DOCTORAL THESIS

“A deed at which humanity shudders”. Mad mothers, the law and the asylum, c1835-1895

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"A Deed at which Humanity Shudders"

Mad Mothers, the Law and the Asylum,

c.1835-1895.

by

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1Broadmoor Criminal Lunatic Asylum 1868

Abstract

The central theme and focus of my thesis is an exploration of the passage of married women who murdered their children through the medico-legal and asylum systems of Victorian England and Wales. In the thesis, I follow the life-journeys of a discrete group of women over a sixty year period from 1835 to 1895. I start by examining their social backgrounds and circumstances. I then sequentially trace their passage through judicial process on to institutional incarceration and onwards to either discharge or retention in those institutions. By examining the histories of this group of criminally insane mothers, I create a detailed analytical study of the varied responses of the legal and the medical establishments to the crime of maternal child-murder and its perpetrators. The responses and attitudes of the male-dominated authorities to insanity in women, especially when it was coupled with criminal violence towards children, reveal much about Victorian cultural constructions and expectations. Contemporary beliefs that a woman's physiology and neurology was inherently fragile and unstable, seemingly helped to shape sympathetic and compassionate views of the accused women. Belief in such female frailty supported the idea that a woman's mental equilibrium could be upset by any mania associated with reproduction. By analysis of asylum records, medical literature, trial transcripts and newspaper reports, I demonstrate that gender-driven socio-cultural and medical assumptions impacted upon both the mothers' legal and medical treatments. Overall I argue that, despite their mental state and the fact that they had committed "a deed at which humanity shudders", the women in this unique group received sympathy and compassion from Victorian society and, in particular, from the male legal, medical and governmental establishments of the day.

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Acknowledgements

I returned to the study of History in 2009, having been awarded my first degree in 1978 from the University of Liverpool. In 2009, after a career in banking and schools finance, I decided to return to studying and in 2012, I graduated from the University of Roehampton, with an MA in Historical Research. My MA dissertation was a study of married mothers who murdered their children and were found to be insane, held in Broadmoor Criminal Lunatic Asylum, between 1863 and 1884. As so many questions arose from this study, I decided to continue researching the subject. I was subsequently accepted as a part-time PhD student, for which I am very grateful. My appreciation and thanks go to the University for affording me the opportunity to continue my exploration and answer many of those questions. In particular, my heartfelt gratitude goes to my supervisors, Dr Meg Arnot and Dr Michael Brown. I have enjoyed and will very much miss, our regular meetings, whether in person or by Skype, and our many and varied conversations. Their approachability, help and friendship, together with their patience with my idiosyncratic grammar and writing style, has been beyond their duties and made my PhD "journey" immeasurably enjoyable. I also wish to thank the staff at the various archives where I have carried out research. Everyone I met gave generously of their time and all were courteous and helpful. They took an interest in my project and for that, I am grateful. In particular, I thank Mark Stevens, County Archivist, at the Berkshire Record Office. His generosity in sharing his wide knowledge of Victorian Broadmoor and its records, is greatly appreciated. I also thank Colin Gale at Bethlem, Museum of the Mind, for letting me have a corner of his office back in 2013 when I first started my research. It was a privilege to be able to access the original Bethlem case books and files. I wish to acknowledge the staff at the Wiltshire History Centre in Chippenham, who provided much help when needed and again, were very engaged with my research into Fisherton House. Finally, amongst

my thanks to the archives, I wish to recognise the staff at the record office of my home city, Liverpool. I will always remember my visits to the Liverpool Record Office, not just the unprecedented access to asylum records, but also for the scouse humour and general good-natured banter, that accompanied my days there.

While undertaking my studies, I have attended a number of conferences and I have made lasting contacts with other PhD candidates from other universities. I especially want to thank Helen Rutherford and Tahany Algranhi, for their encouragement, friendship and support. I must include Angela Clark, a friend from Liverpool University who undertook her PhD at the same time as me, we have propped each other up in tough days, but we've made it – thank you! Special thanks are due to Dr Daniel Grey, who has believed in me and my capabilities, his advice has been invaluable throughout this whole project. Finally, I thank my family for all their support, patience, forbearance and love. My husband, David, has uncomplainingly borne all the highs and lows of research, been my in-house computer boffin and my rock. During this time my son, Tom, went through three years at Liverpool University, putting up with Mother dropping in on her research trips and is now pushing me onwards from New Zealand. Without the love and support of my two men, I would not have reached this point. Thanks are hardly enough. All my life, I have been lucky to have had support from my parents, Charles and Brenda Shakeshaft, in whatever I chose to do. Right up to his death in August 2019, my father always wanted to know how my studying was going and would listen with close attention to the stories I was telling. His strong but gentle lifelong support and guidance in my careers and studies, was unstinting and invaluable. For that reason, I would like to dedicate my thesis to him, with all my love.

For Charles Shakeshaft, 1925-2019.

Abbreviations

BCLA	Broadmoor Criminal Lunatic Asylum.
BFHS	Berkshire Family History Society.
BRHA	Bethlem Royal Hospital Archive.
FHAA	Fisherton House Asylum Archive.
LCLAR	Lancashire County Lunatic Asylum at Rainhill.
LMA	London Metropolitan Archive.
LVRO	Liverpool Record Office.
HO	Home Office.
OBP	Old Bailey Proceedings.
TNA	The National Archive.
WHCC	Wiltshire History Centre, Chippenham.

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Introduction:
"A Deed at which Humanity Shudders":
Historical Context and Cultural Expectations

In December 1846, Mary Ann Beveridge strangled her one-year-old infant son. The following March, at the Hampshire Spring Assizes in Winchester, she was tried on a charge of wilful murder and was acquitted as insane. Evidence was heard that her husband was of "extremely profligate habits" and that "this course of life had entailed great misery on his family."[1] His neglect meant that the family's "meals were reduced to bread and water and the mind of [his wife] became affected."[2] Mary Ann was sent to Winchester Gaol, from where she was immediately released into the Portsea Union Workhouse. There she was placed into the infirm ward, not for a medical reason nor because she was insane but because she was blind. It was reported that she was "stone-blind, and has been so for seven years past", approximately since 1840.[3] She was subsequently discharged back to her family on 24 April 1847. Two years later, in January 1849, Beveridge was again indicted for wilful murder. Her victim was another of her children, five-year-old Thomas, who, like his brother, she strangled. At that time it was suggested by the press that her release in 1847 was an error of judgment on behalf of the authorities: "It appears that after being convicted on the grounds of insanity, her asylum was Winchester Gaol from which she was afterwards transferred, (but by whose orders we cannot understand) to the Hospital of the Portsea Union and then discharged as cured".[4] The local report was picked up by the London-based

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1 William A. Guy, *The Half-Yearly Abstract of the Medical Sciences: Report on the Progress of Forensic Medicine,* no. V. January – June 1847 (Philadelphia: Lindsay & Blakiston), pp. 292-326.

2 Guy, *The Half-Yearly Abstract.* Quotation p. 326.

3 "Child Murder", *Hampshire Advertiser* (30 January 1847), p. 8, col. 3.

4 "Murder of a Child by its Mother", *Hampshire Telegraph* (27 January 1849), p. 5, col. 3.

Morning Advertiser which commented, "The question has to be asked, why was she taken out of the hands of those to whose custody are erroneously consigned prisoners, who have been acquitted of the charge of murder only on the ground of insanity?"[5] Beveridge was readmitted to Winchester Gaol where she remained until 1856. Following representations from Hampshire County Magistrates "protesting against supporting a person who is a Government patient", she was eventually admitted to Bethlem Royal Hospital on 9 January 1856.[6] On 30 May 1863, the day that all the other criminally insane female patients were transferred from Bethlem to the newly opened Broadmoor Criminal Lunatic Asylum, it was noted that "in consequence of her blindness … the Government have allowed her to remain here [Bethlem] as she is … accustomed to find her way about".[7] According to records, Mary Ann did not display any symptoms of insanity, her disability was her blindness and, in reality, she could have been discharged. Her retention as an "incurable" appears to have been for humane reasons. As it was suspected that the main reason for her "insanity", at the time of both murders, was the physical and mental abuse she suffered at the hands of her husband, the medical officers and government officials allowed her to remain in Bethlem.[8] Mary Ann died on 30 March 1874 from "natural causes" and the relevant entry in the "Death and Discharge Register" was annotated in red with the words, "The Last Criminal".[9]

I open my thesis with the biography of Mary Ann Beveridge and her passage through nineteenth-century medico-legal and institutional systems of England, to

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5 "Murder of a Child by its Mother", *Morning Advertiser* (29 January 1849), p. 4, col. 2.

6 BRHA, CBC-03 Incurable & Criminal Patient Casebooks 1778-1864. Mary Ann Beveridge, f. 160.

7 BRHA, CBC-03 Mary Ann Beveridge, f. 160.

8 Roger Smith, *Trial by Medicine. Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), p. 153.

9 BRHA, CBC-03 Mary Ann Beveridge, f. 160.

illustrate the central theme and focus of my study. While on one hand this is an unique case with Beveridge committing a serial killing, on the other, it does illustrate some of the legal and medical benevolence apparent in nineteenth-century England towards married mothers who murdered their children. In the thesis, I place such women at the centre of an examination of the treatment of criminal insanity and child murder in England and Wales, particularly concentrating on those married mothers who were found insane by law, for the murder of one or more of their children. The thesis is an interlinking study of the life-careers of a dataset of 288 women, through the courts and mental institutions and related protocols and procedures, over the sixty-year period between about 1835 and 1895. The selected time span for the thesis was partly dictated by the availability of legal and medical primary sources and partly by the various statutes and legislation which came into being within the three decades. The primary documentation for four particular asylums dictated the the thesis' geographic spread. The extant records for three of these asylums, namely Bethlem Royal Hospital, then situated in Lambeth, south-east London, Fisherton House Asylum in Salisbury, Wiltshire and Broadmoor Criminal Lunatic Asylum in Crowthorne, near Wokingham, Berkshire, are fundamental to my work. They were the dedicated state facilities for the treatment of the criminally insane in the nineteenth century. To add comparison from the county asylum sector and to add a geographic contrast, I also use the excellent records for the Lancashire County Asylum at Rainhill, near Liverpool.[10]

[10] Bethlem Royal Hospital Archive (BRHA), Bethlem Museum of the Mind, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent; Broadmoor Hospital (Broadmoor Criminal Lunatic Asylum) Archive, (BCLA), Berkshire Record Office, Coley Avenue, Reading, Berkshire; Old Manor Mental Hospital (Fisherton House Asylum) Archive (FHAA), Wiltshire History Centre, Cocklebury Road, Chippenham, Wiltshire; Rainhill Hospital (Lancashire County Lunatic Asylum at Rainhill) Archive (LCLAR), Liverpool Record Office, Central Library, William Brown Street, Liverpool.

This Introduction is an overview of the scholarship and key literature which is most closely related to my research and study. I outline the contribution that my research will make to the various existing bodies of scholarship. Mothers who had who had brutally attacked their legitimate children appeared to some commentators to be "getting away with murder", rather than receiving a capital or punitive sentence.[11] In my thesis, I discuss and explore different societal and cultural aspects to explain the readiness with which a verdict of insanity was given to this particular group of female criminal lunatics. I detail and analyse the passage of a discrete dataset of mothers who had killed their own children, through the judicial and asylum systems of nineteenth-century England and Wales. Additionally, I explore and examine the mothers' personal lives, both before and after the crime. The creativity and originality of my thesis has been formed through qualitative analysis of nineteenth century legal, medical and journalistic records, supplemented and enhanced by detailed genealogical, biographical study. By isolating and concentrating on one very specific group of female child-murderers, my work complements and expands the study of nineteenth-century maternal child murder and female madness.

Context and Literature Review

As my thesis covers diverse areas of historical research and several discrete bodies of scholarship, the literature reviewed during my research has been wide-ranging. In the literature and context review I survey some of the main scholarship concerned with infanticide and child murder, female madness, the trials and treatment of female criminal lunatics, the asylum system and the impact of the domestic

[11] Hilary Marland,"Getting Away with Murder? Puerperal Insanity, Infanticide and the Defence Plea", in Mark Jackson (ed.), *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot: Ashgate, 2002), pp. 168-192, p. 170.

environment. Within the latter topic I consider issues of respectability and societal concepts of feminine behaviour and motherhood. Each chapter contains further reflection on these aspects and includes reference to other scholarship on the nineteenth-century medico-legal views of the causes of insanity, female criminal lunacy, and maternal child killing.

Through analysis of the behaviour and circumstances of a relatively small, but specific, dataset of "criminally insane" homicidal mothers, this thesis gives a new dimension to the motivations behind the seemingly benevolent legal and medical treatment they received. Rather than punishment for the crime, explanations were sought for the mothers in insanity, thereby deserving of curative treatment. Incarceration in an asylum was seen as a protective, potentially restorative solution for them. Other women, including violent women, were not afforded similar solutions in this period. They were viewed as deviant and immoral and often despised during the judicial and penal processes.[12] The principal aim of my thesis is to determine what rationales lay behind the decisions to view and treat this group of infanticidal and homicidal mothers in a seemingly tolerant, if not benevolent manner. My research also highlights the dilemmas of Victorian society with regard to maternal child murder and considers the impact of the diagnosis of insanity on popular attitudes towards these "mad mothers". My intention is to demonstrate that the nineteenth-century social attitudes and medico-legal treatment of these mothers were nuanced and informed by cultural mores. In essence, a verdict or diagnosis of insanity was more than just a

[12] Lucia Zedner, "Women, Crime, and Penal Responses: A Historical Account", *Crime and Justice,* vol. 14 (1991), pp. 307-362, p. 308

stratagem to avoid penal or capital punishment for insane women who killed their children.[13]

Concepts of motherhood and gender.

As in other centuries, cultural concepts of a "good mother" were valued in the nineteenth century. The scholarship on the subject of Victorian social expectations of motherhood, from all levels of society, highlights how those expectations differed between the classes.[14] The middle-class ideals of motherhood and concepts of gender-defined roles within the separate spheres of respectable middle-class domesticity have been analysed and reviewed by scholars.[15] To middle-class society, marriage and motherhood were advocated as the apotheosis of a woman's life. As Jeanne Peterson writes "Wifehood … [and] … motherhood certainly, had to be the central focus of her

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[13] Nigel Walker, *Crime & Insanity, vol. 1: The Historical Perspective* (Edinburgh: Edinburgh University Press, 1968), p. 125.

[14] For example: Joanne Bailey, "'Think Wot a Mother Must Feel': Parenting in English Pauper Letters c.1760–1834", *Family and Community History* vol.13, no. 1 (2010), pp. 5-19; Idem., *Parenting in England 1760-1830: Emotion, Identity and Generation* (Oxford: Oxford University Press, 2012); Idem., "The History of Mum and Dad: Recent Historical Research on Parenting in England from the 16th to the 20th centuries", *History Compass*, vol. 12, no. 6, (2014), pp. 489-507; Emma Griffin, "The Emotions of Motherhood: Love, Culture and Poverty in Victorian Britain", *American Historical Review* vol. 123, Issue 1, (2018), pp. 60-85; Idem., *Bread Winner*: *An Intimate History of the Victorian Economy* (New Haven & London: Yale University Press, 2020); M. Jeanne Peterson, *Family, Love and Work in the Lives of Victorian Gentlewomen* (Bloomington & Indianapolis; Indiana University Press, 1989); Melanie Reynolds, *Infant Mortality and Working-Class Child Care, 1850-1899* (Basingstoke: Palgrave Macmillan, 2016); Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918* (Oxford University Press: Oxford, 1993).

[15] See amongst other works: Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850* (London: Routledge, 1987); Peterson, *Family, Love and Work;* Mary Lyndon Shanley, *Feminism, Marriage, and the Law in Victorian England* (Princeton, NJ: Princeton University Press, 1989); Amanda Vickery, "Golden Age to Separate Spheres? A Review of the Categories of English Women's History", *The Historical Journal* vol. 36 no. 2 (1993), pp. 383-414.

life."[16] She would be expected to be a devoted and supportive wife and a nurturing, protective mother. The idealistic model of the Victorian mother as the "angel in the house", unselfishly caring for all and maintaining a moral household was, quintessentially, a middle-class creation.[17] Despite being just one version and one class's construction of family life, it did have some influence on contemporary views of childhood and family relationships.[18]

Despite numerous prescriptive directions on how to be a model mother in the nineteenth century, the reality was very different for working class families.[19] The attributes needed to be seen as a "good mother" within working-class society would not necessarily be acceptable, or recognisable, to middle-class observers. Contemporary middle-class opinion tended to view some working-class mothers as mercenary, materialistic and brutal and was critical of their parenting abilities.[20] The belief that working-class mothers were wanting because they did not display the same emotional reactions and responses to their families, highlights the cultural differences between the two classes' interpretations of a "good mother".[21] The hardships of life

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16 Peterson, *Family, Love and Work*, p. 104.

17 "*The Angel in the House*" is a semi-autobiographical poem written by Coventry Patmore, first published in 1854. It chronicles Patmore's marriage and his love for his wife Emily. The poem describes the ideal wife as being modest and chaste, who unconditionally and submissively loves her husband and cares for and nurtures her chidren. The work gained in popularity in the mid-nineteenth century and its title became synonymous with the "ideal" Victorian, albeit middle-class, housewife.

Sarah Kuhl, "The Angel in the House and Fallen Women: Assigning Women their Places in Victorian Society", *MLA Vides*, vol. 4, Spring 2016, pp. 171-178; Peterson, *Family, Love and Work*, pp. 103-4.

18 James Marten, "Family Relationships" in Colin Heywood (ed.) *In the Age of Empire. A Cultural History of Childhood and Family* (London: Bloomsbury, 2014) pp. 19-38, p. 35.

19 Reynolds, *Infant Mortality* p. 36.

20 Marten, "Family Relationships", p. 22

21 Bailey, "The History of Mum and Dad", p. 499.

suffered by poor families would have placed strain on the inter-familial relationships and maternal affections. The expectation that a "good Victorian mother …[would work]… tirelessly to ensure a clean, well-ordered home" and keep it as a place of family security, would be hard for many.[22] Emma Griffin has written explicitly on the emotions of motherhood within a poor, working-class environment. She uses testimonies taken from working-class autobiographies to answer two main questions, "What did working-class culture in Victorian Britain expect of mothers? How were mothers *supposed* to behave?".[23] The lives of the Victorian working-class could be tough and harsh, factors which could place stress on the emotions of motherhood.[24]

Ellen Ross's 1993 study, *Love and Toil: Motherhood in Outcast London,* argues that rather than being feckless, mothers were important to family dynamics within the poorer classes of society. [25] She highlights the centrality and importance of the mother in managing the family home and economy. Ross argues that "maternal affection" was demonstrated in very different ways in working-class family relations when compared with the middle class.[26] To working-class society, the practical elements of managing the home were the main manifestations of maternal affection, rather than a less practical emotional devotion. The lives of working-class mothers were often economically difficult and domestically challenging, factors which, in themselves, could cause mental stress.[27] To keep maintaining the family unit, mothers would often have to take on paid work.[28] In both urban and rural environments, this

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[22] Griffin, "Emotions of Motherhood", p. 67.

[23] Ibid., p. 66.

[24] Ibid., p. 84.

[25] Ross, *Love and Toil.* p.11.

[26] Ibid., pp. 8-9.

[27] Griffin, "Emotions of Motherhood", p. 84.

[28] Ross, *Love and Toil.* p. 9.

might entail working outside the home.[29] Childcare could be difficult, the older children might look after their younger siblings, a mother could possibly take her infant with her to work or alternatively rely on other kin and neighbours.[30] A working mother from the lower classes was sometimes viewed as morally poor, even evil, because she neglected her maternal role.[31] She would not be a hands-on, nurturing mother, which middle-class observers considered to be "normal" maternal behaviour.[32] To undertake paid work did not mean that the mother was a neglectful mother, but would often be caused by insufficient income coming into the household.[33]

A single, working mother might be portrayed as a bad mother, "farming" her child out by availing herself of the services of a baby-minder or baby-farmer.[34] Public reports from medical professionals and philanthropic societies, led to a belief that infant deaths through neglect and baby-farming, were significant contributory factors to the high mortality rates for children, particularly in urban areas.[35] Highly-publicised infant deaths at the hands of some baby-farmers and reports of widespread infant abandonment and neglect, help to fuel the "moral panic" of the latter years of the nineteenth century.[36] Public moral outrage was driven by the spectre of a "massacre

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29 Griffin, *Bread Winner*, p. 165.

30 Ibid., p. 166.

31 Reynolds, *Infant Mortality*, p. 1-2.

32 Griffin, *Bread Winner*, p. 6.

33 Ibid., p. 162.

34 Carol Smart, "Disruptive Bodies and Unruly Sex: the Regulation of Reproduction and Sexuality in the Nineteenth Century", in Carol Smart (ed.), *Regulating Womanhood* (London: Routledge, 1992), pp. 7-32, p. 23.

35 Ann Higginbotham, "'Sin of the Age': Infanticide and Illegitimacy in Victorian London", *Victorian Studies* vol. 32, no. 3 (1989), pp. 319-37.

36 George K. Behlmer, "Deadly Motherhood: Infanticide and Medical Opinion in Mid-Victorian England" *Journal of the History of Medicine and Allied Sciences* vol. 34, no. 4 (1979), pp. 403-27, p. 423.

of innocents". [37] Lionel Rose suggested in his 1986 book that the increase in infant mortality and infanticide was motivated by economic and social pressures, with a certain amount of liability laid on single, working mothers.[38] Aeron Hunt asserts that popular opinion believed that femininity and domesticity had been "contaminated" by economic interests and infanticide by working mothers was a result.[39] He suggests that prevailing view was that their abilities as a "proper mother", were threatened by the necessity to work, thereby they failed in their maternal role.[40]

Following on from Hunt's point, Melanie Reynolds contends that "the middle-class … were wrong to malign them [working mothers] through their rhetoric and ill-informed evidence".[41] She writes that, although working-class mothers were not embodiments of the "Angel in the House", they were responsible and hardworking in looking after their families' interests.[42] Reynolds argues that, when working-class mothers needed to work to contribute to the family economy, they were pro-active and creative in arranging various schemes of childcare.[43] Reynolds suggests that, as the middle-class ideology of "at-home" mothers influenced employment legislation, the opportunities for mothers to work outside the home diminished. This in turn affected living conditions and health of the poorer classes.[44] In Chapter 1, I review the employment status of the mothers with recorded occupations in my dataset, to

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[37] Higginbotham, "'Sin of the Age", pp. 319-320.

[38] Lionel Rose, *Massacre of the Innocents. Infanticide in Great Britain 1800-1939*, (London: Routledge & Kegan Paul, 1986), p. 21.

[39] Aeron Hunt, "Calculations and Concealments: Infanticide in Mid-Nineteenth Century Britain", *Victorian Literature and Culture* vol. 34, no. 1 (2006), pp. 71-94, p. 79.

[40] Ibid., p. 79.

[41] Reynolds, *Infant Mortality*, p. 163.

[42] Ibid., p. 160.

[43] Ibid., p. 55.

[44] Ibid., p. 38

ascertain whether their working status had an impact on popular and medical views of them and on the causes of their insanity.

Respectability

In contemporary records, the families of the homicidal mothers were frequently described as respectable, honest and caring. Their homes may have been just one room but that did not mean that there was a lack of family and domestic unity.[45] Most levels of society strove for respectability, although what constituted respectability differed between the social classes.[46] Respectability was adjudged by fellow members of a community through diverse and intricate criteria. For the working class, important criteria were whether the father was in employment, whether the wife kept a clean house and whether the children were cared for and fed.[47] Significantly, for married women, it could mean displaying good mothering and housekeeping skills. Working-class mothers were seen as the fulcrum of the home, taking pride in capably managing children and the domestic economy – keeping a respectable home was considered an essential quality in a married woman.[48] Those thought respectable would have good neighbourly relationships and would support their neighbours in crisis.[49] In the opinion of many philanthropic benevolent societies, the model of a working family should be one of hardworking, caring and thriftful mutual support.[50]

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[45] Griffin, *Bread Winner*, pp. 160-189.

[46] Susie L. Steinbach, *Understanding the Victorians. Politics, Culture and Society in Nineteenth-Century Britain* (Abingdon: Routledge, 2012), p.125.

[47] Ibid., pp. 131-132.

[48] Ross, *Love and Toil*, pp. 128-65

[49] Steinbach, *Understanding the Victorians*, pp. 130-4.

[50] Steven J. Taylor, "Conceptualising the 'Perfect Family' in Late Nineteenth Century Philanthropic Institutions" in Carol Beardmore, Cara Dobbing & Steven King (eds.), *Family Life in Britain, 1650-1910* (Basingstoke: Palgrave Macmillan, 2019), pp. 155-178, p. 170.

Urban working families tended to be less residentially stable.[51] The homes would often be just one or two rooms with shared facilities and it is very noticeable that they frequently moved accommodation. Families would sub-let what rooms they had and take in boarders, in order to boost the household economy.[52] From quite an early age, children would contribute to the running of the household.[53] Middle-class ideals of an innocent childhood, carefree and safe, would be beyond the economic means of many working families.[54] To Victorian philanthropic commentators and charitable observers, a working class lifestyle could be damaging to the moral welfare and future of children.[55] The children would be, by the nature of the home situation, exposed to all the behaviours which middle-class observers would consider immoral.[56] Many individual families seemed uncaring and neglectful, behaving in an immoral fashion and this caused the family unit to be fragile. [57] Such conditions have led suggestions that poorer parents lacked emotional connection with their children. Julie-Marie Strange maintains that working-class families were not necessarily perceptibly affectionate but that their emotional ties were demonstrated by the work involved to feed and care for children.[58]

The male authority figures with whom the mothers came into contact, were invariably from the middle class and their personal lives would impact upon their perceptions of the women. It is an assumption that all middle-class families adhered

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[51] Emma Cuming, *Housing, Class and Gender in Modern British Writing, 1880-2012.* (Cambridge. Cambridge University Press. 2016), pp. 28-29.

[52] Ibid., p. 30.

[53] Taylor, "Conceptualising the 'Perfect Family" p. 156.

[54] Marten, "Family Relationships", p. 19.

[55] Taylor, "Conceptualising the 'Perfect Family" p. 156.

[56] Idem., p. 158.

[57] Idem., p. 170.

[58] Julie-Marie Strange, *Death, Grief and Poverty 1870-1914* (Cambridge: Cambridge University Press, 2005), p. 251.

to the domestic ideology of "separate spheres" .[59] This convention was that the "man of the house" would work outside of the home, providing for the family and that his wife, and mother of his children, would provide a domestic safe haven. Her life would be immersed in caring for the moral and physical welfare of her family.[60] Scholars have discussed and challenged the suggestion that this domestic idyll was universally applied.[61] I would agree that, by accepting some of the ideas and rejecting others, each middle-class home would find their own compromise. Middle-class legal, medical and governmental officials accepted many of the domestic values of lower classes as respectable, although they did not always appreciate the difficult socio-economics of poorer families.[62] A respectable, working-class Victorian home would still have the mother at its centre, but expectations of domestic respectability differed. Middle-class observers believed a working-class family to be respectable if the husband was employed, prudent, affectionate and non-violent towards his wife and children. The wife should be a good housekeeper and a fond mother.[63]

Respectability in the period was a gauge by which people were perceived and their behaviour understood. It was a doctrinal code circumscribing personal behaviour, family life and social acceptance, defined by morality and discipline. What was

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[59] A. James Hammerton, *Cruelty and Companionship. Conflict in Nineteenth-Century Married Life*, (London: Routledge, 1995), pp. 71-72.

[60] Hammerton, *Cruelty and Companionship*, p. 2.

[61] See amongst others: Ann Digby, "Victorian Values and Women in Private and Public", *Proceedings of the British Academy*, vol. 78, (1990), pp. 195-215; John Tosh, *A Man's Place: Masculinity and the Middle-Class Home* (New Haven, CT & London: Yale University Press, 1999); Amanda Vickery, "Golden Age to Separate Spheres?".

[62] Jonathan Andrews, "The boundaries of Her Majesty's Pleasure: discharging child murderers from Broadmoor and Perth Criminal Lunatic Department, c. 1860-1920" in Jackson (ed.), *Infanticide*, pp. 216-248, p. 236.

[63] Joanne Begiato, *Manliness in Britain, 1760-1900. Bodies, Emotion and Material Culture* (Manchester: Manchester University Press, 2020), p. 21.

considered to be morally respectable behaviour depended, to an extent, on where the observer believed they stood in society. [64] As David Cannadine writes, "middle-class observers believed only a minority of workers was respectable: the workers themselves often thought otherwise."[65] Cannadine argues that so-called "middle-class Christian virtues" of kindness, decency and prudence, had spread to the lower classes.[66] This was not necessarily the case. Similar cultural expectations of family and of family responsibilities had long existed in the working class, although behavioural emphases differed from middle-class ideals. [67] As Joanne Bailey argues, expected standards of respectable behaviour were well-established in lower class culture. They had their own recognised conventions and knew how their society expected them to behave in order to be considered as respectable.[68]

Analysis of the social background of all parties, including the women, their families and kin and the men from medical and legal authorities, highlights the importance of respectability. To be thought to be respectable, or to always act in a respectable manner, was a dominant cultural and social aspiration for most levels of society. A key strand underpinning my arguments is the influence and effect of relevant differing cultural perceptions on the legal and incarcerel outcomes for these "insane" mothers. In this thesis, I review the significance and impact of contemporary beliefs of respectability on all outcomes for criminally insane maternal child murderers in Victorian England and Wales.

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64 David Cannadine, *Class in Britain* (London: Penguin Books, 1998), p. 90-91.

65 Ibid., p. 92.

66 Idem., *Victorious Century: The United Kingdom 1800-1906* (London: Penguin Random House, 2017), p. 331.

67 Joanne Bailey, "Think Wot a Mother Must Feel: Parenting in English Pauper Letters c.1760–1834", *Family and Community History*, vol.13 no. 1. (2010), pp. 5-19.

68 Ibid., "Think Wot a Mother Must Feel", pp. 15-16.

Marital status and family relationships.

The central theme of this thesis is research into cases of married women who had killed their offspring. Under the prevailing legal provision for cases of maternal infanticide or child homicide, married women particularly presented a problem to the legal world. Their status negated the ideas of shame or guilt of an unmarried mother, which were seen as believably leading to infanticide.[69] Much of the predominant legislation was still rooted in the statutes of 1624 and 1803, so the murderous actions of married mothers would have had the potential to challenge legal views.[70] By mid-Victorian cultural values they had no "excuse" for committing the crime.[71] An essential consideration in my study is the importance attached to marital status in Victorian culture and society.[72] Being married or widowed lent another element of morality to the defence of a female defendant in the eyes of middle-class societal values and, thus, impacted upon cultural, legal and medical views of mothers who murdered their legitimate children.[73]

In order to conduct a comprehensive commentary on the attitudes and reactions of families, public opinion and the male-dominated authorities, I include comparative cases of unmarried mothers. There are far fewer single mothers adjudged as criminally insane in my dataset, but there are incidences of co-habitation and cases where the child was the result of an extra-marital, or in the case of widows, a subsequent relationship. Within the working-class, formal or informal marriage added stability to

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[69] Ginger Frost, *Illegitimacy in English Law and Society, 1860-1930* (Manchester: Manchester University Press, 2016), p. 3.

[70] Infanticide Act 1624. 21 Jac.I. c. 27; "Lord Ellenborough's Act" 1803. 43 Geo 3, c 58.

[71] Frost, *Illegitimacy in English Law*, p. 182.

[72] Carol Beardmore, Cara Dobbing & Steven King, "Introduction" in Beardmore et al, (eds.), *Family Life in Britain*, pp. 1-9.

[73] Anne Marie Kilday, *A History of Infanticide in Britain, c1600 to the Present* (Basingstoke: Palgrave MacMillan, 2013), p. 172-178.

a family.[74] The safe structure of a stable household was fractured by the extra-ordinary violent actions of the wife and mother, unsettling the co-operative relationships with social peers.[75] I discuss the general implications of marital status in Chapter 1 when reviewing the statistical information relating to my dataset. For this, I accepted the status of the women as it was stated in official governmental, legal and medical records.

I explore the importance of family relationships in all aspects of the women's journeys. The reactions of family and kin were an important part of the witness testimonies given in the coroners' courts and in the judicial courts. It was a vital constituent in proving that the accused mother had acted completely against character and convention. Although this thesis is not primarily a case study in the history of emotions, the recent excellent studies of emotions in family and gender history must be acknowledged and referenced.[76] Jan Plamper states that past studies in the history of the family have led to vital discussions about emotions within family life, particularly surrounding familial and spousal love.[77] Jade Shepherd took up this point and her thesis included a succinct analysis of the emotions of fatherhood, as expressed by the male patients in Broadmoor.[78] Like Shepherd, I have found that the case files

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[74] Ginger Frost, *Living in Sin: Cohabiting as Husband and Wife in Nineteenth-century England* (Manchester: Manchester University Press, 2008) p. 226.

[75] Ibid., p. 67; Idem., *Illegitimacy in English Law*, p. 55.

[76] For example: Katie Barclay, "Narrative, Law and Emotion: Husband Killers in Early Nineteenth-Century Ireland", *The Journal of Legal History*, vol. 38 no. 2 (2017) pp. 203-227; Begiato, *Manliness in Britain, 1760-1900*; Griffin, "The Emotions of Motherhood"; Idem., *Bread Winner*; Strange, *Death, Grief and Poverty*.

[77] Jan Plamper, "The History of Emotions. An interview with William Reddy, Barbara Rosenwien and Peter Stearns", *History & Theory* vol. 49 (May 2010) pp. 237-265, p. 262.

[78] Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane 1863-1900" (unpublished PhD Thesis: Queen Mary, University of London, 2013)

at Broadmoor contain valuable material on working-class family emotional relationships. The significance of family bonds was evident during the women's stay in any asylum throughout the sixty years of this study. Family contact was considered important for the patients' welfare, particularly when a release or discharge from incarceration was considered. The existence and quality of intra-familial bonds, as an influence on the social perceptions of the lives and background of the dataset women, lends another nuance to underlying reasons for the apparent benevolent treatment from all authorities. This idea is explored in greater detail in Chapters 6 and 7. I also consider the impact of marital status and familial relationships on contemporary observations on the lives of the women of my dataset, in all chapters of the thesis.

Infanticide and child murder

The term "infanticide" is usually associated with the murder of infants within a year of their birth, however, it was used in the period to describe the killing of children of all ages, up to early teens.[79] The term appeared in the nineteenth century in medical writings and in the press, becoming generally used in public consciousness to refer to the killing of a child of any age, from newborn to adolescent. Pauline Prior comments that, "…the pattern for England in the mid-nineteenth century [was that] infanticide (victim under one year) accounted for 61 per cent of all homicide victims".[80] Elaine Farrell, in her study of infanticide in Ireland, writes that the term "infanticide" was nebulous in both legal and popular contemporary accounts. [81] Farrell analyses Irish court cases of maternal child homicide between 1850 and 1900, where the victim could

[79] Mark Jackson, "The Trial of Harriet Vooght: Continuity and Change in the History of Infanticide" in Jackson (ed) *Infanticide*, pp. 1-17, p. 10.

[80] Pauline Prior, *Madness and Murder: Gender, Crime and Mental Disorder in Nineteenth-Century Ireland*, (Dublin: Irish Academic Press, 2008), p. 121.

[81] Elaine Farrell, *"A Most Diabolical Deed". Infanticide and Irish Society, 1850-1900*, (Manchester & New York: Manchester University Press, 2013), p. 3.

be aged up to three years old.[82] She determines that leniency and compassion toward mothers accused of infant murder, was frequently exhibited in nineteenth-century Irish courts, whether the case was one of newborn murder or murder of older children. [83] In England in this period, legal and social responses to the incidence of infanticide and child-murder were also tempered by such underlying ambivalence.[84]

In 1846, a leader in the *Times* stated, "the most serious feature of the age is the increase of infanticide … human life is losing its value".[85] During the 1850s and 1860s, the incidence of child-killing seemed to reach an all-time high, becoming a subject of heated discussion in journals and newspapers. Articles expressed moral outrage, blaming the loose morals of young people and a declining sense of decent behaviour. An 1852 article in the *Morning Chronicle* began, "It is a very grave consideration for religious persons and for moralists that such crimes as infanticides … have of late years grown with frightful rapidity". The article ascribed this growth to "a deplorable change … [in] … the rural morals of England".[86] The *Era* in 1860 declared that:

> … Infanticide and female barbarity have become so rife among us, so commonplace an ulcer on our … morals, that we neither see the pestilent sore nor feel the subtle poison of its contagion … [we] have grown so familiar with its daily feature that we treat it as a necessity of our civilisation. … [87]

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[82] Farrell, *"A Most Diabolical Deed"*, pp. 75-79.

[83] Idem., p. 79

[84] Frost, *Illegitimacy in English Law*, p. 51-52.

[85] "By far the most serious feature …", *Times*, (18 March 1846), issue 19187, p. 4, col. 5.

[86] "Infanticide in England", *Morning Chronicle*, (10 September 1852), p. 4, col. 4.

[87] "Spread of Infanticide", *Era*, (19 August 1860), p. 9, col. 2.

Two decades later, newspapers were still reporting its growth in reproachful terms: "the least satisfactory portion of the report [*Annual Judicial Statistics*] is that which shows a steady increase of infanticide".[88] Other publications took a less critical view of people's morals and attributed the high rates of unexplained infant mortality, not to immoral lifestyle, but to the living conditions of the poor. An 1861 article from *The Lancet* (reproduced in the *Dublin Medical Press*) discussed the rates of infant mortality in London. It stated that it had been shown that "children were murdered, or deserted that they might die and … they were expressly … ill-fed, ill-clad and generally badly treated". The article concluded, "it is a sad thing to reflect upon … that there should exist plausible grounds for suspicion that the fatal effects upon … children born in … our Great Babylon [are] due to misery and starvation". [89]

Mid-Victorian society was alarmed by the seeming rise in the reported number of cases of infanticide. With medical campaigners and social reformers presenting infanticide as a widespread social problem, public sentiment was stirred up.[90] The "moral panic" of the mid-nineteenth century was a public response to what was believed to be social problem of the poor.[91] The main reasons for infanticide, in particular, were popularly believed to be desperation, poverty and the shame of illegitimacy.[92] The typical perpetrator was perceived as a young, desperate woman from the servant class, who had been probably seduced and abandoned.[93] Another

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[88] *Royal Cornwall Gazette*. 27 September 1888; p. 4, col. 5.

[89] "Infanticide in London", *The Lancet* reproduced in Dublin Medical Press. 16 October 1861. p. 283, cols. 1-2.

[90] Higginbotham, "Sin of the Age", p. 320.

[91] Behlmer, "Deadly Motherhood." p. 414

[92] Ibid., p. 415

[93] "Seduction" would often be used as a euphemism for rape. Barry Godfrey & Paul Lawrence, *Crime and Justice since 1850*, (Abingdon: Routledge, 2015), pp. 98-9; Margaret L. Arnot, "Understanding Women Committing New-born Child Murder" in Shani D'Cruze

was the evil baby-farmer who would take the infant and, with or without the knowledge of the desperate mother, destroy it.[94] Victorian social reformers campaigned to improve the treatment of all poor children and began to focus particularly on the vulnerability of illegitimate children.[95] Lionel Rose suggests in his 1986 book that the increase in infant mortality and infanticide was motivated by economic and social pressures.[96] As the birth rate rose, "surplus" or unwanted children were allowed to die, whether by deliberate neglect or ultimately by infanticide, as a solution to over-population of the poor.[97] In contra-point to Rose's hypothesis that infanticide was a matter of controlling family size and economics, more recent scholarship has concluded that it is not possible to explain, definitively, the reasons for the high incidence of maternal child-homicide in Victorian England.[98] The motives and rationales are as diverse and widespread as the incidents themselves, so there is not one easy applicable theory.[99] As Meg Arnot points out, whilst economic, moral,

(ed) *Everyday Violence in Britain, 1850-1950* (Edinburgh: Pearson Education Ltd, 2000), p. 58:

94 Higginbotham, "Sin of the Age", p. 319.

95 Ibid., p. 319.

96 Lionel Rose, *Massacre of the Innocents. Infanticide in Great Britain 1800-1939*, (London: Routledge & Kegan Paul, 1986).

97 Ibid., p. 187.

98 For example: Margaret L. Arnot, "Gender in Focus: Infanticide in England 1840-1880" (unpublished PhD Thesis: University of Essex, 1994); Daniel J. R. Grey, "Discourses of Infanticide in England, 1880-1922" (unpublished PhD Thesis: University of Roehampton, 2008); idem "'No Crime to Kill a Bastard–Child': Stereotypes of Infanticide in Nineteenth-Century England and Wales", in Barbara Leonardi (ed.) *Intersections of Gender, Class, and Race in the Long Nineteenth Century and Beyond* (Cham: Palgrave Macmillan, 2018) pp. 41-66; Aeron Hunt, "Calculations and Concealments", pp. 71-94; Kilday, *A History of Infanticide*; Hilary Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave MacMillan, 2004).

99 Arnot, "Understanding Women" p. 59.

cultural and social factors of Victorian society might have contributed to the extent of infanticide, they alone do not explain any one particular case.[100]

Rose suggested that the authorities viewed the actions of the murdering mother as an attempt to avoid poverty and the workhouse.[101] The 1834 New Poor Laws put pressure on poorer single mothers. The requirement fell on the mother, rather than the father, to carry the financial burden of her illegitimate child. After the 1844 amendments to the Act, the responsibility of obtaining a maintenance order and of ensuring that it was enforced, fell to the mother herself.[102] Rose's suggestion is an extreme explanation of the reasons for the perceived high incidence of child-killing and not necessarily one supported by the press of the period. An 1838 editorial in the Chester Chronicle said, "The bastardy clause is unjust. The female ought to have a remedy against her seducer; the father of the illicit offspring ought not to be absolved from all charge of it".[103] Elaine Farrell writes that this was also the view in Ireland, that the biological father should take some of the blame for the act of child homicide. He was as much at fault because he should have shared some responsibility and provided for the child.[104]

Obviously blaming these clauses within Poor Laws for the rise in infanticide is applicable to unmarried mothers only, however the fear of destitution and the workhouse was a reality to married women too. Circumstances changed quickly and women suddenly widowed without their partner's income, may have resorted to a

[100] Ibid., p. 66.

[101] Rose, *Massacre of the Innocents, p.32 -34.*.

[102] Kilday, *A History of Infanticide*, p162.

[103] "The Respited Infanticide". *Chester Chronicle* (7 September 1838) p. 3 Col. 2.

[104] Farrell, *"A Most Diabolical Deed"*, p. 76.

drastic solution.[105] Tamar Hager suggests that many women, once alone, could not afford to feed their families and so turned to desperate measures. [106] Anne-Marie Kilday points out that whilst possibly newborn child murder was a way of limiting the size of a family, rarely did such cases come to light, and therefore can not be definitively proven.[107] She states that with the high infant mortality rate, the unexplained death of a baby or young child in an established household with a stable parental relationship, could be attributed to natural causes.[108] Certainly amongst the women admitted to Broadmoor, there were a number whose insanity was attributed to a grief-driven *fear* of destitution, rather that its actual occurrence. Also it was recorded that on many occasions, patients had stated that they had killed their child to spare it the hardships of life. I discuss such cases in Chapter 6 and 7 demonstrating that many different motives could be amalgamated together to find a rational explanation for behind the mothers' insanity and criminal actions.

Kilday identified four main categories of motive for child-killing based on examination of court papers and press reports and the four categories, she asserts, apply to the seventeenth, eighteenth and nineteenth centuries. [109] In this present study the findings for the nineteenth century are the most relevant. The four highlighted categories are shame and isolation; economic factors; deliberate or malicious intent; and medical and psychological explanations. Kilday concludes that, sometimes, all four categories were jointly and severally responsible for the action and that there

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[105] Tamar Hager, "Compassion and Indifference: The Attitude of the English Legal System towards Ellen Harper and Selina Wadge, who killed their Offspring", *Journal of Family History* vol. 33 no. 2. (2008) pp. 173-194.

[106] Hager, "Compassion and Indifference", p. 193.

[107] Rose, *Massacre of the Innocents,* p. 187; Kilday, *A History of Infanticide,* p163.

[108] Kilday, *A History of Infanticide,* p163.

[109] Ibid., pp. 152-182.

could not be one sole reason.[110] This conclusion can be applied to all mothers who killed their own children, married or single. Through this thesis, particularly in the chapters relating to the women's court appearances, all these points are examined as contemporary exculpation for the mothers' state of madness.

In recent years, research has shown the subject of infanticide, indeed child-killing as a whole, to be too complex to be attributed to one section of society. Neither can it be attributed to social politics and cultural mores. [111] In fact, it cannot even be said to be a purely female crime. The records contained in the Broadmoor Archive, illustrate such gender convention is as flawed as the Victorian assumption that illegitimacy was the root cause of infanticide.[112] The majority of patients in the state asylum for child-murder were either married or widowed and this fact applied equally to men as to women.[113] Krissie Glover, Cathryn Wilson and Jade Shepherd focussed their research on men in Broadmoor, with particular emphasis on those who had committed child homicide.[114] They all reiterate the point that most historical enquiry

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[110] Ibid., p. 182.

[111] For example: Margaret L Arnot, "Gender in Focus: Infanticide in England 1840-1880" (unpublished PhD Thesis: University of Essex, 1994); Farrell, *A Most Diabolical Deed*; Grey, "Discourses of Infanticide"; Higginbotham, "'Sin of the Age'"; Kilday, *A History of Infanticide*; Rose, *The Massacre of the Innocents*;

[112] Bailey, "The History of Mum and Dad", p. 500; Alison Pedley, "'A Painful Case of a Woman in a Temporary Fit of Insanity'. A Study of Women admitted to Broadmoor Criminal Lunatic Asylum between 1863 & 1884 for the Murder of their Children." (unpublished MA dissertation, University of Roehampton, 2012); Shepherd, "Victorian Madmen".

[113] Krissie Glover, "Insanity, Infanticide and Gender: Male and Female admissions to Broadmoor Criminal Lunatic Asylum 1875-1900" (unpublished MA Dissertation: Royal Holloway, University of London, 2011).

[114] Glover, "Insanity, Infanticide and Gender"; Shepherd, "Victorian Madmen"; Cathryn Wilson, "Mad, Sad or Bad? Newspaper and Judicial Representations of Men who killed Children in Victorian England, 1860-1900" (unpublished PhD Thesis: University of Essex, 2012).

into infanticide and child-murder has been concentrated on women and, in particular, unmarried mothers. The killing of children by their fathers, or by married mothers, has rarely been studied. Their respective theses address the issue only in respect of homicidal and infanticidal fathers, who were incarcerated in Broadmoor. By extending my investigation and exploration into an earlier time-frame, my research complements their work and adds a wider perspective to the topic of parental child murder in the nineteenth century.

Women and the courts

The nineteenth century saw the development of medico-legal defences, with the emergence of medical testimony and the wide use of the insanity defence.[115] Scholars have examined criminal insanity, the role of the insanity plea in trials, the role of doctors and medical evidence and medico-legal debate.[116] Of particular reference and relevance to my thesis, have been the works of Joel Peter Eigen, Hilary Marland, Roger Smith and Nigel Walker, all of whom have examined criminal insanity in reference to women. In many trials for child murder, whether the specific subject of insanity was mooted or not, the question of whether the defendant specifically knew her act was wrongful and if she had the criminal resolve to damage her child, was frequently raised.[117] The defence of insanity in cases of maternal child

[115] Smith, *Trial by Medicine,* p. 156.

[116] Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-Doctors in the English Court* (New Haven & London: Yale University Press, 1995); Idem., *Unconscious Crime: Mental Absence and Criminal Responsibility in Victorian London* (Baltimore: The Johns Hopkins University Press, 2003); Idem., *Mad-Doctors in the Dock. Defending the Diagnosis, 1760-1913* (Baltimore: Johns Hopkins University Press, 2016); Marland, "Getting away with Murder?" in Jackson (ed.) *Infanticide.* 168-192; Smith, *Trial by Medicine;* Walker, *Crime & Insanity, vol. 1*; Nigel Walker & Sarah McCabe, *Crime & Insanity in England Vol 2 New Solutions & New Problems* (Edinburgh: Edinburgh University Press, 1973).

[117] Eigen, *Unconscious Crime.*

murder, has been described as a legal construct, designed to avoid capital punishment for infanticidal mothers.[118] Walker considered the defence of insanity in the crime of infanticide as a "special defence" which glossed "over the issue of responsibility" and was of interest to "both lawyers and psychiatrists".[119] Roger Smith attributes its success to a widespread benevolence towards mothers who murdered, as they were regarded as fragile beings at the mercy of their physiology.[120] Despite the labelling of the crime of maternal child murder as cruel and atrocious, poverty, domestic violence or indeed the implication of madness, were widely accepted as possible mitigating circumstances for such criminal behaviour.[121] Lucia Zedner writes that the medical profession had achieved a "remarkable achievement … in persuading lawyers of the validity of this psychiatric exculpation, effectively replacing traditional legal discourse with that of psychiatry."[122]

In the nineteenth century, there was a strong movement against capital punishment and for the abolition of hanging. There was an aversion in society and within legal and governmental circles, to find any woman guilty of a capital crime.[123] A comment was made in Parliament in 1865, for instance, that there was "a great

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[118] Smith, *Trial by Medicine,* p. 159; Walker, *Crime & Insanity, vol. 1;* Lucia Zedner, *Women, Crime and Custody in Victorian England* (Oxford: Clarendon Press, 1991).

[119] Walker, *Crime & Insanity, vol. 1,* p. 125.

[120] Smith, *Trial by Medicine,* p. 159.

[121] Alison Pedley, "The Emotional Reactions of Judges in Cases of Maternal Child Murder in England, 1840-1890" in James Gregory, Daniel J. R Grey and Annika Bautz (eds.), *Judgment in the Victorian Age,* (Abingdon: Routledge, 2019), pp. 83-99; Smith, *Trial by Medicine,* pp.143-150.

[122] Zedner, *Women, Crime and Custody,* p. 90.

[123] James Gregory, *Victorians Against the Gallows: Capital Punishment and the Abolitionist Movement in Nineteenth Century Britain* (London New York, I.B. Taurus 2011), pp. 99-100.

indisposition to hang a woman in this country".[124] However, as the last woman was hanged for the infanticide of her legitimate or illegitimate child, was in 1849, I dispute Smith's argument that that the primary objective of "humanitarian sentiment", such as a diagnosis of insanity, was to avoid hanging women. [125] In Chapter 3, I review the utilisation and implications of a plea of insanity in cases of maternal child homicide. I analyse what other factors were at play, which would lend rationale to the seemingly lenient and sympathetic attitude of judges, juries and the general public. To be found insane by law and to be "held in safe custody until her Majesty's pleasure be known", was not necessarily a light sentence and held many problems of interpretation for the judiciary, clinicians and government officials.[126] Chapter 4 is an analysis of these various attitudes to and implications of different incarceral decisions and their impact on the dataset of homicidal mothers.

Criminal lunatics.

Writing in 1877, Dr David Nicholson, the then Deputy Medical Superintendent at Broadmoor, divided the history of criminal lunacy into four periods.[127] The first, he believed, was the period up to 1800, when criminal lunatics were in prison. The second period was between 1800 and 1840, when they were recognised as insane and held in asylums. The third, between 1840 and 1860, he called the "Reactionary Period", when

[124] "Punishment of Death – Select Committee" Parliamentary Debates, 3rd series, vol. 174, HC, col. 2057-2058; C.P.C., minute 2590. 4 March 1865. Quoted in Gregory, *Victorians Against the Gallows*, p. 100.

[125] Smith, *Trial by Medicine,* p. 150.

[126] Lucy Williams & Barry Godfrey, "'Find the Lady': Tracing and Describing the Incarcerated Female Population in London in 1881", in Manon van der Heijden, Marion Pluskota & Sanne Murling (eds.), *Women's Criminality in Europe, 1600-1914,* (Cambridge: Cambridge University Press, 2020), pp. 114-133, p. 119.

[127] David Nicolson, "A Chapter in the History of Criminal Lunacy in England". *Journal of Mental Science (now The British Journal of Psychiatry)* vol. 23. (July 1877), pp. 165-185.

it was recognised that this state of affairs was unsatisfactory and something needed to be done. Finally, he came to what he dubbed the "Broadmoor Period – or Period of Centralization – the present method of disposal".[128] Within the same article, he delineated "two distinct classes of criminal lunatics", the "unconvicted" and the "convicted" lunatic.[129] He wrote that, in his opinion and in the opinion of his superior at Broadmoor, Dr William Orange, the two classes required "different methods of management and treatment".[130] In 1902, a later Broadmoor superintendent, Dr John Baker, defined the two groups thus: "Criminal lunatics" were those patients who had been deemed insane by a court on a plea that they were insane at the time the criminal act was committed. Distinct from these patients were "convicts and felons", who were found to be insane after conviction, during a custodial sentence. He wrote, "In contradistinction they are termed lunatic criminals".[131]

The lack of specific facilities for the criminally insane was an issue throughout the first half of the nineteenth century. The 1840 Insane Prisoners Act authorised the transfer of any insane prisoner to an asylum.[132] If two Justices of the Peace certified a prisoner insane, either before or after trial, the prisoner could then be transferred to an asylum. The provision applied to anyone confined by consequence of a capital or a criminal offence, or any summary conviction other than civil process.[133] In 1816, Bethlem became the first institution in England to have specialist wards or wings for the criminally insane. In order to establish the State Criminal Lunatic Asylum, two

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[128] Ibid., p. 166.

[129] Ibid., p. 179

[130] Ibid., p. 166.

[131] John Baker, MD, "Female Criminal Lunatics: A Sketch". *Journal of Mental Science (now The British Journal of Psychiatry)* vol. 48 (1902), pp. 13-28, p. 16.

[132] 3&4 Vict. c.54 An Act for Making Further Provision for the confinement and Maintenance of Insane Prisoners, 1840.

[133] Walker, *Crime & Insanity Vol 1*, p. 204.

independent blocks (one male and one female) were built. They were administered by the Hospital authorities but maintained at government expense and controlled by the Home Office. [134] Bethlem was the sole such establishment in England and Wales until 1848, when accommodation for less dangerous criminal patients was created at Fisherton House Asylum, near Salisbury. The two asylums could only provide a small number of places for the criminally insane, so other criminal lunatics were housed in county and borough asylums or remained in prison.[135]

By 1851, the number of criminal patients in ordinary private or public asylums had increased to 264 and it was said that the borough and county asylums held more criminal lunatics than Bethlem or Fisherton House together.[136] The Lunacy Commissioners called for the establishment of a separate asylum for criminal lunatics, as they believed that the county and borough asylums were unsuitable for purpose. Lord Shaftesbury, a supporter of the establishment of a dedicated asylum for the criminally insane, quoted a list of reasons against keeping the criminally insane in institutions with the other patients. He concluded, "It is unjust to ordinary patients to associate them with persons branded with crime. The lunatic is generally very sensitive and … [can] feel aggrieved and degraded by association".[137] General opinion was that the presence of criminal patients took attention away from ordinary patients and so damaged the curative atmosphere in the asylum. This was backed by the reports from the Commissioners in Lunacy, which had canvassed the opinion of various asylum

[134] Harvey Gordon, *Broadmoor* (London: Psychology News Press, 2012). Chapter 1.

[135] Ibid., Chapter 1.

[136] Harvey Gordon & Vivek Khosla, "The interface between general and forensic psychiatry: a historical perspective" *Advances in Psychiatric Treatment.* vol. 20 no. 5 (2014) pp. 350-358.

[137] Anthony Ashley-Cooper, 7th Earl of Shaftesbury Speech to the House of Lords, 1852, "Criminal Lunatics" House of Lords Debate 18 May 1852 *Hansard 1803-2005* vol. 126 cc. 1230-1244.

medical superintendents on the subject.[138] In 1856, the Government announced that a state lunatic asylum was to be established and, in the same year, acquired a site on the edge of Windsor Forest, near Wokingham in Berkshire. In 1860, the Criminal Lunatics Asylum Act, "The Broadmoor Act", was passed and in 1863, Broadmoor Criminal Lunatic Asylum was established. [139]

In the earlier half of the century, it was the so-called "convict lunatic" or "lunatic criminals" who seemed to be problematic to and who received most antipathy from, the asylum authorities. Whatever their designation in the asylum might be, in reality, all criminal patients were admitted by warrant from the Secretary of State for the Home Office.[140] For this reason, their release, or retention, was also at the behest of the Home Office, even for those admitted from penal custody. In Chapter 4, I address the question of whether the verdict of the courts, the thoughts of the judiciary and the influence of medical ideas, had an impact on the designation and incarceral destination of the homicidal mother. The chapters contribute to the scholarship on criminal lunacy by showing how the changing views of the criminal responsibility and the role of expert opinion evolved over the sixty-year period.

Insanity Defence.

Central to the development of the defence of insanity, was the growing number of medical men giving evidence in court, claiming some knowledge of insanity and its manifestation. Many scholars have discussed this phenomenon, linking it to the

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[138] *Sixth Report of the Commissioners in Lunacy to The Lord Chancellor. (pursuant to Acts 8 & 9 Vict., c. 100, s. 88)*. (ordered, by The House of Commons, to be printed 8th August 1851), p. 20.

[139] 23 & 24 Vict. c.75 Criminal Lunatics Asylum Act 1860.
Mark Stevens, *Broadmoor Revealed: Victorian Crime and the Lunatic Asylum.* (Barnsley: Pen & Sword Books Ltd., 2013), p. 7.

[140] Walker & McCabe, *Crime and Insanity vol. 2*, pp. 58-9.

gradual emergence of medical specialism, specifically in areas of mental illness and "mad-doctoring".[141] The principle of knowing right from wrong was an important part of the M'Naghten Rules. The M'Naghten Rules were formulated in 1843 as guidelines to assist in judicial decisions about whether the accused should be considered as insane. The Rules state that defendants might be considered to be insane if, at the time of the crime was committed, they were oblivious to the consequences of their actions, they had acted under a delusion, or that they were both delusional and unaware. The Rules form a basis for the standard test of criminal liability in relation to potentially mentally-ill defendants in common law to the present day.[142] In principle, when the tests set out by the Rules were satisfied, the accused could be adjudged insane and then sentenced to an indeterminate period of confinement and treatment in an asylum, or similar secure facility, rather than punitive incarceration.

Joel Peter Eigen, in particular, has scrutinised Victorian trials at the Old Bailey, including trials of women charged with child-killing, highlighting the part delusion played in the use of the insanity defence. [143] He argues that jurists and the judiciary expected that there would be proof of some form of delusion before accepting a defence plea of insanity. He suggests that the Victorians were preoccupied with controlling impulses and mastering emotions and that certain forms of insanity were seen to be more "acceptable" than others.[144] In Chapter 3, I expand upon the

[141] Eigen, *Unconscious Crime;* Idem., *Mad-Doctors;* Arlie Loughnan, *Manifest Madness: Mental Incapacity in Criminal Law* (Oxford: Oxford University Press, 2012); Smith, *Trial by Medicine.*

[142] Daniel M'Naghten's Case Enquiry, 1843. United Kingdom House of Lords Decisions. (1843) M'Naghten's Case UKHL J16 (19 June 1843). Daniel J R Grey, "Discourses of Infanticide in England, 1880-1922" (Unpublished PhD Thesis. University of Roehampton. 2008), pp. 204-205.

[143] Eigen, *Unconscious Crime,* p. 184.

[144] Idem., *Mad-Doctors,* p. 160.

importance of contemporary medical and legal theories to support any "proof" that the defendants were unaware of their actions or, if aware, whether those actions were "right or wrong."

The period of 1835 to 1895 was a time when medical practitioners were pursuing an acknowledged professional social status. The growing importance of medical opinion and evidence in all courts including the coroners courts, led to a power struggle between the medical and the legal worlds. The official post of coroner could be filled either by a lawyer or by a medical man, and led to some public conflict between the professions. [145] When writing about the Victorian social alarm about the high incidence of illegitimate infanticide, Anne Higginbotham suggests that medically-qualified coroners may have had some self-interest in reporting in such infanticide as a social problem.[146] Medically-qualified coroners suggested that they would have "powers of their professional epistemology" to fulfil the role, whereas lawyers believed that legal knowledge was a superior tool to advise an inquest jury.[147] Within the higher courts, barristers and judges would question the veracity and accuracy of medical evidence and, on occasion, question the professional probity of a medical witness.[148] In the thesis, particularly in Chapters 2 and 3, I discuss and demonstrate whether this "conflict" between the two professions impacted upon the success or failure of a plea of insanity

[145] Ian Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest, 1830-1926* (London: Routledge, 2000), p. 17.

[146] Higginbotham, "Sin of the Age", p. 324.

[147] Burney, *Bodies of Evidence,* p.19.

[148] Smith, *Trial by Medicine*, p. 7.

Criminal women.

Nineteenth-century female crime and the law in Britain have been the focus of scholarship for many years.[149] Lucia Zedner writes that, up to the mid-nineteenth century, dominant opinions about women and crime were driven by morality.[150] Where a male offender was immoral, the female criminal was considered deviant and depraved.[151] Views of female crime and criminality were tied in with society's views of the norms of female conduct and behaviour. Zedner also states women's crime was considered an act of deviance against the ideals of womanhood and femininity.[152] Contemporary policy believed that the failings in an woman's character which had led to deviant behaviour, would be "cured" through a number of processes, penal regimes and incarceration.[153] Michel Foucault's theories on incarceration described in *Discipline and Punish* can be viewed as partly relevant to nineteenth-century views of state incarceration of criminals.[154] He contended that a criminal was an enemy of the state and that observation and surveillance were an intrinsic part of incarceration. By watching and disciplining, society would create well-ordered individuals, ideally suited for an efficiently-run industrial age.[155]

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[149] See examples: Caroline A. Conley, *Certain Other Countries: Homicide, Gender and National Identity in Late Nineteenth-Century England, Ireland, Scotland and Wales* (Columbus, OH: Ohio State University Press, 2007); Shani D'Cruze & Louise Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke: Palgrave Macmillan, 2009); Katherine D. Watson, *Poisoned Lives: English Poisoners and their Victims* (London & New York: Hambledon, 2004); Lucy Williams & Barry Godfrey, *Criminal Women. 1850 – 1920* (Barnsley: Pen & Sword, 2018); Lucia Zedner, *"Women, Crime and Custody.*

[150] Zedner, "Women, Crime, and Penal Responses", p. 308.

[151] Ibid., p. 321.

[152] Ibid., p. 309.

[153] Williams & Godfrey, "Find the Lady'", p.118.

[154] Michel Foucault, *Discipline and Punish*: *The Birth of Prisons*, trans by Alan Sheridan (London: Penguin New Ed, 1991).

[155] Foucault, *Discipline and Punish.*

Legal and judicial opinion about female criminal violence, particularly towards mothers who had killed their children, began to alter in the latter years of the eighteenth century.[156] Scholarship suggests that one response to female criminal violence was to attribute such behaviour to psychological, emotional and medical reasons.[157] It was still considered that, although deviant behaviour lay behind female crime, such deviancy was caused by mental problems, rather than moral deficiency.[158] This concept, that there was a tangible "scientific" reason for female violent crime, became widely accepted. [159] The principle that women would only become violent and commit infanticide through emotionally-driven stress and mental illness, increasingly impacted upon court cases and sentencing.[160] Consequently, the role of medical men and "mind-doctors" grew in significance in the courts when such cases were prosecuted. During the century, the influence of quasi-scientific, medical reasons which explained how and why a woman's behaviour could change from normal to deviant, were accepted by the criminal justice system.[161] This "medicalisation" of the female criminal mind, particularly when applied to the seemingly irrational act of

[156] Kilday, *A History of Infanticide*, p. 166.

[157] For example: Kilday, *History of Infanticide*, pp. 167-182; Grey, "No Crime to Kill", pp. 50-51; Marland, "Getting Away with Murder?" pp. 170-171; Dana Rabin, "Bodies of Evidence, States of Mind: Infanticide, Emotion and Sensibility in Eighteenth-Century England", in Jackson (ed.), *Infanticide*, pp. 73-92; Smith, *Trial by Medicine*, pp. 143-148; Ania Wilczynski, "Mad or Bad? Child killers, Gender and the Courts", *British Journal of Criminology*, vol. 37, no. 3 (1997), pp. 416-36, p. 417; Lucia Zedner, *Women, Crime and Custody*.

[158] Zedner, "Women, Crime and Penal Responses", p. 337.

[159] Ibid., p. 338.

[160] Kilday, *History of Infanticide*, p. 166; Smith, *Trial by Medicine*, p. 147.

[161] Zedner, "Women, Crime and Penal Responses", p. 308.

sudden maternal violent behaviour, impacted the opinions of the male-dominated medical and legal authorities.[162]

The discussion about contemporary attitudes to female crime and incarceration also highlights the part that cultural mores and expectations played in the representation of the accused mother in the various courts. Zedner states that descriptions of crime in court frequently referred to the female offender's social background. She asserts that such discussion, outwith the crime itself, was to build-up a negative picture of the offender's character.[163] I contend that the opposite is also true, that such information was used to cast the accused homicidal mother in a positive light. Zedner suggests that how far the intelligence about the female offender's credentials, impacted on sentencing patterns is unknown. [164] In this thesis, I consider the reactions of all protagonists in the courtroom (judges, lawyers, jurists and medical and lay witnesses) with the factors of marital status, respectability and class. I argue that Zedner's "irrelevant" information, did have a vast effect on the court and post-trial experiences of the mothers in my dataset.[165]

The impetus to find an explanation for the extraordinary crime of maternal child murder, was apparent at all stages of the women's passage through the various courts and in the asylums. In this thesis, I consider and discuss why the mothers in my dataset were considered to be female criminals on one hand, but on the other, worthy of special legal attention. It appears that while they had committed a deviant, criminal act, they were not portrayed as morally deficient, but as medically and mentally unwell.[166] The impact of differing notions of family and parenthood, perceptions of

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[162] Clive Emsley, *Crime and Society in England 1750-1900* (London: Pearson Longman, 2005), pp. 152-153; Zedner, "Women, Crime and Penal Responses", p. 308.

[163] Zedner, "Women, Crime and Penal Responses", p. 321.

[164] Ibid., p. 321.

[165] Zedner, *Women, Crime, and Custody*, p. 30.

[166] Ibid., p. 270.

respectability upon medical, legal and public opinion of the accused mothers, offer, in part, an insight into the rationales behind the answer to the question – why were the women of my dataset perceived and treated in the way they were?

Asylums and concepts of insanity

The sixty-year period between 1835 and 1895 was an era of expansion in the asylum system, a time when the asylum became established in the social landscape of the country. Between 1845 and 1890 more than sixty asylums, including Broadmoor, were founded and built. They were built mainly in rural locations away from crowded urban centres, which were perceived as injurious to a calm mental state. [167] While this might sound idyllic, the reality could be very different. Nineteenth-century asylums were complex institutions, each differing from the other depending on each individual establishment's administrative and medical authority.[168] The first hospital for the insane in England was Bethlem Royal Hospital. Founded as a priory dedicated to St Mary of Bethlehem in 1247, it became known as Bethlem Hospital in about 1330 and from about 1403 onwards, housed insane patients.[169] Bethlem was the first state criminal asylum in England until the wards were opened at Fisherton House. These specific facilities proved inadequate and consequently in the mid-nineteenth century, many criminal patients were admitted into county and private asylums.[170] Broadmoor Criminal Lunatic Asylum opened in 1863 and became the sole dedicated institution for those found insane by law. The initial patient population in 1863 was all female,

[167] Elaine Murphy, "The Administration of Insanity 1800-1870" in Roy Porter & David Wright (eds.) *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge: Cambridge University Press, 2003), pp. 334-349, p. 348.

[168] Ibid., pp. 348-349.

[169] Patricia Allderidge, *Bethlem Hospital 1247-1997* (Chichester: Phillimore & Co Ltd., 1997).

[170] Walker & McCabe, *Crime & Insanity, vol. 2*., pp. 4-5.

with the first 100 patients being transferred from Bethlem and Fisherton House. The first male patients arrived at Broadmoor in early 1864. [171]

There have been many publications on the social history of madness, on the treatments used in asylums and on the patients themselves. A great deal of the scholarship has been based upon in-depth analysis of hospital and institutional archival material and the ensuing works have been thought-provoking and informative.[172] Michel Foucault wrote that asylum systems in the eighteenth and nineteenth centuries, which periods he dubbed "the Age of Confinement", were created to control social deviance, achieved by institutional incarceration of the insane and the undesirables of society.[173] His view was critiqued by Andrew Scull for not accounting for historical context and narrative, which omission Scull has subsequently redressed.[174] Scull has written widely about the development of the web of county asylums in the nineteenth century and he attributes the increase in asylum admissions to the great socio-economic changes of the century.[175] He argues that the development of a more commercial society in the late eighteenth and early nineteenth century, had led to the

[171] Stevens, *Broadmoor Revealed*, p. 12.

[172] W. Ll. Parry-Jones, *The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Century* (Oxford: Routledge, 1972 [rep. 2007]); Joseph Melling, Bill Forsythe & Richard Adair, "Families, Communities and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914" in Peter Bartlett & David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community* 1750-2000 (London & New Brunswick: The Athlone Press, 1999), pp. 153-180; L. D. Smith, *Cure, Comfort and Safe Custody*.

[173] Foucault, *History of Madness.*

[174] Andrew Scull, "Rethinking the history of asylumdom" in Melling & Forsythe (eds), *Insanity, Institutions and Society*, pp. 295-315.

[175] Idem., *The Most Solitary of Afflictions: Madness and Society in Britain. 1700-1900* (New Haven & London: Yale University Press, 1993); Idem., *Madness. A Very Short Introduction* (Oxford: Oxford University Press, 2011); Idem., "Rethinking the history of asylumdom" in *Insanity, Institutions and Society*.

growth of working-class regulation, particularly by a new "bourgeois" intelligentsia.[176] In other works, Scull suggests that, after 1834, the public associated county asylums with the "hated" Poor Law, estimating that 90% of the "institutionalised mentally ill" were administered through the Poor Law mechanism. Families would institutionalise their mentally-disordered members because they were unable to work and contribute to the household economy, implying that madness was a class issue, a problem confined to the less well-off. [177]

Essentially, this is a Marxist view of historical class dynamics, not one totally borne out within this thesis, nor within other appraisals of the social history of madness.[178] Scull does, specifically, note that it is difficult to ascertain how asylums were viewed by lower socio-economic groups, as evidential material about working-class opinion of public asylums is very limited.[179] Roy Porter, writing in 1985, spoke of the importance of interpreting the history of the asylum through the patients' experiences and of writing it as "medical history from below".[180] More recently, scholars have focussed on the experiences of asylum patients and through their research in asylum archives, the voices of the inmates are beginning to be heard.[181]

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[176] Scull, *Most Solitary of Afflictions.*

[177] Idem., *Madness,* p.54.

[178] Peter Bartlett, "The Asylum and the Poor Law: the productive alliance", in Joseph Melling & Bill Forsythe (eds), *The Politics of Madness: The State, Insanity and Society in England 1846-1914* (London and New York: Routledge, 2006), pp. 48-67.

[179] Andrew Scull, "Museums of Madness Revisited" *Social History of Medicine*, Vol 6, No 1, (1993), pp. 3–23.

[180] Roy Porter, "The Patient's View: Doing History from Below" *Theory and Society,* vol.14 (1985), pp. 175-98

[181] For example: Cara Dobbing, "The Circulation of the Insane: The Pauper Lunatic Experience of the Garlands Asylum, 1862-1913" (unpublished PhD Thesis: University of Leicester, 2019); Stef Eastoe, *Idiocy, Imbecility and Insanity in Victorian Society: Caterham Asylum, 1867-1911* (Cham: Palgrave Macmillan, 2020); Louise Wannell, "Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-

As asylums became an established part of Victorian society, so perceptions of mental disorder subtly changed. Victorian doctor, John Conolly, wrote unambiguously about treatment of the insane in early eighteenth century England.[182] He described the treatment as brutal and distressing; the use of cages and restraints was supplemented with "quack" remedies and substances such as mercury and camphor, with oil and white wine. Therapies included purging, bleeding and forced vomiting.[183] These were administered in an attempt to reduce the frenzy and to weaken the spirits which supposedly caused madness. According to the prevailing view of insanity, the lunatic had lost "the essence of his humanity - and so had lost his claim to be treated as a human being". [184] As Michel Foucault states in *Madness and Civilization*, it was conceived that a madman's "unchained animality could be mastered only by discipline and brutalizing." By such reasoning, the use of forcible physical restraint could be justified as a means of controlling the insane.[185]

Treatments of Insanity.

Treatment of madness changed considerably, with the evolution of the science of mad-doctoring and changing interpretations of the causes of insanity.[186] In the latter

1910", *Social History of Medicine.* vol. 20. no. 2 (2007), pp. 297-313; Jade Shepherd, "Life for the Families of the Victorian Criminally Insane", *The Historical Journal* vol. 63 no. 3 (2019), pp. 603-632.

[182] John Conolly, *Treatment of the Insane without Mechanical Restraint* (London: Smith, Elder & Co., 1856), pp. 12-16.

[183] John Conolly, (1794-1866). Superintendent of the Middlesex County Lunatic Asylum at Hanwell 1839-1844. Conolly introduced changes in asylum care at Hanwell based its treatment on humane principles of non-restraint and moral therapy. He was influential in the overall changes in practice in all asylums.

[184] Conolly, *Treatment of the Insane* p. 16.

[185] Michel Foucault, *Madness and Civilisation*, p. 79.

[186] Jonathan Andrews, "The Rise of the Asylum in Britain" in Deborah Brunton (ed.), *Medicine Transformed: Health, Disease and Society in Europe 1800-1930* (Manchester:

stages of the eighteenth century, brutal "physicking" gave way to a new approach in the care and treatment of lunatics centred benevolently managing their disorders.[187] This fundamental change to asylum treatment of the mad was moral therapy or moral treament, developed at the York Retreat by Samuel Tuke.[188] In the early years of the nineteenth century, medical treatments based on the methods used for physical ailments such as purging, bleeding and blistering and the use of restraint and confinement were still commonplace. [189] Even as the perceptions and physical care of madness changed and moral therapy gradually became widely accepted in all asylums, existing treatment methods were still used.[190]. Jennifer Wallis notes that some reliance was placed on the health of the physical body, to explain the patient's mental state. [191] Symptoms such as a "coated tongue" or "a weak and irregular pulse" were noted as indications of abnormal health, with possible effects on the mind.[192]. Case book notes

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Manchester University Press. Milton Keynes: The Open University, 2004), pp. 298-326, p. 300.

[187] Jennifer Wallis, *Investigating the Body in the Victorian Asylum. Doctors, Patients and Practices* (Basingstoke: Palgrave Macmillan, 2017), p. 86.

[188] Samuel Tuke (1784–1857) was a Quaker philanthropist and the grandson of William Tuke co-founder (with Samuel's father, Henry) of the York Retreat. In 1811 Samuel published *On the Treatment of those labouring under Insanity, drawn from the Experience of the Retreat,* (York: W. Alexander, 1813) in which he described the Retreat's method of treatment for insane patients. He called the regime "moral treatment" borrowing the term from the French description of Philippe Pinel's work as "traitement moral". The use of the word "moral" was more akin to "morale" in the sense of the emotions and self-esteem, rather than a judgment of behaviour. Michael Brown, *Performing Medicine. Medical Culture and Identity in Provincial England c. 1760-1850* (Manchester: Manchester University Press, 2011).

