited ability to secure consistent and sustained compliance. The increase in the proportion of public asylums reported for having inadequate numbers of staff shows clearly that the reliance on persuasion was not a consistently effective strategy. The sudden reversal in reported staff shortages at the turn of the twentieth century (see Figure 4.7, p. 128), appears to be due to a change in reporting rather than a substantial increase in staff numbers, there being no major change in staff costs at this time. At the private asylums the proportion of sites reported remained low until the late 1890s but then started to increase, a consequence of the change in reporting by the CIL. Whilst spending on staffing at the public asylums did rise, this increase was at well below the level of increase in the number of patients, suggesting that the resistance of local ratepayers to cost increases outweighed the recommendations of the CIL for increases in staff numbers. Even where increases were achieved, the impact was only transitory due to the ever-increasing numbers of pauper patients being detained. In seeking to secure improvements in staffing and the people employed, these results show the CIL supported local developments and training initiatives rather than being an innovator. They did attempt to act as a network for the dissemination of information on practice they thought to be good but there is little evidence to suggest their efforts were effective.

**Overview of the case studies of the Long-standing Issues**

In the case of these long-standing issues that impacted on patient safety, the achievement of compliance has been shown to be an uncertain process when the regulator had to rely on persuasion. This approach appears to have been more successful in the case of the use of mechanical restraint, where reductions in use did occur. However, it remained in common use in both public and private asylums,

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Despite the assertions of Shaftesbury to the contrary.\textsuperscript{165} Given that many doctors were turning to drugs to control patient behaviour, it is by no means certain that more than a part of that reduction was the result of the activity of the CIL. Reduction in the proportion of asylums being reported for having insufficient staff, mainly attendants, appears from these results to have been beyond the capacity of the CIL. Persuasion was not an effective strategy to secure an increase in staffing and improved conditions of employment. These improvements came at a cost and many local authorities, under pressure from the ratepayers, were reluctant to make additional funds available. The pressure to limit the costs of supporting paupers did not just apply to the lunatics and idiots, both workhouses and outdoor relief budgets were also constrained.\textsuperscript{166} The ability to recruit additional staff was also affected by the state of the local labour market. Without local support, the CIL made little consistent and\textbackslash or sustained headway.

The ability of the CIL to secure change was impeded by the lack of a means for requiring that change be made. Persuasion was not reliable and prosecution was not available, neither the high use of mechanical restraint nor low staffing were defined as a misdemeanour. The absence from the legislation of the power to serve a notice requiring change, as per the Factory Act (1833), also limited the ability of the CIL to secure compliance.\textsuperscript{167} This lack was, to a large extent, outside of the control of the CIL. However, it does need to be noted that the CIL did not ever request an increase in their powers, in fact they actively opposed any such proposal.\textsuperscript{168} It was also the case that the CIL did not seek reform of the lunacy laws to establish a minimum staffing standard or prohibition on the use of mechanical restraint. Securing of the latter was highly unlikely due to the lack of consensus within the medical profession.

Aside from opposing an increase in their powers, the CIL decision to make an annual change in which of the teams of commissioners would make inspection visits also impacted on the securing of compliance to these long-standing issues. Unsurprisingly, the way individuals reacted to and reported on an issue varied. This produced inconsistencies from year to year in the emphasis given to failures of compliance. From the perspective of the asylum, such inconsistency made it

\textsuperscript{165} UKPP, PSC, 1859 Session 1 (204), (p. 64); UKPP, CIL, 1882 (357), (p. 91).
\textsuperscript{167} LL, 3 & 4 Gulielmi IV CAP.CIII (1833); Bartrip, 'British Government Inspection', (p. 611).
\textsuperscript{168} UKPP, PSC, 1877 (373), (pp. 546-547).
difficult to determine the priority that should be given to a recommendation, or at the least, made this argument possible. The decision to implement this arrangement was made by the CIL but was influenced by the limitation placed on the number of medical and barrister commissioners, three of each, imposed by the legislation and fully supported by Shaftesbury and the founding members of the CIL.\textsuperscript{169}

\textsuperscript{169} S.III LL, 8 & 9 Vict. CAP.C (1845).
Chapter 5: Securing Compliance of Contemporary Issues

In the last chapter two case studies on long-standing concerns about asylum services were explored. The results showed that: the CIL did secure changes in some but not all asylums; where changes were secured, these resolved the problem for a limited time period; and securing change was dependent upon cooperation from the Visiting Committee, Board of Governors or proprietor. The purpose of this chapter is to review two issues that were contemporary concerns to see if the CIL were able to achieve compliance more consistently with problems that had not become embedded in the asylum system. The two issues selected, attendance at Divine Worship (Specified Issue) and the number of PM examinations (Non-specified Issue), will also be examined by means of case studies using quantitative and qualitative data. As previously, each case study includes an exploration of the background to the issue, a presentation of the findings from the inspection visits and monitoring activity and analysis of the action taken by the commissioners to secure compliance. This chapter concludes with an overview encompassing the findings from all four case studies of the ways that the CIL sought to secure compliance and the factors that influenced their work.

Case Study 3: Attendance at Divine Worship

The place of religious activity in the therapeutic process was complex. In the early modern period, there was a belief that prayer could cure both body and soul. It was also believed that excessive religiosity was both a symptom and evidence of madness. Andrews has reported the prominence given to the role of religion increased in the years after 1780, a change that coincided with the nonconformist religious revival. Despite the traditional role of the monastic orders in providing asylum for lunatics and idiots before the Reformation, attendance at church was not an important element in the pre-nineteenth century treatment regimes. This lack reflected the secularization of treatment. With the development of moral

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1 Sophie Mann, "A Double Care": Prayer as Therapy in Early Modern England", Social History of Medicine, 33 (2020), 1055–75 (pp. 1057, 1059).
3 Andrews, 'Cause or Symptom?', (p. 74).
4 Porter, Madness, pp. 32-33.
therapy in the nineteenth century the place of church attendance for patients changed. Such attendance was seen as an element, alongside work and leisure activities, in the process of re-establishing the pattern of acceptable behaviours that were absent from the lives of lunatics.\(^5\) It should be noted that the lunacy legislation only required the measurement of attendance at Divine Worship and was not concerned about the religious faith or lack of it of the patients. The lack of any commentary on the attendance at religious services of asylum patients in the reports on or criticisms of lunatic asylums suggests that this was not a widely held concern with the general public.

The development of moral therapy took place against a backdrop of a religious revival, started in the eighteenth century, that reached its peak of influence in the 1840s but continued to have an effect into the 1880s. The rise in Evangelicalism and, from the 1830s, the Anglo-Catholic Oxford Movement were responses to concerns about a lack of Christian morality in society at all levels, increasing concerns about how recreation time was used, particularly on the Sabbath, and about a pattern of declining church attendance.\(^6\) The influence of Evangelicalism impacted on the CIL as four of its members, including Shaftesbury, and its first Secretary, Robert Lutwidge (1802-1873), were Evangelical Christians.\(^7\) Their influence led to the decision, never revised, that the CIL would not make routine visits on a Sunday.\(^8\)

As with the use of mechanical restraint, there were conflicting opinions within the medical profession on the issue of religious faith and lunacy. The consensus until the nineteenth century had been that religious fanaticism was both a possible cause and evidence of lunacy.\(^9\) Roy Porter noted that the charge of

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\(^8\) NA MH 50/1, p. 200.
deviance was reported more frequently in belief systems seen as being radical or extreme, such as the millenarians. This concern can be seen from the reaction of the authorities of the Bethlehem Hospital, who excluded John Wesley and his followers from making visits to the patients as these were thought to be harmful. Whilst Dr Conolly thought that half of all cases of lunacy amongst the educated classes, especially women, were caused by ‘perversions of religion’, he argued that religious faith did offer a benefit to the patients through the comfort of a belief in a divine being and from the regularity and order that religious services could bring to the chaotic life of the lunatic. As will be seen, it was the latter point that was addressed by the legislation in 1845.

The approach used by Conolly applied to the whole patient population. A more individual patient focus was suggested in the writings of both Dr John G. Millingen (1782-1862) and Dr William Browne, both of whom had experience as medical superintendents of large public asylums and the latter of being, later in his career (1857-70), a medical commissioner in Scotland. In his book, first published in 1840, *Aphorisms on the Treatment and Management of the Insane*, Millingen argued that the decision about any patient attending religious worship was one for the doctor as this activity could excite or upset a particular patient, whilst calming others. Browne also advocated a case-by-case approach, as noted in his book of 1837 *What Asylums Were, Are, And Ought To Be*:

> To prescribe it as applicable to all cases, would be as wise as to seek the *elixir vitae*; and to exclude it because sometimes injurious, betrays a deplorable ignorance of the constitution and the wants of the human mind.

The first reported consideration by a PSC of the place of religious worship in the treatment of lunatics occurred in 1827 during a review of the care of pauper

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13 Dr Millingen had been employed at Hanwell in 1838, resigning following a disagreement with the Governors. Dr Browne had worked at the Montrose Asylum and been President of the Royal Medical Society of Edinburgh. Andrews, ”*They're in the Trade ... of Lunacy*”, p. 8.
lunatics in the County of Middlesex. As part of the evidence collection, a sixty-two-point questionnaire was issued. This included questions on whether religious services were provided for patients, who determined whether a patient attended these and whether all classes of patients attended the same service.\textsuperscript{16} The focus of these questions was on attendance and not religious belief or conversion. No details of the responses were included in the report and the PSC made no recommendations on the issue of religious services in asylums or whether the religious needs of the patients should be met.\textsuperscript{17} In the legislation that reformed the lunacy laws in 1828 separate requirements were enacted for the public and private asylums. At the former a Church of England chaplain had to be appointed.\textsuperscript{18} At the private asylums the requirement was for the provision of services to be monitored and if none were provided an explanation, in writing, had to be obtained.\textsuperscript{19}

Between 1828 and 1845 the MCL made one report on the benefits of religious worship, which stated that they had failed to find any evidence that attendance at religious services produced a permanent benefit for the patients.\textsuperscript{20} It has not been possible to confirm if the Visiting Justices made these checks as their reports, if not lost, are held in an unknown number of archives.\textsuperscript{21} Despite this lack of evidence of a benefit, when it came to their report in 1844 the MCL included a section that reviewed how some of the asylums provided religious services for the patients.\textsuperscript{22} The MCL emphasised the benefits of church attendance by stating that:

\begin{quote}
The effect is tranquilizing, and productive of good order and decorum, in a remarkable degree, and in some instances permanently beneficial... So long, at least, as the Service lasts, they occupy the Patient's mind, and set before him an example of quiet and decorum.\textsuperscript{23}
\end{quote}

\textsuperscript{16} UKPP, PSC, 1826-27 (557), (p. 11).
\textsuperscript{17} UKPP, PSC, 1826-27 (557), (pp. 4-8).
\textsuperscript{18} S.XXXII LL, 9 Geo. IV CAP.XL (1828).
\textsuperscript{19} S.XXXVIII LL, 9 Geo. IV CAP.XLI (1828).
\textsuperscript{20} UKPP, 'Copies of the Annual Reports made by the Metropolitan Commissioners in Lunacy to the Lord Chancellor, from 1835 to 1841', 1841 (56), (p. 2).
\textsuperscript{21} A check on the holdings at the Cheshire, Clwyd and Shropshire archives found none available.
\textsuperscript{22} UKPP, MCL, 1844 (001), (pp. 150-63).
\textsuperscript{23} UKPP, MCL, 1844 (001), (p. 159).
Whilst endorsing the influence of church attendance on the behaviour of patients, the MCL only considered this in relation to Anglican patients. This approach, consistent with the view of Shaftesbury that the advance of Roman Catholicism be opposed, implied that only certain forms of religious practice were beneficial.\textsuperscript{24} The commentary on the benefits of religious worship, which are vague at best, involved discussion with an unspecified number of medical superintendents. Within this group there was no consensus about the benefits of religious attendance, with the MCL report not indicating any particular reasons for these differences.\textsuperscript{25}

Despite the lack of consensus or a recommendation from the MCL the lunacy legislation of 1845 included requirements relating to the provision of the Anglican service of Divine Worship. The County Asylums Act (1845) perpetuated the requirement from the legislation of 1828 that all publicly funded asylums had to appoint a Church of England chaplain.\textsuperscript{26} The Lunacy Act (1845) required that during their inspection visits the CIL were to monitor the numbers of patients attending Divine Worship. At the private asylums they were also required to assess ‘the Effect thereof’, but at the publicly funded places of detention they only had to report on whether services were provided.\textsuperscript{27} In order to enable patients to attend Divine Worship the CIL included in their guidance to architects the requirement that ‘suitable accommodation be provided’ so that ‘at least half the patients of each sex’ could attend.\textsuperscript{28} When the guidance for architects was updated in 1887 the requirements for the chapel were changed so that the building was ‘capable of comfortably accommodating at least three-fifths of the patients’, with ‘distinct entrances’ for the men and women.\textsuperscript{29} Exactly how the CIL arrived at these standards was not reported, nor was it recorded in the Minutes of their meetings. No separate provision was identified in the guidance for those patients of other denominations.

The attendance at services by patients of other faiths was not addressed within the legislation until the lunacy laws were amended in 1853. Despite the


\textsuperscript{25} UKPP, MCL, 1844 (001), (p. 160).

\textsuperscript{26} S.XLII LL, 8 & 9 Vict. CAP.CXXVI (1845).

\textsuperscript{27} S.LXIV & S.CX LL, 8 & 9 Vict. CAP.C (1845).

\textsuperscript{28} UKPP, CIL, 1847-48 (858), (p. 325).

\textsuperscript{29} CIL, \textit{Suggestions and Instructions}, pp. 5-6.
ending of restrictions on Catholics in 1829, the County Asylums Act (1853) placed limitations on the access to pastoral support for non-Anglican patients. The act stated that a non-Anglican minister could only visit at the request of the patient or a friend and with the consent of the medical superintendent at ‘proper and reasonable times’. These limitations remained in place until 1889 when the Lunacy Acts Amendment Act allowed the Visiting Committee to appoint and pay a ‘minister of any persuasion’. To complicate the situation further, in the following year the Lunacy Acts Consolidation Act (1890) both allowed the Visiting Committee to appoint a minister of any denomination and reinstated the 1853 restrictions. This confusion within the 1890 Act was ignored as asylums appointed Roman Catholic priests, Non-conformist ministers and Rabbis as chaplains and provided separate facilities for the conduct of services.

The substantive change implemented in 1845, making this a contemporary issue, was the inclusion in the legislation of a requirement that the CIL monitor at each inspection attendance at Divine Worship. The inclusion of such a requirement probably reflects the influence of the Evangelical Christians, whose numbers included notable members of the MCL, on the government and during the debates in Parliament. The ability to influence parliamentary debates was facilitated by the small numbers of MPs who attended the debates, with less than 20% of the 656 voting on the lunacy laws in 1845. Despite this ability to influence, it will be seen that the focus of the reports was on the numbers attending services and not the benefits, medical or religious.

**Results from the inspections – Divine Worship**

The results of the review of the Annual Reports showed that low attendance at religious services was far more frequently reported at the public asylums, as shown in Figure 5.1. Until the late 1860s poor attendance at Divine Worship was noted at a substantial minority (20%) of these sites. After this date there was a major increase, peaking at about 62% in the 1890s. Given the trend in the data, the major reduction in reported low attendance at the public asylums in 1905 was

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31 S.LV LL, 16 & 17 Vict. CAP.XCVII (1853).
32 S.77 LL, 52 & 53 Vict. CHAP. 41 (1889).
33 S.276(2) & S.277(3) LL, 53 & 54 Vict. CHAP.5 (1890).
34 UKPP, CIL, 1901 (245), (p. 266); UKPP, CIL, 1907 (225), (p. 381).
an anomalous figure, with no particular cause being identifiable from the relevant Annual Report. The pattern of reporting at the private asylums was markedly different, with very few reports before the 1890s and then a gradual increase to about 20% of these institutions. This pattern reflected the changes in reporting practice for these institutions instigated by the CIL.

Figure 5.1: Comparison Between the Percentage of Public and Private Asylums Reported for Low Attendance at Divine Worship, 1860-1910

In reporting on attendance at Divine Worship the CIL adopted a sliding scale of commentary. Where attendance was high, they would note the fact without much comment. Where it was between 30% and 50% of all patients, they would note that it was a little low. Where the attendance was found to be less than about 30%, they would be more critical, as in the case of the Bedfordshire (Three Counties) Asylum in 1867:

The regular attendance at the Church services presents, we think, a rather small average of Patients, numbering of both sexes at the morning service 146 and at the evening 98. [28% and 19% of the 529 patients detained respectively.] Attempt should be made to increase this as far as practicable.

In establishing the sliding scale, the CIL treated commentary on attendance at Divine Worship differently from that on patient involvement in work and recreational activities. With reference to the latter pair, the CIL made

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36 For an example see Dorset County Asylum: UKPP, CIL, 1884-85 (285), (p. 202).
37 For an example see Surrey (Brookwood) County Asylum: UKPP, CIL, 1884-85 (285), (p. 286).
38 UKPP, CIL, 1867 (366), (p. 110). The total for the evening service included an unknown number of patients who had attended the morning service.
allowance for the increasing numbers of patients who, due to their mental and/or physical condition, were unable to participate in these activities. For attendance at Divine Worship, they made no similar allowance. The attendance figures were also affected by the number of non-Anglican patients who did not participate in these services, which varied by locality. The public asylums in Lancashire all had high numbers of Roman Catholic patients from the Irish immigrant population that settled in the county around Liverpool.\(^{39}\) The CIL did not systematically record the numbers of patients of different faiths, making quantification of the impact on the attendance figures impossible.

Before the 1860s, the CIL reports included no comment about the attendance at services of those of other faiths. Following the appointment of two doctors with experience as medical superintendents of a county asylum, Samuel Gaskell (1807-1886) and James Wilkes, this started to change.\(^{40}\) Whilst the majority of the entries in the Annual Reports continued to relate to low attendance and the size of the chapel, they also started to note when Roman Catholic, Non-conformist and Jewish patients could not attend appropriate services or were only infrequently seen by a minister of their faith.\(^{41}\) This change was continued in all the subsequent Annual Reports and after 1889 they also noted when a public asylum had not appointed a chaplain for other of the denominations.\(^{42}\)

The Lunacy Act (1845) required that the CIL report on both the numbers attending Divine Worship 'and the Effect thereof' for those in private asylums.\(^{43}\) Analysis of the Annual Reports showed that they only included the numbers attending. Whilst Shaftesbury made claims about the benefits to all patients, they collected no statistics nor recorded any cases to evidence these benefits.\(^{44}\) This reporting failure was not a surprise as the identification of the benefit derived from church attendance, in isolation from all other factors, is impossible. This assessment was made more difficult as visits occurred only once every three months at most.

\(^{39}\) UKPP, CIL, 1887 (200), (p. 208). The visit in 1886 recorded 400 Roman Catholics in the total of 1636 patients detained in the Lancashire (Lancaster Moor) Asylum.

\(^{40}\) Wilkes was appointed from the Lancashire (Lancaster Moor) Asylum that served Liverpool. Gaskell was appointed from the Staffordshire Asylum. Subsequently, ex-superintendents of county asylums held two of the three medical commissioner posts.

\(^{41}\) For examples see: UKPP, CIL, 1862 (417), (pp. 123, 130); UKPP, CIL, 1876 (383), (pp. 141, 200); UKPP, CIL, 1901 (245), (pp. 243, 251, 301).

\(^{42}\) UKPP, CIL, 1896 (304), (p. 341).

\(^{43}\) S.LXIV LL, 8 & 9 Vict. CAP.C (1845).

\(^{44}\) UKPP, PSC, 1859 Session 1 (204), (pp. 65-66).
Perpetuation of high levels of non-attendance were contributed to by the ever-increasing number of patients being detained; and the increases in those patients who were physically and/or mentally incapable of such attendance. In response to the former, the CIL noted when they thought that an asylum chapel needed to be extended or replaced. The response of some of the Visiting Committees was to direct the chaplain to conduct multiple services on a Sunday or hold services on the wards. The use of these approaches was noted by the commissioners and supported as a temporary measure to resolve the problem. This intensification of the use of the chapel only provided a temporary solution.

How the existing facility was provided affected the way in which a more permanent solution could be implemented. Where the chapel was a space within the main building, the ability to extend this accommodation was constrained and often impossible. A stand-alone chapel building, the preference of the CIL, offered the opportunity to build an extension. In many instances there was a need for a new, larger, chapel to be built, with the existing provision being deconsecrated and used for another purpose, thereby, maximising the financial investment made by the ratepayers.

Given that the chapel was used for a limited amount of time, the costs of provision were substantial. A 300-place chapel for the Derbyshire County Asylum was built in 1868 at a cost of £1516 (£175,300) to the ratepayers. Four years later, one for 814 patients at the Lancashire (Whittingham) County Asylum cost £4415 (£510,500), with additional spending on a house for the chaplain of £1577 (£205,000). Whilst the CIL made recommendations for these substantial expenditures, it was the ratepayers who had to meet these costs. These expenditures were for Church of England chapels and separate facilities, not always as elaborate, were provided for other faiths. In 1892 a chapel, made from timber and iron, was built for the about 200 Roman Catholic patients at the Lancashire (Lancaster Moor) Asylum at a cost of £419 (£54,400).

For examples see: UKPP, CIL, 1859 Session 2 (204), (p. 18); UKPP, CIL, 1867-68 (332), (pp. 141, 146, 151); UKPP, CIL, 1906 (224), (pp. 289, 374 ).

46 UKPP, CIL, 1863 (331), (p. 80); UKPP, CIL, 1867-68 (332), (p. 146).

47 UKPP, CIL, 1880 (321), (p. 102).

48 UKPP, CIL, 1868-69 (321), (p. 13); UKPP, CIL, 1872 (279), (p. 22). Over the years 1845 to 1910 the separately identified costs of building chapels amounted to a total of £54,716 (£6.6 million).

49 Monies from particular denominations was not routinely available, this not being a parish facility.

50 UKPP, CIL, 1892 (320), (p. 48). In contrast, the Anglican chapels were substantial brick-built structures.
The point at which the CIL could have maximum influence on what accommodation for religious services was provided was when the plans for the proposed asylum or extension were submitted for review. At this point the CIL could delay granting approval if the proposed accommodation was deemed inadequate. When the Holloway Sanatorium plans were prepared one of the identified problems was that there was no chapel. In her study of this institution Anna Shepherd noted that the grant of a licence was delayed until the outstanding issues, including provision of a chapel, were corrected.\textsuperscript{51} This power to influence also applied to the public asylums. As noted by Jane Hamlett, the Visiting Committee for the London (Long Grove) County Asylum was persuaded to include a chapel because of the known concern for such provision by the CIL.\textsuperscript{52} This capability to influence was not absolute, this being demonstrated at three new public asylums in West Yorkshire. The plans for the asylums at Menston, Scalebor and Storthes Hall, approved with the support of the CIL, included a chapel. When the asylums were constructed, the chapels were not built. At Menston the absence was initially attributed to the ongoing works not having been completed.\textsuperscript{53} As time passed and no action was taken the comments of the CIL became more critical:

And here we cannot help again referring to the absence of a chapel or building specially appropriated to Divine Service. We cannot think that the authorities will desire to preserve for the Asylum the unenviable distinction of [Menston] being the only one of similar importance which is not so provided.\textsuperscript{54}

The CIL Annual Reports show that they paid attention to this issue in terms of the numbers of patients attending services. Despite the requirement to do so, the CIL did not report on the benefits to the patients in private asylums of such attendance, because of the impossibility of making this assessment. The reported results show a persistent level of noncompliance but the increasing numbers of patients being detained made it improbable that full compliance was achievable. Whilst the results show persistent non-compliance, the overall level of low

\textsuperscript{51} Shepherd, Institutionalizing the Insane, p. 22.
\textsuperscript{53} UKPP, CIL, 1890 (274), (p. 269).
\textsuperscript{54} UKPP, CIL, 1895 (311), (p. 313).
attendance was not getting worse. The next section reviews how the CIL sought changes in practice to increase attendance and whether it was due to their actions that the situation was not deteriorating.

**Action taken by the CIL – Divine Worship**

As with the issues discussed in Chapter 4, the CIL could only recommend that the Visiting Committee or proprietor took action to ensure that patients attended Divine Worship. As a consequence, they were again left with no option but to use persuasion. As the most frequently reported reason for low attendance was insufficient space in the chapel, reliance on persuasion was not a tactic that was certain to secure change. In some cases, this approach bore fruit and the Visiting Committee took action to enlarge the chapel or replace it. At the Lincoln County Asylum the commissioners reported the chapel as being too small in 1867 and 1868.\(^{55}\) In 1869 they noted that the sum of £1500 (£182,500) had been approved by the Visiting Committee for the construction of a new chapel and that when it was available the old chapel would be deconsecrated and reused as a recreation hall.\(^{56}\) In other instances, such as those of the three asylums in West Yorkshire, the negative comments in the Annual Reports were ignored by the respective Visiting Committees.\(^{57}\) Whether this opposition was based on concern about the costs involved or on religious grounds was not made clear in the Annual Reports.

The fact that between 40% and 60% of the public asylums were identified as being non-compliant shows the limitation of persuasion. However, criticism of this apparent lack of success does have to take account of the ever-increasing numbers of patients being detained and that many of them, with the passage of time, lost the mental and/or physical capacity to attend a church service. The rise in patient numbers was outside of the control of the CIL, as were the decisions on spending on new buildings.

The responses of the CIL to the increased reports of noncompliance at the private asylums after 1895, (see Figure 5.1, p. 143), was inconsistent.\(^{58}\) In the Report of 1910 the CIL noted the lack of provision of religious services at two metropolitan private asylums. For no obvious reason, other than personal differences between the commissioners involved in these visits, action was

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\(^{55}\) UKPP, CIL, 1867 (366), (p. 156); UKPP, CIL, 1867-68 (332), (p. 178).
\(^{56}\) UKPP, CIL, 1868-69 (321), (p. 192).
\(^{57}\) UKPP, CIL, 1904 (232), (p. 386); UKPP, CIL, 1906 (224), (p. 391).
\(^{58}\) UKPP, CIL, 1901 (245), (p. 421).
demanded of the proprietor of the Flower House Asylum, Catford, whilst none was from the proprietor of the Wyke House Asylum, Isleworth.\textsuperscript{59} In reporting on the private asylums the comments made were more general and less critical. For example, in July 1900 the report on the Brislington House Asylum, Bristol, only noted that ‘many of the patients were at chapel’.\textsuperscript{60} Incidents of low attendance did not lead to action to modify or revoke the licence.

In the public asylums there was also noticeable variation from year to year on the emphasis placed on attendance at Divine Worship. In September 1887 the report on the Durham County Asylum detailed the numbers of male and female patients who attended both the Sunday and the weekday services.\textsuperscript{61} In the following year the report simply stated: ‘The provision for, and attendance at, Divine Worship is satisfactory’.\textsuperscript{62} This type of variation was less evident at the private asylums, where the topic was less frequently mentioned in all the reports. This lack of consistency is further evidence of the impact of the annual change in inspection teams and of the differing ideas and approaches of the individual commissioners. The inclusion of this topic as a Specified Issue, when many others, such as staffing, were not also shows the impact on the regulation of asylum services of the Evangelicals, a combination of both an internal and external pressure. The CIL were concerned throughout its lifetime with the level of patient attendance at Divine Worship. What changed after the retirement of the founding commissioners was the attention paid to the provision of religious services for the non-Anglican patients, a small number of such patients had been permitted to attend appropriate churches in the area around the asylum.\textsuperscript{63} The fact that the level of low attendance remained high shows that their actions had only a limited impact. The increasing numbers of patients at the public asylums, and the cost of providing the additional space, made the achievement of the standard difficult to attain in the long-term, a problem that could not be overcome by the regulator.

\textsuperscript{59} UKPP, CIL, 1910 (204), (pp. 501, 507).
\textsuperscript{60} UKPP, CIL, 1901 (245), (p. 429).
\textsuperscript{61} UKPP, CIL, 1888 (289), (p. 180).
\textsuperscript{62} UKPP, CIL, 1889 (207), (p. 200).
\textsuperscript{63} Such excursions outside the asylum estate were not always welcomed by the local community, see UKPP, CIL, 1877 (403), (p. 226).
Case Study 4: PM Examinations

The inclusion of reporting on the increased use of PM examinations in asylums was an issue that showed how the CIL responded to a new concern. None of the reviews of asylum services up to and including the PSC of 1859 had considered whether or how many PM examinations were being conducted on patients who died in an asylum. The CIL did not routinely include this topic as an issue until 1872.64 The delay in collecting statistics on PM examinations did not mean that individual members of the CIL were unaware of the potential importance of this investigation for confirming a cause of death and for the development of medical practice in asylums. In his books *Treatise on Diseases of the Nervous System* and *A Treatise on Insanity and Other Disorders Affecting the Mind*, published in 1822 and 1835 respectively, Dr James Cowles Prichard (1786-1848), one of the first medical commissioners of the CIL, noted that he had used PM examinations to show a link between diseases of the viscera and lunacy.65 Had he been in post longer it is possible that this issue would have been included at an earlier date. Despite his association with the MCL, no mention was made of PM examination in either the 1844 report on the state of asylum services or in the lunacy legislation of 1845. PM examination had the potential to improve the safety of patients by enabling more accurate identification of the cause of death. This potential contributed to the decision by the CIL to include this topic as an inspection issue.

The use of dissection to develop accurate knowledge of the structure of the body started to be common practice in the sixteenth and seventeenth centuries and was based on the work of anatomists and surgeons. This work changed thinking on the structure and function of the body that had remained largely unchallenged from the time of Hippocrates (460-370BC) and Claudius Galen (129-c.210).66 Based on the work of Giovanni Morgagni (1682-1771) at the Anatomy School in Padua, PM examination was used to identify the links between the

64 UKPP, CIL, 1872 (279), (pp. 92-105).
symptoms of disease and changes in anatomical structure, the physical correlates of a disease.\textsuperscript{67}

By the nineteenth century, anatomy was at the centre of medical training. In an article in the \textit{Westminster Review} Dr Thomas Southwood-Smith (1788-1861) stated that ‘The basis of all medical and surgical knowledge is anatomy’.\textsuperscript{68} The practical application of the approach within alienism (psychiatry) was linked to the identification of the locations within the brain for physical activities, such as speech.\textsuperscript{69} This work led to the development of the hypothesis that changes in areas of the brain were linked to the development of lunacy, an idea related to phrenology but with a better scientific foundation.\textsuperscript{70} Some asylum superintendents who were interested in researching the causes of lunacy started to undertake PM examinations on the patients who died in their care.\textsuperscript{71} How useful these PM examinations were in the identification of the causes of lunacy is open to serious question given the rudimentary state of pathology at this time.\textsuperscript{72}

As with other developments in medical practice there were contending views as to the importance and potential benefits of PM examination of lunatics.\textsuperscript{73} Proponents, such as Prichard and Joseph Williams (1814-1882), claimed that there was a connection between the pathology of the brain and lunacy and that a PM examination was essential for the identification of this link.\textsuperscript{74} Others, such as William Benjamin Carpenter (1813-1885), argued that examination of the brain


\textsuperscript{70} J. G. Spurzheim, \textit{Phrenology in Connection with the Study of Physiognomy}, (Boston: Marsh, Cape & Lyon, 1836).

\textsuperscript{71} Catherine Smith, "Visitation by God": Rationalizing Death in the Victorian Asylum', \textit{History of Psychiatry}, 23 (2012), 104-16 (pp. 109-10).

\textsuperscript{72} Elizabeth, T. Hurren, "Abnormalities and Deformities": The Dissection and Interment of the Insane Poor', \textit{History of Psychiatry}, 23 (2012), 65-77 (p. 76).

\textsuperscript{73} Engstrom, \textit{Clinical Psychiatry}, p. 89.

\textsuperscript{74} Williams, \textit{An Essay on the use of Narcotics}, pp. 16-21; William G. Balfour, 'Pathological Appearances Observed in the Brains of the Insane', \textit{Journal of Mental Science}, 20 (1874), 49-60 (pp. 59-60).
produced little useful information. In 1842 Dr Millingen pointed out that it was possible for a person to suffer major head injury without any ‘derangement of intellectual facilities’. The identification of the physical correlates of diseases of the brain, including lunacy, was complicated by the need to complete the dissection of this organ early after death in order to differentiate between pre- and post-mortem structural changes. The lack of reliable cold storage added to the pressure to secure consent quickly. The CIL recognised that PM examination could be used to identify if the patient had suffered physical abuse, indicated by finding fractures not diagnosed before death. These potential benefits were countered by the antipathy of the general population towards PM examination and dissection.

The revulsion felt about PM examination had been fed by the practice of body-snatching and the inclusion of dissection as part of the punishment for murder. The Anatomy Act (1832), which sought to end the practice of body-snatching by allowing any unclaimed corpse in a publicly funded institution to be used for dissection, did little to reduce this revulsion. As the majority of unclaimed corpses were those of paupers whose families could not pay for a funeral, this, according to Ruth Richardson, made dissection seem like a punishment for being poor. Whilst the Anatomy Act contributed to the ending of body-snatching, it did not address the practice of removing parts of a corpse for examination or retention following PM examination. The nineteenth century saw the development of collections of pathological specimens by individual doctors, in the various medical schools, at the medical Royal Colleges and at asylums. Because of the problems

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78 UKPP, CIL, 1873 (256), (pp. 23-24). Fractures were a matter of concern but abuse was not the only explanation. The general debilitated state of pauper patients and a lack of vitamin D could weaken bones, making them more liable to fracture without abuse being inflicted. Jennifer Wallis, ‘The Bones of the Insane’, *History of Psychiatry*, 24 (2013), 196-211 (pp. 198-99, 200-1); Chiara Tesi and Mario Picozzi, ‘Five Autopsy Reports of Rib Fractures in the Mental Hospital of Reggio Emilia (1874-5): Pathogenesis Proposal in Defence of the "Non-restraint" System’, *History of Psychiatry*, 32 (2021), 350-58 (p. 384).
79 LL, *An Act for Consolidating and Amending the Statutes in England Relative to Offences Against the Person* (1828) (9 Geo. IV CAP.XXXI).
80 LL, 2 & 3 Gulielmi IV CAP.LXXV (1832).
81 Richardson, *Death, Dissection*, pp. xv, 176-79.
83 The Hunterian Museum of the Royal College of Surgeons of England is based on the anatomical collection of John Hunter (1728-1793).
of storing these samples it was necessary for them to be regularly replaced. Such collections formed a significant element in the continuing education of doctors. Practice on collecting anatomical specimens varied between asylums, with relatives rarely being informed that body parts had been removed.

In order to identify individual asylum practice on the conduct of PM examinations the CIL completed a one-off survey in 1870. This showed that there were variations in both the numbers being conducted and the arrangements for obtaining consent. Some, such as the Cumberland and Westmorland and Middlesex (Colney Hatch) Asylums, completed these examinations in a majority of deaths. Others, such as the Dorset and Suffolk Asylums, only conducted PM examinations on a minority of cases. Securing consent from a relative was subject to similar variation. At the Essex Asylum no PM examinations were completed without prior consent, whilst at the Leicestershire Asylum consent was not sought. According to the CIL, the concerns of the families about the practice of PM examination were outweighed by the benefits. They adopted a policy that encouraged such examinations, seeking to make it ‘everywhere the rule, and not, as in many instances, the exception’. The policy made allowance for the concerns of families by requiring that consent be obtained and by calling for a delay between death and the PM examination to allow the family to lodge an objection. The CIL also recorded in the Annual Report of 1870 their opposition to any proposal for medical staff to be authorised to complete PM examinations without the consent of the family. An examination could be completed over the objection of relatives if ordered by a coroner.


84 Jonathan Reinarz, 'The Age of Museum Medicine: The Rise and Fall of the Medical Museum at Birmingham's School of Medicine', Social History of Medicine, 18 (2005), 419-37 (pp. 429-30). Whilst the ethics of such tissue removal without consent are questionable the activity was not illegal as the Anatomy Act (1832) only related to the procurement of whole bodies.

85 UKPP, CIL, 1870 (340), (pp. 227-35).


87 UKPP, CIL, 1870 (340), (pp. 243-46).

88 UKPP, CIL, 1870 (340), (p. 31); UKPP, CIL, 1878 (337), (p. 228).

89 UKPP, CIL, 1870 (340), (p. 31).

90 LL, 2 & 3 Gulielmi IV CAP.LXXV (1832).
Results from the inspections – PM examinations

Reporting on the number of PM examinations commenced in 1870, with few comments about the attainment of the suggested benefits.91 In the following year the CIL noted an increase in the number of PM examinations, going on to suggest that ‘as far as possible, [a PM examination be completed] in the case of all insane patients dying in asylums and licensed (sic) houses’.92 As will be seen, in reporting on this issue the focus of the CIL was on the public asylums, with little commentary on the rates at the private asylums. From 1872 the numbers of PM examinations were included in the main tables of patient numbers, admissions, discharges and deaths. In some of the later Annual Reports there continued to be comments in the main text about the total number of PM examinations being completed in the year and the proportion this was of the number of deaths. Comments on individual asylums were incorporated into the entry for that site.

Analysis of the Annual Reports showed that the percentage of PM examinations completed following a death fell at the public asylums, from 60% in 1875 to 40% in 1880. Thereafter, they rose to about 80%, remaining at about this level until 1909. At the private asylums the proportion rose from about 20% in 1875 to a peak of about 43% in 1895, before falling back to 20% by 1909, as shown in Figure 5.2. A distinction found was that the non-pauper patients who died were far less likely to undergo PM examination, a finding also reported by Andrews.93 As an example: in 1886, of the 130 PM examinations completed at the 34 Metropolitan Licenced Houses, 125 were undertaken at the 5 largest pauper asylums.94 The CIL were aware of this differentiation, noting the low rate of PM examinations at the City of London Asylum in 1909, (56%), they remarked that this was ‘no doubt due to the considerable proportion of private patients’.95 The gender of the patients who died in private asylums also affected the PM examination rate. For men this rate was 36% of deaths, but only 27% for deaths amongst women. At the public asylums the rate was about 71% for both men and women.

91 UKPP, CIL, 1870 (340), (pp. 28-31, 243-46).
92 UKPP, CIL, 1871 (351), (pp. 38-39).
94 UKPP, CIL, 1887 (200), (p. 129).
95 Of the thirty-one deaths seventeen were private patients. UKPP, CIL, 1910 (204), (p. 447).
In their commentary on the numbers of PM examinations, the CIL praised those asylums that achieved a rate of more than 60% of deaths being followed by this examination. Failure to achieve this level was followed by criticism that became more severe as the rate fell. Figure 5.3 shows the proportion of public and private asylums reported as having failed to attain the 60% level. At the public asylums between 1875 and 1881 the proportion reported rose to about 42% and then stabilised at between 20% and 40% of these sites, a minority but a substantial one. Examination of the results shows that seven asylums failed to achieve the 60% rate on more than 25 occasions, these being Cornwall (33), Lincolnshire (32), Shropshire (30), Devon (28), Northamptonshire (27), Staffordshire (Stafford) (26) and East Sussex (Hellingly) (26). At the private asylums the reporting of a low PM examination rate was far lower, with less than 10% being identified between 1870 and 1909. The private asylums most frequently reported were The Asylum for Idiots (Earlswood) (15), York Lunatic Hospital (14) and Holloway Sanatorium (12), numbers considerably below the highest of the publicly funded sites. In part, the low rate of non-achievement of the 60% level at the private asylums was the consequence of the commissioners not raising the issue as a concern. During the visit to the Wonford House Asylum, Exeter, on the 18 September 1874 the failure to complete any PM examinations on the nine patients who died resulted in the commissioners only noting that ‘there is nothing special to report with respect to the deaths’.96 This differential in commentary was maintained throughout the remainder of the review period.

96 UKPP, CIL, 1875 (337), (p. 239).
During the inspection visits the CIL reported possible reasons for the low rate of PM examinations, with the most frequently noted at all asylums being the refusal by relatives to grant consent. The rate of refusal varied between different areas of England and Wales. During a visit to the Bedfordshire (Three Counties) Asylum in January 1875 the commissioners noted that PM examinations ‘were made in all but seven instances’ of the 68 deaths. This contrasted with the result for the Sussex (Hellingly) County Asylum, visited in February 1875, when 25 of the 88 deaths were followed by a PM examination. This difference was reported as being due to a prejudice against PM examination in Sussex.\(^97\) Whilst the CIL sought to respect the wishes of the relatives on whether a PM examination should be completed, they were concerned that high levels of refusal could result in a failure to protect patients from harm. During their visit to the Lincoln (Bracebridge) Asylum on the 9\(^{th}\) June 1885 the CIL reported that:

The post-mortem examinations have been 27 [out of 122 deaths]. There seems to be a strong prejudice in this county against autopsies, which we consider unreasonable, as these examinations sometimes detect injuries not ascertained in the lifetime.\(^98\)

A lower rate of PM examination might also be contributed to by the corpses of pauper lunatics being disposed of, when unclaimed, by sale to an anatomy school. The need of these schools was for intact corpses, ones that had been

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\(^97\) UKPP, CIL, 1876 (383), (pp. 128, 234).
\(^98\) UKPP, CIL, 1886 (196), (p. 197).
subjected to a PM examination would not be in an appropriate condition for use in teaching.99 Hurren identified the sources of the corpses used by various anatomy schools. The majority came from the workhouses and MDAs.100 Of the asylums listed only two, Staffordshire (Stafford) and Cambridgeshire, were reported repeatedly by the CIL for having a low PM examination rate, 26 and 14 times respectively. More detailed work on this relationship might be worthy of further study.

Achievement of a high rate of PM examinations was affected by both staffing and capacity issues. The increase in the numbers of PM examinations being completed added to the workload of the asylum medical staff, some of whom were already working at or near full capacity. During the visit to the Kent (Barming Heath) Asylum in November 1875 the medical superintendent stated that he did not have sufficient time to complete more than fifty-four PM examinations out of the one-hundred and fifteen deaths in that year. The CIL noted that he was assisted by ‘only two medical officers’.101 Where the numbers of medical officers increased it was the expectation of the CIL there would be an increase in the numbers of PM examinations being completed. Such was the case at the Devon County Asylum in 1884.102 In the 1890s and beyond the CIL placed more emphasis on employing additional medical staff to undertake a wider range of pathological studies. This change in emphasis was made clear in the entry on ‘Medical staff’ in the report of the visit to the Kent (Barming Heath) Asylum in 1895:

The medical staff now consists of Dr Davies and four assistant medical officers, the junior just appointed to act in that capacity and as pathologist; but little pathological research of the more minute kind appears to be made. Work of this kind is now so universal that we hope it may be found possible to develop it here as tending not only to serve a direct scientific purpose, but also to foster the medical interest of the staff in the cases under treatment.103

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99 This does not preclude their use for the supply of body parts to the anatomy schools.
101 UKPP, CIL, 1876 (383), (p. 176).
102 UKPP, CIL, 1884-85 (285), (p. 199).
103 UKPP, CIL, 1896 (304), (p. 268).
Aside from the need for additional doctors, the CIL also noted if the facilities for the completion of PM examinations were adequate. The lack of a proper dead house (mortuary) at the Northumberland County Asylum was noted in 1874. In the following year, additional accommodation having been provided, the CIL highlighted the need for proper equipment to be supplied. If the Visiting Committee failed to respond, the CIL commentary became more pointed, as in the case of the Staffordshire (Stafford) Asylum:

Only 28 post-mortem examinations have taken place [out of 102 deaths]. This is a matter of regret; but while the mortuary remains in its present state, there is much excuse for the medical staff. We hope that when the rooms set apart for dissection in the detached block shall have become available, different figures will represent the post-mortem examinations at this asylum.

The provision of facilities for PM examinations required the Visiting Committees to make a capital and revenue investment. The plans for the facilities at the London (Claybury) Asylum were costed at £1200 (£158,000) and that at the West Yorkshire (Menston) Asylum at £1500 (£197,000). Once completed the Committee was then faced with the costs of the purchase and upkeep of equipment needed to undertake PM examinations and the testing of pathological specimens. As with the provision of a chapel, the ratepayers were reluctant to fund mortuaries and the associated facilities but opposition was less pronounced, a reflection of the difference in influence of the medical staff and the chaplain.