[189] Andrews, "The Rise of the Asylum", p. 300.

[190] L. Smith, *Cure, Comfort and Safe Custody.*

[191] Jennifer Wallis, *Investigating the Body in the Victorian Asylum. Doctors, Patients and Practices* (Basingstoke: Palgrave Macmillan, 2017), p. 87.

[192] FHAA, J7/190/6, Fisherton House Asylum Casebooks 1855-1866, Catherine Oliver Patient no. 1821, f. 193.

always recorded health issues and potential problems throughout the nineteenth century and beyond.[193] In the Bethlem casebooks, remedies were described as either being "Internal" or "External". "Internal" treatments included the use of tonics and sedation and "External" included leeching, head-shaving, bleeding and restraint and seclusion. [194] As I show in Chapter 6, not all of these remedies fell away as the century progressed, with the exception of mechanical restraint which was only occasionally used in my studied asylums.[195]

Views of the causes of insanity changed as the century progressed and differed between lay observers and asylum superintendents.[196] David Wright explains that, in his opinion, because the law required the medical superintendents to register a "form of mental disorder" on admission, they had a free rein with the classification of patients.[197] Diagnoses such as "Mania, Melancholia, Dementia and Idiocy", were equally applied to men and women. Wright contends that gendered forms of diagnoses, such as "climacteric insanity" or "ovarian madness" were not in general use before 1880.[198] I demonstrate within this thesis that Wright's first point, did not necessarily apply to the women of my dataset. In Chapters 5 and 6, I discuss the fact that the "form of madness" recorded for a criminally insane female patient was, frequently, that which had been assigned by prison doctors and medical examiners before arrival at the asylum. I have found that Wright's second point is not accurate

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[193] Wallis, *Investigating the Body*, p. 87.

[194] BHRA, ARA-09 Series, Box no. A11/3, Admissions Register 2 April 1841-31 December 1841.

[195] L. Smith, *Cure, Comfort and Safe Custody.*

[196] David Wright, "Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England", Jonathan Andrews and Anne Digby (eds) *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (New York: Rodopi, 2004), pp. 149-176, p. 149.

[197] Ibid., p.152.

[198] Ibid., p.170.

either as some of the dataset women had their madness had been attributed to such causes, all through the period of this thesis.

Moral treatment of insanity was based on ideas of developing renewed self-esteem through keeping the mind and body occupied within a domestic environment, supported by good nutrition and exercise.[199] The therapy advocated a life modelled on the middle-class home, with minimum restraint. Patients and staff would eat and work together, recovery would be assisted by a mixture of praise and blame, reward and punishment, thereby enabling the mind to recover self-control.[200] There would be little medical intervention, with restraint restricted to the protection and safety of the individual. The regime was designed to give the mentally-disordered time to recover from the stress and pressure of their former lives, with limited use of tranquilisers or hypnotic drugs.[201]

By the middle of the nineteenth century, a form of moral treatment was utilised in all county asylums. Writing in 1882, Dr Daniel Hack Tuke, son of Samuel Tuke, described the then contemporary care of the mad as an enlightened progression, where compassion and sympathetic behaviour had replaced superstition, ignorance, cruelty and general barbaric behaviour.[202] He propounded that such treatments highlighted Victorian society's modern progressive attitudes towards insanity.[203] Unfortunately, as the century progressed and asylums grew in size, some of the finer points became

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[199] Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), pp. 51-53.

[200] Digby, *Madness, Morality and Medicine*; Roy Porter, *Madness. A Short History* (Oxford; Oxford University Press. 2010), p. 104.

[201] Digby, *Madness, Morality and Medicine*, pp. 53.

[202] Daniel H. Tuke, *Chapters in the History of the Insane in the British Isles* (London: Kegan Paul, Tench & Co., 1882).

[203] Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press Ltd., 2006), pp. 4-5.

diluted. Moral therapy as a regime had become a method of management of inmates, rather than a therapeutic system.[204] Daniel Tuke's high Victorian idealism was challenged by Foucault and Scull as imperialistic. Foucault described the therapeutic, moral treatments as coercive, a way to systematically control the insane who were considered as social outcasts.[205] He described Tuke's therapy as a scheme of treatment as one which replaced the fear of madness with the "anguish of responsibility".[206] Foucault linked nineteenth-century treatments for madness with punishment and a desire for regulated behaviour, submitting that they were aimed at imposing contemporary moral standards on the insane.[207] Scull took this point further describing Victorian alienists as "moral entrepreneurs", men who coupled moral therapy with non-restraint to create a regime which could only be administered by medical practitioners. He called it professional imperialism, created for and by doctors' self-interest. [208]

The reality is more nuanced. Moral therapy, as a treatment given in asylums, was originally developed with a well-intentioned purpose of providing meaningful care. [209] Thomas Dixon argues that moral treatment could be viewed as humane and ethical compared with earlier repressive and intrusive regimes.[210] Moral therapy was generally accepted as the treatment which had the potential for alleviate symptoms of

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[204] Anne Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014).

[205] Foucault, *History of Madness*; Scull, *Most Solitary of Afflictions.*

[206] Idem., *Madness and Civilisation*, p.234.

[207] Foucault, *History of Madness*

[208] Scull, *The Most Solitary of Afflictions* p. 179.

[209] Digby, *Madness, Morality and Medicine*, pp. 53.

[210] Thomas Dixon "Patients and passions: Languages of Medicine and Emotion 1789-1850" in Fay Bound Alberti (ed) *Medicine, Emotion and Disease, 1700-1950* (Basingstoke: Palgrave Macmillan, 2006), pp. 22-52, p.43.

madness through calming the patients' own emotions.[211] While the enduring image of an asylum doctor is one of a dominant patriarch, controlling a despotic regime within the asylum, it is simplistic to assert that the main impetus for Victorian mental health practitioners stemmed from an imperialistic desire for control of the vulnerable.[212]

Women and insanity

The associations drawn between women and insanity during the Victorian period are complex. Elaine Showalter contends that the subordinate social position of women as daughters, wives and mothers, led to contemporary theories that they were emotionally vulnerable and predisposed to mental imbalance. [213] David Wright, like other scholars, does not agree with Showalter's assertion that exploitation of women's mental vulnerability by men, led to a high female asylum population.[214] However, without doubt, it had long been believed that insanity in women was attributable to the female reproductive system.[215] It was well-established that women could suffer mental instability both pre- and post-partum and that the post-partum period could last as long as a woman was lactating.[216] In Great Britain, it was not until 1820, following the publication of Robert Gooch's treatise, *Observations on Puerperal Insanity*, that the condition was categorised as a specific, possibly inescapable, problem.[217] By the mid-

[211] Ibid., p. 42.

[212] Ibid., p. 179.

[213] Elaine Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (London: Virago, 1985), p. 55.

[214] See examples: Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996), pp. 13-14. Digby, *Madness, Morality and Medicine*, p. 174; Wright, "Delusions of Gender?", pp.150-151.

[215] Kilday, *History of Infanticide*, pp. 166-167.

[216] Marland, *Dangerous Motherhood*, pp. 9-15.

[217] Robert Gooch, *Observations on Puerperal Insanity* (London: G. Woodfall, 1820) cited in Grey, "No Crime to Kill", p. 50.

nineteenth century, the notion that a mother could be driven to kill her infant or older child as result of a transitory attack of vicious mental derangement, was well established in England and Wales.[218]

Hilary Marland writes, "no nineteenth-century textbook on diseases of women was complete without a section on puerperal insanity".[219] Mothers who were said to be puerperally insane could be violent towards themselves, their families and their babies and unaware of, or unable to control, such tendencies.[220] The subject of puerperal mania in the nineteenth century is the subject of an excellent body of research and scholarship.[221] Hilary Marland's detailed examination of the topic in her book *Dangerous Motherhood*, is a succinct analysis of the subject.[222] Marland asserts that puerperal insanity was a diagnosis of mental illness which appealed to Victorian clinicians and lay people alike. At a time of heightened anxiety about the dangers of childbearing, and social fears about infanticide and child-killing, puerperal mania was seen to be tangible cause of insanity.[223]

Meg Arnot suggests that, in raising the issue of insanity as a defence in trials of women accused of child-killing, the medico-legal world was demonstrating an

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[218] Grey, "No Crime to Kill", p. 50; Marland, *Dangerous Motherhood*, p. 167.

[219] Hilary Marland, "'Destined to a Perfect Recovery': The Confinement of Puerperal Insanity in the Nineteenth Century", in Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions and Society 1800-1914* (London: Routledge, 1999), pp. 137-156, Quotation p. 140.

[220] Marland, *Dangerous Motherhood.*, p.3.

[221] Marland, "Destined to a Perfect Recovery" Melling & Forsythe (eds.) *Insanity, Institutions and Society* pp. 137-156; Idem., "Getting away with Murder? Puerperal Insanity, Infanticide and the Defence Plea" in Jackson (ed) *Infanticide,* pp. 168-192; Idem., *Dangerous Motherhood.*; Idem "Under the Shadow of Maternity": Birth, Death and Puerperal Insanity in Victorian Britain. *History of Psychiatry*, Vol 23 no. 1. (2012) pp. 79-90; Catherine Quinn. "Include the Mother and Exclude the Lunatic. A Social History of Puerperal Insanity, c 1860-1922." (Unpublished PhD Thesis. University of Exeter, 2003).

[222] Marland, *Dangerous Motherhood*, pp. 3-7.

[223] Ibid., p7.

acceptance of the existence of intimate connections between women's physiology and their minds.[224] The medical conviction, that all stages of motherhood could lead to violent behaviour in women, was brought to the attention of the legal audience through the presentation of such medical evidence in court cases.[225] The belief that the condition was responsible for many cases of infanticide and child murder had significant consequences for the medical and legal treatment of these cases. Puerperal insanity gave the legal world an explanation for what was perceived to be an inexplicable crime, the killing of a vulnerable child by its mother.[226]

Daniel Grey states that puerperal insanity accounted for about 10 per cent of all British women's asylum admissions. [227] Looking at the admissions to the asylums analysed within this thesis, the majority of cases were said to be suffering from insanity associated with a woman's life-cycle and, in particular, causes associated with the puerperal state. An acceptance that the puerperal state could have drastic impact on a woman's mental health, was an important constituent in the armoury of the expert medical witness, whose role in coronial and judicial courts grew in this period. Marland highlights the concerned compassion of the medical profession towards women admitted to asylums suffering from puerperal insanity [228] She also argues that their exculpatory diagnoses of puerperal insanity, encouraged leniency in the legal system.[229] Combined with this, the asylum was promoted as a place for cure, even for those mothers who had killed their children. They would not be imprisoned but would

[224] Arnot, "Gender in Focus", p. 200.

[225] Marland, "Getting away with Murder?", p. 169.

[226] Idem., *Dangerous Motherhood,* p. 200.

[227] Grey, "No Crime to Kill", p. 51.

[228] Marland, *Dangerous Motherhood,* p. 171.

[229] Ibid., p. 171.

be better served in lunatic asylums, where they would be cured of their insanity rather than punished. [230]

Women and asylums - control or cure?

Michel Foucault's theories about institutional social control of deviance could be said to apply to the particular section of the asylum population studied for this thesis.[231] Foucault described the therapeutic treatments as coercive, a way to systematically control the insane who were considered to be social outcasts.[232] By the nature of their admission to an asylum as criminally insane, the women of my study would be subjected to a degree of coercion to conform to social expectations of female behaviour. Marland suggests that many doctors found some satisfaction in treating insanities with a high success rate of alleviation and cure.[233] Louise Hide writes that such satisfaction came from an accomplishment of the doctors' real intention, which was to restore the woman to the heart of her family and home, her "rightful place".[234] While in part this could be true, I would argue that the medical men's compassion and the wish to cure their patients, was also a function of benevolent patriarchy. Foucault argued that paternalistic benevolence, observation and expectations were themselves intrinsically repressive and controlling.[235]

Once in an asylum, the women of this study were subject to the same therapeutic treatment as any other patients, as they were considered to be potentially

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[230] Ibid., p. 172;

[231] Michel Foucault, *Madness and Civilisation*; Ibid., *History of Madness*.

[232] Ibid., *History of Madness*.

[233] Hilary Marland, "Disappointment and Desolation: women, doctors and interpretations of puerperal insanity in the nineteenth century", *History of Psychiatry* vol.14 no. 3 (2003) 303-320, p. 304.

[234] Louise Hide, *Gender and Class in English Asylums, 1890-1914.* (Basingstoke: Palgrave Macmillan, 2014), p. 144.

[235] Foucault, *Madness and Civilisation.*

curable. They were seen as “different” because their insanity had been manifested in a violent criminal act but that fact did not put them into the incurable bracket. [236] Marland describes Showalter's claim that “English psychiatric treatment of nervous women was ruthless, a microcosm of the sex war intended to establish the male doctor’s total authority", as an over-simplification of the doctor-female patient relationship in the nineteenth century.[237] Marland believes that medical men were highly sympathetic to the women's plight, seeking explanations beyond the obvious for their illness. [238] She suggests that they acted in a protective manner to ensure that their patients were sufficiently recovered, before they left their care.[239] Culturally, it was expected that their duty as men was to fulfil a protective role towards the weaker and more vulnerable of society, such as the women of my dataset.[240] The clinicians’ attitude towards female patients was, to a great extent, influenced by a belief that women were more prone to suffer from mental disorder, due to their perceived female frailties.[241] Contemporary cultural expectations of women and motherhood meant that a criminally insane mother’s conduct, both before and during incarceration, was viewed as abnormal and unacceptable. In Chapter 5, I explore whether or not the treatment regime within the asylums was, as has been claimed, a way to indoctrinate the female patients with womanly virtues.[242]

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[236] Hilary Marland, “Languages and Landscapes of Emotion: Motherhood and Puerperal Insanity in the Nineteenth Century” in Bound Alberti (ed) *Medicine, Emotion and Disease,* pp.53-78; Idem., *Dangerous Motherhood* p. 200

[237] Showalter, *Female Malady*, p. 137.

[238] Marland, *Dangerous Motherhood*, p. 8.

[239] Ibid., p. 9.

[240] Anne Shepherd, “The Female Patient Experience in Two Late-Nineteenth Century Surrey Asylums”, in Andrews and Digby (eds), *Sex and Seclusion*, pp. 223-248, p.243.

[241] Marland, *Dangerous Motherhood*, p. 8.

[242] Hide, *Gender and Class*, p. 144; Shepherd, “The Female Patient Experience”, p. 225: Showalter, *Female Malady*, p. 54.

Asylum clinicians and other medical men believed that patients had an excellent prospect of making a rapid and full recovery from conditions to do with the puerperal state. Marland agrees that, for some, their successes led to an element of self-congratulation and arrogance.[243] The interactions between all parties were intricate and multi-faceted, open to more than one interpretation, varying between doctors and patients. Chapter 6 is a detailed examination of the role of the asylum medical superintendents, together with an analysis of their dealings with the homicidal mothers in their care. I analyse and assess the influence of the "man at the top" on the medical and therapeutic environment of the asylum. Examination of their personal and professional biographies explores whether Marland's and Hide's assertions were reflected in the studied asylums.

Discharges from nineteenth-century asylums have been investigated by Jonathan Andrews, Hilary Marland, Joseph Melling, Bill Forsythe, Peter Bartlett and David Wright amongst others, each analysing different aspects of release.[244] Of most relevance to this thesis, is Jonathan Andrews' review of discharges of female infanticidal patients from two criminal lunatic facilities, Broadmoor and the Perth Criminal Lunatic Department in Scotland.[245] Andrews' survey covers a wide range of issues considered by the authorities when they reviewed a case for possible discharge. His discussions about the circumstances and background to the release of women from Broadmoor are particularly pertinent to my research. Co-operation and engagement

[243] Marland, "Disappointment and Desolation", p. 304.

[244] Marland, *Dangerous Motherhood*; Joseph Melling, "'Accommodating Madness': New Research in the Social History of Insanity & Institutions" in Bartlett & Wright (eds), *Insanity, Institutions and Society*, pp. 1-30; Peter Bartlett & David Wright, "Community care and its Antecedents" in Bartlett & Wright, *Outside the Walls of the Asylum*, pp. 1-18; David Wright, "Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century", *Social History of Medicine*, vol.10 (1997), pp. 137-155.

[245] Andrews, "The boundaries of Her Majesty's Pleasure", pp. 216-248.

with asylum life were significant considerations in discussions about discharge and so are further examined in Chapter 7.[246] The chapter summarises and analyses the contemporary deliberations and considerations surrounding the possible discharge, or retention, of criminally insane homicidal mothers from the various asylums. I discuss whether compliance, or indeed non-compliance, with asylum regimes was a demonstration of patient agency in the asylum, and whether that agency impacted on discharge decisions. Within this, I analyse whether a perceived return to socially acceptable "proper" behaviour, was taken as an indicator of recovery. The chapter also includes discussions of the reasons behind long-term retention for some patients who remained in incarceration until death. This thesis will significantly add to the scholarship about nineteenth-century care for the mentally ill, with a focussed discussion of a specific patient group and their experiences of nineteenth-century asylums.

Sources and Methodology

For this thesis, I have developed a dedicated database to control and interrogate records for the 288 subject women and their life-courses. I analysed asylum records, medical literature, trial transcripts and newspaper reports, to trace the women's life-careers through the legal and medical systems over a sixty-year period. My work is illustrated by several case studies or micro-histories. Microhistory, as a method of study, analyses and chronicles the dealings of individuals and small sets of people to find concepts, principles and practices which impact upon their lives. Background biographies for individuals have been created through research carried out in a number of online digital archives. Genealogical websites have been important in gathering data to build personal

[246] Ibid., pp. 233-246.

profiles of the women, thereby enriching their histories and background.[247] Using Microsoft Access to interrogate the database, I undertook a statistical analysis of 288 mothers who killed one or more of their children and were committed to various institutions as insane, between 1835 and 1895. I have created statistical charts and tables which illustrate and support, my argument throughout this thesis.

Although they are available, the existence and retention, of institutional records is sparser for the earlier years of the period. The sparsity can be partially attributed to the fact that the state-provided facilities for the criminally insane were woefully inadequate from 1835 to 1863. Mothers acquitted as insane could be sent to county asylums, retained in prison or released and any surviving records are well-spread over a number of archives. The small, specialist provision at Bethlem Royal Lunatic Asylum and that at Fisherton House Asylum in Salisbury, took some cases but there was no coherent pattern of incarceration in one of these institutions. The clinical records for Bethlem are all digitally available and those for Fisherton House are freely accessible at the Wiltshire History Centre.[248] Both archives have provided a vital source for research into the patients' experiences in the early part of the period.

In the case of Broadmoor, the asylum records are closed to researchers until 100 years after a patient's death. The records for discharged patients whose date of death is unknown, are opened 160 years after their birth date. As the Broadmoor casebooks for 1863 to 1895 are sizeable volumes and contain records for all patients, they are closed until 2034. However, within the Broadmoor Archive, there is a particularly rich source of information held in individual case files. A case file was

[247] The genealogical websites used are www.ancestry.co.uk and www.findmypast.co.uk. Both sites also are sources of government and legal documents.

[248] Bethlem Royal Hospital's (BHRA) records are available at www.findmypast.co.uk and at www.archives.museumofthemind.org.uk. Fisherton House Asylum (FHAA) records are available in the Old Manor Mental Hospital Archive, held at the WHCC.

created for each patient on entry, the majority of which are open for research for the admissions between 1863 and 1895. The case files can contain draft medical reports, Home Office correspondence and official warrants and transfer documentation. The files sometimes include letters from family members, occasionally from the subject themselves, as well as memoranda and other relevant ephemera, all of which contain information about a patient's social circumstances.

My investigation into the homicidal mothers' personal and emotional lives and treatment within the asylum system, has been achieved through an interpretive reading of casebook notes, official correspondence and administrative documents. Numerous works exploring the asylum experience from the patient's point of view have highlighted the difficulties of obtaining individual testimony in the case of pauper patients.[249] Catharine Coleborne has written recently about using asylum archives and cases as stories.[250] She describes the study of the history of the experience of madness as a "complicated process for historians and other scholars."[251] Coleborne suggests that the use of asylum records alone carry an inherent problem because clinical and administrative records were produced about the patients.[252] Through letters held in Broadmoor case files, I have found rare personal reactions from some Broadmoor patients. The majority of the homicidal mothers in Broadmoor were from the working

[249] Examples of specific discussions about the use of primary sources are: Jonathan Andrews, "Case Notes, Case Histories ", pp. 255-281; Brendan D. Kelly, "Searching for the patient's voice in the Irish asylums", *Medical Humanities* vol.42 no. 2 (2016) 1-5; Marland, "Disappointment and desolation"; Leonard D. Smith, "'Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum", *Social History of Medicine* vol.21 no. 2 (2008), 237-252.

[250] Catharine Coleborne, *Why Talk About Madness? Bringing History into the Conversation*, (Cham: Palgrave Macmillan, 2020).

[251] Ibid., p. 15.

[252] Ibid., p. 19.

classes and these particular papers give some insight into the experience of asylum life, particularly from their perspective.

Jonathan Andrews suggests that the case notes could be and probably were, censored by the prudery and prejudice of the Victorian medical officers, especially in the reporting of the sexual language and behaviour of the patients. He emphasises that such notes were not were not written for historians “but for asylum medical staff and for administrators and officials who required to keep tabs on staff and patients".[253] Hilary Marland has a different opinion of the value and content of case book notes, with regard to the relationships between patient and doctor. She found the case books a rich source of social history, in that "they open up a world of direct interaction between the doctors and their patients ... and enable us to explore ... the relationship between women, doctors and mental disorder".[254]

The case books and case files I have examined for this thesis, support both these arguments. The Bethlem casebooks are formal, concerned with medical matters and in a similar manner to those records described by Andrews. Fisherton House’s records are slightly different. The casebooks there are both medical and descriptive, but do not record a patient’s personal experience. Correspondence between the Asylum’s owner and Chief Medical Officer, Dr William Corbin Finch and Whitehall is a rich source of social history. In that particular set of documents there are letters from family members and other interested people. The official case book notes at Bethlem, Fisherton House and Rainhill were written for clinical and medical consumption, as were the equivalent notes available in the Broadmoor case files. As such, they were for reference and use, in the private and official domain of the asylum and were not intended as records of personal reaction to patients and their welfare.

[253] Andrews, “Case Notes, Case Histories”, p. 256.

[254] Marland, “Disappointment and desolation”, p. 305.

Coleborne suggests that, only by supplementing official records with accounts from the patients and their families themselves, can the historian "round out the picture" and produce a meaningful dimension to the stories of "institutionalised people".[255] The individual case files at Broadmoor contain draft and amended documents, draft official documentation and personal and official letters which can have handwritten annotations attached. Unlike the other asylum we do not have access to the official casebooks. The papers give an insight into asylum life and the patient experience, in a rare way. The files document the personal circumstances of the inmates and their families. They contain personal views and opinions about the patients and their progress, all of which adds another dimension to observations on interactions between staff, patients and relatives. Jade Shepherd writes that the ephemera and letters contained in the Broadmoor case files, give a perspective on parenthood and family relationships from a working-class point of view, as well as a middle-class one.[256] Letters from husbands and children to the asylum administration and medical staff tell much about the emotional familial bonds, with surviving letters from some of the patients giving another dimension to the women themselves.

My main sources of information for legal aspects of the women's case-histories, particularly in provincial courts, were newspaper reports about inquest and assize court proceedings. Newspapers played a vital role in constructing the narratives of the subject women's experiences and journeys through the coronial and judicial courts. I have accessed the newspapers of the period through the *British Newspapers Online Archive* and the *Times Digital Archive 1785-2013*. I have also used *Old Bailey Proceedings Online* to analyse those who were tried at the Central Criminal Courts. Joel Peter Eigen used the *Proceedings* transcripts in his extensive studies of Central

[255] Coleborne, *Why Talk About Madness*, p. 19.

[256] Jade Shepherd, "Life for the Families of the Victorian Criminally Insane", *The Historical Journal* vol. 63 no. 3 (2019), pp. 603-632.

Criminal Courts trials.[257] In one article, he describes them as offering "not only the voice of the [...] specialist in mental medicine but also the language employed by the judge, attorney, lay witness and jurors who occasionally questioned the medical witness directly. In some trials, the most audible voice belongs to the prisoner himself".[258] That being said, the transcripts are not full accounts of everything that was said during a trial; for instance, legal arguments were often omitted from the proceedings. For this aspect of Old Bailey trials, I again used *British Newspapers* and the *Times* archives.

Emotion and sentimentality played an important role in popular culture throughout the Victorian period. Press reportage could be very descriptive and vivid and, on occasion proscriptive, about all protagonists' reactions. With regard to the courtroom, Martin Wiener argues that the press used gender as a method "to draw sympathy for ... women, even though (or perhaps because) juries, bar and bench were all male".[259] Wiener contends that Victorian newspapers and periodicals were vehicles for disseminating differing views. This observation has been largely borne out by my research. Depending on their audience, I have found that newspaper articles would highlight different aspects and attitudes. The views expressed by the press to do with class and gender and opinions about the role of personal guilt, responsibility and punishment, would aim to mirror those of the individual newspapers' target readership.[260]

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[257] Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-Doctors in the English Court*; Idem., *Unconscious Crime: Mental Absence and Criminal Responsibility in Victorian London*: Idem., *Mad-Doctors in the Dock. Defending the Diagnosis, 1760-1913*.

[258] Idem., "'Diagnosing homicidal mania': Forensic Psychiatry and the Purposeless Murder". *Medical History* vol. 54, no. 4 (2010) pp. 433-456, p. 435.

[259] Martin J. Wiener, "Convicted Murderers and the Victorian Press: Condemnation vs. Sympathy". *Crime and Misdemeanours* vol. 1, no. 2 (2007), pp. 110-125, p. 112.

[260] Wiener, "Convicted Murderers and the Victorian Press", p. 111.

I have chosen to take a micro-historical, quasi-biographical approach to the research into the life-stories of the dataset of women. Microhistory has been defined as historical method which aim is to isolate ideas, beliefs, practices and actions of individuals and groups. The impact and significance of these such interactions could remain unknown, if researched by more large scale historical strategies.[261] Research into the personal biographies illustrate, and sometimes explain, the circumstances of the women and their crime, from a very different perspective. Through this, I seek ascertain whether there was one definable justification or rationale for the way they were viewed and treated, legally, medically and socially. In order to produce the material for my micro-histories illustrating the thesis, I read many different casebooks, case files and other official documentation. I researched in genaelogical sources and created numerous family trees and a library of individual files for each of the members of my dataset. While being aware of the dangers of bias when reading the sources used for this thesis, I did have personal emotional reactions to some cases. This may have had an impact on my choice of case-studies but nonetheles,s I believe that the chosen illustrative stories help create a new narrative in the history of madness, and female insanity in particular.[262] Many of the textual sources used for this thesis give fresh insight into how female criminal insanity, the law and asylums were perceived and understood by Victorians.

[261] John Brewer, "Microhistory and the Histories of Everyday Life," *Cultural and Social History*, vol. 7, no. 1, (2010), pp.87-109, p. 90.

[262] Coleborne, *Why Talk About Madness*, p. 25.

Thesis Outline and Implications of Research

Thesis outline

Following on from this Introduction, Chapter 1 is an analysis of the background of the mothers who had killed their children and were deemed as insane, in order to clarify the identity of my dataset of women. In the chapter, I use statistical charts to describe and discuss various aspects of the mothers' lives such as their age, their children, their social class, where they lived and their marital status. I also analyse the child victims by their age and gender, their place in a family, as well as the situation and methods of the violent attacks upon them. In the broader historical context, the period covered by this thesis was a time of significant changes within English society. There were large demographic shifts with increasing industrialisation, changes which had a significant effect upon inter-class relationships, families and ideals of domesticity. Although an in-depth analysis of the nineteenth-century working class life is not within the scope of my research, in Chapter 1, I briefly review whether industrialisation and the change from a mainly rural to a more urban society, had an impact on the incidences of maternal child murder.

In Chapter 2, I discuss the role and importance of the coroner's courts to the progress of the mothers through the legal system. A coroner's inquest was, on most occasions, the first official procedure facing the accused mother after the suspicious death of her child. This was, sometimes, followed by an appearance at a magistrate's court, before the woman was committed for trial in the higher courts. Medical evidence given at the inquests, played an essential part in the investigations into violent deaths of children, such as those discussed here. The doctors who had examined the body, or had performed the autopsy, may have been the family's medical attendant. Other witnesses, often personally attached to the accused mother and her victim, included neighbours, witnesses to the act and the local, apprehending official. Within this

chapter, I discuss the impact that the evidence given in the inquests, including medical evidence, had on the coroners' juries' verdicts, as well as its influence on the public view of the putative murderer.

Chapters 3 and 4 are examinations of the criminal trials and subsequent incarceration of the homicidal mothers. Chapter 3 considers the assize court and Central Criminal Court trials, together with the use of the defence of insanity, specifically for mothers accused of child-murder. The analysis is illustrated with court cases, researched through pre-and post-trial correspondence, reports and newspaper reports. In the chapter, I discuss the development of medical ideas about criminal insanity and the introduction of medical witnesses into the courtroom. I include discussion of defence counsel tactics when dealing with medical witnesses. Although insanity was not necessarily initially put forward as a defence, the possibility of insanity manifesting itself in women who killed their children, was invariably raised in their trials. I discuss whether popular views, beyond medical opinion and legal definitions of "acceptable" reasons for insanity, such as destitution and domestic abuse, could lead to a compassionate hearing and result. Within the chapter, I briefly analyse how ideals of masculine behaviour might have impacted on the trials and their outcomes. I consider whether personal beliefs and circumstances could shape the reactions of the juries, lawyers and judges, to the homicidal women before them in court.

The overall purpose of Chapter 4 is to explore the changing carceral policies for the homicidal mothers, designated as insane by the judicial system, in the period 1835 to 1895. My exploration includes discussion of the impact that the evolving criteria defining criminal insanity, had on the future lives of the homicidal mothers and, potentially, on their future mental welfare. An increasing acceptance of medical opinion that the female physiology, itself, could place strains on a mother's sanity, led to a greater willingness to treat the homicidal mothers as victims of illness. Some

members of the judiciary were reluctant to accept dedicated criminal lunatic asylums as anything but places of imprisonment, rather than curative and protective institutions. They disagreed with the medical opinion, that the best course of action for the insane mothers was treatment in a criminal or, indeed, a county lunatic asylum. As incarceration “until her Majesty’s pleasure be known” was seen as an endless sentence, one persistent view was that the facilities for the criminally insane were punitive places.

The remaining chapters in the thesis, concentrate on life within the asylums and the mothers’ ultimate fate, whether outside the institution. Chapter 5 is a comprehensive analysis of my particular group of homicidal women once they were in the asylums, detailing their diagnoses and treatments over time, together with any changes and developments in care. In Chapter 6, I discuss the relationships between medical superintendents in the asylums and the insane homicidal mothers. In the chapter, I discuss whether the personal circumstances of both the senior medical officers in the asylums and the sample group of female patients, could impact upon interactions and relationships in the asylum.

In Chapter 7, I examine discharges of homicidal mothers from the various asylums. I explore what manner of investigation was made into the capabilities of family and kin to care for a released patient. I also analyse whether the medical officers, both senior and junior, had any influence over release. The investigation is divided into two parts, firstly the years before Broadmoor’s opening and then the years after. I conduct an analysis of Broadmoor discharges, highlighting family involvement, allied with changing official protocols and procedures. As the chapter is an exploration of the ultimate fate of the women, I examine the background to those cases where all attempts for a woman’s discharge were unsuccessful. Finally within this chapter, I discuss the circumstances of those women who were not released but who died in the asylum.

The Conclusion draws together arguments from each chapter on the different aspects of the journeys of the criminally insane mothers who murdered their children. I ascertain whether it is possible to describe a typical case which may illustrate the conclusions of the preceding chapters. In so doing, I seek to answer the question of why these mothers were treated and viewed with compassion and humanity and not with indifference and condemnation, despite having committed "a deed at which humanity shudders". [263]

Implications of research

The discrete group of mothers who had killed their children were not necessarily condemned by the male-led medical and legal authorities, nor by Victorian society. This would appear to run contrary to present-day understanding of nineteenth-century concepts of motherhood, respectability and female violence. The perpetration of the crime of child-homicide by a female, was an act which did not fit into any conventional portrayal of a Victorian woman, let alone one of Victorian parenthood.[264] Such violence against their children was contrary to nineteenth-century standards of family life and motherhood, yet the accused women were still afforded sympathy and pity. I analyse different aspects of the lives of a specific, relatively small, group of female criminal lunatics, searching for the possible reasons for the seemingly benevolent treatment they received under the law and within the institutions.

This thesis is a close analytical focus of an unique dataset of women, in a sixty-year time-frame of social change in the Victorian era. It will add a different perspective to the historiographical area of infanticide and child homicide and complement the work of others on the topic. The key issues of my thesis are located in the category of

[263] Lord St Leonards quoted in the "Editorial" *Morning Advertiser* (1 May 1856), p. 4, col. 3.

[264] Barbara Leonardi, "Introduction: The Family Metaphor", in Leonardi (ed.), *Intersections of Gender*, pp. 1-14, p. 4.

gender history, including the consideration of issues of marital status and familial relationships together with reflections on Victorian masculinity and femininity and respectability. I explore the women's lives and show that individual experiences and social background impacted on all aspects of their passage through the Victorian medico-legal system. Overall, this thesis adds a new aspect to the scholarship of nineteenth-century medical, psychiatric and legal history in relation to women.

Chapter 1:
"No mother ever behaved with more affection to her children":
The Accused, the Victim and the Crime.

Introduction

Thirty-year-old Martha Ann Lewis, the wife of a shoemaker from Finedon in Northamptonshire, was known as being "a particularly careful and affectionate mother. No-one could have been a fonder mother or better wife".[1] On 17th August 1859, her father-in-law found Martha Ann sitting, with her head in her hands, in a neighbour's cottage garden, while other neighbours were retrieving the bodies of her two children from a pond. When he asked her what had happened, Martha Ann replied, "They are both in the water. I threw them in".[2] At her trial on 9th December 1859, evidence was given that her demeanour and disposition had changed since her last pregnancy and confinement. The medical superintendent of the local asylum testified that when he met with the prisoner, "she was in a state of great mental depression and unconsciousness".[3] The jury found her not guilty on the ground of insanity and she was committed, in the first instance, to Northampton Gaol.[4] Following a refusal for release, Martha Ann was admitted to Bethlem Royal Hospital on 14th March 1860.[5]

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1 "Northamptonshire Assizes" *Lincoln, Rutland & Stamford Mercury.* (16 December 1859), p. 6, col. 1.

2 "Murder of Two Children at Finedon" *Lincoln, Rutland & Stamford Mercury* (26 August 1859), p. 4, col.6.

3 *Lincoln, Rutland & Stamford Mercury.* (16 December 1859), p. 6, col. 1.

4 TNA, HO13/106/102 Home Office Correspondence And Warrants, "Letter to John Gorke, Esq., at Northampton Gaol. 9 March 1860".

5 BHRA, CBC-03 Incurable & Criminal Patient Casebooks, 1778-1864, Martha Ann Lewis, f. 132.

Four years later, on 13th July 1863, Mary Ann Payne was brought up before Marylebone Police Court charged with the wilful murder of her son, Charles Alfred Payne and with attempting suicide.[6] On 10th June, her neighbour had found Mary Ann, who was four months pregnant, lying senseless on flags at the back of their shared house in Marylebone, having seemingly fallen from the second floor.[7] Investigation in the house revealed the body of her 2-year-old son with his throat cut. When questioned, Payne replied saying, "I have killed my darling: I do not know what made me do it: I must have been mad".[8] Payne was described as being "an affectionate mother and wife in every point". At the trial, friends and family testified that she suffered with lowness of spirits in her previous pregnancies, so much so that she had been sent away to relatives for a rest. John Roland Gibson, surgeon to Newgate, agreed with the evidence given by her local doctor, that pregnancy could cause a morbid and deranged state of mind and his opinion was that she acted "in a paroxysm of insanity". [9] The jury found her not guilty being insane. Mary Ann Payne was admitted to Fisherton House Asylum, near Salisbury, on 27th July 1863, where she gave birth to a boy, William Henry, on 29th November of that year.[10]

Nearly twenty years after Mary Ann Payne's trial, Kate Barrow was tried for the wilful murder of her second youngest child, five-year-old Dora. Newspaper reports of her trial on 26th October 1881, described her as "a very ladylike woman".[11] The

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6 "Murder and Attempted Suicide" *Lloyds Weekly Newspaper* (14 June 1863), p. 1, col. 5.

7 "Extraordinary And Shocking Murder of a Child and Attempted Suicide of the Murderess" *London Evening Standard* (12 June 1863), p. 7, col.5.

8 *Old Bailey Proceedings Online*. July 1863, trial of Mary Ann Payne (21) (t18630713-890).

9 *OBP.*, July 1863, Payne.

10 WHCC., 1902/8 Wiltshire, Church of England Births and Baptisms, 1813-1916. William Henry baptised Parish of Fisherton Anger, Wiltshire. 29 December 1863 by Rev Geo Leoux Wilson, Chaplain to Fisherton House Asylum.

11 "The Child Murder at Slough". *Illustrated Police News*, (5 November 1881). p. 2, col. 2

same reports also note that it took the jury just 15 minutes to find her not guilty, on the ground of insanity.[12] On 25th July 1881, at about 5 o'clock in the afternoon, the Barrow children's nurse went looking for Dora and found her in the bathroom, lying face down in a half-full bath. Her mother, Kate, was sitting in the room apparently unconcerned. Barrow was 37 years old and the wife of a "respectable tradesman" in Upton-cum-Chalvey, near Slough, with six living children at the time of her crime.[13] She was admitted to Broadmoor on 15th November 1881.[14]

Martha Ann Lewis, Mary Ann Payne and Kate Barrow were three women from different social and geographical circumstances, each of them was tried for the murder of their children, acquitted as insane and subsequently designated as criminal lunatics. Lewis was the wife of a skilled artisan from Northamptonshire, Payne was the young pregnant wife of a telegraph clerk living in Marylebone and Barrow was the mother of six children, married to merchant grocer from Buckinghamshire. While they were connected by virtue of their incarcerations in state criminal lunatic asylums, by class and social expectations, they appear to be more disparate. Through an analytical account of the life-courses of such mothers, I seek any common threads, apart from their crime and sentence, to fulfil my aim of finding reasons for manner in which they were treated and viewed by the Victorian medical and legal worlds, and by society generally.

Our view of the women and their journeys through nineteenth-century medico-legal and asylum systems, is received through a prism of contemporary opinion. In this chapter my aim is to create a picture of the dataset of women by a statistical and contextual interpretation of their lives. This scrutinisation of the 288 mothers identifies

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12 *Illustrated Police News*, (5 November 1881), p. 2, col. 2.

13 "The Recent Case of Child Murder". *Leighton Buzzard Observer & Linslade Gazette*, (1 November 1881), p. 8, col.1.

14 BCLA, DH14/D2/2/2/330 Case File: Kate Barrow.

some discernible connecting patterns and characteristics of social behaviour and circumstances. In order to achieve this and to build-up an overall picture, I have created a number of statistical diagrams and charts.

I begin by investigating the personal circumstances, including marital status and age, at the time the crime was committed. This is followed by an evaluation of the women's social class status, which is based on either their personal occupation or the occupation of the designated head of the household.[15] The next area of enquiry is related to physical locations of the defendants' homes and crimes, within England and Wales. I analyse the geographic locations to ascertain whether the incidence of maternal child homicide could be linked to demographic shifts in population density. Allied to this, I briefly examine whether the physical and social living conditions of the homicidal mothers could impact upon the incidence of maternal infanticide and child homicide.

I then conduct a statistical analysis of the child victims themselves. I detail their ages, the circumstances of their deaths, the number of victims in each case and their place within the family unit. By investigating such quantitative information, my intention is to create a framework to inform the qualitative debate about the socio-cultural and familial issues, relating to the mothers and their victims. The data analysis contextualises why all levels of society would seek to find some sort of rationale for such violent maternal actions and exceptionally horrific incidents. The frequently occurring contemporary opinion was that such abnormal and unacceptable behaviour was caused by insanity.

[15] As defined in the Census Returns.

Marital Status and Age.

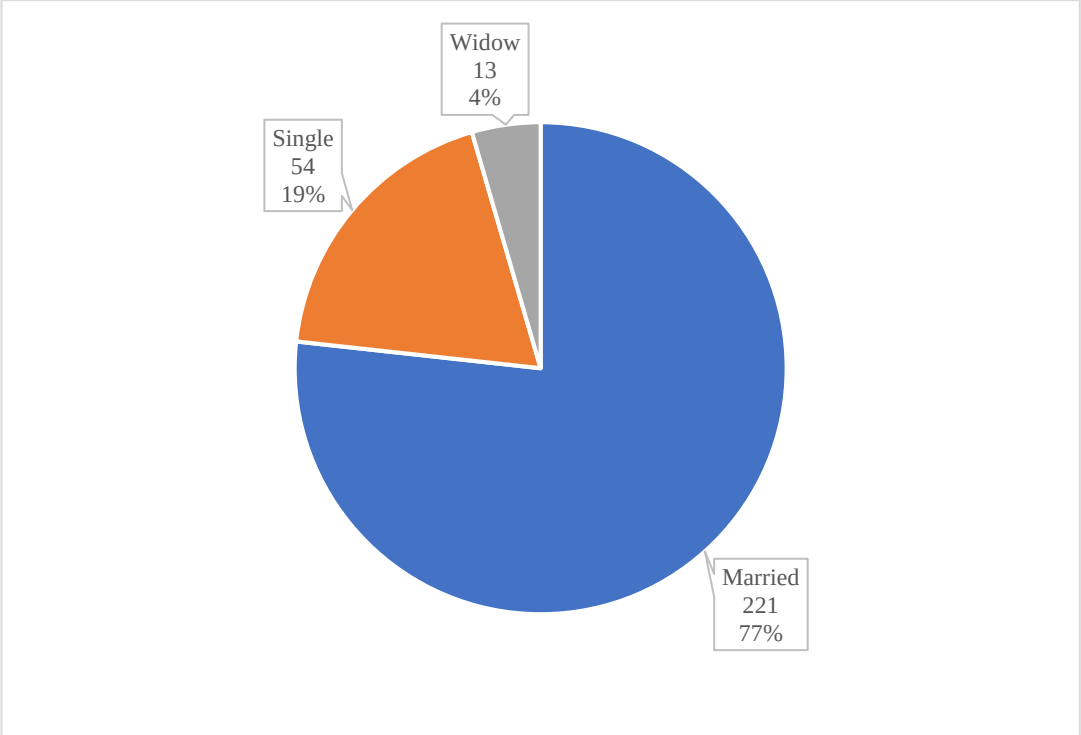

Figure 1:1: *Marital status at the time of crime, 288 women, 1835-1895*

The database created for my research comprises a total of 288 cases of women who were incarcerated between 1835 and 1895, for murdering or grievously harming their children. Of that number, 221 were married, 13 widowed and 54 were single. (Fig. 1:1). Although the life journeys of married women who had killed their offspring are the central focus of this thesis, those of unmarried mothers are also included. Their stories are important as a point of reference and comparison, when reviewing the most attitudes and reactions of families, public opinion and the male-dominated authorities. In my dataset, there are far fewer single mothers adjudged as criminally insane and commonly, they were from the unskilled lower and servant class. For the purposes of the survey in this chapter, the marital designation used is that which was afforded to the subject in the asylum records, court records and newspapers.

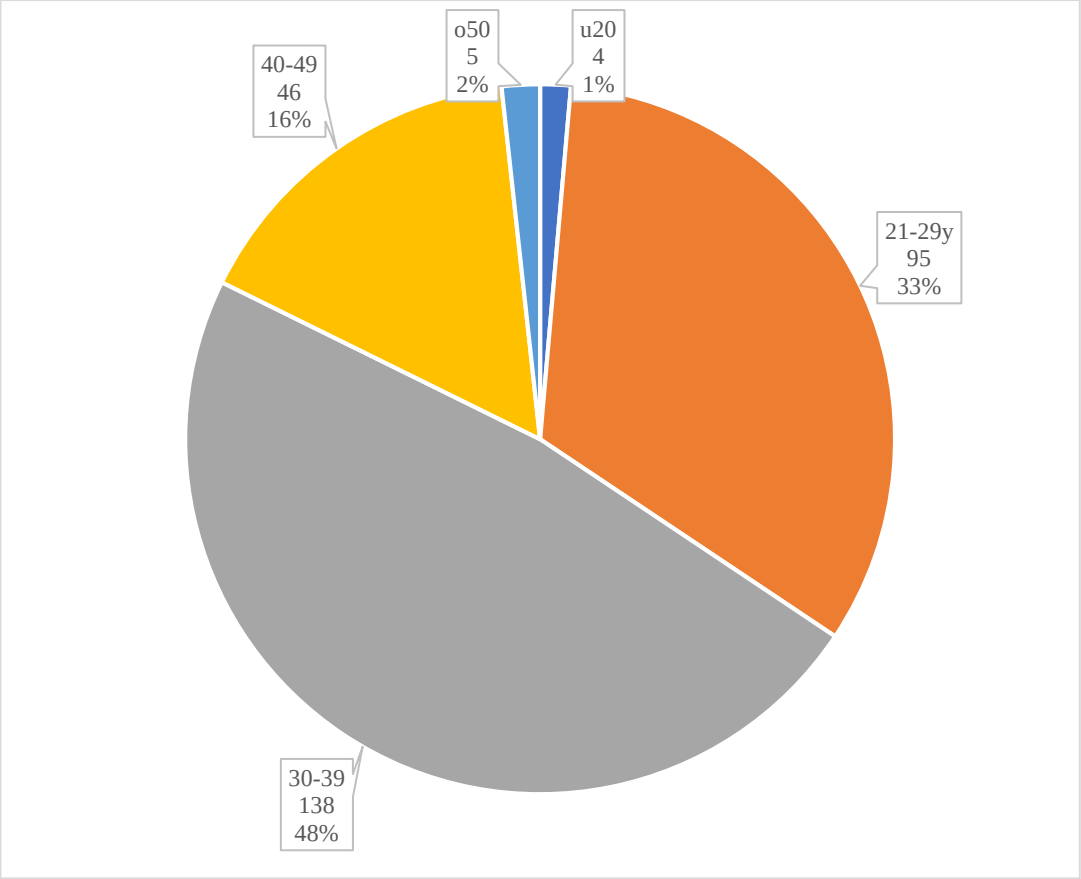

Figure 1:2: *Age ranges of 288 accused mothers, 1835-1895*

My data sample consists of 234 married and widowed mothers and 54 single mothers found to be insane between 1835 and 1895. When the figures are further broken down into age brackets, as in Figure 1:2, it shows that the highest proportion were aged between 30 and 40 years old, with the smallest proportional groups being under 20 and over 50 years of age. Of the 54 unmarried mothers, most were in their twenties (56%) and just four in their teens. There are some incidences of co-habitation and other cases where the woman could be said to be a mistress. There are cases where the woman was married but not necessarily to the father of her victim and, in the case of widows, the child was the result of a subsequent relationship.

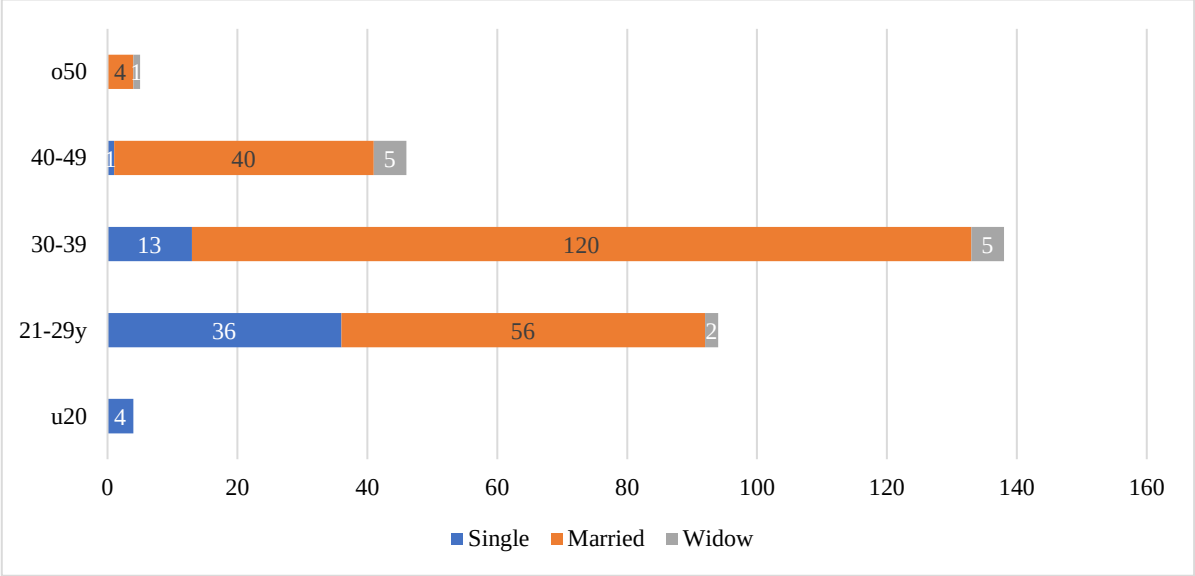

Figure 1:3: *Age and marital status 288 women, 1835-1895*

Ginger Frost suggests that stable cohabital relationships were accepted within working-class families as informal marriages.[16] Frost also acknowledges that her research shows that cohabiting couples were rare in the long nineteenth century.[17] She suggests that such partnerships were more common between 1760 and 1840, than from 1850 onwards.[18] Rebecca Probert, on the other hand, disputes Frost's figures for the earlier period.[19] Probert does agree that such arrangements were likely to be socially acceptable if the "informal marriage" was due an inability to legally marry, such as desertion or disappearance, by one partner.[20] I have found that, if it occurred within my dataset, long cohabitation was seen as adding a permanence to family units.[21] In official records, if the accused mother was described initially as married or widowed,

[16] Ginger Frost, *Living in Sin: Cohabiting as Husband and Wife in Nineteenth-century England*. (Manchester: Manchester University Press, 2008), p. 5.

[17] Ibid., p. 2-3.

[18] Ibid., p. 5.

[19] Rebecca Probert, *The Changing Legal Registrationof Cohabitation: From Fornicators to Family,1600-2010* (Cambridge: Cambridge University Press, 2012), p. 35.

[20] Ibid., p. 62

[21] Frost, "Living in Sin", p. 226.

then that status remained with her, despite any later contrary intelligence which might be received.

By the existing legislation, the charge of infanticide was aimed at unmarried mothers. Samantha Williams suggests that, by claiming to be legally married, co-habitees would potentially place themselves outside the reach of this legislation.[22] I contend that in so doing, the accused would be charged with wilful murder and thereby, potentially, face capital punishment. I suggest that, rather than avoiding infanticide legislation by claiming to be legally married, the aim was to garner favourable official opinion. Throughout my thesis, I note whether the authorities' attitudes to the accused mothers, in court and in the asylum, were indeed influenced in this way.

Later in the chapter, I discuss any underlying causes or mitigating circumstances given for the accused's violent crime. However, it should be noted here that all four of the teenage mothers found insane, according to reports and court and other records, had been "seduced", possibly raped, by an older man or employer.[23] Overall, by far the highest number of mothers, 231, were aged between 20 and 39 years, with 49 being unmarried and 182 married or widowed. Such numbers would

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[22] Samantha Williams, "'They lived together as Man and Wife': Plebian Cohabitation, Illegitimacy and Broken Relationships," in Rebecca Probert (ed.) *Cohabitation and Non-Marital Births in England and Wales, 1600-2012* (Basingstoke: Palgrave Macmillan, 2012), pp. 65-80, p. 77.

[23] BCLA, D/H14/D2/2/2/271 Case File: Ellen Harper. Ellen Harper aged 17, married but cause stated as "seduction & desertion" 1861; D/H14/D2/2/2/507 Case File: Harriet Rose Hopkins aged 19, "love affair & seduction" 1876; BCLA, D/H/14/2/2/2/543 Casefile: Emily Harriet Wilson.

TNA, HO18/379/19. Ann Good aged 18. Extract "[Her] seducer was her Master ... he accomplished the ruin of her person." Letter from Sir Thomas Talfourd, L.J., to Home Office. 7 December 1853; HO144/496/X42157. Emily Wilson (18) "forcibly outraged by her stepfather". Letter from Sir Gainsford Bruce, LJ., 14 May 1893.

appear to show that there was, socially, a preparedness to find mitigating reasons for an accused mother's crime. This cultural acceptance was rooted in a belief that, particularly in the case of legitimate children, to act in a manner so contrary to contemporary values of motherhood, a married (or widowed) mother must have had some form of mental aberration. [24]

Implications of marital status and working mothers.

Melanie Reynolds argues that a trope of Victorian patriarchal ideology was that working mothers were feckless and unfeminine.[25] She writes that, in addition, observers also believed that such mothers should take moral liability for the early deaths of their infants and young children.[26] The belief that working mothers would place strain on the inter-familial relationships and maternal affections, was essentially a middle-class view of reality.[27] Although keeping a respectable, not a "rough", home as a place of family security, was considered important for many, it would be hard to achieve for some families.[28] Respectable mothers would display good housekeeping skills which, for many, would include managing on a small budget.[29] If that included taking paid work inside or outside the home, it did not lessen their ability to viewed as a "good mother".[30] Julie-Marie Strange argues that "maternal affection" was

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[24] Anne Marie Kilday, *A History of Infanticide in Britain, c.1600 to the present* (Basingstoke: Palgrave Macmillan, 2003), p. 172.

[25] Melanie Reynolds, *Infant Motality and Working-Class Childcare, 1850-1899,* (Basingstoke: Palgrave Macmillan, 2016), p. 36.

[26] Ibid., p. 36.

[27] Emma Griffin, "The Emotions of Motherhood: Love, Culture and Poverty in Victorian Britain", *American Historical Review* vol. 123, no. 1, (2018), pp. 60-85, p. 67.

[28] Susie L. Steinbach, *Women in England, 1760-1914,* (London: Weidenfeld & Nicholson, 2004), p. 13.

[29] Ibid., p. 15.

[30] Ibid., p. 14.

demonstrated in very different ways in working-class family relations when compared with the middle class.[31] To working-class society, the practical elements of managing the home were the main manifestations of maternal affection, rather than a less practical emotional devotion.[32] If that included taking paid work outside the home, then it was deemed to be appropriate and respectable, not irregular, maternal behaviour.[33]

Of the 288 mothers in the dataset, 103 have an occupation recorded against their name. Of that number, 53 are designated as single, including three known co-habitees and 50 are married or widowed. Many of the married or widowed women in the dataset were classified in official records by the occupation of their husband. If they themselves had an occupation, it might be additionally listed. There are occasional cases of middle-class wives having an occupation .[34] I have taken all occupations from both admission records and census returns.[35] Women's occupations in the censuses were frequently described as "household duties", although, if they had any other occupation, it would be noted in official records. Rarely do the records or the returns give an indication whether the woman was actively employed at the time of her crime. However, for the purposes of this analysis, I have assumed that the occupation given, reflected the woman's employment status.

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[31] Julie-Marie Strange, *Death Grief and Poverty, 1870-1914* (Cambridge: Cambridge University Press. 2005), p. 251

[32] Ross, *Love and Toil,* pp. 54-55.

[33] Steinbach, *Women in England,* pp. 14-15.

[34] BCLA, D/H14/D2/2/2/316 Case File: Sarah Ann Bull; D/H14/D2/2/2/387, Case File: Mary C Bicknell. In the Broadmoor records Sarah Bull was described as a "Governess", her husband was a "School Board Inspector" and Mary Bicknell was listed as "Teacher" and her husband was a "Warehouse Manager".

[35] The 1871, 1881 & 1891 England and Wales Censuses for BCLA, record any known occupation.

Occupation	**Marital Status and Class**				**Totals**
	Lower Class S	Middle Class S	Lower Class M/W	Middle Class M/W	
Bridle stitcher	1				1
Charwoman	3		6		9
Childminder/wet nurse	1		2		3
Dressmaker/Needlewoman/ Tailoress	1		8	4	13
Factory work/ Machinist	1		3		4
Governess/Teacher		1		3	4
Hatter/Milliner	1		1		2
Hawker	1		1		2
Housekeeper (paid)	5				5
Labourer	4		1		5
Lacemaker			1		1
Laundress			5		5
Lodging House Keeper	1				1
Matchbox/Mantle Maker	2				2
Prostitute			1		1
Servant	30		8		38
Shopwoman/keeper				2	2
Silk Weaver	1		1		2
Straw plaiter			1		1
Weaver			1		1
Totals	**52**	**1**	**41**	**9**	**102**

Table 1:1: Recorded Occupations of 102 women 1835-1895

Favoured occupations appear to be those which could be carried out from a domestic setting.[36] This would not necessarily be less taxing on a mother's mental health, but it would solve a potential problem of childcare. Emma Griffin contends that the earnings from home-based enterprises (in which she includes taking in lodgers) in the main, supplemented other household income. Alone, a woman's earnings would not support a family.[37] It could, in fact, have a more detrimental impact on her general well-being, which could lead to exhaustion and mental disturbance. Frequently the word "exhaustion" is used in diagnoses, coupled with other factors. Mary Ann Daniels was a married boarding house keeper, described in her Broadmoor notes as suffering from "Exhaustion & Melancholia".[38]

Not unsurprisingly, the majority of single woman were servants, which category includes cooks and farm servants. Two of the single paid housekeepers appeared to be co-habitees, possibly mistresses and another was the paid housekeeper to her father and brothers. Rather than exhaustion from work and childcare, a frequent concern was of destitution or fear that they could not afford childcare. This was apparent in the case of Emma Pudney, a silk weaver at Courtaulds, who was refused outdoor relief because she earned 4s a week. She had found that amount insufficient to keep herself and her two sons. Her additional cause of insanity was "Desperation".[39] Likewise Eva Lonnon drowned her thirteen-month-old son because her childminder could no longer keep the child. This was put down to "Desperation and

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[36] Emma Griffin, *Bread Winner. An Intimate History of the Victorian Economy* (New Haven & London: Yale University Press, 2020) p. 167.

[37] Ibid., p. 172.

[38] BCLA, D/14/D2/2/175 Case File of Mary Ann Daniels.

[39] "Child Murder at Halstead", *Bury and Norwich Post* (5 April 1864) p.3, col. 5; BCLA, D/14/D2/2/102 Case File: Emma Pudney *alias* Howard.

Melancholia".[40] In none of these cases was the mother cited as being an evil or bad mother, and notably, despite the children being described as illegitimate neither is there censure for the mother's unmarried state. It would appear, from the press reports, that sympathy lay with their desperate situations.

Class[41].

In an 1878 article in the *Journal of Mental Science*, Dr David Nicolson, the then Deputy Medical Superintendent of Broadmoor, emphatically stated, "*The patients at Broadmoor certainly do not belong to what are commonly called the criminal classes.* [Nicolson's italics]. To suppose that they do is a common error."[42] He was referring categorically to those criminal lunatics detained during her Majesty's pleasure, the so-called "pleasure patients".[43] In the same journal article Nicolson comments that, in his experience, "They [the "pleasure patients"] do not belong to the higher or middle classes of the community; nor (before their offence) do they belong to the lower or pauper classes … insanity spares not the rich or the poor".[44] Nicolson's words underline the fact that, in contemporary opinion, people were admitted to Broadmoor irrespective of their social background. Amongst the female criminal lunatic populations in the studied asylums, there was a definite imbalance of numbers between the various classes, which merits further investigation.

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[40] "Distressing Child Murder at Normandy", *Surrey Advertiser* (10 January 1891) p.5, col. 2; BCLA, D/14/D2/2/456 Case File: Eva Mary Lonnon.

[41] Appendix 1: Classification by Occupation – class listing by gender and recorded occupation.

[42] David Nicolson, "The Measure of Individual and Social Responsibility in Criminal Cases". *Journal of Mental Science* Vol 24. (July1878), Part II pp. 249-273, p. 272

[43] The term "Pleasure patients" was coined to describe those male or female patients who had been found insane before or during their trials and who were being held until her Majesty's pleasure be known.

[44] Nicolson, "Individual and Social Responsibilty", p. 273.

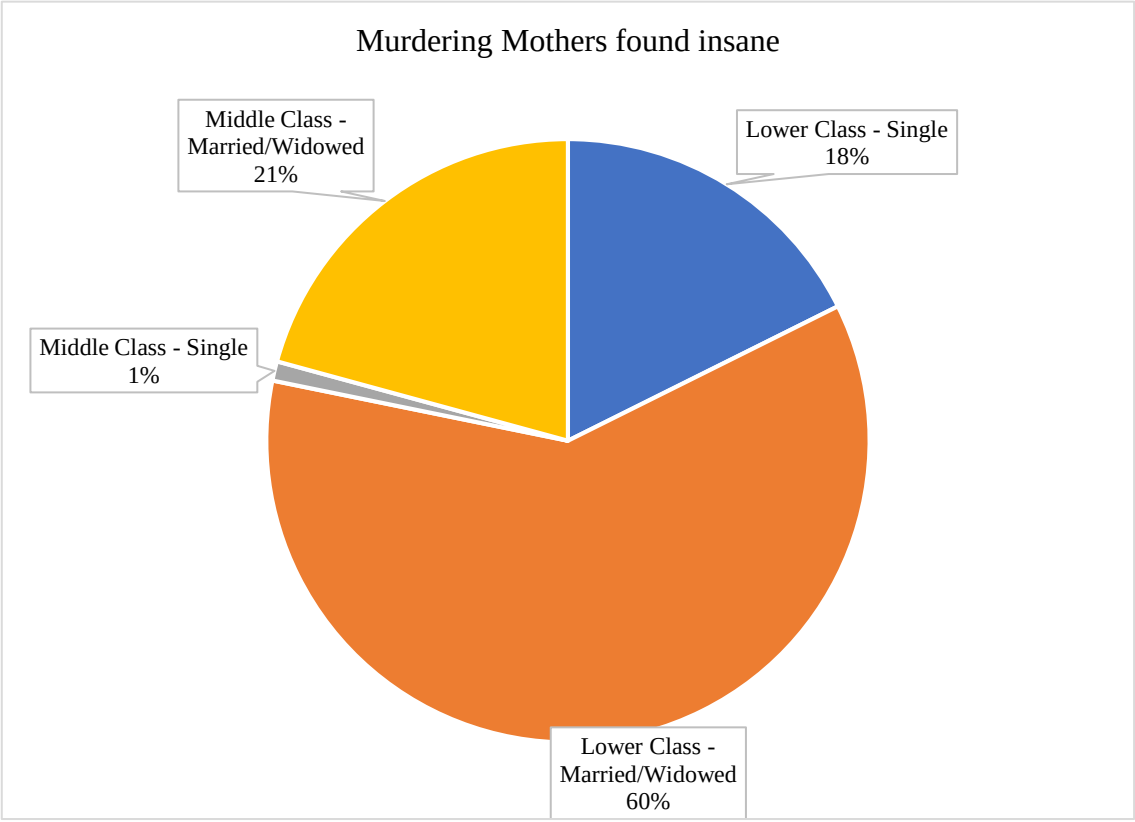

Figure 1:4: *Breakdown of institutional population by class, 1835-1895*

My class definitions, for the purposes of analysis within this thesis, are listed in Appendix 1. They were created from an amalgam of primary sources and several social history studies.[45] As well as these sources, I also partially used the classifications used by the Registrars-General office for the 1891 census return (submitted in 1895).[46] To use class as an impartial appraisal of social position has

[45] 1841, 1851, 1861, 1871, 1881, 1891 England and Wales Census; Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914* (Cambridge: Cambridge University Press, 1985); Simon Gunn, *The Public Culture of the Victorian Middle Class, Ritual and Authority in the English Industrial City. 1840-1914* (Manchester: Manchester University Press, 2000)*;* Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900". (Unpublished PhD Thesis. Queen Mary University, London 2013); Gareth Stedman Jones, *Outcast London. A Study in the Relationship between Classes in Victorian Society* (London, New York: Verso, 2013, first published 1971).

[46] Mr Shaw LeFevre, *Occupations of the People (England and Wales) Enumerated in 1871, 1881 and 1891*. Return on order of the Honourable House of Commons dated 12 March 1895. (London: Eyre & Spottiswoode, September 1895).

always been a complex historiographical issue. The term itself can be emotive and idiosyncratic; membership of a certain social class is amorphous, changing with historical time-periods. If membership of a certain grouping depended on solely income and economic circumstances, then the boundaries became unclear. There is a school of thought that the Victorian class structure, in particular the development of the middle class, was a performative socio-cultural construction.[47] Class identity grew from social conduct and attitudes, which behaviours became markers on how each social grouping viewed the other.[48] Simon Gunn argues that urban nineteenth-century society was defined by a series of opposites, between the educated and the uneducated, or mental and manual labour.[49] I have been aware that creating such social definitions for this study is subjective and that no one method of defining class is correct or definitive.

The nineteenth-century censuses were a systematic collection of data about the population of England and Wales. From 1841 onwards, the occupation of the working members of a household was recorded. The definitions of these occupations could be, at times, somewhat idiosyncratic and depended on the knowledge and comprehension of the enumerator. Generally, the descriptions enabled government statisticians to allocate an individual to a particular social grouping. It was unusual for a middle-class wife to have an occupation outside household duties. A large number of artisan and working-class women were also categorised as "housewives". In these cases, the classification is based on the husband's working position. In the tables, I have defined the class of the family by the occupation of the head of household, as shown in the

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[47] David Cannadine, *Class in Britain* (London: Penguin Books, 1998); Gunn, *Public Culture of the Victorian Middle Class*; D. Wahrman, *Imagining the Middle Class. The Political Representation of Class in Britain c.1740-1840* (Cambridge: Cambridge University Press, 1995).

[48] Gunn, *Public Culture*, p. 188

[49] Gunn, *Public Culture*, p. 4.

census returns. The allocation of the single women to a particular category has been based on their occupation, as listed in admission books and discharge registers for the various institutions. A further breakdown of this section of the institutions' population into the periods before and after the establishment of Broadmoor, show that the proportional class balance was similar.

Of the 288 mothers in my data sample, 225 fall into the skilled or unskilled classification, with just 65 designated as middle class (78% and 22% of the data sample respectively). A further breakdown of the numbers of working-class cases (Figure 1:5), indicates that most of the criminally insane mothers were from the unskilled labouring class. When the figure for those from the middle class is subdivided (Figure 1:6), the indication is that the majority of patients were from the lower income level of the classification. In her study of men in Broadmoor, Jade Shepherd found that the male population comprised a mix of all social classes. She found, as I have done, that the majority were from the lower classes but that there were also male patients from higher income bracket and possibly of a higher social standing.[50] This is not the case for my data sample, where all the 288 women surveyed for this thesis, were from the working and middle classes, with none from higher income or upper classes.

[50] Shepherd, "Victorian Madmen", p. 60.

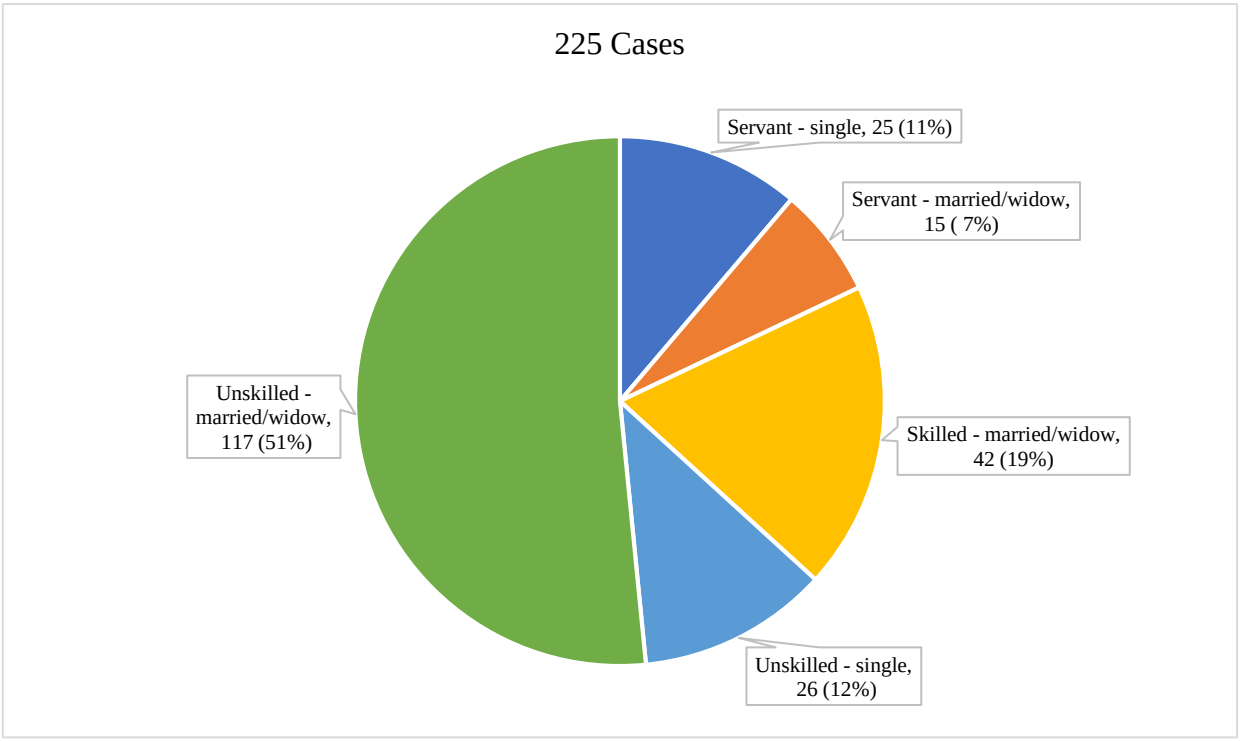

Figure 1:5: *Cases designated as Lower Class 1835-1895*

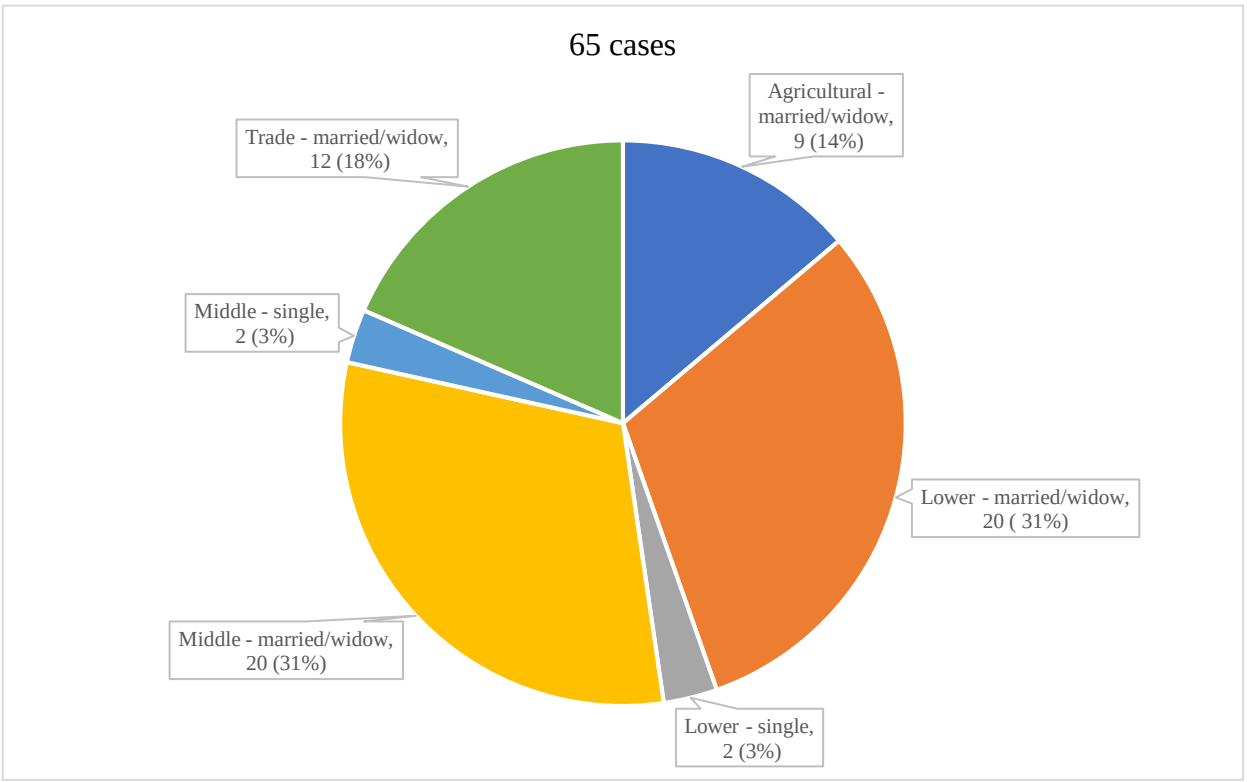

Figure 1:6: *Cases designated as Middle Class, 1835-1895.*

From the censuses, it is apparent that, in Victorian society, the working or labouring population outnumbered the middle and upper classes. The low number of middle-class women and the lack of upper-class mothers, held in the asylums as criminal lunatics and thereby in my dataset, can be attributed to some extent to the relative balances in population. From the information gleaned from the data sample, there seems to be a high increase in middle-class mothers killing their children in the period from 1863 to 1895 (Figures 7 and 8): 15% were middle class for the first thirty years and 24% in the second. There could be a number of reasons for this. Possibly, social aspirations and "upward" mobility, such as those described by Simon Gunn, might have caused changes in definitions of social hierarchy, with more occupations being considered as middle-class.[51]

The increase may also be explained by the number of cases actually identified for the first thirty years of my research period. As previously mentioned, between 1835 and 1863, the place of detention of homicidal mothers, who were adjudged insane by legal process was more random, therefore more difficult to identify. Once Broadmoor opened, practically all these cases, were detained in there. Looking at the Broadmoor admissions registers alongside the census returns figures show that, in April 1871, there were 81 female patients in Broadmoor, 60% of whom had killed or grievously wounded their offspring. By April 1881, the figure had risen to 117, of whom 68% had attacked their children; and by April 1891 there were 152 female patients, 75% of whom were incarcerated for similar crimes.[52] .

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[51] Gunn, *Public Culture*, pp. 1-7.

[52] Census Returns of England and Wales, 1871. Class: RG10; Piece: 1296; Folio: 71; Page: 3; Census Returns of England and Wales, 1881. Class: RG11; Piece: 1320; Folio: 100; Page: 17; Census Returns of England and Wales, 1891. Class: RG12; Piece: 1008; Folio: 82; Page: 23; Census Returns of England and Wales, 1901 indicate a total female population of 174. It is not possible to discern a breakdown of the committed crime as the patients are identified by their initials only.