As part of the reporting on PM examinations the CIL noted if pathological research was being conducted at any particular asylums, but included no further details. Between 1907 and 1913 the Annual Report included an abstract of any scientific work being undertaken. An examination of these reports showed that

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104 UKPP, CIL, 1874 (284), (pp. 195-96).
105 UKPP, CIL, 1875 (337), (p. 172).
106 UKPP, CIL, 1878-79 (342), (p. 298).
107 UKPP, CIL, 1890 (274), (p. 77). The facilities at Claybury provided a service for all of the London County Asylums.
108 The financial records are not sufficiently detailed to identify the revenue costs.
109 For an example of these entries see UKPP, CIL, 1892 (320), (p. 260).
110 UKPP, CIL, 1908 (200), (pp. 65-76). The replacement organisation, the Board of Control, continued to report on the research being undertaken in asylums, ‘First Annual Report of the Board of Control for the Year 1914’, 1916 (6), (pp. 61-81).
only a minority of asylums were reported as participating in research work, as shown in Table 5.1. The distribution of this research work shows no particular geographic pattern. Of the thirty-one sites that reported that research work was being undertaken only nine recorded this activity in four or more years. This Table highlights the importance of the combination of a Visiting Committee prepared to provide funding and the ongoing interest of the Medical Superintendent and the other medical staff. Wallis also showed the importance of this combination in her study of the pathology work at the Yorkshire (Wakefield) Asylum.\footnote{Jennifer Wallis, "Atrophied": 'Engrossed': 'Debauched': Degenerative Processes and Moral Worth in the General Paralytic Body’, in Insanity and the Lunatic Asylum in the Nineteenth Century, ed. by Thomas Knowles and Serena Trowbridge (London: Pickering & Chatto, 2015), pp. 99-113 (p. 101).} The CIL did not record any instances of pathological research being completed at a private asylum.
Table 5.1: Research Reported at Public Asylums by the CIL, 1907-1913

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<th>County Asylums:</th>
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112 UKPP, CIL, 1908 (200), (pp. 65-76); UKPP, CIL, 1909 (213), (pp. 80-95); UKPP, CIL, 1910 (204), (pp. 70-86); UKPP, 'The Sixty-fifth Report of the Commissioners in Lunacy to the Lord Chancellor', 1911 (207), (pp. 71-93); UKPP, 'The Sixty-sixth Report of the Commissioners in Lunacy to the Lord Chancellor', 1912-1913 (185), (pp. 71-100); UKPP, 'The Sixty-seventh Report of the Commissioners in Lunacy to the Lord Chancellor', 1913 (182), (pp. 86-115); UKPP, 'The Sixty-eighth Report of the Commissioners in Lunacy to the Lord Chancellor', 1914 (264), (pp. 76-105); Tatjana Buklijas, 'The Laboratory and the Asylum: Francis Walker Mott and the Pathological Laboratory at London County Council Lunatic Asylum, Claybury, Essex (1895-1916)', History of Psychiatry, 28 (2017), 311-25 (p. 314).
Action taken – PM examinations

The capacity of the CIL to take action where an asylum consistently failed to attain a PM examination rate of more than 60% was, as in other aspects of regulation, constrained by the lack of any specific enforcement power. The review of the lunacy legislation showed that there was no requirement for PM examinations to be completed, although such a justification was reported by Lynsey Cullen as having been used in 1878 at the Oxfordshire County Asylum.113 As a consequence, the CIL had no means of requiring that more PM examinations were performed or investment in staff and equipment made, even though it might provide greater protection for patients. They had to rely on their powers of persuasion and the good will of the relevant, cost-conscious relevant medical superintendent and Visiting Committee or proprietor.

The tactic used by the CIL was to praise achievement of a high rate of PM examination and to criticise those institutions which did not. Thus, the response of the CIL varied depending on the proportion of PM examinations completed. Where the rate was more than 75%, the CIL noted and praised this achievement, such as at the Derbyshire County Asylum in 1881.114 When the rate was between 60% and 75%, the response was a simple note of the numbers conducted.115 Anything below the 60% level received more attention and comment. In November 1877 the CIL reported that only one of the fifty-eight deaths at the Nottinghamshire County Asylum had been the subject of a PM examination. They highlighted that ‘[PM] examinations of patients dying in public asylums are now the rule rather than the exception [and] that this mode of acquiring information … should not be neglected’.116

The CIL also sought to encourage these examinations by showing how they could accurately identify the cause of death. One case, identified by the CIL as an example, was that of MD who died at the West Yorkshire (Wakefield) Asylum on the 14th January, 1878. MD was admitted in October 1877 with a diagnosis of melancholia. Because she was suicidal, she was closely supervised by her nurses,

113 Lynsey T. Cullen, ‘Post-mortem in the Victorian Asylum: Practice, Purpose and Findings at the Littlemore County Lunatic Asylum, 1886-7’, History of Psychiatry, 28 (2017), 280-96 (p. 286). From 1853 all deaths in licenced houses and hospitals had to be reported to a Coroner and he determined if an examination was required, S.XIX LL, 16 & 17 Vict. CAP. XCVI (1853). This was extended to Single Patients by S.44 LL, 25 & 26 Vict. CAP.CXI (1862). It was not until 1890 that this notification applied to all patients but still did not include a requirement to perform a PM examination in all cases, S.84 & S.319 LL, 53 & 54 Vict. CHAP.5 (1890).
114 UKPP, CIL, 1882 (357), (p. 244).
115 For examples see: UKPP, CIL, 1888 (289), (pp. 182, 193).
116 UKPP, CIL, 1878 (337), (p. 228).
but she managed to evade this supervision for an unspecified period in November 1877. When she died no obvious cause of death was identified and a PM examination was completed. The Annual Report stated:

The post-mortem examination of the body, however, revealed the presence of five needles in different parts of her body, by some of which peritonitis had been set up. We are reassured that the actual condition of this patient could not be diagnosed and was not suspected, and that without the post-mortem examination the death could not have been determined to have been a case of suicide, as in fact it was.\footnote{117}{UKPP, CIL, 1878-79 (342), (p. 329). Peritonitis is inflammation of the membrane that surrounds the organs in the abdomen due to infection and the symptoms include: nausea, vomiting, swollen and rigid abdomen and severe pain when the abdomen is touched. Anonymous, ‘Health A to Z: Peritonitis’, NHS, (2017) https://www.nhs.uk/conditions/peritonitis/ [Accessed 12 July 2019].}

In trying to secure a higher rate of PM examinations the CIL had three aims to: overcome the resistance of relatives to grant consent; encourage investment in staff and buildings and/or equipment; and encourage more research into the causes of lunacy. To overcome the resistance of the next-of-kin to granting consent the CIL initially adopted a conciliatory approach, but this changed over time. Before 1875 they advised that consent had to be obtained. After this year they regarded the withholding of consent as unreasonable and suggested that methods be used to ‘obviate [by giving notice] on admission that such examinations were the rule of the asylum, in the absence of a previous prohibition’.\footnote{118}{UKPP, CIL, 1876 (383), (p. 172).} This advice and encouragement was only given to the public asylums.

The change in approach by the CIL can be seen when, in 1876, they advised the medical superintendent of the Denbighshire (North Wales Counties) Asylum of means by which other of his colleagues were bypassing the objections of family and friends.\footnote{119}{UKPP, CIL, 1877 (403), (p. 195).} One of the methods reported was that used by the medical superintendent of the Lancashire (Whittingham) Asylum. Where the relatives refused consent, he would decline to issue a death certificate, instead securing an order from the coroner to require that a PM examination be completed.\footnote{120}{UKPP, CIL, 1889 (207), (p. 229).}
method was also suggested to the medical superintendent of the Glamorgan County Asylum to overcome the low consent rate identified at the inspection in March 1896.\textsuperscript{121} Clearly, the wishes of the family had become of significantly less importance to the CIL. This change in approach applied in the years before and after the death of Shaftesbury, so was not the consequence of a change of chairman.

The second approach used by the CIL to increase the number of PM examinations was to try to ensure that asylums had the resources needed. Conducting more PM examinations added to the workload of the medical staff. The Annual Reports noted where the CIL were of the opinion that an increase in the medical staff was required. In the early years they asked for medical officers to be appointed to assist the medical superintendent in his duty of supervising patients, as highlighted in the report on the visit to the Middlesex (Colney Hatch) Asylum in September 1858.\textsuperscript{122} After 1875 the requests for additional medical staff became more directed at the appointment of doctors to undertake PM examinations and pathological research. During the visit in April 1883 to the Devon County Asylum the commissioners stated that the low rate of PM examinations was due ‘no doubt, to the want of strength in the medical staff’.\textsuperscript{123} Six years later the advice had become more direct, as in the case of the Bedfordshire (Three Counties) Asylum in August 1889:

\begin{quote}
We recommend for the consideration of the Committee our suggestion that a third medical officer should be employed to assist in the wards, and to devote himself to the pathological research, which it is so desirable to encourage in our Asylums. With the appointment of such an officer the provision of the means and apparatus with which to pursue his studies would, of course, be necessary.\textsuperscript{124}
\end{quote}

The last sentence of the above quotation makes clear that the CIL was asking for more than simply an additional member of staff. Where, in the opinion of the commissioners, the mortuary and PM room facilities were inadequate they

\textsuperscript{121} UKPP, CIL, 1897 (279), (p. 253).
\textsuperscript{122} UKPP, CIL, 1859 Session 2 (204), (p. 23).
\textsuperscript{123} UKPP, CIL, 1884 (280), (p. 190).
\textsuperscript{124} UKPP, CIL, 1890 (274), (p. 161).
would encourage the Visiting Committee to make the required investment. During the visit to the Shropshire County Asylum in November 1879 the commissioners reported that the low rate of PM examinations was as much due to ‘the shed’ being used as the objections of relatives and that proper provision needed to be made as quickly as possible.\footnote{UKPP, CIL, 1880 (321), (p. 281).}

Initially, as in the case of the Shropshire Asylum, the CIL made little or no comment on the lack of scientific equipment, such as a microscope. Later this changed as the CIL sought to encourage more detailed scientific work to be completed, which required the provision of more accommodation and equipment. At the Durham County Asylum in July 1889, where all but one of the 107 deaths was followed by a PM examination, the following comment was made:

> This is very satisfactory, but we regret that scientific investigations are much crippled here by the absence of any provision whatever, at public cost, of a laboratory, a museum, or even microscopic or photographic instruments. In a public lunatic asylum these should be considered in the light of necessary aids to the medical staff.\footnote{UKPP, CIL, 1890 (274), (p. 185).}

The third element of the CIL approach was to encourage medical staff to undertake anatomical research into the causes of lunacy so that new treatments might be developed. This work was initiated by individual medical superintendents and the CIL sought to encourage others by publishing information on planned studies and the results of work completed.\footnote{UKPP, CIL, 1908 (200), (pp. 65-76).} The initiative of the CIL to publicise research in asylums came long after the first publication in 1853 of a journal for alienists, *The Asylum Journal*, by the Association of Medical Officers of Asylums and Hospitals for the Insane.\footnote{This journal was redesignated as the *Journal of Mental Science* in 1858 and from 1962 it became *The British Journal of Psychiatry*. The Association, upon receipt of a Royal Charter in 1926 became the Royal Medico-Psychological Association. From 1971 it was renamed as the Royal College of Psychiatrists.} Given the small number of asylums that reported work, shown in Table 5.1, the impact of this initiative by the CIL was limited. The promotion of research work by the CIL, whilst novel for this regulator, was not an

\footnote{125 UKPP, CIL, 1880 (321), (p. 281).}
\footnote{126 UKPP, CIL, 1890 (274), (p. 185).}
\footnote{127 UKPP, CIL, 1908 (200), (pp. 65-76).}
\footnote{128 This journal was redesignated as the *Journal of Mental Science* in 1858 and from 1962 it became *The British Journal of Psychiatry*. The Association, upon receipt of a Royal Charter in 1926 became the Royal Medico-Psychological Association. From 1971 it was renamed as the Royal College of Psychiatrists.}
innovation instigated by them and showed again how they were a reactive organisation.

The rationale of the CIL for encouraging PM examinations focused on the benefits for all patients, improved protection, and for the medical staff, greater medical knowledge, and increased interest in their work. To achieve these benefits, it was the stated policy of the CIL for PM examination to be standard practice in all asylums. Examination of the Annual Reports showed that the encouragement to perform PM examinations was only applied to the public asylums. This result adds weight to the suggestion by Richardson that the poor were being punished for their need of support.

In assessing the benefits derived from the PM examinations the CIL was dependent upon the quality of the records maintained by the medical staff. In the Annual Reports there are only occasional references to the PM examination records being of poor quality, a problem that was linked to a lack of sufficient medical staff. Sometimes when the PM examination records were found to be poorly completed, as during the June 1896 visit to the Portsmouth Borough Asylum, the commissioners did note the impact on their usefulness in securing the expected benefits. Despite this recognition, the CIL did not routinely report that they made an assessment of this material. In order to test the quality of these records the catalogues of the archives for the counties of Shropshire, Cheshire and Clwyd were reviewed. This showed that only the Clwyd Records Office (hereafter CRO) held the records for PM examinations in a county asylum. These records, for the years 1880 to 1894 were examined to assess the quality of the record-keeping.

A random sample of 40 of the 385 PM examination records were examined. This showed that more men than women underwent PM examination and in only a minority of cases was the brain examined (see Table 5.2). Examination of the brain was, in this sample, more frequently performed on men than women. The sample of records also showed that the time gap between death and the PM examination being completed ranged from 6 to 48 hours, with a mean of 30 hours for men and 38 hours for women.

129 UKPP, CIL, 1870 (340), (p. 31); UKPP, CIL, 1871 (351), (pp. 38-39).
130 Richardson, Death, Dissection, pp. xv, 176-79.
131 For examples see UKPP, CIL, 1888 (289), (p. 166); UKPP, CIL, 1895 (311), (p. 198).
132 UKPP, CIL, 1897 (279), (p. 361).
133 CRO [HD/1/414], 'Post Mortem Reports (26 May 1879 - 28 August 1895)'.

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Table 5.2: Review of PM Examination Results for the Denbighshire (North Wales Counties) Asylum, 1880-1894

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<th>Mean Age</th>
<th>Brain exam.</th>
<th>Mean delay (Hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>222</td>
<td>23</td>
<td>57</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Female</td>
<td>163</td>
<td>17</td>
<td>55</td>
<td>6</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: Denbighshire (North Wales Counties) Asylum Post-mortem Reports 26 May 1879, to 28 August 1895.

The review of these records showed marked variation in the amount of information being recorded from these examinations. In a small number of cases the record comprised only of the name of the patient, the date of death and the delay period, with the rest of the page left blank. In others the record comprised of a list of the organs, their weight and a brief note on their appearance, such as ‘Appears healthy’. In a few cases the record extended over two or three pages, with a detailed description of all of the organs. It was not until 1892 that the records included a statement of the cause of death, this being added at the top of the page. None of the records showed who had carried out the examination. The results for the Denbighshire Asylum are very similar in terms of content and variation in quality to those reported by both Cullen and Wallis. This variation in the quality of recording was ignored by the visiting commissioners, their focus being on the numbers of PM examinations being completed. As with the management of suicidal patients, Chapter 3 (see pp. 87-88), the CIL appeared to be reluctant to criticise medical staff about poor record keeping.

It is clear from this case study that the CIL failed to implement its stated policy, that PM examination be completed in the case of all deaths in ‘asylums and licensed (sic) houses’. Encouragement by the CIL was applied to the cases involving pauper patients but this was omitted for the non-pauper patients. In seeking an increase in the number of PM examinations being completed, the CIL encouraged investment in additional medical staff. Some of these new appointments might have been experienced pathologists but in many instances,

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134 CRO [HD/1/414], 197.
135 CRO [HD/1/414], pp. 53, 74.
136 For example see: CRO [HD/1/414], p. 325.
137 Cullen, ‘Post-mortem in the Victorian Asylum’, (pp. 286-97); Wallis, Investigating the Body, pp. 87, 147.
138 UKPP, CIL, 1881 (401), (p. 205).
139 UKPP, CIL, 1871 (351), (pp. 38-39).
they were doctors new to the specialties of alienism (psychiatry) and pathology. As a consequence, the achievement of the claimed benefits may have been compromised. In addition, the CIL also had to balance the competing pressures from the claimed benefits of this procedure and the resistance from the families. Whilst the CIL recognised the latter; it was the former which took precedence in the case of paupers. As with both mechanical restraint and staffing discussed in Chapter 4, the achievement of a high rate of PM examinations was dependent on local cooperation, particularly where additional funding was required. The results show that there was a progressive increase in the numbers of PM examinations being conducted at the public asylums. This increase occurred due to a combination of changes in medical practice and pressure from the CIL but the balance between these cannot be identified. The records of the CIL do indicate how the combination of resource pressure, limited capacity and the resistance to granting consent by relatives impacted on medical practice and a means of improving the safety of patients. Thus far, as noted by Wright, et al and Cullen, the conduct of PM examinations in asylums has received only limited attention.\textsuperscript{140}

Overview of securing compliance on all issues

Chapter 3 showed how the CIL used inspection and monitoring to identify the incidence of noncompliance for both the Specified and Non-specified Issues. Chapters 4 and 5 have examined the ability of the CIL to secure changes so that noncompliance was corrected. The four case studies selected for detailed examination cover the combination of long-standing and contemporary and Specified and Non-specified Issues: mechanical restraint, staffing, attendance at Divine Worship and PM examinations. Across these cases the results have been found to be consistent, with the CIL able to secure compliance in some but not all instances. Where compliance was secured, this was often a temporary achievement for reasons beyond the control of the CIL. This section sets out the reasons for these outcomes by reviewing the results from the four case studies.

Across all four case studies, the ability of the CIL to secure consistent and lasting compliance was limited by the lack of powers of enforcement that were under their direct and immediate control. In the case of the licenced houses, the

lunacy legislation did allow for the licence to be amended, not renewed or revoked. It also allowed for individuals to be prosecuted where the non-compliance was defined as a misdemeanour. In none of these instances was the final decision to take action in the control of the CIL. All the commissioners could do was make a non-binding recommendation for a licence to be amended, not renewed or revoked or for a prosecution to be commenced to the Lord Chancellor or the JPs. What remained was for the CIL to try to persuade the appropriate Visiting Committee, Board of Governors or proprietor to take action. What none of the lunacy legislation included was a method of securing compliance that was stronger than persuasion but did not involve a judicial or quasi-judicial process. Such an intermediate power, the issue of a notice requiring action be taken, had been available and used effectively by the Factory Inspectorate between 1833 and 1844. ¹⁴¹ Being able to issue such a notice could have enabled the CIL to more consistently secure changes that protected the patients from harm. The potential benefit of such power was demonstrated by the success that the CIL had when they used the threat of action to revoke the licence to persuade proprietors to take remedial action, or where they used delay of approval of proposals for new or adaptations to existing asylums to secure amendments that achieved compliance and greater protection or improved facilities for the patients.

The absence of enforcement powers under the direct control of the CIL was not simply a decision imposed on them. Throughout the chairmanship of Shaftesbury, the CIL rejected all attempts to grant them additional enforcement powers. Even after the death of Shaftesbury (1885), the CIL were, at best, ambivalent about being granted more powers. This was shown by their reaction to having to publish a list of approved instruments of mechanical restraint (see p. 117). ¹⁴² It was not simply that the CIL lacked power, a point noted by Mellett. The case studies show that they were reluctant to use the limited power to influence that they had, which applied both during and after the chairmanship of Shaftesbury. ¹⁴³

The limited enforcement powers in the control of the CIL and the resistance to these being increased were not the only influence on the ability of the CIL to secure compliance. All of the case studies and the results from Chapter 3

¹⁴² UKPP, CIL, 1890 (274), (p. 358); UKPP, CIL, 1895 (311), (pp. 403-4).
¹⁴³ Mellett, ‘Bureaucracy and Mental Illness’, (p. 244).
demonstrate that there was considerable variation between the inspection teams in how they identified and commented on examples of noncompliance. That there were differences between the individual making the inspection visits was not a surprise because each person came with a different set of experiences, attitudes, perceptions and expectations. Had the published reports included the names of the commissioners making each of the visits it would have been possible to trace these individual differences and their impact, as Bartrip and Fenn did in relation to the Factory Inspectorate.\textsuperscript{144} This inter-commissioner variation was compounded by the annual change in which of the teams made the visits, an unreviewed and unrevised policy decision of the founding members of the CIL. Given the differences in emphasis and requirement, the consistent and continued achievement of compliance was compromised which in part explains the different results reported in the secondary literature. As the achievement of consistency across England and Wales was one of the purposes of central government regulation, the practice of the CIL and the actions of individual commissioners undermined national policy.

Some of the differences in the securing of compliance to protect the patients were the consequence of the way the legislation had been drafted, creating an inherent weakness in the system for regulating asylums. Having a revokable licence for the private asylums, but not for the public asylums, was an obvious difference built into the system. This capacity, or even the threat of invoking it, enabled the CIL to secure changes that were of benefit to the patients in private asylums, such as those achieved at the Holloway Sanatorium (p. 42). To be effective, the threat had to be credible. This credibility could not be relied on as the Lord Chancellor and JPs frequently ignored the recommendations of the CIL. Without a licence that could be revoked, patients detained in the public asylums were at a clear disadvantage in terms of the protection available to them.

All the case studies show that the achievement of compliance by persuasion was entirely dependent on the cooperation of the Visiting Committee, local ratepayers and their representatives, the Boards of Governors and the proprietors. Whilst the differences in emphasis placed on the various reported issues made the defining of priorities difficult, the case studies have highlighted that the fundamental restraint was that of meeting any additional costs. These costs could be one-off payments, building a new chapel or mortuary, or recurrent,

\textsuperscript{144} Bartrip and Fenn, 'The Evolution of Regulatory Style', (pp. 213-17).
wages for additional staff, or a combination of both. None of the public asylum costs were met by the central government during the review period, other than an indirect payment to the Poor Law authorities.\(^\text{145}\) The costs of asylum services were just one of the demands on the relatively small number of local ratepayers. In the private asylums, costs were also a factor as there was a risk of the asylum pricing itself out of the market. The differing reactions to the meeting of the costs is another part of the explanation for the different conclusions reported in the secondary literature. These reactions to recommendations also varied over time under the influence of the state of the local economy.

The influence of other interested parties could also affect the securing of compliance. Highlighted in the case studies on the use of mechanical restraint and PM examinations was the influence of the medical profession. As both case studies demonstrate, the CIL needed the support of the medical staff to secure changes. The case studies also show that this support was patchy but over the course of the review period did result in reduced use of restraint and increased numbers of PMs. Without this support it is unlikely that the CIL could have achieved these results and what they did achieve was the consequence of a common direction of travel. The CIL may have tried to act as conduit for new ideas and practices by publishing information in their Annual Reports, but the very limited readership of these documents undermined this initiative.

The case study on Divine Worship showed how a small but influential group could influence the working of the CIL and the ability of this regulator to adapt to changing circumstances. The requirement that an Anglican Chaplain be appointed to each public asylum and that those patients who were able should attend services in a consecrated chapel showed one of the influences on the work of the CIL, that of the Evangelical Christians. Whilst the legislation included these requirements, the focus of the inspection and monitoring work of the CIL was on the number of patients attending the services, not on their beliefs. Even when the influence of this interested party started to wane the CIL continued to monitor attendance, a response to the way that the ethos of moral therapy, as exemplified by the York Retreat, underpinned their work. What did change over the lifetime of the CIL was the attention paid to attendance of those of other faiths at services

\(^{145}\) The four-shilling grant to cover the difference between a workhouse and an asylum placement for a pauper lunatic was paid to the Guardians, who then used the monies as part-payment to the asylum.
within their own religious tradition. Despite this shift towards a more ecumenical approach, a distinction between the Anglicans and the others was maintained, demonstrated by the higher expenditure on the Anglican chapels.

Across all four of the case studies the results show that the CIL did have some success in securing compliance. The problem was that the success was neither universal nor permanent. The combination of a lack of directly controlled enforcement powers, an unwillingness to use the powers held, disagreement with proposed changes by the Visiting Committees and proprietors, problems for ratepayers with meeting the costs of changes and the influence of interest groups, all compromised the ability of the CIL to secure compliance to varying degrees. The next chapter will consider if these factors also affected the process of enforcement when prosecution was used.
Chapter 6: Enforcement by Prosecution

Like other nineteenth century regulators, the CIL routinely used persuasion to try to secure compliance, but there were circumstances when the intervention of the court was required.1 The lunacy legislation of 1845 granted the CIL the power to initiate a prosecution in some cases but, as noted above (p. 25), this was altered in 1889 and 1890 when the role of senior ministers was increased.2 Ministerial control of the use of prosecution was also exercised through the need for the CIL to secure funding from the Treasury to meet the costs of each case.3 The legislation required the CIL to investigate potential cases, based on information collected during inspection visits or provided to the commissioners by other sources, such as relatives or ex-patients. This chapter examines when and how the CIL made the decision to prosecute, including the factors that they took into account; how the process of progressing a case was influenced by internal and external factors; and the outcome of the cases that were taken forward. Detailed examination of the use of prosecution for protecting patients, not previously attempted in a review of the work of the CIL, shows that whilst a minority of cases went to trial the majority of these resulted in conviction. This suggests that the CIL was highly selective about which cases were progressed to trial, only actioning those which appeared to have a high chance of success.

The decision to prosecute involved a sequence of binary choices: was noncompliance identified; was there sufficient evidence to show noncompliance; was the available evidence credible; was it probable that a judge and jury would accept that evidence; and was it in the public interest to proceed with the case? In practice, as this study will show, this apparently simple but necessarily nuanced process of decision-making was influenced by a range of factors. These included the influence of vested interests, political pressure, problems with the securing of evidence, financial constraints, and the general attitude towards the use of

1 Roberts, Victorian Origins, p. 287; Peter Bartrip and Paul Fenn, 'The Administration of Safety: The Enforcement Policy of the Early Factory Inspectorate, 1844-1864', Public Administration, 58 (1980), 87-102 (p. 95); Otter, The Victorian Eye, p. 119; Mills, Regulating Health, pp. 2-3; Murphy, 'The Lunacy Commissioners', (pp. 514-16); Elaine Murphy, 'The New Poor Law Guardians and the Administration of Insanity in East London, 1834-44', Bulletin of the History of Medicine, 77 (2003), 45-74 (p. 52).
3 UKPP, PSC, 1877 (373), (p. 538).
prosecution by regulators.\textsuperscript{4} Studies of other regulators suggest that similar influences impacted on the decision to prosecute.\textsuperscript{5} The taking of unsuccessful or, in the opinion of ministers or law officers, unnecessary legal action could result in criticism, that the regulator was being too intrusive, overbearing, unaccountable and using public monies extravagantly. Equally, a lack of action was seen as reprehensible where public sensibilities were offended.\textsuperscript{6} As this chapter demonstrates, this tension highlighted the competing pressures on a regulator.

\textbf{When could prosecution be used?}

Prosecution involved taking the person accused of committing an offence through a legal process that was under the control of the judiciary. For cases relating to the lunacy legislation, the CIL was not in sole control of the process. The decision being made in conjunction with the Lord Chancellor, the JPs, the government law officers and the Treasury. The CIL was empowered to investigate where the lunacy law may have been broken, whether identified at inspection or reported to them by relatives, coroners or others, and present their evidence with a recommendation for legal action to be commenced. This recommendation had to be made within the twelve-month time limit specified in the relevant law(s).

Analysis of the lunacy legislation (1845 to 1891) showed that prosecution could be initiated for a variety of reasons. Of the twelve Specified Issues listed in Table 2.4 (p. 47), only operating an unlicenced asylum, detaining a patient without certificates and an order, and not maintaining the required records were prosecutable. Within the Non-specified Issues list, (see Table 2.5, p. 48) only assault of a patient by a member of staff and neglect of a patient were prosecutable. In the legislation of 1845 40 of the 205 clauses defined a prosecutable offence.\textsuperscript{7} Further offences and variations on the original list were


\textsuperscript{5} Poovey, \textit{Making a Social Body}, p. 10; Otter, \textit{The Victorian Eye}, p. 99; Bartrip and Fenn, 'The Administration of Safety', (pp. 95, 100); Bartrip, 'British Government Inspection', (pp. 616-18); Bronstein, \textit{Caught in the Machinery}, pp. 129-31.

\textsuperscript{6} Being too intrusive resulted in criticism of Chadwick during his time at the General Board of Health, whilst being insufficiently intrusive marked the end of his involvement with the PLC. Hamlin, \textit{Public Health}, p. 269; UKPP, PSC, 1846 (663-I)/(663-II), (pp. vi-vii).

\textsuperscript{7} LL, 8 & 9 Vict. CAP.C (1845); LL, 8 & 9 Vict. CAP.CXXXVI (1845).
added as the lunacy laws were amended over the years 1846 to 1891. The CIL made no analysis in their Annual Reports of the cases prosecuted. Examination of the grounds for prosecution and the cases progressed shows that they fell into one of the following four categories: failures of licencing; illegal admissions; maltreatment of a patient and administrative failures. A summary showing the number of clauses within these categories in the lunacy legislation is given in Appendix 4 (p. 236).

As a detailed investigation of the Annual Reports shows, the recommendation to prosecute was based on consideration of the particular offence, whether the quality of the evidence was sufficient to both support the proposed action and secure conviction, and if there was an alternative, non-judicial, means of securing compliance available. Some offences, such as maltreatment or neglect that resulted in injury to one or more patients, required rapid action to prevent others from being harmed. In these cases, the proposal to prosecute followed on quickly from the confirmation, through the collection of evidence, that the alleged offence had been committed. Where the offence related to the noncompletion of records or a failure to submit required information, immediate prosecution was not employed. Here the CIL used alternatives, such as requests for the records to be kept or the returning of incomplete records for correction by the originator. It was only in the case of persistent failure that prosecution was proposed. Even in cases involving operating an unlicenced asylum, prosecution tended to follow an attempt at trying to persuade the alleged offender to take action to either obtain a licence or transfer the people detained to a licenced house or county asylum. Where no action was taken a proposal for prosecution would follow. All proposals to prosecute were reviewed and considered by the Lord Chancellor, for the asylums in the Metropolis, or the JPs, for all other areas. This process of review provided an opportunity for interested parties, both supporting and opposing the recommendation, to influence the decision being made. Such influence could occur through a formal approach to the relevant authority or through the informal social networks that permeated Victorian and Edwardian society. Where the criminal law was broken, whether by a patient

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8 By 1891, when the last lunacy law relating to the work of the CIL was enacted, 143 of the 913 clauses defined a prosecutable offence in all of the legislation.
or member of staff, the police investigated the offence. In these cases, the
decision on prosecution was made by the law officers. The CIL investigation of
such a case was of any breach of the lunacy laws.

The reporting of offences

The reporting on prosecutions by the CIL was inconsistent. A variable amount of
information on cases prosecuted was included in a section of the main text of the
Annual Report, which in some instances included commentary on the outcome. It
was rare for the CIL to report the defence case, other than noting where a
defendant lacked knowledge of the lunacy laws. Sometimes the commissioners
noted prosecutions in the feedback on an inspection visit. Because it was not
possible to confirm that the references to prosecuted offences in both places
related to the same case, those in the main text, where the offender was identified,
have been included.

As previously noted, all private asylums for two or more patients had to be
licenced. The licence was valid for a specified period of up to thirteen months and
defined the maximum number of non-pauper and pauper patients of each gender
that could be admitted. Failure to obtain a licence, renew it or comply with any
conditions imposed were all prosecutable offences. Between 1845 and 1910 the
CIL reported that there were 80 individuals identified as operating an unlicenced
asylum. Of these 62 cases were prosecuted and 49 convictions secured. These
numbers are not complete because in 1848 the Annual Report stated that there
had been an unspecified number of instances where unlicenced premises were
being operated but that action was taken in only one of these. The CIL used
discretion in progressing cases and frequently did not prosecute individuals who

1845-1914*, Journal of Social History, 31 (1997), 371-405 (pp. 373-74); Murphy, ‘The New Poor
Law Guardians’, (p. 331); Roderick A. W. Rhodes, ‘Policy Networks in Sub-central Government’, in
Markets, Hierarchies & Networks: The Coordination of Social Life, repr. edn ed. by Grahame
14 (p. 203); Anne Isba, ‘Trouble with Helen: The Gladstone Family Crisis, 1846-1848’, History: The

10 Where a patient committed a serious offence, a trial would be held but the patient deemed to be
unfit to plead, with a transfer to an asylum for the criminally insane following. For an example see:
UKPP, CIL, 1886 (196), (p. 186).

11 For examples see: UKPP, ‘The Sixth Annual Report of the Commissioners in Lunacy to the Lord
Chancellor’, 1851 (668), (pp. 17-20); UKPP, CIL, 1884-85 (285), (pp. 118-19).

12 As examples see: UKPP, CIL, 1847-48 (858), (pp. 172-73); UKPP, CIL, 1851 (668), (p. 19).

13 S.XIV-S.XXVI, S.XXIX, S.XXX, S.XLI-S.XLIV & S.LVII LL, 8 & 9 Vict. CAP.C (1845). These were
unchanged by the later legislation.

14 UKPP, CIL, 1847-48 (858), (p. 171).
claimed no prior knowledge of the lunacy laws. Instead, they allowed the offender to either transfer the patients to a licenced house or public asylum or apply for a licence, achieving their objective of securing compliance.

Securing a conviction for operating an unlicenced asylum was not always straightforward. As discussed in Chapter 4, the diagnosis of lunacy and idiocy was uncertain in the nineteenth century, with the distinction between normal but eccentric behaviour and lunacy being subject to interpretation. As a consequence, the claim that a person was detaining lunatics and thereby operating an unlicenced asylum was open to challenge. In 1867 a Mr Shaw was accused of operating an unlicenced asylum in a house in Boreham Wood, Hertfordshire. Evidence from an ‘eminent London physician, Dr Blandford’ confirmed the two people in detention were lunatics. At the trial at Hertford Assizes, Mr Shaw was convicted but sentencing was deferred to allow an appeal on whether the two people were in fact lunatics. The appeal failed and Shaw was sentenced to two months imprisonment and fined the very substantial sum of £100 (£11,450).³⁸

Thirty years later the uncertainties of diagnosis continued to plague the legal process, probably contributing to the CIL reluctance to use prosecution. In 1897 the widow of Mr Shaw was reported to the CIL for operating an unlicenced asylum. At the request of the CIL Dr Henry Maudsley (1835-1918), the leading alienist, assessed the two men detained at a house in Elstree, Hertfordshire. He confirmed that they were of unsound mind, and that they were being cared for by an ‘an old and very deaf lady’ in a house that was ‘old, neglected and in need of repair’. Prosecution was instigated but the magistrates at the Barnet Petty Sessions concluded that neither detainee was a lunatic within their interpretation.

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³⁵ For examples see: UKPP, CIL, 1850 (735), (p. 12); UKPP, CIL, 1852-53 (285), (pp. 29-30).
³⁷ Dr George Fielding Blandford (1829-1911) was a medico-psychologist and lecturer at St. George’s Hospital, London. In 1877 he was President of the Medico-Psychological Association. D. A. Power and Nicholas Hervey, ‘Blandford, George Fielding (1829-1911)’, in Oxford Dictionary of National Biography, ed. by Sir David Cannadine (Oxford: Oxford University Press, 2004; Revised 2021), [Accessed: 25 May 2022].
³⁸ UKPP, CIL, 1867-68 (332), (pp. 58-62).
⁰ Dr Henry Maudsley was a past Medical Superintendent of the Manchester Royal Lunatic Asylum (1859-1862) and joint editor of the Journal of Mental Science (1863-1878). He was a major contributor to the fund that established the Maudsley Hospital, London. T. H. Turner, ‘Maudsley, Henry (1835-1918)’, in Oxford Dictionary of Biography, ed. by Sir David Cannadine (Oxford: Oxford University Press, 2004; Revised 23 September 2010), [Accessed: 25 May 2022].
of the legislation and dismissed all the charges. Commenting on this decision, the CIL stated that if this interpretation were widely applied it would ‘render inoperative’ the lunacy legislation.\textsuperscript{21} The case of Mrs Shaw was not a unique example. In 1906 a Mrs Chalk was prosecuted for non-notification of the detention of two Single Patients in separate houses. In one case she was convicted and the other acquitted.\textsuperscript{22} Such variation in the interpretation of the law by judges was a problem for other regulators: the work of George Behlmer on the school’s inspectorate reports that the attempt to secure higher attendance was often undermined by decisions of the judiciary.\textsuperscript{23}

These cases highlight two issues with the use of enforcement powers by a regulator. Firstly, where the regulator was reliant on the receipt of information from third parties to determine noncompliance there was a low probability of the real number of instances being identified. The total number of Single Patients, wealthy individuals admitted to a private house under the care of a designated doctor, notified to the CIL rose from 160 in 1849 to 593 in 1910.\textsuperscript{24} It is, however, impossible to know if either figure represented the true number. The same uncertainty applied to the numbers of unlicenced houses being operated. The 80 people reported by the CIL between 1845 and 1910 could have been the majority or just the tip of the iceberg. Secondly, the above cases show that prosecution was not certain to produce the expected result even when clear evidence had been presented. This was partly due to the lack of a widely accepted consensus of what constituted madness. Variants of these two problems affected the enforcement by prosecution process in all of the other areas of noncompliance.

The process of prosecution was by no means a certain method of securing compliance, but the CIL found that the threat of such action could be sufficient incentive to persuade some proprietors to take the recommended action. At their visit to the Hoxton House Asylum, London, in February 1851 the CIL had noted the need for various improvements, including to the diet of the pauper patients. The proprietor was informed that unless improvements were made the CIL would recommend revocation of the licence. At their visit in May 1851 the commissioners noted that improvements had and were being made. No further action was taken

\textsuperscript{21} UKPP, CIL, 1897 (279), (pp. 42-44).
\textsuperscript{22} UKPP, CIL, 1906 (224), (pp. 72-73).
\textsuperscript{24} UKPP, CIL, 1850 (291), (p. 10); UKPP, CIL, 1910 (204), (p. 63).
by the CIL. The threat of revoking the licence could focus the attention of the proprietor on the need to take corrective action. This was effective only so long as the threat was credible. If the proposal of the CIL was not adopted by the Lord Chancellor or JPs, or the request for funding rejected by the Treasury, then the credibility of the regulator was called into question. This tactic for effecting change could only be applied to the private asylums. As the publicly funded asylums were not licenced this means of effecting change was unavailable, placing both the pauper and non-pauper patients admitted to these sites at a disadvantage in terms of the protection available.

The second group of prosecutable offences related to the prevention of inappropriate admission and included the proper completion of certificates and orders by specified people before detention, with the intention of preventing such events. Failure to follow the detention process correctly, including the completion of the required documentation, could invalidate the admission and render the medical staff and others involved liable to prosecution. The focus of the document checks was on the process of detention and the proper completion of the paperwork. There was no assessment of the accuracy of the diagnosis. From the beginning the CIL reported that there were numerous problems with the admission paperwork, as this comment in the First Annual Report makes clear:

The Commissioners have found it scarcely practicable in many instances to compel medical practitioners, when certifying the insanity of private patients, to set forth, with any degree of care and correctness, the facts upon which their opinion is formed; and the exceeding inaccuracy of numerous certificates has added materially to the amount of correspondence in which the commission is engaged.

In their Further Report of the Commissioners of 1847, an addendum to the second annual report, the CIL stated that at least 1000 of the medical certificates for the private patients had been found to be inaccurate. The identified but

25 UKPP, CIL, 1860 (338), (pp. 20-31).
26 S.XLV, S.XLVI, S.XLVII, S.XC and Schedules LL, 8 & 9 Vict. CAP.C (1845). S.LI LL, 8 & 9 Vict. CAP.CXXVI (1845). These requirements were maintained in all subsequent legislation.
27 UKPP, CIL, 1847 (471), (p. 2).
unquantified error rate for pauper patients was reported to be much lower. Because of the high error rate found, the CIL sought and secured an amendment to the lunacy laws in 1853 that permitted them to return any detention documentation found to contain errors for correction by the person who completed it. The CIL never reported the numbers of documents sent for correction.

An analysis of the cases that were prosecuted shows that the CIL adopted different approaches between the three possible locations of detention (see Figure 6.1). At the public asylums only a very small number of cases were progressed, but all resulted in conviction. Considering the very large numbers of pauper patients being admitted to the public asylums, the small number of prosecuted cases is unlikely to reflect the real incidence of poorly completed admission documentation. Similarly, with the reported level of inaccuracies for the private asylums, the number of cases pursued and successfully prosecuted was also very small. The Others category, which included those Single Patients whose names had not been notified to the CIL and people detained in unlicenced premises, was the largest group and the most frequently prosecuted.

In the majority of cases the CIL’s criticism of the medical profession for non-completion of paperwork did not translate into prosecutions. Fifty-six cases of a doctor’s failure to correctly complete the required certificates and orders were considered for prosecution but only 18 (32%) were progressed. One of the unprosecuted cases was that of Drs Dawson and Burton. In 1851 the CIL reported that they had failed to examine a patient prior to certification. The CIL decided not

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28 UKPP, CIL, 1847-48 (858), (pp. 18-20).
to prosecute them as they had acted for the ‘sole purpose of placing in security a dangerous lunatic who was then at large’. Instead, the doctors had to publicly acknowledge that they had committed an offence.\(^{30}\) Such a pragmatic approach was not always used. In October 1866 the CIL received notification of the admission of a male patient to the Southall Park Asylum, London. This person had been treated by Mr George Naylor, a surgeon, for the previous year. One of the certificates, signed by Naylor, described the patient as ‘a person of weak and imbecile mind’. The CIL asked that Dr Maudsley and another doctor, as expert witnesses, examine the patient. They confirmed the patient was insane, potentially treatable, and not an incurable imbecile. A prosecution was initiated and the case heard at the Central Criminal Court on 21 December 1866. Naylor was convicted and sentenced to appear and receive judgement when called.\(^{31}\) As no further punishment was imposed, the CIL was surprised and dissatisfied at the leniency shown and included the following comment in the relevant Annual Report:

> We feel strongly that the case was one of such clear and persistent violation of the law as to call for a penalty of an amount sufficient to deter other Medical Practitioners from similarly infringing its express provisions, of which none can now claim ignorance. Unless the measure of punishment be proportioned to the education and position (professional and otherwise) of defendants, prosecutions are in our opinion useless, if not positively mischievous.\(^{32}\)

Not all asylum proprietors were doctors. The CIL used prosecution more frequently when improper completion of admission paperwork was identified at asylums operated by non-medically qualified proprietors. Of the 34 cases reported, 16 (47%) were prosecuted and 10 convicted. Again, there were variations in when the CIL chose to progress a case and, in the decision, reached at trial. In March 1869 the CIL were informed by the police that a Miss M.V. had been found late at night on a street in Wandsworth, London, complaining that she was being held as a prisoner by the Rev. Mr G. M. Irvine. She was reported as having a deranged

\(^{30}\) UKPP, CIL, 1851 (668), (p. 19).
\(^{32}\) UKPP, CIL, 1867 (366), (pp. 45-46).
mind and was returned by the police to the care of Mr Irvine despite her objections. Investigations by the CIL showed that Miss M.V. had a long history of lunacy and that she had been in the care of Irvine without certificates or orders for a number of years. Irvine was prosecuted and the case heard at the Central Criminal Court on 7 June 1869. At trial he pleaded guilty, without reported comment on his knowledge of the lunacy laws, and, at his own recognizance, was required to appear and receive judgement when called.\textsuperscript{33} The CIL made no comment about this decision. The outcome of the case against Mr George Burn from 1873 contrasts markedly with that of Irvine. Burn, the former proprietor of a provincial licenced house, was found to have detained Mr E.W without certificates and an order. At trial he also pleaded guilty but was imprisoned for one month.\textsuperscript{34} The reasons for the differences in sentencing decision are unclear.

Inconsistency was not limited to the decisions of the court. In 1879 the CIL reported that they had received information from an unstated source that eight people had been detained in separate locations without the required documentation. Only in four of these did they seek an Order from the Lord Chancellor to undertake inspection visits. The outcome from the visits made was that all four of the people detained were subsequently certified, with an unspecified number being moved to asylums. The Commissioners went on to note that:

\begin{quote}
It seemed to us, however, that all the persons who had thus broken the law had done so through ignorance… In the circumstance, therefore, we did not consider it necessary to prosecute any of the persons so offending, although, in the case of a tradesman…, it appeared proper to require from him a formal apology, inserted in “The Times,” “Standard,” “Lancet,” and a local paper [in Peterborough], as the condition on which we consented to abstain from a prosecution.\textsuperscript{35}
\end{quote}

By defining the process for detaining a patient the intention of the legislators was to prevent inappropriate admission. The proper completion of the required documentation was fundamental to this process. Despite being allowed,

\textsuperscript{33} UKPP, CIL, 1870 (340), (pp. 59-61); Anonymous, Regina v Gordon Marvin D'Arcy Irvine, (1869), http://www.oldbaileyonline.org, [Accessed: 5 March 2018]
\textsuperscript{34} UKPP, CIL, 1873 (256), (pp. 77-78).
\textsuperscript{35} UKPP, CIL, 1878-79 (342), (p. 126).
by the Lunacy Act (1853) to return incomplete or inaccurately completed admission documentation for correction, the CIL never published the number of times this power was used.\textsuperscript{36} This omission makes the assessment of the effectiveness of the CIL impossible in relation to this basic protection for the patients.