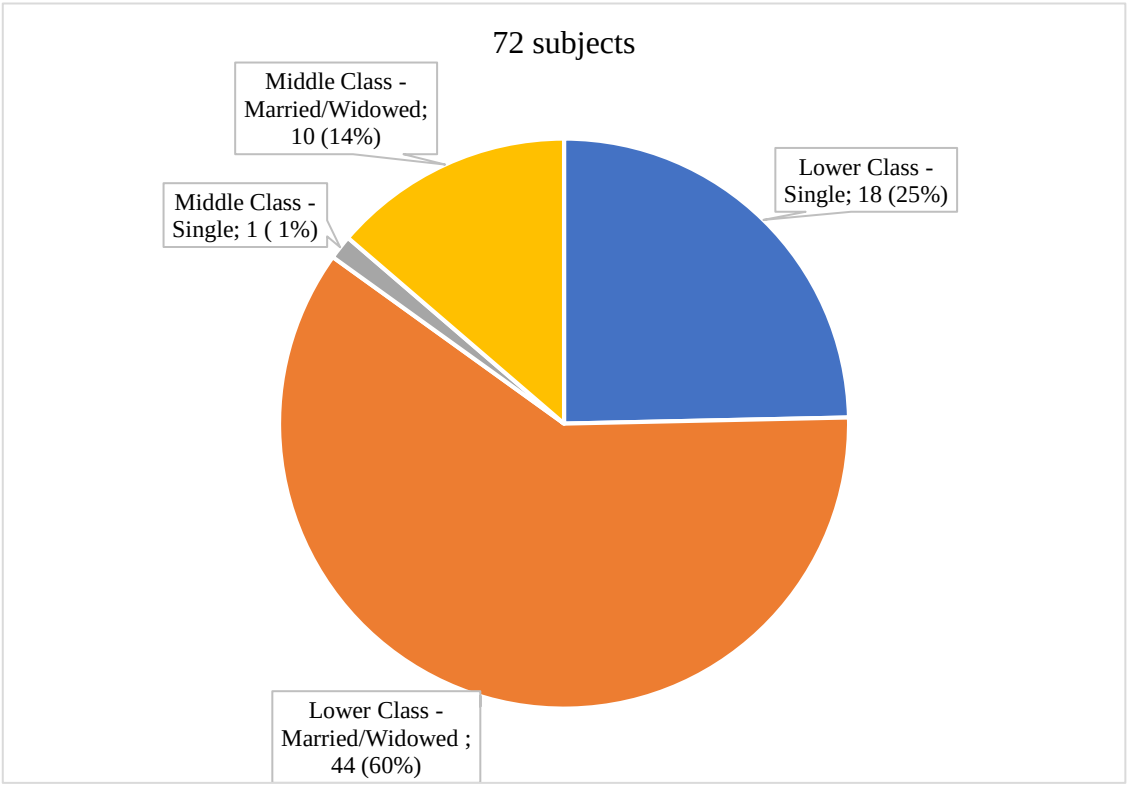

Figure 1:7: *Breakdown of institutional population by class, 1835-1863 (May)*

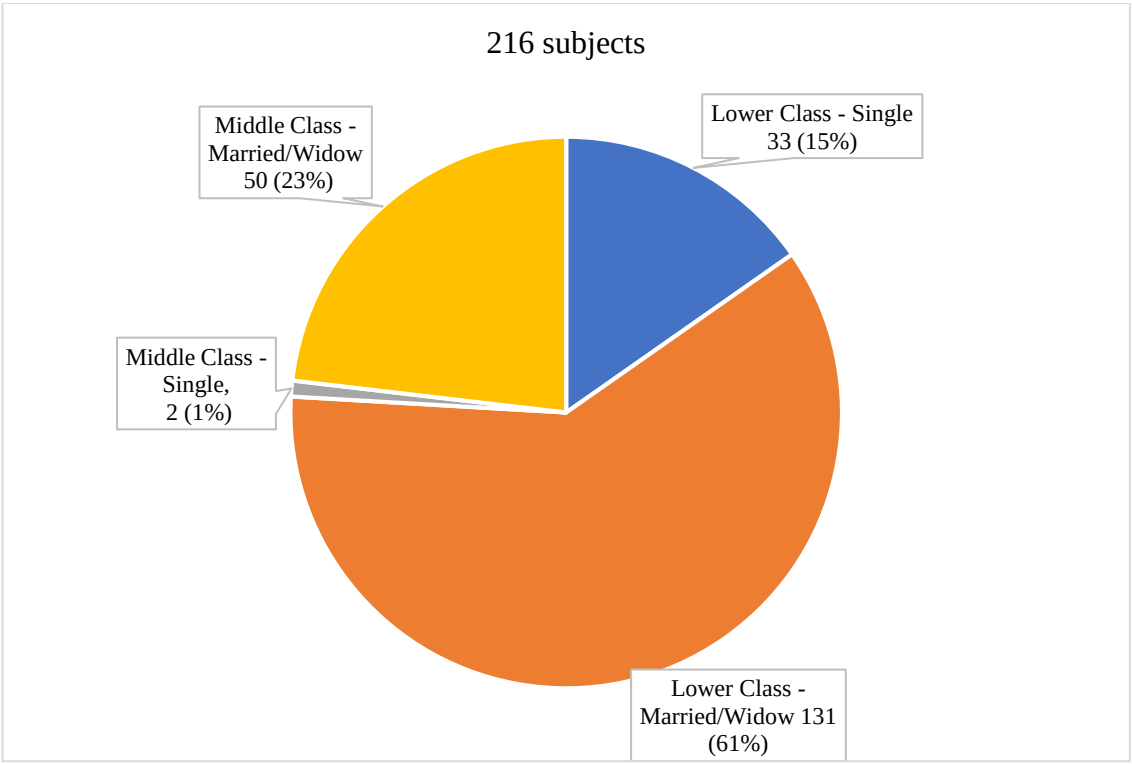

Figure 1:8: *Breakdown of institutional population by class, 1863 (June) -1895*

The increase could also be partially attributed to changes in sentencing patterns, again following the establishment of the dedicated state criminal lunatic asylum. In Chapter 4, I discuss such changes and the impact they had on the "typical" life-journey of these mothers, highlighting the differences between the two halves of the period. I have found that those women within my dataset who were seen to be better educated, possibly middle class, spent less time in incarceration. The attitudes of authorities to those women and their families are covered in detail in later chapters. What does become apparent is that the familial social circumstances of the female patients had impacted on the manner and circumstances of their incarceration and release.

Another speculative explanation for the smaller number of middle-class women could lie in personal domestic circumstances. Potentially, they should have had more help in the home in difficult times.[53] This home-based supervision would come from visiting family and doctors, supported by the presence of monthly nurses and servants.[54] However, when individual cases taken from my data sample are reviewed, it is clear that even the existence of such support, did not always prevent the mother from harming her child. For instance in the case of Kate Barrow quoted at the beginning of this chapter, the presence of a children's nurse in the house did not stop her from drowning her daughter.[55] Similarly, Martha Baines, the wife of a chemist from Kendal, poisoned her five-month old baby with bleach in 1875. This was despite her husband employing a "girl" to help and watch over her. He had refused to have

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[53] Alison Pedley, "'A Painful Case of a Woman in a Temporary Fit of Insanity'. A study of women committed to Broadmoor Criminal Lunatic Asylum between 1863 and 1884 for the murder of their children". (University of Roehampton. Unpublished M.A. Dissertation, 2012).

[54] Hilary Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004), p. 7.

[55] BCLA, D/H14/D2/2/2/330, Barrow.

Martha admitted into an asylum "to rest".[56] As a final example, Eliza Agar, the wife of a warehouse manager, deliberately placed her baby on the parlour fire, having sent the nurse out of the room on an errand.[57]

In his 1902 treatise, *Female Criminal Lunatics*, Dr John Baker of Broadmoor Criminal Lunatic Asylum, wrote,[58]

> … It is a sad fact to record but the registers of Broadmoor show that 253 women slaughtered their children. […] In addition, maternal violence was responsible for attempts on the lives of 33 infants [...] it was only an accident that a fatal result did not ensue. […] I consider [there to be] 286 cases of infanticide [in Broadmoor] …[59]

As previously mentioned in this chapter, David Nicolson believed that the prevention of crime by insane persons was a social duty. He held that all sections of society, irrespective of class, should bear some responsibility in protecting the mentally vulnerable from a potentially criminal deed.[60] He specifically targeted, "puerperal cases of criminal lunacy", which he stated were "often due to positive neglect or unkindness in the nursing after childbirth". He was firmly of the opinion that, "criminal phases of lunacy" were preventable by a timely intervention of

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[56] BCLA, D/H14/D2/2/2/251, Case File: Martha Baines.

[57] TNA, HO144/129/A34007 Home Office Registered Papers. "Criminal: AGAR, Elizabeth Matilda; Court: Central Criminal Court; Offence: Murder of her one-month old child; Sentence: Criminal Lunatic".

[58] BCLA, John Baker, M.D., Deputy Medical Superintendent. 1896-1902, Medical Superintendent, 1902-1912.

[59] John Baker, "Female Criminal Lunatics: A Sketch" *Journal of Mental Science (now The British Journal of Psychiatry)*, vol. 48 (1902) pp. 13-28, p. 15.

[60] Nicolson, "Individual and Social Responsibility" p. 272.

"relatives, friends, medical advisers and neighbours". Such care and protection was particularly pertinent for a mother "who has shown previous signs of depression, or a tendency to insanity".[61]

Nicolson's opinion, that the mentally vulnerable needed safeguarding, is particularly relevant to many of the cases discussed in my thesis. Within working class households, this type of support would be given by, in the most part, spouses, neighbours and kin but it was often sporadic.[62] Hilary Marland suggests that strange or unusual behaviour could often be missed, or assigned to domestic worries about restoring a house to normality.[63] From witness testimonies at inquests and trials I would agree with Marland's point. Such statements were used to "excuse" the lack of supervision by kin and neighbours. Comparisons were made of the woman's "normal" behaviour to show that she had shown no incipient signs of insanity and, therefore, she was not watched. Issues of responsibility and blame recur in other aspects of the women's post-crime lives. In Chapter 2, I discuss the implication of such issues at coroner' inquests, and again in Chapter 3 in relation to trial evidence and verdicts,. The question of the responsibilties of husbands, family and kin was an important consideration if a patient was released from an asylum.[64] This and the abilities of

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[61] Ibid., p. 264.

[62] Hilary Marland, "Languages and Landscapes of Emotion: Motherhood and Puerperal Insanity in the Nineteenth Century" in Bound Alberti (ed) *Medicine, Emotion and Disease,* pp. 53-78, p.68-69.

[63] Ibid., p. 69.

[64] Jonathan Andrews, "The Boundaries of her Majesty's Pleasure: Discharging Child-Murderers from Broadmoor and Perth Criminal Lunatic Department 1860-1920", in Mark Jackson (ed.) *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot: Ashgate. 2002), pp. 216-248, p.219; Alison Pedley' "Family Union and the Discharge of Infanticidal Married Mothers from Broadmoor Criminal Lunatic Asylum, 1863–1895", in James Gregory & Daniel J. R. Grey (eds.) *Union and Disunion in the Nineteenth Century* (Abingdon: Routledge, 2020) pp. 223-241, p. 224.

family and kin to care for and protect a potentially vulnerable woman, are scrutnised in Chapter 7.

Geographical locations.

The two following charts (Figures 1:9 and 1:10) were created from the database using the location of trials and court hearings for the 288 cases of maternal infanticide/child homicide between 1835-1895. The county denominations used to create the distribution map are based on the post-1974 reorganisation of counties in England and Wales. The figure for London constitutes the cases heard at the Central Criminal Court, this number does not include those heard in modern-day Greater London. Cases heard in Croydon, for instance, are counted in the figure for Surrey. [65] As appearances in courts and trials took place near to where the attack had happened, the analytical geographical map (Figure 1:9) is based on the location of various assize court hearings. The bright red shading shows that by far the highest number of trials heard (84 cases) were at the Old Bailey. The darker shading within the regions show the areas with over 10 incidences of maternal child murder. The cities in the shaded areas are Liverpool (19 cases), Leeds (14), Manchester (12) and Birmingham (11). The following chart (Figure 1:10) shows the regional spread of cases as a percentage of the total of 288 cases.

[65] A listing explaining the geographical areas is attached at Appendix 2.

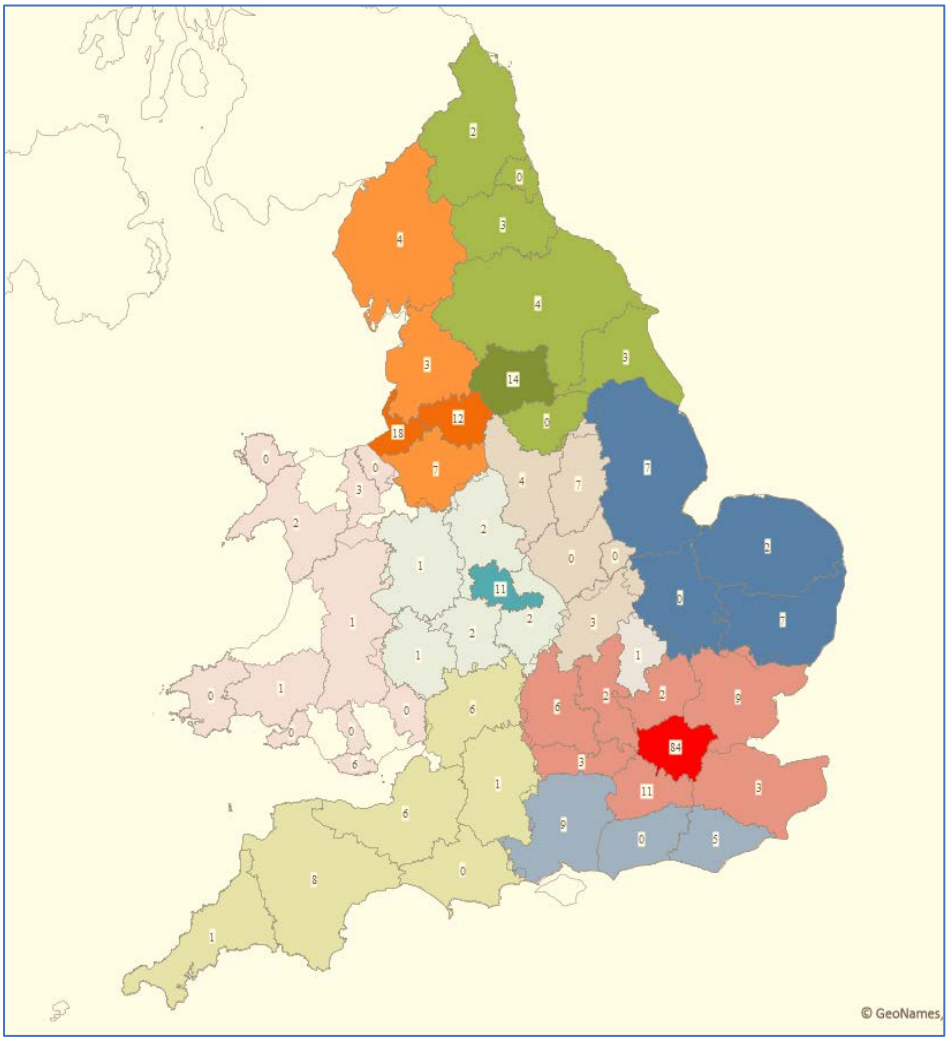

Figure 1:9: *Geographic distribution by county in England and Wales.*

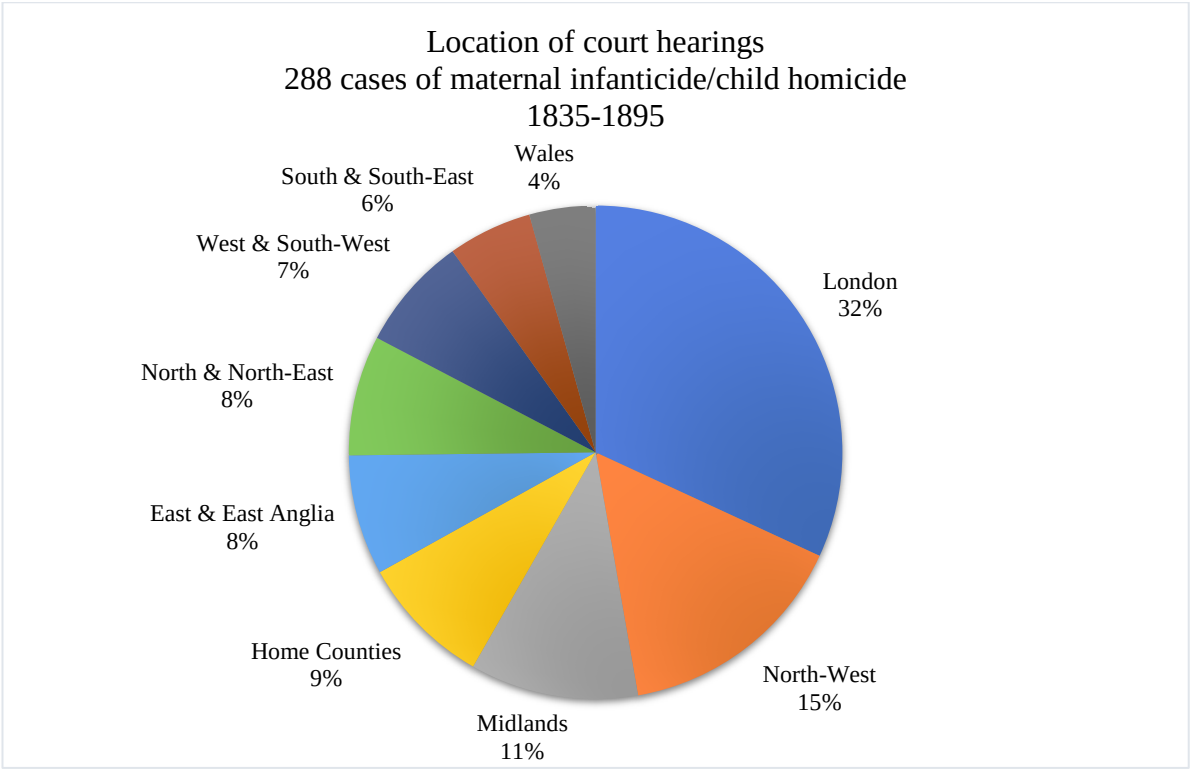

Figure 1:10: *Cases by percentage & regional location of originating courts.*

The accused mother would be tried, or at least listed for trial, at the Assize hearing nearest to where the crime had been committed. About one third of the women incarcerated originated from the Central Criminal Court at the Old Bailey and the metropolitan area of London. The next largest number originated in the industrial and urban areas of the north-west of England, encompassing the industrial areas of Lancashire, Manchester and the port of Liverpool (Figure 1:10). When the statistics are broken down into two periods, 1835 to 1862 and 1863 to 1895, the Central Criminal Court cases are still dominant but the balance changes in the latter thirty years. Before the 1860s, the Home Counties and the Midlands were more prominent than the North-West of England which situation changed. (Figures 1:11 and 1:12).

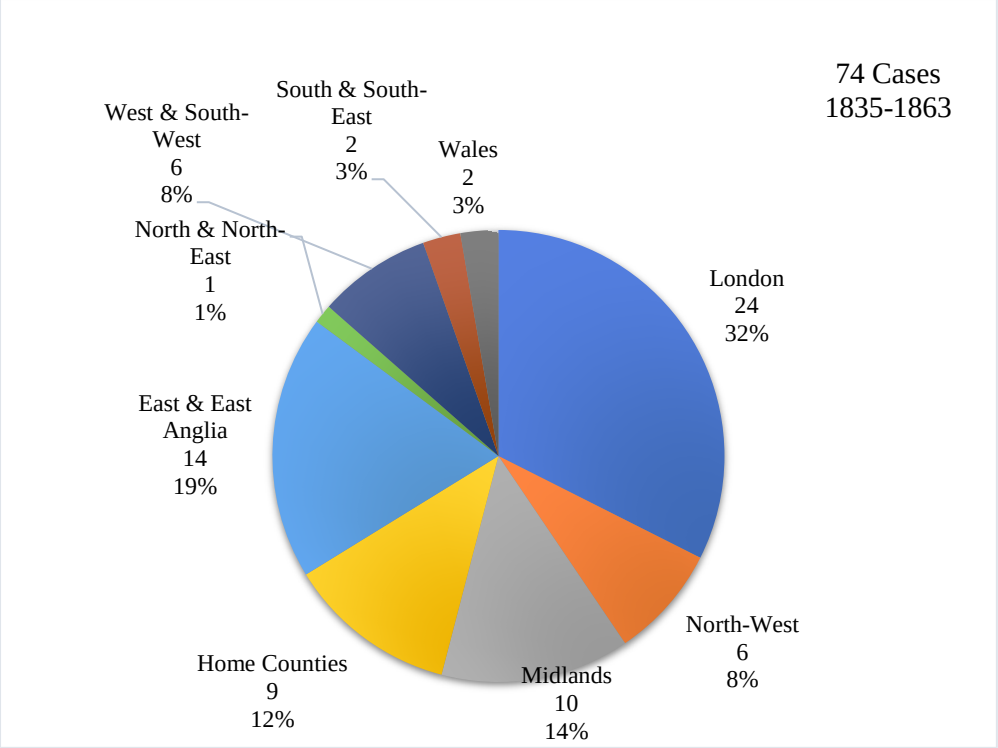

Figure 1:11: *Cases by geographic location of originating courts, 1835-1863*

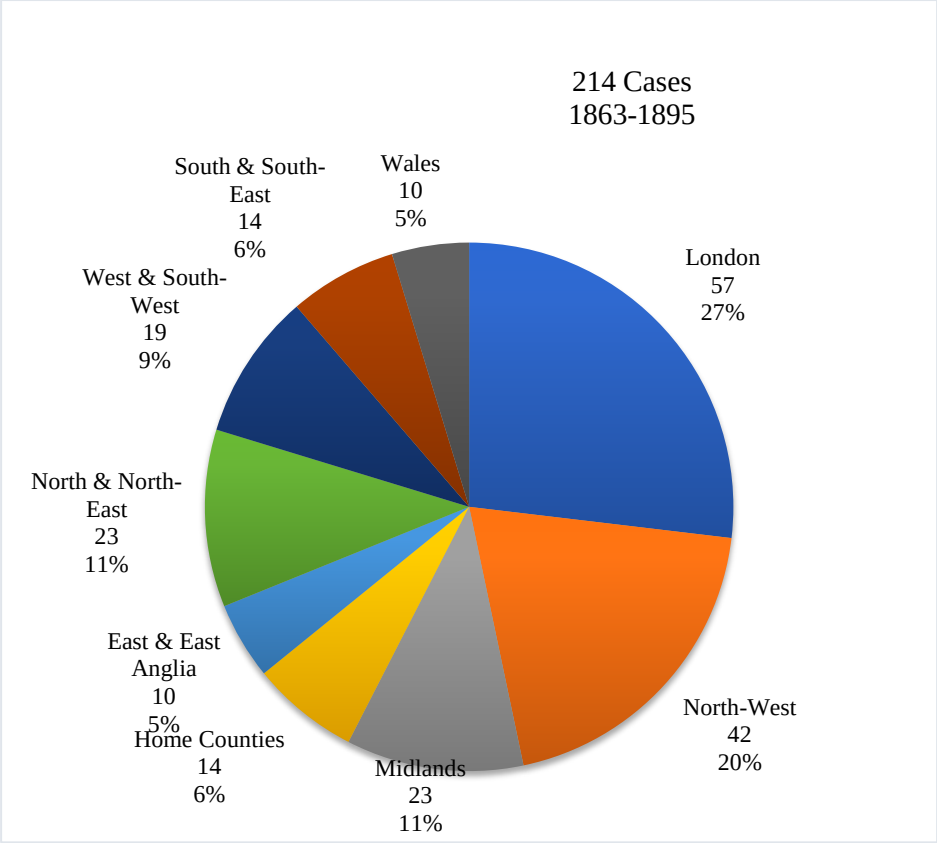

Figure 1:12: *Cases by geographic location of originating courts, 1863-1894*

The population of England and Wales altered significantly over the sixty-year time span of this thesis. As employment trends moved from rural to urban centres and the national economy moved from an agricultural to an industrial basis, the population of industrial centres grew. In the early 19th century, there were areas of rapid growth in the industrial districts of Lancashire and Yorkshire. By the mid-century, the industrial expansion of the north-east of England was driven by mining and new heavy industries, such as shipbuilding and iron smelting. Further, the mining areas of South Wales, the East Midlands and Yorkshire grew, as better mining techniques reached the deeper coalfields.[66] Industrial urban centres had a high incidence of poverty and deprivation, which may have played a part in the execution of the crime. The geographical bias towards the larger centres of population and industry could suggest that the insanities suffered by the women in my dataset, were caused by difficult and

[66] "Rate of Population Change" A Vision of Britain Through Time. Great Britain Historical GIS Project (2004) University of Portsmouth. www.visionofbritain.org.uk.

insanitary living conditions. High rates of infant mortality were often suggested by popular opinion to have been caused by wilful neglect and cruelty, in overpopulated industrial areas.[67] To test this hypothesis, I have taken the example of cases within my dataset which occurred in Liverpool.

In 1841, the population of Liverpool, regarded at the time as England's largest port and second city, was 286,457. By 1861 it was 462,749 and by 1891 had grown to 617,032.[68] This increase was driven by inward migration from Ireland, North Wales and surrounding counties.[69] The city had some of the poorest and most deprived slum areas in England, as well as some of most affluent districts of the period. As I noted earlier, within my dataset I have identified nineteen cases which occurred in the Liverpool area, the highest number outside the jurisdiction of the Central Criminal Court at the Old Bailey. Throughout this period, public opinion viewed the slum areas of cities like Liverpool, as hotbeds of crime and disease, caused by poverty and insanitary conditions.[70] It is noteworthy that the split between the social classes of the relevant cases from my dataset, was virtually equal. Nine of the mothers were from the city's middle-class population and ten from the lower classes. In subdividing the lower classes into skilled, artisan and unskilled (including seamen and other marine labour) groupings, three households came into the first group, with six in the second. These six households were in courts or on streets which were situated in areas

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67 Griffin, *Bread Winner*, p. 3.

68 "Liverpool: Trade, population and geographical growth", in William Farrer and J Brownbill, (eds.) *A History of the County of Lancaster: Volume 4*, (London, 1911), pp. 37-8.

69 Elizabeth J. Stewart, *Courts and Alleys. A History of Courtyard Housing in Liverpool,* (Liverpool: University of Liverpool Press, 2019), p. 4.

70 Emily Cuming, *Housing, Class and Gender in Modern British Writing, 1880-2012.* (Cambridge: Cambridge University Press. 2016), p. 28.

described as slums.[71] Destitution and deprivation not only were given as root causes of the accused mother's insanity or crime, they might also be included as additional factors.

Social and sanitary investigations, and the subsequent press reports, publicised the extent to which real deprivation and insanitary conditions existed. To some of the mothers just the fear of destitution was suggested to have been a causal factor in their mental condition. Privation and poverty were directly cited as causes of insanity in only two of the six cases in Liverpool's slum dwellings. Alcohol consumption and intemperance were vices popularly attributed to poorer communities in the city. Drunkenness was cited as a major causes of all crime but was particularly attributed to the poor Irish community in Liverpool.[72] Within the group of eighteen women, five of the ten working-class women were said to be intemperate and drunks; and four were of Irish origin.

Fear of destitution was apparent in cases of middle-class maternal child homicide too. Three of the middle-class mothers from the Liverpool dataset were said to have been frightened that they were facing impoverishment and destitution. Knowledge of the conditions of the poor in the city would be contrary to their own middle-class views of domesticity and something to be feared.[73] Analysis of other cited causes for the middle-class women's insanity shows that circumstances were

[71] The terms court houses, alleys or "back houses" were used to describe a group of buildings built behind a street house and arranged around a small yard. Due to the poor construction and bad ventilation, they were considered to be unsanitary and unhealthy. Contemporary inspection reports on the conditions frequently cited them as the source of diseases such as cholera and typhoid. Stewart, *Courts and Alleys,* p. 5.

[72] Catherine Cox, Hilary Marland & Sarah York, "Emaciated, Exhausted and Excited: The Bodies and Minds of the Irish in Nineteenth-Century Lancashire Asylums". *Journal of Social History,* vol. 46, no. 2 (2012), pp. 500-524, p. 500.

[73] Cuming, *Housing, Class and Gender,* p. 28.

slightly different. Alcohol was not mentioned and none were connected to domestic abuse, except, perhaps, for one where the marriage was described as "unhappy". The other women suffered from conditions ranging from religious delusions to persecution complexes, often allied with female physiological reasons. Detailed study of this group would be an area of local historical research which, while of interest, does not fall within the purview of my thesis. In Appendix 3 I have listed the nineteen cases together with some biographical details of the women. I have also included two images which illustrate the difference between living conditions in nineteenth-century Liverpool. [74]

To say there was a synonymous connection between social deprivation in the home environment and the crime ignores the complexities of the issue. Just as is true of making too close a link between the death of a child and cruel neglect, care needs to be taken in speculating that the domestic conditions of the women could be a prime factor in their crime.[75] Possibly the social conditions may have excacerbated the situation but they were often taken as another underlying cause for insanity. As I have shown with the Liverpool example, it is more likely that larger population numbers would just mean a relatively higher number of cases. A brief review of the given sources of insanity in all 288 records indicate that thirty-three (11%) were attributed to destitution and privation. Although poor living conditions were frequently mentioned, they did not always feature as a major causal factor. Endemic diseases such as typhoid and tuberculosis, which could manifest themselves in mental disorder, were referenced in casebooks. There were two cases amongst the Liverpool sample but the presence of such diseases was listed alongside other contributory reasons. The

[74] See Appendix 3: "Liverpool cases 1835-1895." (List of cases and photographs).

[75] Strange, *Death, Grief and Poverty*, p. 232.

contemporary understanding of these connections will be further reviewed in Chapter 5, when I discuss asylums and diagnoses of insanity.

The child victims.

Throughout the women's journeys through the medico-legal systems, the responses of the authorities and the public were focused on the accused women, together with their medical and personal life-histories, rather than the child victims. There were 344 children killed or grievously harmed, by the 288 women in my database. Unexpectedly, public reaction did not often fix on the fact that the defendants had committed a deed of ultimate violence against the more vulnerable members of their families. This was despite socio-cultural expectations that these were the very members who should have been nurtured and protected, particularly by their mothers. Although the central theme of the thesis is the lives of insane mothers who had violently attacked their children, it is important that some time should be spent on profiling the victims, in order to add further background to the assaults.

This section of the chapter contains a number of statistical charts relating to the children. The charts are analyses of the children's ages and gender, their place within the family and the method and location of the attacks. The first two charts illustrate the connections between gender and age: Figure 1:13 highlights the age spread of the young victims and Figure 1:14 similarly shows the gender balance by age groups. Next in this group of charts, Figure 1:15 is a representation of the overall gender balance, to ascertain any indications that a child's gender particularly led to it becoming a victim. The next two charts relate to the actual violent attacks. Figure 1:16 shows the location of assault, whether in the family home, in another domicile such as an employer's home or a workhouse, or in a public location, such as rivers or canals. Finally, Figure 1:17 lists the methods utilised by the mothers to highlight whether the

crime could be considered to be a premeditated attack or a spontaneous random act of madness.

Children, age and gender.

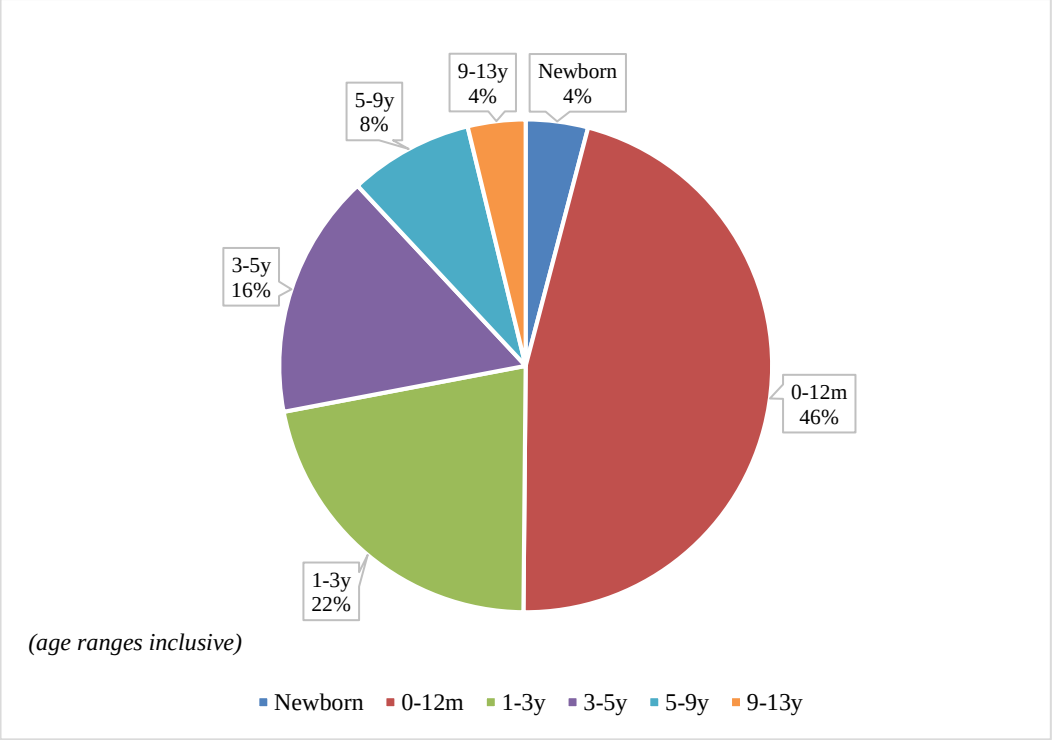

Figure 1:13: *Child victims by age (percentages in age grouping)* [76]

The oldest child to be killed or harmed was 12 years old and the youngest new-born. Only 14 of the 344 killed or harmed children, identified in my dataset, were described as new-born. The above chart indicates that, with nearly 50% of the maternal killings occurring before the child reached its first birthday, children appeared to be at their most vulnerable within the first twelve months of life. When considering the ages of the child victims of Broadmoor patients, Jonathan Andrews compared cases of paternal child homicide with maternal cases. From this, he found that there were, amongst the male patients, few murders of infants and more cases of the killing of

[76] The ranges of age groups for the chart are ages up to the last parameter – this is clarified in Figure 1:15.

older children. [77] From his findings Andrews suggests that men were more likely to assault or kill older children, whereas women's attacks were more connected with difficulties connected with new-born or young infants. Unfortunately, although my investigations support this theory for non-Broadmoor maternal cases, I do not have sufficient information with regard to non-Broadmoor paternal child homicide cases to conduct a comparable exercise. Jade Shepherd does not discuss the ages of the child victims in her study of paternal child murder, although she does attribute paternal child homicide to the socio-environmental roles in child-rearing. She writes that many of her male subject patients in Broadmoor had killed their children from a sense of protective paternalism, a perceived failure to provide as a father should. [78] Again, this could be due to social circumstances as, culturally, women would be expected to bear the stress and responsibilities of young infants, while the fathers would provide economic support. The statistics in the above charts, bear out both Andrews' and Shepherd's conclusions. Within his sample groups from Broadmoor and Perth Criminal Lunatic Department, Andrews found that few of the murders were of infants under 3 months old. He concludes that this was a sign of court clemency towards women for the killing of new-borns after 1849. [79] From my research, I suggest that while this may be the case for new born murders, it is not the case for those victims under 3 months as a whole. I found that 46% of the deaths occurring before the age of 12 months, were of infants under 3 months old (11 weeks, 6 days). This statistic lends weight to the theory that a woman's violent compulsions towards the younger infants, were caused by post-partum mental derangement. As I discuss in later chapters in this

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[77] Jonathan Andrews, "The Boundaries of her Majesty's Pleasure: discharging child-murderers from Broadmoor and Perth Criminal Lunatic Department 1860-1920", in Mark Jackson (ed.) *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot: Ashgate. 2002), pp. 216-248, p. 223.

[78] Shepherd, "Victorian Madmen", p. 221-4.

[79] Andrews, "The Boundaries of her Majesty's Pleasure", pp. 220-1

thesis, if an accused mother's criminal act could be attributed to mental illness, both before and after childbirth, she would commonly receive similar mercy in court to that suggested by Andrews.

Throughout the whole period, there were, on average, more girls murdered or grievously assaulted by their mothers than boys. As shown in Figure 14 of the 344 violent assaults and deaths, 41% were of male children and 58% female (the gender of two of the new-borns does not appear to have been recorded). When broken down by age and gender (Figure 1:15), the percentages differ slightly. In the three to twelve months old age bracket, there were 57 assaults on girls and 50 on boys of the 107 in total (53% and 47% respectively). If we look at the one to six years bracket, covering young childhood, then the percentages change. In over two-thirds (69%) of the attacks, the victims were female and one-third (31%) male. The total number for these two groupings was 126 cases; 79 assaults on girls and just 47 on boys The trend for the older age groups is similar to that for the children under twelve months old, with 18 females and 13 males being killed or harmed.

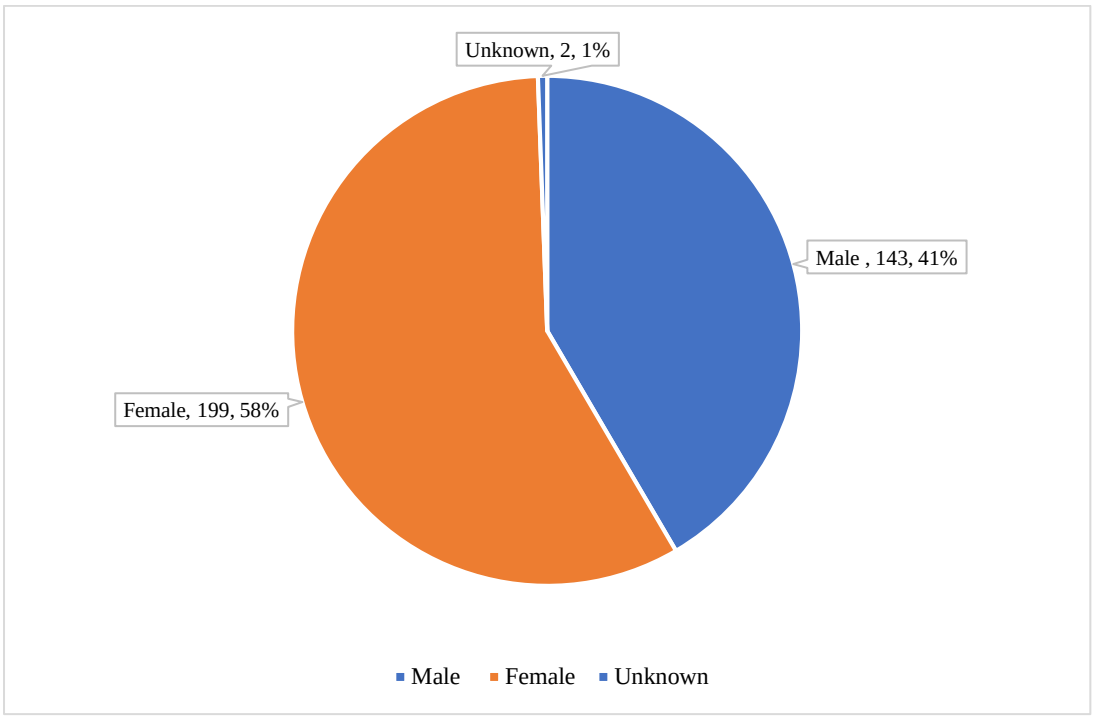

Figure 1:14: *Child victims. Gender balance, 1835-1895.*

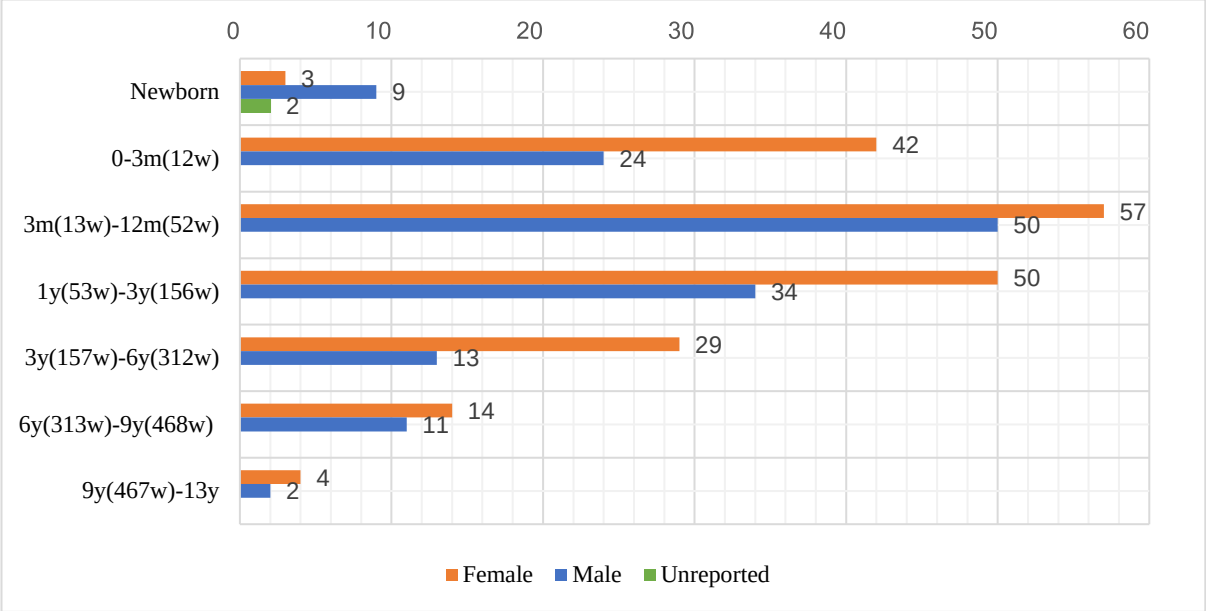

Figure 1:15 *Child victims. Gender balance by age & gender, 1835-1895.*

It is very difficult to ascertain whether the victims' gender had an impact on their fate. If we accept, as contemporary opinion frequently did, that the mother was in a delusional and psychotic state of mind when she committed her crime, then the gender of the child does not appear to be an issue. None of the records and sources I have used, specifically state that the gender of the child had an influence on a mother's action. In one or two instances, it has been noted that the mother may have been taking revenge on her husband, as in the case of Mary Ann Brough. [80] In an infamous and highly publicised case, Mary Ann Brough killed six of her children in 1845, which act was said to be revenge on her husband for his nefarious behaviour. [81]

In other cases, the mother was said to have a repugnance towards her child because of disfigurement. Dr Charles Hood at Bethlem wrote of Emma Sanderson that "she always had an aversion for this child because it was born with a mark on its face." The case book goes on to note, "Notwithstanding the aversion to this child, she would

[80] BHRA, CBC-03 Incurable & Criminal Patient Casebooks, 1778-1864, Mary Ann Brough, f. 113.

[81] Roger Smith, *Trial by Medicine*, (Edinburgh: Edinburgh University Press, 1981), pp. 157-60.

yet at times contemplate it with pity." Emma told the Bethlem doctors that she felt that she did not want to "expose him [her baby] to a great deal of annoyance" and that she "would not leave [him] to be hunted through the world and a burden to [his] father." [82] In other cases where women gave any rationale for killing their child, a frequent explanation was that they felt that they would be protecting the child from potential life difficulties by sending it to a "better" place. On other occasions, the homicidal mothers would state that they did not know why they had committed the murder but that they had felt compelled to do so at the time.

From his research and analysis of the Broadmoor cases, Jonathan Andrews suggests that the insanity defence was more likely to be successful as a defence for cases involving assaults on older children and multiple killings.[83] I agree with his assessment to an extent. However, I also suggest that it was successful in cases where a mother's unpredictable and dangerous behaviour at the time of the killing was attributed to personal and physiological traumatic events. This does not, however, explain the gender imbalances with regard to the victims of my dataset, particularly of those aged between twelve months and six years old. A partial answer may lie in infant mortality rates and the survival rates between male and female children. Another speculative suggestion might be that the homicidal mother may have been suffering from manias associated with subsequent pregnancies, or other personal traumas, which had an effect on her mental state. For instance, according to Broadmoor records, when she drowned her daughter in 1881, Kate Barrow had been suffering from puerperal depression and had been in "very indifferent health" after the birth and natural death of a child in January of that year.[84] Although it is not within the scope of this brief survey, there is merit in further research to find common factors for those cases where

[82] BHRA, CBC-02, Incurable & Criminal Patient Casebooks, Emma Sanderson, f. 185.

[83] Andrews, "The Boundaries of her Majesty's Pleasure", p. 220-1.

[84] BCLA, DH14/D2/2/2/330, Barrow.

the victim was aged between one and six years and was not the youngest sibling in a family.From my research, therefore, I suggest that the success of a defence of insanity lay more in the circumstances of a mother's perceived insanity, than in the age of the child. Neither age of the child victim, nor its gender, necessarily impacted upon the treatment meted out to the mother.

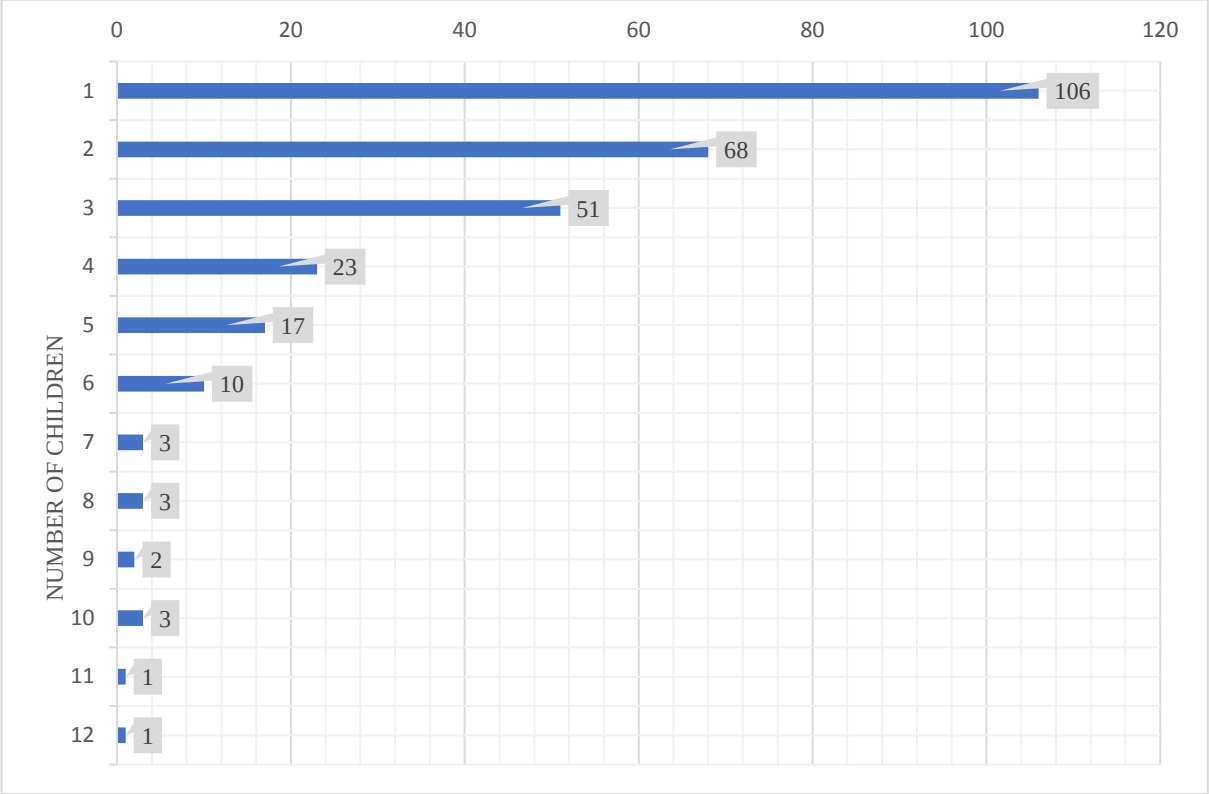

Figure 1:16: *Family size at time of murders, 1835-1895*

As can be seen from Figure 1:16, 106 mothers killed, or grievously assaulted, their only child. The other 182 cases I classify as multiple assaults. In these cases, 146 had attacked just one of their children, 36 two or more and, of that number, 18 destroyed all their children at the one time. Within my dataset, there was one mass killing, one re-offence and one suggested case of serial killing; the perpetrator in each case was admitted into Bethlem Royal Hospital. The highest number of children destroyed at one time was by Mary Ann Brough, which case I have classified as a mass, rather than multiple, killing. The one re-offence found in the sixty-year period

was that of Mary Ann Beveridge, quoted at the beginning of the thesis.[85] The possible serial murderer was Ann Byrom. Her case notes from Bethlem suggest she had allegedly serially killed three new-borns just after their births. This "fact" was not mentioned at her trial in 1837 after the death of the third child and emerged once she was incarcerated in Bethlem.[86]

The mass killing by Mary Ann Brough in 1845 was an exceptional occurrence and the unique nature of the circumstances behind the crime sets it apart from other case studies in this thesis. It was a notorious case, attracting notoriety and outrage. There was public horror at what was described as a massacre because of the circumstances and the number of children killed at the one time.[87] Other aspects of the case added to its infamy. Mary Ann Brough had been, at one time, the wet nurse to Prince Albert Edward, Prince of Wales and her husband was in the service of the exiled French monarchy. The Brough's marriage was, allegedly, a stormy relationship, with suggested adultery by both parties. The murders of the children were said to be an act of vengeful vindictiveness by Mary Ann Brough on her husband. It was also said that she had been suffering from insanity and had an inability to temper her actions.[88] But as Roger Smith writes, "Not even the alienists, at or after the trial, supposed that the murders would have occurred without the history of adultery".[89] The Byrom, Beveridge and Brough cases are noted here for their singularity.

The attacks: location and method.

When the location of the death of the victim and the methods employed are analysed, there is rarely a suggestion of pre-meditation. The cases which took place in

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85 BHRA, CBC-03 Mary Ann Beveridge, f. 160.

86 BHRA, CBC-02 Ann Byrom, f. 44; BCLA, D/H14/D2/2/2/38, Case File: Ann Byrom.

87 BHRA, CBC-03 Mary Ann Brough, f. 113.

88 Smith, *Trial by Medicine*, pp. 157-60.

89 Ibid., p. 160.

a public place, away from the accused's place of residence, could possibly be the exceptions to this statement. In these scenarios, most of the attacks were either attempted or successful drownings. Of 108 such cases, 59 occurred in the public domain, with the act being discovered, sometimes witnessed, by strangers and bystanders.

In a number of such cases, the mother tried to commit suicide at the same time but survived where her child drowned. When suicide was attempted in tandem with the drowning, the act was proffered in court as an indication of the mother's state of mind and another proof of her insanity. On admission to an asylum, whether criminal, county or private, all patients were reviewed to see if they showed "suicidal tendencies" and, thereby could be a danger to themselves. Under English law, this "dangerousness", whether to the patient's self or to others, was not a prerequisite for incarceration as insane, although its perceived presence was often taken as further proof of insanity.[90] In his 1901 paper, Dr John Baker specifically stated that, "suicide completed, attempted or contemplated almost invariably accompanies the infanticide". He believed that the idea of suicide came with a depression caused by such factors but because of maternal bonds, the mother irrationally believed that she should not leave the child behind, so it had to die first. Baker attributed such thoughts to a number of factors, including over-lactation, grief, over-work and anxiety, all of which would strain "their overwrought brain".[91]

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[90] Anne Shepherd & David Wright, "Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint." *Medical History,* vol. 46 no. 2, (2002), 175-96.

[91] Baker, "Female Criminal Lunatics", p. 15; Katherine D. Watson, *Medicine and Justice: Medico-Legal Practice in England and Wales, 1700-1914* (London & New York: Routledge, 2020), pp. 159-160.

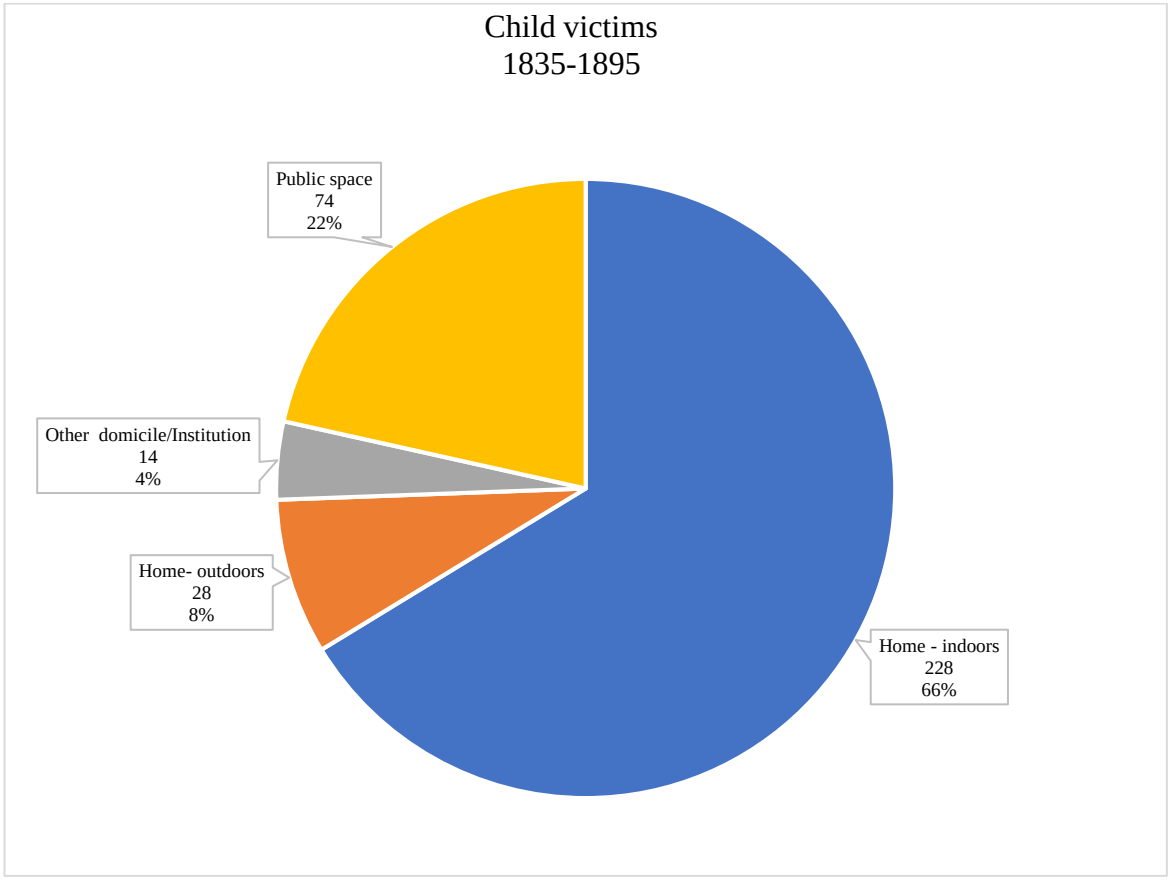

Figure 1:17: *Location of crime, 344 attacks, 1835-1895*

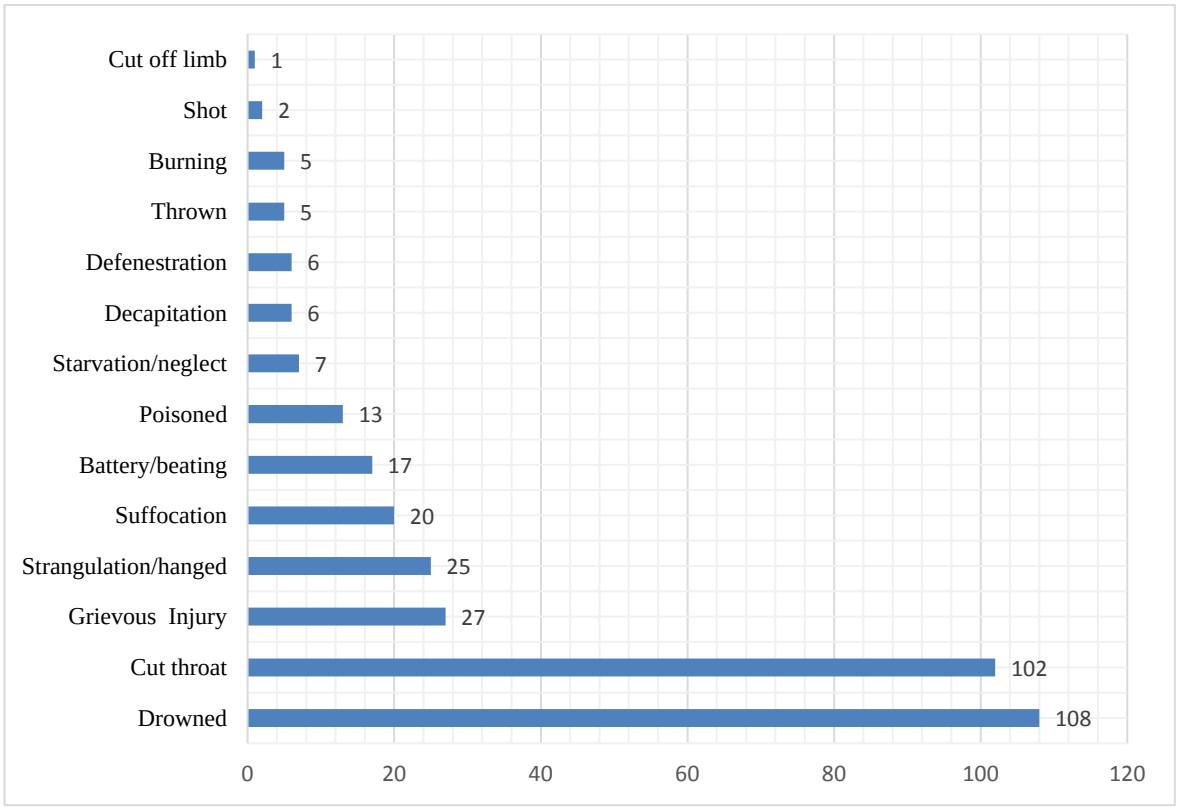

Figure 1:18: *Child victims method of killing or injury, 1835-1895.*

An analysis of where the killings occurred supports the theory that many of the murders were spontaneous attacks: 69% of the crimes were in the home and 22% in

the public domain (Figure 1:17). Within a domestic setting, children could be murdered with instruments which would be close to hand, like a kitchen knife or a razor. Household linen would be used in cases of suffocation or strangulation; and drownings in the home environment were in the bath or copper or water-butts (Figure 1:18). Within all levels of society, the Victorian ideal of home was considered to be a female-dominated space, a place which should provide safety and some security, to the family.[92] The fact that the attacks, both serious and fatal, happened within the domestic sphere, would be another factor in proving that the woman must have been mentally deranged to kill.

Conclusion

Reviewing the statistical charts in this chapter, the profile of the "typical" subject could be said to fit the following description. The mother would be married, aged between thirty and forty years, living in an urban conurbation or the metropolitan area of London and classed as being from the unskilled lower working class. Her child victim would be female, aged under twelve months and an only child. The attack would have occurred in the family home, with a household objects as the weapon. An implement such as a knife, a razor, or another sharp implement would be used, or if the death was by drowning, the bath or copper. The bald reading of the statistics does not allow for any extenuating circumstances which might have lain behind the mother's violence. Mitigating factors were often reported in the courts, in newspaper reports and then further recorded in asylum and institutional records. As mentioned earlier in the chapter, the four teenage cases were all afforded compassion because the young women had been seduced and abandoned. Seduction along with domestic abuse was seen as an offence against a cultural moral code of behaviour towards women.

[92] Ellen Ross, "Fierce Questions and Taunts: Married Life in Working-Class London 1870-1914", *Feminist Studies* vol. 8 (Autumn 1982), pp. 575-602.

Likewise, poverty and privation, as underlying aspects, could engender similar sympathies. Women who were the victims of illness, grief and other factors beyond their control, were also met with compassion. It was, in many cases, these other causes which were emphasised to create sympathetic consideration, both in the courtroom and in the public domain.

It is important to consider the individual class concepts of "proper" familial behaviour, when reviewing and analysing the statistical information. Diagnoses and suggestions of insanity were often attributed to interruptions in the normal patterns of life and behaviour, which the mainly middle-class male authorities would expect of women. The home-lives and relationships of working-class women were scrutinised by men from the professional middle class, by the press and by the public. Domestic circumstances were dissected and commented on and sometimes found wanting. Despite this, within newspaper reports and indeed within case book records, authors also would go to great lengths to emphasise the decency and propriety of the household. The larger part of the 288 women in the dataset, came from the lower income brackets but rarely were they designated as being of the criminal class. They were seen as victims of misfortune, rather than being members of a felonious underclass.

This is apparent when those causes were allied with obstetric and gynaecological issues of pregnancy, childbirth and lactation, menstruation, miscarriage or menopause. The prevalence of causes connected with female reproduction appears to confirm that contemporary medical theories about the connections between the female body and mind, were accepted. The idea that the female mind was vulnerable to any biological bodily change, thereby causing the woman to behave in an extra-ordinary and violent manner, became an acknowledged motivation for her subsequent vicious actions. Witness statements, in all courts, would frequently contain phrases to the effect that the accused woman was a fond mother,

until she went through some catastrophic personal event. In the ensuing chapters, particularly those concerned with coroner and judicial court appearances, I expand on the impact that "other" causal evidence had on all aspects and outcomes, for the women of my dataset.

Much of the discussion in this thesis is about how the subjects were treated by men in authority, the press, the public and their families. I explore the impact of differing concepts of "correct" social behaviour and respectability on the views of the various authorities and agencies. Both these avenues review the women and their experiences through third-party opinions and views. My aim in this chapter is to contextualise the women and their lives, to assign some individualism to them, before they became cogs in the wheels of the medico-legal system. From my research for this chapter and the thesis as whole, it has become evident that different principles of behaviour and respectability played a significant part in determining the quality of the women's passages through judicial and medical processes. The authorities' reactions were impacted by their cultural perceptions of other classes' expectations of respectable domestic and personal behaviour. Those reactions were tempered by the social backgrounds of each of the parties, as different classes had varied ideals and expectations of family and family duty.

The three women whose case histories I quoted at the beginning of this chapter, were all eventually discharged from their respective asylums. Martha Lewis was confined in Bethlem for two years, receiving a Royal Pardon in April 1862 and, at that point, went to stay with friends in Nottingham.[93] In later years, her husband became the Head Storekeeper at Warwickshire County Lunatic Asylum where Martha herself became Head Attendant.[94] Mary Ann Payne was released as recovered to join her

[93] BHRA, CBC-03 Martha Ann Lewis, f. 132.

[94] TNA, 1881 England Census. Class: RG11; Piece: 3090; Folio: 108; Page: 2.

husband and surviving son, returning to Fisherton House for a short stay in 1871.[95] Kate Barrow was conditionally discharged to the care of her husband in 1888 and the family moved away from Buckinghamshire to Warwickshire to escape the ignominy of Broadmoor.[96] Their stories will reappear further in this work to illustrate various other aspects of the life-journeys of mothers who murdered their children and were found to be criminally insane.

[95] FHAA, J7/190/9 Patient Casebook 1862-1871, Mary Ann Payne, ff 170-172. Payne's second stay is discussed in more detail in Chapter 7.

[96] BCLA, DH14/D2/2/2/330, Barrow.

Chapter 2:
"Wilful Murder is the blackest of verdicts":
Investigation: Coroners and Inquests.

Introduction

On the morning of 17 May 1889, Ada Smyth (nee Pulsford) drowned her six-month-old son in the bath at her father's house in Barnstaple. On the same day, an inquest into the child's death was convened by the borough coroner, Mr Incledon Bencraft, in the Council Chambers at the Guildhall in Barnstaple. The Pulsford and Smyth families were represented by their family solicitor, Mr William Roberts. Ada Smyth and her family, the Pulsfords, were known to be educated and "worthy" citizens. She was respectably married to a master coachmaker in Cape Town, South Africa and her father, "an old and much respected tradesman of the town" owned a monument masonry business.[1] After visiting the Pulford home to view the body, the inquest began in earnest. There was much debate about Ada's mental state and some confusion over whether the jury should be discussing this subject at all. The jurors themselves felt mystified as to their very purpose, with one saying, "Will you enlighten us as to what we are here for?" When the coroner attempted to advise the jury that the state of Smyth's mind was not their business, the Pulsford's family solicitor accused him of "usurping the rights of the jury" and of prejudging the result of any "higher tribunal" by requesting a verdict from the jury of wilful murder, manslaughter or death by misadventure. The disrupted inquest proceedings continued with the coroner suggesting that "the jury were going astray" and demanding that he "must be allowed

[1] "Drowning of a Child at Barnstaple", *Western Times* (17 May 1889), p. 5, col. 4.

to have control of [his] own court".[2] He then cleared the courtroom in order that the jury could consider their verdict, reminding them that "it would be their verdict and not his to give." Further discussion of "a heated character" ensued, with jury members doubting the right of the coroner to remain in the room whilst they deliberated. After three hours consultation, the jury still could not reach a verdict. In the light of the jury's failure, Bencraft adjourned the enquiry to the next assizes when, he said, he would report what had happened and that "it would then be for the judge to deal with the matter". [3]

By the nineteenth century, coroners had been charged with investigating violent or unexplained sudden deaths for over six hundred years. [4] If an enquiry into a death was deemed necessary, the inquest would be held within twenty-four hours. Many practices still followed traditional lines; once a suspicious death had been reported, the local coroner and his jury would view the deceased's body, examine witnesses, reach a conclusion and give a verdict on the cause and manner of the death, whether by natural causes, accident, suicide or homicide.[5] Coroner's courts were parochial bodies convened to investigate the probable causes of local unexplained and suspicious deaths.[6] The disorderly nature of the Smyth enquiry, described at the beginning of the chapter, provides an insight into the wrangling and drama that could occur in the coroner's court. All boroughs with a Court of Quarter Sessions had to appoint a coroner and such appointments were ostensibly lifelong, or for as long as the coroner wished to continue. The appointees did not have to have a professional

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2 *Western Times* (17 May 1889), p. 5.

3 "The Murder of an Infant at Barnstaple" *Western Times* (25 May 1889), p. 5, col. 4.

4 Ian Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest, 1830-1926* (London: Routledge, 2000), p. 21.

5 Ibid., pp. 21-88; Katherine D. Watson, *Medicine and Justice: Medico-Legal Practice in England and Wales, 1700-1914* (London & New York: Routledge, 2020), pp 6-8.

6 Watson, *Medicine and Justice,* p. 7.

qualification to become a borough coroner but many were legally or medically trained.[7] At the inquest, the responsibility of the coroner was to act as an advisor to the inquest jury on matters of coronial law and admissible testimony, with no role in the final verdict. The jury's role was to produce that verdict, perhaps naming the probable perpetrator, for onward transmission to a higher, judicial court. There were no firm guidelines on the nature of the evidence to be taken and it could range from factual through to opinion and supposition.

In his book, *Bodies of Evidence,* Ian Burney suggests that the role of an inquest jury was an important feature in the interactions between the law and social standards. [8] Theoretically, the jury represented the views of ordinary people, standing as mediators, either as "a pristine oracle of public opinion" or as a hindrance to precise enquiry. Sometimes a jury could be disparaged as being ignorant and biased or equally it could be admired as being an independent arbiter of public opinion. [9] The result was that the coronial system often reflected local prejudices, personal rivalries and principles. Edward Law Hussey, borough coroner for Oxford between 1877 and 1894, described a quintessential coroner. He "must not be too thick-skinned" and "be prepared to discharge his duties under a constant sense of … the fiercest criticism which was not always fair or favourable."[10]

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7 Victor Bailey, *"This Rash Act" Suicide across the life-cycle in the Victorian City* (Stanford: Stanford University Press, 1998), pp. 38-39.

8 Burney, *Bodies of Evidence,* pp. 5-6.

9 Ibid., p. 6.

10 John Law Hussey, *Miscellanea Medico-Chirurigia: 2nd Part, Occasional Papers and Remarks* (Oxford, 1896) quoted in Elizabeth T. Hurren, "'Remaking the Medico-Legal Scene': A Social History of the Late-Victorian Coroner in Oxford" *Journal of the History of Medicine and Allied Sciences,* vol. 65, no. 2, (2010), 207-252, p. 218.

A coroner's jury could be made up of between twelve and twenty-three men, depending on local practice and the coroner's preference.[11] In reality, in mid-nineteenth-century England and Wales, there were usually between twelve and fifteen jurors at an inquest. To sit on a jury, a juror did not require a professional qualification and in some parts of the country the jury itself became semi-professional, with a regular foreman and jury members. In Newcastle upon Tyne the borough coroner, John Theodore Hoyle, repeatedly worked with the same twelve men but would summon others, in the expectation that some would not attend.[12] Officially the task of the inquest jury was to decide and give an opinion on "who the deceased was and how, when and where the deceased came by his death."[13] Jurors often were men of local standing such as tradesmen and shopkeepers, although working-class artisans could be and were regularly, summoned as members. [14]

From an administrative point of view, it was economically practical for a coroner's officer to serve multiple summonses in the nearby area, so jurors were summoned from the vicinity of the death.[15] The jurors' familiarity with the locale would have an effect on their views and potentially on the verdict.[16] The coroner's inquest became a venue for administering a form of community justice. All these factors have led to the coroner's court being described as a medium for the more marginalised in Victorian society to challenge medico-legal authority and administer

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[11] Bailey, *"This Rash Act"*, p. 47.

[12] Helen Rutherford, "'Hoyle and Trouble: Fire Burn and Cauldron Bubble': The Coroner in an Emerging Industrial Society". Northumbria University Law School Christmas Conference, 10 December 2015, Newcastle upon Tyne.

[13] 50 & 51 Vict., C.71. "An Act to Consolidate the Law relating to Coroners", Coroners Act, 1887.

[14] Bailey, *"This Rash Act"*, p. 47.

[15] Watson, *Medicine and Justice*, p. 85.

[16] Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Oxford University Press, 1987), p. 40.

popular justice.[17] In this chapter I show that it was not only local knowledge which could prejudice the discussions and outcomes of inquests. Social mores and personal preconceptions, as well as emotional reactions, also could impact on inquest verdicts, particularly in cases of maternal child-murder.

The Medical Witness Act of 1836 gave coroners the power to compel qualified medical witnesses to conduct autopsies but they did not always happen.[18] although the value of post-mortem medical evidence became apparent, autopsy reports were not a routine part of medical evidence given in testament at inquests. A factor in the lack of autopsies was the cost. the costs of organising coroner's inquests fell to various bodies and were a contentious issue throughout the nineteenth century. As Katherine Watson notes that the coroner's officers were effectively "gatekeepers", who took on a semi-forensic role in deciding which cases merited an autopsy.[19] As doctors were able to claim fees for undertaking post-mortems, occasionally, for reasons of economy, an autopsy was not occasioned.[20] Watson notes that in the case of deaths in hospitals, prisons, workhouses or an asylum, the medical evidence, if given by the institution's medical officer, was expected to be free of charge.[21] In cases of maternal child murder, the doctor who examined the child's body externally, may have also carried out a post-mortem. In my research, I have rarely found cases where the accused mother has gone straight to a magistrates court without an inquest on the child's body; such cases are where there is no question of the cause of death.

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[17] Joe Sim & Tony Ward, "The Magistrates of the Poor? Coroners and deaths in custody in nineteenth-century England" in Michael Clark & Catherine Crawford (eds.), *Legal Medicine in History* (Cambridge: Cambridge University Press. 1994), 245-267, p. 263.

[18] 6 & 7 Wm IV C 89. "An Act to Provide for the Attendance and Remuneration of Medical Witnesses at Coroners Inquests" 1836.

[19] Watson, *Medicine and Justice,* p. 84.

[20] Anderson, *Suicide in Victorian and Edwardian England,* p. 27.

[21] Watson, *Medicine and Justice,* p. 84.

The medical man who had initially viewed the deceased child and spoken to the mother,would be asked his opinion on the mother's mental state. This opinion may have been solicited by the coroner, jury and other representatives for the mother. It was also frequently given, unsolicited, by the doctor in question. The medical witnesses were not always experts in the field of mental illness and, as there was little formal practical training in "mind-doctoring", assessment would come from personal observation and experience. A medical officer from the local asylum was occasionally be summoned to give a statement on the alleged insane mother's demeanour and mental state.[22] This information was requested despite the fact that, officially, her mental health was of no concern to the jury. The medical evidence given and recorded at an inquest would be called on at the subsequent trial and the medical men would then be cross-examined on their evidence as given in the coroner's court. Any testimony regarding the mental health of the alleged murderer was of significant importance to the higher judicial courts. In this chapter I discuss medical evidence in the context of coroner's inquiries. However, as the same deposition and medical evidence formed the base for counsel argument in the judicial courts, I will review this evidential material once again in Chapter 3.

In most cases, the inquest was the first official procedure to be faced by an accused mother and the verdict of the coroner's court impacted significantly on the future course of her life. It was at this investigative stage that the first questions about a woman's sanity often arose and discussions about her and her family's mental-health history began. Opinions were offered by and sought from, medical men and other witnesses, who were possibly friends and family, as well as various other interested parties. Not unsurprisingly, many of those testifying would offer their opinion on the woman's state of mind. Additionally, if the witness knew the family, they would refer

[22] Watson, *Medicine and Justice,* p. 121.

to any history or suggestion of insanity amongst her kith and kin. As such, witness statements and depositions informed the jury's views and influenced the verdict. The records of coronial courts are a valuable source of social history, described as "one of the great neglected sources of English local history."[23] Direct witness testimony was recorded in some detail by a legal official such as the coroner's clerk. Witness depositions are a valuable source of the minutiae of ordinary lives and the many complex reactions of those involved in a case. As a record of people's experiences, they afford us access to personal opinion and thoughts about the circumstances of the crime, its child victim and the alleged perpetrator. By necessity, the clerk would summarise and paraphrase what a witness said, possibly because the witness was overly verbose or because the officer might not always have heard exactly what was said. The deposition was always read back to the witness, whether or not they were literate, before they were asked to sign or put their mark to it, to render the deposition legally binding. The personal statements contained in the depositions were, by the nature of their recording, mediated through a third party, so potentially they were not unadulterated accounts and accordingly they should be read bearing this proviso in mind.[24]

Local newspapers would carry very detailed accounts of the coroner's court proceedings, especially if the death under investigation was suspicious. As with all

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[23] Bailey, *"This Rash Act"*, p. 5: Watson, *Medicine and Justice*, p. x (preface).

[24] Mediation of contemporary cultural opinion is a subject of scholarly debate see for example: - Fay Bound Alberti, "Introduction: Medical History and Emotion Theory", in Fay Bound Alberti (ed) *Medicine, Emotion and Disease, 1700-1950.* (Basingstoke: Palgrave Macmillan, 2006), pp. xiii-xxviii, p. xvii; Barbara H. Rosenwein, "The History of Emotions. An interview with William Reddy, Barbara Rosenwein and Peter Stearns". *History & Theory,* vol. 49 (2010) pp. 237-265; Martin J. Wiener, "Convicted Murderers and the Victorian Press: Condemnation vs. Sympathy". *Crime and Misdemeanours*, vol. 1: no. 2 (2007), pp. 110-125.

court-reporting, by playing to the sensitivities of their audience through the tenor of the writing, newspapers performed an important function. Like the depositions, the accounts of the coroners' enquiries published in the press are mediated sources. The first account would often be published in the local newspapers, picked up by London-based publications, then spreading nationally through a network of publications. The coroners' courts were viewed as fruitful sources of "good" stories.[25] The press would play on the sadness and unusual nature of the case, record the reactions of the witnesses and comment on the demeanour, appearance and family circumstances of the alleged homicidal mother. The report from the *Liverpool Mercury* on the inquest into the death of 2-year-old John Carr Bradley in 1856, described the inquest as "Melancholy"; the suffocation by Emma Kirby of her baby was dubbed a "Shocking Child Murder" and described by the *North Devon Journal* in 1886 as a "horrid and distressing … infanticide"; and the committal of Mary Ann Morgan for the murder of her daughter in 1883, was called a "Tragedy".[26] Sympathetic and poignant descriptions of the alleged murderer assisted in conveying a view that the mother was likely to be ill, possibly mentally unstable but not evil or malevolent. Press depictions stated that Agnes Bradley was an "unhappy woman", Emma Kirby was "low and melancholy" and Mary Ann Morgan was "greatly depressed" and "unfortunate.[27] Newspapers made their readership aware of the economic circumstances and the social

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[25] Judith Rowbotham, Kim Stevenson & Samantha Pegg, *Crime News in Modern Britain. Press Reporting and Responsibility, 1820-2010* (Basingstoke: Palgrave Macmillan, 2013), p. 103.

[26] "Melancholy case of poisoning by a mother", *Liverpool Mercury* (29 December 1856), p.4, col. 7;"Shocking Child Murder by Wife", *North Devon Journal* (12 July1866), p. 8. cols. 4-6; "The tragedy at Swansea. Committal of Mrs. Morgan for murder", *South Wales Daily News* (23 November 1883), p. 3, col. 8.

[27] *Liverpool Mercury* (29 December 1856), p.4.
North Devon Journal (12 July1866), p. 8.
South Wales Daily News (23 November 1883), p. 8.

position of the family. The *Liverpool Daily Post* described Agnes' husband, James, as "a respectable townsman … a ships' draughtsman" [28]. The Welsh press made that it known that Mary Ann Morgan was the wife of a professional and respected local government officer; "Mrs Morgan, wife of Dr William Morgan, public analyst of Swansea, developed … violent traits … and murdered her youngest child".[29] The domestic circumstances of Mary Ann Beveridge were described as "unfortunate" because "the family had for a long time suffered privation, due to the dissipated and reckless habits of the husband".[30] Clearly such reporting would impact the public view of the putative murderer, engendering compassion and sympathy.

Victorian newspapers and journals reported widely on crime and punishment. The reading public appear to relish crime reportage and reports on inquest proceedings were part of the whole crime narrative. This narrative ranged from discovery and investigation of any crime, through inquest, indictment, trial and on to acquittal or punishment.[31] Cases of maternal child murder, in particular, would be reported in detail in their local vicinity. Possibly because of the shocking nature of the crime, these local reports were picked up by other provincial and national papers and thereby disseminated throughout the country. The suspicious circumstances of a child's death, together with the graphic nature of the given evidence, seemed to make such cases extremely newsworthy to popular sensationalist press, such as *Illustrated Police News*. This particular genre of publication gave its readership graphic narratives enabling them to "pore over the details of how a murderer … perpetrated … her crime."[32] The

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[28] "Coroners Court, Yesterday – Painful Case", *Liverpool Daily Post* (2 January 1857), p. 4, col. 3.

[29] "District News", *Wrexham Advertiser* (23 November 1883), p. 8, col.4.

[30] "Strangulation of a Child by its Mother", *Hampshire Advertiser* (30 January 1847), p. 8, col. 5.

[31] Rowbotham, et al, *Crime News in Modern Britain*, p. 6.

[32] Ibid., p. 6.

report of the inquest into the murder of three-year-old Elizabeth Ann Roberts in the *North Wales Chronicle* of the 16th May 1885, although entitled "Horrible Murder by a Mother in Caernarvon", described the medical explicit evidence in an undramatic manner.[33] Equally, the home circumstances of the family were given as background and possible explanation. When the story was reported in the *Illustrated Police News*, Elizabeth Ann's murder and the unsuccessful attempt at suicide by her mother, Sarah Roberts (or Dobbins), were considered to be sensational enough to be the subject of a front page illustration.[34] The report recorded certain details of the case in graphic detail and there was a hint of bias against Sarah, as a "bad" wife and mother. Victorian newspapers and journals not only acted as a means of distribution of information but also as a forum for the discussion of opinions on personal guilt, responsibility and punishment. Culturally, the views and opinions of the readers, journalists and correspondents would be shaped by social position, class and gender.[35] For the researcher, they are a source and indicator of contemporary popular opinion. Despite being open to bias and inaccuracies, these historical press reports are an essential source to inform historical knowledge of the proceedings in all courts in Victorian England and Wales.

Coroner and Inquest Juries

In 1882, at the beginning of the inquest into the death of three-year-old Gertrude Lee, the borough coroner for Maldon, Essex, addressed the inquest jury on their duties saying, "There is one thing I may as well speak about … and that is that the state of mind of any person who may have committed an offence is not a subject

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[33] "Horrible Murder by a Mother in Caernarvon", *North Wales Chronicle* (16 May 1885), p. 6, col. 5.

[34] "Shocking Tragedy. (Subject of Illustration)", *Illustrated Police News* (23 May 1885), p. 2, col. 2.

[35] Wiener, "Convicted Murderers and the Victorian Press", p. 111.

for your jurisdiction".[36] He continued, "That will be left to a higher tribunal – to the judge and jury at the Assize."[37] Jurors were entitled to question witnesses directly, which they frequently did and they could add riders to their verdicts.[38] The riders, when allowed, often apportioned blame away from the homicidal mothers, finding mitigation in insanity or in the neglect of others. Frequently a coroner would remind jury members that the state of the mother's mind when she committed the crime was not of their concern, whilst also ensuring that those very details were heard within the court. "The jury … wished to add … an expression of their opinion that the mother was insane … But the coroner said this would have no weight with the assize court."[39] This did not, however, always necessarily deter the coroner from making his own comments, which would also be noted and recorded. For instance, at the inquest into the murder of Matthew Sanderson in 1850, the coroner informed the jury that as "Mrs Sanderson's father and sister had died while labouring under an attack of mental derangement" he had no doubt that "her mind was deranged" when she killed her son.[40] Part of the role of the coroner was one of containment and regulation of the level of emotions surrounding the investigation of the murder. On one level he would need to have some emotional detachment from the inquest proceedings but he would also need to maintain elements of compassion in his interactions. [41] The innocence of the child victims and the apparent vulnerability of their homicidal mothers as victims of circumstance, could incite "moral emotions" such as guilt, compassion and self-

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[36] "Child Murder at Maldon", *Essex Herald* (22 July 1882), p. 4, col. 2.

[37] *Essex Herald* (22 July 1882), p. 4.

[38] Burney. *Bodies of Evidence,* p. 5.

[39] *North Devon Journal* (12 July1866), p. 8.

[40] "Murder and Attempted Suicide", *John Bull* (1 April 1850), p. 4, col. 3.

[41] Barbara H. Rosenwein, "Problems and Methods in the History of Emotions", *Passions in Context. International Journal for the History and Theory of Emotions*, no. 1 Spring (2010).

reproach.[42] As will be demonstrated in this chapter, the coroner's emotional reactions to the circumstances of a child's death and to the homicidal mother herself, are apparent in remarks to the jury and in the summings-up of cases.

The inquest into the death of Frederick Smyth which began this chapter, highlights how prejudices could impact upon on an inquest jury and the subsequent verdict. Ada Smyth was "a woman of education and accomplishment" who was "dotingly attached" to her son and her father as "an old and much respected tradesman of the town".[43] The inquest jury members were being asked to give a verdict on someone from a local family of social standing who they could not believe would be capable of murder: "the jury were unanimous in not returning a verdict of wilful murder but that the difference was to a verdict of misadventure or … of found drowned."[44]

Such bias was even more apparent at the Alice Maud Morgan inquest in 1833. The foreman advised that jury members were very reluctant to include the word "murder" in their verdict despite the coroner's advice that they were bound so to do. After hearing significant evidence that Mary Ann Morgan had been suffering from "great mental depression", the jury foreman enquired whether she could be immediately removed to an asylum "to avoid the degradation of prison". Mary Ann Morgan was the wife of the borough analyst, William Morgan, clearly a woman known to the jury members and part of the respectable middle-class society of the town. She is referred throughout the newspaper report on the inquest as "Mrs Morgan "and as an "unfortunate lady".[45]

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[42] Ciara Breathnach & Eugene O'Halpin, "Scripting Blame: Irish Coroner's Courts and unnamed Infant Dead, 1916-32", *Social History*, vol. 39, no. 2 (2014) pp. 210-228, p. 211.

[43] *North Devon Journal* (12 July1866), p. 8.

[44] "Drowning of a Child at Barnstaple. The Inquest", *The Western Times* (17 May 1889), p. 4, col. 6.

[45] *South Wales Daily News* (23 November 1883), p. 3.

Although the remit of the inquest jury was to give a verdict on the cause of the child's death, this did not prevent them from wishing to record their opinions on the circumstances of that death. The juries' riders were not part of the formal verdict and did not form part of the indictment at the assizes or Central Criminal Court. They did, on occasion, apportion blame or express disapproval and, as Burney suggests, they gave an "extra-legal communal judgement regarding the conduct of individuals."[46] Although these addenda were not generally considered permissible, juries frequently requested that some sort of statement about the mother's supposed mental disorder be added to their verdict, or that the verdict was worded to reflect their opinion. After his full summing-up of the medical evidence at the inquest into the fatal poisoning of John Carr Bradley by his mother in 1856, Mr Philip Finch Curry, the borough coroner for Liverpool, advised "the jury that they had nothing wha'ever [sic] to do with the state of mind of the prisoner" and that they were "to find to the facts only and leave the rest to another tribunal." The jury may not have been supposed to make comment upon the mother's state of mind, yet the coroner would often make sure that the information was recorded, thereby ensuring the woman's actions could be attributed to influences beyond her control. As the comment in the *Liverpool Daily Post* said, "[T]he verdict being, of course, equivalent to wilful murder"."[47]

The coroner's court was something of a public forum where anyone could speak, with the permission of the coroner. As well as the jurors and the coroner being permitted to interrogate witnesses, members of the general public could submit their ideas and occasionally their diagnosis of the cause of insanity. In 1883 Mr T. Kimber of Alexandra Road, Reading asked the coroner at the inquest into the death of Alice Lawrence if he may ask a question "seeing the woman had no legal adviser. He had

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[46] Burney, *Bodies of Evidence,* p. 5.

[47] *Liverpool Daily Post* (2 January 1857), p. 5.

been a friend for [sic] the woman for ten years."[48] Kimber then proceeded to question the omission of evidence which would have shown "that the woman [Hannah Lawrence, the supposed killer] was in an unsound state of mind" and that "he felt … a rider should be added to verdict" to that effect. The coroner replied that "they could not take into consideration the state of … her … mind", continuing that "he was bound to a certain form. They had nothing to do with the woman's state of mind".[49]

Mr Justice Day commented in 1885 that "a coroner's jury were very often led away by sympathy or some other cause to return a verdict … without the slightest justification".[50] Certainly, with cases of maternal child murder, local awareness and knowledge of the state of the households involved does seem to have impinged on the jury's opinion. On occasions, the jury members' emotional engagement with the case could be seen in subsequent words and actions. One jury member at the inquest into the death of William Thomas Beck became very upset at what he perceived as the unjust wording of a verdict of wilful murder: "Mr Gunn said that by returning a verdict of wilful murder … it included the unhappy woman amongst the blackest of criminals." When it was pointed out to him that his role was to consider only who had committed the act and not to take into account any evidence heard about her mental health, Gunn expostulated "It is for me to consider whether I shall be dragooned against my conscience …No, I will sit here until I rot first … wilful murder is the blackest verdict we could think of". The other jury members remarked "that they wished to be as 'charitable' as they could" and eventually were persuaded to agree to the wilful murder verdict, qualifying it with a rider expressing their opinion "that the said Mary Ann Elizabeth Beck was not at the time accountable for her actions."[51]

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[48] "The Case of Child-Murder at Reading", *Reading Observer* (25 August 1883), p. 3, col. 4.

[49] *Reading Observer* (25 August 1883), p. 3.

[50] "Central Criminal Court", *Morning Post* (28 October 1885) p. 3, col.6.

[51] "The Wardington Child Murder ", *Banbury Advertiser* (9 March 1876), p. 3, col. 1.

As men of the local community, jurors could be judgmental and, perhaps, patriarchal in their views on the social conditions and circumstances of the woman and her family. The riders to jury verdicts and other post-inquest gestures, give an indication of their views on the case and their views on the possible mitigating circumstances surrounding the murders. Aspects of judgment by social peers were apparent in the verdict at the end of the inquest into the deaths of Ernest and Lizzie Lewis. The jury, in giving their verdict of "Wilful Murder" against Martha Ann Lewis, censured her husband for his negligent conduct.[52] It had been noted that William Lewis was much affected when he had himself given evidence to the inquest, which had taken place the day after his children had been drowned by his wife. He was reproached by the jury because they felt "strong indignation … against the husband for not taking proper care of his wife after she had attempted suicide" three days before the children's drowning.[53]

The men of the jury viewed Lewis as having failed in his masculine duty of safeguarding his wife. In the long nineteenth century, there was an expectation that men would fulfil certain standards of respectable behaviour within the domestic sphere. In all social classes, a good husband and father would provide for his family economically and protect their welfare.[54] As such, manliness became a behavioural code which could be policed by other men.[55] The criticism of William Lewis is an

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[52] "Murder of Two Children by their Mother", *London Daily News* (20 August 1859), p. 3, col. 4.

[53] "Murder of Two Children by their Mother", *Sheffield Daily Telegraph* (22 August 1859), p. 4, col 3.

[54] Carol Beardmore, "Balancing the Family: Edward Wrench, Baslow G.P., c1862-1890" in Carol Beardmore, Cara Dobbing & Steven King (eds.), *Family Life in Britain, 1650-1910* (Basingstoke: Palgrave Macmillan, 2019), pp. 113-134, p. 114.

[55] John Tosh, "Masculinities in an Industrializing Society: Britain, 1800-1914", *Journal of British Studies* vol.44, no. 2 (April 2005), pp. 330-342, p. 335.

example of a body of men, made up of his superiors and his peers, suggesting that he had failed in a basic duty and apportioning blame for a calamitous event. The same sense of possible censure was apparent at the inquest into the death of Emma Kirby's baby. The jury returned a verdict of wilful murder and wished to add "an expression of their opinion that the mother was insane." The coroner advised once again that this would have no weight at the assize but went on to add a comment of his own about the circumstances surrounding the crime, that "although not the least blame rests upon the husband, who is in great distress at the misfortune which has happened to him, it is to be regretted that she was not more narrowly looked after". [56]

Censorious commentary about third-parties in a case from both coroners and from their juries was not a rare occurrence. Coroners and their juries would frequently take a "moral" stance and suggest that the "blame" for the mothers' madness and subsequent deadly actions, should be apportioned to outside influences. Blame was put on third-parties for not watching her, thereby allowing some delusional insanity to manifest itself in the murder of her child. In cases where the mother obviously was "mad", the interrogation of witnesses would bring out other possible causes of madness, beyond medical opinion. Time and again the inference was that the woman had clearly not been protected from danger when there was an intimation that she might commit some rash deed. Such apportioning of blame to someone or something else other than the women themselves, would encourage public sympathy for the accused and ease the male coroner's officials' social and moral conscience.

Blame, as a social concept, has been described as a base for legal systems and as a means of reconciling moral dilemmas.[57] This was apparent in the case of Sarah Lancastell, where the coroner was severely critical of the parish relieving officer. After

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[56] *North Devon Journal* (12 July 1866), p. 8.

[57] Breathnach & O'Halpin, "Scripting Blame", p. 211.

the premature birth of her baby in September 1863, Lancastell's neighbours were concerned about her strange behaviour and her attending doctor requested that the parish relieving-officer find a nurse to care for Lancastell, giving the reason that he felt she would harm the child. Unfortunately, the help did not materialise and Lancastell killed her child. In his summing-up, the coroner partially placed the blame for the baby's death on the relieving officer, "a very strange part of this sad affair is the conduct of the parish relieving officer, who … has indirectly allowed the occurrence to take place".[58] In this case, the words of the coroner were picked up and given higher authority by Mr Justice Compton, the presiding judge at the Winter Assizes where the Lancastell case was heard. Crompton castigated the Board of Guardians saying, "it is mistaken economy to deprive certain cases of sufficient … attention". Lancastell was arraigned by the Grand Jury as unable to plead and the judge made a further comment that, "he regretted that the poor woman had not been properly attended to at the time." [59]

Many jurors took their role seriously as quasi-representatives of the people and handled their human relationships carefully. If a suspicious death was sensitive or upsetting, such as a child-murder, they were required to show a deal of discretion and tact. The jury's riders might contain words of sympathy to the families of the mother and victim but the members also made more philanthropic, practical gestures. At the end of the Bates inquest in 1880 it was noted that "the jury gave their fees to the Infirmary" and, after the 1893 inquest into the death of Charles James Suckling, the jury "gave their fees to the distressed husband [and] increased the amount to 25s".[60] Burney describes a nineteenth-century inquest as an "open tribunal … with a lay jury

[58] "Child Murder at Llandaff", *Cardiff Times* (25 September 1863), p. 5, col. 6.

[59] "Glamorganshire Winter Gaol Delivery", *Cardiff Times* (25 December 1863), p. 6, col. 1.

[60] "The Case of Child Murder – The Inquest" *Northampton Mercury* (17 January 1880), p. 7, col. 2; "The Tragedy near Ipswich" *East Anglian Daily Times* (20 May 1893), p. 7, col. 6.

and an elected official … cast as a traditional check on authority by an active and watchful citizenry".[61] Joe Sim and Tony Ward take the idea further and suggest that coroners could be said to be "magistrates of the poor", championing the ordinary man against authority and that the inquest was a progressive body standing for reform and social improvement.[62] In terms of their personal authority in local life, the coroners were not always revered; however that did not stop many from using the platform of the inquest to castigate other authoritative bodies.[63] Amongst the inquest reports researched for this chapter I have found many incidents like the Sarah Lancastell case in 1863 and that of Sarah Bates in Northampton in 1880, which bear out Burney's, Ward's and Sims' arguments.

The coroner in the Bates inquest advised his jury that, although it "did not fall within their province", they should be aware that the examining surgeon and the relieving officer had failed the Bates family by not telling them that Sarah Bates was out of her senses and by not taking correct due precautions. The coroner made a categorical statement which did not strictly fall within the scope of the inquiry and which, potentially, could have had an influence on the inquest outcome. He said that it should be noted that, in his opinion, "If proper precautions had been taken, this terrible catastrophe might have been prevented." The jury's final verdict was that "the mother caused the death of her child whilst in a state of unsound mind". The coroner at the time said that he would accept this verdict as one that, in law, amounted to a verdict of wilful murder and that although the jury had nothing to do with her state of mind, their remarks were noted.[64] While the verdict from the coroner's court was

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61 Burney, *Bodies of Evidence*, p. 2.

62 Sim & Ward, "Magistrates of the Poor", pp. 245-68.

63 Hurren, "Remaking the Medico-Legal Scene", p. 209.

64 *Northampton Mercury* (17 January 1880), p. 7.

decided upon by the jury, the coroner himself was influential by virtue of his control of the inquest procedures and by his summings-up of the evidence heard.[65]

Medical witnesses and medico-legal evidence

Medical evidence at the inquests played an essential role in the investigations into all violent deaths. [66] When parental child murder, particularly at the hands of a mother, was suspected, that evidence could take two significant forms. There was the clinical evidence to do with the deceased child and there was the personal, potentially more emotional, evidence concerning the putative murderer. As well as presenting details of the post-mortem appearance of the child victim and any autopsy results, the medical witness was often asked to give an opinion on the mother's supposed mental state at the time of the murder. With the exception of the rare appearance of a clinician with asylum experience, they would give a diagnosis despite a general lack of substantial knowledge about mental illness.[67] The additional evidence suggesting insanity was given more weight if it were given by a doctor who had been personally attending the woman and her family and therefore knew the medical history. At the inquest, clinical evidence of post-mortem appearance, autopsy reports or chemical analysis results (in poisoning cases) were usually presented in a dispassionate manner, despite the details being disturbingly graphic for many of the audience. When it came to the questioning about other possible reasons for the mother to have killed her child, the medical witness's responses could be coloured by a personal emotional reaction and by professional conceit. The variations in the medics' reactions, from sympathetic to arrogant, appear to have been dependent on their professional confidence, personality and relationships with patients.

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65 Watson, *Medicine and Justice,* pp. 157.

66 Ibid., pp. 154-155.

67 Bailey, *This Rash Act*, p. 52-3.

Dr Edward Statter gave the medical evidence at the 1856 inquest in Liverpool into the fatal poisoning of John Carr Bradley. He had been the Bradley family medical attendant for some years and it was he who had reported the child's death to the coroner. He also carried out the post-mortem, although how thorough this might have been is debateable. [68] Throughout the nineteenth century there was a movement to take the task of undertaking an autopsy away from general practitioners and attempts to give more specific training in forensic post-mortem examinations, thereby creating a specialised field of medicine.[69] Discussion of contemporaneous perceptions of the "amateur autopsy" being imperfect and biased is not within the purview of this chapter.[70] However as the discussion had implications in terms of medical jurisprudence, it will be reviewed in the next chapter in relation to the medical expert witness in judicial courts.

In the case of Agnes Bradley, after delivering his autopsy report, Statter continued his evidence by detailing the history of his dealings with the Bradley family and, more specifically, with Agnes. He stated that he had been attending her for a few months prior to the murder: "I had attended her from the 12th of June last to the 20th of the following October for that disease [melancholic monomania] but I did not see her [from October] until I was called on 25th of December last.". Describing how her mental derangement had manifested itself on that Christmas night, he continued "On that occasion she stated she was lost … and that as the child was innocent and happy she thought she would send it away to God ... She cried bitterly and lamented when she saw the convulsions caused by what she had done, … she thought the deceased

[68] TNA, PL 27/14, Palatinate of Lancaster: Crown Court: Depositions 1856-1858. "The Deposition Statement of Edward Statter".

[69] Burney, *Bodies of Evidence*, pp. 114-117.

[70] Ibid., p. 116.

would go to God without pain." [71] By indicating that she was acting under delusion when she poisoned her son, Statter was inferring that Bradley's act could be attributed to the state of her mind.

At the inquest into the death of Ellen France, the witness statement given by Dr McLoughlin demonstrates compassion and an amount of self-blame for not being more aware of the possibility of violence in the France household. Dr McLoughlin of Aspull, Lancashire, had cared for Mary France and her family on many occasions and stated in his deposition statement that he "knew her very well" having "attended her some weeks before where her children were ill" when "[s]he was then suffering from want of rest and worry."[72] He was discernibly concerned that he had misread Mary's "state of nervousness" and he categorically said, "in fact I now consider that she was then suffering from dementia." Within his statement McLoughlin described Mary France's maternal behaviour as evidence that her murderous conduct was out of character saying, "she seemed an exceptionally good Mother, excessively fond of her children and nursed them very well."[73] Retrospectively, McLoughlin appears to be regretting his inability to spot the signs of incipient insanity in Mary France's obsessive parental behaviour.

On occasion the medical witnesses sought to distance themselves from the woman and her crime. [74] As well as inferring that their patients disturbed mental state lay at the root of the homicidal actions, some medical witnesses sought to divert professional and peer criticism by implicating neglect by other parties. In the case study which opened this chapter, doctor to the Pulsford family , Dr J. W. Cooke, gave

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[71] TNA, PL 27/14, "Deposition Statement".

[72] TNA, ASSI 52/9, Assize: Northern Circuit: Criminal Depositions and Case Papers, 1887. "The Deposition Statement of Edward Percy Plantagenet McLoughlin".

[73] TNA, ASSI 52/9, "Deposition Statement".

[74] Watson, *Medicine and Justice,* p. 150.

a very sympathetic portrait of Ada Smyth (nee Pulsford) to the enquiry into the drowning of her son Frederick. He did, however, suggest that some responsibility for her actions should lie with her family for not following his instructions. He informed the inquest that he had requested that Ada Smyth's child be taken away from her at night and cared for by a nurse, as she was suffering from melancholia. Unfortunately, on the night Smyth killed her son the nurse had not arrived and her mother-in-law decided not to stay with her; she was left alone. [75]

Likewise, Dr R. G. Burton, a local doctor in Hanwell who had attended Ann Goring prior to and after, the birth of her daughter, Alice in November 1880, abjured responsibility for her actions. He deposed that, "he had noticed that the mother was suffering from mania and in a delicate state of health". He continued that, "he gave directions that she should be watched" but "these instructions … were not carried out."[76] Mr W. A. Royds, a Reading-based surgeon gave evidence at the 1883 enquiry into the death of Alice Lawrence. In his deposition he confirmed that Hannah Lawrence was a patient of his and that he had seen her medically before she killed two-month-old Alice. He stated that, whilst he thought Lawrence was reserved and did not seem well, he did not consider it necessary for her to be watched as "there was a lot of people about".[77] The next day Lawrence drowned her baby at her home and Royds was called to attend at their house and examine the body. His witness statement added, "I did not think it a case which required watching, as she continued to improve whilst I was attending her."[78]

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[75] *The Western Times* (17 May 1889), p. 5.

[76] "Inquests", *London Evening Standard* (30 December 1880), p. 6, col. 6.

[77] *Reading Observer* (25 August 1883), p. 3.

[78] BRO, R/J/Q6/30/47, Reading Borough Records: Coroners Inquisitions, 1839-1912. Coroner's Inquisition: Alice Lawrence, Reading St Mary, 20 August 1883.

Inferences that the crime had been occasioned by a lack of supervision, negligence or irresponsible behaviour by family and kin of the accused mother passed the blame to others. Apportionment of responsibility or blame has been already commented on as a social concept, as a way of reconciling a moral dilemma and a method by which compassion could be created for the murderous mother.[79] The criticism of third-party institutions such as the local Poor Law Union was more removed from the emotional nature of the child's death and the mother's physical and mental state, whereas the medical "blame-shifting" was more personal. Where it occurred, it seems to have been a defensive action against potential censure by peers, as if the medical witnesses felt that they themselves were being policed or judged by the coroner and his court. Implicit too would be a desire to protect their professional and personal reputation and their standing in the local community. These medical men were subtly standing aloof from the community of the coroner's court and away from any implied communal sympathetic emotion voiced by the jury members or indeed the coroner.

Family, friends and neighbours as witnesses

Moving on from the evidence of the medical witnesses, the testimonies of the lay witnesses often convey a sense of sadness, as well as bewilderment and incomprehension at the nature of the events that had taken place . Lay understandings of the manifestations of insanity, played a part in the witnesses' interpretations of the tragic events.[80] Katherine Watson contends that when lay witnesses gave medical evidence, it was a spontaneous expressions of what they had seen and their reaction to the accused.[81] At a fundamental level, inquests were scenes of palpable emotion,

[79] Breathnach & O'Halpin, "Scripting Blame", p. 212.

[80] Watson, *Medicine and Justice:* p. 121.

[81] Ibid., p. 121

partially due to the relationship of the lay witnesses to the deceased child and its mother and partially due to the rapidity with which the inquest took place. The tragic events would still be fresh in the minds of all witnesses and the proximity of the inquest venue to the crime scene would have impacted on all parties and their testimonies. Watson suggests that while lay testimonies and depositions were not taken as a diagnosis of insanity, juries, coroners and later judges, took account of their impressions.[82]

The press reports and deposition statements can be read as contemporary records of the grief of family and friends on the violent death of the child. The grief of Edward Suckling was commented upon in press reports of his son's inquest, not as an unusual occurrence but to confirm that he was a good father and husband; "the father who stated [that] the body viewed was that of his son Charles John James Suckling aged four years … he last saw 'the little dear' alive … on Wednesday morning."[83] In his account of the circumstance of his son's death to the inquest jury, Thomas Beck demonstrated that he was a caring father and that he was bewildered by his wife's act. He refers to his son as "the dear child" and his reaction to the situation was to exclaim, "oh dear, oh dear what shall I do?"[84] The home life of the bereaved family was of interest to the jury and frequently remarked on by the press. When questioned on his relationship with his wife, Suckling advised that Emily Suckling had been admitted twelve years previously to the Ipswich Borough Asylum and that in the immediate three months before the murder, he told the court, "her restlessness [had] become more marked". They had "moved into no fewer than four different homes to please her fancy and to relieve her of her worries." [85] In answer to a jury member about

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[82] Ibid., p.122.

[83] *East Anglian Daily Times* (20 May 1893), p. 7.

[84] *Banbury Guardian* (9 March 1876), pp. 7-8.

[85] *Bury Free Press* (20 May 1893), p. 8.

whether there was any truth in the assertion made by Emily Suckling that he had ill-treated her, he said, "None at all, sir; I have always been good to her". The court believed his testimony and in his summing up, the coroner described the facts of the case as characterising "one of the saddest and most distressing (cases) that have occurred in … (my) …experience." [86] As previously noted the coroner and the jury reacted to his visible distress with a donation of money.

If it could be shown that the accused mother had suffered domestic difficulties, privation or indeed violence, then her behaviour may be mitigated. Such circumstances could also explain her insanity, especially if it were deemed to be a temporary insanity which would subsequently impact on her reception at the higher court. Ann Goring had told her attending doctor in the weeks before she murdered her daughter that "she had no food in house". However, her husband categorically stated that "she had lately been strange in her manner … the Witness said he had not kept his wife without food."[87] In his emotional testimony William Lewis described the last time he saw his wife and children: "she turned round and smiled and said to me 'ta, ta' I laughed and said in a joking manner, 'oh, good morning to you.' That was the last time I saw the children alive … I had no quarrel with her."[88] An ideal "good husband" would encourage and care for his wife even if she seemed to be at odds with the world. Isaac Ryan was commended for looking after Hannah Ryan following her "recent confinement and consequent depression. He left her in the morning with an encouragement to be cheerful but returned to the death of his child".[89]

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[86] *East Anglian Daily Times* (20 May 1893), p. 7.

[87] *London Evening Standard* (30 December 1880), p. 5.

[88] "Murder of Two Children by Their Mother" *Western Daily Press* 22 August 1859 p. 4, col. 3.

[89] "Child Murder at Prestbury", *Northwich Guardian* (18 February 1871), p. 4, col. 6.

When witnesses were questioned about the women and the circumstances of their crime, they rarely disagreed with the medical testimony and often accepted an element of responsibility for the situation. At the inquest into the death of Maud Levesley, James Levesley, the child's father, was specifically asked if he had been cautioned by a medical man to watch his wife's behaviour because she might injure the child. Levesley accepted that he had and then justified his action saying, "I did not have anyone to watch her as Dr Chapman advised, because in my opinion it would only excite her."[90] This was not as callous as it might seem; Rose Levesley had been dependent on chloral for many years and her husband had been trying to wean her off the drug, even trying to enlist the help of the local druggist in his endeavour. The killing of her child was a culmination of many years of family difficulties.[91] In many cases, the spouse of the homicidal mother frequently took responsibility for his wife's actions by accepting that he should have protected her more from her own state of mind and health.

Many of the witness statements contain reference to the women's abilities as mothers and their relationships with their children. Analysis of the remarks in the depositions contributes to our understanding of the cultural expectations of motherhood in Victorian Britain. The concept of a good mother was increasingly idealised in Victorian society as one of nurture and care; maternal love was demonstrated by good housekeeping and attending to the family's well-being.[92] A harmonious home was important as a sign of respectability, as was a good relationship between husband and wife. The neighbour to the Sanderson family described Thomas

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[90] TNA, CRIM 1/20/6 1149328, Central Criminal Court: Depositions. Defendant: LEVESLEY, Rose. Charge: Murder. Session: March 1884. "The Deposition Statement of James Levesley".

[91] TNA, CRIM 1/20/6 1149328: "The Deposition Statement of James Levesley".

[92] Emma Griffin, "The Emotions of Motherhood", p. 72.

Sanderson as "a kind father, prudent man and affectionate to the extreme to the accused herself – perhaps too much."[93] A marriage breakdown or a husband not behaving as provider and protector of a family would often be taken as good reason for mitigation for the woman's act. Emily Lee had been deserted by her husband and she had been living with her daughter in a Maldon workhouse. She had left the workhouse and been wandering destitute for a week, before drowning four-year-old Gertrude in a pond. Neighbours' descriptions of Lee clearly pointed out her strange, distracted behaviour as an indication of her insanity.[94]

At the inquest into the death of James Beveridge in 1849, despite the fact that he was the second child to be murdered by his mother, Mary Ann, the inquest heard that her husband's profligate behaviour lay at the root of Mary Ann's actions. She was described at both the 1847 and 1849 inquests as "having affection for her children (which) seemed her only consolation." The newspaper account did also note that, "The coroner who held the inquest on the body of the former child [Thomas, who died in 1847] was of the opinion that the prisoner was a monomaniac, more particularly with regard to her own offspring." [95]

Scholars have explored Victorian expectations of mothers from all levels of society and commented upon elemental differences due to class cultural expectations.[96] A linking thread between all was that mothers were expected to have an emotional bond with their children. As Emma Griffin writes, "the love between a

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[93] "Infanticide and Attempted Suicide", *Kentish Independent* (13 April 1850), p. 2, col. 3.

[94] *Essex Herald* (22 July 1882), p. 4.

[95] "Crown Court" *Hampshire Telegraph* 10 March 1849 p. 2, col. 2.

[96] For example: Joanne Bailey, *Parenting in England 1760-1830: Emotion, Identity and Generation* (Oxford: Oxford University Press, 2012); Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class,1780-1850* (London & New York: Routledge, 1987); Ellen Ross, *Love and Toil: Motherhood in Outcast London*, 1870-1918 (Oxford: Oxford University Press, 1993).

mother and her child [was and] is one of the most elemental of human emotional experiences."[97] Witnesses at the inquest would quote examples of good mothering to emphasise the accused's maternal virtues. At the Lawrence inquest, "the Foreman asked whether the woman [Hannah Lawrence] had always seemed kind to the child? The witness [Mrs Seward, a neighbour] replied in the affirmative".[98] Expressed cultural views of "good" motherhood and "true" womanliness were frequently demonstrated in inquests. Hannah Ryan was described by her neighbour as "a kind, steady, respectable woman and lived on the best of terms with her husband".[99]

Emma Nelms was the mother of twelve children, described by a family friend as "always kind to her children and an excellent mother, most affectionate and always kept them clean. She had a large family". Her neighbour attributed Nelms' mental derangement to worry that the family would suffer because the family income would be reduced as her two eldest sons were out of work. "Nelms [the father] was kind to his children but there was a large family and … she said 'We are half-starved. I shall go mad surely'."[100] From this description it is possible to picture how, sometimes, the circumstances of a working-class household could cause the mental collapse of the mother. Emma Nelms was struggling to fulfil her expected role as carer for the family, within her cultural norms of good house-keeping. As Emma Griffin writes "they [working class mothers] lived in a harsh world" which constrained emotional functions within poorer lower-income families.[101] All the women examined in this

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[97] Griffin, "Emotions of Motherhood", p. 64.

[98] *Reading Observer* (25 August 1883), p. 3.

[99] *Northwich Guardian* (18 February 1871), p. 3.

[100] "Murder of an Infant by its Mother", *Oxford Journal* (16 January 1886), p. 4, col 2. BCLA, D/H14/D2/2/2/392 Case File: Emma Nelms.

[101] Griffin, "Emotions of Motherhood", p. 85.

study had contravened the fundamental cultural expectation of maternal behaviour, that of a natural, nurturing bond with their vulnerable child.

Conclusion

As referred to in the Introduction, the nineteenth century saw recurrent moral panics about the rates of infant death and infanticide. The public outcry and panic were partly fuelled by the press. The majority of newspapers would report inquests into suspicious child deaths in detail, thereby drawing the public attention to "every single case of child murder brought before our coroners."[102] To an extent this moral alarm was also driven by contemporary commentators such as Dr Edward Lankester, the coroner for Middlesex. He not only recorded more verdicts of wilful murder than other coroners but also wrote about the fact.[103] He estimated that 12,000 women in London had murdered their babies, a figure which was picked up and used by social commentaries at the time.[104] This "estimation" was not borne out by the number of child-murder and infanticide cases tried at the Central Criminal Court, for instance, and was probably slightly inflated to prove a point.[105]

The role of the coroner was not to comment and judge the "moral compass" of his community but it was to investigate sudden and violent deaths.[106] An inquest was

[102] *Daily Telegraph* (13 September 1865) quoted in Tony Ward, "Legislating for human nature: legal responses to infanticide, 1860-1938" in Jackson (ed) *Infanticide*, pp. 249-269, p. 253.

[103] Ward, "Legislating for human nature", p. 254.

[104] Shani d'Cruze & Louise Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke: Palgrave Macmillan, 2009), p. 79.

[105] Anne Marie Kilday, *A History of Infanticide* (Basingstoke: Palgrave Macmillan, 2003), pp. 119-120.

[106] Margaret L Arnot, "Understanding women committing new-born child murder in Victorian England" in Shani D'Cruze (ed) *Everyday Violence in Britain, 1850-1950* (Edinburgh: Pearson Education Ltd, 2000), pp. 55-69, p. 56.

convened to investigate a suspicious death and, if the proceedings determined that homicide was the cause of death, to produce an indictment to send the accused mother on to the assizes or Central Criminal Court for a criminal trial. The coroner's court was a place where emotions were shown and shared amongst all parties. The witnesses were often personally attached to the child victim and to the accused mother. The doctors who had examined the body or performed the autopsy may have been the family's medical attendant; other witnesses included neighbours who may have discovered the body, witnesses to the act and the local policeman who apprehended the woman. In many cases, more especially in smaller communities, the family of the victim and mother would be known to the jury members and that acquaintance could impact on the final verdict. The coroner would play a diplomatic role and be aware of local prejudices and personalities in order to keep an orderly court. Adolphus E. Church, Coroner for the Sokens in Essex, summarised their purpose in a letter to a local newspaper in 1887. He wrote, "Coroners are bound to hold inquests, the reasons for which must be obvious to all, thus preventing any case from being improperly hushed up and clearing up any doubt which might otherwise exist."[107] In general, the views and statements given in the coroner's court and the interactions between all parties laid a foundation for the treatment of and attitudes towards an accused mother throughout her journey through the medico-legal system.

[107] "Letter to the Editor" *Essex Standard* (27 August 1887), p. 5, col. 4.

Chapter 3:
"The Humanity of the Law":
Trials: Prosecution, Defence and Judgement.

Introduction

At the Old Bailey on 14th January 1884, in a case heard before Mr Justice Hawkins, Mrs Annie Player was found "Guilty of the act [wilful murder] as charged," and sentenced to "be detained in custody as a criminal lunatic until Her Majesty's pleasure be known."[1] Annie Player had been accused of throwing her seven-month-old son, Willie, out of a bedroom window at the family home. She had tried to commit suicide at the same time by clambering out of the window but was held suspended by her hands and supported by her feet by her neighbours. The incident was the subject of a front-page picture and a short piece in the *Illustrated Police News*, "Christmas Number" (1883).[2] When she appeared at the Magistrate's Court she was described by the press as "very exhausted" and "in a delicate state of health".[3] Nevertheless she was sent to H.M. Gaol Clerkenwell, on remand, before her trial at the Old Bailey. While she was in Clerkenwell, Annie made three attempts at suicide which confirmed the prison surgeon's opinion that she was "a person of an unsound mind."[4] She was examined on three occasions for signs of insanity by Dr William Orange, Medical

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1 OBP, *Old Bailey Proceedings Online*, January 1884, Trial of Annie Player (25) (t18840107-219).

2 "Attempted Suicide", *Illustrated Police News* (15 December 1883), p. 1; illustration. "Attempted Suicide (subject of illustration)", *Illustrated Police News* (15 December 1883), p. 2, col. 2.

3 "Hammersmith" *London Evening Standard* (19 December 1883), p. 3, col. 8; "A Brutal Mother" *Bury and Norwich Post* (4 December 1883), p. 3, col. 4.

4 OBP, January 1884, Player.

Superintendent of Broadmoor, twice with Dr Robert Mundy Gover, formerly resident surgeon at Millbank and now Medical Inspector of Prisons.[5] Orange gave evidence at her trial and said of her that, "she is decidedly a proper person to be confined in a lunatic asylum and placed under proper care and treatment with a view to her recovery."[6] Annie was admitted to Broadmoor on 25th January 1884.[7]

The previous chapter established the complexity of inquest procedures in cases of maternal child killing by mothers eventually found insane. In this chapter, I continue this narrative with analysis of the allegedly insane mothers' passage through the criminal justice system. Like most of the cases in the metropolitan area of London, Annie Player's appearance at the Central Criminal Court followed an inquest verdict of wilful murder of her son and a hearing before a magistrate, from where she was remanded on a charge of murder and attempted suicide. For the accused women in the provinces, their next stage on the journey would be a trial hearing in the assize court. The case would first be brought before a grand jury who would decide if there was sufficient evidence in a case to put a defendant on trial. If it were decided that there was a "true bill" to answer, the woman would then be brought into the dock and face trial by jury. On occasion, the case would not proceed beyond the grand jury hearing, with a defendant being declared unfit to plead on the basis of the prosecution evidence of insanity.[8] Katherine Watson states that from her research, she has found that cases of possible madness, if verified by medical opinion, were not heard at assizes and "diverted from the criminal justice system".[9] While that maybe applicable to many

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5 ""Robert Mundy Gover", *Munks Roll*, vol. 4, Royal College of Psychiatrists, p. 294.

6 OBP, January 1884, Player.

7 BCLA, D/H14/D1/1/1/2 Admissions Register 1868-1900.

8 Roger Smith, *Trial by Medicine*. *Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1982), p.20.

9 Katherine D. Watson, *Medicine and Justice: Medico-Legal Practice in England and Wales, 1700-1914* (London & New York: Routledge, 2020), p. 163.

cases involving single mothers, I have found in my research that where the verdict of the coroners' and magistrates' court were "wilful murder", the accused mother would face the higher tribunal. The implications of the "unfit to plead" findings are discussed in Chapter 4 as it impacted upon legal and medical opinion about the women's incarceral and institutional futures.

In court, not only would the details of the woman's crime be scrutinised but so too would be her domestic circumstances, home-life, social status and respectability. Personal health issues, both physical and mental, were discussed along with those of familial background, to highlight any hereditary causes of insanity. It has been said that to some members of the lower and working classes, the court room was a public forum where they could prove their innocence of a criminal act. [10] To most of the women in this study, the overall impression gleaned is that it was a bewildering, alien place; a male-dominated environment of formal behaviour and erudite speech. The proceedings were led by figures of authority with whom, in other circumstances, the women may never have had contact.[11] By analytical review of the statements and evidence, this chapter examines the manner in which the accused women and their crimes were presented by the prosecution and defence counsels and the reaction of both the judges and the juries to the testimonies given by both lay and medical witnesses.

The level of violence the women had used towards their child victims was contrary to Victorian ideals of gender. However, when the cases came to court, the female defendants were, for the most part, afforded a sympathetic hearing. Through the use of emotive argument, the words of the male legal professionals in the

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[10] Shani D'Cruze, *Crimes of Outrage. Sex, Violence and Victorian Working Women* (London: UCL Press, 1998), pp. 139-140

[11] Katie Barclay, *Men on Trial. Performing Emotion, Embodiment and Identity in Ireland, 1800-1845* (Manchester: Manchester University Press, 2019).

courtroom urged compassionate understanding for the murderers. The importance of emotion in shaping the courtroom narratives and trial reporting has been discussed by scholars and historians who have argued that female offenders received more sympathy than men in the nineteenth century.[12] Katie Barclay writes that "emotion plays a central role in the construction of legal narratives" and comments that recent scholarship has challenged former conceptions that the law was a purely rational process.[13] The emotional narratives deployed and performances enacted, in cases of maternal homicide, from counsel and witnesses to the judiciary and juries, played their part in building a picture of the murderer as an ill, misguided or sad, rather than a bad, evil, woman.[14] In so doing the perceived threat of maternal violence was reduced and some sort of balance was restored to the socio-cultural ideals of motherhood. Murderous behaviour could be assigned to insanity and forces beyond the control of a

[12] Amongst others; Margaret L. Arnot, "Gender in Focus: Infanticide in England 1840-1880, (unpublished PhD Thesis: University of Essex, 1994); Idem., "Perceptions of Parental Child Homicide in English Popular Visual Culture 1800-1850", *Law, Crime and History* vol.1 (2017) pp. 16-74; Katie Barclay, "Narrative, Law and Emotion: Husband Killers in Early Nineteenth-Century Ireland" *The Journal of Legal History,* vol. 38 no. 2, (2017) pp. 203-227; Idem., *Men on Trial;* Barry Godfrey & Paul Lawrence, *Crime and Justice since 1850* (London & New York: Routledge, 2015); Smith, *Trial by Medicine*; Judith Rowbotham, Kim Stevenson & Samantha Pegg, *Crime News in Modern Britain. Press Reporting and Responsibility, 1820-2010* (Basingstoke: Palgrave Macmillan, 2013); Anne Schwan, *Convict Voices: Women, Class and Writing about Prison in Nineteenth-Century England* (Durham, New Hampshire: University of New Hampshire Press, 2014); Martin J. Wiener, *Men of Blood. Violence, Manliness and Criminal Justice in Victorian England* (Cambridge: Cambridge University Press, 2004); Lucia Zedner, *Women, Crime and Custody in Victorian England* (Oxford: Clarendon Press, 1991).

[13] Barclay, "Narrative, Law and Emotion:", p. 226.

[14] Schwan, *Convict Voices,* p. 35.

weaker, female mind. The "medicalisation" of the maternal murderer added a nuance to nineteenth-century views by creating an atypical female violent criminal.[15]

I explore how medical opinions, emotional reactions and socio-cultural perceptions of the homicidal women influenced the way they were viewed in the legal context. There were changes in legislation and in the practice of law during the nineteenth century, which impacted on the trials of the accused homicidal women. After the passing of the "Prisoners' Counsel Act" in 1836, both prosecution and defence counsel had the right to access pre-trial statements and to address the jury.[16] Despite the evolution of ideals of "manliness" away from displays of overt sentimentality in public, throughout the period of this study most, if not all, the men involved in the cases would act with an apparent sympathetic concern towards the mentally-vulnerable female defendants in court. [17] Barclay emphasises that all barristers' speeches tended to be oratorical using emotive language to influence the judges and juries to arrive at just and, in cases of maternal child homicide, humane verdicts.[18] Courtroom lawyers used evocative language in speechmaking, creating narratives to support their cases and to influence judicial opinion. Legal speeches reflected cultural and social concepts of behaviour, arousing sympathy by highlighting different facets of a defendant's character and actions. Such rhetoric would be a persuasive tool in influencing the ultimate verdict.[19]

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[15] Lucia Zedner, "Women, Crime and Penal Responses: A Historical Account". *Crime and Justice,* vol. 14 (1991), pp.307-362, p. 308.

[16] 6&7 Will. IV. c.114. Trials for Felony Act 1836.

[17] Thomas Dixon, "The Tears of Justice Willes" *Journal of Victorian Culture*, vol. 17 no. 1 (2012), 1-23; Idem., *Weeping Britannia. A Portrait of a Nation in Tears*, (Oxford: Oxford University Press, 2015), pp. 169-182.

[18] Barclay, *Men on Trial*, pp. 139-141.

[19] Barclay, "Narrative, Law and Emotion."; Idem., *Men on Trial.* p. 131; Wiener, *Men of Blood,* p. 126.

Evidence from expert medical witnesses was essential in establishing the defendant's state of mind and fitness to plead, as well as establishing that she was insane at the time of the murder. Contemporary medical theories about the physiological and psychological effects that reproduction and its attendant conditions could have on the female body and mind, had bearing upon the way in which women were viewed in both the legal and public context.[20] Evidential "proof" that the accused mother was insane and appeared to be unaware of the consequences of her criminal actions, or was acting under delusion at the time that the crime was committed, was considered to be as important as medical evidence in proving insanity.[21] The concept of criminal responsibility was a subject of medico-legal argument in the nineteenth century. Several cases examined for this thesis highlight some of the differences of opinion and are used in various chapters as examples of the contemporary perceptions of delusion and responsibility. In this chapter I discuss how different concepts in medical and legal thinking on criminal responsibility and delusion and medical evidence of insanity, impacted upon the women's trials. The same divergent opinions and understandings of criminal responsibility led to discussion about the best place of incarceration and, indeed, the efficacy of those institutions for cases of maternal homicide, which debate I analyse in Chapter 4.

Throughout the review of the women's experiences in the courtroom, it is evident that social expectations and emotional norms influenced the interactions between various parties. Emotional responses and narratives shaped by contemporary cultural expectations of "decent" behaviour, played a powerful role in nineteenth-century courtroom dynamics. Perceptions that an accused mother could be a casualty

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[20] Nigel Walker, *Crime & Insanity in England, vol. 1. Historical Perspective,* (Edinburgh: Edinburgh University Press, 1968), p. 125.

[21] Joel Peter Eigen, *Unconscious Crime: Mental Absence and Criminal Responsibility in Victorian London,* (Baltimore: The Johns Hopkins University Press, 2003), p. 184.

of her social environment, as well as of medical circumstances, influenced the emotional responses of legal men and the men's personal beliefs and circumstances could colour their emotional reactions.[22] In the chapter, when discussing the influence of emotion on legal attitudes, I highlight the background to judicial responses. Judges were high profile cultural figures in the popular press of the time; their speeches were often recorded in detail, allowing access to their views on particular cases.[23] As a result of this public profile, there was popular interest in judges' careers with the printing of collectible *cartes de visite* and picture profiles in popular journals.[24] Some had worked as journalists themselves and believed that a positive view of legal professionals and judges in particular, should be promoted by the press.[25] Others published somewhat self-promoting reminiscences and collections of their adversarial speeches.[26] Analysis of such material, while it is based mostly on their professional careers, can assist in assessing whether emotion and opinion, in conjunction with educational and personal background influenced judicial decisions.

Emotion and sentiment played an important role in popular culture throughout the Victorian period. Legal argument and process was recorded by journalists and other writers and was important in disseminating information about court cases to the

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[22] Alison Pedley, "The Emotional Reactions of Judges in Cases of Maternal Child Murder in England, 1840-1890" in James Gregory, Daniel J.R Grey & Annika Bautz (eds.) *Judgment in the Victorian Age* (London & New York: Routledge, 2019), pp. 83-99.

[23] Craig Newbery-Jones, "Judging the Judges: The Image of the Judge in the Popular Illustrated Press" in Gregory, et al., *Judgment in the Victorian Age,* pp. 161-81.

[24] Leslie J. Moran "Cartes de Visite and the First Mass Media Photographic Images of the English Judiciary: Continuity and Change" in Gregory, et al., *Judgment in the Victorian Age,* pp. 43-60.

[25] Rowbotham, et al., *Crime News in Modern Britain,* p. 47.

[26] For instance: Sir Henry Hawkins, Baron Brampton, in R. Harris (ed.) *The Reminiscences of Sir Henry Hawkins, Baron Brampton,* (London, Thomas Nelson 1904); R. Harris, *Illustrations in Advocacy, with an Analysis if the Speeches of Mr. Hawkins, Q.C. (Lord Brampton),* (London: Stevens and Haynes, 1915).

wider public. For research purposes, newspaper articles and court reports are essential in revealing the part emotion and respectability played in the construction of legal narratives and in the courtroom in general. Although cultural analysis of such narrative sources is not central to this thesis, modern-day access to nineteenth-century courtroom dynamics is mediated through newspaper reports. Therefore, I will briefly review the influence of reporting on social and professional attitudes.

Testimony from the accused mother's peers about her normal behaviour and respectable home life, would lend weight to the idea that her violent actions were totally out of character. A woman's respectability of manner and of domestic circumstances, was integral to how she was viewed in the press, in the courtroom and by the judge and jury. Sympathetic accounts of the personal appearance and manner, in court, of an accused mother helped to shape public perceptions of her. An emotional display or an air of general distracted bewilderment would elicit sympathy and possibly impact the court's verdict. Social status could play a part in the way the women were perceived in court. As stated in preceding chapters, notions and concepts of respectability were an important part of Victorian society, especially in the middle and lower classes.[27] Its significance in the evidence of neighbours and friends would not be lost on the judge and jury and would support the defence of insanity. The illustrative case studies contained within this chapter once again highlight the importance of supportive statements from family, friends and other peer-group witnesses.

[27] Among other cited works: David Cannadine, *Class in Britain*, (London: Penguin Books, 1998),; Emma Griffin, *Bread Winner. An Intimate History of the Victorian Economy* (New Haven & London; Yale University Press, 2020); Louise A Jackson, *Child Sexual Abuse in Victorian England,* (London and New York: Routledge. 2000); Susie Steinbach, *Women in England, 1760-1914. A Social History* (London: Weidenfeld & Nicholson, 2004).

As juries had the final part to play in the trials, the penutimate section of this chapter considers their role in court cases involving maternal child homicide and insanity. As comments or opinions from the jury and its members were rarely recorded, it is difficult to analyse their approach to the homicidal women.[28] Their role as the ultimate decision-makers on the facts of the case is highly significant when considering the success of a defence or prosecution and in deciding the fate of the accused woman. The conclusion will draw together the various strands examined and discussed in the chapter. Gender-driven ideals and socio-moral issues of behaviour, respectability, social status and family life, impacted on the women's experiences within the Victorian legal system. Socio-cultural values, shaped by personal experience and emotional circumstances, coloured all opinion given in court trials. This impact is discussed in order to ascertain whether, ultimately, such values had an influence on the verdict and, thereby, the future lives of the homicidal mothers.

Criminal responsibility and delusion

The issues of criminal responsibility and delusion were highly significant in the trials of mothers accused of killing their children. The nineteenth century saw the development of medico-legal defences with the emergence of medical testimony and the use of the insanity defence with respect to women on trial for infanticide and child murder. In any trial for child murder, whether the specific subject of insanity was mooted or not, the question was frequently raised of whether the defendant was aware that her act was wrongful at the time and whether she had had the criminal resolve to damage her child. This particular point, of knowing right from wrong, was an

[28] Helen Rutherford, "Unity or Disunity? The Trials of a Jury: R v John William Anderson: Newcastle Winter Assizes 1875", in James Gregory & Daniel J.R. Grey, (eds) *Union and Disunion in the Nineteenth Century*, (London & New York: Routledge, 2020), pp. 242-58, p. 248.

important part of the M'Naghten's Rules.[29] In principle, when the tests set out by the Rules were satisfied, the accused could be adjudged insane and be sentenced to an indeterminate period of confinement and treatment in an asylum or similar secure hospital facility, instead of a punitive incarceration.[30] Along with the debate on criminal responsibility, the existence of unconscious impulse and delusion was discussed by contemporary medical practitioners.

The leading Victorian authority on medical jurisprudence was Dr Alfred Swaine Taylor who, in 1844, published *The Principles and Practice of Medical Jurisprudence,* which eventually became the medico-legal handbook of choice.[31] Taylor had extensive experience within the legal system and was openly critical of prosecution or defence attorneys engaging medical, or scientific, witnesses to prove or disprove evidence. He suggested that a system of independent, non-partisan experts who would not be accused of bias or prejudice, would be a preferable system. In *Medical Jurisprudence,* he wrote about insanity as a defence to criminal charges and the "civil responsibility of lunatics." [32] He discussed the various medical and legal definitions of the term, highlighting the question of responsibility and stating that "the rule of law … is that no man is responsible like a sane person for any act committed

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[29] UKHL J16 (19 June 1843), The Case of Daniel M'Naghten; 10 C1 & Fin 200: 8 ER 718. United Kingdom House of Lords Decisions. (1843) "M'Naghten's Case".

[30] Smith, *Trial by Medicine*, p.19.

[31] Dr Alfred Swaine Taylor (1806-1880), Professor of Medical Jurisprudence at Guys Hospital, 1831-1877. The acknowledged Victorian authority on medical jurisprudence, who published *The Principles and Practice of Medical Jurisprudence.* The book became the standard reference book for medical examiners and forensic pathologists. It ranged widely over the causes of death through foul play. Taylor frequently appeared as a witness for the Crown and his assistance was often sought in criminal investigations. Helen Barrell, *Fatal Evidence. Professor Alfred Swaine Taylor & the Dawn of Forensic Science* (Barnsley, Pen & Sword History, 2017).

[32] A. S. Taylor, *The Principles and Practice of Medical Jurisprudence* (London: J. Churchill, 7th edition, 1861), pp. 660-661.

by him while in a state of insanity." In his opinion, "[the] acts of the insane generally arise from motives based on delusion". [33] He qualified this by stating that he believed that the presence of delusion at the time of the criminal act should not be taken as the sole sign of insanity but be one amongst others. He wrote that for a defence of insanity to be successful, "[the] insanity must be proved to have existed at the time of the perpetration of the act. Whether the prisoner is or is not insane when placed on his trial is immaterial in reference to the question of responsibility". [34] Taylor was critical of this legal principle of responsibility and concluded that "it has been abundantly proved that the test of responsibility … is of a purely theoretical kind and cannot be carried into practice."[35]

Despite Swaine Taylor's views, historian Joel Eigen suggests that the judiciary and jurors would, nevertheless, expect to be presented with some evidence that the defendant was deluded at the time of the murder before accepting a defence of insanity.[36] This seems to have been true in the trials of the homicidal mothers under discussion and, accordingly, explanations for the cause of delusional behaviour were sought and presented in court. It was not uncommon for zealous and exaggerated religious behaviour to be cited as a possible cause of strange conduct and mental breakdown. With a crime such as maternal child murder, it was difficult to prove absolutely that the mother was acting under a delusion at the time of the crime as, more often than not, there were no witnesses to the murder. As Eigen writes which I, too, have found, medical observational evidence could only "prove" the mother was insane by analysis of her reported and observed behaviour before and after the event.[37]

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[33] Ibid., p. 660.

[34] Ibid., p. 661.

[35] Ibid., p. 676.

[36] Eigen, *Unconscious Crime*, p. 184.

[37] Eigen, *Mad Doctors*, p. 113.

By its nature, this evidence was circumstantial, if not hearsay and could not conclusively prove that she was mad or delusional at the time she killed her child.

At the trial of Agnes Bradley in Liverpool in 1859, Mr Justice Willes highlighted to the jury that if they believed that the defendant was not in a sound state of mind "because she believed that she was acting under a command of God, higher than the Law", then they should acquit the defendant as insane "when she did the act which was murder."[38] In asylum records, medical men would frequently refer to excessive and exaggerated religious behaviour as an indicator of insanity, rather than a cause. Dr David Nicolson, Deputy Medical Superintendent at Broadmoor Criminal Lunatic Asylum from 1876 to 1886, Medical Superintendent from 1886 to 1898, attributed "the great frequency at which … infanticides occur" to the mother having "an insanely exaggerated extension of religiousness and foreboding, accompanied by an overwhelming sense of personal unworthiness and unfitness to live". [39] He continued that in murdering her child, the mother sought to protect it from a "horrible life as pictured by her anguished mind." [40] Other mental illnesses, such as puerperal mania and monomania, as well as physical illness and deprivation, were viewed as root causes of the damage to the women's minds and reason.[41] Those causes were exacerbated by, or manifested themselves in, exaggerated religious imaginings and behaviours. I discuss the diagnoses and manifestations of insanity in the homicidal mothers patients of my dataset, in greater detail in Chapter 5.

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[38] "The Murder of Three Children by Their Mother*" South London Chronicle*, (27 July 1861), p. 3, col. 1.

[39] David Nicolson, "An Address on Mind and Motive: Some Notes on Criminal Lunacy." *The Lancet* vol. 182 no. 4698 (1913) pp. 783-850, p. 847.

[40] Ibid., p. 848.

[41] Hilary Marland, "Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century", *History of Psychiatry* vol. 14, no. 3, (2003) pp. 303-320, p. 306.

The debate about criminal responsibility and the rights and wrongs of the M'Naghten's Rules continued through the century.[42] Dr William Orange was particularly critical of the legal reliance on the M'Naghten Rules arguing that "there are certain forms, or rather stages of insanity in which there are no delusions".[43] He believed that individuals could be both insane and aware that their actions were wrongful. Orange's comments in the Home Office papers on the case of Eliza Matilda Agar in 1884, illustrate his opinions in this regard and also highlight some of the difficulties that medical witnesses faced when called upon to ascertain a defendant's fitness to plead and stand trial. His comments also highlight possible challenges faced by the jury when asked to consider whether the accused was insane at the time the act was committed. The questions asked of the medical expert, to establish whether the accused "is in a fit state of mind to plead to the indictment" were, in Orange's opinion, relatively straightforward and "plainly intelligible". [44]

When a medical witness was asked in full trial whether the accused was insane at the time of the criminal act, Orange asserted that, because "the questions [were] founded upon the answers returned by the judges in M'Naghten's case" such questions were "by no means simple or intelligible." [45] Orange believed there were anomalies in legal practice regarding insanity which needed addressing and in his opinion, the Rules were wanting because of the uncertainties attached to their authority, scope and exact

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[42] Eigen *Unconscious Mind*, p. 66; Daniel J R Grey, "Discourses of Infanticide in England, 1880-1922" (Unpublished PhD Thesis. University of Roehampton. 2008), pp. 204-205.

[43] Dr William Orange Medical Superintendent at Broadmoor Criminal Lunatic Asylum, 1870–1886.

TNA, HO144/129/A34007 Home Office Registered Papers: "Criminal: AGAR, Elizabeth Matilda; Court: Central Criminal Court; Offence: Murder of her one-month old child; Sentence: Criminal Lunatic".

[44] TNA, HO144/129/A34007 Case: Agar. "Report of Dr Orange dated 17th June 1883".

[45] Ibid., 17 June 1883.

meaning. He suggested that questions asked in court should be simplified, making them more practical to ensure that the "point for consideration [be] freed from the puzzling metaphysics with which it is surrounded." [46] Fundamentally, he felt that the initial starting point for the Court and jury should be whether the accused was treated as "an ordinary felon or as a criminal lunatic". His belief was that medical witnesses should not be bound "by precise legal rules" and should be able "to make a critical examination of the individual case, with a view to ascertaining whether Mental Disease does or does not exist." [47]

The discussion of responsibility was obviously not just relevant to cases of maternal child homicide. However, accepting that the accused woman was delusional, or unaware of the criminality of her actions, gave more weight to the argument that she was insane at the time. The medical evidence given in court would point to physiological reasons and hereditary traits to support the diagnosis of insanity. If this was backed by "proof" of her lack of responsibility, signs of delusion at the time of the act, or "proof" that the defendant had been displaying signs of mental derangement before the crime, the defence of insanity would likely be accepted by the judge and jury. Although the M'Naghten Rules were formulated to bring some continuity to the legal interpretation of criminal responsibility, the issue was problematic. In practice, as has been shown by scholars, the Rules were rarely mentioned by name in court and their interpretation could be either loosely or rigorously applied by different advocates and judges.[48] The differences in interpretation between the medical and legal professions could be a source of friction, particularly between the medical expert witnesses and the judges.

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[46] Ibid., 17 June 1883

[47] Ibid., 17 June 1883.

[48] Eigen, *Mad Doctors*, p. 142; Grey, "Discourses of Infanticide" p. 205.

Criminal responsibility and the defence of insanity

In his testimony to the court in March 1848, Mr Bell, a surgeon from Felstead, Essex, stated that when he attended Martha Prior a week after her normal confinement, he had found her countenance to be haggard and "her eyes vacant and wild" and he had recommended that she be watched. He concluded his evidence by saying that Prior was not aware of what she was doing when she killed her child "or if she were, that she was incapable of controlling her actions." [49] The judge, Mr Justice Denman, interjected at this point, questioning whether the impulse could be considered uncontrollable if the mother had done as Martha Prior had done and appeared to plan the killing. [50] Prior had initially asked for her baby, who was given to her despite the doctor's instructions and fifteen minutes later she requested a razor. She then "appear[ed] to deliberately inflict the injury" with the razor. [51] Denman's argument was that, to all appearances Martha Prior had premeditated the murder, in which case she was not delusional nor unconscious of her deed: ergo she was criminally responsible. In order to be absolutely certain that the defendant was responsible for her criminal actions, her rationalisation for committing the crime would have to be sane and believable. For instance, the claim that by killing her children, a mother was ensuring them a happy future in heaven, would be neither sane nor rational.[52] Prior admitted that she had killed her baby, knowing it was wrong but in her deranged state she said that she was certain she was going to hell and, as she was going to die anyway, leaving her child, she believed that, "it [her child] might as well go first".[53]

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[49] "Lent Assizes. Home Circuit Chelmsford" *Morning Advertiser* (11 March 1848), p. 4, col. 3.

[50] Smith, *Trial by Medicine*, p.109.

[51] "Lent Assizes" *Morning Advertiser* (11 March 1848).

[52] Smith, *Trial by Medicine*, p. 109.

[53] Ibid., p. 110.

Despite this, Justice Denman was quite certain in his opinion that she was criminally responsible but acknowledged that his view diverged from the medical view and probably from the popular views of insanity and its manifestations.[54] When he addressed the jury, he disparaged the surgeon's explanation of Prior's mental state given in evidence. Denman argued that Mr Bell's suggestion that Prior "committed the act under an uncontrollable impulse, acting upon a mind previously diseased" was "a rashly formed judgement of the medical gentleman", continuing, "great danger … would prevail … if people were taught that a sudden impulse was an excuse for a crime."[55] In his concluding words, Denman said that "[he] could not help thinking that such opinions were given too often by scientific men upon too slight a foundation for the safety of the public."[56] Denman's speech illustrated some of the differences of opinion on perceptions of insanity and criminal lunacy between the medical and legal worlds.[57] When a judge cast doubt on a doctor's professional opinion or status in court, he could undermine the medical evidence given to prove a woman's insanity. Later in this chapter, I address this issue and highlight how doctors justified their professional opinions and positions.

The existence of other extenuating circumstances were given as underlying reasons for irrational actions outside the norms of maternal conduct and morally acceptable behaviour. Religious fervour and grief were accepted as factors which could lead to unconscious actions or uncontrollable impulses. Despite its socially undesirable aspects, insobriety was sometimes accepted as an explanation of irresponsible, rash and negligent behaviour. If the woman had been driven to drinking by domestic circumstances or a misfortunate life event, then insanity related to

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54 Ibid., p. 110.

55 *Morning Advertiser* (11 March 1848), p. 4.

56 Ibid., p. 4.

57 Smith, *Trial by Medicine*, p.109.

intemperance appears to have been tolerated. In 1866, Mary Lyons was accused of attempting to drown her four-year-old daughter in the River Aire in Leeds. She was described in court as having "always been a quiet, peaceable and inoffensive woman until she took to this habit of drinking." [58] Her defence counsel suggested that she had been suffering from delirium tremens when she threw her daughter from a bridge into the river. Female drinking habits differed from class to class and what was considered a reasonable and acceptable level of consumption to middle-class society differed to that of working-class society. [59] To both groups, the ideal moderate level was governed by concepts of respectability. One explanation for the seemingly tolerant attitude to insanity brought on by alcohol misuse, could lie in contemporary views of the female temperament. In his summing-up in the Lyons' case, Justice Lush said that perhaps there were other causes which "might have overpowered [Lyons'] reason … Those causes, aggravated by the influence of drink, might have brought on diseases of the mind." [60] Some believed that women's resolve in the face of adverse and life-damaging situations, would not be strong and by seeking refuge in drink. Evidence had been given that Lyons was often intoxicated but it was also suggested that the "fear of public disgrace and the reports being circulated about her" were enough to unbalance her mind. [61] Louise Hide notes that contemporary observers suggested that middle-class women might drink through boredom and intellectual ennui.[62] Other doctors linked women's excessive drinking to an "unstable nervous organisation".[63] Both

[58] "Attempted Murder in Leeds" *Leeds Mercury* (21 December 1866), p. 4, col.1.

[59] Thora Hands, *Drinking in Victorian and Edwardian Britain. Beyond the Spectre of the Drunkard* (Basingstoke (Open Access): Palgrave Macmillan, 2018), pp. 129-143

[60] *Leeds Mercury* (21 December 1866) p. 4.

[61] *Leeds Mercury* (21 December 1866), p. 4.

[62] Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), p. 35

[63] Ibid., p. 35.

suggestions demonstrate a belief that feminine weakness and lack of responsibility lay at the root of alcohol-induced insanity.

Respectability and compliance with social expectations were important factors in peer-group witness testimonies about the accused women and the circumstances of their crimes. Grief was taken as a plausible cause of delusion, and causing uncontrollable urges, which possibly resulted in the woman committing a crime. such as child murder. At Liverpool Assizes in December 1876, the defence counsel for Agnes Martha Morris sought proof that she was delusional when she shot her children by highlighting her odd manner in the months preceding the crime.[64] Her husband had died suddenly in November 1875, from which time her behaviour had become increasingly eccentric. She believed that she was almost destitute and that her children were starving and badly fed. She had disagreements with friends and neighbours and accused all of conspiring behind her back. Morris was the widow of a bank manager, living in an affluent part of Liverpool and was relatively well-off. She was a member of the professional middle class. Her strange behaviour culminated in an abortive attempt to buy prussic acid and eventually she obtained a handgun on a pretext.[65]

Throughout her trial the defence counsel asked each witness, lay and medical, their thoughts on the state of her mind, despite the fact that she had obviously been planning some sort of violent act for a while.[66] Dr Banks, the surgeon of Kirkdale Prison, said in his testimony, “she probably thought she was doing a right act in sending her children to heaven. She was overcome by an irresistible impulse; that’s what constitutes the form of mania of which I consider her the victim.” [67] The judge,

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[64] “The Domestic Tragedy at Great Crosby”, *Liverpool Mercury*, 12 December 1876 p. 8, col. 4.

[65] BCLA, D/H14/D2/2/2/261/6 Case File: Agnes Martha Morris. “Schedule A: Statement Accompanying Criminal Lunatic” Januray 1877; Draft Report to Home Office.

[66] *Liverpool Mercury*, (12 December 1876), p. 8

[67] Ibid., p. 8

Mr Justice Lindley, asked Dr Banks to clarify exactly what he considered to be an "irresistible impulse". Banks replied, "a sane man could control his passion even when in a towering passion [sic]; an insane man could not."[68] Establishing that the defendant lacked awareness and was criminally irresponsible at the time of the murder was a vital strand in establishing the accused's insanity. Delusion and unconscious impulse, whether caused by intemperance, grief or exaggerated religious fervour, were very important in order to explain any dramatic changes in a woman's behaviour which would cause her to kill her child. Both defence and prosecution counsel would submit evidence to the court to demonstrate that the woman's conduct was outside the norms of sane maternal behaviour.

The Defence of Insanity

The art of advocacy in English and Welsh courts developed through the nineteenth century and, as the adversarial court changed, the use of more specialised defences, such as insanity, grew.[69] In 1836 the Trial for Felonies Act ("Prisoners' Counsel Act") gave defendants the right to have defence counsel.[70] From the implementation of the Act, barristers acting for the defence were able to access pre-trial statements, to address the jury directly, to cross-examine witnesses and make speeches on behalf of their clients.[71] The prosecution had to prove their case, rather than a defendant having to prove innocence.[72] With both the prosecution and defence being able to address the juries and conduct cross-examinations, the ability to deliver

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[68] Ibid., p. 8

[69] Cerian C. Griffiths, "Advocacy in Criminal Trials" in Jo Turner, Paul Taylor, Sharon Morley & Karen Corteen (eds), *A Companion to the History of Crime & Criminal Justice* (Bristol: Policy Press, 2017) pp. 1-3, p. 2.

[70] 6&7 Will. IV. c.114. Trials for Felony Act 1836.

[71] Griffiths, "Advocacy in Criminal Trials", p. 2.

[72] Ibid., p. 1.

well-honed speeches became an essential part of a barrister's role. There was an element of performance in advocacy. Katie Barclay describes the art of rhetoric and oratory as "a medium designed to transmit emotion" and points out that it formed part of contemporary elite male education.[73] As the nineteenth-century barristers and judiciary were highly, perhaps classically, educated they would have been schooled in oratory. The higher courts have been referred to as "theatres of justice" and that the advocates and the judiciary were acting in an expected manner. In cases such as those reviewed in this this thesis, it would appear that compassionate words and demeanour were expected and, therefore, integral to their role.[74]

While the speeches might hold a modicum of the men's emotional reactions to the case and the accused, it can be said that their words could be examples of the advocates' rhetorical skills. Katie Barclay argues that, in early-nineteenth-century Irish courtrooms, the barristers' use of evocative language blending argument and evidence, was clever emotional manipulation or management.[75] This was true in English and Welsh courtrooms too. The use and delivery of emotive language by counsel would be deliberately calculated to garner sympathy and compassion for his client and her circumstances. Barclay suggests that counsel were asking juries to make decisions based on evidence but those decisions would also be based on certain emotional truths which were felt mutually by all. It was not a manipulation of physical or verbal evidence but an acknowledgment that emotion had a role to play in legal

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[73] Barclay, *Men on Trial*, p. 127.

[74] See:- Barclay, *Men on Trial* (2019); Tim Hitchcock, 'Whispers and Cries – listening to the voices of the dead at the Old Bailey,' Keynote lecture, The Digital Panopticon Conference: The Global Impact of London Punishments 1780-1925, Liverpool 13-15 September 2017; Linda Mulcahy, *Legal Architecture* (London & New York: Routledge, 2011) pp. 176-7; V Nagy, *Nineteenth Century Female Poisoners: Three English Women who used Arsenic to Kill* (Basingstoke: Palgrave Macmillan, 2015), p. 132.

[75] Barclay, *Men on Trial*, p. 140.

processes, so long as it led to justice being served.[76] The grand juries in English and Welsh courts were made up of local gentry and middle-ranking professionals, such as merchants and wealthier tradesmen. The petty jury included the same men as well as ordinary local ratepayers. The social and cultural backgrounds of many jurors would give them an appreciation of the barristers' use of emotive language and phraseology. Whatever their level of education, they understood that the purpose behind the rhetoric was to ensure justice for the defendant.[77]

Mr Douglas Straight Q.C. used affecting language to create an evocative narrative in his opening address in the case of Elizabeth Marchant at Surrey Assizes in 1873. His speech was documented in detail by a court reporter who wrote, "He … [Straight] … argued that she was driven to despair by the ill-treatment she received from the man Fordham … [T]he parties went to live together as man and wife but with no bond of the Church to compel the man to support her and her child. … [H]er affection for that child … [was] … as strong as anything in nature." [78] Likewise, in his closing statement to the jury, Straight emphasised Marchant's vulnerability still apportioning a large amount of blame to her partner. It was reported that, "[Straight] made a powerful appeal to the jury" stressing Marchant's ill-treatment at the hands of her lover and that her "demeanour was like that of a person filled with mad despair."[79] As Barclay suggests, I have found that, in the cases I have reviewed, legal speech-making was an art. The court room gave advocates an opportunity to practise their skills in emotive rhetoric, to convince the juries and judges of the truth of their particular interpretation of the evidence.

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[76] Ibid., p. 140.

[77] Ibid., p. 140.

[78] "Murder at Epsom" *Croydon Advertiser & East Surrey Reporter* (2 August 1873), p. 2, col. 1.

[79] "*Croydon Advertiser* (2 August 1873), p. 2.