The third category of prosecutions were related to the maltreatment of patients, a long-standing concern. Maltreatment covered a range of actions and inaction by asylum staff and others. The CIL reported instances of both cruelty, such as a patient being assaulted, and neglect, arising from inadequate care. In all the CIL identified a total of 715 cases of maltreatment between 1845 and 1910. Of these 222 prosecutions were initiated and 190 convictions secured. The distribution of these cases into the categories of cruelty, Table 6.1, and neglect, Table 6.2, shows substantial variations in outcome. Where cases were prosecuted there was a high rate of conviction.

Table 6.1: Comparison Between the Numbers of Possible Cases of Cruelty Identified, those Prosecuted and the Numbers of Convictions by Asylum Type, 1845-1910

<table>
<thead>
<tr>
<th>Asylum:</th>
<th>Cases</th>
<th>Prosecuted</th>
<th>Convicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>232</td>
<td>143</td>
<td>123</td>
</tr>
<tr>
<td>Private</td>
<td>70</td>
<td>40</td>
<td>37</td>
</tr>
<tr>
<td>Others</td>
<td>20</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 6.2: Comparison Between the Numbers of Possible Cases of Neglect Identified, those Prosecuted and the Numbers of Convictions by Asylum Type, 1845-1910

<table>
<thead>
<tr>
<th>Asylum:</th>
<th>Cases</th>
<th>Prosecuted</th>
<th>Convicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>283</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Private</td>
<td>91</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>19</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

Cruelty to patients took a number of forms, the most common of which was a member of staff hitting a patient and causing injury. The problem with taking these cases to court was in securing sufficient evidence to prosecute the offender. Within the enclosed world of the asylum, where staff shortages were prevalent, individuals had many opportunities for inflicting abuse without anyone

\textsuperscript{36} S.XI LL, 16 & 17 Vict. CAP. XCVI (1853).
else being present. This lack of clear evidence can be seen by the large differences between the potential cases and the prosecutions shown in the tables above. This problem was compounded by the cautious approach adopted by the CIL towards accusations from patients. In reporting the case of John Coates, a patient who died at the Durham County Asylum in 1873, the CIL noted that the evidence to show that an attendant had maltreated him would be hard to secure because:

The attendants, being the persons implicated, were not likely to criminate (sic) themselves, and it is very rarely that the statements of the patients can be safely relied on, the more intelligent of them being often deterred from stating what they have seen, from fear that they themselves may afterwards be ill-treated.\(^37\)

There was also a caution on the part of the judiciary about accepting the evidence of a person who had been certified as insane and who was detained in an asylum. This issue was tested in the case of Samuel Hill, an attendant at the Peckham House Asylum, London. In December 1850, whilst returning Moses James Barnes to bed in the infirmary, Hill threw Barnes to the floor. The assault was witnessed by Richard Donelly, another patient. Hill did not report the event for three days. Treatment of Barnes, who was found to have fractured three ribs and an arm, was consequently delayed, contributing to his death on 2 January 1851.\(^38\) Hill was prosecuted, and the case heard at the Old Bailey on 3 February 1851. He was convicted but appealed the decision of the trial judge to allow the evidence of Donelly. At appeal the decision of the trial judge was confirmed and Hill was sentenced to twelve months imprisonment.\(^39\) Despite the precedent of this ruling, the CIL continued to be cautious about using patient evidence in prosecutions.

Problems with the reliability of witness evidence was not limited to that from the patients. William Swift was admitted to the Middlesex (Colney Hatch) Asylum in February 1860 after he had attempted to strangle the Master of the Workhouse in which he was detained. He committed no further acts of violence

\(^{37}\) UKPP, CIL, 1874 (284), (p. 153).
\(^{38}\) UKPP, CIL, 1851 (668), (pp. 17-18).
until May 1860 when he was involved in a struggle with an attendant named Gann. Gann admitted that he had, in self-defence, hit Swift and that he managed to subdue him only with assistance from the staff of a neighbouring ward. Three days after the incident Swift suddenly died. A PM examination showed that Swift had a ruptured liver and ‘many fractured ribs and the sternum was also found to be fractured’.40 As the Visiting Committee was investigating the case the CIL took no immediate action.

On 2 July the Home Office forwarded a letter from the Secretary of the Alleged Lunatics Friends’ Society and a copy of the depositions to the coroner. In the light of this material the CIL instituted an investigation, which concluded that two attendants, William Slater and William Vivian, had assaulted Swift. Dr Tyerman, a Medical Officer of the asylum, reported that the various injuries from this assault had been the cause of death. Slater and Vivian were committed for trial at the Old Bailey. At the trial Dr Tyerman changed his evidence, stating that the injuries from the altercation with Gann may have been a contributory factor. Given the uncertainty over which injuries had caused the death, both Slater and Vivian were acquitted.41

A decade later the CIL again found problems in securing evidence during the investigation into the death of a patient, Rees Price. In a report, dated the 7th February 1870, Mr William Campbell and Dr John Cleaton, barrister and medical commissioner respectively, presented the findings from their investigation at the Carmarthen Asylum.42 Price had been admitted on 1 January 1870 from the Llandovery Workhouse and died seven days later. A PM examination found that he had suffered eight fractured ribs. The cause and timing of these injuries was not known. Evidence was taken from 18 asylum staff and 7 staff of the Workhouse, but the commissioners were only able to recommend that one asylum attendant be dismissed. In their report they noted that:

In cases of this description, as well as in all others involving the ill-treatment of patients in asylums, there is great difficulty in obtaining direct or satisfactory proof. The attendants very

40 UKPP, CIL, 1861 (314), (p. 56). The report does not include either the date of the incident or of the death of Swift.
42 UKPP, CIL, 1870 (340), (pp. 227-34).
frequently endeavour to screen each other, and patients who may have witnessed an act of violence are often tutored by them to support their statements, or are prevented, through fear of the consequences, from speaking openly.\footnote{UKPP, CIL, 1870 (340), (p. 227).}

The use of prosecution where cruelty was alleged was not the only option available to the CIL, as shown by the case involving John Monkhouse Scott. On 7 February 1851 Scott, a pauper patient admitted to the Dunston Lodge Licenced House, Gateshead, whilst in an excited state, bit the arm of the proprietor, John Wilkinson. In response, Dr Rowe, the Medical Attendant, removed Scott’s two front teeth. Despite making inspection visits in 1851 and 1852, the CIL only became aware of the case in January 1853 after being contacted by the JPs for Westmorland and Cumberland, who had forwarded information received from an ex-patient of Dunston Lodge. Wilkinson, in response to enquiries by the CIL, admitted the facts and justified the action as being ‘the means of doing the patient good’. Rowe, who no longer worked at the asylum, confirmed in writing that he had removed the teeth on the basis that ‘Scott was a dangerous lunatic, and (in his belief) incurable, and was in the habit of biting’. The CIL summoned Wilkinson, Rowe and other witnesses to a meeting. On questioning it was found that the bite had been superficial and that Scott had no history of such behaviour. In response to the incident Wilkinson had also had Scott mechanically restrained and then flogged him with a riding-crop. Rowe had, in the presence and with the consent of Wilkinson, removed the healthy teeth. Because the case was out of time the CIL could not recommend that Wilkinson and Rowe be prosecuted. Instead, they secured from the Lord Chancellor an Order to prevent Wilkinson from renewing the Licence. No further action was reported to have been taken against Rowe.\footnote{UKPP, CIL, 1854 (339), (pp. 25-27).}

Without recourse to a court case the CIL effectively punished the proprietor. Despite this success, it was not an approach reported to have been used again by the CIL.

A particular form of maltreatment that attracted the attention of the CIL was that of the sexual abuse of female patients by male patients (or staff/visitors). In their guidance to architects, the CIL specified that all plans had to show
‘sufficient means of effecting a complete separation of the sexes’. This concern was also reflected in the Proposed Rules for the Government of Lunatic Asylums published by the CIL in 1847. The taboo on the mixing of the sexes, even when they were relatives of the patient, was spelt out:

That the male and female patients be kept in separate wards and that no male attendant, servant, or patient be allowed to enter the female wards; nor any female to enter the male wards, except in cases where the resident Medical Officer shall deem it advisable to appoint nurses or female servants to attend for that purpose.

That upon every visit made by a male relative or friend or by a parish officer, to a female patient, the Matron or a female attendant accompany the visitor and remain in the room throughout the interview.

Despite this obvious concern about female and male patients, visitors and staff having contact, before 1889 the CIL reported no breaches of the rules. It was only after this date that twelve instances were reported, one at a private asylum (Fisherton House) and the rest at public asylums. In each case the CIL asked for this mixing to be stopped. Mixing between male staff and female patients was discouraged because it could lead to inappropriate liaisons, both consensual and non-consensual. Concern about such liaisons was included in the follow up to the PSC on the lunacy laws that reported in 1877. The CIL proposed that it be made a criminal offence for male staff to have ‘carnal knowledge of a female patient’. When the law was amended in 1889 a clause was included that made such behaviour a misdemeanour punishable by up to two years imprisonment. This clause also stated that a woman detained in an asylum was not mentally competent, precluding the defence that the contact had been consensual.

45 UKPP, CIL, 1847-48 (858), (p. 324); CIL, Suggestions and Instructions, p. 5.
46 UKPP, CIL, 1847-48 (858), (pp. 334, 336).
47 UKPP, CIL, 1906 (224), (p. 69).
48 For examples see: UKPP, CIL, 1890 (274), (p. 206); UKPP, CIL, 1897 (279), (p. 409); UKPP, CIL, 1899 (255), (pp. 288-90); UKPP, CIL, 1909 (213), (p. 394).
49 UKPP, CIL, 1878-79 (342), (pp. 126-37).
50 S.82 & S83 LL, 52 & 53 Vict. CHAP. 41 (1889).
In the years prior to 1889 the CIL only reported on two cases where male staff had sexual relations with a female patient. In October 1874 an unnamed female patient, who had been admitted to the Yorkshire (East Riding) Asylum for more than two years, gave birth to a child. An engineer employed at the asylum admitted that he was the father. He was dismissed but criminal proceedings were not initiated as there was no corroborative evidence.\(^{51}\) In the second case, patient M.A.T. gave birth to a child at the Middlesex (Colney Hatch) Asylum on 13 June 1880. After M.A.T. accused a plumber of being the father, the CIL undertook an inquiry. Despite denying the allegation and there being no corroborating evidence the plumber was dismissed. Prosecution was not progressed due to lack of evidence but the CIL did note that control of the keys to the female division was very lax.\(^{52}\)

Cases of alleged improper sexual conduct were problematic to prosecute. A female patient, N.W., accused a male attendant of assaulting her on 9 September 1901 whilst she was working unsupervised in the house of the medical superintendent. The CIL investigation found that N.W. had been admitted in 1894 in a delusional state from a workhouse where she had given birth to an illegitimate child. Her delusions were of a sexual character. Her evidence was described by the commissioners as ‘conflicting and contradictory’ and being without corroboration. The CIL concluded that, whilst there had been poor supervision of N.W. and the accused attendant had been remiss in his duties, there was no basis for a prosecution.\(^{53}\)

Not all the failures to secure a conviction were the consequence of a lack of evidence. In March 1906 a decorator named Tunnicliffe, employed by a contractor to redecorate part of the Cheshire (Parkside) Asylum, was witnessed to ‘misconduct himself with a female patient’. He was prosecuted for having carnal knowledge of a female patient under the terms of S.324 of the Lunacy Act (1890) and unlawfully and carnally knowing an idiot or imbecile as specified in S.5(2) of the Criminal Law Amendment Act (1885). As he was not directly employed by the asylum the trial judge decided that S.324 did not apply and dismissed this charge. The jury decided that Tunnicliffe had had carnal knowledge of the patient but that he did not and could not know she was a lunatic or imbecile, a requirement of

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\(^{51}\) UKPP, CIL, 1875 (337), (p. 34).

\(^{52}\) UKPP, CIL, 1881 (401), (pp. 96-97).

S.5(2). On this basis he was found not guilty. In response the CIL proposed a change to S.324 to include all people working on the asylum site.\textsuperscript{54} The change was implemented after the CIL was replaced, under the terms of An Act to Make Further and Better Provision for the Care of the Feeble-Minded and Other Mentally Defective Persons and to Amend the Lunacy Acts (the Mental Deficiency Act, 1913), by the Board of Lunacy.\textsuperscript{55}

Section 324 of the 1890 Act was not totally ineffective. In August 1898 an accusation was made by a female patient at the Cumberland and Westmorland Asylum that Dr. John M. Campbell, the Medical Superintendent, had been improperly intimate with her.\textsuperscript{56} The Visiting Committee investigated the case and found six patients who made similar allegations. On the recommendation of the CIL the case was prosecuted, the case being heard at Carlisle Assizes. The defence showed that Dr Campbell had been delusional and not responsible for his actions at the time of the offence. He was found to be guilty but insane and detained at Her Majesty’s Pleasure.\textsuperscript{57} Despite this outcome there is no record of Dr Campbell having been struck off the medical register, but did result in the ending of his medical career.\textsuperscript{58}

It seems probable that the incidence of improper contact between staff and patients did not suddenly arise in the late 1880s. Given the instructions for the separation of the sexes in the design specification, the CIL anticipated a potential problem from the outset. The numbers of cases are, probably, an underestimate of the real incidence. The risk of sexual abuse of male patients was not mentioned in the Annual Reports.

Other forms of neglect did not lead to attempts to secure changes in the lunacy laws. The problem in securing adequate evidence of alleged neglect can be seen from the fact that only 28 of the 393 possible cases were progressed, with only 19 resulting in conviction (see Table 6.2, p. 181). The most frequently reported form of neglect was the failure of the staff to prevent patients from

\textsuperscript{54} UKPP, CIL, 1907 (225), (pp. 69-70).
\textsuperscript{55} S.56 LL, 3 & 4 Geo. V CHAP. 28 (1913).
\textsuperscript{56} Cara Dobbing and Alannah Tomkins, 'Sexual Abuse by Superintending Staff in the Nineteenth-century Lunatic Asylum: Medical Practice, Complaint and Risk', History of Psychiatry, 32 (2021), 69-84 (pp. 76-78).
\textsuperscript{57} UKPP, CIL, 1899 (255), (pp. 58-59).
\textsuperscript{58} Smith, Medical Discipline, pp. 355-56; Dobbing and Tomkins, 'Sexual Abuse by Superintending Staff', (p. 78).
committing suicide, self-murder being a matter of considerable public concern.\textsuperscript{59} For those commissioners who were Evangelical Christians prevention was an important matter as suicide was defined as a mortal sin.\textsuperscript{60} Whilst both suicide and attempted suicide were, at this time, criminal offences the view of the medical profession was changing, with the causal association that made suicide an indicator of lunacy being called into question. This change had no immediate effect on asylum services, it being a medico-legal issue.\textsuperscript{61} It did mark the start of a long period of reformation that eventually led to the decriminalisation of suicide and attempted suicide in 1961.\textsuperscript{62}

In order to prevent, or at least minimise, suicides the CIL argued for at-risk patients to be kept under close observation at all times and for the medical staff to issue detailed written instructions on the level of supervision in each case. Despite these measures being implemented patients continued to commit suicide. Table 6.3 shows the distribution of the identified cases of suicide reported by the CIL. It also shows where the coroner criticised the staff and where legal action was taken against an attendant. The CIL commented on these cases and, despite their obvious concern, only a small minority were prosecuted. Of those prosecuted, conviction was secured in the majority of cases. It is notable that none of the alleged offenders were doctors.

\textbf{Table 6.3: Distribution of Suicides by Asylum Type and the Outcome of Cases, 1845-1910}

<table>
<thead>
<tr>
<th>Asylum</th>
<th>Cases</th>
<th>Coroner Criticism</th>
<th>Prosecuted</th>
<th>Convicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>184</td>
<td>15</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Private</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Where the action or inaction of staff had contributed to a suicide there was no consistent consequence for the continued employment of that person. At the

\textsuperscript{59} Anderson, 'Did Suicide Increase', (p. 149); Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-murder in the Age of Non-restraint', \textit{Medical History}, 46 (2002), 175-96 (pp. 178-79).


\textsuperscript{61} Georgina Laragy, "A Peculiar Species of Felony": Suicide, Medicine, and the Law in Victorian Britain and Ireland, \textit{Journal of Social History}, 46 (2013), 732-43 (pp. 733, 738).

\textsuperscript{62} S.1 LL, \textit{An Act to Amend the Law of England and Wales Relating to Suicide, and for Purposes Connected Therewith} (1961) (9 & 10 Eliz. II CHAP.60).
public asylums 35 staff implicated in the failure to prevent a suicide had their employment terminated, with another 13 either required or allowed to resign. The largest group, 47 staff, were reprimanded by the relevant Visiting Committee. The comparable figures for the private asylums were 13 dismissed, 4 resigned and 13 reprimanded. There was only one person admonished at any of the other sites where a lunatic committed suicide and in none of the cases at these other locations was any further action taken.

How a member of staff implicated in the maltreatment of a patient was dealt with was determined by a combination of their culpability, the post held, past performance in that post, and any mitigating factors, such as staff shortage or unclear instructions. The outcome, a consequence of the effect of these local considerations, was that from the perspective of the regulator there was little consistency in the consequences in cases of neglect. Henry Peters, the head attendant at the Northumberland House Asylum, London, was fined the substantial sum of £15 (£1865) in 1880 when patient HS committed suicide after the prescribed constant observation was not maintained.63 Less than a year later, an unnamed nurse at the Berkshire County Asylum received a severe reprimand for allowing a suicidal patient to take a knife, used by the staff to prepare food, and commit suicide.64 The doctor at the Dunston Lodge Asylum, Gateshead, went unpunished in 1881 despite failing to provide ‘sufficiently careful orders’ for the attendants to maintain close observation of patient JM, who was known to be suicidal.65 The need to allow for any local factors or differences in circumstances of a particular case, compromised the achievement of common standards across England and Wales.

Another form of neglect that attracted the attention of the CIL was where patients suffered scalds when being bathed. Between 1845 and 1910, the CIL reported on 23 cases, with 21 of the patients dying from the injuries sustained. Twenty-one of the cases related to public asylums, one to a workhouse in Bristol and the other to a private asylum for idiots. The cases involved one or more members of staff failing to follow the rules for the bathing of patients that all asylums were required to have in place. Despite these cases being due to the

63 UKPP, CIL, 1881 (401), (pp. 114-15).
64 UKPP, CIL, 1882 (357), (p. 99).
65 UKPP, CIL, 1882 (357), (p. 154).
neglect of duty by staff only a minority resulted in prosecutions and a smaller number in convictions. How the cases were dealt with is shown in Table 6.4.

Table 6.4: Comparison Between the Asylum Types on How Cases of Neglect by Staff that Resulted in Scalding were Dealt With, 1845-1910

<table>
<thead>
<tr>
<th>Asylum:</th>
<th>Cases</th>
<th>Death</th>
<th>Prosec</th>
<th>Convict</th>
<th>Dismiss</th>
<th>Reprim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>21</td>
<td>20</td>
<td>6</td>
<td>4</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Private</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Prosec(tion); Convict(ion); Dismiss(ed from post); Reprim(anded only)

As with the other instances of neglect there was an inherent inconsistency in how these cases were addressed, demonstrated by comparing the outcome of two cases at the Surrey (Brookwood) Asylum in different years. On 4 August 1868 attendant Albert Tatford prepared to bath an unnamed patient. Because the water was too hot to use, he left the patient alone in the bathroom whilst completing other work. When he returned the patient was in the bath and had been severely scalded, dying five days later. Tatford, who should not have run the hot water first and then left the patient unattended, was dismissed but not prosecuted.66 Four years later an unnamed attendant ran hot water into a bath for use in ward cleaning. He left the bathroom door unlocked and an unnamed patient climbed into the bath and was scalded, causing his death eight hours later. During the investigation the attendant was suspended from duty. The CIL recommended that he be dismissed. The Visiting Committee, ignoring the view of the CIL, determined that ‘the welfare of the asylum would be best promoted by reinstating him in his situation, after admonishing him, he having been suspended for three weeks’67. The latter case makes clear the limited ability of the CIL to influence local decision-making.

Variations in outcome also applied in the small number of cases of scalding that were prosecuted. The trials of attendants William Cooper, Surrey (Wandsworth) Asylum, Edward Hall, Somerset and Bath Asylum, and an unnamed nurse at the Birmingham (Winson Green) Borough Asylum, resulted in different outcomes despite their actions having led to the death of a patient from scalds.

66 UKPP, CIL, 1868-69 (321), (pp. 39-40).
67 UKPP, CIL, 1873 (256), (p. 45).
Cooper was imprisoned for one month, Hall for one year and the nurse was acquitted. As with the cases related to patient suicide and staff culpability, the impact of local factors and circumstances could result in apparently inconsistent conclusions and outcomes being reached. From the perspective of the regulator such apparent inconsistency compromised their work on securing basic standards to protect patients from harm, undermining part of the justification for expending public money on regulation.

Comments by the CIL on the various sentencing decisions in cases of scalding that did not meet their expectations suggests that the commissioners saw this form of noncompliance as a black and white issue. In their view, such neglect, supported by clear evidence, should have resulted in conviction and the application of an appropriate level of punishment. The absence of any details of the defence case or of mitigation offered makes it impossible to assess fully what influenced the judicial decision on sentencing. From the perspective of the CIL, the prosecution of staff for major failings in the care of patients was a matter of chance.

The final and largest group of prosecutable offences related to the completion and submission of the information returns defined in the legislation. Despite the importance of records in enabling the CIL to complete its work, there was a wide difference between the numbers of identified incidents and the cases prosecuted. At inspection the CIL reported about 500 instances of inadequate record keeping at the Public Asylums and 260 at the Private Asylums. Of these reported instances only a very small minority were identified as possible cases for progression to prosecution, see Table 6.5.