The right to address the jury was a significant asset to the defence, giving them the ability to elucidate on any evidence given by expert witnesses. Eigen writes, "[t]hroughout the first half of the nineteenth century, defence attorneys continued to craft carefully worded questions that elicited from the medical witnesses the most forensically friendly opinions".[80] Barristers used their cross-questioning skills to clarify medical evidence for the jury (and possibly the bench) in such a way that their particular desired outcome to the trial would be attained. They did not manipulate so much as strategically manage the experts' answers, to confirm that the defendants were not acting in a normal fashion at the time of their criminal act. Medical evidence was vital in order to prosecute a case and therefore also required by prosecution counsel. Prior to 1879, the Home Office could direct the Treasury Solicitor to institute criminal proceedings and give advice on prosecutions in capital cases. In 1879, the "Prosecution of Offences Act" created the Office of the Director of Public Prosecutions (DPP) and its attendant role of public prosecutor.[81] The Act stipulated that the DPP, through the Treasury Solicitor, would take charge of court case prosecutions which possibly involved capital charges. Under the Act and its subsequent amendments, the Treasury Solicitor was directed to require and employ medical men of experience and repute, to visit prisoners before their trial to examine them for potential insanity.[82]

In his opening statement at the trial of Sarah Ann Hanson in Oxford in 1885, Mr Gough, prosecution counsel, said that "he was happy to say in these days the strictest enquiry was made into all circumstances attending a crime of this sort." [83]

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[80] Eigen, *Unconscious Crime*, p. 159.

[81] 42 & 43 Vict. c.22. Prosecution of Offences Act 1879.

[82] G. Roger Chadwick, "Bureaucratic Mercy: The Home Office and the Treatment of Capital Cases in Victorian England" (unpublished PhD thesis, Rice University, Houston Texas. 1989), p. 281.

[83] "The Child Murder at Thame" *Oxford Journal* (4 July1885), p. 8, col. 5.

After saying that the medical gentlemen consulted were convinced that Hanson "at the time she committed this offence did not know right from wrong and was, in fact, perfectly insane", he suggested to the jury that they "find a verdict of not guilty on the ground of insanity." [84] The defence counsel acknowledged that the prosecution had submitted sufficient evidence of Hanson's insanity to render his role unnecessary. He spoke on behalf of her family and said that "he ought to express how deeply those related to the prisoner and interested in her, felt the kindness which had been displayed on the part of the prosecution in facilitating her defence by calling … the witnesses they had". [85]

As noted in the Introduction, the use of insanity as a defence in cases of infanticidal mothers has been labelled as a convenient legal justification to avoid capital punishment.[86] Certainly the idea of hanging a mother, even if she had murdered her own child or children, was culturally and morally repugnant to many in Victorian society. However, to interpret the defence of insanity as merely a medico-legal ploy robs it of its nuance. If it could be "proved" that the defendant was mentally deranged at the time of her crime, then cultural convention could accept that a mother would only carry out such violent acts if she were mad. Insanity gave a "bearable" explanation for the abhorrent act of infanticide or child murder. Compassionate treatment and acceptance of female insanity was reinforced by evidence, which suggested that the "madness" had been caused by physiological forces, or that the defendants were delusional and unaware of their actions.

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[84] *Oxford Journal* (4 July1885), p. 8.

[85] *Oxford Journal* (4 July1885), p. 8.

[86] Walker, *Crime & Insanity, vol.1*, p. 125; Smith, *Trial by Medicine*, p. 159.

Medical Testimony

The growing number of medical men giving evidence in court and claiming knowledge of insanity and its manifestation, was pivotal in the development of the defence of insanity. The phenomenon has been discussed by scholars and has been linked to the gradual emergence of medical specialism, specifically in areas of mental illness and "mad-doctoring."[87] The nineteenth-century social perception that women who committed crimes such as infanticide and child-murder must be suffering from madness and that the madness was caused by their physiology and inherent emotional weaknesses, has also been widely discussed.[88] In the nineteenth century, the medical witnesses in court were drawn from all areas of medicine: hospital physicians and surgeons, visiting prison doctors, asylum medics and domestic medical attendants. Some claimed a specialist knowledge of insanity, whereas others would refer to past experience when giving opinion. Exclusively female forms of mental illness, such as puerperal mania, were part of insanity discourse by the mid-century and often given as the diagnosis of insanity in cases of maternal child homicide.[89]

The most common medical witnesses in the higher courts were prison and police surgeons and other local medical men. Eigen suggests that, in the metropolitan

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[87] See amongst others: Eigen, *Unconscious Crime;* Idem., *Mad-Doctors in the Dock;* Arlie Loughnan *Manifest Madness: Mental Incapacity in Criminal Law* (Oxford: Oxford University Press, 2012); Hilary Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain (*Basingstoke: Palgrave Macmillan, 2004); Smith, *Trial by Medicine;* Watson, *Medicine and Justice.*

[88] See amongst others: Anne-Marie Kilday, *A History of Infanticide in Britain, c.1600 to the Present* (Basingstoke: Palgrave Macmillan, 2013); Marland, *Dangerous Motherhood*. Walker, *Crime & Insanity, vol.1*; Lucia Zedner, *Women, Crime and Custody in Victorian England* (Oxford: Clarendon Press, 1991).

[89] Arnot, "Gender in Focus", p. 200. Loughnan, *Manifest Madness* p. 210; Hilary Marland, "Getting away with Murder? Puerperal Insanity, Infanticide and the Defence Plea" in Mark Jackson (ed.) *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot: Ashgate, 2002), pp. 168-192.

area of London, such medical men had become specialists in finding signs of insanity in prisoners under their care and that this hands-on experience was accepted by the courts as expert knowledge.[90] Recent research has found that this also applied in provincial courts.[91] Recognised expert medical writers were known to appear at the Old Bailey as well as other practitioners in the field of mental medicine, including medical superintendents from Bethlem, Broadmoor and from other London asylums. The work of expert writers was occasionally referenced in the provincial courts but they themselves rarely appeared outside London. For instance, Mary Lyons' defence counsel referenced a case of insanity, quoted by Swaine Taylor, as "illustration of his argument that a person labouring under Delirium Tremens was not criminally liable".[92] Swaine Taylor does not appear as a medical expert witness in any of the cases in my research, despites his work regarding forensic evidence being quoted.

Other renowned medical writers did, however: Dr Forbes Benignus Winslow, for example. Winslow was actively involved in the care and management of psychiatric patients and wrote extensively on the medico-legal aspects of insanity. He promoted himself as an expert witness for cases involving the insanity plea.[93] At the trial of Ann Cornish Vyse at the Old Bailey in 1862, the prosecution and defence counsels between them, called on seven different medical experts to give evidence.

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[90] Eigen, *Mad-Doctors,* pp. 68-9.

[91] Catherine Cox & Hilary Marland, "Broken Minds and Beaten Bodies: Cultures of Harm and the Management of Mental Illness in Late Nineteenth Century England and Irish Prisons", *Social History of Medicine,* vol. 31, no.4, (2018) pp. 688-710.

[92] *Leeds Mercury* (21 December 1866), p. 4.

[93] Dr Benignus Forbes Winslow (1810-1874) published *On Obscure Diseases of the Brain and Mind* in 1860 which was considered a standard textbook for a period. He was instrumental in founding the Journal of Psychological Medicine and Mental Pathology. He was called as an expert witness in many trials and gave key evidence in the trial of Daniel M'Naghton. Jonathan Andrews; Winslow, Forbes Benignus (1810-1874) *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004).

Vyse had murdered two of her daughters and the defence lay in the supposition that, at the time of the killing, that she was unaware of her actions. Despite the fact that he had not met or physically examined Vyse, Forbes Winslow took to the stand to validate the medical evidence already given.[94] His opinion was delivered with certainty and some pomposity: "I have been in Court during the whole of the day and I have heard the evidence in this case … the act was committed by the prisoner [when] she was suffering under … paroxysmal insanity." He continued, "This is a kind of insanity perfectly well understood by medical men and is an acknowledged disease."[95] Vyse was pregnant at the time, a fact which appeared to be overlooked by all the experts. She was sent to Fisherton House where she gave birth to a son.[96] I will revisit her story in Chapter 5, when discussing how the insane mothers were viewed and treated in the asylums.

The availability of specialised expert opinion in the capital not only informed the outcome of trials but also added to the knowledge of the legal fraternity in court, which they then disseminated on the circuit. In 1873 at the trial of Elizabeth Marchant, Mr Douglas Straight Q.C. quoted the case of Ann Vyse when cross-examining a local doctor. He suggested that the occurrence of homicidal mania was a "momentary insanity … which … might create an irresistible impulse to commit such an act ... [as in] … the case of Mrs Vyse, of Ludgate Hill." [97] The doctor in question did not know the case but agreed that such mania could induce someone to "suddenly commit a crime and shortly after be deeply penitent". [98] Differences in the type of expert medical

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[94] OBP, *Old Bailey Proceedings Online*. July 1862, trial of Ann Cornish Vyse (t18620707-746).

[95] "The Murder on Ludgate Hill" *Times* (8 July 1862), p. 13, col. 3.

[96] FHAA, J7/190/5. Fisherton House Asylum Patient Case Book. Ann Cornish Vyse; patient no. 1934, f. 21.

[97] *Croydon Advertiser* (2 August 1873) p. 2.

[98] *Croydon Advertiser* (2 August 1873) p. 2.

opinion consulted in cases of maternal child homicide, can be seen between London and the provinces.[99]

The expert medical witnesses at the local assizes were more likely to be medical officers from the county and local asylums, an acknowledgement of their expertise in the treatment of insanity. Such asylum medical officers and superintendents would visit the defendant before the trial, usually in the initial place of confinement, to assess their mental state. At Liverpool Assizes in 1887, the prosecution counsel in the trial of Mary Anthony advised the jury that the prosecution had "decided that it was important and proper to place before the jury such medical opinions so as would guide them in returning a verdict."[100] Dr Thomas Lawes Rogers, medical superintendent of Rainhill County Lunatic Asylum, had been instructed to examine her before the trial and, in addition, there had been a thorough investigation of Anthony's family and medical background. [101] It was reported that "the prosecution had also made enquiry as to the prisoner's former state of mind … Inquiries had also been made into the antecedents of the prisoner and as to any hereditary symptoms of insanity in the family." The results of the enquiries evidenced, in the opinion of the prosecution counsel, "the prisoner's temporary insanity."[102]

Occasionally the medical officers and superintendents of Broadmoor would be consulted. These consultations occurred more frequently after 1879, with the changes in legislation and the appointment of medical experts by the Treasury Solicitor. The appointed medical experts would examine potentially insane prisoners before trial and then their reports would be presented in court. In the previously mentioned case of

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[99] Watson, *Medicine and Justice,* p. 97.

[100] "Shocking Murder by Mother." *Liverpool Mercury* (5 August 1887) p. 8, col.8.

[101] TNA, ASSI 52/9 Criminal depositions and case papers. Murder: Mary Anthony. "Medical Report, Dr Thomas Lawes Rogers. 5 July 1887".

[102] *Liverpool Mercury* (5 August 1887), p. 8.

Sarah Ann Hanson, Dr William Orange was appointed by the Treasury Solicitor as the medical expert to examine Hanson in Oxford Gaol prior to her trial in 1885. He did not give evidence in court but his written diagnosis of puerperal melancholia and homicidal mania was passed on by the governor of the prison.[103] If the evidence was given by, or written by, a recognised specialist, it would appear that the judges and juries would accept their advice about the manifestation and characteristics of insanity. Katherine Watson writes that the word "specialist" was used to denote expertise in an area of medicine, such as an asylum affiliation. To further underline their authority, medical experts would, on occasion, present their credentials as an expert witness. Watson states that she found very few self-identified in this way. While not disputing this, I have found contrary evidence.[104]

In the case with which I opened this chapter, before giving his opinion about Annie Player, Dr Orange began his evidence thus, "I have been 14 years medical superintendent of Broadmoor Criminal Lunatic Asylum and connected with the asylum for 21 years."[105] As noted, on his two visits to Annie Player in Clerkenwell his companion was Dr Robert Mundy Gover who, in addition to his role as Medical Inspector of Prisons, had given evidence to the 1880 enquiry into criminal lunacy.[106] Again, their visits and examinations were by instruction from the Treasury Solicitor to establish whether Annie Player was mentally fit to stand trial.

Based on his study of the *Old Bailey Sessions Papers,* Eigen maintains that the Home Office directive actually led to a decrease in the number of asylum superintendents giving evidence as the century progressed. He suggests that the superintendents' role was taken up by "general and specialised hospital physicians

[103] *Oxford Journal* (4 July1885), p. 2.

[104] Watson, *Medicine and Justice,* p. 96.

[105] OBP, January 1884, Player.

[106] "Gover", *Munks Roll*, p. 294.

who catered to nervous diseases and epilepsy."[107] This might be the case for London but in the counties, the experts were the local asylum medical men and their role was not usurped by hospital physicians.[108] Eigen appears to discount the number of appearances by the prison surgeons, who presented themselves as experts in the field and, possibly, Eigen considers appearances by men like Orange and his successor, David Nicolson, as specialist physicians. In both London and the provinces, the prison surgeons continued to appear as experts in diagnosing madness; their knowledge gleaned from years of experience of dealing with criminal lunatics.[109] Their initial diagnoses of the type and cause of madness in the criminally insane were accepted by the asylum doctors as a starting point for treatment when the women were admitted into their institutions. This point will be discussed further in the chapters relating to asylum entry, treatment and care.

Doctors who may have been in court to give evidence on other aspects of a case, were often asked for their opinion on the mother's supposed state of mind at the time of the crime.[110] On occasion, those medical men who had examined a defendant prior to her court appearance to confirm that she was mentally fit to be tried, would also be asked to give an opinion on her mental state at the time of the commission of the crime. Even if the evidence was given by an acknowledged specialist, it was speculative in nature. Dr Orange's opinion on Annie Player, although "informed", was related more to her mental state at the time of the trial than at the time of her crime.[111] In 1887, during the trial of Annie Cherry at the Old Bailey, Dr Henry Bastian examined

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[107] Eigen, *Mad-Doctors in the Dock*, p. 92.

[108] Ibid., pp. 68-9.

[109] Catherine Cox & Hilary Marland, "Broken Minds and Beaten Bodies: Cultures of Harm and the Management of Mental Illness in Late Nineteenth Century England and Irish Prisons'" *Social History of Medicine* vol. 31, no.4, (2018) pp. 688-710.

[110] Watson, *Medicine and Justice*, p. 203.

[111] "Central Criminal Court, Jan. 14." *Times*, (15 January 1884), issue 31030, p. 12, col. 1.

Cherry twice whilst she was in custody and, in his opinion, she had "no trace of unsoundness of the mind about her." [112] He believed that, from her reported history, she must have been in the early stages of melancholy following a difficult birth which "often [caused] homicidal and suicidal tendencies".[113] She was found "guilty of the act but insane at the time of its commission" and admitted to Broadmoor. She was only in the Asylum for eighteen months, which would appear to bear out Bastian's opinion that by the time of her trial she showed no signs of insanity.[114]

Evidence from the medical specialists in insanity was essential in establishing a defendant's state of mind and fitness to plead. There was much contemporary inter-disciplinary debate about the implications of being found "unfit to plead" and about the impact that such a decision would have on the future incarceration and lives of the homicidal mothers. This discussion is explored in greater detail in the next chapter. The medical evidence regarding a woman's mental state at the time of her crime was also pertinent in these decisions. The medics who had dealt with the defendant at the time of her crime were prison and police divisional surgeons, and local doctors and physicians. [115] They had seen, spoken to or examined the woman soon after the violent attacks had occurred. Although their evidence in court was to the most part a reiteration of their inquest deposition statements, cross-examination by counsel could draw out more information about other background circumstances.

In August 1848, Sarah Grout murdered two of her children at West Thurrock. The local surgeon, Mr Robert Jordison, who had been called in to examine the children's bodies, also examined Grout. He suggested that, because she was unstable

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[112] OBP, *Old Bailey Proceedings Online*, May 1887, Trial of Annie Cherry (21) (t18870523-659) .

[113] OBP, May 1887, Cherry.

[114] BCLA, D/H14/D2/2/2/411 Case File: Annie Cherry.

[115] Watson, *Medicine and Justice*, p. 103.

when he saw her the previous day at his surgery, Sarah was not accountable for her actions when she killed her children. He said that, "she appeared vacant, dejected and gloomy" and that he had always considered her to be " a person of very weak mind". He also testified that when he had seen her a few hours after the crime she was in a most deplorable state of anxiety and stupidity … most decidedly in an unsound state of mind". Jordison gave his firm opinion that "she did not know what she was about when she killed the children." [116] The evidence was accepted, despite the fact that it was supposition about the state of Grout's mind, as he had not physically witnessed her actions.

If the evidence of a woman's mind being weakened by specifically female "problems" was given by a medical man, ordinary or specialist, it was frequently accepted as being sufficient to prove her insanity. There are numerous examples of medical testimony being taken as the most important evidence of a woman's irrationality. In the case of Harriet Rowe in 1866, Mr G. H. Furber, a local Maidstone surgeon, was called to see Rowe and to examine the body of the drowned baby at the crime scene. He stated that he was of the opinion that Rowe was not of a sound state of mind at that time. After further questioning he said that, "it was not an uncommon thing for women, when nursing … to fall into a state in which they were not accountable for their actions". After his evidence, the prosecution counsel suggested that the "best interests of justice would be served … by leaving the case in the hands of the jury." [117] As in London, provincial prison surgeons and doctors proved that they were experts in insanity. As Marland and Cox have discovered, these prison medical men prided themselves on recognising insanity and rightly claimed a specialist

[116] "Murder of Two Children at West Thurrock" *Chelmsford Chronicle* (16 March 1849) p. 4, col. 5.

[117] The Alleged Murder in Maidstone", *Maidstone Journal and Kentish Advertiser* (24 December 1866), p. 9, col. 3.

expertise in identifying genuinely insane prisoners.[118] In 1877, at a trial at the Cumberland Assizes, the judge, Baron Huddleston, closely questioned Dr McDougall, assistant prison surgeon at Carlisle Gaol on his experience of insanity and insane persons. Dr McDougall had stated that "[i]t sometimes occurs that prisoners, when charged with a serious offence, conducted themselves as if insane but this was a very marked case [of insanity]". [119] Huddleston responded, "You have had persons 'shamming' in your charge? Witness – Yes, at times but they are always found out. I don't think this prisoner is making a sham. She does not understand what you say to her." [120] The provincial doctors were able to stand their ground and have confidence in their assessments of the accused women, even in the face of close questioning by the judges.

The medical expert witnesses would be expected to deliver the testimonies in a factual and clinical manner but, as previously stated, cases of child death and murder carried with them an underlying emotional current. It is difficult to categorically say that this did not impact on the doctors too. Emotional involvement might not be apparent in the evidence of medical examiners appointed by the Treasury Solicitors but where the doctors had been personal physicians to the accused or where they had been at the scene of the murder, it might have been more so. These particular medics had usually already given their evidence at the inquest or in the magistrate's court and, by the time the cases came up at the higher tribunal, the immediate emotional impact would be diluted. They were educated men and their personal opinions would be influenced by their cultural backgrounds. When giving evidence in court, the medical men would try to show some measure of professional detachment as well as sympathy.

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[118] Cox & Marland, "Broken Minds and Beaten Bodies", p. 689.

[119] "The Egremont Child Murder", *Carlisle Patriot* (23 February 1877), p. 6, col. 2.

[120] *Carlisle Patriot* (23 February 1877), p. 6.

To show themselves as emotionally involved in a case could jeopardise the worth of their evidence and do more harm than good to the defendant's cause.

As demonstrated in "*The Egremont Child Murder*" case above and in the Martha Prior case, judges could sometimes undermine or doubt a doctor's evidence. The medical men would not wish to show professional vulnerability and overt displays of emotion could weaken a case. The doctors' evidence played an essential part in the trials and was likely to be more effective if delivered in a factual, unemotional manner. The barristers would emphasise the tragedy and seek compassionate understanding from the jury and judges with their more emotive interpretation of the facts. The growing use of medical evidence in court cases in the nineteenth century, especially those involving women accused of killing their children, brought to the attention of a wider audience what was a general medical belief that all stages of motherhood could lead to mental instability and, hence, to violence.[121] However, proving insanity at the time of the execution of the crime was difficult. Attesting that the defendant was insane at the time of the trial or within the period between the inquest and the court case did not necessarily mean that she had been mad at the time of her act. In order to bring a verdict of insanity, medical evidence from doctors who had seen the accused around the time of the crime, coupled with possible corroboration from friends, family and other witnesses, was essential to the judge and jury.

Witnesses

Domestic violence by women against children was threatening to contemporary ideals of the home as a safe haven, with the mother at its centre. By

[121] Eigen, *Unconscious Crime,* p. 75; Hilary Marland, "'Destined to Perfect Recovery' The Confinement of Puerperal Insanity in the Nineteenth Century", in Joseph Melling, & Bill Forsythe (eds) *Insanity, Institutions and Society 1800-1914* (Abingdon: Routledge, 2000), 137-156, p. 140.

creating a picture of a woman wronged and driven to dreadful acts, lawyers played to the emotional and social sensibilities of those in the courtroom. If it were shown that the accused were ultimately "respectable" women who had been led to violence by uncontrollable forces and unfortunate circumstances, they were treated with sympathy. Martin Wiener argues that, during the nineteenth century, judges and reformers participated in "a discourse of moralization", disseminating essentially middle-class male ideals of respectability to the nation through the courtroom.[122] Judges have also been described as moral arbiters, protectors of contemporary moral values, who would respond to socio-legal problems with understanding.[123] Respectability of lifestyle and behaviour fitted the middle-class moral code of the time. However, to consider respectability as a purely middle-class creation obscures its importance to other levels of society.[124] As the lay witnesses could be from the same social background as a defendant, their idea of respectability could impact upon proceedings in court.[125] In order to support the defence case, it was important to convey the impression that the defendant's home-life before the murder was respectable and that her "criminal" actions were out of character.

The testimonies of the ordinary men and women who knew the accused, helped the court and public observers to make sense of the seemingly inexplicable crimes. Their witness statements would describe the defendant's behaviour and demeanour before the crime and the events leading up to its commission. Despite only knowing Annie Player for three weeks, her neighbour, Amelia Newby, described Annie as

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[122] Martin J. Wiener, *Reconstructing the Criminal: Culture, Law and Policy in England, 1830-1914,* (Cambridge: Cambridge University Press, 1990), p. 269.

[123] Newbery-Jones, "Judging the Judges", pp. 170-171.

[124] Louise A Jackson, *Child Sexual Abuse in Victorian England,* (London & New York. Routledge, 2000), p. 108.

[125] Shani D'Cruze, *Crimes of Outrage. Sex, Violence and Victorian Working Women,* (London: UCL Press, 1998), p. 190.

seeming "an unhappy sort of woman" but "very kind to [her] children".[126] The eye-witness remarks of neighbours could be taken as the necessary "proof" of a deranged mind around the time of the commission of the murder. For example, after cutting the throat of her baby, Sarah Freeman ran to the house of her neighbour, Jane Smart, who described her as being "very wild about the eyes" and wearing a bloody apron. [127] Another witness, Abram Tun, a thatcher, went into the Freeman's cottage and took the knife from the frantic Freeman while another neighbour saw to the child. He also described Freeman as looking "very queer and wild about her eyes." To his evidence he added that he had known Freeman's brother, who had died in a lunatic asylum after two- or three-years confinement there.[128] This evidence of familial insanity added more weight to the suggestion that Freeman was insane at the time of the murder. Such evidence appealed to the common conceptions of insanity and its manifestations and, when heard in conjunction with the professional opinion of medical men, would leave no doubt in popular opinion that the defendant was indeed mad.

The main overseers of a working woman's reputation were her friends and neighbours. A woman's household skills and parenting prowess were key components of respectability, recognised not only by her peers but also by outside social agencies and investigators and by the courts.[129] Even though Jane Smart had described Sarah Freeman as being distraught about possible destitution and her husband's continued unemployment through ill-health, she still emphasised that Freeman was "an affectionate mother" and that she "lived on good terms with her husband."[130] In 1849 Mrs Emma Creek, the neighbour of Sarah Grout, who stood accused of murdering her

[126] OBP, January 1884, Player.

[127] "The Lavendon Child Murder", *Northampton Mercury* (26 April 1879), p. 7, col. 4.

[128] *Northampton Mercury* (26 April 1879), p. 7.

[129] D'Cruze, *Crimes of Outrage*, p. 192.

[130] *Northampton Mercury* (26 April 1879), p. 7.

son and daughter with a billhook, deposed that, "She always seemed very kind to her children." [131] The witness continued that she had observed "in May last and since then she had had very strange ways but latterly she had seemed rather better. She seemed more like a woman deranged in her mind." [132] Another neighbour said that she had told him that she had suicidal thoughts but "did not want to leave behind but her two children." [133] Despite her known drinking problems, Mary Lyons' neighbours were keen to emphasise her virtues as a mother and her respectability. Her next-door neighbours told the court that "she was a very good mother and always treated her child kindly", a point which was corroborated by Lyons' cousin who said that Lyons had been "a kind mother."[134] Emma Lewis was a single mother who stood trial before Lord Justice Coleridge at the Nottinghamshire Assizes in July 1852. She was described as "a person of respectable connexions" who "formed an intimacy with a man named Clark, the result of which was … an illegitimate child". His "refusal … to marry her had preyed upon her mind" thereby affecting Lewis's reason and driving her to murder. [135] Despite her status as an unmarried mother and a lowly milliner, her status of being respectably poor and an abandoned woman appears to have given Lewis special consideration.

The appearance and the demeanour of the defendants would have an impact on the reactions of the reading public to a case and, doubtless, on the jury too. Susan Burfield was reported as being "a pleasant-looking woman". However, the report continued that she was "presenting all the appearances of a person mentally deranged … She appeared to be muttering something to herself and a nervous twitching …

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[131] *Chelmsford Chronicle*, (16 March 1849), p. 4.

[132] Ibid., p.4.

[133] Ibid., p. 4.

[134] *Leeds Mercury* (26 December 1866), p. 2.

[135] "Emma Lewis" *Globe* (17 July 1852), p. 4, col.4.

betokened the excitement under which she was labouring."[136] The report gave a complex message, that being pleasant-looking and respectable did not protect from maniacal episodes, nevertheless the poor defendant should be afforded some compassion. Martha Lewis was described as "a good-looking woman and respectably-dressed woman of twenty-five years of age", which no doubt resonated with the jury at her trial in 1859.[137] Likewise, in 1876, Mary Ann Elizabeth Beck was also described as "a good-looking and respectably dressed young woman" at her trial.[138] The *Times'* description of Agnes Bradley left no doubt about how contrary and deplorable her crime was to her social status. "The prisoner['s] … appearance denoted her superior position in life," and "the mother [Bradley] had always manifested the tenderest affection [to her children]."[139] The form of words used by the media would convey a message to their readership that, although the crime was horrendous, it was out of the ordinary for respectable persons such as these women.

If the woman were seen to be grieving or disconcerted, or even unaware of her surroundings in court, sympathy would be gained for her plight. It was also important for the impression to be conveyed that the home life of the family before the murder was harmonious and that there was affection between the wife and her husband. All this evidence would be gleaned from the statements of neighbours and friends and was important to appeal to the judge and jury, in order that a verdict of insanity be brought. As Shani D'Cruze writes, the provincial Victorian press was very keen on presenting the respectable aspect of court cases.[140] As noted in the previous chapter, the Victorian

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[136] "A Mother attempting to Drown her Child: A Sad Case", *Herts Advertiser* (8 August 1885), p. 7, col. 1.

[137] "The Murder of Two Children by their Mother", *The Scotsman* (22 August 1859), p. 2, col. 3.

[138] "Child Murder at Wardington", *Banbury Guardian* (9 March 1876), p. 7, col. 4.

[139] "Northern Circuit", *Times*, (28 March 1859), issue 23265, p. 11, col. 5.

[140] D'Cruze, *Crimes of Outrage*, p. 188.

press discussed and disseminated opinion on personal guilt, criminal responsibility and how it related to the defendants in court. Popular opinion would be impacted by the cultural biases of the journalists and correspondents, as the reading public's access to court procedures was through the media.[141] The newspaper accounts of courtroom vindications of the defendants from their peers, which emphasised respectability of life-style, home and personal nature, suggested that such values were relevant to all classes. Louise Jackson found that press court reports on child abuse, would reinforce the connections between acceptable social behaviour and respectability, no matter the background of the defendant.[142] As mentioned in earlier in this chapter and in Chapter 2, the press emphasis on socially positive respectable attributes of respectability, coupled with vulnerability was instrumental in engendering sympathy and compassion for the accused women across all aspects of their careers through the medico-legal system.[143]

Juries

Analysing the influence of the testimonies of medical men and the prejudices of counsel and judges on court cases is all very well but the final decisions on the outcome of the trial lay with the jury.[144] At both the Central Criminal Court and in the assize courts, there were two different types of jury, the "Grand Jury" and the "Petty" or "Petit" jury. The two juries had very different roles. In essence, at the start of the assizes, the grand jury would vet the indictments and statements, hear evidence from the prosecution and their witnesses but not evidence from the defence or defendant.[145]

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[141] Wiener, "Convicted Murderers and the Victorian Press," p. 111.

[142] Jackson, *Child Sexual Abuse*, p. 126-127.

[143] Rowbotham, et al., *Crime News in Modern Britain.*

[144] Eigen, *Mad-Doctors*, p. 174.

[145] Watson, *Medicine and Justice*, p.8

If the evidence was believed to be sufficient to warrant a trial, the case was approved as a “true bill” and the defendant put on trial. The petty jury or trial jury consisted of twelve jurors and this jury heard the evidence in a trial, deciding on the innocence or guilt of a defendant. [146] As mentioned earlier in this chapter, the grand jury was made up of men mostly from the middle-ranking professions and landowners, described as the "best figures in the county".[147] The petty jury additionally included ratepayers. The two bodies were considered to be stolidly reliable and able to arrive at a just verdict. Eigen describes the juries at the Old Bailey as being “stubbornly independent” men who would mix a “healthy dose of folk knowledge” with the information gleaned from all testimonies both expert and lay to arrive at their verdicts.[148] The description equally applies to the juries in the assize courts up and down the country, where local knowledge and opinion could impact upon decisions.

Judges rarely publicly expressed dissatisfaction with the jurors and the relationship between the judge and the jury was, usually, one of mutual respect. In the case of Sarah Freeman in 1879, it was reported that; “in summing up [the judge] said the jury had imposed upon them a very solemn authority and one that would exercise their sound judgement as well as their good healthy sound feeling.”[149] In the Martha Prior case quoted earlier in this chapter, Justice Denman recognised the independence of the jury. In his summing-up, he acknowledged that his views on whether Prior was responsible or not for her criminal actions would not be popular with the jury and that

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[146] Ibid., p.8.

[147] Sir William Blackstone described grand jurors as "gentlemen of the best figures in the county." Sir William Blackstone, *Commentaries on the Laws of England*, Vol 4: p. 299 quoted in Barbara J.Shapiro, *Beyond Reasonable Doubt and Probable Cause: Historical Perspectives on the Anglo-American Law of Evidence.* (Berkeley: University of California Press, 1991), p. 85, f/n. 118.

[148] Eigen, *Mad-Doctors*, p. 174.

[149] *Northampton Mercury* (26 April 1879), p. 4.

he accepted that the jurors would "no doubt … act upon the testimony of the medical gentleman." He recognised that the jury would accept "the medical gentleman['s]" evidence and act independently of his judicial direction, "as they should as final decision makers". [150] There were a few mid-century murder cases where the jury returned a lesser verdict than that preferred by the judge. Wiener suggests that this divergence was due to the jury having different ideas of what constituted mitigating circumstances for a killing, particularly where murder was motivated by passion rather than by calculation.[151]

Judges would suggest verdicts either for conviction or not and express clear opinions of the facts of the cases as they saw them, expecting the juries to follow their instructions. Despite this, a jury could still react in a contrary way to a judge's expectation by interpreting the evidence for themselves and then returning an unforeseen verdict. Within my research, although it is rare for a jury not to follow a judge's direction to find a woman insane, they might diverge from that direction and add recommendations to a guilty verdict. Mary Ann Parr, who would eventually be the first patient in Broadmoor, was accused of suffocating her week-old baby at Bingham Union Workhouse, Derbyshire in December 1852.[152] The jury returned a verdict of guilty with a very strong recommendation to mercy. Justice Jervis, whilst agreeing with the verdict, did not seem to harbour the same view on mercy describing the jury as "indulgent", saying, "Mercy does not rest with me, I shall … forward to

[150] "Lent Assizes. Home Circuit Chelmsford", *Morning Advertiser* (11 March 1848) p. 4, col. 3.

[151] Martin J. Wiener, "Judges v. Jurors: Courtroom Tensions in Murder Trials and the law of Criminal Responsibility in Nineteenth-Century England, *Law and History Review.* vol.7, no. 3 (1999), pp. 467-506, p. 481.

[152] BCLA, D/H14/D2/2/2/1 Case File: Mary Ann Parr.

the proper quarter the recommendation … from the indulgent jury … and whatever is fit and right … will be taken into consideration."[153]

In much the same way as the defence and prosecution barristers could be said to use emotive language in "managing" evidence to obtain a favourable verdict, judges would also manipulate juries. If he held strong personal beliefs on a topic, a judge could use persuasive language to encourage jurymen to arrive at a verdict in keeping with his personal views. Sir Henry Hawkins did not like the idea of potentially lifelong incarceration in asylums and was known to ensure the jury returned a guilty verdict in order to avoid the sentence which would have followed an acquittal on the ground of insanity. He wrote in his *Reminiscences* that he would word his advice to the jury so that the death sentence could be passed, albeit with his full recommendation for mercy, to avoid the asylum. Commenting on a case of maternal homicide where he felt he had to "discountenance" the proposed plea of insanity he said, "[I asked] the jury whether, 'without being insane in the ordinary sense, the woman might not have been at the time of committing the deed in so excited a state as to not know what she was doing.'" [154] It was an ambiguously worded question, which had resulted in his desired verdict. As he reminisced, "I obtained a verdict of guilty but that the woman at the time was not answerable for her conduct, together with a strong recommendation to mercy." [155] In his opinion this was a verdict in keeping with justice, if not strictly the law.

Judges were known to engaged in emotive oratory in the courtroom, which would impact on the juries' decisions. Katie Barclay suggests that the intellectual interactions between juries, counsel and the judiciary demonstrate that justice in the long nineteenth century could only be determined by men of the elite classes.[156] While

[153] "Infanticide at Bingham" *Nottinghamshire Guardian* (10 March 1853), p. 2, col. 2.

[154] Hawkins, *Reminiscences,* pp. 226-227.

[155] Ibid., p. 227.

[156] Barclay, *Men on Trial*, p. 141.

partly agreeing with Barclay, I would argue that, due to the more varied social classes of jurymen in English and Welsh courts, this is not quite accurate. The judiciary and barristers were in all likelihood more highly-educated and their words would certainly have some influence on juries' verdicts.[157] However, the juries were made up of "respectable and dependable citizens" who would make their decisions based on experience and common-sense as well as the given evidence on a case.[158].

For the most part, judges trusted the juries to reach correct and just verdicts although, on occasion, they would be surprised by a result which was contrary to what they believed was the right one.[159] In 1866 Sir James Fitzjames Stephen noted to the Capital Punishment Commission that juries had become reluctant to convict in cases they did not consider to be real murder.[160] Having expressed clear opinions and instructions on the presented evidence in their summings-up, judges could be thwarted and irritated, by jury obduracy but these acts of independence give an indication of the nature of the jury members and their reactions to the circumstances of the cases before them. Unlike inquest juries, the juries in the high courts deliberated in camera.[161] For that reason, it is difficult to ascertain their emotional reactions to any case, not just infanticide and child-homicide cases.

One case where a jury's opinions and compassionate opinions were displayed was that of Martha Ellen Birkenhead at the Liverpool Assizes in 1876. Martha Birkenhead appeared before Mr Justice Lindley at the Winter Assizes, indicted on a

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[157] Watson, *Medicine and Justice,* p. 83

[158] Phil Handler, "Judges and the Criminal Law in England 1808-1861" in Paul Brand and Joshua Getzler (eds.), *Judges and Judging in the History of the Common Law and Civil Law; from Antiquity to Modern Times* (Cambridge: Cambridge University Press, 2012), pp. 138-174, p. 153.

[159] Ibid., p. 153.

[160] Ibid., p. 154.

[161] Rutherford, "Unity or Disunity?", p. 243

charge of causing the death of her infant daughter by negligence.[162] The jury deliberated for many hours but were unable to agree on a verdict and clearly had doubts about the evidence in the case. They were twice called back into court by Lindley who failed to understand why they could not reach a verdict and enquired how he might clarify evidence.[163] Their main objection to reaching the suggested verdict of manslaughter, was that some of the responsibility for the child's death should lie with the parish authorities. Birkenhead had handed the child to the parish authorities twelve days before it died. Some of the jury members suggested the child's underlying lack of strength, as well as the alleged neglect, could be said to exonerate Birkenhead and that they objected to the potentially lengthy prison sentence which would follow a guilty verdict. The jury members were exercising a degree of independent thinking and determination, which eventually led to their dismissal and the postponement of the case to the next assizes. "His Lordship said … they had been dwelling too much upon the law and too little upon the facts … they ought not, in fairness to any judge … distrust him in the exercise of … discretion [in sentencing] … that the law had imposed upon him".[164] Newspaper reports of the case give a sense that this reaction by an assize jury was unusual and noteworthy. The *Liverpool Mercury* subtitled their article "A Troublesome Jury" and the *Wigan Observer* subtitled their piece, "Obstinate Jurymen."[165]

Judges

The judges could and did, have an influence on the juries' verdicts at the trials. Their role, in simple terms, was to interpret the evidence and explain the law to the

[162] "Alleged Starvation of a Child." *Liverpool Mercury* (18 December 1876), p. 6, col. 4.

[163] "The Sankey Bridge Starvation Case" *Wigan Observer* (22 December 1876), p. 6, col. 3

[164] *Liverpool Mercury* (18 December 1876), p. 6.

[165] *Liverpool Mercury* (18 December 1876), p. 6; *Wigan Observer* (22 December 1876), p. 6.

jury and to control proceedings within the courtroom. A judge's personal understanding of the defendant's situation in life, her family relationships and his understanding of the reported state of her mind, would affect his decision on a trial's course. A judge was responsible for summing up the evidence for the jury, which could occur when both prosecution and defence had presented all their evidence or when the judge felt that enough evidence had been heard enough for the jury to come to a decision. It is from the judicial addresses to the court, whether they were before the grand or petty jury, that judges' personal beliefs can sometimes be discerned.[166] Wiener submits that, as the century progressed, judges increasingly accepted that personal responsibility was inapplicable in cases where women had killed their infants and that a psychiatric view of such cases was more appropriate.[167]

Judges, however, had the opportunity to demonstrate their personal reactions to court cases and it was not unknown for them to display emotional and sometimes tearful responses. It was noted at the Liverpool Assizes in March 1859 that Sir James Shaw Willes "became painfully afflicted ... at one time he buried his face in his notebook and shed tears" at Agnes Bradley's trial.[168] Willes was well-known for his lachrymose reactions to particularly tragic court cases and his behaviour could be described as being more in line with that of early-nineteenth-century judges, when emotional judicial reactions were more common.[169] In 1840, at Oxford Assizes, Baron Gurney was noted as being "much affected" when passing the death sentence on Celia Tippen for the murder of her infant son "amid the tears of a crowded courtroom".[170] As the century progressed, tearful displays were not so common, nor so tolerated. An

[166] Schwan, *Convict Voices*, pp. 113-114.

[167] Wiener, *Reconstructing the Criminal*, pp. 268-269.

[168] *Times*, (28 March 1859), p. 11.

[169] Dixon, "Tears of Justice Willes", pp. 1-23; idem *Weeping Britannia.* pp. 169-82.

[170] "Spring Assizes." *Times*, (8 April 1840), issue 17326, p. 7, col. 6.

editorial comment in the *Glasgow Herald* in 1870 castigated Sir Fitzroy Kelly for shedding tears when passing the death sentence on Margaret Waters, the so-called "Brixton Baby Farmer". They wrote, "We confess that we cannot understand this display of feeling still less can we admire it. It seems to us closely akin to that morbid sentiment which makes pseudo-philanthropists treat every capital criminal as a victim and converts the hangman's cap into the martyr's aureole."[171]

In 1899, Mr Justice Bucknill cried as he passed the death sentence on a female defendant and it was noted in the *Halifax Courier* that "[it] is not often that a judge gives way to tears in his court." The newspaper report suggested two reasons for his behaviour. Firstly, the female defendant had made a "pathetic appeal … for mercy for the sake of her children" and secondly that "Mr Justice Bucknill … pronounced the capital sentence for the first time in his judicial career." [172] Both were considered rational and acceptable explanations for the emotional behaviour at a time when a significantly desirable attribute of manliness was control of feelings.[173] Sir Henry Hawkins wrote of the conflict which could face judges if personal emotions were allowed to impact on the correct application of the law. He wrote that "in many cases the feelings of the Judges would interfere with the course of justice and murderers would receive more sympathy than their victims … and yet Judges have sympathy."[174] He did not expect that judges should be devoid of compassion but that it should be applied in the correct manner; the integrity of the law should take precedence over judges' personal feelings and emotions.

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[171] "Editorial", *Glasgow Herald* (26 September 1870), p. 4, col. 2.

[172] "Gossip of the Week - a Judge in Tears." *Halifax Courier* (25 November 1899), p. 7, col. 6.

[173] Pedley, "The Emotional Reactions of Judges", p. 93.

[174] Hawkins, *Reminiscences*, p. 226.

Conclusion

In 1846, the same editorial on the subject of infanticide in the *Times* quoted in the Introduction, also commented on the trials of new-born child murder. It declared that, "Not a day passes but the disclosures of … a trial establish the melancholy truth that human life is losing its value". The writer continued, "The laxity of the verdicts and leniency of the sentences … prove … we are becoming familiarized with the crime [infanticide] and we consider it palliated by extreme provocation of circumstances. Crime … is crime and its guilt rests somewhere". [175] The author placed the blame on poverty and self-preservation caused by the callousness of a society that punished rather than helped those in poverty. The "laxity" and "leniency" of sentencing was attributed to extenuating circumstances which would drive a mother to murder her child. The truism that women should not be prone to violence and that they would naturally protect their young children and not harm them, was a widely-accepted cultural belief. A mother must be mad to step away from the role of nurturing motherhood, attack her own children and commit a crime which was so outside the society's norms.

Contemporary opinions influenced claims made by the erudite legal fraternity, affected courtroom perceptions and impacted the outcomes of trials. The presentation of the defendants and their cases by the advocates and the summings-up by the judges might clarify the evidence but cultural sensitivities about the vulnerability of women would impact results. There was always a reluctance to find a woman guilty of a capital crime. Moreover, if the guilty woman was the mother of her victim, there was a willingness in court to find culturally acceptable explanations for her violent behaviour. Extenuating circumstances of violation, domestic violence, negligence and deprivation, as well as physiological factors, were accepted as underlying reasons for

[175] "By far the most serious feature …", *Times*, (18 March 1846), issue 19187, p. 4, col. 5.

any mental disorders. To find her insane or to accept that she was insane at the time of her crime was a more socially and culturally tolerable verdict than guilty of murder and its consequent death penalty.[176]

The hypothesis that personal values and social situations would influence emotional responses to female defendants and, specifically, mothers who had murdered their children, may be an overly simple interpretation of the reality. As with the other male authority figures who came into contact with the homicidal mothers on their life-journeys through the medico-legal systems, the reactions of the male legal world would be coloured by the men's social and educational background. Those who had been brought up in the early Victorian period were influenced by a society which accorded sentimental emotions considerable cultural significance: this was an era of "pathos" within writing and literature. Overt displays of emotions in life were acceptable and the sight of judges and others weeping in court was considered to be appropriate in certain situations. As the century progressed, the more excessive sentimental displays of emotion of the so-called Dickensian period seemed to disappear. By the end of the century, exhibitions of obvious emotion were viewed as not being acceptable manly English behaviour and public tearful reactions were for women and children.[177]

The medical men who gave evidence in court ranged from the doctor who had examined the body of the child post-mortem and potentially dealt with the accused woman at the time, to medical experts brought in to give an opinion on her mental state. By presenting their evidence in an unemotional manner, their emotional engagement with a case could appear to be distant and clinical. Their personal opinions about the circumstances of the crime and of the defendant were not necessarily

[176] Arnot, "Perceptions of Parental Child Homicide", p. 33.

[177] Pedley, "The Emotional Reactions of Judges", pp. 93-4.

apparent but may only be given if they were sought in cross-questioning. In this manner, the medical men would be seen to maintain their professional integrity, even in the face of opposition from prosecution council and, occasionally, from the bench. Compassionate sensitivity did not disappear from later Victorian socio-cultural views and advocates and the judiciary still wished to be viewed as understanding and sympathetic.[178] That being said, unnecessary over-sentimentality was not considered an attribute in applying correct legal process and it was not considered appropriate for emotion to rule one's head.

Over the whole period, the criteria which defined criminal insanity evolved and these changes impacted on the future lives of the homicidal mothers and, potentially, on their future mental welfare. The next stage in the homicidal mothers' life-journey was incarceration in an institution, an asylum or prison. They would have no more contact with the defence or prosecution barristers and any decisions about their future lives would be taken by the Home Office, in consultation with judges and medical men. Some members of the judiciary did not necessarily agree with the medical experts when it came to their assessments of the state of the accused woman's mind and the circumstances of her crime. However, the influence of medical men's opinion on bureaucratic procedures in relation to the incarceration of criminal lunatic mothers, increased as medical understanding of mental illness grew through the nineteenth century.

[178] Ben Griffin, *The Politics of Gender in Victorian Britain. Masculinity, Political Culture and the Struggle for Women's Rights* (Cambridge: Cambridge University Press, 2012), p. 173.

Chapter 4:
"Detained until her Majesty's pleasure be known"
Beyond the Verdict.

Introduction

In 1837 Hannah Smith was tried at the Lent Assizes at Stafford for drowning her youngest child. She was acquitted as insane and sentenced to be detained at her Majesty's pleasure.[1] She was held in Stafford Gaol until October 1837, when she was "prepared for removal to Bethlem" and transferred on 7th November.[2] Smith was one of the first patients transferred into Broadmoor Criminal Lunatic Asylum in 1863, dying there in 1870.[3] Twelve years after Smith's trial, at the Essex Assizes in March 1849, Sarah Grout was also acquitted as insane after being indicted on two counts of murder, one of her son James, aged four and the other of her daughter, Mary Ann, aged two.[4] Grout was committed to Springfield Gaol, later transferred to Hoxton House Asylum and then to Essex County Lunatic Asylum in 1855, before her release in 1858.[5]

On 22nd September 1862, Adelaide Cole was tried for the wilful murder of her fifteen-month-old son, Charles. Witnesses at her Old Bailey trial testified that she had had periodic bouts of strange behaviour and was in a "low desponding state" at the

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1 TNA, HO17/126/YX31, Home Office Criminal Petitions: Series I, "List of Criminal Lunatics in the Gaol at Stafford".

2 BHRA, CBC-01 Incurable & Criminal Patient Casebook 1778-1840, Hannah Smith, f. 202.

3 BCLA, D/H14/D2/2/2/9, Case File: Hannah Smith.

4 "Law and Police. Child Murder", *The Lady's Newspaper* (17 March 1849), p. 14, col. 2.

5 TNA, HO18/305, Home Office Criminal Petitions: Series II, 1850, "Surgeons' Recommendation of Removal of Milicent Page, Sarah Grout, Martha Prior and Esther Playle from Springfield Gaol, Essex to an Asylum."

time of the murder. [6] The medical evidence confirmed that "she was in a state of very low melancholy" with what was thought to be "precedent to … homicidal mania".[7] Cole was found "Not Guilty being insane", returned to Newgate and then transferred to Fisherton House Asylum, on 11th November 1862.[8] She died there on 23 June 1864 from phthisis.[9] In a fourth example case from 1883, Mary Ann Morgan, wife of a much-respected local government officer and scientist in Swansea, drowned her two-year-old daughter, Alice Maud Morgan, in the bath.[10] Following examination by Visiting Magistrates and two doctors appointed by the Home Office, she was certified as insane and committed directly to Broadmoor, on the warrant of the Home Secretary, without facing trial.[11] She remained there until her death in 1926.[12]

In the period from 1835 to 1895, changes in official practices regarding the incarceration of all legally insane criminals impacted the lives of the 288 mothers, under discussion in this thesis. The institutional careers of the four women whose stories open this chapter, illustrate the variations and inconsistencies as to which establishment they might be committed. In the previous chapter, I discussed how concepts of criminal responsibility and delusion impacted on the way in which the women were perceived in court. Within this chapter, my aim is to explore how those

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6 OBP, *Old Bailey Proceedings Online*, September 1862 Trial of Adelaide Cole (30), (t18620922-957).

7 OBP, September 1862, Cole.

8 FHAA, J7/190/4, Fisherton House Asylum Patient Case Book. Adelaide Cole; patient no. 1940, f. 31.

9 FHAA J7/190/4, Cole; f. 31.

10 "The tragedy at Swansea. Committal of Mrs. Morgan for murder" *South Wales Daily News* (23 November 1883) p. 3, col. 8.

11 TNA, HO144/128/A33589, "Lunacy: Proposed acceptance of bail pending murder trial at Assizes. Criminal: Morgan, Marianne [sic]; Court: Swansea P.C.; Offence: Murder; Sentence: Criminal Lunatic. 1883-1884".

12 BCLA, D/H14/D2/2/2/362, Case File: Mary Ann Morgan.

same concepts affected the official policies of imprisonment for the homicidal mothers, who were adjudged insane in the sixty years between 1835 and 1895. The chapter is divided into two chronological sections, 1835 to 1863 then 1863 to 1895, covering the periods before and after the opening of Broadmoor Criminal Lunatic Asylum. Both sections investigate the changing contemporary understandings of criminal insanity in women, the differing official views of which would be the "correct" place of incarceration for these insane mothers and a discussion of what happened after the sentence "to be detained until her Majesty's pleasure be known" was pronounced.

Between 1835 and 1863 married, homicidal mothers, who had been found insane by judicial process for the murder of their own children, could be held in a variety of establishments or even simply discharged. Institutions included prisons, private and county asylums and the inadequate, specialist criminal lunatic facilities at Bethlem Royal Hospital and Fisherton House Asylum.[13] After 1863, practically all cases were admitted to the new Broadmoor Criminal Lunatic Asylum. Using case studies, I discuss the possible reasons behind the use of differing institutions and briefly address the impact and changing influence of outside bodies, such as Poor Law Unions, on the decisions surrounding incarceration. The development of asylum care for the criminally insane and its place within the general nineteenth-century expansion of institutional care for the insane, will be examined in greater detail in the next chapter. For the moment, this development is considered principally in terms of medical, judicial and governmental opinion on the ideal place of detention for insane homicidal mothers.

[13] Roger Smith, *Trial by Medicine. Insanity and Responsibility in Victorian Britain* (Edinburgh: Edinburgh University Press, 1982), p. 23.

The decisions about where the insane mothers should be detained were always informed by medical opinion.[14] Previously, I explored the role that the evidence of medical men played in influencing the outcomes of trials. In this chapter, I discuss how that medical opinion was also important in informing the relevant authorities about the value of detention in a dedicated institution. Roger Chadwick analysed the records of the Home Office between 1860 and 1890 to find what principles and patterns of deliberation drove the administrative decisions about the prerogative of mercy. [15] He argues that attitudes and "mercy" were very different in the latter half of the nineteenth century, once such decisions passed from the Crown (via the Privy Council) to the Home Secretary of State and his office. [16] His analysis of exchanges between the judiciary, doctors and administrators, are relevant to my research.

As the influence of early psychiatric medicine in the form of asylum doctors became more accepted by Home Office officials, the role of the prison doctors in decisions about incarceration seemed, on one level, to diminish. However, my investigation shows that their observations and diagnoses, together with their medical opinion, were crucial to the asylum medical authorities. As the prison doctors had contact with the accused women from soon after the criminal act, their observations about the possible causes of insanity and the accused's general state of health, were valuable to the asylum. [17] While I investigate the rationale behind the women's

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[14] Catherine Cox & Hilary Marland, "Broken Minds and Beaten Bodies: Cultures of Harm and the Management of Mental Illness in Late Nineteenth Century England and Irish Prisons", *Social History of Medicine,* vol. 31, no.4, (2018) pp. 688-710.

[15] G. Roger Chadwick, "Bureaucratic Mercy: The Home Office and the treatment of capital cases in Victorian England" (unpublished PhD thesis, Rice University, Houston Texas. 1989).

[16] Ibid., p. 281.

[17] Katherine D. Watson, *Medicine and Justice: Medico-Legal Practice in England and Wales, 1700-1914* (London & New York: Routledge, 2020), p. 162.

institutional confinement as criminal lunatics, the diagnoses and causes of that confinement will be considered in greater depth in the next chapter.

Any differences in legal and medical opinion about where the women should be incarcerated and treated were often apparent in "unfit to plead" cases. Some women were admitted into an asylum without a full trial by jury, having been found insane on arraignment; in other words, they had been considered either unfit to plead or unable to understand the court proceedings. I discuss this matter later in this chapter but 16% of my dataset were admitted to Broadmoor this way (Table 4:2). In such cases, the opinion of medical men was, once again, of paramount significance to the woman's fate. In other cases, the insanity of the charged homicidal mother was so obvious that it was deemed necessary to admit her directly to an asylum by way of a Home Secretary's warrant, thus by-passing a trial. Within this chapter I use the stories of Martha Baines (1876) and Mary Ann Morgan (1883) to illustrate the contemporary unease amongst some members of the judiciary over the range of the executive powers of the Home Office within the justice system. Rather than raising objections to the accused mother's actual incarceration, the judges in these two cases sought to protect the offender's right to a trial by jury.

The two cases and that of Eliza Agar (1884), also illustrate the discussions that surrounded those cases where it was believed that even bringing the case to trial would irreparably damage the physical and mental health of the woman. Although there was a growing acceptance of theories concerning the cause and effects of insanity, particularly in cases of maternal child murder, differences of opinion still existed between the judiciary and the medical profession about the efficacy of asylum incarceration and' on some occasions, it was not unknown for a judge's views to override expert medical opinion. There was a continuing discussion about unconscious impulse and criminal responsibility between medical men and judges in relation to the

destiny of these mothers.[18] Rather than running counter to the course of justice, medical evidence of insanity was used to prove that the mother had acted unconsciously and out of character, as a consequence of her mental state at the time of the murder of her child. If the women were committed to an institution by law, then they would be ensured of receiving what the medical experts believed would be the correct care for recovery from mental derangement, rather than punishment for the crime.

Criminal lunacy and the insane homicidal mother

The chart at Figure 4:1 (page 171) is a graphical illustration of the annual admittances of insane maternal homicides for the sixty-year period, 1835-1895. The chart clearly demonstrates the variances in places of detention before the opening of Broadmoor. There appears to be a marked growth in the number of cases in the latter part of the century. In this section, I discuss possible reasons for the increasing numbers and the rationale behind the differing choices of institutions. After 1863, once Broadmoor was fully operational, the overwhelming majority of insane homicidal mothers were committed there. The reason for this is the fact that there was a dedicated asylum, with the capacity to take all criminal patients. The marked increase in the numbers of this class of "criminal lunatic" in the 1860s and 1870s, can be allied to changes in the diagnoses and interpretations of mental illness. These evolved through the increasing numbers of men specialised in alienism (early psychiatry) and psychology.

[18] Alison Pedley, "The Emotional Reactions of Judges in Cases of Maternal Child Murder in England, 1840-1890" in James Gregory, Daniel J.R Grey & Annika Bautz (eds.) *Judgment in the Victorian Age* (London & New York: Routledge, 2019) pp. 83-99, p. 90.

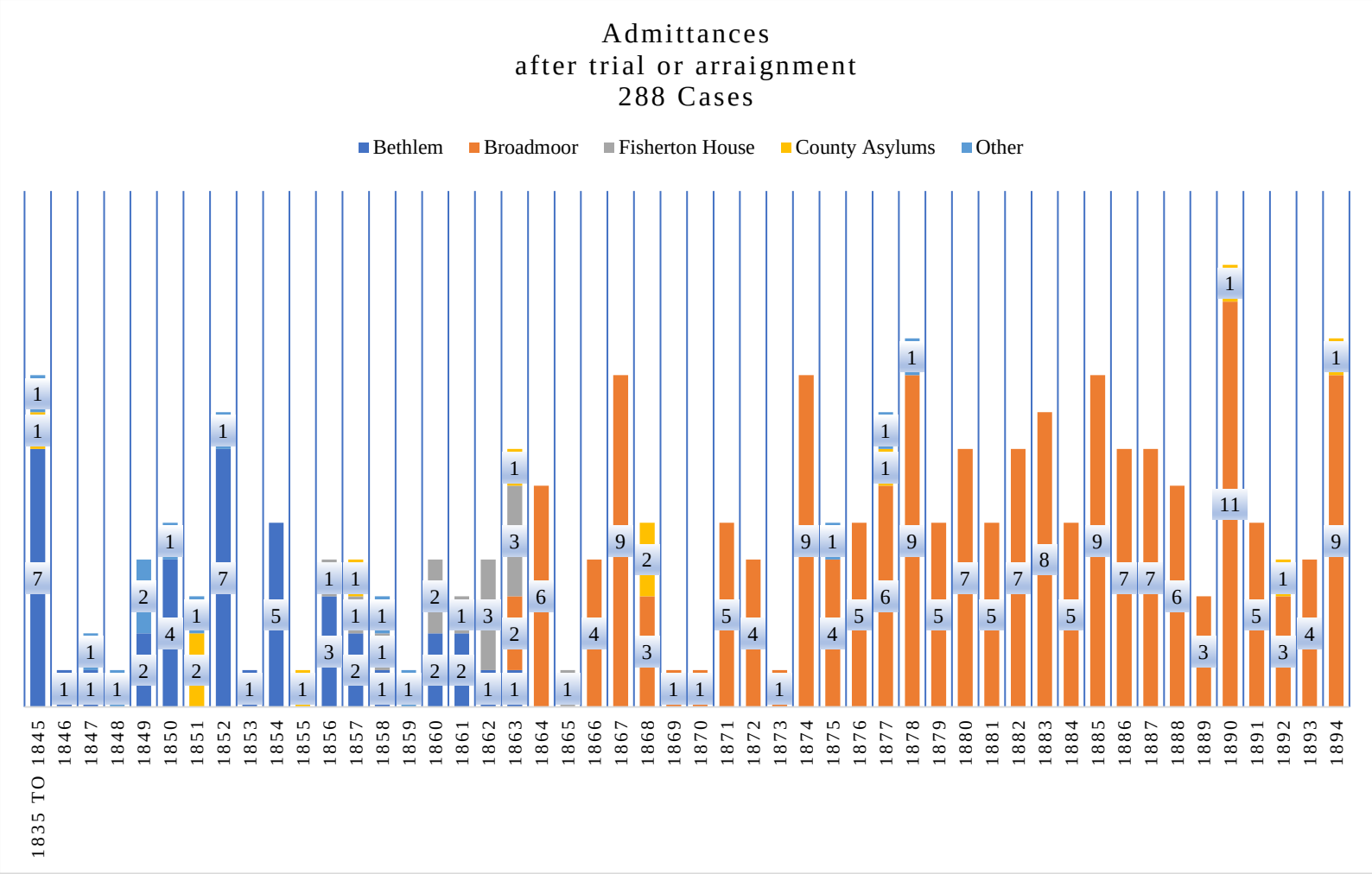

Figure 4:1: *Initial place of incarceration, 1835-1895.*

As I discussed in the Chapter 4, in the later part of the century, there was an acknowledgement within the legal fraternity that medical evidence had a significant role in court cases. Medical expert opinion was given more credence and impacted upon the future lives of the insane mothers. In the mid-century, Dr William Charles Hood, Medical Superintendent of Bethlem Royal Hospital, published a paper entitled *Suggestions for the Future Provision of Criminal Lunatics*, in which he gave his opinions on and propositions for, the care of the criminally insane.[1] In particular he referred to mothers who had killed their own children, suggesting that they should be in a facility where they would be helped and cured. Within his paper he described them as "one class of sufferers who have a peculiar claim upon our sympathies – those unfortunate women … who in a state of aberration, after confinement, destroy their own offspring". He continued that, in his view, "the most amiable and gentle of her sex may in the agonies of childbirth or some days afterwards, be attacked with puerperal mania and commit infanticide".[2]

As Hilary Marland discusses in her extensive scholarship on puerperal insanity, the view that homicidal mothers who had killed their children should be treated with care persisted through the century.[3] Puerperal mania and related mental-illnesses were viewed by the nineteenth-century medical world as potentially remediable conditions. Belief in the "curability" of such specifically female mental-illnesses was fundamental to asylum medical staff, who held that the sufferers would

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1 Wm. Charles Hood. M.D., *Suggestions for the Future Provision of Criminal Lunatics* (London: John Churchill, Soho. 1854).

2 Ibid., pp. 162-164

3 Hilary Marland, "Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth century", *History of Psychiatry* vol. 14, no. 3, (2003) pp. 303-320; Idem., *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave MacMillan, 2004).

recover with the right treatment in the right conditions.[4] While medical understandings and treatment of such conditions are considered in detail in Chapter 5, which focusses on asylums and asylum care, it is of relevance here. Medical confidence in the curative environment of an asylum supported the doctors' view that incarceration in such institutions was the most suitable and humane solution for criminally insane mothers. In 1902, echoing Hood's sentiment, John Baker wrote that the majority of women held in Broadmoor for the murder of their children had killed out of "morbid and mistaken maternal solicitude" and were "acquitted on the plea that they were insane at the time such acts were committed … therefore… free from the taint of crime …having been held irresponsible for the acts … by the virtue of their affliction".[5]

Before 1863, while county asylum medical superintendents might object to the presence of convict patients ("lunatic criminals") in their asylums, they did generally accept homicidal mothers as genuine patients. They seem to have agreed with Hood's opinion that such patients deserved sympathy and help. After 1863, when the women invariably went into Broadmoor, the opinions of contemporary medical men still supported the belief that the homicidal mothers were mentally ill, deserving of care and treatment and not punishment as criminals. The medical authorities, for the most part, agreed that a homicidal mother who had killed her child whilst insane was an object of pity and rightfully deserved her place in a curative institution; she was a "true criminal lunatic."[6]

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4 Idem., "Disappointment and Desolation", p. 306.

5 John Baker, "Female Criminal Lunatics: A Sketch", *Journal of Mental Science* vol. 48 (1902), pp. 13-28, p. 13-4.

6 Ibid., p. 16.

Before Broadmoor, 1835 to 1863.

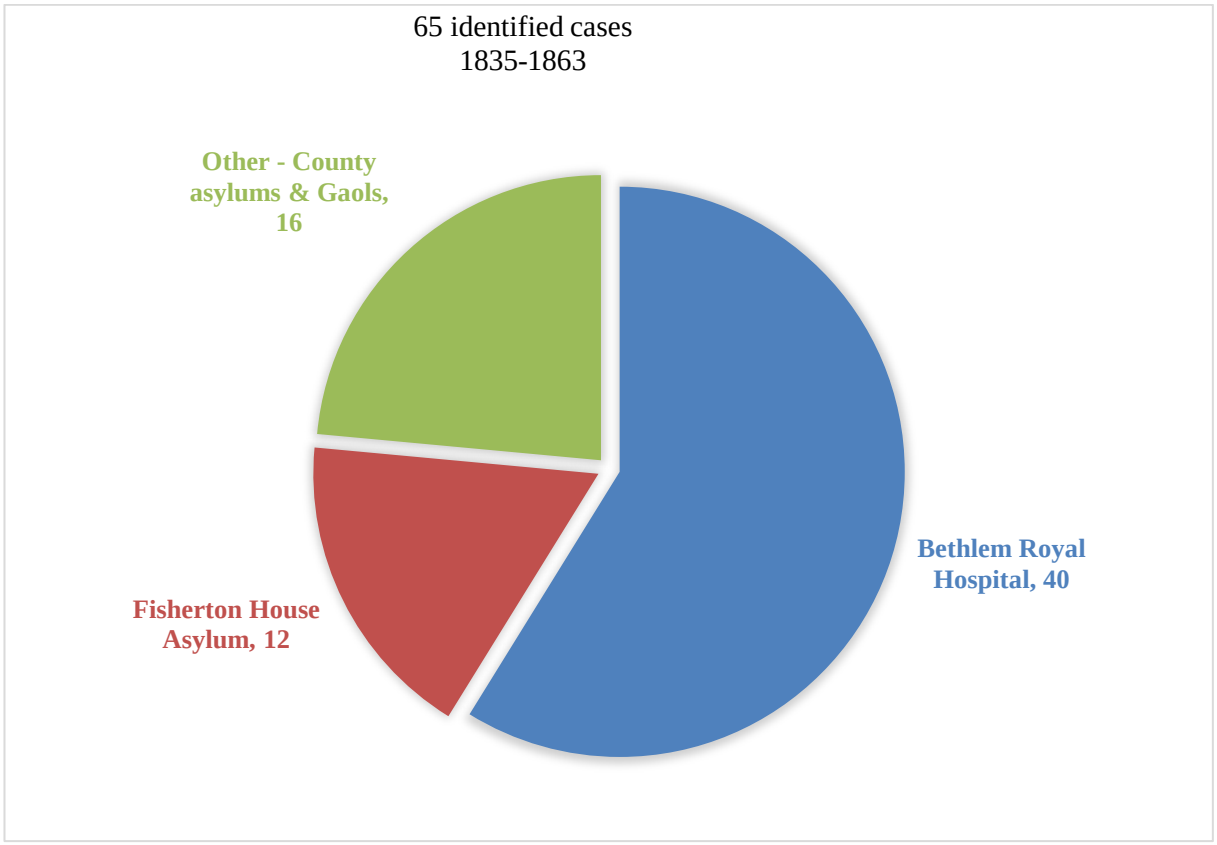

Figure 4:2: *Initial Place of Incarceration for Homicidal Mothers Deemed Insane, 1835-1863.*

Despite the existence of Bethlem and latterly of Fisherton House, in the thirty years before Broadmoor's opening, there was no discernible, consistent pattern to where insane homicidal mothers might be incarcerated. As can be seen in the diagram at Figure 4:2, not all cases of criminal lunacy were routinely admitted into Bethlem. This was despite its official status as the state criminal lunatic facility in the first thirty-six years of the nineteenth century.[7] I have identified 68 cases of maternal child homicide between 1835 and 1863 and of that number, 40 were firstly admitted to Bethlem. An acquittal of a mother for the murder of her child by reason of insanity was not a direct instruction for her to be committed to an asylum. Despite a jury

[7] Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker & Kier Waddington, *The History of Bethlem* (London: Routledge, 1997).

passing down a verdict of not guilty but insane and the judge sentencing the defendant to be held until her Majesty's pleasure be known, there was no automatic passage to an asylum from remand. In all cases, the authorisation of a doctor, usually the holding prison's medical officer, was needed and his opinion on the woman's behaviour and mental state was of paramount importance. When the decision was made about the place of detention, the opinion of the trial judge was rarely sought. As I will demonstrate further on in this chapter, as the century progressed the role of the judge changed and his opinion became of equal, if not greater, importance to medical opinion in such matters.[8] Once a defendant had been admitted as a criminal lunatic, to whichever institution, their future career through the penal or asylum system came under the jurisdiction of the Home Office. Although this was the case in the years before and immediately after the opening of Broadmoor, as the involvement of the Home Office grew in line with legistion.[9] Procedures and protocols to do with the movement of criminal lunatics evolved and grew in number. I discuss the changes in more detail in relation to Broadmoor and I also address them in Chapter 7 of this thesis.

The influence and importance of the prison surgeons' official opinion is illustrated by the cases of Ann Colley and Hannah Smith in 1837. Ann Colley was tried at the Stafford Summer Assizes in 1837 for the murder of three of her children and acquitted as insane. Despite the judge's direction, she was detained in Stafford gaol and not sent to the local asylum. [10] A petition was submitted in August 1837 to the Home Secretary from her husband who was acting on the advice that "the removal of his wife from the County Gaol of Stafford to the County Lunatic Asylum at Stafford…would be requisite as she was more fit to be an inmate of an asylum than

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8 Chadwick, "Bureaucratic Mercy", p. 280.

9 Ibid., p. 281.

10 "Murder of Three Children by Their Mother", *Morning Chronicle* (24 July 1837) p. 6, col. 3.

that of a gaol".[11] The surgeon to the prison, Mr Robert Hughes, vetoed the move, saying "she is subject to attacks of nervous anxiety with palpitations…but very few medical men would venture to certify that she is insane" and that "a certificate of insanity would be to no avail".[12] Unfortunately, Ann Colley subsequently suffered another "maniacal attack" and committed suicide in the prison in October 1837. At the inquest into her death, it was reported that Colley's husband had visited her and "very incautiously gave her a locket containing portions of the hair of the murdered children." This act was reported as having unhinged her mind and consequently Colley hanged herself "with a silk handkerchief" in the prison privies. Despite Hughes reiterating his opinion that Colley had not displayed insane behaviour in the time leading up to her suicide, the inquest verdict was "Insanity". [13]

The case was notorious at the time, was widely reported in the press and was the subject of at least two broadsides.[14] It is too speculative to say that Hughes was influenced by the recording of Colley's crime and court case but he would have been aware of the graphic and prolific reportage at the time.[15] The press accounts of her trial were quite respectful in tone and not uncompassionate towards Colley. She was the wife of an ex-police superintendent, referred to as "Mrs Colley" and described as

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[11] TNA, HO17/106/TX40, H.O. Criminal Petitions: I, "Petition of George Colley 12 August 1837".

[12] TNA, HO17/106/TX40, H.O. Criminal Petitions: I, "Letter from Robt. Hughes, Surgeon. 6 August 1837".

[13] "Suicide of Ann Colley" *Globe* (10 October 1837) p. 4, col. 5.

[14] "Dreadful murder of three children by their mother", Crime: Broadsides: Murder and Executions folder 5 (1), 1837, *John Johnson Collection of Printed Ephemera* (Oxford: Bodleian Library); "Horrible murder of three children by their mother" Broadside, 1837. Broadsides-England-19th century *Crime and Execution Broadsides* (Cambridge, Mass.: Harvard Digital Collections Harvard Law School Library, Harvard University).

[15] Anne Schwan, *Convict Voices: Women, Class and Writing about Prison in Nineteenth-Century England* (Durham, New Hampshire: University of New Hampshire Press, 2014), p. 35.

"rather well educated for her station …[and] … a kind and affectionate wife and mother."[16] The cause of her mental breakdown was blamed on her husband's dismissal from the police and subsequent domestic difficulties. This sympathy is less apparent after her suicide, when she was referred to as a "wretched woman" and her death reported in an impersonal manner: "the effect of strangulation on the brain was so great as to baffle medical skill."[17]

Hannah Smith was also tried at Stafford, at the Lent Assizes of 1837, having been accused of wilfully murdering her youngest child by drowning. Like Ann Colley, she was acquitted as insane and sentenced to be detained at her Majesty's pleasure. Her conduct in gaol was described as "that of an Insane Person" and her bodily health was "Bad from refusing food." Robert Hughes was once again the doctor involved in her case. Although there is no physical written record of his opinion on the state of Smith's mind, Hughes must have been convinced that her behaviour and demeanour were sufficiently insane to justify her transfer to an asylum for on the 14th October 1837 she was "prepared for removal to Bethlem", where she was admitted on 7th November.[18] Casebook notes for other patients in Bethlem indicate that, on many occasions, if the woman displayed insane behaviour whilst on remand in the local or county prisons, then the opinion of the prison authorities could assist her entry into Bethlem.

It is not clear from the available papers, however, why Smith was admitted to Bethlem, rather than Stafford County Asylum. At this time, 1837, prison surgeons influenced where a criminal lunatic should be held, as is clearly shown in this case:

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16 "Murder of Three Children by Their Mother", *Morning Chronicle* (24 July 1837) p. 6, col. 3.

17 *Globe*, (10 October 1837) p. 4.

18 TNA, HO17/126/YX31, H.O. Criminal Petitions: I, "List of Criminal Lunatics in the Gaol at Stafford".

both Colley and Smith had come under the care of Hughes. It is worth noting at this point that, before *The Prison Act 1865,* the role of prison surgeon was a part-time one and prison surgeons were only required to examine prisoners on an ad hoc basis.[19] These infrequent medical examinations could explain why signs of insanity in inmates were occasionally missed. After 1866 and the implementation of the 1865 Act, more frequent medical observations were arranged and it was the prison surgeon who would most likely detect any signs of mental derangement.[20] I will return to this point later in the chapter, when discussing the evolving role of medical expert opinion in the nineteenth century. Potentially, this could lead to tensions arising between prison medical officers and asylum doctors, particularly in cases where a female prisoner had been improperly retained in gaol when she should have been removed to an asylum for treatment.

The absence of a cohesive policy on the confinement of criminal lunatics before 1862 meant that the women's incarceral journeys could take very different paths. In the case of Sarah Grout, quoted at the beginning of the chapter, she was committed to Springfield Gaol after her trial in 1849. In the previous year Martha Prior had been found not guilty, on the grounds of insanity, of the murder of her 13-day old daughter. She, too, was sent to Essex County Gaol at Springfield as a criminal lunatic. Likewise, two years later, in March 1851, Milicent Page and Esther Playle each stood trial for murdering their children. Page had cut the throat of her month-old baby and Playle had violently assaulted her five-year-old daughter, before cutting the child's throat. Both women were acquitted on the ground of insanity to "be kept in confinement, subject to the pleasure of her Majesty."[21] They were admitted to

[19] 28 & 29 Vict. C126 Prison Act 1865.

[20] Nigel Walker, *Crime and Insanity in England: Volume One: The Historical Perspective* (Edinburgh: Edinburgh University Press. 1968), p 226-229.

[21] "The Child Murder at Chelmsford", *Chelmsford Chronicle*. (7 March 1851), p1, col. 7.

Springfield Gaol, appearing in the 1851 Census alongside Prior and Grout and designated "Criminal Prisoner- acquitted as insane."[22]

Later in 1852, all four women were the subject of a successful application from the Visiting Magistrates of the gaol, supported by the prison surgeons, for their transfer to a lunatic asylum. On 20 May 1851 they were admitted to Hoxton House Asylum as criminal patients and, eventually, all four were released. Martha Prior was released as cured in August 1851 following formal petitioning by her husband.[23] Grout, Page and Playle were all transferred as "ordinary lunatics" to Essex County Asylum and subsequently also released as recovered.[24] A speculative reason for their detenion in Springfield Gaol, rather than an asylum, appears to have been an economic one.

All four cases could have been candidates for Bethlem Royal Hospital at the time of committal but, instead, they went into a county gaol. In the cases of Prior and Grout, it initially seemed that they would serve some sort of custodial punishment for their crime, rather than receive specialised care for insanity in an asylum. Although Playle and Page were initially admitted to Springfield Gaol in March 1851, by May of that year the prison surgeons were stating that "the Gaol is not a fit place for them" and suggesting that all the women should be transferred to a more suitable environment. The surgeons' letter categorically states that the women were "now quiet and well-conducted" and would be better served in an asylum as they did not need close confinement but, rather, useful employment. They should remain in safe custody of some kind to protect them from a recurrence of their insanity and as some protection for the public too: "We recommend that they be removed from the Gaol both on their

[22] TNA, HO17/1776/464/2, 1851 England and Wales Census, Springfield, Chelmsford, Essex, Schedule 1. Piece 1776. Folio 464. Page 2.

[23] TNA, HO18/305, Home Office Criminal Petitions: Home Office Criminal Petitions: Series II . "Petition of Charles Prior and other supporting correspondence. 30 July 1851"

[24] TNA, MH94/3 to MH94/15 UK Lunacy Patients Admission Register, 1846-1912.

own account and on public grounds."[25] The request for the women's removal to an asylum was driven by the prison surgeons, once again demonstrating the importance attached to the opinion of the medical men who had contact with the women. As the women were to be held until her Majesty's pleasure be known, petitions for removal, whether from prison to the asylum, or between the asylums, were made, via the Home Office, for referral to the Crown in the form of the Privy Council.[26] The subsequent release warrants were signed by Queen Victoria herself and an unconditional discharge could be followed by a full Royal Pardon. This changed in 1861 when the power of reprieve and commutation from the judiciary and the Privy Council was moved to the Home Office and, with the opening of Broadmoor in 1863, the protocols for release and discharged changed. I review the methods of discharge and release in greater depth in Chapter 7 of this thesis.

In the thirty years before Broadmoor, decisions about where the women should be incarcerated were sometimes predicated on economic grounds as well as on medical opinion. Financial considerations are noticeable in the change of institution for Grout, Page, Playle and Prior. When the four women were admitted into Hoxton House Asylum, there was no county asylum available in Essex and their maintenance was paid for by their respective Poor Law Unions.[27] In 1855, the Guardians for the Orsett Union wrote to Lord Palmerston as Secretary of State, requesting that Sarah Grout be transferred to the county asylum: "The costs of maintenance of the Lunatic is now borne and paid by the Guardians of the Union and as the expenses are somewhat less in the County Asylum, it is of course desirable that she should be moved to that [Essex

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[25] TNA, HO18/305, H.O. Criminal Petitions: II, "Surgeons' Recommendation of Removal of Milicent Page, Sarah Grout, Martha Prior and Esther Playle from Springfield Gaol, Essex to an Asylum. 19 May 1850".

[26] TNA, HO18/305, H.O. Criminal Petitions: II, "Petition of Charles Prior". for Martha Prior's release was headed "To the Queen's most Excellent Majesty in Council".

[27] Essex County Lunatic Asylum opened at Brentwood in 1853.

County Lunatic Asylum] establishment."[28] Similarly, in the case of Mary Ann Beveridge, the town council of Portsmouth and the local magistrates in Hampshire objected to having to support her as a criminal lunatic in Winchester Gaol, stating that she should be in a government institution. She was duly transferred to Bethlem, where she was "maintained at the public expense."[29]

The place of incarceration after trial may have been due, in part, to the fact that the women were held in the county gaol before their trials. If the accused woman's insanity was confirmed by medical men, she could be removed from prison to the local asylum to recover before her trial. When Agnes Bradley murdered her son on Boxing Day in 1856, she was taken, in the first instance, to Kirkdale Gaol, Liverpool where she spent three weeks.[30] While there, her behaviour and the evidence of her doctor persuaded the authorities that she should be transferred to the County Lunatic Asylum.[31] On 22nd January 1857 she was admitted to Lancashire County Lunatic Asylum at Rainhill. Her case notes say that she described herself as "a damned woman and ... too wicked to live" and that she had made two attempts at suicide.[32] Whether these attempts were made in Kirkdale is not noted but as no suicide attempts were given as evidence of her insanity at the inquest, it might be inferred that she had become suicidal in prison.[33]

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[28] TNA, HO18/305/31, H.O. Criminal Petitions: II, "Letter from Orsett Union. 22 January 1855".

[29] TNA, HO13/104/193, H.O. Correspondence and Warrants, Copy "Letter to the Town Clerk of Portsmouth from Horatio Waddington. 10 December 1855".

[30] "Coroners Court, Yesterday – Painful Case", *Liverpool Daily Post* (2 January 1857), p. 4, col. 3.

[31] LVRO, LCLAR, M614 RAI/8/3 Female Patient Case Book 1856-1859, Agnes Bradley.

[32] LVRO, M614 RAI/8/3, Bradley.

[33] LVRO, M614 RAI/8/3, Bradley.

Admittance into Rainhill meant that her trial was postponed and at this point Bradley was confined as an ordinary patient, not as a criminal lunatic, nor as a pauper patient. She did not improve very rapidly in the asylum and it was not until March 1859, two years after the crime, that it was felt she could face trial. Dr Rogers, the Medical Superintendent at Rainhill, said that, although there were "peculiarities" about Bradley, he did not believe that they were "sufficient to constitute insanity." She went to trial on 26th March 1859 and "bore the ordeal better than could have been expected". [34] She was acquitted as insane and returned to Rainhill, designated as a "criminal lunatic". She then required sanction from the Secretary of State at the Home Office before she could be released and discharged.

The trial judge, Lord Justice Willes, wrote to the Home Secretary on 27th March 1859, receiving a reply dated 8th April from the then Home Office permanent undersecretary, Horatio Waddington, confirming "that under all circumstances Mr Estcourt has felt warranted in advising her Majesty to authorize this woman's release from further confinement".[35] Bradley was duly released to the care of her husband. It was obviously felt it would serve no further purpose to retain her in the asylum, as to all intents and purposes she appeared cured. Despite there being two provisions for criminal lunatics at Bethlem and at Fisherton House Asylum in Wiltshire in 1859, Bradley escaped being sent to either by being returned to Rainhill. Thus, the direct intervention of the judge impacted a woman's future and, in the case of Bradley, it meant she was immediately released. Cases where a judge might try to exert more influence on where the women should be confined were more common later in the

[34] LVRO, LCLAR, M614 RAI/8/3 Bradley.

[35] TNA, HO13/106/8, H.O: Correspondence & Warrants, Rt. Hon. Thomas H. Sotheron-Estcourt, Home Secretary.

century, as will be discussed. Had the Bradley case taken place just five years later, it is possible to speculate that she might have been sent to Broadmoor.

Broadmoor, 1863 to 1895.

In December 1863, a report in the *Era* about Sarah Mitchell, informed its readers that she would be confined in "Broadmoor Prison [sic] … a Government establishment intended … solely to the reception of criminal lunatics", after she was acquitted, on grounds of insanity, for the murder of her child. The report continued,

> … It [Broadmoor] is not yet completed and at present only a small number of females are confined in it … when it is perfect it is understood that the Government intends to remove all criminal lunatics at present confined in Bedlam and other establishments to this prison which, by its construction and internal arrangements, is specially adapted for the reception of such persons.[36]

The opening of the dedicated state criminal lunatic asylum, under the ultimate control of the government, put a different complexion on the detention of the criminally insane after 1863. Roger Chadwick believes that the Home Office became more involved with the fate of criminal lunatics in 1879 following the *Prosecution of Offenders Act* and the establishment of the Department for Public Prosecutions.[37] As discussed in the previous chapter, the Act led to more official involvement of medical men, including specialists in mental illness, prior to the cases being brought to trial. Dr Orange and Dr Nicolson of Broadmoor are important examples of men thus

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[36] "The Marylebone Murder", *Era* (6 December 1863), p. 15, col. 4.

[37] 42 & 43 Vict. C.22 Prosecution of Offences Act 1879.
Chadwick, "Bureaucratic Mercy", p. 281.

consulted. Chadwick argues that the increasing involvement of the Home Office with criminal lunatics led to longer discussions and more protocols surrounding the potential release, or continued incarceration, of the criminally insane from Broadmoor.[38] The links between greater centralisation of the criminal justice system and the increasing Home Office involvement with criminally insane women is most visible in changing protocols for release and will be addressed in detail in Chapter 7.

The changes are relevant here as they led to an increased role for third-party medical experts within the medico-legal system. By bringing in experts such as asylum superintendents to act as consultants, the Home Office officials were exercising bureaucratic control over decisions about incarceration.[39] The external consultants were used to verify medical assessments of insanity in the homicidal mothers before trial and before admission to Broadmoor. Thus, the value of expert opinion, in the form of specialists in care for the mentally deranged, played an important role in informing decisions at the Home Office. This did not mean that the diagnostic opinions of the prison surgeons were of any less importance in the system; however, the weighting of those opinions was subtly changed.

The 1865 *Prisons Act* brought in regular weekly medical inspections of prisoners by a qualified doctor in all places of detention, including centrally-controlled prisons and local gaols. As prisoners on remand were usually held in local facilities, it was often the resident gaol surgeon who would observe any signs of insanity in a detainee. As mentioned in the previous chapter, many of these medical men claimed that, through experience, they had developed an expertise in diagnosing mental disorders and in recognising cases of feigned mental illness. They believed they were well qualified to determine who was insane and who was not.[40] This knowledge was

[38] Ibid., p. 281.

[39] Walker, *Crime and Insanity. Vol 1,* pp. 226-9.

[40] Cox & Marland, "Broken Minds and Beaten Bodies", p. 175.

the result of close observation of individual cases when in confinement, rather than from the theories of asylum doctors and other medical men. When a patient was admitted to Broadmoor, they were accompanied by a pro-forma "Schedule A - Statement respecting Criminal Lunatics", a document which was sent with each criminal lunatic on admittance to Broadmoor from another institution, usually a prison.[41] This document contained relevant information about the patient, including a supposed cause of the attack of insanity and whether they were suicidal or a danger to others. Obviously, the form was completed from observations by the staff at the previous place of incarceration, such as the prison surgeon but would give a putative diagnosis of insanity to the asylum staff which was invariably accepted and recorded in asylum records.[42] The next chapter will discuss the diagnoses and the treatment in the asylums in detail. What is important here is that, despite the fact that the role of the prison doctors was diminished by the greater involvement of the Home Office and their appointed medical experts, within the medical profession there was general agreement about theories of the cause and effect of insanity, particularly in cases of maternal child murderers.

Unfit to plead, arraignment and direct admission

Nigel Walker suggests that the implementation of the 1865 Act contributed to the increase in cases where the accused were found unfit to plead or insane on arraignment and were sent straight to Broadmoor without a full trial.[43] Although Walker was specifically referring to cases other than murder, it is worth assessing the numbers of homicidal mothers admitted to Broadmoor as unfit for trial, to see if there

[41] BCLA, series D/H14/D2/2/2, Female Patient Case Files. A "Schedule A" was held for most admissions to Broadmoor. Full title - "Statement respecting Criminal Lunatics to be filled and transmitted to the Medical Superintendent with every Criminal Lunatic".

[42] Cox & Marland, "Broken Minds and Beaten Bodies", p. 176.

[43] Walker, *Crime and Insanity. Vol 1*, pp. 226-9.

was a discernible increase as a result of closer medical attention. I have identified relatively few such mothers within my database. As shown in Table 4:1 below, there were just sixty-nine admissions out of two hundred and thirty-seven between 1863 and 1895. It is difficult to ascertain whether the number of "unfit to plead cases" admitted to Broadmoor rose significantly after 1865, as the majority of the entries between 1863 and 1866 (when the Act was implemented) had been transferred from Bethlem or Fisherton House and records of the original court verdict were not necessarily transferred with the patients. After 1869, the number of cases found insane on arraignment remained more or less consistent with a reduction for the years between 1880 and 1884 when just 17% of admissions were arraignment cases.

Mothers who had murdered their children Admissions 1863 to 1895.					
	Verdict				
Year of Admission	**Not tried**	**Arraigned Insane**	**%age total)**	**Tried and insane**	**Totals**
1863-1865	2	2	11%	32	36
1866-1869	2	2	18%	18	22
1870-1874	2	9	40%	16	27
1875-1879	1	10	34%	21	32
1880-1884	4	6	28%	25	35
1885-1889	-	11	32%	23	34
1890-1895	5	13	35%	33	51
Totals 1863-1895	16	53	16%	167	237

Table 4:2: *Broadmoor Criminal Lunatic Asylum; admissions between 1863 &1895.*[44]

[44] BCLA, D/H14 D1/1/1/1 Admission register: males and females 1863-1871; D/H14 D1/1/1/2 Admission register: males and females 1871-1900; D/H14 D1/15/1 Discharge register: males and females 1863-1900.

The provision that an accused person could be found insane on arraignment was contained in the 1800 *Criminal Lunatics Act* and was not a new phenomenon after 1863.[45] For a case to be arraigned, evidence of a person's unfitness to be tried had to be presented to a judge and a specifically empanelled jury. Evidence of the accused's mental incapacity was presented with testimony from medical expert witnesses such as prison surgeons or asylum superintendents.[46] In August 1885, Susan Burfield appeared in the dock at the Hertfordshire Assizes, Watford, on an indictment of the attempted murder of her three-year-old daughter in May of that year. In his opening address to the Assizes, Mr Baron Huddleston had said that although "the prisoner was clearly not in her right mind" he recommended that the Grand Jury should find a true bill to answer, "so that the matter might be investigated in the court below".[47] Burfield was duly brought to court before "a jury … sworn to determine the question whether she was in a fit state to plead." She was described as pleasant-looking but presented "all the appearances of a person mentally deranged. She appeared to be muttering something to herself and [had] a nervous twitching of her mouth".[48]

Burfield had been held in HMP St Alban's since her appearance at the magistrates court on 26th May where she had been committed for trial. It was suggested by the bench at that court that the "special attention" of the medical officer and the governor of the prison "should be called to her condition".[49] At the arraignment hearing, the prison medical officer, Dr J. T. N. Lipscomb, advised the court that he had observed her constantly and that she was "labouring under a variety of delusions,

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[45] 39 & 40 Geo. 3, c.94, The Criminal Lunatics Act 1800. This Act was subtitled "An Act for the Safe Custody of Insane Persons Charged with Offences".

[46] Watson, *Medicine and Justice*, p. 162.

[47] "Herts Summer Assizes", *Herts Advertiser* (8 August 1885), p. 7, col. 3.

[48] *Herts Advertiser* (8 August 1885), p. 7.

[49] "A Mother attempting to drown her child: A Sad Case", *Herts Advertiser*. (8 August 1885), p. 7, col. 3.

there was no doubt she was insane." [50] At Huddleston's direction, the jury found that Burfield was not in a fit state to plead. She was admitted to Broadmoor on 6th August 1885.[51]

The discussions surrounding arraignment cases did not necessarily impact the decision about where the accused woman would be incarcerated. As the proceedings acted as legal confirmation of the mother's mental derangement, she was invariably committed to an asylum. After 1863 that asylum was usually Broadmoor although, on occasion, there were some criminal lunatic admissions to other asylums. What is demonstrated by the process of arraignment is that the medical men's knowledge and understandings of insanity and its causes were vitally important to the future life-path of mothers who murdered their children. Under the terms of the 1840 *Insane Prisoners Act,* insane offenders awaiting trial could be transferred directly to an asylum on a Home Secretary's warrant signed by two justices of the peace and two doctors.[52] While the Act did not stipulate that a trial would not be held if an offender was in an asylum, in practice that was what happened. As Roger Smith points out, the action was not viewed favourably by members of the judiciary, because it seemed to hand more power to local justices, medical men, and the Home Office.[53]

Martha Baines, the wife of a chemist and druggist from Kendal, murdered her five-month-old child on 5th November 1875 and had been admitted by direct warrant to Broadmoor in December 1875. [54] In his charge to the Grand Jury at the Westmorland Spring Assizes in 1876, Mr Justice Brett stated that he was doubtful about the legitimacy of direct admission to Broadmoor and about the legality of an offender

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[50] *Herts Advertiser*. (8 August 1885).

[51] BCLA, D/H14/D2/2/2/385, Case File: Susan Burfield.

[52] 3&4 Vict. C.54. The Insane Prisoners Act 1840.
Smith, *Trial by Medicine,* p. 21.

[53] Ibid., p 92.

[54] BCLA, D/H14/D2/2/2/251, Case File: Martha Baines.

being confined as a criminal lunatic without the case being brought to the assize court. He said, "I know of no right that anyone has to confine her as if she were a criminal.… [and] …I know of no law by which she can be confined as a criminal lunatic without a bill being found by the Grand Jury."[55] His objection appeared to be that the Home Secretary's warrant circumvented the high court system. By being admitted to Broadmoor, Martha Baines had been designated a criminal without fair trial.

Rather than suggesting that Baines had avoided trial, Brett was taking issue with the choice of institution, as an asylum for criminal lunatics. He understood and accepted that insane offenders could be admitted to asylums before trial saying, "It may be that by certain certificates of medical men she may be confined in a county asylum … [and] … be treated with every consideration and kindness until, if it be so, she is cured." [56] It would appear that, to Brett, an admission into Broadmoor was a penal detention, ignoring the right of *habeas corpus*.[57] The Grand Jury did bring a true bill against Martha Baines, in her absence, but because she was already confined in Broadmoor, her trial was carried over to the following assizes. At those assizes, Mr Justice Lindley advised the Grand Jury that Baines remained in Broadmoor and still was not in a fit state to be tried.[58] Martha Baines never faced trial and, after a stay of two years, was discharged from Broadmoor to her husband's care, "her sanity now … re-established."[59]

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[55] "The Assizes – Westmorland. The Judge's Charge", *Kendal Mercury* (4 March 1876), p. 8, col. 2.

[56] "*Kendal Mercury* (4 March 1876), p. 8.

[57] The *writ of habeas corpus*, often shortened to *habeas corpus*, is the requirement that an arrested person be brought before a judge or court before being detained or imprisoned. Smith, *Trial by Medicine*, p. 92.

[58] "Maiden Assize for Westmorland", *Carlisle Express and Examiner* (8 July 1876), p. 4, col. 2.

[59] BCLA, D/H14/D2/2/2/251, Case File: Martha Baines, "Draft Report to Home Office", 24 July 1877.

Mary Ann Morgan was admitted to Broadmoor without trial, following the inquest into her daughter's death, on a Home Office Warrant.[60] The Stipendiary Magistrate for Swansea wrote to the Home Office on 22nd November 1883, immediately after hearing the case in court. He advised that the coroner had signed a warrant to commit Morgan to H.M.P. Swansea but her doctor had suggested that such "confinement & the alarm … [of it] … would probably intensify the Lunacy."[61] As the local magistrate, he was seeking advice on how to proceed. On the Home Office's instruction, Morgan was examined in the prison by three JPs and two doctors and duly certified as insane. It was suggested that she should be sent to the county asylum of Carmarthenshire to await trial. [62] However, she was committed to Broadmoor on the warrant of the Home Secretary.[63] Chadwick commented on this particular case, the outcome of which he attributed to the growing confidence of the Home Office bureaucracy in its authority on legal procedure.[64] Certainly, the action was not viewed favourably by Mr Justice Stephen at the Swansea Lent Assizes where Mary Ann Morgan was due to stand trial. When acceding to the prosecution's application for postponement of the trial on the grounds of Morgan's insanity, Stephens made his opinion about the procedure clear. He said that "persons accused of crime …[are] … entitled by various Acts to have their cases tried at the assizes" but by this action he

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60 TNA, HO145, Criminal Lunacy Warrant and Entry Books, 1882-189. Warrant no. 131, Mary Ann Morgan, 28 November 1883.

61 TNA, HO144/128/A33589, Home Office Registered Papers, Home Office Memorandum. "Lunacy: Proposed acceptance of bail pending murder trial at Assizes. Criminal: Morgan, Marianne [sic]; Court: Swansea P.C.; Offence: Murder; Sentence: Criminal Lunatic. 1883-1884".

62 TNA, HO144/128/A33589: Morgan, Letter 22 November 1883.

63 TNA, /A33589, Memorandum: 22 November 1883.

64 Chadwick, "Bureaucratic Mercy" pp. 62-63.

did not see "what there was to prevent a person … from being shut up in a lunatic asylum for life without trial."[65] He described it as a serious defect in the law.

The cases of Martha Baines and Mary Ann Morgan illustrate that members of the judiciary did not object to insane homicidal mothers being directly admitted to Broadmoor by Home Secretary's warrant, their objection was to a perceived undermining of judicial procedure. By defending a person's right to a trial before imprisonment, the judges were protecting the right of *habeas corpus*.[66] However, if a homicidal mother's insanity was so patently clear from medical examination and she was already confined in an asylum, it was plain that she would be unfit to plead and stand trial.[67] While the debate can be viewed as a judicial defence of the ancient right, it was also a dispute between the Home Office and the legal authorities about the role of the criminal lunatic asylum. The different interpretations of Broadmoor's status, whether it was a place of punishment and imprisonment or an asylum and a place for the cure, was one which continued through the late-nineteenth, the twentieth and into the twenty-first centuries. As a former Clinical Director of Broadmoor said in 2012, "It cannot be stated too often that Broadmoor is a hospital, never a prison" Despite what popular, and occasional professional understandings might have been and despite housing the criminally insane, Broadmoor was a curative institution.[68]

Judges' opposition to the confinement of child murderers in Broadmoor was particularly noticeable in cases involving young, single mothers. There seems to have been a conflict between paternalistic pity and correct procedure in such cases, which may have stemmed from a cultural belief that the accused needed nurturing and

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65 "Serious Defect in the Law", *Banbury Advertiser* (21 February 1884), p. 3, col. 4.

66 Smith, Trial by Medicine, p. 91.

67 Daniel. J. R. Grey, "Discourses of Infanticide in England, 1880-1922," (unpublished PhD thesis, University of Roehampton, 2009).

68 Dr Kevin Murray in Harvey Gordon, *Broadmoor* (London: Psychology News Press, 2012), p.xix.

guidance, not confinement and punishment. In 1894, Emily Wilson was tried in Leeds before Mr Justice Gainsford Bruce for the murder of her illegitimate baby. In a letter to the Home Office, Bruce expressed his consternation that she might not be insane and therefore should not be in Broadmoor. "The judge had great compassion for her sad case – he hopes for an early release."[69] His intervention was the subject of a report in Wilson's Home Office file, the purpose of which was to ascertain how long similar cases remained in Broadmoor and whether their retention was justified in terms of their crime and insanity.[70]

The two other cases referred to in the report were those of Annie Cherry and Matilda Wilcox, both of whom were in Broadmoor. There was no comment about the trial judges in the reference to Wilcox. However, the writer noted that the judge in the case of Cherry, Sir Henry Hawkins, "wanted immediate release [of the accused] not go to the Asylum at all." [71] In his *Reminiscences*, Hawkins wrote that he believed that "in the case of poor creatures who make away with their … offspring in the agony of their trouble and shame, there were always found very strong reasons for … very limited periods of imprisonment".[72] He also wrote that on such occasions, he would prefer to receive a guilty verdict with a full recommendation to mercy and pass the death sentence. His rationale in these situations was that a commuted death sentence with a limited period of penal servitude, would be preferable to a potentially endless"lifelong imprisonment" in an asylum.[73]

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[69] TNA, HO144/496/X42157/3, Home Office Registered Papers: Home Office Memorandum. "Lunacy: Emily Harriet Wilson. Murder, guilty but insane. Conditional discharge 1894-1899".

[70] TNA, HO144/496/X42157/3: Wilson. Undated annotation.

[71] TNA, HO144/496/X42157/3: Wilson. Undated annotation.

[72] Henry Hawkins, Baron Brampton. *The Reminiscences of Sir Henry Hawkins, Baron Brampton* ed. By Richard Harris K.C. (London, Thomas Nelson 1904), p. 289.

[73] Hawkins, *Reminiscences,* p. 227.

Periodically, legal opinion might lean towards the preference that a motion of "nolle prosequi" be issued by the court but this was a rare occurrence.[74] Although no formal motion was issued in the case of Eliza Agar, it was suggested as a possibility in the discussions surrounding the case.[75] The story also illustrates some of the differences in opinion between judges and medical experts in matters of criminal responsibility and incarceration. Agar's trial was postponed four times while the Home Office discussed the best course of action with Dr William Orange, the superintendent of Broadmoor and the appointed judge, Henry Hawkins. In accordance with his firmly-held belief in appropriate asylum care, Orange asserted that the correct place for women like Agar was in the protective atmosphere of an asylum. Hawkins, as previously shown, had an aversion to incarceration without a definitive end, whether curative or punitive.

In 1883, Eliza Agar, the wife of a warehouse manager, placed her four-week-old baby on the nursery fire. Despite a medical instruction that she was not to be alone with the child, the monthly nurse had left the room for a short while. Her doctor specifically stated that "after … confinement she [Eliza Agar] has suffered from Puerperal Mania" and that she was considered a risk to the child.[76] Agar appeared before magistrates at Barnet Police Court on 18th February 1883 and was committed for trial at the Old Bailey.[77] Agar was not remanded in prison but allowed to remain with friends and family, bailed against the surety of her husband and two brothers. Dr Orange was instructed by the Treasury Solicitor to examine Agar, which examination

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[74] "Nolle prosequi" an entry made on the court record when the prosecutor in a criminal prosecution undertakes not to continue the action or the prosecution.

[75] Grey, "Discourses of Infanticide", p. 206.

[76] TNA, HO144/129/A34007, Home Office Registered Papers. "Criminal: Agar, Elizabeth Matilda; Court: Central Criminal Court; Offence: Murder of her one-month old child; Sentence: Criminal Lunatic. 1883-1884".

[77] TNA, HO144/129/A34007: Agar. Notes.

he initially undertook on 16th May, concurring with her doctors that she was suffering from puerperal mania, which was still ongoing. [78] He met with Agar again on 12th June, after which meeting he sent his detailed report to the Home Office. Following his comments on criminal responsibility and awareness quoted in Chapter 3, Orange wrote that he believed Eliza Agar had known what she was doing when she killed her baby. [79] The deposition evidence of the doctors tending her at the time pointed to the fact that she was in a state of puerperal insanity and that she found the child "a bother to her", which was possibly, Orange suggested, a malicious motive for murder. [80]

In these circumstances, if she were considered well enough to face trial, under the M'Naghten Rules, then in Orange's opinion "it might be quite possible, according to the law for the poor creature to be sentenced to death, a result too horrible to be seriously contemplated." [81] In his report, Orange advised that in his opinion, Agar had improved in health enough to face arraignment or trial, possibly at the next Sessions at the Central Criminal Court. Despite the fact this suggestion could lead to the death sentence, Orange was still firm in his opinion that Agar had been insane when she assaulted her child and that she would be better served by a stay in Broadmoor. However after his report was submitted, there was a movement aimed at avoiding her admittance into the Asylum.

Hawkins was particularly against her removal to Broadmoor. In a letter to the Home Secretary, W. Vernon Harcourt, he categorically stated that because Agar was not responsible for her actions when she killed the child, she had not committed a crime. "[It is] beyond all doubt that at the time she caused the child's death she was

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[78] TNA, HO144/129/A34007: Agar. "Report of Dr Orange dated 17th June 1883".

[79] Ibid.,

[80] Ibid.,

[81] Ibid.,

not responsible … She has been guilty of no crime." [82] He had no doubt that she had killed her child but he did not believe she should be confined at all, certainly not within an asylum. [83] In a somewhat extraordinary manner, Hawkins acted as defence, jury and judge in this case. The judge's stance caused a dilemma for the Home Office who consulted once again with Orange. Orange advised that he could do no more. In his opinion, if Agar had originally been admitted to Broadmoor instead of remaining at home, he would still say that she was in no fit state to be discharged. [84] It appears that Hawkins' opinion of Broadmoor was that it was a place of punishment and not a fit place for someone such as Eliza Agar. "I believe that to commit her to a Criminal Lunatic Asylum … would be absolutely destructive to her chances of recovery … It is impossible to punish her for she has committed no crime and confinement … would be destructive to her reason & worse than death to her."[85] Despite the importance attached to Orange's medical opinion by the Home Office, Hawkins' view prevailed. The compromise was that Agar remained at home, with watchful nursing care and if she suffered any recurrence of her illness she would be confined in an asylum.[86]

As well as demonstrating possible conflicts between medical and judicial opinions on criminal responsibility and incarceration, the Agar case also highlights the personal beliefs of men in authority. The involvement of emotion in judicial decisions was discussed in the previous chapter, with particular reference to Hawkins' personal opinion. Here, he appears to have taken a personal stance to protect a woman who he described as "an object of sympathy and pity".[87] He admitted that he had taken an

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[82] TNA, HO144/129/A34007: Agar. "Letter from Sir Henry Hawkins to W. Vernon Harcourt 10th July 1884".

[83] Ibid.

[84] TNA, HO144/129/A34007: Agar. "Report 17th June 1883".

[85] TNA, HO144/129/A34007: Agar. "Letter 10th July 1884".

[86] TNA, HO144/129/A34007: Agar.

[87] TNA, HO144/129/A34007: Agar. "Letter 10th July 1884".

unusual interest in the case and was "anxious that the most humane course" should be taken with her future care.[88] This humane course in his opinion was not for her to admitted into an asylum and certainly not to Broadmoor.

Orange, on the other hand, believed that the best place for Agar was in the safe confines of Broadmoor, where she would receive the appropriate care leading to her recovery. His reports and notes on the examination of Agar in the papers give an idea of his conviction in the appropriateness of confinement in an asylum in such cases. He believed that the regime in Broadmoor would help towards Agar's recovery from puerperal mania and potentially cure her insanity. The following chapter on treatment in the asylums will expand upon this and the role and importance of the medical superintendents are discussed in detail in Chapter 6. The case here was very unusual. On most occasions after 1863, if a homicidal mother was found to be unfit for trial or her insanity was defined by legal and medical opinion in court, she would be admitted to an asylum. Except for a few cases, that asylum was Broadmoor. While some judges might express their doubts about the efficacy of asylum treatment for some women, in the medical men's opinion confinement for possible cure in such places was the correct course of action.

Conclusion

Establishment ideals of femininity shaped the judgment of women, especially mothers, as perpetrators of child-murder and there was a paternal compassion towards the supposed feebleness and susceptibility of women. Suppositions of moral strength and a clear perception of motherly behaviour as being virtuous, temperate and dependable, were challenged when a mother killed her own child. Insanity was used to rationalise a socially objectionable crime, with an underlying acceptance that the

[88] TNA, HO144/129/A34007: Agar. "Letter from Mr E T E Beasley, Counsel, in case of Reg-v-Agar. 4th July 1884".

women were not criminals but victims of mental incapacity, which led to them not being accountable for their actions. The decisions made about incarceration between 1837 and 1863, before the opening of Broadmoor, were not so arbitrary as first appears. The opinion of the prison doctor was paramount and if he did not detect recognisable signs of insanity then he would not suggest admission to an asylum. For those who did go into an asylum, they could be detained in a dedicated facility for the criminally insane, if there was space available, or in local asylums or prison if not. The cost of maintenance was a consideration to the local outside agencies and this seemed to have a bearing on the place of detention. The economic aspects of asylum care and their bearing on the welfare of the insane homicidal mothers, impacted upon the potential discharge or retention of patients.

The discussions after the opening of Broadmoor centred more upon the efficacy of asylum care, with differing opinions held by the medical men and members of the judiciary. There was a sympathy among both judges and officials at the Home Office towards homicidal mothers who had acted outside of acceptable female behaviour and against society's expectations of motherhood. An increasing acceptance of medical accounts of the strains that female physiology could place on a mother's sanity, led to a greater willingness to treat the homicidal mothers as victims of illness. However, amongst some of the judiciary, there was a reluctance to view Broadmoor as anything but a place of imprisonment, rather than place of cure. There was also some disagreement on whether treatment in an asylum, criminal or not, was the best course of action for the insane mothers. In this respect personal opinion, together with medical diagnoses of madness, played a part in the decision process surrounding which incarceral institution the women would be placed. The end of trial and the subsequent discussions, marked the final contact that the mothers who had murdered their children would have with the legal system. The next stages on their journeys would be under the control of the medical world and of government

bureaucracy. Their treatment in the institutions would be regulated by clinicians and medics with their potential release and discharge ultimately decided by the Home Office, albeit with medical advice. The remaining chapters in the thesis concentrate on their lives within the asylums, those with whom they came into contact there and their futures, whether outside the institution or not.

Chapter 5:
"She is decidedly a proper person to be confined in an asylum"
Life and treatment in the Asylum.

Introduction

On 25th September 1889, following the birth of her fourth child, Elizabeth White was admitted to Bethnal House Private Lunatic Asylum. On 10th December, her coachman husband removed her and took her home, believing that she was recovered from her depression.[1] On the 14th December, he had taken his employer out in her carriage leaving Elizabeth at their home in Wimpole Mews, with a neighbour who was helping her with the four boys. At some point in the morning, Elizabeth deliberately took her three eldest children into another room where she suffocated Joseph, aged seven and attempted to murder five-year-old George. At her Old Bailey trial, the medical superintendent of Bethnal House said that he believed she had not recovered sufficiently to be discharged. He also advised that he had had no authority to detain her, as she was discharged by the order of the lady who had her admitted – namely, her husband's employer.[2] Elizabeth White was found guilty but insane at the time of the act and admitted into Broadmoor. By 1893 it was noted although "she was progressing very satisfactorily" and that she had "good bodily health [but] it is too soon to discharge at present."[3] Her eventual release in September 1894 came about because her husband was considered to be "a very respectable man" and his employer,

1 TNA, MH94/6 Lunacy Patients Admission Registers, 1846-1912. Piece 29 1889-1890.

2 OBP, *Old Bailey Proceedings Online*, January 1890, trial of Elizabeth White (38) (t18900113-129).

3 BCLA, D/H14/D2/2/2/442/8, Case File: Elizabeth White.

a Mrs Dunn of White Waltham, Berkshire "promise[d] to look after her welfare."[4] Elizabeth White had a relatively short stay in Broadmoor and, despite her previous confinement in an asylum, she was not considered to be incurably insane and beyond help. Sadly, five years after her release, she appears to have relapsed into severe depression and she committed suicide on the railway line at Maidenhead.[5]

Once the courts had committed a homicidal mother to an indefinite stay in an asylum, her crime became a side issue to her mental illness. Jade Shepherd finds that for patients admitted as "pleasure patients", the concern was for their mental illness, not their crime.[6] For the other criminal patients, those admitted from prison after conviction, there was more disdain at the nature of their habits, personal and criminal.[7] I have not investigated the equivalent women patients for this thesis but I believe their situation would be worthy of further study. In most of the cases I have reviewed, the asylum doctors were keen to ascertain and understand why the crime had been committed but little mention was made of the act after admission., Theories that certain conditions and disorders could drive women to commit violent and murderous acts were accepted by the clinical staff, who also accepted and understood that some of

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4 BCLA, D/H14/D2/2/2/442/8, White, Notes on reverse of "Report of the Superintendent 31st July 1893".

5 BCLA, D/H14/D2/2/2/442/12, White, Newspaper cutting "Fatality on the GWR Near Maidenhead" publication unknown.

6 "Pleasure patients" was a term used to describe those male or female patients who had been found insane before or during their trials and who were being held until her Majesty's pleasure be known.

7 Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900" (Unpublished PhD Thesis, Queen Mary University London. 2013), pp155-156.

those conditions, such as puerperal mania, could disappear almost as rapidly as they appeared.[8]

That appears to be the case in the story of Elizabeth White. Because her history indicated that her homicidal maniacal episode could be attributed to the puerperal depression that had seen her admitted to Bethnal House, it was almost expected that she would recover with the right care once in Broadmoor. Analysis of infanticidal and homicidal married mothers' asylum experiences illustrate the changes and developments in the diagnoses over sixty years. In this chapter I will review the experiences of the group of homicidal mothers once they were in the asylums, highlighting developments in the diagnosis and treatment of mental illness and the impact that these developments had on the women's lives.

The period 1835 and 1895 was an era of development in the asylum system and in medical treatment of insanity. Nationally, large county asylums were established, becoming accepted as part of the local community.[9] The regime of treatment in all the asylums was based on the principles of moral therapy, which was designed to give the mentally-disordered time to recover from the stresses of their former lives. The underlying principles were that mentally-ill patients would recover rational control over their minds and actions, if they were treated with a mixture of

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[8] Hilary Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave MacMillan, 2004), p. 189.

[9] Amongst many works on treatment and asylum development see: Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985); Thomas Dixon, "Patients and Passions: Languages of Medicine and Emotion, 1789-1850", in Fay Bound Alberti (ed) *Medicine, Emotion and Disease, 1700-1950* (Basingstoke. Palgrave Macmillan, 2006), pp. 22-52; Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014); Leonard D. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England*, London: Leicester University Press, 1999).

praise and blame, reward and punishment.[10] An essential part of the moral therapy philosophy was the belief that a patient would find a route back to sanity and rationality through sympathetic personal interactions.[11] As environmental factors were seen as playing an important role in the etiology of mental problems, if the right atmosphere of calm and respect could be created for patients, then moral therapy was accepted as the treatment with the most potential to "cure" the insane. [12]

Anna Shepherd writes that, as the century progressed and asylums grew in size, some of the finer points of moral therapy became diluted and it became a patient management scheme rather than a curative regime.[13] Foucault described it as a coercive method of systematic control of the insane who were considered as social outcasts.[14] To an extent, this applies to criminally insane patients. The regulatory elements of the treatment were considered necessary to coerce the criminal lunatic back to conformity and "normal" behaviour expected of their particular social culture.[15] Victorian society acknowledged that, as criminal patients had been proven to be insane and irresponsible for their actions, then they should be treated in a suitable establishment to relieve and possibly cure their insanity. To this end, they needed a cure in order return to their families and their expected place in the home. Thomas Dixon argues that, despite Foucault's assertion, moral therapy was still the only and most humane way of achieving this goal. Dixon's contention is applicable to the cases studied herein. [16]As Anna Shepherd states, the need to conform to socially acceptable

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[10] Roy Porter, *Madness. A Brief History* (Oxford; Oxford University Press, 2002), p. 104-5.

[11] Digby, *Madness, Morality and Medicine*, p. 34-5

[12] Ibid., p. 34

[13] Shepherd, *Institutionalizing the Insane*, p. 127.

[14] Michel Foucault, *History of Madness*, trans. by John Murphy and Jean Khalfa (London and New York: Routledge, 2006).

[15] Shepherd, "Victorian Madmen", p. 158.

[16] Dixon, "Patients and Passions", p. 41.

behaviour, was reflecting the expectations of outside society, rather than control in the asylum. [17]

After the homicidal mothers had been admitted into an asylum, recommendations concerning continuing incarceration or possible release depended on the opinions of the staff, particularly those of the medical staff. John Bucknill argued that insanity could often be caused by an emotional disorder rather than by a physical or intellectual problem.[18] Reading a patient's behaviour, if it seemed to be driven by her emotional state, was essential in the treatment of certain forms of insanity. A potent attribute for Victorian medical men, whatever their metier, was to be sympathetically attuned to their patients.[19] Understanding and interpreting any seemingly emotionally driven behaviours was a part of a successful doctor-patient relationship. [20] Certainly, in the case of the medical superintendents and other medical staff within the asylums, symbiotic emotional interactions were vital to successful treatment.

Medical opinion was that all women, no matter what their background, were governed by their physiology. The strains of pregnancy, childbirth and early motherhood were understood to be difficult emotional experiences and these strains

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[17] Anne Shepherd, "The Female Patient Experience in Two Late-Nineteenth Century Surrey Asylums", in Jonathan Andrews and Anne Digby (eds) *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (New York: Rodopi, 2004), pp. 223-248, p. 225.

[18] John C. Bucknill, M.D., "Correspondence on the Theory of Emotional Insanity" *Journal of Mental Science* vol. 20 (1874) pp. 484-6,

[19] Alison Moulds, "Making your Mark in Medicine: The Struggling Young Practitioner and the Search for Success in Britain, 1830s-1900s", *History,* vol. 104, no. 359 (2019), pp. 83-104.

[20] Hilary Marland, "Languages and Landscapes of Emotion: Motherhood and Puerperal In sanity in the Nineteenth Century", in Fay Bound Alberti (ed) *Medicine, Emotion and Disease, 1700-1950* (Basingstoke. Palgrave Macmillan, 2006), pp. 53-78, p. 68.

were particularly perilous to the balance of the female mind. [21] Mitigating social and environmental circumstances, together with the acceptance of female "physical and mental fragility … agreed to be latent in all women", allowed for them to be treated compassionately.[22] Despondency and depression were intrinsic to all forms of mental disorder and the words "gloomy", "melancholic" and "despairing" appear often in the case notes. [23] Respectability of manner, behaviour and language were considered important indications of restored sanity.[24] As Anne Shepherd writes, the ultimate aim of medical superintendents and officers was to try to restore rationality and peace to the women's mental states so that they could return to their normal lives, once released.[25] If the homicidal mothers were discharged, they did not always return to the life as they knew it before their incarceration. They would be more closely watched by their family and kin for signs of incipient insanity, the reality was that within their society, they were never believed to be totally cured. [26] I discuss this factor in greater detail in Chapter 7, when reviewing the process of discharges from the various asylums.

The asylums' *raison d'etre* was to assist the return of their inmates to "normal" life. There would always be patients who acted in a way which ran contrary to the expectations of the asylum staff. Small acts of rebellion, such as refusals to work or to socialize with other patients, can be read as possible signs of patient agency, taking

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[21] Marland, p. 73.

[22] Idem., *Dangerous Motherhood,* p. 200.

[23] Shepherd, "The Female Patient Experience", p. 236.

[24] Ibid., p. 243.

[25] Ibid., p. 243.

[26] Ibid., p. 244.

some little control of their own lives. [27] However, as I show in this chapter, eventually, even those women who "rebelled" against the system were only discharged once they behaved in a respectable and sane manner, as defined by the asylum authorities. For the research for this particular chapter I have examined asylum casebooks, official and personal correspondence and official administrative documents. The notes were written in daily practice and, together with the other documents, give an insight into the asylum experience of the homicidal mothers.[28]

Diagnosis and causes of insanity

On admission to an asylum, the majority of the homicidal mothers surveyed for this thesis had their insanity attributed to mental disorders associated with female physiology (Figure 5:1). When broken down into the six separate decades, it can be seen that, on average, 38% of these admissions were specifically for those disorders associated with reproduction (Table 5:1). Further analysis shows that 79% of the insanities were designated as being triggered by the "puerperal condition" (Figure 5:2).

[27] Cara Dobbing, "The Circulation of the Insane: The Pauper Lunatic Experience of the Garlands Asylum, 1862-1913 (unpublished PhD thesis, University of Leicester, 2019); Shepherd, "Victorian Madmen", p. 158.

[28] Jonathan Andrews "Case Notes, Case Histories and the Patient Experience of Insanity at Gartnaval Royal Asylum, Glasgow, in the Nineteenth Century" *Social History of Medicine* vol. 11, no. 2 (1998), pp. 255-281.

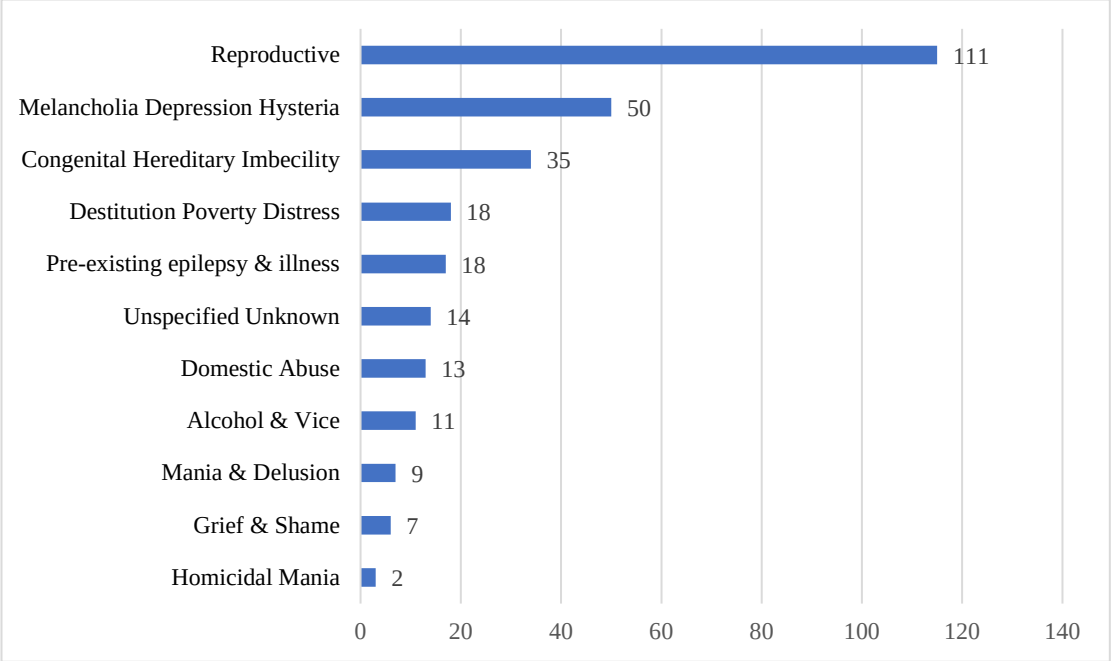

Figure 5:1: *Recorded causes of insanity from asylum records, 1835 to 1895*

Years	**No. of Asylum Admissions**	**Assigned cause - Reproductive**	**Percentage Admissions per decade**
1835-1844	8	3	38%
1845-1854	31	13	42%
1855-1864	41	8	20%
1865-1874	50	21	42%
1875-1884	68	31	46%
1885-1895	90	35	39%
Totals	288	111	39%

Table 5:1: *Assigned causes of insanity, 1835 to 1895*

Puerperal mania and related mental illnesses were viewed by the nineteenth-century medical world as potentially remediable conditions.[29] The contemporary medical belief that, with the right treatment in the right conditions, women suffering from puerperally related mental illness would recover, was fundamental to asylum clinicians.[30] Of all the causes of insanity recorded, puerperal insanity was met with perhaps the most sympathy and compassion; its occurrence was classless and was generally considered to be a cruel turn of fate. [31] Although killing one's child constituted the antithesis of acceptable maternal behaviour, insanity and infanticide also were viewed as part of femininity and maternity, "an intrinsic part of motherhood."[32] It has been said that most "pleasure patients" who had committed homicide, neither had a history of criminality, nor displayed the behavioural traits of the criminal classes.[33] Charles Mercier, a prominent late nineteenth-century alienist and medical superintendent, wrote that "the homicidal act of an insane person is usually an isolated act, done in a mood of intense exasperation and not likely to be repeated."[34] This description is certainly applicable to the homicidal and infanticidal women surveyed. Their criminal acts were perceived as having been committed because of mental breakdown caused by desperation, misguided feelings, or delusion.

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[29] Marland, "Languages and Landscapes", p. 73.

[30] Idem., "Disappointment and desolation: women, doctors and interpretations of puerperal insanity in the nineteenth century", *History of Psychiatry* vol. 14, no. 3, (2003), pp. 303-320.

[31] Idem., *Dangerous Motherhood,* p. 200.

[32] Ibid., p. 200.

[33] Harvey Gordon & Vivek Khosla, "The interface between general and forensic psychiatry: a historical perspective", *Advances in Psychiatric Treatment* vol. 20 no. 5 (2004), 350-358, p. 351.

[34] Charles Mercier, *Criminal Responsibility* (Oxford: Clarendon Press, 1905), pp. 123-4.

During the nineteenth century, the definitions and explanations of insanity evolved, with causes being attributed to many varied factors.[35] Poverty and domestic distress, remorse after seduction and grief after the loss of a partner were cited, as were intemperance, domestic violence and, as in many of the cases reviewed, insanities associated with female reproduction. [36] In the case of criminally insane homicidal mothers, if the women were considered respectable in their habits and lifestyle, then poverty and destitution were seen as causes or mitigating circumstances for their insanity and, thereby, for the crimes committed. As well as moral and social causes, an inherited propensity to insanity influenced medical thinking.[37] According to her file at Fisherton House, Ann Lacey's insanity had been caused by over-lactation but there was mention in her case-notes that there was existing insanity in her family: "there is an aunt in Leicester Asylum". [38] The hereditary tendency to madness was classless and provided further explanation, beyond tangible medical reasons, for a "decent" mother to kill her child. There were said to be cases of insanity in Mary Ann Morgan's middle-class family; it was noted that "One of the brothers of her father died … in an asylum near London and a cousin of her father is now in the county asylum at Bridgend."[39] Although certain problems were thought to be prevalent amongst the poorest of

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[35] Jonathan Andrews, 'The Rise of the Asylum in Britain'. in Deborah Brunton (ed.) *Medicine transformed: Health, Disease and Society in Europe 1800-1930* (Manchester: Manchester University Press: Milton Keynes: The Open University, 2004), pp. 298-326. Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), p. 19; Melling & Forsythe, *Politics of Madness*, pp. 46-7.

[36] Hide, *Gender and Class*, p. 19; Melling & Forsythe, *Politics of Madness,* pp. 46-7.

[37] Andrews, "The Rise of the Asylum", pp. 298-326.

[38] FHAA, J7/190/8, Casebooks: Fisherton House Asylum 1855-1866, Ann Lacey, Patient 1394, f. 153.

[39] TNA, HO144/128/A33589, Home Office Registered Papers. "LUNACY: Proposed acceptance of bail pending murder trial at Assizes. Secretary of State has not authority to sanction this; CRIMINAL: MORGAN, Marianne [sic]; COURT: Swansea P.C.; OFFENCE: Murder; SENTENCE: Criminal Lunatic. 1883-1884".

society, others were recognised as occurring, whatever the sufferer's background, circumstances and previous medical history.

Those mothers who committed their murderous deed while suffering from puerperal insanity, were looked on with some sympathy. Gynaecological causes of insanity were regarded as unpredictable and incomprehensible events and those who suffered mentally through them were looked on with sympathy. In his survey, *Female Criminal Lunatics*, written in 1901, Dr John Baker wrote that the majority of the infanticidal women in Broadmoor in 1900 were suffering from mental disorders associated with female physiology. [40] He described these disorders as gestational and they were, namely insanity of pregnancy, puerperal insanity and insanity of lactation. He described insanity in pregnancy as the rarest and puerperal insanity as the most common; although he disputed where the differentiation should be made between puerperal insanity and lactational insanity. [41] In common usage, the latter two causes often came under the general term of "puerperal mania" and he believed that they should rather be regarded as insanities caused by "puerperal melancholia". Baker's assertion was that puerperal insanity as a cause should only be assigned to murders which occurred in the puerperal period "within two months of parturition", otherwise they should be described as being caused by lactational insanity.[42] The earlier asylum records I have examined did not differentiate quite so finely between the two causes. Therefore, while noting Baker's statements, the breakdown as shown in Figure 5:2 is based on the cause as stated in the case records, or on the entry documents for each case. Despite these differences in terms, Baker's observations from the end of the

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[40] John Baker, "Female Criminal Lunatics – A Sketch."*Journal of Mental Science (now The British Journal of Psychiatry)* vol.48. (1902) p. 13-28.

[41] Ibid., p. 16.

[42] Ibid., p. 17-19.

century on the reasons behind mothers' mental illnesses are relevant for the whole period between 1835 and 1895.

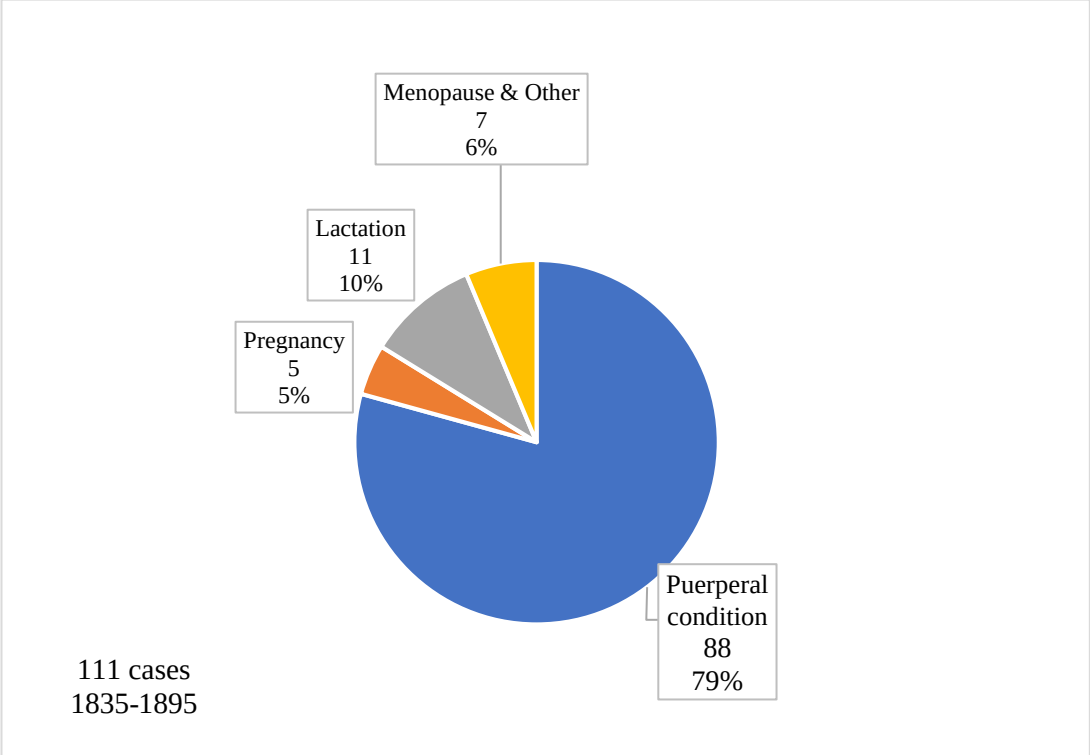

Figure 5:2: *Reproductive causes of insanity, 1835 to 1895*

Puerperal mania, in all its forms, was viewed by contemporary medical men as a temporary and curable mania, given the right set of circumstances and conditions. Explanations for insanity of pregnancy and puerperal mania differed and often the actual cause was attributed to some pre-existing circumstance or delusion which had triggered the sudden onset of mania. Melancholia and depression of spirits were often mentioned in concert with puerperal factors. For example, Mary Coleman attempted to strangle her two-month-old child in a fit of "puerperal melancholia". She had "a melancholy view of her prospects of life and fear of her family coming to great want and distress".[43] According to her case book notes from Bethlem, Elizabeth Thew suffered from epilepsy, or epileptic-type fits and this was cited as the main cause of her insanity. Up to the time of her crime she had shown no sign of insanity. Her "fit"

[43] BCLA, D/H14/D2/2/2/123, Case File: Mary Coleman.

of violence was explained as being an "epileptic seizure", brought on by childbirth and domestic disagreement.[44] The incidence of poverty and poor social conditions were believed to underlie many cases of child-murder. This was particularly relevant to those cases which were specifically related to lactation.

Baker described the effect of the strain of lactation thus: "depression comes on, everything looks black and dismal, the idea takes possession of her that want and poverty are in store." [45] Lactation was an exhausting process and many of the mothers were not in the best of health. The women were often described as being good mothers with respectable homes but they became weighed down with other domestic concerns which impacted on their mental stability. The strain of breastfeeding, caring for their families and overwork in running the household, when they themselves were depleted and exhausted, led to mental breakdown. In 1856, the Bethlem case notes for Mary McNeil state that she was suffering from "Melancholia" and that "at the time she committed the act she was suckling a child 11 months old and was much debilitated from suckling".[46] Sarah Allen was also admitted to Bethlem in 1856 and transferred to Broadmoor in 1863. She had attempted to drown her two children whilst suffering from "delusional melancholia" caused by over-lactation. Maria Borley's insanity was originally attributed to ill-treatment at the hands of her husband. When she was in Bethlem, it was further noted that "she was suckling her second child … [and] … she was actually starving for want of sustenance … and in this weak state she drowned her infant".[47] After her removal to Fisherton Asylum, the records state that her moods changed with catamenia (menstruation) which caused "considerable languor" but not

[44] BHRA, CBC-03 Incurable & Criminal Patient Casebook 1850-1857, Elizabeth Thew, f. 41.

[45] Baker, "Female Criminal Lunatics". p. 21.

[46] BHRA, CBC-04 Incurable & Criminal Patient Casebook, 1857-1862, Mary McNeil f.199

[47] BHRA, CBC-03 Maria Borley, f. 106.

insanity.[48] Likewise, Ann Lacey's insanity was not only associated with lactation and possible family inclination to madness but also with menstruation; her relevant attack of insanity had occurred "during the usual catamenial periods".[49]

Specifically, female health problems associated with maternity were frequently linked to poverty, predisposition and hereditary issues and also family relationships and grief. Emily Lee drowned her three-year-old child, the cause of her insanity being attributed to "domestic trouble" as she had been "deserted by her husband and left in distress".[50] As shown in previous chapters, the diagnosis of insanity and its cause had, for the most part, been given by the medical men involved with the women before their incarceration in the asylums. The original assigned cause of insanity remained prominent in the women's records for the duration of their stay in the asylum, although over time the medical officers would add other factors and symptoms to the notes. This further information gave a secondary explanation for the mental breakdown and therefore it was not unknown for the patient to have more than one cause of insanity listed.

During their time in the asylums, the patients were routinely examined by the medical officers. The aim of the examinations was to assess the patients' physical health and to determine any continuing indications of insanity. The results were recorded in the casebooks were not intended to be a full historical record of the patients' stays in the asylums but as aids to the inmates' clinical management.[51] The notes are a source of contemporary medical practise and on occasion, records of the

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[48] FHAA, J7/190/6, Fisherton House Asylum Casebooks 1855-1866, Maria Borley Patient 1367, f. 341.

[49] FHAA, J7/190/8, Fisherton House Asylum Casebooks 1855-1866, Ann Lacey Patient 1394, f. 153.

[50] BCLA, D/H14/D2/2/2/341, Case File: Emily Lee.

[51] Andrews, "Case Notes, Case Histories", p. 256.

patients' own words.[52] Jennifer Wallis writes that physiological examinations were very important to Victorian alienists' research into the links between the physical body and the workings of the mind.[53] Extracts from the casebooks at all the asylums studied for this thesis support Wallis's assessment. Physical symptoms such as a "coated tongue" or "a weak and irregular pulse" were noted as indications of abnormal health, with possible effects on the mind.[54] The main purpose of the meetings was to ensure the patients were physically healthy but medical staff would also listen to the patients talking about themselves and occasionally, in the case of my sample of women, their crime and their children. The doctors' regular observations would note any secondary issues which were believed to have played a role in causing the woman's insanity.

Occasionally the patients themselves could indicate other possible circumstances through discussion of their backgrounds and home-lives. Such observations and factors were duly noted in the records and were considered when discharge or release was mooted. In the casebooks at Rainhill, details of the medical examinations were described as "Progress of Case" and, indeed, did record the patient's progress to recovery. Agnes Bradley went from being described as a "miserable defected [sic] person" who would not eat and believed she was "too wicked to live", to someone who could "talk calmly about her child … in the most affectionate terms" and was "at ease on [the] subject [of its death]".[55] The examinations were not some early form of talking therapy but were to evaluate whether the woman could be considered as restored to mental normality and possibly cured. In Broadmoor, Margery Nattress was reported as having had a calm and lucid conversation with Dr

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[52] Jennifer Wallis, *Investigating the Body in the Victorian Asylum. Doctors, Patients and Practices* (Basingstoke:. Palgrave Macmillan, 2017), p. 87.

[53] Ibid., p. 90.

[54] FHAA, J7/190/6, Fisherton House Asylum Casebooks 1855-1866, Catherine Oliver Patient no. 1821, f. 193..

[55] LVRO, LCLAR, M614 RAI/8/3, Case Books 1856-1860, Agnes Bradley.

Orange in 1873 and he wrote of her, "she feels stronger and better than she used to. She is grateful for the care and kindness received".[56] She was subsequently recommended for discharge.

Respectability of the patient's domestic situation and her personal conduct within that domiciliary sphere, were important considerations when possible reasons were being sought for her illness. It was important to establish that her murderous act had been contrary to her way of life and completely out of character. On her admission to Bethlem, Sarah Allen was described as "An interesting and amiable looking woman, who has led a quiet and, it is said, exemplary life."[57] In 1852, Maria Chitty's behaviour changed in the weeks leading up to her committing murder and attempted murder of two of her children. She was said to be suffering from an "impulsive mania". [58] Despite being described as "always evinc[ing] the greatest affection for her children" she had "latterly neglected her duties". [59] She was considered to have been neglectful in not only caring for her family and household but also in ignoring "her religious duties." She had attended "religious meetings of a different denomination, Methodist meetings, at all hours". [60] Chitty's clinical notes indicate that her religious zeal was seen as an indicator of her insanity, although, her case notes attribute blame to "her husband … the cause of her mental derangement". [61]

Over the sixty years in question, medical interpretations of the causes of female insanity laid more emphasis on the female reproductive function. When describing puerperal insanity, Victorian medical men noted that, in diagnosed cases of puerperal mania, attacks were frequently preceded by certain similar, recurring symptomatic

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[56] BCLA, D/H14/D2/2/2/157, Case File: Margery Nattrass.

[57] BHRA, CBC-03, Sarah Allen, f. 166.

[58] BHRA, CBC-03, Maria Chitty, f. 38.

[59] BHRA, CBC-03, f. 38.

[60] BHRA, CBC-03, f. 38.

[61] BHRA, CBC-03, f. 38.

behaviours. In 1846, Dr John Conolly noted that, in his experience, in cases of postnatal mental illness, "a quick pulse [was] an indicator of mischief … together with want of rest and sleep, a … quickness of manner and irritability".[62] Other "premonitory symptoms" of the condition recorded by medical men, noted that the condition could be accompanied by "delusions", "strong aversion to her child and husband", "anger", "vociferous and violent gesticulations", "great excitability" and "incessant talking."[63] Nineteenth-century doctors did not know what caused this category of insanity, although they believed that the onset of puerperal manias could be associated with a mother's and her family's medical history.

As has been said before, for a mother to commit infanticide, in its broader definition, represented a total rejection of the culturally accepted maternal bonds, feelings and duties. The belief that a woman's mental state and capacity was determined by her biological make-up was common to medical, legal and lay debate. [64] Medical explanations for married mothers murdering their children were influenced by gender expectations. The view was grounded in an acknowledgment of a woman's perceived weaker physical and mental states and, in an acceptance that childbearing and motherhood could put immense strain on the body, constitution and mind. [65]

In an 1878 journal article David Nicolson wrote:

> … [In] a woman who has shown previous signs of depression or tendency to insanity, the functional commotion she has undergone and the anxiety and foreboding produced by altered physical and domestic

[62] Marland, *Dangerous Motherhood*, p. 38.

[63] Ibid., p. 38.

[64] Ibid., p. 38.

[65] Ibid., p. 38.

> relations, are apt to drive her past herself and raise up in her mind terrible ideas and temptations…[66]

Nicolson believed that if a woman had ever shown any inclination to depression or insanity, then she should not be left alone, she should have "the companionship of some or any person, so that another 'will' than her own may, by its presence, strengthen her resistance to the fearful suggestions of murder and self-destruction".[67]. Nicolson believed that protection of vulnerable women by outside parties would certainly lessen the number of maternal infanticides. As he wrote in 1878, in his opinion, "puerperal cases of criminal lunacy ... are so often due to positive neglect or unkindness in the nursing after childbirth". [68] He continued;

> … As regards the prevention of criminal acts in cases of puerperal insanity, I do not know, that the influence of Lying-in Hospitals and of proper nursing, where the patient is not left to herself, has ever been estimated … [69]

Nicolson was suggesting that contemporary postnatal support, where available, might be efficacious for vulnerable mothers prone to insanity, although the supposition was unproven.[70] The temporary nature of puerperal manias gave the asylum authorities a problem. It was understood that, should the woman fall pregnant again, the affliction had a high probability of recurrence. Protection against relapse played an important

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66 David Nicolson, "The Measure of Individual and Social Responsibility in Criminal Cases" *British Journal of Psychiatry*, Vol 24 (1878), pp. 249-273, p. 264

67 Ibid., p. 264-5.

68 Ibid., p. 264.

69 Ibid., p. 264

70 Ibid., p. 265.

part in the discussions surrounding potential discharge of the homicidal mothers. I return to this discussion in Chapter 7, when I review the authorities' investigations into family circumstances when discharge from the asylum was considered. .

Life in the asylum

As I indicated to at the beginning of this chapter, the routines of life under a moral therapy regime followed familial lines, loosely structured on Victorian, essentially middle-class, ideals of domesticity. The medical superintendent was the father of the house, the matron was a mother figure, the attendant staff perhaps older siblings and the patients, the children. [71] In Chapter 6, I discuss the significance of this structure, specifically in relation to the paternal role of the medical superintendent. This family structure was an important principle of Samuel Tuke's theory of moral therapy, as was useful employment for patients. A patient's employment was calculated to match their physical and mental capabilities. Tuke believed that, "of all modes by which patients may be induced to restrain themselves, regular employment is perhaps the most efficacious."[72] By 1854, the majority of public asylums and a number of private asylums, in England had adopted, to a greater or lesser extent, the methods of moral therapy and, by the mid-century and the opening of Broadmoor, it was standard practice in the management and treatment of the insane. [73]

Although the concepts of moral therapy were generally accepted as the way to treat the insane from the mid-century onwards, it was often supplemented with the use of other methods.[74] Medical treatments based on the methods used for physical ailments such as purging, bleeding and blistering and the use of restraint and

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[71] Hide, *Gender and Class*, p. 91.

[72] Samuel Tuke, *Description of the Retreat, an institution near York, for insane persons of the Society of Friends* (York:. W. Alexander, 1813), p. 89.

[73] Andrews, "The Rise of the Asylum", p. 300.

[74] L. Smith, *Cure, Custody and Safe Custody*, p. 200.

confinement were commonplace early in the century.[75] The records of Bethlem and of Fisherton House indicate that the favoured treatment method was a mixture of the "old" methods and the "new", perhaps gentler, methods.[76] Mechanical restraint was occasionally used in Bethlem, although this fell from use after the appointment of Dr Charles Hood in 1852.[77] In 1861, Fisherton House was described as being "remarkab[ly] quiet, more especially as no bodily restraint is used, nor is there any separation seclusion of any patient." The writer added that, "there are no padded rooms for violent patients."[78] This was not the case in all asylums, where seclusion and sedation were utilised as the forms of control. At Broadmoor, the use of seclusion in particular, was explained as being necessary for the safety of the patients. Dr Orange wrote in 1875 that "the use to a certain extent of individual separation … or seclusion as it is termed, is found to be unavoidable, especially during those portions of the day when the attendants are occupied with cleaning … and serving the meals."[79] In all asylums, including Fisherton House, there was a wider use of newly developed drugs from the 1850s onwards. Tranquilisers, or hypnotic drugs such as chloral hydrate and sulphonal, along with morphia, were used mainly to calm and sedate, which had the effect of creating a more tranquil atmosphere in the asylums.[80]

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[75] Ibid., p. 201.

[76] FHAA, ARA-09 A11/3, Admission Register, 2 April 1841 - 31 December 1842: J7/190/1-9, Fisherton House Asylum Casebooks, 1854-1875.

[77] Colin Gale & Robert Howard, *Presumed Curable: An illustrated casebook of Victorian psychiatric patients in Bethlem Hospital* (Petersfield: Wrightson Biomedical Publishing Ltd, 2003).

[78] "Opening of the New Chapel at Fisherton House Asylum". *Salisbury and Winchester Journal*, (28 May 1859), p 7, col 3.

[79] BCLA, D/H14 A2/1/1/1, "Annual Reports Broadmoor Criminal Lunatic Asylum for the year 1875".

[80] Andrews, "The Rise of the Asylum", p. 321.

The metaphorical conception of an asylum population as a familial unit shaped various aspects of nineteenth-century views of the insane.[81] Ironically, the homicidal mothers had lost the ability to fulfil their maternal and domestic roles, were now treated as children themselves. In 1853, a patient in Rainhill, Ella Sutcliffe, was described as being "thin & rather short, very girlish looking".[82] Another patient, Bridget Doyle, was described as being "passionate [and] quarrelsome" although she could be "pulled up and brought to reason with a little management", just as a father might manage a recalcitrant child.[83] Patients were frequently described in terms associated with childish behaviour; Jane Gerrard, admitted to Rainhill suffering from puerperal mania, was "quarrelsome and mischievous" and in Broadmoor Lucy Keary was described as someone "troublesome" and "sullen" who "will go days without speaking – sometimes taking food and at others, refusing … meals".[84] Maria Borley's behaviour on admittance to Fisherton House was described as "vivacious" but it was also "mischievous, not inclined to violence but is likely to be troublesome."[85] In 1877 William Orange wrote "the discipline of the insane in an asylum … is very much like the discipline of the nursery" and as late as 1910, Claybury Asylum was described as a "huge and … very refractory nursery". [86]

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[81] Hide, *Gender and Class*, p. 92.

[82] LVRO, LCLAR, M614 RAI/8/2, Casebook: Female Patients 1853, Ella Sutcliffe, Admission no.722.

[83] LVRO, LCLAR, M614 RAI/8/1, Casebook: Female Patients 1851, Bridget Doyle, Admission no.174.

[84] LVRO, LCLAR,, M614 RAI/8/2. Casebook: Female Patients 1851, Jane Gerrard, Admission no. 141; BCLA, D2/2/2/284, Case File: Lucy Keary, Handwritten note by William Orange, October 1878.

[85] FHAA, J7/190/6, Maria Borley Patient no. 1367, f. 341.

[86] William Orange, "An Address on the Present Relation of Insanity to the Criminal Law of England." *The British Medical Journal*, October 13, 1877, p. 510; Dr Robert Jones, Medical Superintendent, Claybury Asylum quoted in Hide, *Gender and Class*, p. 92.

Employment was an important aspect of moral treatment and one which was considered essential in assisting any patient's recovery from mental disorder. Work within the asylum has been described as coercive and it has been suggested that the different types of employment were designed to fit patients into stereotypical roles.[87] Andrew Scull asserts that all moral treatment existed to transform asylum patients into "a bourgeois ideal of the rational individual".[88] These viewpoints, while being in part true, disregard the nuance in the purpose of employment as a part of moral therapy.[89] Louise Hide highlights that employment was also believed to be a way to restore a patient's confidence in themselves and thereby restore a rational state of mind. She also remarks that Scull's observations maybe partially true, she finds that it was also essential to restoring self-sufficiency and confidence in the patients. [90]

Hide makes the point that patients would rebel and use resistance to work as an act of defiance against the authority of the asylum.[91] Even in the criminal asylums, willingness or unwillingness to conform was a form of agency and, perhaps, giving the patients a modicum of control over their destiny. When she was in Bethlem, Eliza Clark was described as "rarely if ever occupy[ing] herself in any hospital work". Her refusal did not endear her to the staff, especially when it was observed that she would occupy herself with tasks which satisfied her. The case notes record that "whenever she has the opportunity [she] works at lace-making, at which she is adept". [92] Once

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87 Hide, *Gender and Class,* p. 104.

88 Andrew Scull, *Social Order/Mental Disorder. Anglo-American Psychiatry in Historical Perspective* (Berkeley & Los Angeles: University of California Press,1989), p. 89.

89 Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), p. 63; Jade Shepherd. Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900 (Unpublished PhD Thesis Queen Mary University of London. 2012).

90 Hide, *Gender and Class,* p. 102.

91 Ibid., p. 103.

92 BHRA, CBC-02 Incurable & Criminal Patient Casebook, 1816-1850, Eliza Clark, f. 103

she arrived in Fisherton House, her reported behaviour and demeanour changed and she was described as "very orderly and industrious – her time has been employed in fancy work and lace-making". Eliza was discharged from Fisherton just four months after her arrival from Bethlem as she was "in every aspect perfectly convalescent, exhibiting no delusion whatever [and] cheerful". [93]

Throughout the sixty years, the casebooks and casefiles from the various asylums contain particulars about the women and their lives in the asylum. Details such as physical appearance, work ethic, physical health, sociability and general behaviour were recorded. The wording and descriptions give a sense of the patients' lives and also give some indication of the interactions with staff. Words such as "well-conducted" and "industrious" appear in the casebook notes, as do comments on a woman's demeanour, containing words like "cheerful" or "tranquil". Catherine Savell was described as "a very well-conducted woman" and "her manner has been uniformily [sic] cheerful".[94] Elizabeth Thew appeared to be a model patient, in Bethlem, for she was "cheerful and well-behaved, industrious and obliging."[95] In 1861 she was transferred to Fisherton House from Bethlem, where her casebook notes described her as "well-conducted" and "industrious", often "cheerful" or "tranquil". She received a Royal Pardon in 1862 and was released.[96] In 1894, Elizabeth White, whose story opened this chapter, was described as "Sane, cheerful and industrious", which meant she was looked on favourably and consequently "Dr Nicolson thinks she might be discharged … without undue risk".[97]

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[93] FHAA, J7/190/5, Fisherton House Asylum Patient Case Book, Eliza Clark Patient no. 1240, f. 44.

[94] BHRA, CBC-03, Catherine Savell, f. 105

[95] BHRA, CBC-03, Elizabeth Thew, f. 41.

[96] FHAA, J7/190/5, Elizabeth Thew, Patient no. 1225, f. 34.

[97] BCLA, D/H14/D2/2/2/442/8, Case File: Elizabeth White. File notes 1893-1894.

There were those, however, who had seemingly brought their situation on themselves through careless living and had opened themselves to the possibility of mental disorder. Mary Lyons "had some disputes with her husband and had been drinking for some time … seemed careless of the value of her own life & her child's … intemperate at times for 3 or 4 years past".[98] Ann Amess "had led a previously quarrelsome life with her husband & her other relations and ... she, with them, was intemperate in her habits."[99] Intemperance and insobriety were viewed as a sign of unacceptable behaviour, but could be mitigated if it were perceived that the woman had been driven to drink by her situation. In Rainhill, Bridget Myles was diagnosed as suffering from "Melancholia after murdering her child", and "it appears she has latterly taken to drinking."[100] She was transferred to Broadmoor, where it was discovered that she had been "beaten by her drunk husband and in consequence had turned to drink herself." Myles did not leave Broadmoor, dying there in 1909. Up to that time she was still treated with care and compassion, with her sister and surviving daughters being encouraged to visit and correspond with her.[101] For all asylum patients it would appear that family and background, in themselves, may have been seen as possible factors in causing a patient's mental distress.[102] As I discuss in Chapter 7, Their presence was also considered as necessary to a patient's recovery.

Physical appearance seemed to have an effect on the staff's perceptions of the women. In each of the asylums reviewed, the case notes always contained a physical description of the woman, usually without further comment. However, the notes at Fisherton House contain a hint that there was an expectation that physical appearance

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[98] BCLA, D/H14/D2/2/2/119, Case File: Mary Lyons.

[99] BCLA, D/H14/D2/2/2/276, Case File: Ann Amess.

[100] LVRO, LCLAR, M614 RAI/8/4, Casebook: Female Patients 1860-1865, Bridget Myles.

[101] BCLA, D/H14/D2/2/2/150, Case File: Bridget Myles.