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible cases</td>
<td>7</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Prosecuted cases</td>
<td>1</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Convicted cases</td>
<td>1</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 6.5: Comparison Between the Numbers of Cases of Failure to Maintain Required Records by Asylum Type, 1845-1910

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68 UKPP, CIL, 1872 (279), (p. 63); Anonymous, Regina v William Cooper, (1871), https://www.oldbaileyonline.org, [Accessed: 17 September 2019]; UKPP, CIL, 1887 (200), (p. 100); UKPP, CIL, 1890-91 (286), (p. 62).
In the years between 1845 and 1850 the CIL noted that there were problems with record keeping but did not name the offenders or identify any of the asylums involved. Rather, they made general comments, for example: ‘the various books required to be kept… are for the most part regularly, and in some cases very carefully kept’. This comment was followed by the CIL noting that doctors in three asylums in the provinces had failed to make the required entries. The failure by one of these doctors was such that ‘the neglect appeared to us to be so gross’ that prosecution was recommended. There is no comment on the outcome of the case. For an unexplained reason, after 1851 the CIL did start to name the individual being prosecuted and the organisation with which they were associated.

The rationale behind the decision to prosecute for failing to maintain the required records was difficult to identify. Persistent failure would seem to be an obvious reason, but this was not always the case. In the Report of 1861, the CIL set out the various problems identified at the Bethel Hospital, Norwich. The commissioners noted that during the inspection visits on 24 July 1857, 14 May 1858, 14 June 1859 and 19 May 1860 that the case books and other records were imperfectly kept. Despite this finding the CIL did not proceed to prosecution, instead they admonished the Board of Governors. This outcome contrasts with the treatment of Dr Joseph Seaton in 1880. Seaton, the proprietor of Halliford House Asylum, Surrey, was found to have failed to maintain the medical admission, medical visitation, case and the discharge books during the year up to the inspection being reported. In this instance the CIL chose to recommend prosecution. At his trial at the Hampton Magistrates Court, Seaton entered a plea of guilty and was fined the substantial sum of £25 and unspecified costs (£3,075). The level of fine imposed shows that the magistrates regarded this as a serious offence.

This lack of consistency by the CIL also extended to whether action should be taken at all. On 2 October 1871 Mr George Burton, a manic and aggressive patient admitted to the Nottingham County Asylum, died. The PM examination found he had sustained seven rib fractures on the left and a further five on the right. The inquest jury concluded that he ‘died from injuries to the ribs accidently received’. Dr Stiff, the medical superintendent, did not report the case

70 UKPP, CIL, 1861 (314), (pp. 27-32).
71 UKPP, CIL, 1881 (401), (pp. 125-26).
to the CIL but did make a record in the Case Book. Rather than deal with this as a case of maltreatment, the CIL focused on the failure to report material information.\textsuperscript{72} No prosecution was recommended but the inconsistent approach to dealing with potential maltreatment weakened the process of regulation.

As with the other reasons for prosecution already discussed, there was variation in how the different magistrates responded to the failure of record keeping. Again, the decisions were influenced by unspecified local circumstances. Mr Henry Speed, the medical officer to the North Deptford District of the Greenwich Guardians, Mr T Bedford, clerk to the Horsham Union, and Mr Buye, clerk to the Totbury Guardians, were each prosecuted for repeatedly failing to make required returns to the CIL. Each were fined different amounts on conviction, these being £3 (£373), £2 (£266) and £5 (£628) respectively.\textsuperscript{73}

The cases of administrative failure included a mixed cluster of offences, such as: a disqualified person continuing in post as a commissioner or member of the Visiting Committee; the non-publication by the clerk to the JPs of the names of the members of a Visiting Committee; a doctor certifying a person for an admission to an asylum in which he had an interest; and a person refusing to be a witness during an investigation by the CIL. The fine, payable on conviction, ranged from a maximum of £2 to £50 per offence (£249 to £6217), the largest for refusing to be a witness.\textsuperscript{74} There are no reports of a prosecution for any of these offences. It is not clear, if there were no cases, whether the CIL chose not to propose a prosecution or that a proposal to prosecute was rejected.

A particular concern of the CIL was the failure to transfer promptly potentially treatable pauper lunatics to the county asylum. Included in the legislation of 1845, and later, were clauses that allowed the prosecution of any medical officer, relieving officer, overseer of the poor or police officer for failing to or obstructing a transfer.\textsuperscript{75} Despite their oft repeated concerns about this issue the Annual Reports only record four instances when a prosecution was proposed and progressed.\textsuperscript{76} Caution needs to be exercised when considering this issue because of the problem of determining when a particular patient was curable and that

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\textsuperscript{72} UKPP, CIL, 1872 (279), (pp. 57-58).
\textsuperscript{73} UKPP, CIL, 1881 (401), (p. 108); UKPP, CIL, 1888 (289), (p. 94); UKPP, CIL, 1901 (245), (p. 58).
\textsuperscript{74} S.XXIII, S.XIX, S.XXIII & S.C LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{76} UKPP, CIL, 1860 (338), (pp. 82-85); UKPP, CIL, 1870 (340), (pp. 54-55); UKPP, CIL, 1875 (337), (pp. 56-57); UKPP, CIL, 1877 (403), (pp. 45-46).
under the terms of An Act to Amend the Law Relating to Lunatics (the Lunacy Laws Amendment Act, 1862) admissions of incurable lunatics to a workhouse infirmary was authorized.\textsuperscript{77}

Before 1853, the problem of the non-transfer of potentially treatable pauper lunatics was exacerbated by the failure of some local Poor Law officials to provide the CIL and PLC with information on where all of these people were located. The failure to provide this information was a misdemeanour and the CIL did consider proposing prosecution.\textsuperscript{78} Such an approach would probably have had a negative impact on the already fragile relationship between the CIL and the central and local Poor Law authorities.\textsuperscript{79} Rather than using prosecution, the CIL sought and secured an amendment to the lunacy laws that allowed the medical staff to be paid for completing the required return.\textsuperscript{80} This change in the law appears to have resolved this problem as only one person, Dr Sime in Sheffield, was reported to have been fined, £5 (£609), for noncompliance.\textsuperscript{81} The CIL could and did use the threat of prosecution as a means of securing compliance, doing so in 1891 to secure an apology and the meeting of the legal costs from the clerk of an unnamed Union who had persistently failed to supply required information.\textsuperscript{82} This pragmatic and proportional use of enforcement powers shows the potential of a power, in the control of the CIL, between persuasion and prosecution.

Whilst the CIL tended towards caution in proposing that prosecution was instigated, they could be selective in the evidence they accepted. During the inspection visit to the Lancashire (Whittingham) Asylum on 17 February 1889 the head attendant, Mr Wright, reported that he had observed the second attendant of the infirmary ward, Mr Catterall, strike a patient. Other staff on the ward reported that they had not seen this alleged event. The Chairman and Vice Chairman of the Visiting Committee, who were in attendance for the inspection visit, investigated the incident and determined that Catterall be demoted. The feedback from the commissioners, who thought the punishment insufficient, appears to show a selective use of evidence based on the status of the witness:

\textsuperscript{77} UKPP, PSC, 1859 Session 1 (204), (pp. 6-7); UKPP, PSC, 1877 (373), (pp. 541, 551). S.8 LL, 25 & 26 Vict. CAP.CXI (1862).
\textsuperscript{78} S.LV LL, 8 & 9 Vict. CAP.CXXVI (1845). UKPP, CIL, 1859 Session 2 (204), (p. 74).
\textsuperscript{79} Murphy, ‘The Lunacy Commissioners’, (pp. 505-7).
\textsuperscript{80} UKPP, CIL, 1859 Session 2 (204), (pp. 74-75).
\textsuperscript{81} UKPP, CIL, 1910 (204), (pp. 66-67).
\textsuperscript{82} UKPP, CIL, 1892 (320), (p. 82).
The attendants in the ward say they *did not* see Catterall strike the patient. Negative evidence is, however, useless in the face of the affirmative evidence of the head attendant, who says he *did* see it, and we think that Catterall ought not to be any longer in charge of insane persons, and the question of prosecution should gravely be considered.\(^83\)

A similar disregard for the available evidence can be seen in a second case. On 4 June 1903 Mr W.F.B. died from bronchopneumonia, his death being accelerated by his having multiple rib fractures, six on the right and seven on the left. He had been a patient for nineteen years at the Kent (Chartham) Asylum and was described as ‘a quiet demented male patient’. Neither the Visiting Committee nor the inquest jury were able to identify how or when the injuries had occurred, nor whether any individual was culpable. Despite the lack of any evidence the Annual Report included the following comment:

> [The CIL] feeling satisfied that such severe injuries could not have been sustained without the knowledge of some person or persons in charge of the deceased, suggested to the Asylum [Visiting] Committee the desirability of discharging such attendants as had direct charge of the patient. The Committee did not however adopt this view.\(^84\)

Throughout its lifetime only a small minority of the possible prosecutable offences were progressed by the CIL. A detailed review of these cases over time appears to show that the number progressed did increase in the years following the death of Shaftesbury in 1885 (see Table 6.6). Whilst a much larger number of possible cases was identified between 1886 and 1913 than between 1845 and 1885, the average number of cases progressed to prosecution and that resulted in conviction show a much less substantial difference (see Table 6.7). The high probability of securing a conviction was unchanged over the review period. It is unclear if the increase in the number of potential cases represented a change in the willingness of the CIL in the post-Shaftesbury years to propose prosecution for

\(^{83}\) UKPP, CIL, 1900 (246), (pp. 302, 304). Italics in original.

\(^{84}\) UKPP, CIL, 1904 (232), (p. 44).
noncompliance, a deterioration in the standard of asylum services or a combination of both. The failure to substantially increase the numbers of prosecutions showed that the reluctance of the CIL under Shaftesbury to use confrontational methods was perpetuated. These results also indicate the degree of resistance to the use of prosecution by those authorised to sanction this action.

Table 6.6: Comparison Between the Numbers of Cases Identified, Prosecutions Undertaken, and Convictions Secured in the Periods 1845-1885 (<1886) and 1886-1910 (>1886) by Asylum Type

<table>
<thead>
<tr>
<th>Asylum:</th>
<th>Cases</th>
<th>Prosecutions</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public:</td>
<td>&lt;1886</td>
<td>&gt;1886</td>
<td>&lt;1886</td>
</tr>
<tr>
<td>Licence</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Admission</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>134</td>
<td>375</td>
<td>58</td>
</tr>
<tr>
<td>Administration</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>144</td>
<td>376</td>
<td>61</td>
</tr>
<tr>
<td>Private:</td>
<td>&lt;1886</td>
<td>&gt;1886</td>
<td>&lt;1860</td>
</tr>
<tr>
<td>Licence</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Admission</td>
<td>8</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>59</td>
<td>111</td>
<td>16</td>
</tr>
<tr>
<td>Administration</td>
<td>11</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Totals:</td>
<td>79</td>
<td>119</td>
<td>27</td>
</tr>
<tr>
<td>Others:</td>
<td>&lt;1886</td>
<td>&gt;1886</td>
<td>&lt;1886</td>
</tr>
<tr>
<td>Licence</td>
<td>36</td>
<td>43</td>
<td>21</td>
</tr>
<tr>
<td>Admission</td>
<td>53</td>
<td>34</td>
<td>2</td>
</tr>
<tr>
<td>Maltreatment</td>
<td>25</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Administration</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>114</td>
<td>67</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 6.7: Comparison Between the Mean Number of Potential Cases Identified, Progressed to Prosecution and Convictions Secured in the Years Before and After 1886

<table>
<thead>
<tr>
<th>Cases:</th>
<th>&lt;1886</th>
<th>&gt;1886</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>Prosecuted</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Convicted</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Overview and analysis of securing compliance using prosecution

The detailed examination of the lunacy laws completed for this thesis has shown that the lunacy legislation did include clauses that enabled legal action to be taken

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85 UKPP, PSC, 1859 Session 1 (204), (p. 34); UKPP, PSC, 1877 (373), (p. 547).
against individuals who failed to comply with the law. Whilst these powers were included in the legislation, their use was not fully in the direct control of the CIL. What is not known is the total number of cases discussed with the Lord Chancellor or JPs where the proposal to and funding for a prosecution was rejected, making it difficult to assess the influence of the CIL on the decision to prosecute. The analysis also showed that the use of prosecution was constrained by: the way the legislation was drafted, with greater protection available for the non-pauper patients; a fixed time limit of twelve months for a prosecutable case to be brought to trial; the problems of securing reliable evidence; the attitudes of the CIL towards the use of the judicial system; political pressure, at both the local and national levels, to either encourage or discourage proceeding to prosecution; and the impact of local factors and circumstances that might produce an unexpected outcome at trial. Undertaking a prosecution was both a costly and a time-consuming process. The evidence suggests that only cases that were likely to lead to conviction were pursued, and that cases involving failures that might cause immediate harm to patients were prioritised.

The differential between the public and private asylums was very explicitly made by having separate legislation for the services relating to these two groups from 1774 until 1890. Even when the Lunacy and County Asylums Acts were consolidated into a single Act in 1890 the legislation was structured to maintain the distinction between the asylum types. As previously noted, the patients admitted to private asylums did have the inherent additional protection offered by the ability of the CIL to recommend that the licence be revised, revoked or not renewed. The use of both revocation and non-renewal was constrained by the CIL having to resolve the problem of what would happen to the people in detention at the time of closure. The scale of this limitation, noted by Martin Campbell in his work on the Scottish Commissioners in Lunacy, depended on the number of patients that had to be relocated, with reprovision for five patients being easier to arrange than for 100 or more.\textsuperscript{86} The consequence was that the larger private asylums had greater protection from revocation or non-renewal, a fact recognised by the MCL in their report of 1844.\textsuperscript{87} The patients admitted to private asylums also had greater protection because of the more frequent inspection visits, making the

\textsuperscript{87} UKPP, MCL, 1844 (001), (pp. 44-45).
identification of offences within the time limit of twelve months for a prosecution to be commenced more likely.\textsuperscript{88}

The problems of securing reliable evidence that a prosecutable offence had been committed was a common problem to all asylums, as was the level of credibility attributed to any witnesses, with the patients generally being considered unreliable. This problem with the gathering of evidence was made worse in the public asylums by the less frequent inspection visits. These visits were not made to a fixed schedule, with the time gap between them varying. This variation can be seen from the dates of the consecutive visits to the Cheshire County Asylum on 10 March 1869 and 25 July 1870.\textsuperscript{89} With a twelve-month time-limit, any misdemeanour that was committed between March and July 1869 would be out of time before the CIL was aware that a potentially prosecutable offence had occurred. This flaw in the regulatory arrangements was built into the legislation but was not challenged by the CIL. Because of the longer time gap between visits, the simple fading of memory over time and the effects of how recall was encouraged further weakened the ability to secure reliable evidence to protect the people detained in the public asylums.\textsuperscript{90}

The ability of the CIL to identify and progress prosecutable offences was also affected by its increasing workload. To achieve the target of completing all of the visits, in the absence of an increase in the number of commissioners, the length of the inspection was reduced, particularly in the public asylums (Table 2.6 p. 51). This reduced the opportunity to identify possible offences and to investigate these. The CIL, under the chairmanship of Shaftesbury, were unwilling to increase the number of professional commissioners. This reluctance was combined with a general limitation on the resourcing of regulators in the nineteenth century and beyond. Compared to some, like the Mines Inspectorate, it can be argued that the CIL were relatively well resourced.\textsuperscript{91} An increase in the numbers of inspectors could lead to more prosecutions. This was the case at the Factory Inspectorate, where, following the retirement of Alexander Redgrave (1818-1894) from the post of chief inspector in 1891, the number of inspectors and prosecutions increased.\textsuperscript{92}

\begin{itemize}
  \item \textsuperscript{88} S.LXI, S.LXII & S.CX LL, 8 & 9 Vict. CAP.C (1845).
  \item \textsuperscript{89} UKPP, CIL, 1870 (340), (p. 124); UKPP, CIL, 1871 (351), (p. 135).
  \item \textsuperscript{91} MacDonagh, \textit{Early Victorian}, p. 82; Pellew, \textit{The Home Office}, p. 128.
  \item \textsuperscript{92} Peter Bartrip and Paul Fenn, "The Measurement of Safety: Factory Accident Statistics in Victorian and Edwardian Britain", \textit{Historical Research}, 63 (1990), 58-72 (pp. 62-63).
\end{itemize}
Because of the reluctance of the CIL to recommend prosecution, both during and after the chairmanship of Shaftesbury, it cannot be determined if an increase in the number of professional commissioners would have made any difference in the case of the CIL.

Whilst the CIL made strong statements about the intention to use the judicial system to protect the vulnerable patients such as - ‘Patients are so much in the hands of attendants, that it is of the utmost importance to punish proved assaults, as a warning to others’ - the rhetoric did not match the reality. The difference between the numbers of offences identified and those that were prosecuted, supports the charge, made by the MP Lewis Dillwyn, that the CIL was lax in its enforcement of the law. During a House of Commons debate in 1876 he criticised both the laws, as being ‘inherently bad’, and the CIL, for failing to enforce them as strongly ‘as they ought to be’. It is interesting to note that this criticism was directed at the CIL and not the senior ministers and JPs, those who had significant influence on when prosecution was, or was not, used. Dillwyn also suggested that Shaftesbury, as chairman of the CIL, was responsible for the failure to secure changes and improvements in the lunacy laws and culpable for the consequent harm that may have come to some patients. He went on to suggest that the CIL was inherently compromised as any such prosecutions ‘would be virtually indictments against themselves’. This chapter has argued that the CIL was not wholly to blame for the failure to fully enforce the lunacy laws. The legislation placed constraints on what they could do. These were compounded both by the unwillingness of Shaftesbury to use the tactic of confrontation and prosecution, and by the senior ministers, when they failed to issue orders in support of CIL recommendations.

The unwillingness to use prosecution was partly caused and compounded by the uncertainties built into the judicial process, where a range of contextual factors could be influential. The reliability of witnesses has been seen to have been a major impact on outcome, with the credibility of both patients and staff open to question. Even in the face of strong evidence from expert witnesses the outcome was still uncertain as the opinion of the judiciary could not be relied upon

93 UKPP, CIL, 1884 (280), (p. 326).
or predicted. Given that the prosecution process was expensive, the reluctance to use public money was understandable and a failure to achieve conviction could lead to criticism by the Treasury.\textsuperscript{96} Repeated failures to secure a conviction could also have a negative impact on the credibility and standing of the regulator, an outcome that might lead to an increased incidence of their advice and recommendations being downplayed or ignored. However, the failure to take action when noncompliance was evident also undermined the CIL and the regulatory system.

The problems and constraints that applied to the CIL also applied to the other regulators established in the nineteenth century. Securing accurate information on the age of a child, required by the Factory Inspectorate, was all but impossible before the registration of births was made compulsory in 1836.\textsuperscript{97} For the Mines Inspectorate the investigation of cave-ins, where both the potential witnesses and evidence were buried, made it all but impossible to apportion responsibility and liability.\textsuperscript{98} Whilst the regulators were blamed for failures to secure changes that, at the least, maintained the status quo, it is clear from the evidence in this review that their ability to take action was seriously constrained.

This chapter has shown that the limitations on the ability of the CIL to initiate a prosecution was compounded by their unwillingness, particularly but not exclusively during the chairmanship of Shaftesbury, to propose prosecution or advocate for an increase in their powers. Whilst the number of cases progressed to prosecution was low, the evidence does show that the cases prosecuted were highly likely to lead to a conviction, despite all the variables that affected a decision by the judiciary. What is not clear from the evidence in the Annual Reports was whether the number of reported cases accurately reflected the real incidence of prosecutable offences. As with the inspection process and the use of persuasion to secure change, the identification of possible cases was influenced by the working arrangements of the CIL. This analysis has also highlighted that the numbers of cases progressed to prosecution was affected by the costs incurred. These results, whilst supporting the views of Bartlett, Scull and Forsyth and Melling that the commissioners lacked authority to enforce the lunacy laws, show more clearly that the limitations on the CIL in pursuing a prosecution were

\textsuperscript{96} UKPP, PSC, 1877 (373), (p. 538).
\textsuperscript{97} Higgs, The Information State, pp. 74-75.
\textsuperscript{98} Mills, Regulating Health, pp. 109-10.
substantially outside of their control. Responsibility for not progressing the case against a prosecutable offence was more diffuse than has previously been recognised.

Chapter 7: Discussion and Conclusions

This thesis has sought to examine the effectiveness of the CIL from a different perspective from the previous studies by using a detailed analysis of the findings from the inspection visits recorded in the Annual Reports to build a national picture of its internal operations. Examination of the secondary literature showed that scholars, using a local history or an administrative history approach, had arrived at a range of conclusions about the CIL, from important contributor to irrelevance.\(^1\) The majority of the extant studies reviewed the work of the CIL from the perspective of a particular asylum or groups of asylums over a limited time period.\(^2\) The conclusions drawn related to how the Visiting Committee or proprietor for these particular asylums responded to the comments and recommendations of the regulator, arguably limiting the ability to generalise the results across England and Wales and leaving unanswered questions on whether the effectiveness of the CIL changed in the later years of its existence. This study starts to start filling this gap by undertaking an examination of the day-to-day work of the CIL from the perspective of the regulator which encompassed the whole of its remit area, England and Wales, and its working life, 1845 to 1914. This alternative perspective on the CIL has been made practicable by the availability online of copies of the Annual Reports of the CIL and copies of the various Lunacy and County Asylum Acts. This availability has allowed a detailed record of the work of the CIL to be developed.

This thesis has used an analysis of the lunacy legislation and Annual Reports to build an understanding of the aims, focus and impact of the CIL. By detailing the agenda of the CIL over time, the issues it highlighted for the asylums to address and examining how this agenda was implemented, this thesis has also demonstrated, in greater detail than previously, the limitations that influenced its ability to protect lunatics and idiots from harm across its remit area and lifetime. This study has shown more clearly how the interaction between the statutorily defined remit of the CIL, the resources available, the decisions on how it organised and implemented its agenda and the influences on the asylum system as a whole, impacted on this regulators’ ability to protect those being detained from harm. This

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\(^1\) Smith, ‘The Keeper Must Himself be Kept’, pp. 211-12, 214, 215; Murphy, ‘The Lunacy Commissioners’, (pp. 499-500).

alternative perspective starts to explain the differences found between the earlier studies on the CIL which focussed on particular periods and/or places. Comparisons with other regulatory agencies set up in England and Wales in the nineteenth century show that, to varying degrees, the factors affecting the CIL were inherent in the regulatory arrangements. The approach adopted in this study was to focus on the CIL using a detailed analysis of the Annual Reports. This approach has its limitations but was needed to establish an in depth understanding of the day-to-day work of the CIL. Future work, with some possibilities outlined below, will be needed to further clarify understanding of this regulator. Before moving on to discuss the findings from this study, consideration has been given to trying to measure its overall performance in the period 1860 to 1910, the years for which detailed information was available.