[102] Dobbing, "The Family and Insanity", pp. 144-148

might reflect the women's character and history. Eliza Clark was described as having a "countenance [which] indicates intelligence and kindness of disposition which is confirmed by conversation".[103] A suggestion, perhaps, that she might be an unlikely person to commit murder. This supposition was firmly stated in the case of Sarah Dickenson. "She has an intelligent expression … appears generally dejected but kind and benevolent. She probably would be one of the last who could be suspected of having committed any heinous crime."[104] In Bethlem Amelia Burt was described as "almost cheerful in her manner as can be devised and she frequently smiles" but there is a sense of compassion from the writer as the report continues, "the expression of her countenance however still indicates much depression".[105]

In many cases, the asylum staff's perceptions of the female patients were impacted by the women's conduct and responses to other patients and the staff. Any antipathy on behalf of the staff seems to have been reserved for the women's response to the treatment they received, rather than their crime. A lack of respectability in a woman's demeanour and actions could colour the staff's opinion, although her subsequent conduct could also change that view. The clinicians' frustrations with patients can be seen in occasional deprecating notes in the case books. In 1837 Dr Alexander Morison, at Bethlem, wrote that Hannah Smith had "an insatiable venereal appetite", although by 1854 his successor, Dr Charles Hood, sympathetically recorded her as being "a quiet inoffensive woman whatever her former state of mind might have been".[106] Hood was not always as tolerant of the female patients. He wrote caustically of Eliza Clark that "she has proved herself a discontented person expecting more

[103] FHAA, J7/190/5, Eliza Clark f. 44.

[104] FHAA, J7/190/5, Sarah Dickenson Patient no 1239, f. 142.

[105] BHRA, CBC-03 Amelia Burt, f.50.

[106] BHRA, CBC-03 Hannah Smith, f.33.

attention than any other patients [sic]".[107] He was disapproving of Eliza Pegg's behaviour saying that "there is a great display of sensuality in all her actions."[108] Neither woman behaved in an acceptedly respectable manner when they were at Bethlem. Eliza Pegg was also the source of trouble for the staff at Fisherton House, where she attacked other patients and the attendants. [109] Similar conduct at Bethlem had led to her being placed in a padded cell and, on one occasion at Fisherton House, her head was shaved and "a blister applied to the nape of the neck" in an effort to control her. She also was given a tepid bath which eventually "had the desired effect of tranquillizing her." [110] There was no mechanical restraint of Pegg, however, her treatment at Bethlem and at Fisherton House was quite severe.

Although a patient's social position did not influence the medical treatment she received, it could influence her material life in the asylum. The Fisherton House case notes for Ann Cornish Vyse record that "this patient resides with the private patients" and that she had "two rooms to herself, the sanction [of] Secretary of State having been obtained by the Husband." It was also noted that she had "daily walks with an attendant beyond the limits of the Asylum and enjoys good health." [111] There does not appear to have been an obligation for Ann Vyse to undertake employment and she was allowed a lifestyle in keeping with her status as the wife of a respected businessman in the City of London. [112]

In Broadmoor, as well as being allowed personal possessions, the patients were allowed extra comforts if they, or their relatives, could afford them. This was relatively common on the men's side of the asylum, where there were a number of patients from

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[107] BHRA, CBC-03. Eliza Clark, f. 103.

[108] BHRA, CBC-03, Eliza Pegg, f. 67.

[109] FHAA, J7/190/5, Eliza Pegg Patient no. 1223, f. 111.

[110] FHAA, J7/190/5 Pegg , f. 111.

[111] FHAA, J7/190/5, Ann Cornish Vyse Patient no. 1934, f. 21.

[112] FHAA, J7/190/5, Vyse, f. 21.

the professional classes. It was more unusual on the female side, where there were few patients from more privileged backgrounds. Before Agnes Morris's arrival, her family solicitor wrote to Dr Orange stating that she had "about £100 per annum at her disposal and with this sum ... we are anxious to procure for her such ... comforts as can be given."[113] Dr Orange replied that "there are in the asylum ... several inmates whose social position was ... equal and superior to that which would appear to have been held by this lady ... and from the opening of the asylum the practice of ... allowing ... reasonable extra comforts supplied out of funds...supplied by relatives or in their own right ... has been fully regarded." In the same letter, Orange stated that "the inmates who are allowed to receive extra comforts are not thereby removed out of the category of ordinary criminal lunatic." [114] In other words, money and privilege might make confinement in an asylum more tolerable but it would not buy a way out of the fact that the patient was still officially criminally insane.

Among the patients with less influence or available funds, good behaviour and conduct were rewarded by concessions and a certain amount of free movement. In 1857, Maria Borley, now a patient in Fisherton House, was described as "intelligent, quiet very well-behaved. She is also very industrious making herself useful in the kitchen … and assisting the upper servants." By May 1858 she was allowed to go on errands into Salisbury and she was described as "very well trusted". [115] This trust and relative freedom eventually led to other problems. Borley was discharged as "recovered" in November 1859. However, the asylum was subsequently advised that

[113] BCLA, D/H14 2/2/2/261/16, Case File: Agnes Martha Morris. "Letter dated 28 January 1878".

[114] BCLA, D/H14 2/2/2/261/18, Case File: Morris. "Letter dated 15 February 1878".

[115] FHAA, J7/190/6, Maria Borley Patient 1367, f. 341.

she was pregnant and the putative father was a gardener at Fisherton House.[116] This was a unique occurrence amongst the cases studied, an extreme consequence of the trust that could be built up between the asylum staff and patients.

Apart from the medical officers, the staff who dealt directly with the women were always female, with the matron taking overall charge of the female patients' welfare. At Broadmoor, it was categorically stated that she would see all the female patients at least twice a day, "enforcing kindly but firmly the observance of all rules made … for the guidance of attendants … in the care and treatment of the patients".[117] Another important stipulation came from the *Rules* and that was that "kindness and forbearance [were] the first principles in the care and management of persons of an unsound mind". [118] In the Broadmoor archive there are letters of appreciation sent by discharged patients and their families, thanking the whole staff for their care. Richard Nicholls wrote to Dr Orange in 1878 saying, "I … thank Matron for the attention and kindness she has shown to my wife and also the attendants under whose immediate care my wife was placed."[119] The women gained favourable opinion by acting with qualities such as diligence and deference, traits associated with contemporary respectable female behaviour. This could have a profound impact on whether the women would be considered as recovered enough to warrant release. Requests for release or discharge were more likely to be favourably considered and recommended for those patients who had worked hard, without trouble and complaint. In Chapter 7

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[116] FHAA, J7/131/1, Correspondence Criminal Lunatics and their maintenance at Fisherton by the Commissioners in Lunacy 1854-1875. "Letter from the Office of Commissioners in Lunacy to Dr Corbin Finch, Fisherton House Asylum".

[117] BCLA, D/H14/B1/2/2/1, Records of the Medical Superintendent. "Rules for the Guidance of Officers, Attendants and Servants of Broadmoor Criminal Lunatic Asylum".

[118] BCLA, D/H14/B1/2/2/1, "Rules for the Guidance of Officers".

[119] BCLA, D/H14/D2/2/2/188, Case File: Annie Nicholls, "Letter from R C Nicholls rec'd 15 April 1878".

when looking at the background to release and discharges, I further consider the importance of behaviour and conduct in those decisions.

Pregnancy and Childbirth

In May 1854, Catherine Savell was admitted into Bethlem after her trial at the Old Bailey for the wilful murder of her three-month-old infant.[120] In December, she was transferred to Brixton Gaol as it was believed that she was about to give birth. On 24th January 1855, she was returned to Bethlem because "It has turned out that she was not pregnant. She had all the symptoms but was not."[121] It was possibly a phantom pregnancy, however the records do not record whether she had had a medical examination. Charles Hood noted in the case book that the doctors and attendants had decided that Savell was pregnant because it was "her firm impression which was founded on … experience of having given birth."[122]

The criminal lunatic facilities could not exercise any choice in their admissions, as they were legally bound to take those found to be insane by judicial process. If a pregnant and homicidal mother were adjudged as insane and incarcerated as a ciminal lunatic, the child's birth would need to be dealt with in-house. Normal pratice for the Bethlem authorities appears to have been to send any patients, criminal or not, to another institution if they were believed to be pregnant.[123] The other criminal lunatic facilities, Fisherton House and Broadmoor, dealt with childbirth within the asylum. Their dealings with pregnant patients highlight some of the differences in the personal approaches of the medical superintendents. They would act in a medically professional manner and they would be anxious to protect the mother's safety and

[120] OBP, *Old Bailey Proceedings Online*, May 1854, trial of Catherine Savill [sic] (t18540508-682).

[121] BHRA, CBC-03, f. 105.

[122] BHRA, CBC-03, f. 105.

[123] BHRA, CBC-03, Ann Raven, f. 47; CBC-03 Catherine Savell, f. 105.

well-being. [124] Most county and private asylums would prefer not to admit expectant mothers, as pregnant and lactating women would require extra nursing and attention. If they did accept such cases, the asylum authorities would remove any babies born there soon after birth.[125] Childbirth was seen as a danger to any woman's stability but as some of the mothers of my sample group had had their mental illness attributed to puerperal manias connected to previous confinements and indeed to the pregnancy itself, they were believed to be particularly at risk. [126] It was imperative that they be safeguarded against relapse and shielded from any possible opportunity to re-offend.

At Fisherton House, the expectant mothers were treated well, with one to one nursing care and help, which would also provide necessary close supervision. In 1864, Dr Finch wrote to Whitehall, justifying the costs involved in the confinements of Martha Hocken, Anne Cornish Vyse and Mary Ann Payne, each of whom had a baby in the Asylum. In the letter he stated, "These patients had in each case destroyed their children and there was the great probability that without incessant care and watchfulness they might repeat the offence."[127] Finch also commented that, in incurring the extra expenses, he was following a pattern set down in the earlier case of Harriet Salmon. For her confinement in 1861, Harriet Salmon was given "a separate room, an exclusive nurse, medical attention, … extra washing and a proper provision of child clothing."[128] In all four cases, the infants stayed with their mothers for nearly a year, until weaned, which the Fisherton House management felt was the kindest

[124] Shepherd, *Institutionalizing the Insane,* p. 65; Stevens, *Broadmoor Revealed,* p. 120.

[125] Shepherd, *Institutionalizing the Insane,* p. 67.

[126] Marland, *Dangerous Motherhood,* p.130.

[127] FHAA, J7/131/1, Correspondence: Criminal Lunatics,"Letter to H. Waddington dated 28th September 1861".

[128] FHAA, J7/131/1, Correspondence: Criminal Lunatics."Letter from W.C. Finch M.D. dated 18th September 1861".

treatment for both mother and child. As a policy, it would help the mother survive the more dangerous period when post-natal problems could set in.

While Broadmoor accepted and cared for pregnant women through their confinements, they tended to follow the same principle as other asylums and attempt to remove the babies from their mothers and the asylum within a short time-frame. Catherine Dawson was the first patient to give birth in Broadmoor; her son was born on 26 December 1866.[129] After her husband declined to take the child and after negotiations with her local Poor Law Union in Lancashire, the baby was sent to Chorley Union Workhouse on 25 February 1867. [130] The Broadmoor superintendents took a view on the mother's state of mind before making a decision about removing the child. In 1885, it was reported that "A woman who was admitted in July … gave birth to a child in the following month, which she nursed for five weeks after which she became too restless to be any longer trusted with it."[131] Other patients who appeared to be reasonably sane were allowed to nurse their children for the first few months of their lives.[132] Sometimes it was decided the child would be safer with its family, preferably its father. As reported in the Annual Report for 1888, "L. O., who was admitted on the 10th of February, gave birth to a son on 2nd of April … At the husband's request, the child was transferred to the care of his wife's relations."[133] If, as happened on occasion, family or kin were unwilling to take the baby, it would be

[129] BCLA, D/H14/D2/2/2/113, Case File: Catherine Dawson.

[130] Stevens, *Broadmoor Revealed*, p. 124.

[131] William Orange, "Twenty-third Annual Report of the Medical Superintendent." *Annual Reports upon Broadmoor Criminal Lunatic Asylum with Statistical Tables, for the year 1885*, (London: Eyre & Spottiswood, 1886), p. 9.

[132] BCLA, D/H14/D2/2/2/146, Case File: Mary Meller; D/H14/D2/2/2/177, Case File: Margaret Cummings.

[133] David Nicolson, "Twenty-sixth Annual Report of the Medical Superintendent." *Annual Reports upon Broadmoor Criminal Lunatic Asylum with Statistical Tables, for the year 1888* (London: Eyre & Spottiswood, 1890), p. 7.

entrusted to the care of the mother's local Poor Law Union or an orphanage. Sarah Dobbin's son was sent to St Alban's Home in Worcester when he was ten weeks old.[134] While this may appear to be heartless, the medical superintendents were firmly of the opinion that Broadmoor was not a place for a young child and that the mother's welfare came first. As Orange commented on Sarah Dobbins after the baby's departure, "[she] gradually recovered, and is now tranquil, although often very depressed and melancholic."[135] That being said the authorities did try, for the most part, to protect the child's welfare.[136] The care and treatment of expectant mothers, their childbirth and their new-borns in the asylums, is an area of research which would merit further discussion but at present it is beyond the scope of this thesis.

Conclusion

All the women under discussion had been detained in an asylum as criminal lunatics and their treatment did not differ from that meted out to other women confined in county and private asylums. The treatment given in the first part of the period, before the opening of Broadmoor, was less uniform than in later years, due partly to developments in understanding of insanity and partly to the fact that a dedicated facility would have a more consistent pattern of treatment. There was a contemporary cultural acceptance that the effect of childbirth on a woman's body and mind was perilously uncertain. Potentially dangerous insanity was one of many adverse medical disorders which could affect a woman after confinement. The diagnosis of puerperal insanity or mania began to be recognised in the 1830s and by the middle of the century it was the prominent part of medical discourse on female insanity.[137] The actual root

[134] BCLA, D/H14/D2/2/2/384, Case File: Sarah E. Dobbins.

[135] William Orange, "Twenty-third Annual Report ", p. 9.

[136] Stevens, *Broadmoor Revealed*, p. 121.

[137] Marland, "Languages and Landscapes", p. 59.

cause of the condition could differ from case to case but it was mostly characterised by melancholia, delusional beliefs, hallucinations and acute distress. [138] The accepted belief was that the disorder could cause a mother to harm herself, as well as making her violent towards her children and others.[139] Such conditions could cause violent criminal behaviour, which was contrary to the accepted maternal role. Dr John Baker described this role as "a function which exists for protection of the weak and [that] a mother provides for her children by every means in her power."[140]

In all asylums, whether county, private, or state criminal facilities, the treatment for mental illness in the Victorian era centred on keeping the mind and body occupied through occupational therapy, suitable amusements and religion. As evidenced by the various records of the institution, life in the asylum for the homicidal mothers was controlled by the medical superintendent and his staff. In the next chapter I concentrate on the medical superintendents of the asylums and their manner of management and control of their respective asylums and patients would impact the socio-cultural environment as well as the medical regime in the institutions.The quality of the women's experience would be dependent on how they conformed to the authorities' expectations of behaviour and this, in turn would impact on whether they would be considered recovered enough to be released. The length of time the women remained in the asylums depended on various factors which evolved and changed over the period. Some patients improved quickly and would be released within a short time frame, whereas others would be incarcerated for longer, if not for the rest of their lives. I analyse the protocols of release and the discussions surrounding the discharge of criminally insane mothers in depth in Chapter 7.

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[138] Ibid., p. 54.

[139] Idem., *Dangerous Motherhood*, p. 173.

[140] Baker, "Female Criminal Lunatics", p. 21.

Chapter 6:
"A depth of sympathy and a breadth of charity"
Medical superintendents and their impact on asylums and patients.

Introduction

Elizabeth Pryce was committed to Broadmoor Criminal Lunatic Asylum on 17th March 1865, for the wilful murder of her infant daughter and attempted suicide. There was a doubt in her diagnosis of insanity and it was felt that desperation, rather than mental instability, had driven her to murder. She had been seduced, let down by the father of her child and then thrown out of the family home.[1] Elizabeth was an intelligent, personable young lady and was allowed to socialise widely in Broadmoor, not only creating friendships with other patients but also relaxed connections with the staff.[2] Dr William Orange, the medical superintendent at the time, interacted with her in a paternalistic manner. He appeared to appreciate that she was one of the better educated women in his care and, perhaps because of her relative youth and the distressing circumstances of her crime, he took a quasi-parental interest in her. He introduced her to his family and was active in securing her release from the institution.[3] After her discharge she wrote to him in a personal but deferential manner saying, "Will you kindly remember me to … your Lady and family?"[4] In another letter

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1 BCLA, D/H14 2/2/2/107/1, "Schedule A: STATEMENT respecting Criminal Lunatics to be filled up and transmitted to the Medical Superintendent with every Criminal Lunatic." Case File: Elizabeth Pryce.

2 BCLA, D/H14 2/2/2/107, Pryce.

3 BCLA, D/H14 2/2/2/107/4, Pryce,"Warrant for Conditional Discharge".

4 BCLA, D/H14 2/2/2/107/5, Pryce, "Letter to Dr William Orange 27 February 1874".

she wrote, "your unbounded kindness to me, has made an impression … I was and am still, … grateful to you for all the kind consideration you bestowed upon me."[5]

In 1894, Charles Mercier described the ideal Medical Superintendent as one "who combines the two qualifications of high scientific attainments and high administrative capacity".[6] Mercier continued, "For his patients he should have a depth of sympathy and a breadth of charity such that he places … without effort or self-consciousness their interests, their comfort, their welfare in the foremost front of his endeavour".[7] In other words, the perfect superintendent should combine such qualities as compassion and understanding with his professional achievements. The senior and arguably the most important person on the asylum staff was the medical superintendent. Louise Hide describes the role as *sui generis*, representing the asylum to the outside world. [8] His individual and professional style defined the character of the institution, notwithstanding the limitations of imposed official accountability and medical specialisation.[9] Within the institution, the medical superintendent could be described as the *paterfamilias* of the institution and had specified duties of patient care. In these, and in day-to-day medical and pastoral matters, he was supported by his assistant medical officers and the asylum attendants.[10] By virtue of being the "man

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5 BCLA, D/H14 2/2/2/107/6, Pryce, "Letter 11 March 1874".

6 Charles Mercier M.D., FRCS worked at Buckinghamshire County Asylum in Stone, near Aylesbury, Assistant Medical Officer at Leavesden Hospital and at the City of London Asylum, Dartford, Kent. He was the resident physician at Flower House Asylum in Catford In 1902 he became a lecturer in insanity at the Westminster Hospital Medical School. "Charles Arthur Mercier", *Munks Roll*, vol. 4, Royal College of Psychiatrists, p. 463.

7 Charles Mercier, *Lunatic Asylums: Their Organisation and Management* (London: Griffin & Co., 1894), pp. 197-198.

8 Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2004), p. 46.

9 Ibid., p. 47.

10 Ibid., p. 49.

at the top" of the institution's hierarchy, the medical superintendent was responsible for the welfare of everyone in the asylum, including the wellbeing and safety of the whole staff.[11] The final decisions about inmates' physical, medical and mental treatment lay with him, whether they were criminally-insane homicidal mothers or "ordinary" mentally-ill patients.[12] The desired outcome was to cure their patients, restoring them to a rational and sane state, as defined by nineteenth-century standards.[13] The relationships and interactions between the medical men in authority and the sample group of women under discussion in this thesis, were important factors in effecting recovery and were informed by contemporary behavioural expectations of gender and social status.

This chapter is an exploration of the relationships between the senior medical figures of four asylums and my sample group of homicidal mothers. I specifically focus on Sir Charles Hood at Bethlem, Dr William Orange and Dr David Nicolson at Broadmoor and Dr Thomas Lawes Rogers at Rainhill County Lunatic Asylum. By way of contrast, I also evaluate the approach of the proprietors and medical superintendents of Fisherton House Asylum, Dr William Corbin Finch, Senior, and Dr John Lush. Without giving a hagiographical account of the men, I examine how far the personal circumstances of these senior medical officers influenced life in their asylums. I also demonstrate that that the institutional careers of the homicidal mothers were impacted by the outlook and opinions of clinicians. These attitudes were, in turn, informed by contemporary constructions of gender, by expectations of respectability and personal experience. The medical superintendents' personal cultural and domestic

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[11] Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England*. (London: Pickering & Chatto, 2014), p.43.

[12] Hide, *Gender and Class*, p. 52.

[13] Shepherd, *Institutionalizing the Insane*, p. 173.

backgrounds potentially influenced and prejudiced their dealings with the patients.[14] As described in preceding chapters, the concept of respectability in the Victorian period was a cultural ideal of a well-ordered, controlled and civilised society. Discernible "respectable" behaviour, both before and after admission to the asylum, together with respectability of domestic circumstances mattered to the medical officers.[15] The compassion and pity shown by these men to the homicidal mothers, could be said to stem from their middle-class ideals of what they believed to be "decent" and acceptable behaviour.[16] In this chapter, I debate whether the care and attention given did not just stem from professional principles, but also came from personal life-experiences.

The nineteenth century was a period when all medical men were constructing professional identities and the development of the asylum system had led to the emergence of the new cadres of psychology and alienism.[17] Within the asylums, doctors treating insanity were working in an environment where their own concerns and emotions could impact upon the lives of their patients.[18] For this chapter, through a nuanced reading of the case book notes as well as other relevant papers, I have investigated the medical superintendents' relationships with the sample group of homicidal mothers. As indicated in previous chapters, the creation of the case book

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[14] Ibid., p. 52.

[15] Lorraine Walsh, "A Class Apart? Admissions to the Dundee Royal Lunatic Asylum. 1890-1910", in Jonathan Andrews & Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry,* (Amsterdam & New York: Rodopi, 2004), pp. 249-270, p. 265.

[16] Shepherd, *Institutionalizing the Insane*, p.173.

[17] Michael Brown, *Performing Medicine. Medical Culture and Identity in Provincial England c.1760-1850* (Manchester: Manchester University Press, 2011).

[18] Thomas Dixon "Patients and Passions: Languages of Medicine and Emotion 1789-1850" in Fay Bound Alberti (ed) *Medicine, Emotion and Disease, 1700-1950* (Basingstoke: Palgrave Macmillan, 2006), pp. 22-52, p. 40.

notes were intended to document the medical and recovery progress of the patients, although on occasion there are hints of the writer's emotional response to the case before him.[19] By comparing the contents of the case books with published professional writings, I use the notes to gauge if there was any significant patient-doctor emotional connection. To a greater or lesser degree, the books offer an insight into the extent to which personal circumstances could influence interpersonal encounters between the medical staff and the insane patients.

The style of management in the institutions may have had many similarities, but there were also significant differences. Bethlem, Broadmoor and Rainhill were all ultimately public institutions. Broadmoor and Bethlem were designated as state facilities for the criminally insane, overseen by Whitehall. Rainhill was a county lunatic asylum with diverse inmates, including a number of criminal patients. It is worth noting that Fisherton House was dissimilar in ownership and organisation to the others. Because of its commercial origins and despite a twenty-year commission as a criminal facility, many of the practices followed were more akin to those of a private asylum. The proprietors and medical superintendents, Drs Finch and Lush, appear to have responded to the Whitehall authorities in a less deferential manner than their contemporaries and appeared to expect more autonomy in their establishment. Within the asylums, the doctors treating insanity were working within an emotional environment, where their own concerns and feelings could impact on the experience of mothers. In all asylums, as in all fields of medicine, medical men of the day did not have many cures to offer. To have some control over one's emotions was important in the formation of professional identity but it did not necessarily mean that they should

[19] Jonathan Andrews, "Case Notes, Case Histories and the Patient Experience of Insanity at Gartnaval Royal Asylum, Glasgow, in the Nineteenth Century", *Social History of Medicine*, vol. 11, no. 2 (1998), pp. 255-281.

not have some fellow feeling or be aloof. The ability to show compassion in their patient care was valued as an indication of accomplishment and success in practice.[20]

Earlier in this thesis, I suggest that moral therapy, or management, did contain repressive, controlling elements as suggested by Foucault and Scull.[21] While the original intention behind familial discipline came from a well-intentioned interest in patients' welfare, it is, nevertheless, an example of patient control.[22] In his 1813 monograph, *Description of the Retreat,* Samuel Tuke wrote, "it [the patients' demeanour and behaviour] is not allowed to be excited beyond that degree which naturally arises from the necessary regulations of the family … All patients are generally induced to adopt orderly habits."[23] Moral treatment was originally based on creating a co-operative relationship between the doctors and their patients. An important part of its philosophy was that the medical men should adopt a benign didactic approach to their patients. [24]It was believed that this approach would help to alleviate the patients' psychological suffering and build-up their self-worth; in effect the doctor should act as a compassionate mentor and father figure. Benevolent paternalism is clear in cases where the patient was young and misguided, as in the case of Elizabeth Pryce cited at the beginning of this chapter. With other patients the paternalism was less apparent, that relationship was more akin to that of an employer

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[20] Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford: Oxford University Press, 1999), p. 261.

[21] Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason,* trans. by Richard Howard, (London: Routledge, 2001); Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven & London: Yale University Press, 1993), p. 179.

[22] Anne Digby, *Madness, Morality and Medicine. A study of the York Retreat. 1796-1914* (Cambridge; Cambridge University Press, 1985), pp. 51-53.

[23] Samuel Tuke, *Description of the Retreat, an institution near York, for insane persons of the Society of Friends* (York:. W. Alexander, 1813), pp. 90-91.

[24] Hide, *Gender and Class,* p. 92.

or benign benefactor. Whether motivated by paternalism, benevolence or professional probity, the medical superintendents' reactions to and relationships with, their patients controlled the future lives of the homicidal mothers in their care. [25]

Emotional engagement

In general, the Victorian attitude to the role of emotion in medicine was ambivalent. Sympathetic involvement with their patients was regarded by Victorian doctors as an important part of their medical arsenal, playing an essential part in diagnosis and treatment of illness.[26] On the other hand, undue involvement could damage the doctor's perceived professionalism and be antithetical to scientific development.[27] An important factor in the creation of gravitas and professionalism for Victorian medical practitioners was the control of emotion and the control of emotional involvement with their patients. Mastery of emotions was a key skill for doctors when developing their professional identity. Yet, having such control did not mean that a doctor should be unapproachable or unsympathetic.[28] In 1890, Jukes de Styrap wrote "if you cannot … unite knowledge of physic with intelligent comprehension of the thoughts, feelings and desires of mankind … you will be sadly deficient."[29] His book is a somewhat rhetorical guide for aspiring general practitioners but it did propound that a doctor's emotional response to his patients was essential in maintaining good interpersonal relationships. De Styrap also advised his readers to ensure that they regulated and modified their emotions, so that professionalism would

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[25] Ibid., p. 92.

[26] Michael Brown, "Redeeming Mr Sawbone: compassion and care in the cultures of nineteenth-century surgery", *Journal of Compassionate Health Care,* vol. 4, no. 13 (2017);

[27] Douglas Small, "Masters of Healing: Cocaine and the Ideal of the Victorian Medical Man", *Journal of Victorian Culture*, vol. 21, no. 1, (2016), 3-20, p. 18.

[28] Digby, *Evolution of British General Practice,* pp. 261-2.

[29] Jukes de Styrap, *The Young Practitioner* (London; H.K. Lewis, 1890), pp 1-2.

be maintained in their relationships with their patients: "expressions of sincere sympathy and interest tend to inspire great confidence … you can and should … manifest some anxiety and interest in all cases and avoid exhibiting indifference in any."[30] The ability to nurture good interactive relationships was a potent gift for any doctor but in the field of mental healthcare, it was of fundamental significance.

Analysis of the medical superintendents' emotional responses is subjective and often speculative. They had all trained and started, their careers in general medicine and surgery. Their eventual vocational character came from working with the insane in various institutions, including prisons and asylums. Their professional persona as experts in their fields came from past experience of working with and observing, institutional insane populations.[31] In order to assess the impact of the medical men's emotional engagement with the criminally insane mothers in their care, the challenge is to not seek contextual validation of theories from available primary sources. Analysis of such sources needs nuanced reading to find emotional reactions, such as proof of compassion and empathy, or indeed censure and criticism. I would argue instead that, to an extent, the emotional responses of the doctors were tempered by the individual's view of the respectability of the female patients' home-lives, families and demeanour, as well as any influence from their own life experiences. As husbands and fathers, the medical superintendents may well have been personally horrified by the act these women had committed but this was not necessarily shown in their professional lives.

The particular men I have been researching did not leave private papers, diaries or personal correspondence. Dr Charles Hood, Dr William Orange and Dr David Nicolson were quite prolific published writers, while Finch, Lush and Rogers made

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[30] Ibid., pp. 33-4.

[31] All the nineteenth century medical superintendents at Broadmoor had, at some point in their careers, practiced within the penal system as prison medical officers.

contributions to local and national professional medical bodies. All medical superintendents had to write annual reports to the Commissioners in Lunacy, which were published for public consumption. Other work was produced for government committees, for various specialized journals and also for presentation to medical colleagues. The reports, articles, talks and occasional references in case book notes, may have included indications of personal feelings and attitudes but usually they were written in consequence of professional experience. The clinical notes in the case books and files contain evidence of engagement with their patients and, on occasion, give an insight into the impact of the patients' social position and respectability on the medical superintendents' opinion. The asylum clinicians rarely commented frankly and personally about the difficulties before them.

Charles Hood wrote, "it would be indelicate and improper of me to expiate upon the peculiar features of any case under my charge in Bethlehem [sic]".[32] Patient confidentiality was essential and this was as true for criminal patients as for other patients. It is difficult to accurately ascertain the medical superintendents' emotional reaction to any of their patients. The records for Fisherton House and Broadmoor both contain correspondence and ephemera, which contain some indications of a clinician's personal feelings. As previously noted, the Broadmoor case files contain rough notes and copies of reports to the Home Office, together with correspondence with patients and their families. Finch's correspondence and papers from Fisherton House on the subject of criminal lunatics and the asylum's case books all contain some personal commentary and opinion.[33]

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[32] Wm. Charles Hood. M.D., *Suggestions for the Future Provision of Criminal Lunatics* (London: John Churchill, Soho. 1854), p. 161.

[33] FHAA, J7/131/1, Correspondence Criminal Lunatics and their maintenance at Fisherton by the Commissioners in Lunacy, 1854-1875. (4 bundles).

The resident Medical Superintendent

The ideal personal emotional temperament of a medical man was said to encompass important assets of "cool, philosophical composure" and control of temper.[34] A powerful quality for Victorian doctors was the ability to have an emotional rapport of some kind with their patients, whatever their medical specialism.[35] For the medical superintendents and other medical staff within the asylums, having a sympathetic connection with their patients' physical and mental welfare was vital to successful treatment. Contemporary comments on the medical superintendents emphasised their calm authority and sympathetic demeanour. On his resignation from Broadmoor in 1886, Orange's style of management was described as being "characterised by a judicious firmness, combined with … kindly consideration for … the unfortunate patients … under his care."[36] David Nicolson wrote of Orange, that he was "ever sympathetic with those in trouble and ready to help when appealed to".[37] Nicolson, himself, was lauded as "honourable, caring independent and fearless".[38] William Corbin Finch, senior, was described by contemporaries as being "well-known … for kindness and humanity".[39] Charles Hood apparently treated his patient charges with "wise thoughtfulness" and was himself "at once thoughtful and energetic".[40] While these observations are quoted from newspaper articles, citations or obituaries

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[34] de Styrap, *The Young Practitioner*, p. 32.

[35] Alison Moulds, "'Making your Mark': The struggling young practitioner and the search for success in Britain, 1830-1900." *History*,vol.104, no.104 (2019) pp. 83-104.

[36] "Dr Orange, C.B.", *The British Medical Journal* vol. 1, no. 1327 (5 June 1886), p. 1075.

[37] David Nicolson, "Obituary: William Orange," p. 67.

[38] "Obituary: David Nicolson, M.D.. CB.LL.D., MD.", *The British Medical Journal* (9 July 1932), p. 80.

[39] "Opening of the New Chapel at Fisherton House Asylum", *Salisbury and Winchester Journal* (28 May 1859), p 7, col 3.

[40] Henry Morley, "The Star of Bethlem" *Household Words* no. 386 (15 August 1857), pp. 145-68, p. 147.

which are somewhat laudatory and favourable towards their subject, they are an indication of the qualities expected of senior medical figures in the institutions.

The Lunacy Act of 1845 placed qualified medical men in control of the asylums, rather than external, non-resident administrators. By the 1845 County Asylums Act, on-site residency became compulsory for supervisory physicians and doctors.[41] This residency brought the day-to-day contact with the patients nearer to medical superintendents, giving them the chance to observe their charges on a more personal level. [42] Thomas Lawes Rogers noted that this contact would not have been possible without the assistance of a like-minded staff of medical officers: "undoubtedly when in any establishment the number of patients exceeds 500, the Medical Superintendent cannot possess that intimate personal acquaintance with every individual case which is desirable for the patient's sake … they [the medical officers] simply do their best in existing circumstances."[43] That being said, the inspecting Commissioners in Lunacy wrote of him, "Dr Rogers appears to have an intimate knowledge of the case of every patient under his care."[44] Rogers was known for wishing the best for his charges, despite the circumstances of their institutional committal. As he wrote, "people are sent to asylums … kept there against their will and therefore their condition should be made … happy and comfortable."[45] Part of that comfort would come from personal contact with the medical staff in charge of their

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41 8 &9 Victoria c. 100 Lunacy Act 1845; 8 & 9 Victoria c. 126 County Asylums Act 1845. Shepherd, *Institutionalizing the Insane*, p. 42.

42 Ibid., p. 43.

43 LVRO, LCLAR, M614 RAI 40/28/1, Thomas Lawes Rogers, "Superintendent's Report to the Committee of Visitors for 1869", Annual Report on the County Lunatic Asylum at Rainhill 1869.

44 LVRO, LCLAR, M614 RAI 40/2/29, "Report on the County Lunatic Asylum at Rainhill, 1863".

45 Thomas Lawes Rogers, "An Address to the section of Psychology of the British Medical Association in Liverpool", *The British Medical Journal*, (4 August 1883), p. 232.

treatment. It is possible to speculate that his comment about being unable to know all his patients well, was an expression of his personal discomfort at not being able to give patients his full attention.

An important consequence of the required residency of the medical superintendent was that his presence would lead to a continuous senior medical attendance on site. It also led to personal interaction between the superintendent and the patients, which propagated the familial atmosphere, as desired by the tenets of moral therapy.[46] The medical superintendent was the patriarchal figure, on hand to administer stability and security by his presence and the asylum population was his family. The idealistic models of domestic harmony for the asylum populations were obvious in a literal sense too. The necessity to have the superintendent living in close proximity to his charges, meant that his family home would need to be within the asylum precincts.[47] In this respect, the superintendent's family and home could be said to act as a model of an ideal and moral family, adding a sense of everyday "ordinariness" of life to the asylum community. The idea of the asylum as a family home was reflected through the domestic lives of the medical superintendents reviewed here. Charles Hood and his wife raised their young family at Bethlem, with his two younger children being born there. Dr Rogers of Rainhill, Dr William Orange and Dr David Nicolson at Broadmoor, were all single on their original appointments to their respective asylums, marrying whilst in office and then raising their families on the site of the asylum. The extended Finch family lived at Fisherton House, or in houses in the grounds of the Asylum, for the whole of the nineteenth century and into the early twentieth century.

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[46] Hide, *Gender and Class*, p. 52.

[47] Ibid., p. 52.

The appointment of Dr William Charles Hood as Bethlem's first resident physician in 1852, came in the wake of the publication of a damning report on Bethlem's regime.[48] Hood was an ardent advocate of non-restraint and he took on the task of improving the medical administration and practice in the Hospital. By his early death in 1870, he had introduced extensive reforms, successfully introducing non-restraint and basic occupational therapy. [49] The changes owed a lot of their success to Hood's enthusiastic, hands-on approach. This is evidenced by the fact that, after his death and the loss of his influence, there was an increase in the use of seclusion and mechanical restraint was re-introduced.[50] An important differential between Hood and his predecessors at Bethlem was his and his family's residency at the Hospital. In an 1857 article in Charles Dickens' *Household Words*, journalist Henry Morley commented upon the fact that he had observed Hood's children playing with some of the patients in the gardens. "They [the children of Dr Hood] are trusted freely among the patients … sufferers feel that surely they are not cut off from fellowship … not objects of harsh distrust – when little children … play with them and prattle confidently in their ears." In his lay opinion, he continued somewhat fulsomely, that the presence of "the resident physician's family" was an "embodiment of the good

[48] In 1835, Dr Alexander Morison was appointed as one of two inspecting physicians to Bethlem. He held the position at Bethlem in addition to his private practice and to similar roles in other Surrey asylums. Morison was not totally in favour of moral management or treatment, for instance, he did not advocate the total abolition of means of restraint such as straitjackets. In 1852 he was embroiled in a controversy over the treatment of Bethlem patients and at the ensuing Commission of Inquiry, details emerged of his remoteness from the day-to-day management of hospital affairs. He retired from his post in 1852 and was replaced by Dr Charles Hood. "Biography - Alexander Morison", www.museumofthemind.org.uk (Bethlem Royal Hospital).

[49] Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker & Keir Waddington, *The History of Bethlem* (Abingdon: Routledge, 1997), p. 484.

[50] Ibid., p. 484.

spirit that had found its way into the hospital." [51] The presence of Hood's family also gave a sense of "normality" to the campus, encouraging social interaction between patients and other persons. Hood's practical reforms at the Hospital were a demonstration of his perception of himself as a responsible *paterfamilias*. This perception was driven by his belief in treating the patients with care and kindness.

Hood's reforms at Bethlem impacted on the administration and protocols of the ancient institution of Bethlem. If the force of his personality, as it has been said, influenced the reforms and changes, it could follow that his personal beliefs and experience would have an effect on the individual treatment of his patients.[52] His professional writings and notes infer that, in his opinion, paternalistic nurturing would lead to the cure and release of Bethlem's patients. The criminal and incurable inmates benefitted from his changes but they were not the principle target group of patients. It should be noted that his changes were mainly made to make the hospital more attractive for patients who were used to a certain comfortable standard of living.[53] During his time in office, the pauper and criminal patients were gradually replaced by men and women of education and culture. One of Hood's aims for the hospital was that it should be "an institution for the reception and cure of no person who is a proper object for admission to a county asylum." In other words, not paupers but the "educated working-class" and members of the "impoverished middle-class", such as clerks, bookkeepers, governesses and such people who had "broken down … checked by sudden failing of the mind".[54] Achieving this aim of helping "the poor, though

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[51] *Household Words* (15 August 1857), p. 147.

[52] Colin Gale & Robert Howard, *Presumed Curable: An illustrated casebook of Victorian psychiatric patients in Bethlem Hospital* (Petersfield: Wrightson Biomedical Publishing Ltd, 2003).

[53] Wm. Charles Hood, *Statistics of Insanity. A Decennial Report of Bethlem Hospital from 1846-1855* (London: Batten, 1856) quoted in Andrews et al. *History of Bethlem*, p. 496

[54] *Household Words* (15 August 1857), p. 149

educated and the insane of the middle-class", was assisted by the opening of Broadmoor and the complete removal of criminal patients by the end of 1864. [55] Many of the new patients could afford to pay for their keep and the improved amenities at the Hospital gave them, as far as possible, the comforts to which they had been accustomed in their own homes.

William Orange was the Deputy Medical Superintendent at Broadmoor when he married in 1864.[56] He and his wife were described as "an ideally happy and domesticated couple, given to hospitality and cheerful entertainment of friends and neighbours." [57] They had five children: four daughters and a son, all born at Broadmoor during Orange's tenure.[58] By paying attention to the intellectual progress and education of his children and his daughters in particular, Orange followed a characteristic pattern of behaviour for professional men such as doctors and the clergy.[59] His daughter, Margaret, followed in his footsteps into the field of mental science. In 1897, she was appointed as an assistant medical officer on the female wards

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[55] Wm. Charles Hood, *Statistics of Insanity. A Decennial Report of Bethlem Hospital from 1846-1855* (London: Batten, 1856) quoted in Andrews et al. *History of Bethlem*, p. 496

[56] Mark Stevens, *Broadmoor Revealed: Victorian Crime and the Lunatic Asylum* (Barnsley: Pen & Sword Books Ltd, 2013), p. 55.

[57] David Nicolson, "Obituary: William Orange, CB, MD and FRCP. Official and Personal: An Appreciation" *The British Medical Journal* (13 January 1917), p. 69.

[58] His son went to Winchester College and Oxford. His four daughters variously attended Brighton Ladies' School, Cheltenham Ladies' College and Kensington High School. One went on to Girton College, Cambridge and another to the London School of Medicine for Women.

Richard Lansdown, "William Orange CB, MD, FRCP, LSA; A Broadmoor pioneer". *Journal of Medical Biography*, vol.23, issue 2 (2015), pp. 114-22.

[59] John Tosh, *A Man's Place. Masculinity and the Middle-Class Home in Victorian England* (New Haven & London: Yale University Press, 2007), p. 66.

at Claybury Asylum, Essex.[60] Unfortunately and with tragic irony, she was forced to resign in 1901, following two vicious attacks by patients. Her father had resigned his post in 1886, in consequence of a patient assault in 1882.[61]

Orange's successor at Broadmoor, David Nicolson, was a Scottish Presbyterian, who came to the hospital through the prison service. Nicolson also enjoyed a stable home life raising three daughters at Broadmoor and fully involving his wife and family with the asylum.[62] He was known to entertain the occasional patient at the family home. Dr Pat McGrath, the medical superintendent in 1958, wrote in his memoirs about a conversation he had had with one of Nicolson's daughters. She told him that William Chester Minor would occasionally have dinner with the family.[63] Socialisation with the families of resident staff was considered a useful aid to a return to normal life.

An exception to the rules on residency could be found at Fisherton House. In the early nineteenth century, Fisherton House was acquired by Dr William Corbin Finch, a surgeon from London.[64] The Finch family remained as proprietors and senior

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60 In the years between 1835 and 1895 there were no female doctors working in the asylums researched. By 1899 there were ten female medical officers permanently employed in English and Welsh asylums, including Dr Margaret Orange.

61 Hide, *Gender and Class,* p. 60.

62, Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900" (Unpublished PhD Thesis, Queen Mary University London. 2013).

63 Dr William Chester Minor, the subject of the novel *The Surgeon of Crowthorne* by Simon Winchester (1984), was an American doctor confined in Broadmoor for murder and was a contributor to the first Oxford English Dictionary; Stevens, *Broadmoor Revealed,* p. 56.

64 William Corbin Finch (senior) was proprietor of three other Licensed madhouses, Laverstock House also near Salisbury, Kensington House and The Retreat on the Kings Road both in London. Fisherton House was taking private and pauper patients from 1813 and was supervised by Charles Finch, uncle of Corbin Finch Snr until the late 1840s. William Ll. Parry-Jones, *The Trade in Lunacy. A Study of Private Madhouses in the Eighteenth and Nineteenth Centuries* (London: Routledge & Kegan Paul, 1972).

management until the early years of the twentieth century. In the early decades of the nineteenth century, the asylum was managed by Finch's uncle, Charles Finch, who was not medically qualified. William Corbin Finch provided the medical gravitas needed to prove the asylum's worth as a curative institution.[65] Dr William Corbin Finch (senior) succeeded Charles Finch as proprietor and, in turn, was succeeded by his son, Dr William Corbin Finch (junior) and son-in-law, John Lush.[66] Dr John A. Lush was a nephew of Finch's wife and he joined the Finches as a co-proprietor and medical superintendent in 1862.[67] The asylum was not only the Finches' business but it was also the family home. The 1841 census shows that William Corbin Finch was living on the premises with his wife and young family, the younger William Finch being just 10 years old at the time.[68] By 1871 Dr Lush was living at Fisherton House with his wife Sarah (nee Finch) and their children. William Corbin Finch, junior, and his wife also lived at Fisherton in another house on the campus, which house was eventually incorporated into the hospital buildings.[69] Residency was not so much of a requirement for the extended Finch family as a way of life.

The Broadmoor Medical Superintendent's house, "Kentigern", was on the Asylum's estate, described in later years as "a large Victorian house a hundred yards

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65 Ibid., p. 68.

66 "Public health and medical services" in R. B. Pugh & Elizabeth Crittall (eds.) *A History of the County of Wiltshire: Vol 5* (London: 1957), pp. 318-347.

67 John Alfred Lush was a G.P. in Salisbury and became one of the proprietors of Fisherton House after his marriage to Sarah Martha Finch daughter of Dr Wm. Corbin Finch Snr., in May 1853. "John Alfred Lush", *Munks Roll*, vol. 4, Royal College of Psychiatrists, p. 204.

68 TNA, HO17/1167/250/1, 1841 England Wales & Scotland Census, Fisherton Lunatic Asylum, Fisherton Anger, Wiltshire.

69 TNA, 1871 England Wales & Scotland Census, RG10; Piece: 1952; Folio: 84; Page: 1.

from what was then the Main Gate", opposite the main walls.[70] Despite the fact that the medical superintendents were required by the terms of their appointment to reside at their asylums, the physical siting of the medical superintendents' houses in the grounds of the asylum, rather than within the main buildings, would give the men a sense of separation from their workplace. Having a little distance between work and home, might well have helped towards them enjoying a settled family life and a companionate marriage. Such households have been described as those "best served by the husband who regarded the home as the first call on his leisure but who spent his working hours elsewhere".[71] It was an accepted middle and professional class perception that the "man of a house" needed an escape from the undoubted difficulties they faced in their professional lives.

Conversely, on-site residency could be detrimental to the personal welfare of the superintendents. With a potential inability to escape from asylum affairs, to have "no hour in which he can occasionally get out of sight of his charges", the men could suffer profound effects on their wellbeing, causing damage to their fitness for office and health.[72] Charles Hood died of pleurisy in 1870 at the relatively young age of 52, his "naturally robust and vigorous constitution" was said to have been compromised by "incessant work".[73] An inspecting Commissioner in Lunacy described the position of the role of the Broadmoor medical superintendent as beingan "anxious, dangerous

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[70] Patrick McGrath, son of the last Medical Superintendent of Broadmoor Dr Pat McGrath (1958-1981), writing about his childhood home in "Memoir - A Boy's Own Broadmoor."*1843 Magazine,* (Sept/October 2012).

[71] Tosh, *A Man's Place,* p. 60.

[72] Dr Thomas Kirkbride, Superintendent of Philadelphia Hospital for the Insane, Philadelphia, P.A., U.S.A. quoted in Hide, *Gender and Class,* p. 52.

[73] Edward G. O'Donoghue, *The Story of Bethlem Hospital from its Foundation in 1247* (London: T. Fisher Unwin, 1914), quoted in Andrews et al, *The History of Bethlem* p. 487.

task."[74] The first three superintendents of Broadmoor all suffered from ill-health caused by physical attacks in the asylum. [75] In 1870, Dr John Meyer died suddenly in office from apoplexy; he had never fully recovered from an attack from a patient in 1866. William Orange was assaulted in 1882 by Henry Dodwell and it was suggested that this incident led to his resignation four years later, in 1886. His successor, David Nicolson, was the only superintendent to be attacked twice, once in 1884 and a second time in 1889. [76]

Perceptions of benevolence and paternalism.

In their professional capacity, all the medical superintendents were expected to be paternally caring and benevolent. Dr William Corbin Finch, senior, at Fisherton House and his medical staff cared for their patients but it can be argued that Finch saw himself as more of a benevolent master of a household, than a father. Fisherton House was a family-owned commercial enterprise and, in many aspects, the views and attitudes expressed by Finch were proprietorial, rather than patriarchal. Finch was very protective of the welfare and health of his patients but he was also very sure of his own integrity and reputation. He was not just unapologetically self-protective but also defensive of the care in Fisherton, particularly in the handling of criminal patients. In 1854, concerns were raised by the Visiting Justices over "criminal lunatics associating with pauper (not private) patients."[77] Dr Finch wrote a report for the Home Secretary in which he defended the practices of the Asylum, particularly in regard to the employment of female criminal patients. He advised that they were indeed employed

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[74] "Memorandum of Inspection", *Annual Reports upon Broadmoor Criminal Lunatic 1889* p. 10.

[75] Stevens, *Broadmoor Revealed,* p. 23.

[76] Ibid., p. 23.

[77] FHAA, J7/131/1, Correspondence: Criminal Lunatics, "Copy of Visiting Justices Entry 19 December 1853".

"at Needlework, in the Laundry, in the Kitchen and even in my own nursery". [78] His reason for the seeming lenient treatment was that he believed that these particular women were "a better class of criminals". He further justified the situation saying, "I have yet to discover what evils have come from this practice (a practice too pursued, I believe, in every Asylum in England – excepting Bethlehem [sic] Hospital)". [79]

In the same report, Finch describes his institution's view and treatment of criminal patients. He wrote that, in Fisherton, there was "an absence of all restraint" and that, "in seven years, the time the Criminal Patients have been under my care [there have been] no suicides." He continued, "every possible effort is made to keep criminal patients in perfect security." [80] The criminal patients in Fisherton House had been sent there because they were regarded as "less dangerous" and Finch believed he was justified in preparing them for possible discharge back into the community. In Chapter 7, in my exploration of the protocols of release and pardon, I specifically return to the discharges from Fisherton House as they differed from those of other asylums.

While some patients, such as Elizabeth Pryce, viewed the medical superintendent as a kindly father figure, others saw him more as a protective benefactor. This aspect of the medical superintendent's role commanded dutiful respect, rather than filial devotion. Correspondence in the Broadmoor files from discharged patients and from those hoping for discharge, was written in a deferential manner. Elizabeth Harris wrote to Orange in 1872, after her initial release saying, "I cannot find the words as I could wish to thank you for your great kindness to me."[81]

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[78] FHAA, J7/131/1, Correspondence: Criminal Lunatics, "Letter dated 2 January 1854 to H. Waddington, Under Secretary of State signed Wm. Corbin Finch".

[79] FHAA, J7/131/1, Letter, 2 January 1854.

[80] FHAA, J7/131/1, Letter, 2 January 1854.

[81] BCLA, D/H14/D2/2/2/189/6, Case File: Elizabeth Harris "Letter dated 16th April 1872".

In her request for discharge to "Dear Husband & Darling Children", Sarah Bates wrote, "What I will know you carnt [sic] do all for me but you kindly do what you can."[82] Amelia Burt, who was originally in Bethlem then transferred to Broadmoor, wrote on her release in 1870 after seventeen years in confinement, that she was "truly sensible of the care and the kindness I have received for so many years".[83] The same regard can be seen in communications from family and kin, even after the death of their family member. In 1916 Alfred Freeman, son of Sarah Freeman, wrote, "To the Superintendent. Dear Sir, I am taking the liberty to write to thank you … for the great kindness that was shown to my Mother … through her illness and her long stay … I felt it my duty to write has [sic] we could not come again [to Broadmoor]."[84]

The role of the medical superintendent as a protector and benevolent mentor, is clearly apparent in the case of Elizabeth Harris.[85] She was admitted into the Asylum on 10 January 1872, after standing trial at the Old Bailey for the malicious wounding of her two girls and being found "not guilty but insane. To be detained at her Majesty's pleasure."[86] A memorandum in her case file attributed her insanity to "exhaustion caused by profuse haemorrhaging accompanying a miscarriage."[87] In March 1872, she was released from Broadmoor but by the middle of April she was writing to Dr Orange asking for help. "I think you would not say coming home had improved me … for truly I am not nearly as well as I felt when I left Broadmoor. I cannot tell why for I

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[82] BCLA, D/H14 2/2/2/303, Case File: Sarah Bates, "Letter to William Orange, 12 July 1884".

[83] TNA, HO18/350, Criminal Petitions: Series II. "Amelia Burt, Letter to Secretary of State at the Home Office 28 February 1870".

[84] BCLA, D/H14/D2/2/2/299, Case File: Sarah Freeman, "Letter from Alfred Freeman. 24 July 1916".

[85] BCLA, D/H14/D2/2/2/189, Case File: Elizabeth Harris.

[86] OBP *Old Bailey Proceedings Online*. January 1872, trial of Elizabeth Harris (35) (t18720108-156).

[87] BCLA, D/H14/D2/2/2/189/20, Harris, "Memorandum dated August 1872".

use every means in my power to keep well." Her husband was a very exacting man and the staff at Broadmoor felt that his demands on Elizabeth had exacerbated her exhaustion and depression. In the same letter, Elizabeth said, "I am sometimes so weary of myself … I should be right glad to be sent away anywhere." [88] It was arranged for Elizabeth to spend some time with a community of Anglican sisters in their "House of Mercy" at Clewer near Windsor from May 1872.[89] The aim was to gradually prepare her for return to her home by undertaking gentle household tasks, without too much interference from her husband. The medical officers, led by Orange, believed that active and protective intervention was needed to maintain her sanity and stop her sliding into melancholy depression. Elizabeth Harris did eventually return to her family in 1873, staying in correspondence with Orange, who regularly assisted the family with small financial donations and practical help.[90]

Although many of Broadmoor's patients and family appear to have had warmth and respect for the medical superintendents, there were those who did not, believing the medical men to be part of a conspiracy denying them freedom. Mary Bennett wrote directly to Orange, "I see you as the sole fault of my being here … a lifetime you have had out of me … I do blame you that I am not at my house."[91] Sarah Bull wrote, "It seems as if Dr Orange has quite made up his mind to keep us here for life … I fear I shall never get out of this living tomb."[92] Sadly this was in her suicide

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88 BCLA, D/H14/D2/2/2/189/6, Harris, "Letter 16 April 1872".

89 BRO, D/EX 1675, Records for The House of Mercy, Clewer, Windsor. TheCommunity of St John the Baptist was an Anglican religious community established in 1852 Clewer to run a home for unmarried mothers and fallen women.

90 BCLA, D/H14/D2/2/2/189, Harris.

91 BCLA, D/H14 2/2/2/111, Case File: Mary Bennett. "Letter to William Orange (undated)".

92 BCLA, D/H14 2/2/2/316, Case File: Sarah Bull, "Handwritten note 1883". I revisit Sarah Bull's history in more detail in Chapter 7 when I discuss the circumstances surrounding deaths in the asylums.

note, thereby apportioning some of the blame for her depression to the refusal of the medical staff to consider her fit for discharge. Orange's subsequent reports on her case, reflect a sense of failure on his and his staff's behalf, in not protecting their mentally fragile patients.[93]

Families would also express dissatisfaction with the treatment their wives and mothers received in the asylums. Richard Harris wrote to Dr Orange in 1873 during his wife Elizabeth's stay in Clewer, expressing his dissatisfaction with the situation. He demanded her return, saying, "I was willing for my wife to have 3 months holliday [sic] to recruit [sic] her health and I must say … that would be quite sufficient but according to Dr Grieve there is very little chance of her return for some while." He concluded his letter, "I … pray that my wife will not be unnecessarily kept away from those duties which it is justly required of her." [94] Orange, while acknowledging the contemporary belief that the best place for a wife and mother was in the centre of her family, also understood that in certain cases it was better for her to be distanced from domestic pressures. In a memorandum about Elizabeth Harris's case, he stated, "the husband … is far from judicious and it would not be prudent to trust her to his care."[95]

In most cases, the medical superintendents believed that, where possible, husbands should shoulder some of the responsibility for the patient's future mental and physical health if she were discharged. Generally, as noted in the previous paragraph, the asylum medical staff accepted the contemporary social belief in a woman's place being in the home and this was frequently referred to in case books and files. Medical reports within the Broadmoor case files express this belief, with statements such as, "it is a sad thing for a wife and mother to be separated from her

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[93] BCLA, D/H14 2/2/2/303, Case File: Sarah Bates, "Letter to William Orange 12 July 1884".

[94] BCLA, D/H14/D2/2/2/189/1, Harris, "Letter from Richard Harris dated 16 July 1872".

[95] BCLA, D/H14/D2/2/2/189/20, Harris, "Memorandum dated August 1872".

family" and that, "she is capable of attending to her domestic affairs at home".[96] The doctors would also lay the blame on the spouses for their wives' mental deterioration if it were thought that they, the husbands, were shirking their marital obligations as guardians, providers and carers. In this way, the medical superintendent's position as *paterfamilias*, or benevolent mentor, appears to have extended to the families of patients and particularly towards the husbands. Once the women were in the safety of the asylum, the protective functions were assumed by the medical superintendents, as part of the paternalistic expectations of the post. Husbands could find themselves rebuked if it were felt that they were neglecting their spousal duties. For instance, William Allen, husband of Bethlem transferee Sarah Allen, steadfastly refused to write to or visit her after her transfer to Broadmoor in 1863. Dr Meyer wrote to him, "it appears that it is 8 years since you last saw her and you might find that during that long period a considerable improvement … in her mental condition."[97]

Some women treated their spouses with repugnance, believing them to be the cause of their troubles. Mary Ann Taylor was in Rainhill suffering from puerperal mania after the birth of her second child. She appeared "very fond of her baby" but she had attempted to throw her eldest child out of the window. She also "had taken an aversion to her husband who she called an assassin." After six months of treatment her bodily and mental health improved but despite this, it was noted "she still has the same aversion to her poor husband." [98] When wives appeared unreasonable in blaming their husbands for the circumstances of their incarceration, the expressed opinion of

[96] BCLA, D/H14/D2/2/2/259, Case File: Elizabeth Carr, "Letter 26 September 1877": D/H14/D2/2/2/251, Case File: Martha Baines.

[97] BCLA, D/H14/D2/2/2/2, Case File: Sarah Allen, "Letter from Dr John Meyer. May 1872".

[98] LVRO, LCLAR, M614 RAI/8/1, Case books: Female Patients, Mary Ann Taylor, ff. 109-112.

medical officers seem to carry a note of a sympathetic, almost personal, identification with the spouse.

The medical superintendents were aware of the threat of domestic trouble and possible violence within the homes of patients, so would try to act to protect the vulnerable. As mentioned in the case study which opened this thesis, Mary Ann Beveridge's insanity was attributed to the abuse she had suffered at the hands of husband. The case notes on her background, written around the time of her admission to Bethlem in 1856, note that, "About 9 years ago she suffered from great depression of spirits in consequence of the ill-treatment of her husband & whilst in this state, destroyed one of her children." The notes continued, "Her husband's continued unkindness brought her again into the same state of mental unsoundness and she killed another of her children."[99] The author of the notes was Hood, who was clearly acknowledging that an abusive spouse and domestic difficulties were the main causes of her mental illness, not her blindness or general health. Throughout her Bethlem case notes, subsequent medical men show compassion towards her. As I noted in the introduction, she was not transferred out of Bethlem to Broadmoor in 1863, nor was she considered for release, presumably from a reluctance to return her to a potentially dangerous situation. She became an "incurable patient" and notes in the "Incurable Casebook" categorically state that she was no longer insane. In 1864 she was "quite sane, gentle in her behaviour and very grateful for all that is done for her."[100]

Medical superintendents placed importance on the significant effect the relationships of friends and families with the patients had on the cause of mental illness. Maria Chitty was admitted into Bethlem in 1852, for the murder of her child.[101]

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[99] BHRA, CBC-03 Incurable & Criminal Patient Casebook 1850-57, Mary Ann Beveridge f. 160.

[100] CB-063 Incurable Patients Book 1805-1893, Mary Ann Beveridge, f. 123.

[101] BHRA, CBC-03 Maria Chitty, f. 38.

Her husband, William, was seen as the root of her mental breakdown. Hood laid some blame on "her husband's conduct [which] was to some extent the cause of her mental derangement." [102] He was regularly admitted to the Hospital. On his first admission in 1851, he was described as "a very dangerous lunatic". His insanity was ascribed to "Hereditary indisposition, intemperance & general indulgence of the passions." Chitty had reportedly "threatened his wife & son – he bought a large pointed knife and has been using fire arms in idle sport." [103] Charles Hood referred to this insane conduct in Maria Chitty's own case notes, although there is no direct reference to William's stays in the Hospital.[104] On William's next admission in 1853, the case book notes do refer to Maria stating that she was "in the Criminal Dept. [sic] ... for destroying her child."[105] William Chitty was re-admitted in 1860 and once again in 1867, each time at the request of their surviving children. There was obvious disharmony in the household caused by the insanity of both parents and this was noted in detail by the medical staff at Bethlem. It was explicitly stated on William's 1860 admission, that he and Maria had lived together "quite comfortably" for a while, after she had received her free pardon. Early in 1860, she had shown "some signs of mental disorder" and this had caused him to drink and "his mental symptoms [to] appear".[106] Maria died in 1863 and, in April 1867, William was once again admitted to Bethlem. He returned home in December of that year.[107] William appeared to have lived with his son Henry and his family from that date forwards, until his death in 1878.[108]

[102] BHRA, CBC-03, Maria Chitty, f. 38.

[103] BHRA, CB-052, Male Patient Case book 1851-52, William Chitty, f. 44.

[104] BHRA, CBC-03, Maria Chitty, f. 38.

[105] BHRA, CB-060, Male Patient Case book 1853, William Chitty, f. 52.

[106] BHRA, CB-076, Male Patient Case book 1860, William Chitty, f. 15.

[107] BHRA, CB-090, Male Patient Case book 1867, William Chitty, f. 28.

[108] TNA, 1871 England Wales & Scotland Census. RG10; Piece: 8122; Folio: 13; Page: 18.

Rebecca Loveridge was admitted to Broadmoor in 1884, after drowning her youngest child and attempting suicide. On her admittance, the cause of her insanity was attributed to "hereditary & domestic trouble (husband drank & ill-treated her)".[109] Rebecca had been treated very badly by her whole family. In an early report, Dr Orange wrote "her elder children have been the source of much worry to her ... the two eldest boys instead of doing the work ... would play ... she would do the work for them in addition to her own housework ... her eldest daughter [was] often saucy to her."[110]

The history of domestic troubles, abuse and familial economic circumstances were important to the asylum authorities, when a patient was assessed for discharge. These circumstances took on a greater significance as the century wore on and appear to have been quite critical to decisions made at Broadmoor. An important factor in those decisions was that the future guardians should be emotionally capable of caring for a vulnerable patient, able to keep them safe and to guard against potential relapse. These evaluations are analysed in detail in the next chapter but here they cast a light on the authorities' perceptions of the patients' social circumstances. By getting assurances that there would be suitable supervisory care and support for released patients, the asylum authorities were seeking to safeguard the future lives of their charges. If the safeguards were seen to be too weak or unworkable, then the female patients would be retained in asylum care. Chapter 7 contains a detailed investigation and analysis of the circumstances and protocols surrounding release from, or retention in, the asylums discussed in this thesis.

David Nicolson believed that society in general, as well family and kin should shoulder some responsibility for the care of criminal lunatics, irrespective of social

[109] BCLA, D/H14/D2/2/2/365, Case File: Rebecca Loveridge, "Schedule A".

[110] BCLA, D/H14/D2/2/2/365, Loveridge, "Report August 1884".

status. His argument was, if society accepted that "some portion of our criminal lunacy is preventable, we … establish that it is … the … practical responsibility of society … to prevent the performance of criminal acts by insane … members of the community."[111] The issue of social responsibility and the criminally insane, particularly for the 288 mothers of my dataset, is discussed Chapter 7, in the context of potential discharges from asylum care. In many cases, perceptions of social responsibility informed the official discussions and consideration, around the release of criminally insane mothers. Nicolson believed that society had a responsibility to be watchful over its mentally vulnerable members;

> … If we were to tot up the amount of crime committed by lunatics under such circumstances [intentional or unintentional neglect], … we would speedily realize … how grave the *duty* of society becomes, in regard … to the proper care of the insane … [112]

Respectability

As I outlined in the Introduction, there is an argument that suggests that the aim of asylum treatment was not to cure patients but also to instil and restore socially acceptable behaviour. For female patients this would be a restoration of such "womanly" virtues as modesty, deference and docility; an essentially idealistic middle-class view of womanhood.[113] This middle-class ideal was a caring, dependent,

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[111] Nicolson, "Individual and Social Responsibility". p. 272

[112] Ibid., p. 264.

[113] Lisa Appignanesi, *Mad, Bad and Sad: A History of Women and Mind Doctors from 1800 to the Present* (London: Virago Press, 2008); Anne Shepherd. "The Female Patient Experience in Two Late-Nineteenth Century Surrey Asylums" in Jonathan Andrews & Anne Digby (eds.) *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004) pp. 223-

emotional and passive woman "looking on the outside world from the safety of her domestic realm."[114] A "god-fearing", moral and respectable household was one of patriarchal authority, with the mother as "the keeper of her husband's conscience and controller of her children's moral destiny".[115] Whether or not the medical superintendents were influenced by their personal social background and beliefs, these concepts of acceptable and respectable female behaviour appear to filter through into the asylums and to have, consequently, impacted on the lives of the patients. Martha Baines was the wife of a chemist from Kendal who had poisoned her five-month old baby with bleach. [116] Her eighteen-month stay in Broadmoor, from December 1875 to August 1877, was relatively short. The doctor's report recommending her release suggest that, in his opinion, Martha Baines' future safety appeared to be assured because she was "in a respectable position in life & her husband is able & willing to provide for her".[117]

Often, for many differing reasons, the patients' respectability, domestic and personal, was of more importance to the medical officers than where the patients stood on the social scale. [118] For the most part, the medical men were from the conventional professional class and enjoyed stable, middle-class domestic circumstances. As the chief medical and executive officers of their respective institutions, they represented the asylum to the outside world and commanded some social standing. William

248; Elaine Showalter, *The Female Malady. Women, Madness and English Culture 1830-1890* (London: Virago Press Ltd, 1985).

[114] Hide, *Gender and Class,* p. 8.

[115] John Tosh, "New Men? The Bourgeois Cult of Home"in Gordon Marsden (ed.) *Victorian Values: Personalities and Perspectives in Nineteenth Century Society* (Abingdon: Routledge, 2014), pp. 87-91.

[116] BCLA, D/H14/D2/2/2/251, Case File: Martha Baines.

[117] BCLA, D/H14/D2/2/2/251/3, Baines, "Report to Secretary of State at the Home Office (draft) 24 July1877".

[118] Shepherd, *Institutionlizing the Insane,* p.173.

Orange came from a strong Huguenot background which upbringing might have had an effect upon his view of family life and on the woman's role therein.[119] Dr Charles Hood was the son of a doctor and as previously mentioned, the Finch family was a medical dynasty, specialising in caring for the insane. They were all married to daughters of either professional men, or minor landed gentry and their households could be described as middle-class in nature. They also had some level of social standing in their local areas.[120] Generally, the majority of female patients in the asylums were from the lower-middle and working classes. [121] For the early years of the period studied, Bethlem held all classes of patient but after the 1864 removal of criminal lunatics to Broadmoor, there were more middle-class patients and fewer from the working class. [122] Broadmoor was created to hold just criminal lunatics, regardless of background and as shown previously, the female population was predominantly working-class, with a few middle-class and no upper-class patients. [123]

Social background and status appear to have impact on asylum attitudes, when dealing with criminal lunatic mothers. Two cases at Bethlem admitted in the 1850s are possibly a demonstration of this impact. Catherine Savell, the wife of a linen draper, was admitted to the Hospital in June 1854 and Martha Ann Lewis was admitted in 1859. Both women were pardoned and released within three years of admission.[124] Catherine Savell's case book notes report that, when she drowned her baby, her spirits

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[119] Lansdowne, "William Orange CB, MD, FRCP, LSA", pp. 114-115.

[120] For example; William Corbin Finch Snr was Mayor of Salisbury in 1842. John Lush was elected Member of Parliament for Salisbury in 1868, which seat he held the seat until 1880. ("Obituary. John Alfred Lush, M.D., F.R.C.P." *Journal of Mental Science*, vol. 34, no. 147, p. 471).

[121] Anna Shepherd, *Institutionalizing the Insane*, p. 42.

[122] Gale & Howard, *Presumed Curable*, Introduction.

[123] David Cannadine, *Class in Britain* (London: Penguin Books, 1998), p. 90-91.

[124] BHRA, CBC-04, Criminal Patient Case Book 1857-1862, Martha Ann Lewis, f. 132.

were so low that, "her husband had been strongly recommended to place her in some asylum" but he had not done so.[125] He had arranged for their servant and Catherine's grandmother to stay with her and their other child. The family background appears to have been a comfortable one. [126] It was noted that she did not show any signs of insanity on admission and that, "since her trial th[e] depression has passed off … no symptoms of a disordered mind has been shown".[127] As described in the previous chapter, Savell was tranferred to, and back from, Brixton Gaol seemingly pregnant. Whether she had suffered a phantom pregnancy, or it was an attention-seeking charade, the incident was not referred to again for the remainder of her stay. In 1856 Catherine Savell received a royal pardon and was released to the care of her husband on 23rd July of that year.[128]

Twenty-four-year old Martha Lewis, the wife of a respectable artisan, William Lewis, a master shoemaker, was admitted to Bethlem in 1860. It was written that, in 1859, "soon after her accouchement … she destroyed her [two] children" and had subsequently been diagnosed as suffering from puerperal mania at the time. [129] It was noted that she was now showing "no signs of mental disorder." Martha was "a prepossessing young woman in appearance and manner" with an "amiable appearance" and "educated". [130] Over the next two years until her pardon in 1862, she was variably described as being "in good health", "industrious" and "very well-conducted".[131] Martha was not a middle-class patient but she was certainly from the respectable educated working class desired by the Bethlem authorities. As a victim of

[125] BHRA, CBC-03, Catherine Savell f. 105.

[126] BHRA, CBC-03, f. 105.

[127] BHRA, CBC-03, f. 105.

[128] BHRA, CBC-03, f. 105.

[129] BHRA, CBC-04, f. 132.

[130] BHRA, CBC-04, f. 132.

[131] BHRA, CBC-04, f. 132.

puerperal insanity, which was believed to be one of the most treatable of insanities, Martha would be treated well.[132] She also earned his regard through her behaviour and he was active in securing her release within a short time-frame. She received a royal pardon on 24th April 1862 and returned home to her family. [133]

Savell and Lewis were patients at Bethlem in the period when Charles Hood was Resident Physician and Superintendent. They were young married women who had relatively short careers in Bethlem and they were released back to the care of their families, despite committing "a deed at which humanity shudders".[134] The reasons behind their release possibly lie in the Hospital's (Hood and his medical team) view of their social status as respectable wives and mothers. Both were said to have committed their murders while insane and that their insanity was due to "puerperal causes". [135] As on admittance, in both cases, the women were said to no longer be displaying any signs of insanity, a situation which did not change throughout their stays, they were to all intents recovered from their madness. This would be expected of puerperal insanity, as it was generally considered as a temporary and curable mental condition.[136] In the doctor's eyes, they were cured and, therefore, could be trusted and released.

The case of Catherine Dawson is an illustration of how a medical superintendent's perceptions could influence a patient's asylum life. Catherine Dawson was eventually transferred from Rainhill to Broadmoor, having been initially

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[132] Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004), p. 139.

[133] BHRA, CBC-04, f. 132.

[134] Lord St Leonards quoted in the "Editorial" *Morning Advertiser* (1 May 1856), p. 4, col. 3. Also quoted by Hood, *Suggestions for the Future Provision of Criminal Lunatics*, p 163.

[135] BHRA, CBC-03, f. 105; f. 132.

[136] Marland, *Dangerous Motherhood*, p. 200.

admitted to Rainhill in 1862.[137] In 1864, she was re-admitted to Rainhill as a criminal lunatic, after she killed one of her children.[138] She escaped shortly afterwards and remained at large for some months, hidden by her family. Dr. Lawes Rogers wrote in his 1865 Annual Report that, "[Dawson] was considered to be a very dangerous person to be at large, persevering efforts were made to find her … frustrated by the connivance of her husband and sister." [139] Catherine was eventually found but only after her husband and sister had been brought before a magistrate and threatened with legal action. [140]

Once in Rainhill, she appears to not have received the same degree of understanding as other pauper patients who were considered to be of a more "respectable" backgound. Catherine's case book notes unsympathetically refer to her as "this woman" and as being "a source of great anxiety to those having charge of her". Her appearance was described as " a very low condition & looks a picture of misery." [141] From her notes it becomes clear that she was thought to be one of the undeserving poor. Catherine was Irish and the wife of an itinerant labourer, which, in Rainhill, could have counted against her. Irish patients were seen as being highly troublesome and problematic to control.[142] In 1866, Dr Rogers noted how "the character of a large proportion of the patients in this Asylum, being drawn from the

[137] BCLA, D/H14/D2/2/2/113, Case File: Catherine Dawson.

[138] LVRO, LCLAR, M614 RAI/8/3, Case Book: Female Patients 1856-1860, Catherine Dawson, ff. 65-66.

[139] LVRO, LCLAR, M614 RAI/40/28/1, Thomas L. Rogers. "Report of the Medical Superintendent. Annual Reports Lancashire County Asylum at Rainhill 1865-1870", pp. 102.

[140] Ibid.

[141] LVRO, M614 RAI/8/3, Dawson, ff. 65-66.

[142] Catherine Cox, Hilary Marland & Sarah York, "Emaciated, Exhausted and Excited: The Bodies and Minds of the Irish in Nineteenth-Century Lancashire Asylums", *Journal of Social History*, vol. 46, no.2 (2012), pp. 500-524, p. 503.

Irish quarters in Liverpool, is intrinsically bad and their mental condition such as to afford no hope whatever of ultimate recovery."[143]

While there is no doubt that Dr Rogers felt she was a fitting candidate to be in Rainhill, there is a sense of exasperation in his attitude towards her and her lack of gratitude for her care. There is an element of condescension, possibly class or ethnically driven, in Catherine's notes towards her domestic circumstances. The case notes give the sense that to start with, he was trying and wanting to help, but ended up being frustrated with both Catherine and her family. They were not doing anything to help themselves or her cause. [144] Professionally, Dr Rogers would be inclined to have more compassion for and care more about, compliant patients, than for patients like Catherine. Neither she nor her domestic circumstances were considered respectable and she appeared to have not held any interest in being helped to recovery. [145]There was probably also some self-recrimination and annoyance that she had absconded from the asylum, while under his charge. It is noticeable that Rogers was thankful, and relieved, when the Home Office decided to transfer her to Broadmoor as "unfit to plead". [146]The final comment on Catherine's Rainhill notes were written after her transfer to Broadmoor. It was somewhat acerbic, saying, "one unfortunate result following this temporary absence from restraint … she has given birth to a child." [147]

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[143] LVRO, M614 RAI/40/28/1, "Report of the Medical Superintendent" (1866), p.106.

[144] LVRO, M614 RAI/8/3, Dawson, ff. 65-66.

[145] LVRO, M614 RAI/8/3, Dawson, ff. 65-66.

[146] TNA, H.O. 8/179 England and Wales, Prison Registers 1770-1935, "Quarterly Returns of Female Patients in the Broadmoor Asylum. !8 March 1869", f. 73, reg no. 113, Catherine Dawson.

[147] LVRO, M614 RAI/40/28/1, "Report of the Medical Superintendent" (1866), p. 105.

Conclusion

The institutional view of the patients could be driven by resistance to or compliance with treatment and care and by their responses towards the medical staff. The medical superintendent was the head of his institution, the man in charge and by its nature, his position should have commanded respect. Any emotional engagement between him and his patients would be patriarchal in nature and not one of social equality. His compassion came from a middle-class understanding of life and relationships and from his experiences in working with the insane. The desired aim of all the medical superintendents was to, ultimately, restore the women to stable and safe home lives, while recognising that the women's position within those homes would have changed. A mother who had murdered her child had offended against the accepted criteria of respectability amongst their peer group and against society in general. Rather than being capable of managing the household and nurturing the family, they would now need to be looked after and be managed themselves, to ensure that there would be no relapse into insanity. The respectability of a household and the capability of its members to provide that protection were important aspects when the authorities were considering potential release from protective incarceration.[148]

As quoted at the beginning of the chapter, Charles Mercier's description of a medical superintendent is an ideal that many would strive for. As a medical superintendent himself, Mercier's words could be interpreted as a validation of the function he and his colleagues served. Alternatively, it could be a description of the aspirations of highly professional medical men. The cultivation of good interpersonal skills was a powerful addition to any doctor's armoury but in the field of mental health care it was of vital importance. The medical superintendents could be said to encapsulate the middle-class, professional and masculine virtues of rationality, ethical

[148] Anna Shepherd, *Institutionlizing the Insane*, p.173.

firmness and compassion. They were not attempting to cure bodily illnesses but they were attempting to alleviate and cure mental infirmities. Once the homicidal mothers had been committed by judicial process to an indefinite stay in the asylums, their continuing captivity or possible freedom lay in the hands of the medical superintendents.