The overall performance of the CIL
In order to consider if the CIL was effective, its impact across all of the matters that it was required to examine, the Specified Issues, and the larger group that it chose to review, the Non-specified Issues, needs to be measured. Ideally this measurement would include a comparison between the reported compliance and non-compliance before and after the establishment of this regulator. As noted by Bartrip, such statistics are rarely available, and were not in this case.³ In the absence of the necessary information, this study has used changes in the reported level of compliance over the lifetime of the CIL to make an assessment of its impact on the care of the lunatics and idiots. The conclusions reached using this approach can be affected by changes in the asylum system and by how the measurement of reported compliance and non-compliance is made. In the case of the asylum system, there were significant changes in the numbers of patients and asylums (see Tables 1.1 and 1.2, p. 22), which must be taken into account.

The simplest measurement of effectiveness is a count of all reported instances of non-compliance in each year. Using this measure showed that for the Specified Issues the reported incidence of non-compliance was higher at the public than the private asylums but that the overall rate was not increasing (see Figure 7.1). In contrast, the incidence of non-compliance for the Non-specified Issues shows a marked increase amongst the public asylums and a much smaller increase at the private asylums over time (see Figure 7.2). These results suggest

³ Bartrip, 'British Government Inspection', (pp. 612-13).
that the CIL had a particular problem with persuading the Visiting Committees to make changes for those issues that the commissioners regarded as matters of concern. They also suggest that the public asylums were more liable to be non-compliant for all issues, markedly so for the Non-specified Issues.

To take account of the major increase in the numbers of pauper patients being detained, the rate of reported non-compliance per 1000 patients was calculated for all the Specified and Non-specified Issues. This method produced a very different outcome from that of a simple count. These results suggest that for both the Specified and Non-specified Issues the overall rate of non-compliance at the public asylums fell between 1866 and 1910. At the private asylums the rates were roughly consistent with those at the public sites until about 1895, when they rose (see Figures 7.3 and 7.4). The change at the private asylums after 1895 reflected the revision in the reporting practice of the CIL, when the findings were reported in increased detail in the Annual Reports. These results suggest that the
regulator had more problems in securing compliance at the private asylums and that they were able to secure some limited changes at the public asylums.

Using the proportion of asylums reported for non-compliance, the method used in the review of the individual issues in Chapters 3, 4 and 5, produces results that are a combination of both the other measures. Here the proportion of public asylums reported was higher than the private asylums but the overall rate across both the Specified and Non-specified Issues showed little change over time (see Figures 7.5 and 7.6). These results suggest that the impact of the CIL on the reported incidence of non-compliance was to maintain a steady state across the asylum system in England and Wales. Given the increasing numbers of paupers being detained and the changes in the numbers and size of the public asylums, the overall lack of deterioration in reported non-compliance indicates that the CIL did have some impact on the asylum system.
The marked differences in the results between these methods makes clear the importance of establishing both the what and how of that measurement. Some of the variation in outcome from the conclusions of previous studies arises from differences in what was being measured and how that measurement was made. The figures above, and those presented in Chapters 3 to 5, challenge the conclusion in the secondary literature that the CIL was either effective and had an impact on the asylum system as a whole or that it was wholly ineffective.\textsuperscript{4} The fact that the incidence of non-compliance remained stable, when allowance is made for the changes to the asylum system, shows that they did succeed in reducing some potential harms to patients. Examples of this impact were the improvements in firefighting arrangements and reduction in the proportion of epileptic patients who suffocated at night. Whilst the CIL secured improvements in some areas such as these, the figures also show that, overall, their impact was limited. In some

\textsuperscript{4} Hervey, 'The Lunacy Commission Vol 1', pp. 274-75; Forsythe, Melling, and Adair, 'Politics of Lunacy', p. 87; Smith, 'The Keeper Must Himself be Kept', p. 214; Bartlett, \textit{The Poor Law of Lunacy}, p. 228; Murphy, 'The Lunacy Commissioners', (pp. 499-500).
instances, such as resolving the problem of overcrowding or securing a high attendance at Divine Worship, it was, at best, transient.

This top-down perspective on the overall influence of the CIL masks how the ability of this regulator to secure compliance varied between asylums. Examination of the evidence from individual institutions showed that the response of Visiting Committees and proprietors varied, some adopting the recommendations of the CIL promptly, some doing so slowly and some rejecting them. For example: following the fire at the London (Colney Hatch) Asylum in 1903 the CIL surveyed the state of fire protection and detection in all of the temporary buildings on asylum sites and requested plans for the discontinuation of the use of these facilities.\(^5\) At the Brighton Borough Asylum the temporary buildings were taken out of use. In contrast, the London Asylums Committee successfully lobbied the Home Secretary for approval to continue using temporary buildings, including those remaining at Colney Hatch.\(^6\) The lack of consistency in securing compliance to protect the patients applied to all the individual Specified and Non-specified Issues that the CIL reported on. The results from the overall assessment of the performance of the CIL builds on and gives detail to the results from the earlier studies of this organisation. These results show that the ability of the CIL to secure compliance and protect patients was affected by a number of influences, these being considered in the next section.

Factors influencing the performance of the CIL
The results from the quantitative analysis of the Annual Reports showed the changes in both the issues and the levels of those issues being reported by the CIL, used here as a measure of compliance. Overall, this measurement showed that the impact of the CIL on the asylum system and level of reported compliance was limited to maintaining a steady state within a dynamic system. This outcome may have been all that the drafters of the legislation sought, but it is clear from the way that the CIL commented on the results of its work that their expectations and claimed achievements were higher. As recorded in the Annual Report for 1850 and in the evidence of Shaftesbury to the PSC hearings in both 1850 and 1877:

\(^5\) UKPP, CIL, 1903 (231), (p. 16).
\(^6\) UKPP, CIL, 1904 (232), (pp. 20-30). The Asylums Committee, having failed to secure the support for its proposals from the CIL, lobbied and secured the agreement of the Home Secretary to continue to use temporary buildings on all of the eight sites it controlled.
The general tenor of such Entries indeed has been favourable, and we now have the satisfaction of reporting that the various Institutions for the insane throughout the country are in an improved state.\textsuperscript{7}

I [Shaftesbury] must say that now, owing to the constant vigilance and the general improvement of all things medical, superintendents, and the proprietors of the houses, pay the very greatest deference to our opinion, and I think they are exceedingly anxious to carry the law into effect.\textsuperscript{8}

The results of the quantitative analysis do not fully support the claims of Shaftesbury in his evidence to the PSC of 1877, showing instead that not all Visiting Committees and proprietors were as compliant as his statement claimed. Whilst the quantitative data does add detail to the picture of the CIL, not included in the previous studies, it fails to explain why the work and efforts of the CIL did not achieve more. The qualitative analysis starts to address this issue by highlighting the factors that influenced the work and working of the CIL. These influencing factors included a combination of: the effects of the requirements of the lunacy legislation; the working arrangements of the CIL; the responses to recommendations made by the Visiting Committees and proprietors to changes in practice and/or the environment; and external influences on the asylum system from interested parties. Comparison with other of the English and Welsh regulatory organisations established in the nineteenth century shows that many of the influencing factors were common to all.

The detailed review of the lunacy legislation, which set out the role and working arrangements of the CIL, has shown how the way the statutes were framed limited its capacity to secure common standards of provision, thereby undermining a purpose of central regulation. Whilst both the Lunacy Act (1845) and the County Asylums Act (1845) made significant changes to the asylum system, they also locked-in much that had previously been in place. These retentions, such as separation of the arrangements for paupers and non-paupers, between the public and the private asylums, and between the Metropolis and the

\textsuperscript{7} UKPP, CIL, 1850 (735), (p. 5).
\textsuperscript{8} UKPP, PSC, 1877 (373), (p. 538).
rest of England and Wales, limited the ability of the CIL to achieve a common approach across all sites. This finding partly explains why the earlier studies showed inconsistency in their conclusions.

The effectiveness of the CIL was further compromised by the way that the lunacy, and other related, legislation was worded. The County Asylums Act (1845) required that ‘every County or Borough shall either erect or provide an Asylum for the Pauper Lunatics’. This accommodation was for those pauper lunatics ‘deemed curable or dangerous’, with the incurable being ‘transferred to such separate or additional Building’.\(^9\) The fact that there were problems in the identification of the potentially curable and that what was meant by ‘dangerous’ was never defined, either in the lunacy legislation or, other statutes (the Poor Law Amendment Act (1834) for example) created a loophole.\(^10\) The CIL, in seeking to have patients transferred to asylums, and the PLC\(\backslash\)PLB, who sought their retention in the less expensive workhouses, used different interpretations of the words ‘curable’ and ‘dangerous’ to justify their respective contradictory positions. Because the CIL had no power to influence how lunatics and idiots were treated in workhouses, beyond reporting the findings from their visits, their ability to perform their duty of protecting these people from harm was severely limited. This was made worse in 1867 when legislation was enacted that established the MDAs, as places for the detention of incurable lunatics and idiots in London, that were specifically defined as workhouses and not asylums. As workhouses detaining lunatics or idiots they still had to be inspected.\(^11\) The CIL did have some capacity to influence the lunacy legislation, as shown by securing the disbandment of the Private Committee for Single Patients in 1853, but this was limited.\(^12\)

A constraint that was imposed by the legislation on the work of the CIL, as with the other regulators, was on the level of resourcing made available to deliver the workload. The Lunacy Act (1845) both increased the workload, by making all locations in England and Wales where lunatics or idiots were detained subject to inspection, and reduced the number of commissioners undertaking inspection visits from 20 to 6.\(^13\) The Act of 1845 included no provision for the number of commissioners to be increased at a later date. As the workload increased over the

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\(^9\) S.II &S.XXVII LL, 8 & 9 Vict. CAP.CXXVI (1845).
\(^10\) S.XLV LL, 4 & 5 Gulielmi IV CAP.LXXVI (1834).
\(^12\) S.XXVII & S.XI LL, 16 & 17 Vict. CAP.XCVI (1853).
course of the century (see Tables 1.1 and 1.2, p. 22), the consequence was that the length of the visits, particularly to the public asylums was reduced (see Table 2.6, p. 51), thereby limiting the ability to identify noncompliance that might cause harm to a patient. Despite this lack of resources being identified in the reviews of the lunacy laws in 1859 and 1877, the opposition of Shaftesbury blocked attempts to increase the numbers of professional commissioners.\textsuperscript{14} Following the death of Shaftesbury (1885) attempts were made by the CIL, with some support from the medical profession, to secure additional professional commissioners but without success until 1911, just before the CIL was replaced in 1913.\textsuperscript{15}

Aside from the constraint imposed by the limitation on the resourcing of the CIL, the legislation also placed major limitations on the action that the commissioners could take in the event of noncompliance being identified. The lunacy laws of 1845 and later did not grant the CIL a means of requiring that the Visiting Committee, Board of Governors or proprietor take action. The effect of this limitation was to force the CIL to rely on persuasion as the means of securing compliance, a strategy that had limited and variable impact. In the face of continued noncompliance all that the CIL was authorised to do was to make a recommendation to the Lord Chancellor, JPs or government law officers to take further action. This action differed between the asylum types and with whether the issue complained of was defined as a misdemeanour.

In the case of the licenced houses, the CIL could recommend that the licence be revised, not renewed or revoked.\textsuperscript{16} The evidence presented shows that this threat to the licence could be effective in securing changes in practice and/or the environment. This outcome indicates the potential benefit of the CIL having an enforcement power stronger than persuasion but less formal than legal action. The opportunity for securing beneficial changes in this way was not available in respect of the unlicenced public asylums. Where action or inaction was defined as a misdemeanour, the CIL could recommend, in some cases initiate, legal action, so long as the twelve-month time limit had not been breached.\textsuperscript{17} The results in Tables

\textsuperscript{14} UKPP, PSC, 1859 Session 1 (204), (p. 34); UKPP, PSC, 1877 (373), (p. 547).
\textsuperscript{15} LL, An Act to Provide for the Appointment of Two Additional Commissioners in Lunacy and to Transfer Power of Making Vesting Orders from the Judge in Lunacy to the High Court (1911) (1 & 2 Geo. V CHAP. 40); Anonymous, 'The Lunacy Commission', The British Journal of Psychiatry, 56 (1910), 321-22 (p. 322); LL, 3 & 4 Geo. V CHAP. 28 (1913).
\textsuperscript{16} S.XLI & S.XLII LL, 8 & 9 Vict. CAP.C (1845).
\textsuperscript{17} S.CV LL, 8 & 9 Vict. CAP.C (1845).
6.1 and 6.2 (p.181) clearly show that there was a marked reluctance to pursue prosecution on the part of the CIL, senior ministers and JPs and the Treasury.

The limited powers of the CIL to require that action be taken to achieve compliance was recognised at the time but Shaftesbury was able to resist all attempts for those powers to be increased.¹⁸ The results from this work confirm the conclusion of both Mellett and Murphy, that the CIL lacked authority or, at the least, the means of enforcing that authority.¹⁹ It has become clear that the limited capacity of the CIL to take enforcement action arose from a combination of the terms of the legislation and the opinions and preferences of the commissioners, particularly the founding members.

This study, for the first time, notes that the lunacy legislation did not include a mechanism for the work and working of the CIL to be subject to a formal and regular review, beyond the publication of their Annual Report. When the CIL failed to complete the required elements of its work, such as monitoring the effects on the patients of work and recreational activities or attendance at Divine Worship, the ministers overseeing this regulator took no action. This absence of oversight and appraisal appears, from the evidence, to have contributed to the lack of review by the commissioners of the decisions of the founding members of the CIL. This lack of reconsideration was also contributed to by the very low turnover of commissioners in the years 1845 to 1885. When new commissioners were appointed, there were some changes made, such as the inclusion of details of the attendance at religious services of non-Anglican patients. Change, when it came, tended to follow some public criticism, such as the increased attention focussed on fire precautions after the fire at the Southall Park Licenced House in 1883 (see p. 86).

The limitation on manpower resources and the fixity of the decisions of the founding commissioners had other impacts on the work and working of the CIL. This impact affected both the identification of noncompliance and the securing of changes in practice and/or the environment in which people were detained. To deliver its workload, the CIL implemented a set of circuits that encompassed the country and organised the visits within geographical areas (see Table 2.2, p. 46). The evidence shows that for most years this arrangement successfully ensured

¹⁸ UKPP, PSC, 1877 (373), (pp. 546-47).
¹⁹ Mellett, 'Bureaucracy and Mental Illness', (p. 244); Murphy, 'The Lunacy Commissioners', (pp. 499-500).
that all institutions were inspected within the required time. However, the ability to effect change was undermined by the decision of the founding commissioners to change the team making the visits to each of the circuits on an annual basis. Whilst this reduced the risk of regulatory capture, it also prevented the establishment of a good working relationship between the commissioners and the Visiting Committees, Boards of Governors and proprietors. This annual change in team contributed to the differences in conclusion reached about the effectiveness of the CIL in the secondary literature.

Despite the limited manpower of the CIL, the list of issues reviewed during the inspection visits was substantially increased as the commissioners used their power to define twenty-five Non-specified Issues (see Table 2.5, pp. 48) that should be scrutinised. When reporting on these matters, individual commissioners adopted differing approaches to what was reported, the emphasis given to the topic and any results and the priority for any action that needed to be taken. The effect of these differences on individual asylums can be seen in the results shown in Figures 3.14 to 3.17 (see pp. 94-95). Differences in how individuals identify, record and respond to a particular issue is the consequence of their prior experience, beliefs and attitudes. Shaftesbury, for example, whose son died following an epileptic fit, was particularly concerned about the prevention of the death of patients with epilepsy. These variations in response by the commissioners, which cannot be fully removed, also contributed to the differences in the outcome of the earlier assessments of the effectiveness of the CIL.

As an adjunct to the on-site inspection of the various asylums and other locations where lunatics and idiots were detained, the CIL monitored their activities through the collection of data. The information gathered during the visit could only give a very limited picture of how an individual asylum operated, and did not include relevant information from other sources, such as the Poor Law authorities. By receiving, collating, and analysing the information returns, the CIL were able, so long as that information was accurate, to build a more comprehensive picture of the state of asylum services in England and Wales. The use of the information returns in this way made this monitoring an integral part of the regulation process and not just an end in itself or another example of the Victorian need for and fascination with statistics. The major caveat here was about the accuracy of the

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20 Battiscombe, Shaftesbury: A Biography p. 204.
information being provided. The commissioners did comment on inaccuracies in the information provided to them, including that relating to the detention process and the recording of the use of mechanical restraint and seclusion. Whilst prosecution could be used when statutorily required information was not provided, the CIL, with the exception of the detention documentation, had no power to secure accurate information returns other than by persuasion. Again, the ability of the CIL to protect patients was thereby compromised. Undertaking this monitoring work contributed significantly to an increase in the workload of the CIL and resulted in the increase in the number of clerks employed from two in 1845 to nine by 1900.

In order to achieve its objective of protecting the patients from harm, the CIL had to both identify failures in compliance and secure changes in practice and/or the environment in which care was provided to resolve such failures. As already noted, there were constraints placed on the action that the CIL could take to secure change. The primary tool available to them was to persuade the relevant Visiting Committee, Board of Governors or proprietor to implement the recommended action. As can be seen from the results reported in Chapters 3, 4 and 5, the responses to this approach varied both between individual asylums and at the same asylum over time. Underlying these variations were two factors. The first, related to recognition that the proposed change was needed or wanted. Traditionally, the provision of support services was a matter for local determination, with no real role for central government. The new interventionist style of government was not always welcome, producing resistance to the implementation of recommendations. The second factor was that of meeting the costs of implementing the recommendations. These costs, both capital and revenue, fell to the local ratepayers to meet by an increase in the rates. Central government, until 1876, made no contribution. In that year the government started to make a grant-in-aid payment to offset part of the additional cost to the Guardians of an asylum placement for pauper lunatics. The costs incurred by the ratepayers could be substantial and if the local or national economy was under

\[22\] As examples see: UKPP, CIL, 1847-48 (858), (p. 18); UKPP, CIL, 1866 (317), (pp. 46-48).
\[23\] All of the lunacy acts included prosecution for non-provision, for example see: S.XXVIII & S.LII-S.LV LL, 8 & 9 Vict. CAP.C (1845). Numerous errors in detention documentation were noted by the CIL, see UKPP, CIL, 1847-48 (858), (p. 18). From 1853 they were permitted to return such documents for correction, S.XI LL, 16 & 17 Vict. CAP. XCVI (1853).
\[24\] S.XI LL, 8 & 9 Vict. CAP.C (1845); Mellett, 'Bureaucracy and Mental Illness', (p. 226).
\[25\] S.XXXV LL, 8 & 9 Vict. CAP.CXXVI (1845).
\[26\] UKPP, CIL, 1897 (87), (p. 23).
pressure finding the required funds could be a problem. At the private asylums the situation was analogous: implementing changes might lead to an increase in the fees paid by the patients to the point where they became unaffordable. With the private asylums there was the additional possibility of securing change by recommending an amendment to the terms of the licence. The potency of this method was dependent on the Lord Chancellor or the JPs being willing to implement such a recommendation, which was by no means certain. Delay and a reluctance to implement recommendations was an inevitable outcome.

Despite the CIL not having a means of enforcing the implementation of recommendations aimed at protecting the patients from harm, they were criticised for failing to take action. A good example of this situation relates to the overcrowding of the public asylums. The results shown in Figure 3.8 (see p. 82) clearly demonstrate that the increase in the numbers of patients far outstripped the construction of new asylums and the extension to the existing sites despite the repeated recommendations of the CIL for counties and boroughs to implement plans for new facilities.\(^{27}\) The ongoing commentary by the CIL on this issue clearly shows no sign of the complacency suggested by Scull.\(^{28}\) What these results highlighted was the lack of action by the various Lord Chancellors to use their power to require the county and borough authorities to provide additional asylum accommodation, a point not previously noted in the secondary literature.\(^{29}\) Blaming the CIL for a failure over which they had no control was unreasonable.

The interaction between a regulator and the organisation or individual subject to regulation was also influenced by other interested parties, both professional and lay. In the case of the regulation of asylums these can be, loosely, located in one of the following three groups: medical interests; non-medical advocates; and other official bodies. Of these groups the one most directly involved and upon whose cooperation the CIL had to rely was the medical profession, in particular those doctors employed in asylums. The evidence in the case studies on the use of mechanical restraint and the numbers of PM examinations being completed very clearly shows this dependence: without support from within the profession for a move away from the use of restraint, or a desire to conduct post-mortem research it seems unlikely that the CIL would have

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\(^{27}\) For examples see: UKPP, CIL, 1867 (366), (pp. 4-7, 12); UKPP, CIL, 1888 (289), (pp. 208, 257).
\(^{29}\) S.VIII LL, 8 & 9 Vict. CAP.CXXVI (1845).
been able to push through substantive change. These case studies also make clear that in securing changes in practice, the CIL had to negotiate the differences in opinion within the medical profession. How successful they were is open to question, it not being possible to determine if the reduction in the use of mechanical restraint came from the action of the CIL or a change in practice by the doctors or (as seems most likely) a combination of both. What has been shown was the reluctance of the CIL to publicly criticise the doctors working in asylums, unless exceptional circumstances applied, such as the sexual misconduct with female patients by Dr Campbell at the Cumberland and Westmorland Asylum in 1898.30

The CIL was also subject to the pressure of public opinion. How much influence these opinions had on the CIL depended on their source. Despite the important role of members of the family of a lunatic or idiot in the detention, treatment and discharge processes, the annual reports suggest there was little direct contact between family members and the CIL.31 This may have been the consequence of the CIL being perceived as too remote, with, as suggested by Louise Wannell, the families preferring to communicate with the medical superintendent.32 Also not frequently in contact with the CIL, but with more impact, were organisations established to represent patients being detained, such as Alleged Lunatics' Friends Society. These organisations tended to represent groups within the patient population and lobbied for the interests of that group. Such organisations could bring information to the attention of the CIL of possible cases of abuse, the Alleged Lunatics’ giving notice of cases of wealthy patients allegedly being wrongfully detained.33 The advantage these groups had over the patients’ relatives was that they were better at eliciting the interest of the press in the cases they pursued. Untoward attention from the press did prompt the CIL to take action. In the aftermath of the fire at the Southall Park Asylum in 1883 the press reported extensively on the inquest jury criticism of the CIL.34 This attention prompted the

30 UKPP, CIL, 1898 (259), (pp. 58-59).
31 McCandless, ‘Dangerous to Themselves and Others’, (pp. 89-90); Scull, Most Solitary, pp. 274-75; Mary-Ellen Kelm, ‘Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915’, Journal of Family History, 19 (1994), 177-93 (pp. 181, 190); Smith, ““Your Very Thankful Inmate””, (p. 246); Suzuki, Madness at Home.
33 Wise, Inconvenient People, pp. 85-86, 395-400.
commissioners, to address the fire prevention and fighting arrangements in both public and private asylums (see p. 86). Whilst the CIL could appear to be bureaucratic and inflexible, when pressured it could respond quickly. However, this capacity to respond was rarely evident unless an external influence was applied.

The final group of influencers on the work of the CIL were the other official organisations and bodies with which they had to interact. Between 1845 to 1913 the most involved in their day-to-day work, aside from the Visiting Committees and county or borough authorities, were the national and local Poor Law authorities. In its dealings with these other agencies, such as that with the PLC/PLB on where pauper lunatics were to be detained, the position of the CIL was weakened by its political isolation from the Home Office, the government department that determined if public monies could be used for new asylums or the extension of existing sites. The reason for this isolation was unclear but may have been influenced by the animosity between Shaftesbury and Sir James Graham (1792-1861), the Home Secretary in 1845. With limited influence, recommendations from the CIL were often negated by the lobbying of the Home Office by the relevant Visiting Committee or county/borough authority. Such intervention could have tragic consequences, such as the fire in a temporary building at the London (Colney Hatch) Asylum in 1903 that resulted in the death of fifty-one female patients.

The politically weak position of the CIL was further demonstrated by the authorisation for the Asylum Committee of London to establish and operate asylums for incurable patients, the MDA sites that were exempt from the requirements of the lunacy legislation, other than being inspected each year by the CIL.

In seeking to try to show the detail of the work and working of the CIL, this study has strongly focussed attention on their published reports. The lack of accessible alternative sources to offer balance and perspective was a recognised weakness of the methodology. This weakness was accepted in order to develop a more detailed view of the internal workings of the CIL than has previously been presented. It is very evident that other perspectives need to be explored but the


UKPP, CIL, 1903 (231), (p. 16).

S:30 LL, 30 Vict. CAP.VI (1867).
time and resource constraints limited the ability to do so as a part of this study. Rather, this work needs to be seen as a starting point for further work which, in all probability, will refine the conclusions drawn here.

This further work could lead in two different directions. The first would be to undertake a comparison between regulators in different jurisdictions. An obvious example would be between the home nations, where differing arrangements were implemented. The methodology adopted here might be employed to generate detailed comparable data. This could be extended to international comparisons, depending on the availability of appropriate source material. The other possible direction would be to use the detailed information on individual asylums, developed for this work, to complete detailed comparisons with the records from a specified asylum. Such work could explore how individual cases of complaints by patients and their families were or were not addressed.

The evidence presented in this thesis shows that the performance and effectiveness of the CIL was influenced by a range of factors outside of its control. As but one of a larger group of regulatory agencies established in the nineteenth century, the question arises as to whether these influences were unique to it or affected other of these organisations, making them inherent to the system of regulation. A fundamental weakness of the CIL was the lack of a power it controlled to require that action be taken on a recommendation. Apart from the Factory Inspectorate between 1833 and 1844, other regulatory organisations also lacked such power. This brief exception was when the Factory Inspectors could issue a notice that required action to be taken by the factory owner. This power was found to be effective but was disliked by the factory owners and others, who successfully achieved its revocation when the Factory Act was revised in 1844. Amongst the opponents of a regulator having this power was Shaftesbury, this at the time when he was chairman of the MCL and preparing a report on the establishment on a new regulator for asylum services. Whilst this limitation of the powers of the regulators was a deliberate decision of the various administrations and legislators, it has to be recognised that the attitudes, ideas and approaches of the people appointed to the inspectorates and commissions also influenced the use of enforcement powers. It was not just Shaftesbury and the CIL who exhibited

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38 S.XVIII LL, 3 & 4 Gulielmi IV CAP.CIII (1833).
39 S.II LL, 7 & 8 Vict. CAP.XV (1844).
a reluctance to have and use stronger powers of enforcement. Jamie Bronstein, in her study of workplace accidents, noted that the factory inspectors, who were of the same class as the factory owners, tended to use warning rather than prosecution.\(^41\) The study of the development of styles of regulation in the nineteenth century by Bartrip and Fenn also noted the emphasis given to persuasion and frequent visiting as the preferred approach.\(^42\) Clearly, the non-confrontational approach advocated by Shaftesbury was not out of character with the other regulatory organisations of this period.

With six professional commissioners and a support staff of clerks the CIL was not the most poorly resourced of the regulators. Review of the secondary literature showed that limited resourcing was a common feature of the various regulatory organisations established during the nineteenth century.\(^43\) For example: the Mines Inspectorate, established in 1850, comprised of four inspectors each of whom had to visit about 400 mines within the large geographic area for which each were responsible. In addition, they had to attend meetings and inquests and complete their own secretarial work as no support staff were employed.\(^44\) Whilst the CIL opposed the appointment of additional commissioners, but not clerks, other of the regulators did secure increased numbers of inspectors and assistant commissioners. Within the first five years of being established the PLC had to increase the number of Assistant Commissioners, from nine to thirteen, because the workload could not be met by the original staff complement.\(^45\) Comparisons in the resources available between the inspectorates were made more complex because in some cases, such as the Factory Inspectorate, deputy inspectors with limited powers could be appointed.\(^46\) Limited resourcing may have been common ground but securing more staff was not impossible and not resisted by all. Limitation on the appointment of inspectors or commissioners with full powers was a common feature, but, as in the case of the Anatomy School Inspectorate, increases could be secured when supported by the other inspectors.\(^47\)

The analysis of the lunacy legislation identified differences in the protection provided between the pauper and non-pauper patients and between the

\(^{41}\) Bronstein, *Caught in the Machinery*, p. 129.
\(^{42}\) Bartrip and Fenn, 'The Evolution of Regulatory Style', (pp. 204-6).
\(^{43}\) Moran, *The British Regulatory State*, p. 46; Pellew, *The Home Office*, pp. 126, 133; MacDonald, 'Procuring Corpses', (pp. 383-85); MacDonagh, 'Regulation of Emigrant Traffic', (p. 171).
\(^{46}\) S.XIX LL, 3 & 4 Gulielmi IV CAP.CIII (1833). S.II LL, 7 & 8 Vict. CAP.XV (1844).
\(^{47}\) MacDonald, 'Procuring Corpses', (p. 386).
public and private asylums. Similar disparities also applied to other of the protective legislation as these only applied to parts of the working population or to specific working locations. The early Factory and Mines Acts only provided protections for women and for children under 16/sixteen. Both also only applied to designated factories and mines. It was not until the 1870s that protective legislation was applied to the whole working population in factories, as recognition was given to occupational diseases. The reduction and removal of these various disparities continued long into the twentieth century.

These brief comparisons do suggest that many of the limitations and pressures placed on the CIL were not unique to them. These influences, most of which applied limitations on the capacity of the regulator to protect the vulnerable, were inherent parts of the system over which the particular regulatory organisation had only very limited, if any, control. Responsibility for failures of regulation attributable to these factors cannot properly be assigned to the regulatory organisation but rather to the administrations and legislators who established the nineteenth-century inspectorates.

It is very clear from the analysis of the lunacy legislation that the CIL was not a free agent able to define and implement its own agenda fully and unilaterally. Examination of the primary legislation has shown that much of its role was inherited from the earlier attempts to regulate private asylums. The drafters of the legislation did include innovation, such as having a single organisation carrying out all inspections. Yet this substantial improvement in the protection of the people being detained was diluted by the limitation placed on the number of people completing this inspection work to six and not including a means of increasing this number. This limitation within the legislation went further. By not granting the CIL powers requiring the Visiting Committee, Board of Governors or proprietor to take action, the linkage between identifying noncompliance and securing compliance were weakened. The impact of these imposed constraints was augmented by the decision of the commissioners, influenced by the ideas and status of Shaftesbury, to keep the numbers of professional commissioners at six, to rely on persuasion and to make an annual change in which of the teams of commissioners would visit each circuit. The consequences of these imposed constraints and the decisions on

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how the CIL completed its work can be seen in the results presented in chapters 3, 4 and 5. From the England and Wales perspective, the inconsistency that, in part, prompted this study was a feature and effect of the way the legislation was drafted and the way that the CIL organised its work. Despite having a structure where the people making the inspection visits were full members of the Commission, this unique arrangement made little difference in securing consistent standards throughout England and Wales.

To demonstrate effectiveness, the regulator has to have the capacity to both identify the need for changes in practice and/or environment and to secure those changes. Generally, the CIL was able to identify some issues of noncompliance better than others. Failure to provide sufficient accommodation of a suitable standard, to heat and ventilate buildings and provide enough food could be identified from simple visual inspection. Where a patient had been assaulted was far less obvious as similar bruising and other injuries could be found from both an innocent fall or an assault. Given that inspection visits were limited in number it is not surprising that the commissioners focussed on the more obvious physical issues. The capacity of the CIL to accurately identify all failures of compliance was influenced by both the level of resourcing and the predetermined visiting schedule. As noted above, the limitation on the level of resourcing of the CIL was both an imposed condition and the consequence of the choice and the influence of Shaftesbury, a choice to which the other commissioners acquiesced. Whilst the minimum number of visits to be made in each calendar year was specified in the lunacy legislation, the CIL could opt to make additional routine visits.49 They exercised this right in only one case, that of the Registered Hospitals that admitted lunatics, increasing routine visits to two per year. Given the reported lack of criticism of these sites, particularly when compared with the commentary on the public asylums, this decision seems to reflect a peculiar priority.

Examination of the effectiveness of the CIL has to take account of its place within the much larger set of arrangements for providing support to paupers, as explored by Bartlett.50 Whilst the numbers of pauper lunatics and idiots was substantial, with a total of 102,958 being detained in both public and private asylums on 1 January 1914, they were only a minority (13%) of the identified

49 S.LXII & S.CX LL, 8 & 9 Vict. CAP.C (1845).
50 Bartlett, *The Poor Law of Lunacy.*
pauper population, some 775,078 at 31 December 1913.\textsuperscript{51} The focus of the Home Office, responsible for overseeing the working of the Poor Law and for approving spending on public asylums, was on the larger problem, rather than the concerns of the Lord Chancellor, to whom the CIL reported. Having the CIL separated from the remainder of the support for paupers within central government acted as a further constraint on the ability of the commissioners to secure compliance.

Against this backdrop of constraints, the fact that the CIL was able to secure some changes in practice and provision when forced to rely on the tactic of persuasion is testament to the effort they put into their work. Much of the opposition to the implementation of changes in practice and provision arose because these came with a cost that the local ratepayers were unable or unwilling to meet. Some local authorities were willing to raise additional funds if the economic conditions and other spending priorities allowed. Often, in the face of poor economic conditions or where other priorities were deemed more pressing, or a combination of both, a rapid response was not possible. In a limited number of cases the Visiting Committee or proprietor simply ignored a recommendation, an action which the CIL was unable to challenge. Even when the central government did provide a contribution to funding, the four-shilling grant, this was only paid by an indirect route via the Guardians and the effect of which was not seen as totally beneficial.\textsuperscript{52}

What this study has made clear is that, like the other regulatory organisations, the CIL was the subject of external constraints on its capacity to perform its duties and that these limited its ability to secure compliance and protect the patients. Some were inherent in the legislation, the differences in protections for paupers and non-paupers and public and private asylums. Others were the consequence of contradictions between individual statutes. Others still were the consequence of lobbying by ratepayers, in respect of the public asylums, and the proprietors of private asylums. The impact of this lobbying was on the drafting of the legislation or on the implementation of recommendations for action or investment proposed by the CIL. These influences were beyond the ability of the CIL to control but it was not uncommon for the regulator to be held responsible if problems arose even when recommended action was not adopted.

\textsuperscript{52} UKPP, CIL, 1897 (87), (p. 23).
On balance the analysis presented in this thesis shows that the CIL did have an impact on the way that asylum services were provided but that it was limited and, in many instances, transient. They did hold responsibility for some of their limited impact but to a large extent they were constrained and contained by the system within which they had to operate. In reality the CIL was as much a captive of the asylum system as any of the detained patients. The following description of the treatment of a patient in an asylum from 2018, when compared to the quotation page 1 of this thesis, shows that the problems that regulation was established to address have yet to be resolved:

Bethany is 17 years old… But this teenager has not felt the sun or the wind on her face for nine months. And she rarely laughs. Instead, she is shut away in solitary confinement behind a locked door, fed three times a day through a hatch like a dangerous creature in a zoo.

You might assume Beth has carried out some terrible deed to be locked up like this for the past 21 months. ... But she has committed no crime … this teenage girl has learning disabilities … She is far from alone in being imprisoned … At least 825 others with learning disabilities are stuck in hospitals because of “delayed discharge”.53

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Appendices

1: Legislation Relating to the Care of Lunatics and Idiots 1845-1914

An Act for the Regulation of the Care and Treatment of Lunatics (1845) (8 & 9 Vict. C.100)

An Act to Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England (1845) (8 & 9 Vict. C.126)

An Act to Amend the Law Concerning Lunatic Asylums and the Care of Pauper Lunatics in England (1846) (9 & 10 Vict. C.84)

An Act for the Amendment of the Laws Relating to the Provision and Regulation of Lunatic Asylums for Counties and Boroughs in England (1847) (10 & 11 Vict. C.43)

An Act for the Regulation of Proceedings under Commissions of Lunacy, and the Consolidation and Amendment of the Acts Respecting Lunatics so Found by Inquisition, and Their Estates (1853) (16 & 17 Vict. C.70)

An Act to Amend an Act Passed in the Ninth Year of Her Majesty, “for the Regulation of the Care and Treatment of Lunatics” (1853) (16 & 17 Vict. C.96)

An Act to Consolidate and Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England (1853) (16 & 17 Vict. C.97)

An Act to Amend the Lunatic Asylums Act, 1853, and the Acts passed in the Ninth and Seventeenth Years of Her Majesty, for the Regulation of the Care and Treatment of Lunatics (1855) (18 & 19 Vict. C.105)

An Act to Make Better Provision for the Custody and Care of Criminal Lunatics (1860) (23 & 24 Vict. C.75)

An Act to Amend the Law Relating to Commissions in Lunacy and the Proceedings Under the Same, and to Provide More Effectually for the Visiting of Lunatics, and for Other Purposes (1862) (25 & 26 Vict. C.86)

An Act to Amend the Law Relating to Lunatics (1862) (25 & 26 Vict. C.111)

An Act to Explain and Amend “The Lunatic Asylum Act, 1853,” and “The Lunacy Act Amendment Act, 1862” with Reference to Counties of Towns Which Have Courts of Quarter Sessions, but no Recorder (1865) (28 & 29 Vict. C.80)

An Act for the Establishment in the Metropolis of Asylums for the Sick, Insane, and Other Classes of the Poor, and of Dispensaries; and for the Distribution over the Metropolis of Portions of the Charge for Poor Relief; and for other Purposes Relating to Poor Relief in the Metropolis (1867) (30 Vict. Cap.6)
An Act to Amend the Metropolitan Poor Act, 1867 (1871) (34 Vict. Ch.15)

An Act for Amending the Lunacy Regulation Acts (1882) (45 & 46 Vict. C.82)

An Act to Amend the Law Relating to Lunatics (1885) (48 & 49 Vict. Ch.52)

An Act for Giving Facilities for the Care, Education, and Training of Idiots and Imbeciles (1886) (49 Vict. Ch.25)

An Act to Amend the Acts Relating to Lunatics (1889) (52 & 53 Vict. Ch.41)

An Act to Consolidate Certain of the Enactments Respecting Lunatics (1890) (53 & 54 Vict. Ch.5)

An Act to Amend the Lunacy Act 1890 (1891) (53 & 54 Vict. C.5)

An Act to Constitute a Lunatic Asylums Board for the County Palatine of Lancaster and to Transfer the Existing County Pauper Lunatic Asylums to Such Board to Repeal the Lancaster Annual General Sessions Act and for Other purposes (1891) (54 Vict. Ch.20)

An Act to Amend the Lunacy Acts 1890 and 1891 (1908) (8 Edw. VII Ch.47)

An Act to Provide for the Appointment of Two Additional Commissioners in Lunacy and to Transfer the Power of Making Vesting Orders from the Judge in Lunacy to the High Court (1911) (1 & 2 Geo. V Ch.40)

An Act to Constitute a Lunatic Asylums Board for the West Riding of the County of York to Transfer Certain County Asylums to Such Board and for Other Purposes (1912) (2 & 3 Geo. V Ch.101)

An Act to Make Further and Better Provision for the Care of Feeble-Minded and Other Mentally Defective Persons and to Amend the Lunacy Acts (1913) (3 & 4 Geo. V Ch.28)
2: List of Members of the CIL by Appointment Type and Dates of Appointment

Chairman:
Ant
hony Ashley-Cooper seventh Earl of Shaftesbury 1845-1885
Thomas Salt 1886-1891
Edward George Percy Littleton Hatherton 1892-1898
William Frederick Waldegrave 1899-1913

Secretary:
Robert W. Skeffington Lutwidge 1845-1855
John Foster 1856-1860
William Cecil Spring Rice 1861-1865
Charles Palmer Phillips 1866-1871
Charles Spencer Percival 1872-1888
George Harold Urmson 1890-1895
Hardinge Frank Giffard 1896-1900
Lionel Lancelot Shadwell 1901-1903
Arthur Hill Trevor 1904-1906
Barnard Thornton Hodgson 1907-1911
Oswald Eden Dickinson 1912-1913

Medical Commissioners:
Thomas Turner 1845-1855
John Robert Hume 1845-1856
James Cowles Prichard 1845-1849
Henry Herbert Southey 1845-1846
Samuel Gaskell 1850-1866
James Wilkes 1856-1878
Robert Nairne 1857-1883
John Davies Cleaton 1867-1893
William Rhys Williams 1879-1888
Reginald Southey 1884-1898
John A. Wallis 1894-1897
Thomas Clifford Allbutt 1889-1891
Frederick Needham 1892-1913
E. Marriott Cooke 1898-1913
Sidney Coupland 1899-1913
C. Hubert Bond 1912-1913
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<td>Barnard T. Hodgson</td>
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**Lay Commissioners:**

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<td>Francis Barlow</td>
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<td>Edward Adolphus Seymour</td>
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<td>Henry Morgan Clifford</td>
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<tr>
<td>Dudley Francis Fortesque</td>
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<tr>
<td>Thomas Salt</td>
<td>1884-1885</td>
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<tr>
<td>Frederick Archibald Vaughan Campbell Viscount</td>
<td>1886-1891</td>
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<tr>
<td>Emlyn</td>
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<td>William F. Waldegrave</td>
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**Honorary Commissioners:**

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<td>Edward Nugent Leeson sixth Earl of Milltown</td>
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<td>Hon. Henry Davenport</td>
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<td>Dr John Davies Cleaton</td>
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<td>Charles Bagot</td>
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1 The names in *italics* were the people who had been appointed as Secretary and then transferred to a vacant Barrister Commissioner post.

2 The medical and barrister commissioners could be appointed to this group after retiring from one of the substantive posts.
### 3: Listing of the Spearman’s Correlation Coefficients Between the Specified and Non-specified Issues

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<th>Specified Issues:</th>
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<td>Inadequate statutory records</td>
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<tr>
<td>Inappropriate admission</td>
<td>SI02</td>
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<tr>
<td>Divine Worship not provided</td>
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<tr>
<td>Inadequate diet</td>
<td>SI04</td>
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<tr>
<td>Inadequate occupation</td>
<td>SI05</td>
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<tr>
<td>Mechanical restraint used</td>
<td>SI06</td>
</tr>
<tr>
<td>More patients than registration</td>
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<tr>
<td>JPs not visiting</td>
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</tr>
<tr>
<td>Building in poor repair</td>
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<tr>
<td>Insufficient staff</td>
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<tr>
<td>Inadequate heating</td>
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<td>Inadequate bedding</td>
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<td>Inadequate clothing</td>
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<td>Inadequate ventilation</td>
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<td>Inadequate management</td>
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<td>Inadequate water supply</td>
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<tr>
<td>Multiple bathing</td>
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<tr>
<td>Assault: Staff on patient(s)</td>
<td>NS13</td>
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<tr>
<td>Assault: Patient on patient</td>
<td>NS14</td>
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<tr>
<td>Assault: Patient on staff\visitors</td>
<td>NS15</td>
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<tr>
<td>Patient suicide</td>
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<tr>
<td>High death rate</td>
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<tr>
<td>Unnatural death of a patient</td>
<td>NS18</td>
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<tr>
<td>Neglect of patient(s) and duty</td>
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<td>Non-statutory records not kept</td>
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<td>Outbreak of infectious disease(s)</td>
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<td>Seclusion used</td>
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<tr>
<td>Post mortem rate low</td>
<td>NS23</td>
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<td>Inadequate fire precautions</td>
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<tr>
<td>Death of an epileptic patient due to suffocation</td>
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## Public Asylums: Specified Issues
### Correlations Between +0.5 and 1.0 and -0.5 and -1.0

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Public Asylums: Non-specified Issues
Correlations Between +0.5 and 1.0 and -0.5 and -1.0

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4: Numbers of Clauses that Defined a Prosecutable Offence in the Lunacy and County Asylum Acts 1845-1910

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<th>Act:</th>
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<th>Admit</th>
<th>Maltr</th>
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<td>1891 Ch65</td>
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Notes: Licen = Failure of licencing; Admit = Illegal admission; Maltr = Maltreatment and neglect; Admin = Administrative failures; Clauses = Total number of clauses in Act
~ Relating mainly to private asylums
# Relating mainly to public asylums

The level of punishment varied with the offence. The majority of the fines were set at between a maximum of £2 (£249) and £20 (£2490) for each offence. For some offences, refusal to be a witness during a CIL investigation or a Poor Law medical officer failing to visit all pauper lunatics every three months, the fine was up to a maximum of £50 (£6217) for each offence. Inability to pay a fine could result in imprisonment. The most severe penalty, imprisonment for up to two years with hard labour, applied to a member of staff having carnal knowledge of a female patient.
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