Asylum patients' conduct was frequently described as juvenile and, it was thought, they needed disciplined "parental" order to control the childish elements of their behaviour. Patriarchal rule, or paternalistic discipline, in the asylums was not necessarily about oppression but was thought of as a necessary method of control for restless and difficult patients. Inmates who began to exhibit signs of rational and calm behaviour were more likely to be viewed favourably and receive reward for their conduct. This protective and somewhat patronising, component of the asylum staff's care impacted on the experiences of the women of my sample group in the asylum and on their future lives if released. The authority of the medical superintendent who replaced a husband, a father, relatives, employers and friends, reigned supreme over the patients' lives.

This was apparent in discussions surrounding female patients and, in particular, for the married mothers. The medical superintendents were accountable for their welfare until that care could be passed on to husbands or other trustworthy family members. The medical superintendents' opinions about a homicidal mother were an important factor in the relationship between him and his patients. In its turn, that doctor-patient relationship played an essential part in securing the mothers' futures, whether in an institution or in the community. The criminal lunatic asylums were duty-bound to pass their obligation for the future welfare of their discharges and the safety of the public, on to other responsible parties. The circumstances of future guardians would need to be acceptable in order that the discharged patient would be safe from harm, and from harming others. That transference of responsibility was of paramount

importance in consideration of any discharge or release, which subject is covered in greater detail in the next chapter.

Chapter 7:
"The authorities would feel nothing but pleasure in discharging her, if it be done with safety."
Discharge, return and death in the asylum.

Introduction

On 8th March 1859, an official at the Home Office wrote to the Governors of Bethlem Hospital informing them that, Sir Thomas Sotheron-Estcourt, the Home Secretary, was "disposed to advise [the] restoration to liberty" of Sarah Jackson, a criminal patient, if she had friends "able and willing to take charge of [her]".[1] Dr Hood replied saying that, as she had "been quite sane since 1852", he could see no reason for her retention.[2] After discussion with her family and local Parish Union, Sarah Jackson was released on 11 July 1859 and it was noted in the relevant casebook that "she has received the Royal Pardon and left the Hospital with her sister [to] reside in Enfield".[3]

Sarah Bates was admitted to Broadmoor on 10th February 1880, after being tried for the murder of her six-month-old daughter, Florence.[4] She had been found not guilty but insane and was to be detained until her Majesty's pleasure be known. Her

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1 TNA, HO13/106/231, Home Office, Correspondence & Warrants, Letter Book. 1859-1862, "Letter to the Governors of Bethlem Hospital 8th March 1859".

2 TNA, HO13/106/11A, Letter Book, 1859-1862, ""Letter to the Governors of Bethlem Hospital 19th April 1859".

3 BHRA, CBC-02 Incurable & Criminal Patient Casebooks. 1778-1864, Sarah Jackson f. 168.

4 *Northampton Mercury,* (17 January 1880), p. 2. col. 5.

insanity was attributed to severe melancholia brought on by over-lactation.[5] In February 1881, her husband, James Bates, began enquiring about the worth of petitioning for release, eventually receiving a positive answer in 1884.[6] Sarah was discharged from Broadmoor in June 1886 but returned after her husband asked for help.[7] For the next fourteen years the family and Sarah herself, sought permission for another release. In 1904, she was discharged to the care of her daughter and son-in-law and, at her own request, later transferred to the care of her husband.[8] Following another bout of depression and an attempt at suicide, she returned to Broadmoor in 1905, where she then remained until her death in 1911.[9]

The two cases quoted at the outset of this chapter illustrate the changes made between 1835 and 1895 to the protocols and system for the discharge of criminal lunatics from an asylum. Throughout the sixty years under review in this thesis, criminal lunatics could only be released by order of the Secretary of State at the Home Office because they were held at her Majesty's pleasure.[10] Over time, the procedures involved in obtaining a discharge evolved and became more stringent and formal. Not only did the wording and terms of the discharge warrants alter but so did the officials' expectations of the patients, their families and lives. For the years between 1835 and

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5 BCLA, D/H14/D2/2/2/303. Case File (1): Sarah Bates, "Warrant for Admission, 3 February 1880".

6 BCLA, D/H14/D2/2/2/398, Case File (2): Sarah Bates, "Letter from J. Bates, 19 July 1881; Letter from Dr Orange to J. Bates, 27 August 1884".

7 BCLA, D/H14/D2/2/2/398, Bates, "Letter from J. Bates to Dr Orange, 9 July 1886".

8 BCLA, D/H14/D2/2/2/661, Case File (3): Sarah Bates, "Warrant of Conditional Discharge, 6 July 1904".

9 BCLA, D/H14/D2/2/2/661, "Letter from Sarah Bates to Dr Brayn, 19 December 1904"; "Revocation of Warrant, 14 January 1905.

10 Jonathan Andrews, "The Boundaries of Her Majesty's Pleasure: discharging Child-murderers from Broadmoor and Perth Criminal Lunatic Department, c.1860-1920" in Mark Jackson (ed) *Infanticide. Historical Perspectives on Child Murder and Concealment, 1550-2000.* (Farnham: Ashgate. 2002), pp. 216-249, p. 224.

the 1860s, the procedure for discharge of the criminally insane was similar to the asylum discharge practice for any insane patients. [11] Official approaches concerning release would come from petitions and requests to the Crown, through the medium of the Home Office.[12] Unlike the later years, there does not seem to have been any official enquiry into the ability of family and friends to care for the released patient, just a confirmation of their preparedness to take in the dischargee.[13] In this respect, the discharge of a criminal lunatic followed similar lines to that of pauper lunatics from public asylums. The decision relied not only on medical evaluations of whether the criminal patient was now sane and recovered from insanity, but also on the willingness of family and friends to accept the woman back into the household.[14] In the early part of the period, protection of the woman's future mental health was viewed as a duty of friends and family but it was not a pre-requisite of discharge. This changed over time and the criteria altered.

In this chapter, I first examine discharges of homicidal mothers from various asylums in the years before Broadmoor's opening, to explore what investigations did take place and to ascertain whether the medical men had any influence over release. I then conduct an analysis of the discharges from Broadmoor, highlighting family involvement, changing official protocols and procedures. Once Broadmoor was firmly established, the Asylum's medical staff and Home Office officials believed they had a lasting duty of care to protect the future sanity of the discharged women and that they also had a duty to ensure public safety. Dr Orange wrote in 1885, "no persons

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[11] David Wright, "The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England: The Case of Buckinghamshire, 1853-1872" in Joseph Melling and Bill Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (Abingdon: Routledge, 1999), pp. 93-113, p. 93.

[12] Andrews, 'The Boundaries of Her Majesty's Pleasure", p. 224.

[13] Ibid., p. 94.

[14] Ibid., p. 94-95.

[…] are set at liberty under such circumstances as to render it reasonably probable that they will not again prove a danger to the community".[15] Jonathan Andrews wrote in 2002, that the dynamics of discharge from Broadmoor had rarely been examined.[16] Jade Shepherd covered the topic in detail in her 2013 thesis and by wrting this chapter, I add to and complement their scholarship. [17]This chapter illustrates how the decision-making process changed both at the Asylum and at the Home Office over a wider ranging time span and includes pre- and post- Broadmoor years. The processes and the success of asylum discharge processes impacted on the future lives of all the incarcerated criminally-insane homicidal mothers.

There were cases where the attempts by family and friends to secure a woman's discharge were unsuccessful. In the final section of this chapter, I discuss the circumstances of those women who were not released but who died in the asylum. Some were discharged but returned and then remained in the institutions until their deaths. Others were never discharged. I examine the interactions between the asylum authorities, the Home Office and the families and friends, with regard to both unsuccessful discharge requests and those who were never considered suitable for discharge. At Broadmoor, there was encouragement for the families and kin groups to remain in touch with the patients throughout their incarceration. Conversely, the clinicians kept the families informed of the health and welfare of their family member. While such interactions appear to reflect a paternalistic concern on behalf of the asylum staff, they can also be viewed as a demonstration of increasing social

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[15] William Orange, "Twenty-Third Annual Report of the Medical Superintendent", *Reports upon Broadmoor Criminal Lunatic Asylum with Statistical Tables for the Year 1885* (London: Eyre and Spottiswoode. 1887), p. 6.

[16] Andrews, 'The Boundaries of Her Majesty's Pleasure", p. 218.

[17] Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900" (Unpublished PhD Thesis, Queen Mary University London. 2013).

intervention fuelled by middle-class philanthropic ideals. There was a perception in the nineteenth century that the "better-off" classes had a responsibility for both the moral and physical welfare of the poorer sections of society. [18] As Graham Mooney observed in relation to the growing involvement of bureaucracy in areas of public health, ideas of protective domesticity were central to Victorian, mainly middle-class, ideals of the home. [19] The reactions and scrutiny of the authorities in the later years of the period reflect the intentions behind such philanthropic interventions.

The discussions contained within all casebooks and case files illustrate contemporary cultural attitudes towards these women and their families and contain valuable and illuminating material about interpersonal relationships and family life. I discuss how the recurring factor of respectability seemed, once again, to be central to the authorities' decisions. Recent studies have highlighted the part that family and kin groups played in the admission and discharge of patients in county asylums.[20] As the homicidal mothers of my sample group had been admitted into asylum care by legal process, the family unit had no influence over their entry into the institutions. However, they did have a role in the discharge process. As with concepts of respectability, there were class differences in the perception and cultural expectations of the family unit. [21] Where a request for discharge was successful, I include, where possible, a brief resumé of the lives of the women after discharge from the Asylum. Through the use of case-studies, I show that social and economic factors, together with

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[18] Graham Mooney, *Intrusive Intervention: Public Health, Domestic Space and Infectious Disease Surveillance in England, 1840-1914* (Rochester, USA: University of Rochester Press. 2015), pp. 15-16.

[19] Ibid., p. 16.

[20] Cara Dobbing, 'The Family and Insanity: The Experience of the Garlands Asylum, 1862-1910' in Carol Beardmore, Cara Dobbing and Steven King. (eds) *Family Life in Britain, 1650-1910* (Basingstoke: Palgrave Macmillan. 2019), pp. 135-154, p. 136.

[21] Ibid., p. 149-150.

concerns over intellectual capability and respectability, were as important as medical reports in the process to discharge from asylum care mothers who had murdered their children.

Discharge from the Asylum

Deliberations surrounding discharge and the comments made about the women, are important in building the complete story of the murdering mothers' journeys. Correspondence between the Home Office and the asylums and procedural medical reports, for instance, help to clarify understanding of cultural attitudes to this particular class of criminal lunatic. The authorities did place some emphasis on issues of public safety because, after all, the women had committed murder. Although the procedure and protocols changed over the years, there is value in analysing the interactions between the women's families and the authorities, the criteria for release and the different methods by which the discharge decisions were made. Between 1835 and the mid-1860s, patronage, third-party interest and the economic circumstance of a patient's family played a different part in the authorities' discharge decisions compared with those made in the later decades. For criminal lunatic patients the meaning of "conditional discharge" changed over next thirty years, from one where the patient herself agreed to the conditions of her release, to one where another party took on the responsibility for the fulfilment of those conditions. Up to the late 1860s, the possibility of unconditional discharge and pardon existed. Where a discharge was conditional, there was an obligation on the patient herself to accept the terms of her release. I will discuss the consequences of this in more detail later in this chapter.

Criminal lunatic patients were always under the control of the State. The implications of a "conditional discharge" at any point in the sixty-year period was that, effectively, the woman remained "under her Majesty's pleasure" and could be recalled to an asylum at any time, if she were considered to be at risk of harming herself or

others. An essential point which should be remembered is that incarcerations "at her Majesty's pleasure" were by their nature unfixed, indeterminate sentences. Legally, they would last for as long as the offender was considered to be unfit to be at large, a danger to themselves or others and for as long as they were thought to be insane, unable to take care of themselves, or be cared for by others.[22] In 1883, the Trial of Lunatics Act changed the wording to be used in court from "not guilty but insane" to "guilty but insane" which appears to have had an influence on the status of criminal lunatics; by being found guilty rather than acquitted, they became convicted offenders.[23] The following year, 1884, saw the implementation of the Criminal Lunatics Act, by which the conditions and obligations of discharge changed. Under the previous acts, the protocols around release and discharge of patients appear to have been concentrated upon those lunatic criminals who had been found insane after sentencing, or in prison.

The discharge of criminal lunatics, such as the subject women of my thesis and any follow-up on their well-being after discharge, was more ad hoc and sporadic, with no formal reporting required, possibly because they were not convicted. The 1883 Act changed their legal status and consequently, they appear to have become more confined. Their future lives, whether in the asylum or at large, were now closely monitored by the State. The 1884 Act formalised reporting procedures for both the asylum and the guardians of discharged patients. The superintendent of any asylum was obligated to report on the condition of any criminal lunatic in his care at least once a year and, in his turn, the Secretary of State would consider "the condition, history

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[22] Andrews, "The Boundaries of Her Majesty's Pleasure", p. 224.

[23] 46 & 47 Vict., c. 38 Trial of Lunatics Act, s2. By this act the verdict for cases where the defendant was found to be insane was changed from "not guilty by reason of insanity" to "guilty but insane at the time of the criminal act." This change was in response to the concern of Queen Victoria, after an assault on her person, that the verdict of "not guilty on the ground of insanity" was not a deterrent.

and circumstances of such lunatic and determine whether he ought to be discharged", at least every three years.[24] In the same section of the Act, it was laid down that reports on the condition of the discharged criminal lunatic "shall be made to a Secretary of State by such persons at such times and containing particulars as may be required by the warrant of discharge".[25]

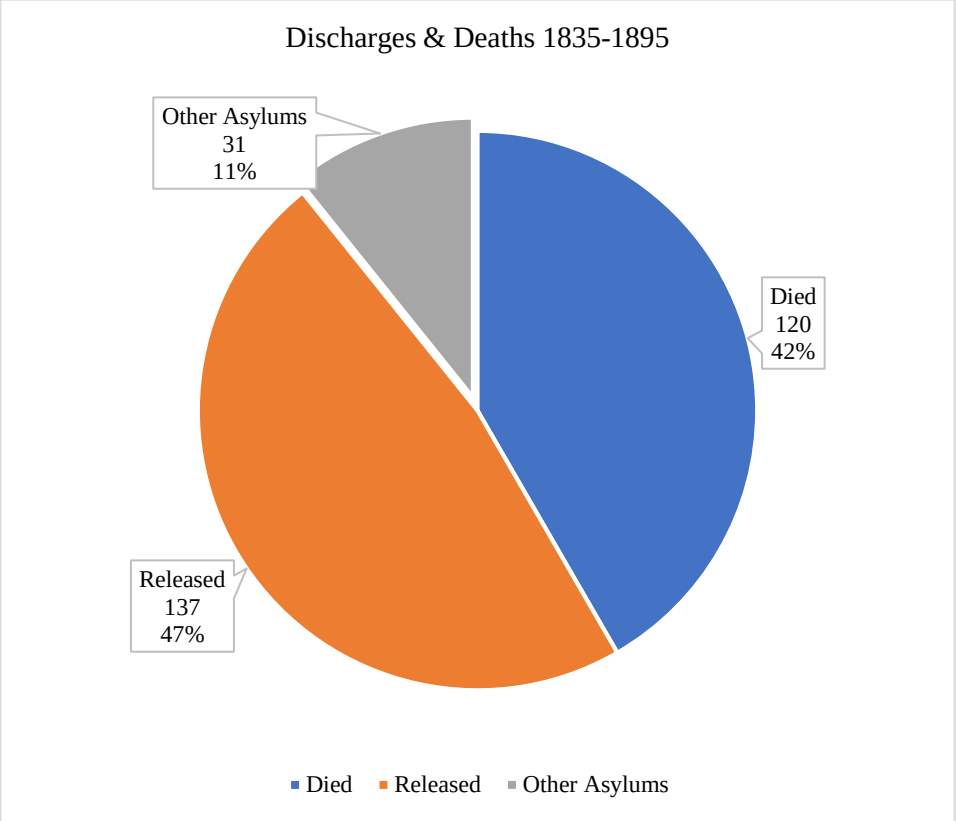

Figure 7:1: *Discharges of 288 mothers admitted between 1835 and 1895*

Figures 7:1 and 7:2 are graphical representations of the outcomes for the women of my sample group. The numbers were taken from the various asylum discharge registers which, in cases of conditional discharge, also recorded the name of the patient's future guardian.[26] As can be seen in Figure 7:1, the numbers of women

[24] 47 & 48 Vict., c. 64 Criminal Lunatics Asylum Act 1884. S4 Periodical report of Criminal Lunatics (1).

[25] 47 & 48 Vict., c. 64 Criminal Lunatics Asylum Act 1884. S4 Periodical report of Criminal Lunatics (2).

[26] BRHA, DDR-02 & DDR-03, Register of Discharges & Deaths; FHAA, J7/176/2, Register of Discharges & Deaths 1845-1880; BCLA, D/H14/D1/15/1, Discharge

released compared relatively closely with the numbers of those who died in the asylum. A slightly higher proportion of women over the sixty years, 42%, remained in the respective asylums until death and 11% were transferred to other asylums. When the women were transferred to other asylums, their official status changed from criminal lunatic to pauper or "ordinary" lunatic. The wording used in the Broadmoor registers was "fit for an ordinary asylum".[27] Potentially, the identified thirty-one women may have remained in asylum care for the rest of their lives.

For this thesis, I have only explored the occasional transfer case to ascertain what pattern a woman's life could follow after her incarceration as a criminal lunatic. As stated in the Introduction, I have also looked at cases of single women who murdered their children to discover any social bias in the authorities' attitudes towards them. Figure 7:2 appears to indicate that unmarried mothers were more likely to be transferred to another asylum rather than be released. It is difficult to categorically link this with social attitude, without a thorough examination of each case. There is potential in researching the outcomes for all those women who were transferred, as part of an exploration of nineteenth-century asylum experiences. However, as this chapter examines the circumstances of discharge and death of those, mainly married, mothers who remained designated as criminal lunatics, a detailed examination of the transfer cases is not within the scope of my research.

Register - male & female 1864-1900; D/H14/D1/17 (3 volumes) Registers of Deaths – male & female 1864-1965.

[27] BCLA, D/H14/D1/15/1, Discharge Register.

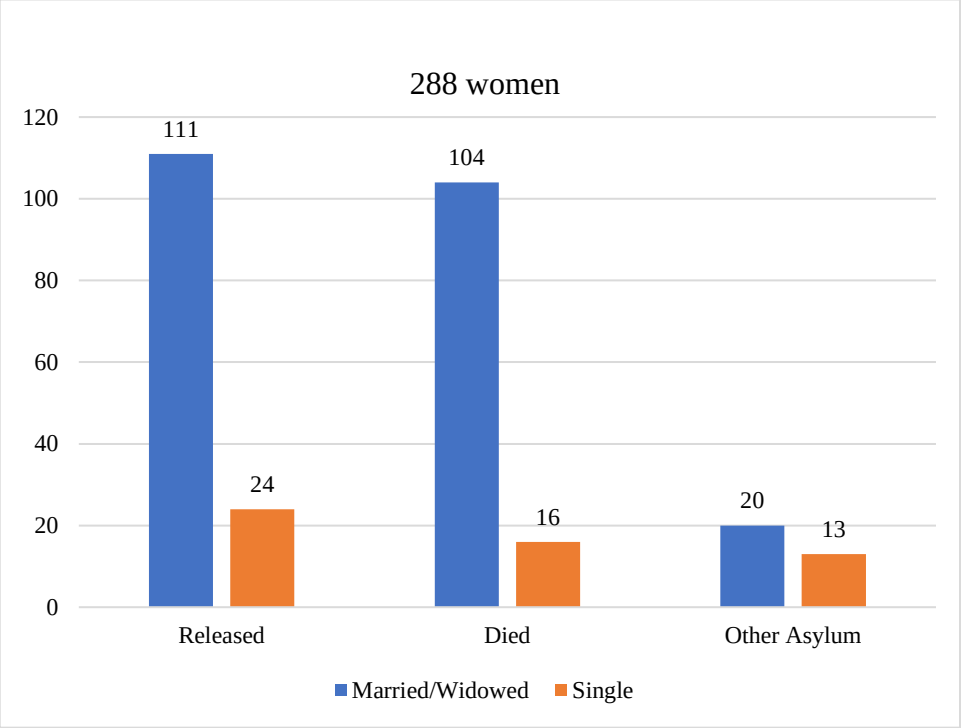

Figure 7:2: *Discharges by marital status (admissions between 1835 & 1895)*

Discharge procedures 1835 to 1867

As shown in the chart below (Figure 7:3), I have identified 37 cases where the homicidal mother was admitted to an asylum as a criminal lunatic from 1835 and was subsequently released or deceased before 1867 without going into Broadmoor. Of this number five died whilst in the institution, one woman was transferred to a county asylum and the majority, 31 (86%), were released. Depending on when they were released, they could receive a Royal Pardon, be conditionally discharged on a Home Secretary's warrant, or be released back to their friends and family as recovered.

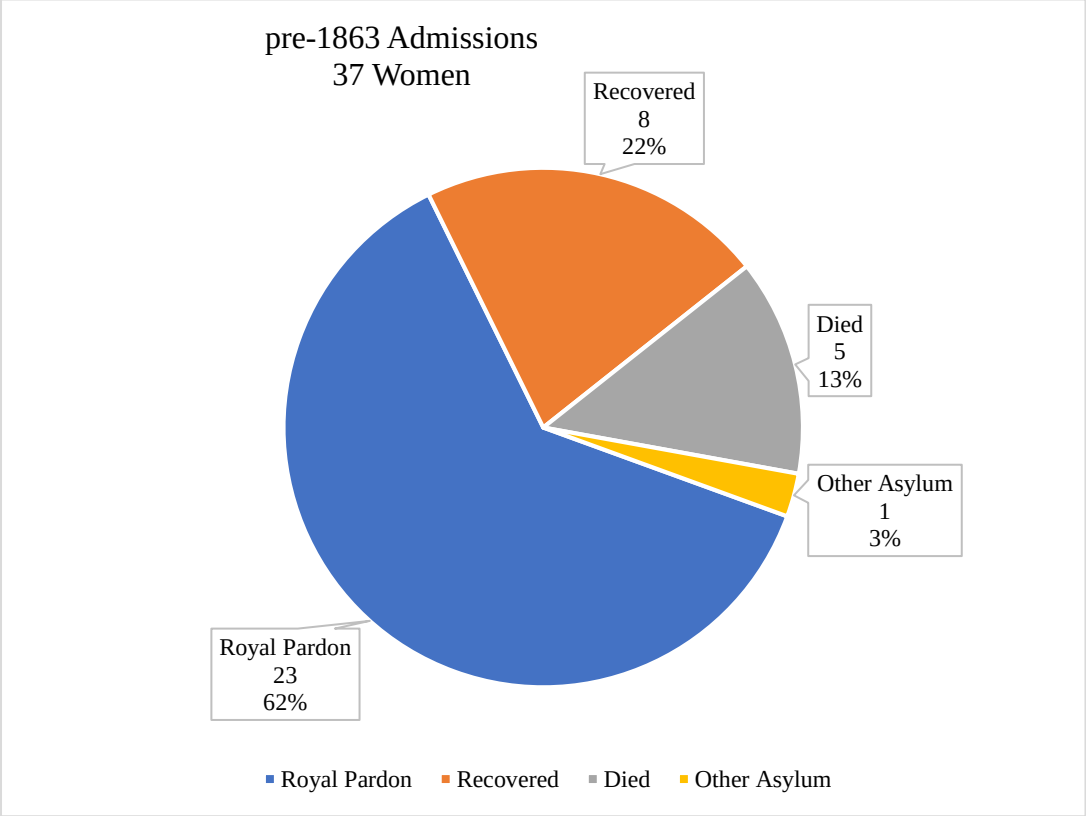

Figure 7:3: *Discharges of pre-1863 admissions (not Broadmoor) with destination.*

The initial approaches about obtaining a possible release could come from any quarter; the patients' families, friends, the asylum authorities, or other third parties. Before the 1860 and 1867 Criminal Lunatics Acts, decisions regarding the discharge of criminal lunatics were taken at Privy Council level on the recommendation of the Secretary of State and discharge warrants were physically signed by Queen Victoria.[28] It would seem from records that such warrants were regarded as "Royal Pardons" and carried with them an indication of absolute discharge. The 1860 Act had made provision for the so-called "convict lunatics" or "lunatic criminals" once they had reached the end of their term of imprisonment. If it were certified that they were now "of sound Mind [sic]", they would receive their discharge; if not they would be

[28] 23 & 24 Vict., c. 75 Criminal Lunatics Asylum Act 1860 ("The Broadmoor Act") amended in 30 & 31, Vict., c.100 Criminal Lunatics Act 1867.

admitted to a County Asylum as pauper lunatics.[29] After 1867, the Secretary of State at the Home Office was "empower[ed] … to discharge, absolutely or conditionally, any Criminal Lunatic".[30] The opinions and recommendations of the asylum authorities were merely advisory and only the Home Office or Privy Council could sanction the release of patients. Under the terms of the 1853 Lunatic Asylum Act, the Secretary of State had the power to allow "a Lunatic to be absent from the State Asylum on trial".[31] The 1860 Act also allowed for absences from the asylum on a trial basis, with the permission of the Secretary of State.[32]

The Commissioners in Lunacy stated in their 1867 report to Parliament that these powers had been extended to cases of "Criminal Lunatics generally, in whatever Asylums or places of confinement they may be". The report specifically states that this had been allowed for "Criminal Lunatics at Fisherton House and elsewhere who were not dangerous to themselves or others".[33] The provision fell away in later years although it was still in use in the early days of Broadmoor. Patients at Fisherton House were regularly given a measure of pre-discharge freedom and worked alongside the pauper patients. When challenged about the practice, the proprietor, Dr Corbin Finch, defended his policy saying that, "the advantages to this Class of Patient are great" as, he believed, such freedoms and associations prepared all patients for life outside the

[29] 23 & 24 Vict., c. 75 Criminal Lunatics Asylum Act 1860. "VIII: Provision for Discharge of Persons confined after their Term of Imprisonment has expired."

[30] HC, *Twenty-first Report of the Commissioners in Lunacy to the Lord Chancellor*, p. 14. House of Commons, Parliamentary Papers Online.

[31] 16&17 Vict., c.97 Lunatic Asylums Act quoted in *Twenty-first Report of the Commissioners in Lunacy*, p. 14.

[32] 23 & 24 Vict., c. 75 Criminal Lunatics Asylum Act 1860. "IX: Secretary of State may permit any Lunatic to be absent from Asylum on Trial".

[33] *Twenty-first Report of the Commissioners in Lunacy*, p. 14.

asylum.[34] He went on to describe the case of Sarah Dickenson who had been admitted to Fisherton House on 15 February 1854 from Bethlem where she had been since 1844, after her trial for the murder of her infant son.[35] Dr Corbin Finch had himself employed Dickenson as he described, "I took her into my service as private cook where she … [discharged] … her duties in a most exemplary manner. I then recommended her to a family at Lymington, where she is still living, respected and esteemed by her employers".[36] She had been discharged on a Royal Pardon as recovered in December 1854. This policy placed some responsibility for the outcome of her future life on to the discharged woman herself.

The formal discharge papers issued in accordance with the 1860 and 1867 Acts indicate that, as the discharged patient herself signed her agreement to the terms, the authorities expected her to have an understanding of her responsibilities. The only condition contained within the document was that the discharged patient would immediately return to custody, if required to by the Home Secretary. Such a return would occur if the dischargee was adjudged to be "a person unfit to be at large".[37] The wording of the warrant continued to be used for early discharges from Broadmoor and such warrants were still signed by the released patient. In November 1867, in response to the provisions in the Criminal Lunatics Act, the last remaining female criminal lunatic patients were moved from Fisherton House Asylum.[38] Within the group of twenty women were five mothers who had murdered their children, Ann Lacey,

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[34] FHAA, J7/131/1, bundle 1 of 4, "Copy letter from Dr Wm. Corbin Finch, Fisherton House Asylum to H. Waddington at Home Office 2 January 1857".

[35] FHAA, J7/190/5, Fisherton House Asylum Casebooks, 1855-1866, Sarah Dickenson Patient no 1239, f. 142.

[36] FHAA J7/131/1 bundle 2, "Letter 2 January 1857".

[37] FHAA J7/131/1 bundle 3, Sample – "Warrant for conditional discharge of Martha Hocken, 3 August 1867".

[38] FHAA J7/131/1, "Warrant for the Removal of Ann Lacey and Others. 26 November 1867".

Harriet Goodliffe, Harriet Salmon, Sarah Lancastell and Eliza Kirby. Ann Lacey was initially discharged in 1868 but was readmitted and remained until her death in 1884. Lancastell and Salmon were eventually conditionally discharged to their families but Kirby and Goodliffe did not recover sufficiently to allow the medical men to support their release.[39] Eliza Kirby died in Broadmoor in 1887 and Harriet Goodliffe in 1920.[40]

Broadmoor discharges.

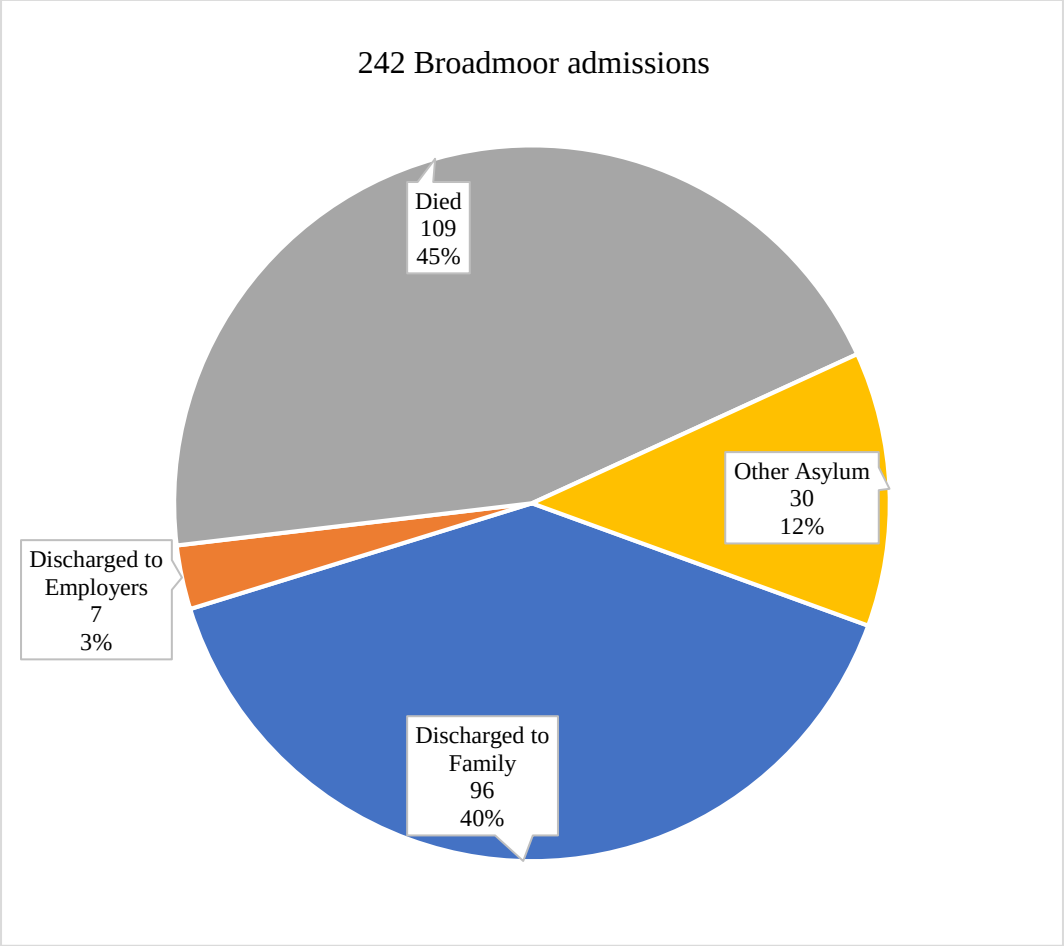

Figure 7:4: *Discharges from Broadmoor of admissions between 1863 and 1895*[41]

[39] BCLA, D/H14/D2/2/2/126, Case File: Sarah Lancastell; D/H14/D2/2/2/136, Case File: Emma Kirby; D/H14/D2/2/2/138, Case File: Harriet Goodliffe; D/H14/D2/2/2/139, Case File: Harriet Salmon; D/H14 D/2/2/2/166, Case File: Ann Lacey.

[40] BCLA, D/H14/D2/2/2/136, Case File: Emma Kirby; D/H14/D2/2/2/138, Goodliffe.

[41] BCLA, D/H14/D/1/15/1, The deaths recorded here are for those women who were never released, those who returned after initial discharge are not included.

Between 1863 and 1895, there were 242 mothers admitted to Broadmoor for murdering or violently assaulting their children. As shown in Figure 7:4, 133 (55%) of the group were discharged and 109 (45%) died in the Asylum. Of the 133 patients who left Broadmoor, 103 were released to the care of family members or to that of employers and 30 were transferred to other asylums as no longer criminal but still "fit for an ordinary asylum".[42] As the focus of this thesis is on the women who were married or widowed, these statistics are broken down further in Table 7:1. The numbers contained therein give an indication of the importance of family involvement in the Broadmoor discharge process. Additionally, the table also highlights the fact that the majority of women remained in an asylum, although not necessarily Broadmoor, until their deaths.[43] It is important to note that twenty-one women who were initially discharged, returned to Broadmoor and died there; this point is addressed in greater detail later in the chapter.

[42] BCLA, D/H14/D2/2/2/244, Case File: Louisa Ashley, "Medical Certificate, 16 December 1903."

[43] BCLA, D/H14/D/1/15/1, Some patients were transferred to other asylums as "ordinary lunatics", others were transferred to Rampton Criminal Lunatic Asylum, Nottinghamshire. In 1899, the Lunacy Commissioners decided an additional facility was required as BCLA had become overcrowded. Rampton was opened in1912, taking a number of patients including some women of my dataset. Some were transferred back to BCLA before their deaths. Information from Introduction to BRO, BCLA, D/H14 Catalogue.

Discharges from Broadmoor					
To the care of:	**Single**	**Married/ Widow**	**Total**	**%age of total**	**%age of discharges**
Husband		46	46		34%
Siblings	6	13	19		14%
Parents	4	12	16		12%
Children (adult)	1	9	10		8%
Other Relatives	1	4	5		4%
Total to Family care	12	84	96		72%
Other Asylums	11	20	30		23%
Employers	5	2	7		5%
Discharges – total	28	106	134	55%	100%
Died in Asylum (exc. readmissions)	14	93	107	45%	
Total: "Discharges Removals & Deaths"	42	199	242	100%	

Table 7:1: *"Discharges, Removals & Deaths": admissions between 1863 & 1895.*[44]

The discharge process at Broadmoor changed after its opening in 1863 from a system similar to that of Bethlem and Fisherton House to one which became more stringent and controlled. One of the first female patients to be discharged was Mary Ann Harris, who had been admitted to Fisherton House in August 1862 for the attempted murder of her child. She was transferred to Broadmoor in June 1863, along with forty-nine other women who were to help fill the first hundred places in the new criminal lunatic asylum.[45] In January 1864, George Harris, husband of Mary Ann Harris, enquired of the Home Secretary whether his wife might be considered well

[44] BCLA, D/H14/D/1/15/1, 242 cases admitted in the period 1863 to 1895 for murder or attempted murder of their child.

[45] FHAA, J7/131/1 bundle 2, "Transfer Warrant to Fisherton House Asylum signed by Sir George Grey, Home Secretary on behalf of Her Majesty's Privy Council dated 22 May 1863".

enough for release.[46] After enquiries into the facts about Mary Ann's case and into the state of her mind, Harris was advised that "Sir George Grey has felt warranted in authorizing the Superintendent of Broadmoor … to grant her leave of absence upon trial."[47] Mary Ann Harris duly left Broadmoor with a parole warrant and an allowance of ten shillings a week, which lasted until her full discharge was granted in September 1864.[48] Only four women of my sample group, including Mary Ann Harris, were released before 1867. All four discharges were treated in the same manner; the women returned to their homes and families with an allowance and an unconditional discharge.[49] The first discharges from Broadmoor seemed to follow a similar path to Home Office sanctioned releases from prison and county asylums and the release criteria were a hybrid of prison and asylum procedures.

There was a change in procedure after 1867, when the provisions of the Criminal Lunatics Act added formal conditions to the warrants of discharge as previously described. In the early stages of Broadmoor's history, the authorities at the Home Office appear to have regarded the patients as prisoners first and as lunatic patients second. Whitehall letters would refer to the patients as prisoners and the wording of the warrants would suggest that their incarceration was custodial rather than medical. Although the Home Office required a medical certificate from the asylum doctors regarding the patient's state of mind, there is no mention within the release document of this fact. As an example, the wording on the warrant for Ann

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[46] TNA, HO13/107/247, Home Office, Correspondence & Warrants, 1859-1862, "Letter to Mr George Harris from H. Waddington" 8 January 1864.

[47] TNA, HO13/108/2 H. O. Correspondence & Warrants, "Memorandum 18 July 1864".

[48] BCLA, D/H14/D2/2/2/73, Case File: Mary Ann Harris, "Warrant of Parole dated 14 July 1864." & "Warrant for Discharge (signed Victoria R) 20 September 1864".

[49] BCLA, D/H14D2/2/2/73, Harris discharged 14 July 1864; D/H14/D2/2/2/4, Mary Ann Raby discharged 12 October 1864; D/H14/D2/2/2/20, Jane Torkington discharged 16 October 1864; D/H14/D2/2/2/106, Sarah Rylands discharged 31 August 1866.

Lacey states, “Ann Lacey accepts her discharge out of Custody on the condition that she return into the same or other Custody whenever required to do so by an Order in writing under the hand of one of her Majesty’s Principal Secretaries of State”.[50] The warrant was signed by Lacey on 21 September 1868, the day of her release. The officials were not unaware of the risks attached to releasing the seemingly recovered patients and even in the early days of Broadmoor, advice was given to husbands about treatment of their wives on release.

Dr William Orange became Medical Superintendent in 1870 and, during his tenure, medical opinion became more significant and official requirements grew. Orange always believed in the importance of the curative nature of Broadmoor and when he was Deputy Superintendent the lack of medical input in his duties frustrated him.[51] In 1868 Dr Meyer, the then Medical Superintendent, recorded in his official journal that Orange had protested, “I am not doing my duty I am not doctoring the patients”.[52] Details of a patient’s physical and mental health were considered necessary to discharge discussions and, increasingly, so were examinations of her family background and potential future living circumstances.[53] Also, from this time there seems to have been a change in expectations of the patients themselves. As shown in early conditional discharges, the discharged woman signed that she personally accepted the conditions of her discharge from the asylum, thereby having some say in her future life. This began to change from the early 1870s and eventually such confirmations disappeared from discharge documents. The warrant issued for the

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[50] BCLA, D/H14 D/2/2/2/166, Case File: Ann Lacey, “Warrant for conditional discharge 21 September 1868”.

[51] Jade Shepherd, “‘I am very glad and cheered when I hear the flute’: The Treatment of Criminal Lunatics in Late Victorian Broadmoor” *Medical History,* vol. 60, no. 4, (2016) pp. 473–491. p. 489.

[52] BCLA, D/H14/A2/1/3/1, Superintendent’s Journal, 1863-1870.

[53] Andrews, “Boundaries of Her Majesty’s Pleasure”, p. 224.

discharge of Sarah Allen in August 1872 was similarly worded to that of Ann Lacey and it bore Allen's signature. There is, however, a further clause attached to the document which reads, "We most readily enter into agreement jointly and severally to take all proper care of Sarah Allen and … should there be any tendency to relapse or should she leave without consent … we will write to you [Secretary of State for the Home Department]."[54] This was signed by her brother-in-law and proposed guardian on behalf of himself and his wife, Ann.

The role of the superintendent in the discharge procedure was not formalised until 1884 and the implementation of the Criminal Lunatics Act. The Act stipulated that "it shall be the duty of the superintendent … to take all reasonable means for his [the criminal lunatic] being placed under the care of some relation or friend".[55] This did not mean that the superintendent had gained any more autonomy in deciding who should be discharged. The Home Secretary and the Home Office remained as the ultimate decision-makers, informed by the annual reports about patients from the asylum and by the research undertaken to ensure a safe future for patients, as stipulated in the Act. As time went on, conditions placed on the guardian became even more regulatory and protective. They tended to be aimed at keeping the discharged woman from relapse into insanity by placing restrictions on her living arrangements and movements. Conditional discharges increasingly meant that former patients were supposed to spend every night at the address to which they had been discharged. Guardians were obliged to get permission for ex-patients to spend even one night away from that address, a condition which was not always fulfilled.[56] The discharged

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[54] BCLA, D/H14/D2/2/2/2/29, Case File: Sarah Allen. "Warrant of conditional discharge 19 August 1872".

[55] 47 & 48 Vict. c.64. Criminal Lunatics Act 1884. S6. "Duty of Superintendent on Discharge or Expiration of Sentence".

[56] Andrews, "Boundaries of Her Majesty's Pleasure", p. 254.

patient, consequently, lost some control over decisions about her life; in effect, she would be treated as she had been in the asylum, more like a child than an adult.

The role of family

The women's crime and subsequent incarceration, had a social impact on the families and friends of the homicidal mothers, with long-term confinement potentially profoundly impacting family dynamics.[57] In many cases, although not understanding the reasons behind the women's criminal acts, relatives would support their errant family members.[58] In his study of county asylum releases, David Wright demonstrates that patient discharge was not dependent solely on medical evaluation, nor was it age or gender specific. That being said as with county asylums, more women were discharged from Broadmoor than men. Jade Shepherd found in her study of men in Broadmoor between 1863 and 1900, 23% of all women patients and just 7% of men were discharged.[59] This is, in part, explained by cultural perceptions of gender roles within family and kin groups. In his Annual Report for 1885 Dr Orange wrote that it was easier to find care for female discharges than it was for men. In his opinion, relatives and friends were more willing to offer a home and more able to supervise women ex-patients than they were men. Orange wrote that the conditions and the circumstances of discharge were set in order "to render it reasonably probable that they [the discharged] will not prove a danger to the community." He continued, "it is

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[57] Alison Pedley, "Family Union and the Discharge of Infanticidal Married Mothers from Broadmoor Criminal Lunatic Asylum, 1863-1895" in James Gregory & Daniel J. R. Grey (eds.), *Union and Disunion in the Nineteenth Century* (Abingdon: Routledge, 2020) pp. 223-41, p. 224.

[58] Ibid., p.225.

[59] Jade Shepherd, "Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900" (Unpublished PhD Thesis, Queen Mary University London. 2013).

more difficult to ensure these conditions in the case of men than in the case of women".[60]

Despite the women having committed a violent crime, it was considered that they would be "easier" to manage by their new guardians, because, culturally, they were thought to be more naturally passive. In the same report, Orange also attributed the higher proportion of female discharges to biological reasons, writing, "A considerable number of the women have been sent to this asylum in consequence of having killed their children … the mere lapse of time removes … the risk of repetition of this offence."[61] There was not an official policy of retaining mothers who had murdered their children beyond their child-bearing years but, unofficially, such reasoning does appear to have been a factor in delaying discharges.[62] The authorities in the asylum always sought to guard against the risk of insanity caused by pregnancy when a mother was discharged and keeping her in until menopause was one such method. Later in this chapter, I discuss the expected role of husbands in averting this risk.

The desire and the ability, of a patient's family and friends to take them back into the domestic sphere was an important consideration in the process.[63] In the first half of the period, up to the late 1860s, the concern for the patient's future welfare centred more upon financial abilities of the family to care for discharge, than their social and domestic circumstances. In the case of Sarah Jackson described at the

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[60] Dr William Orange, *Reports of the Superintendent and Chaplain of Broadmoor Criminal Lunatic Asylum for the Year 1885* (London: George E. Eyre and William Spottiswoode, 1887), p. 7.

[61] Ibid., p. 6.

[62] Andrews, "Boundaries of Her Majesty's Pleasure", p. 230.

[63] David Wright, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century" *Social History of Medicine*, vol. 10, no. 1, (1997) pp. 137–155, p. 139.

beginning of the chapter, her friends and family were, initially, quoted as not being "willing to take charge of her", although the guardians of the parish union at Enfield agreed to maintain her but in the local workhouse. Eventually, after discussions with the Home Office, Jackson's sister agreed to take responsibility for her. The Home Office duly sent a discharge warrant to the governors of Bethlem, advising them that "Sec. [sic] Sir George Lewis ... received from the prisoner's sister ... assurance that if released she will be properly taken care of by her friends".[64] Sarah Jackson was released from Bethlem to the care of her sister and remained living in Enfield until her death in 1889.[65] Jackson's husband had been a gunsmith at the Royal Small Arms Factory in Enfield, as were her sons and other family members. In the thirty years after she left Bethlem, Jackson lived with various different members of her extended family, including her surviving children. All belonged to the community of workers at the Royal Enfield factory and all lived in the same road, a demonstration of an extended family caring for one of its members.[66]

At Broadmoor, there seemed to be some confusion amongst relatives about how to approach the question of release with the authorities. Discharge procedures were not routinely explained to interested parties and appear to have been given on a "need to know" basis. In county lunatic asylums, families could make a direct request to the superintendent for the release of a relative.[67] Although, like their counterparts in the state facilities, county asylum medical superintendents had little say in who was *admitted* to the asylum, they did have great influence over who was discharged and

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64 TNA, HO13/106/27, H.O., Correspondence & Warrants, re Sarah Jackson.

65 LMA, dro/004/a/01/067, London Church of England Burials, 1813-2003.

66 TNA, 1861 England Census, Class: RG 9, Piece: 800, Folio: 8, Page: 6; 1871 England Census Class RG10, Piece: 1345, Folio: 96, Page: 7; 1881 England Census Class: RG11, Piece: 1395, Folio: 85, Page: 10.

67 Dobbing, "The Family and Insanity", p. 138-139.

the ultimate discharge decision lay in their hands.[68] Perhaps, because they regarded the medical superintendent at Broadmoor as all-powerful in such matters, there were cases of relatives appealing directly to him, thereby following the "normal" route for discharge. These demands and requests were invariably answered by the medical officers with a reminder to the relatives that the decision was not theirs to make and that Whitehall must be petitioned. Despite this, many families persisted in their direct hounding of the medical superintendent, using different strategies.

The family of Mary Bennett frequently requested that she be released and that they would come and collect her when the Medical Superintendent of Broadmoor gave them a time.[69] Dr William Orange reminded them on each occasion that only the Home Office could sanction her release. There is a sense of exasperation in Orange's reply that, "it is only right that I tell you ... to save you needless trouble ... the question of liberation of persons from this asylum ... rests solely with the Secretary of State for the Home Dept."[70] Issues of social status and respectability, as well as the perceived capability of family and friends to adequately support and care for a discharged patient, played a part in the discharge decisions.[71] These, of course, were not impartial criteria, being highly prone to cultural biases. In their observations of the domestic circumstances of the patients, both the asylum medical officers and Home Office officials seem to adhere to the contemporary, arguably middle-class, cultural ideals. A fundamental view in Victorian society was that a woman's place was in the home

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[68] Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), p. 142; Wright, "The Discharge of Pauper Lunatics" p. 107.

[69] BCLA, D/H14/D2/2/2/111, Case File: Mary Bennett, "Letter from H. Spence to Dr Orange, 30 July 1867"; "Letter from E. Cooper to Dr Orange, 9 December 1875"; "Letter from A. Stokes (M.P.) to Dr Orange, September 1876".

[70] BCLA, D/H14/D2/2/2/111, "Letter from Dr Orange to Mrs E. Cooper ,21 December 1875".

[71] Andrews, "Boundaries of Her Majesty's Pleasure", p. 243.

caring for her family and spouse. Sometimes medical men were critical of relatives, not necessarily understanding their ways of life; clinicians could view family interventions as damaging to the patient's welfare. For Ann Amess, "the character of her domestic relations" did not "warrant a favourable consideration" for release.[72] Her family requested her discharge on four separate occasions between 1881 and 1886; each time Orange recommended that the petition be refused. Amess's family were described as "thoroughly disreputable" and their circumstances as "woeful." [73] Amess was never discharged; she died in 1899 and was buried in the Broadmoor Burial Ground.[74]

For some, insanity was viewed as a shameful stain on a family's reputation and the stigma, or shame, of a family member being in an asylum was hard for many families to bear.[75] Agnes Morris's family and friends distanced themselves from her after she was admitted to Broadmoor in 1877. Having the funds for a comfortable life, she convinced herself that she would be better in a private asylum, nearer her home in Liverpool.[76] This move was vigorously opposed by her family and friends, ostensibly to protect her other children. It was noted in her case file that "her own family [do not] make any move about her release".[77] The guardian of her surviving children requested that her communications to them be monitored, as the children had been greatly disturbed by her letters.[78] This aspect of families distancing themselves from the

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[72] BCLA, D/H14/D2/2/2/276, Case File: Ann Amess, "Report to Home Office by Dr Orange, 21 March 1882".

[73] BCLA, D/H14/D2/2/2/276, " Report to Home Office by Dr Orange, 17 March 1886".

[74] BFHS, 3 January 1900 St John the Baptist, Crowthorne, Ann Amess (64) Berkshire Burial Records.(see Appendix 4).

[75] Andrews, 'Boundaries of Her Majesty's Pleasure", p. 244.

[76] BCLA, D/H14/D2/2/2/261, Case File: Agnes Martha Morris, "Letter from Laces, Bird, Newton & Richardson (Solicitors), 15 January 1877".

[77] BCLA, D/H14/D2/2/2/261/55, "Memorandum to Home Office, 4 April 1885"..

[78] BCLA, D/H14/D2/2/2/261/22, "Letter from Rev. R. Gough, 23 May 1878".

asylum is relevant when considering the reasons for nearly half of the women of my sample remaining in the asylum until their deaths. Later in this chapter, I consider the interactions between the families and friends of the mothers and the asylum authorities in the cases of these long-term patients.

Joseph Melling and Bill Forsythe suggest that "intense anxiety" existed amongst the friends and family of pauper patients regarding their treatment in asylums.[79] However, Cara Dobbing in her more recent work on families and inmates of Garlands Asylum, Carlisle, finds that not all members of the public feared the asylum, once they had come into contact with it.[80] Jade Shepherd finds, as I do, that much of the correspondence from family and kin, suggests that Broadmoor was seen as a place of recuperation and recovery.[81] The asylum was regarded as somewhere for their wife, daughter or mother to regain her sanity and, consequently, lead to her release. She would then be able to resume her place in the heart of the family. The daughter of Eliza Kirby wrote to Dr Orange,

> … my Father and self will yield to every wish of yours as regards the care of my mother … After this long time, we miss her more and more each day. I am often overcome with emotion to know that I have one [a mother] with much love in her heart towards us … I assure you that nothing shall be left unturned for her happiness and comfort … [82]

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[79] Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 1996), p. 100.

[80] Dobbing, "The Family and Insanity", p. 140.

[81] Jade Shepherd, "Life for the Families of the Criminally Insane" *The Historical Journal* (Cambridge University Press 2019), pp. 1-30, p. 19.

[82] BCLA, D/H14/D2/2/2/136/29, Case File: Emma Kirby, "Letter from Miss Emily Kirby 5 October 1878".

Alongside the moral and social conditions of the families, the educational levels of the proposed guardians and their ability to understand the needs of the women on their release featured amongst the important considerations for the authorities. Despite the best of intentions from the family and friends, sometimes their intellectual abilities and economic circumstances were viewed as a potential risk to the woman's future welfare. Andrews attributes this to a lack of understanding of the nuances and mores of working-class society by the, mainly, middle-class officials and doctors.[83] When the women were admitted to the asylums, their levels of literacy were recorded and played a part in the assessment of suitability for discharge. [84] Similarly, the literacy level and intelligence of their husbands and extended families appeared to be of significance in the authorities' decisions about the relatives' capabilities as potential guardians. [85]

The case of Emma Luke is an illustration of the judgmental attitude of officials both at the Home Office and Broadmoor.[86] Applications for Emma Luke's release began within a few months of her admission but met with little success.[87] Thomas Luke, her husband, was a nail caster and they lived in a poor area of Aston, Birmingham. Despite the humble state of their home life, the couple were regarded as respectable people in the local community; Emma was described as having "a character amongst her neighbours for industry and respectability".[88] Thomas Luke was described as a "hardworking respectable man" but it was noted that he was rather short

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[83] Andrews, "Boundaries of Her Majesty's Pleasure", p. 237.

[84] Ibid., p. 236.

[85] Ibid., p. 236.

[86] BCLA, D/H14/D2/2/2/252, Case File: Emma Luke; Andrews, "Boundaries of Her Majesty's Pleasure", p. 232.

[87] BCLA, D/H14/D2/2/2/252. Various letters 1875-1878.

[88] "Another Shocking Tragedy in Birmingham", *Worcestershire Chronicle*, (23 October 1875), p. 7, col. 4.

of employment at the time of the murder.[89] Dr John Isaacs, Assistant Medical Officer at Broadmoor, doubted Luke's ability to protect Emma and guard against potential relapse. In 1876, he wrote disparagingly that "her husband does not … possess the necessary degree of intelligence which would enable him to have his wife properly taken care of". The report also said that Luke did "not appear to be in sufficiently good circumstances … to prevent the future possibility of violence on her part to herself or to others".[90]

Emma was discharged in 1878 into the care of friends, not Thomas, although she did return to her husband sometime before 1881.[91] They had five more children after her release, with no apparent need for Emma to return to an asylum following the births.[92] The Luke household was regarded as respectable by their local community and Emma was described as a fond mother and good housewife, both important social virtues. While the officials at Broadmoor and the Home Office may have had doubts about the Luke's, their friends and neighbours did not. The support of their peers helped in securing a quick release. This is an illustration of the socio-cultural importance of the role of kin and community in poorer sections of Victorian society, as described by scholars, and noted in the Introduction.[93]

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89 "Insanity & Murder", *Worcestershire Chronicle*, (18 December 1875), p. 5, col. 6.

90 BCLA, D/H14/D2/2/2/252, "Draft report for Home Office, May 1877".

91 TNA, 1861 England Census, Class: RG9 Piece: 3104, Folio: 65, Page: 38.

92 TNA, 1901 England Census, Class: RG13, Piece: 2855, Folio: 188, Page: 3.

93 For example: Emma Griffin, *Bread Winner. An Intimate History of the Victorian Economy.* (New Haven & London: Yale University Press, 2020); Ellen Ross, *Love and Toil: Motherhood in Outcast London 1870-1918* (Oxford & New York: Oxford University Press, 1993); Susie L. Steinbach, *Understanding the Victorians. Politics, Culture and Society in Nineteenth-Century Britain* (London & New York: Routledge, 2012).

Husbands

It is discernible throughout the sixty years under discussion that the authorities expected that the husbands of the homicidal mothers would both be active in seeking their wives' discharge and responsible with regard to the patient's mental and physical welfare on her release. There was often a proviso that the men should guard against creating a situation where there was a possibility of relapse,which, in the case of many, was the occurrence of another pregnancy. Dr Hood agreed to the release of Emma Sanderson from Bethlem in order that she could join her husband in Tennessee but he took "care … to mention the circumstance of the liability of a return of mania were she again in the same condition [pregnancy]".[94] Hood also believed that Thomas Sanderson had made a great effort to provide a safe and secure future for his wife and family. He had emigrated to the USA and set up a business: "I have emigrated to this State … with a view of making a home for my Wife where her misfortune is unknown".[95]

The Medical Superintendents of Broadmoor would also request compliance from the spouses for patients they discharged. An 1867 letter from the Home Office about Ann Wilson sent to a petitioner for her release advised that the Home Secretary, Gathorne Hardy, agreed to Wilson's conditional discharge.[96] The letter continued, "her husband [is] to be informed that … it is the opinion of the Medical Officers that when insanity has occurred at the time of childbirth … as in the present case, there must always be a risk of a recurrence of the insanity at the birth of subsequent

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[94] BHRA, CBC-03 Incurable & Criminal Patient Casebooks, 1850-1857, Emma Sanderson f. 185.

[95] TNA, HO18/276, Home Office: Criminal Petitions: Series II, "Letter from Thomas Sanderson 1 April 1852".

[96] BCLA, D/H14/D2/2/2/18, Case File: Ann Wilson, "Warrant for Conditional Discharge. 5 September 1867".

children".[97] Annie Howell was described as being "not at all unlikely to relapse into insanity more especially in the event of her becoming pregnant." It was advised that her husband, Captain James Howell, "should be clearly informed of the risk of the occurrence of a relapse into insanity and that suitable provision should be made for taking necessary steps to avert danger".[98] John Ashley wrote, "it is our desire that she [his wife Louisa] be restored to us … there is little probability of her having more children, she would be free from those cares which were the cause of her mind giving way".[99]

The medical men's preference that the husbands should be involved and remain in touch with their wives did not mean that there was a lack of awareness of the threat of domestic violence in the homes of some of their patients.[100] As described in Chapter 6, the asylum clinicians recognised that domestic disharmony and violence could have devastating effects on a woman's mental state.[101] When Sarah Beagley was admitted to Broadmoor in 1882 after strangling her child, her attack of insanity was attributed to "Lactation and domestic trouble".[102] In her case file, a draft medical report for the Home Office noted that, "[her] husband was unfaithful … acknowledged being with other women." [103] She appears to have "lived very unhappily with her

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[97] TNA, HO13/109/174, H.O., Correspondence & Warrants, "Letter to Dr John Meyer, Broadmoor. 5 September 1867".

[98] BCLA, D/H14/D2/2/2/288, Case File: Annie Howell, "Report to Secretary of State at the Home Office (draft) 10 July1879".

[99] BCLA, D/H14/D2/2/2/244, Case File: Louisa Ashley, "Letter 30 March 1879 John Ashley to Dr William Orange".

[100] Pedley, "Family Union", p. 230.

[101] Shani D'Cruze, *Crimes of Outrage: Sex, Violence and Victorian Working Women* (London: UCL Press, 1998).

[102] BCLA, D/H14/D2/2/2/344, Case File: Sarah Beagley, "Schedule A: Statement to Accompany Each Criminal Lunatic 30 September 1882".

[103] BCLA, D/H14/D2/2/2/344, Beagley, "Copy of medical report to Home Office, 26 June 1885".

husband … was a wife and mother at 14, [in Canada] 1st husband dead, married to 2nd husband 13 years … has always suffered from headaches; both husbands have struck her about the head".[104] This was a possible acknowledgment by the medical staff that her treatment by her spouses and her domestic circumstances, lay at the root of her mental illness. In 1890, Sarah Beagley's husband applied for her release but his request was refused. Dr Nicolson had received a letter from her son that accused his father of drinking to excess and of being the cause of all the family problems.[105] Eventually, in 1895, Sarah was released to the care of another of her sons, who was accepted as a worthy guardian as he was "respectably employed as a bricklayer" and "always a teetotaller".[106]

When a mother was missing from a home, her key cultural roles in the domestic sphere of everyday management and childcare caused problems within a household. Sometimes family needs seemed to override potential domestic problems for a discharged patient and pragmatic motivation played a part in release decisions. [107] Rebecca Loveridge's family all had treated her disrespectfully and were seen to partly caused her mental deterioration.[108] In 1885 a memorandum to the Home Office stated, "her husband promises well now but it was his unkind treatment of her that she went mad & drowned her baby… too soon for discharge."[109] During her time in Broadmoor, he was described as being "most attentive" and because he "promise[d] well … and … quite prepared to sign an undertaking" to care for her, Rebecca was released to his

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[104] Ibid.

[105] BCLA, D/H14/D2/2/2/344, Beagley, " Letter from Pvt J. Beagley to Dr Nicolson, 21 February 1890".

[106] BCLA, D/H14/D2/2/2/344, Beagley, "Warrant of Discharge, 12 August 1895".

[107] Andrews, "Boundaries of Her Majesty's Pleasure", p. 242.

[108] BCLA, D/H14/D2/2/2/365, Case File: Rebecca Loveridge

[109] BCLA, D/H14/D2/2/2/365, Loveridge, "Memorandum to Home Office signed WO and DN, 10 February 1885".

guardianship. She returned to the family home in Kingsteignton, Devon, where she remained with no recorded instance of relapse until her death in 1922.[110] This appears to be an occasion when the authorities appeared prepared to take a risk, believing that the need for the mother to return to run the home and family should be prioritised over the discharged patient's welfare. Rebecca Loveridge's case demonstrates that sometimes the clinicians believed that some choices, while carrying risk, were worth taking and also highlights some of the inconsistencies which could occur in discharge decisions.[111]

When it came to discharge decisions, release would not be agreed irrespective of the domestic situation and, as far as possible, the authorities sought to protect the vulnerable woman. Blame was often laid on husbands for their wives' mental deterioration through not fulfilling their expected masculine role of faithful provider and carer.[112] Elizabeth Hillier was admitted to Broadmoor in 1875 and by 1877 she was described as sane and as having shown no sign of relapse. It was noted that her husband had regularly visited her for two years but then had ceased to do so because he had "found connexion with another woman by whom … he has now two children".[113] The doctors at Broadmoor believed that Elizabeth should be allowed to leave to the care of her brother as she was well and would be able to contribute to her own maintenance. Orange wrote that his concern was that her mind would not be "strong enough to bear up against troubles consequent upon her husband's

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[110] BCLA, D/H14/D2/2/2/365, Loveridge, "Memorandum to Home Office signed DN, 30 September 1885" & "Warrant of Discharge 4 November 1885"; GRO, England & Wales, Civil Registration Death Index, 1916-2007. March 1922 Vol 5b p. 211.

[111] Pedley, "Family union and the discharge of infanticidal married mothers", p. 231.

[112] Ginger S. Frost, *Living in Sin: Cohabiting as Husband and Wife in Nineteenth-Century England* (Manchester: Manchester University Press, 2008), p. 89.

[113] BCLA, D/H14/D2/2/2/246, Case File: Elizabeth Hillier, "Report to the Home Office. 1 July 1881".

misconduct" and, therefore, he requested that the Home Office "take steps for effecting some settlement with respect to her marital position".[114]

Despite the authorities' preference that a released mother should return to her marital home and the care of her husband, some spouses decided that they could not be responsible for a mentally-fragile wife. Charles Oldman was an attentive husband, regularly visiting and writing to his wife Ellen after her admission into Broadmoor in 1878. Although initially he seemed willing to take responsibility for her on discharge, in 1882 when the final decision came to be made, he admitted that he felt unable to cope with her care.[115] Ellen Oldman's stepfather had written to Dr Orange in April 1880 offering to look after his wife's daughter, an offer which was accepted after the Asylum received Charles Oldman's refusal.[116] Sarah Allen's husband refused to communicate with her and, despite pressure from the Broadmoor authorities, would not consider taking her home.[117] When Dr Orange wrote to inform him that she would be released to the care of her sister he replied, "I sincerely hope that the arrangements … add to her [Sarah's] comfort and still more to the friends whose … feeling has urged them to take upon themselves so serious a responsibility".[118]

Patronage

In many cases of discharge throughout the sixty years under discussion the intervention and patronage of third-party agencies added weight to discharge application for all patients. As previously discussed in Chapter 4, in the case of Agnes

[114] BCLA, D/H14/D2/2/2/246, Hillier ,"Report to the Home Office. 1 July 1881".

[115] BCLA, D/H14/D2/2/2/274, Case File: Ellen Oldman, "Letter from Charles Oldman to Dr Orange, 16 March 1881".

[116] BCLA, D/H14/D2/2/2/274, Oldman, "Letter from Samuel Rainbird to Dr Orange, April 1880".

[117] BCLA, D/H14/D2/2/2/2/31, Case File: Sarah Allen.

[118] BCLA, D/H14/D2/2/2/2/31, Allen, "Letter from W. B. Allen 31 August 1872".

Bradley in 1859, the direct intervention of the trial judge led to her unconditional discharge as a criminal lunatic and release from Rainhill.[119] In 1852, Thomas Sanderson petitioned Lord Palmerston about the possible release of his wife and Palmerston personally took the case to Privy Council.[120] Likewise, Charles Barrow enlisted the support of Viscount Curzon in 1888 when successfully petitioning for his wife's release.[121] Other families sought help from their local MPs, magistrates and other influential figures and such interventions often spurred the Home Office into seeking information from the asylums. The appraisals by doctors and officials of the respectability of the patients' friends and families and their general social circle were very reliant on the opinions of local officials and on employers, both of the woman and of her husband. As such people were of similar backgrounds to the clinicians and officials, their judgements of the domestic situations of the families were accepted as true assessments. Favourable third-party confirmation of a family's capacity to be responsible for the wife and of the quality of the circumstances of family and home, was considered desirable by all officials.

The campaign for Sarah Bates' release was backed by local community leaders and her husband's employer. A local Wesleyan minister wrote of James Bates that "the man has conducted himself so as to gain true esteem … his life is free from reproach and the children always appearing clean and neat and comfortable".[122] Bates's employer wrote "I have always found him to be a very industrious & honest man" adding that "they always lived very happily together" and that the "home was a

[119] LVRO, LCLAR, M614 RAI/8/3 Case Books 1856-1860, Agnes Bradley.

[120] TNA, HO18/276, Home Office: Criminal Petitions, "Letter to Lord Palmerston dated 1 April 1852".

[121] BCLA, D/H14/D2/2/2/330, Case File: Kate Barrow. "Letter from Viscount Curzon, 10 October 1887" & "Warrant of Discharge, 20 November 1888".

[122] BCLA, D/H14/D2/2/2/398, Case File (2): Sarah Bates, "Letter from Rev. G. Harrison, 29 July 1884".

very comfortable one".[123] In 1886, when writing to the Home Office in support of Sarah's release, Dr Orange advised that, "her husband and father are … in a position to give her a good home and their respectability is testified by the Mayor of Northampton".[124]

On occasion the reference could go against the family. In 1886, Mary Coleman's proposed discharge to the care of her son was aborted after a local doctor, Dr Henry Ormerod, wrote to the Medical Superintendent. He advised that the son was illiterate and although working, the family circumstances were poor and Ormerod questioned whether it was realistic to expect the son to be able to look after his mother.[125] Despite the favourable medical report from the asylum medical staff, Ormerod's letter sounded a note of caution and Mary Coleman was not discharged. She died in 1902, still in Broadmoor.[126] The two cases illustrate the impact that employers or local authority figures could have over the destiny of patients in the asylum. The referees were of a similar social and professional position to the officials at both the Home Office and Broadmoor and their advice would be very influential on the decision to discharge or retain the women.[127]

There is evidence of a benevolent, philanthropic type of patronage playing a part in the discharge procedure. As previously mentioned, Dr Corbin Finch actively helped and supported dischargees from Fisherton House, helping them to find permanent positions in service once released. In 1874 Lucy Thompson received financial aid from the Discharged Prisoner's Aid Society in Birmingham following her release. She was originally discharged to live with her brother in Birmingham but

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[123] BCLA, D/H14/D2/2/2/303, Case file (1): Sarah Bates, "Letter from Thomas Britten to Dr Orange, 7 July 1882".

[124] BCLA, D/H14/D2/2/2/398, Bates (2), "Annual Report to Home Office, 25 May 1886".

[125] BCLA, D/H14/D2/2/2/123, Case File: Mary Coleman, "Letter dated 18 March 1886".

[126] BCLA, D/H14/D2/2/2/123, Coleman.

[127] Andrews, "Boundaries of Her Majesty's Pleasure", p. 236.

due to violent family disagreements she moved out. Lucy wrote to the Chaplain at Broadmoor asking for financial help, which was provided by the Society through his offices.[128] In the latter decade of the century, the Salvation Army could take an interest in the potential discharge of some of the women. They would take them into one of their receiving homes or a rescue home for "rehabilitation" and training, with the intention of helping them to find positions.[129] Eva Lonnon was discharged from Broadmoor in 1895 to the care of Mrs F. H. Lawrence and the Salvation Army.[130] By the 1901 Census she is recorded as living in Penge, with members of the Salvation Army and her occupation is recorded as "S.A. Servt (sic)", and her status as "Inmate of S.A. Home.[131] By 1911, she was a cook in the household of a retired Royal Naval Lieutenant Commander, in Fareham.[132]

Former employers would also take an interest in the welfare of the discharged patient. Between 1875 and 1883, Sarah Fletcher's former mistress, Mrs Annie Litton, a rector's wife and Fletcher's husband's employer, R. Coxwell Rogers, unsuccessfully sought to help in obtaining her release.[133] The exchange of correspondence between

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[128] BCLA, D/H14/D2/2/2/105, Case File: Lucy Thompson, Series of letters August 19/22/25, 18 September 1874 and 7 May 1875. Discharged Prisoner's Aid Society –if needed the DPAS would apply to the Chaplain at Broadmoor hospital for a grant of 40/- to aid released "prisoners".

[129] "The purpose of Salvation Army rescue homes was to "rescue" women from their old lives. Spiritual improvement was seen as paramount, with an emphasis on the women gaining salvation. In addition, skills were taught that would help women find work after leaving the home". Kevin, Archive Research Assistant, "A closer look at The Salvation Army's London Rescue Homes", Feb. 2020. Retrieved from Salvation Army, International Heritage Centre blog.

[130] BCLA, D/14/D2/2/456 Case File: Eva Mary Lonnon.

[131] TNA, Census Returns of England and Wales 1901, Class: RG13, Piece: 650, Folio: 82; Page: 25.

[132] TNA, Census Returns of England and Wales 1911, Class: RG14, Piece: 5655, Schedule: 12.

[133] BCLA, D/H14/D2/2/2/152, Case File: Sarah Fletcher.

Dr Orange and the two separate employers is an illustration of a contemporary assumption of the correspondents that they had a lasting moral duty to look after their staff. Despite their assurance that her husband was "willing and anxious to take the poor woman home", Orange did not recommend her release. In 1896, Mrs Constance Booth of the Salvation Army wrote to Broadmoor enquiring whether a petition from them would facilitate a successful release of Sarah Fletcher to their care. Once again, the request was refused; it was felt that Fletcher had never totally recovered and would easily relapse once again into insanity.[134]

In 1871 Hannah Ryan was admitted to Broadmoor for the murder of her daughter Lizzie. At the time of the murder, Hannah's husband Isaac was coachman to a Mrs Brocklehurst of Butley Hall in Prestbury, Cheshire.[135] Mrs Brocklehurst was the wife of William Brocklehurst who served as MP for Macclesfield between 1868 and 1880. In 1872 Mrs Brocklehurst wrote to Dr Orange enquiring how she should proceed in helping to get Hannah discharged and he advised petitioning the Home Secretary. Hannah was discharged in August 1875, ostensibly to her husband's care but Mrs Brocklehurst did take her into her personal service. It was Mrs Brocklehurst who gave the asylum the assurance that she would take care to protect Hannah from any potential relapse into insanity.[136] Similarly, Elizabeth White, the subject of the opening case study in Chapter 5, was supported on her discharge by her husband's employers, Mr and Mrs George Dunn of Wooley Hall, White Waltham, Berkshire.[137] Such social interventions highlight the cultural interactions in Victorian society with

[134] BCLA, D/H14/D2/2/2/152, Fletcher, "Letter dated 27 October 1896 to Mrs Constance Booth, Mare Street, Hackney".

[135] BCLA, D/H14/D2/2/2/187, Case File: Hannah Ryan.

[136]BCLA, D/H14/D2/2/2/187, Ryan, "Letter dated 7 August 1875 from Mrs Mary Brocklehurst, Stanhope Terr., Hyde Park".

[137] BCLA, D/H14/D2/2/2/442/8, Case File: Elizabeth White.

middle and upper classes believing they had a moral duty and social responsibility to look after the welfare of their staff and their families.[138]

Relapse and return

At the beginning of the sixty years under discussion, a release was not dependent on whether or not the family could safeguard the patient's mental state. The asylum authorities were expected to advise the Home Office whether the patient was sane and recovered from the insanity which had caused her crime and family and friends were approached as carers for the dischargee's physical welfare, rather than as guardians of her mental state. This is demonstrated in an 1868 letter from the Home Office to Broadmoor about a potential release: "I am directed to request that … [you] … will endeavour to ascertain whether the prisoner's [sic] family are in a position to take care of her and whether they are willing to do so in the event of her release".[139] If family and friends did not provide a home, a discharged criminal lunatic would become the responsibility of her parish union and possibly go into a workhouse. The implication in Whitehall communications was that the officials at the Home Office were concerned that a discharged criminal lunatic patient should no longer be the responsibility of the state but would be sufficiently looked after by family or parish unions. The conditional clause in the discharge warrant only obligated the woman to return to custody on the Secretary of State's warranty if she should relapse into insanity or was considered to be unfit to be at large. Of the thirty-seven non-Broadmoor cases, only one returned to her original place of incarceration and it is not clear from the records whether her second stay was financed by the Home Office.

[138] Susie L. Steinbach. *Understanding the Victorians. Politics, Culture and Society in Nineteenth-Century Britain.* (London & New York: Routledge, 2016), p. 132.

[139] BCLA, D/H14/D2/2/2/166, Case File: Ann Lacey, "Letter dated 8 July 1868".

Mary Ann Payne was discharged on a conditional warrant from Fisherton House to her family home in Marylebone on 7 August 1867.[140] On the 11 October 1871, in accordance with the terms of her discharge warrant, she was readmitted to Fisherton suffering from "religious fancies and … she conceives she must destroy her friends and herself". Her casebook notes suggest that, unlike her previous admission when her insanity had been attributed to her pregnancy, this time her mental state was related to drinking: "this woman has some of the symptoms of delirium tremens". Payne was given treatment and rest. By 1 November 1871 she was recorded as being quiet and industrious.[141] Other research shows that prior to her admission in 1871, Mary Ann had been living in London apart from her husband who was living in Wantage, Berkshire.[142] Nowhere in her notes is there an indication that she returned because of an official request; neither does it appear that the Home Office was aware of her readmittance. Therefore, unlike later cases in Broadmoor, there was no obligation for Payne to remain in Fisherton House while another official enquiry into her re-release was conducted. She was released from Fisherton House as recovered on 18 January 1872 and joined the rest of her family in Wantage, where she remained until her death.[143]

Most of those women discharged from Fisherton House or Bethlem were unconditionally released with a Royal Pardon; I have found no record of any returning to either asylum as a criminal lunatic. It is possible that some returned to non-criminal asylum care at some point in their lives, but investigation of this would be beyond the scope of my research. In later years and particularly with Broadmoor patients, great

[140] FHAA J7/190/9, Patient Casebook 1862-1871, Mary Ann Payne, ff. 170-172.

[141] FHAA J7/190/9, Mary Ann Payne, f. 177.

[142] TNA, 1871 England Census Class RG10 Piece 251 Folio 46 Page 20 Islington, London.

[143] BFHS, Parish Records, SS. Peter & Paul, Wantage. Mary Ann Payne, Death Date 31 December 1903.

care was exercised in trying to ensure that the future situation of discharged homicidal mothers would be appropriate; all officials involved in assessing suitability for discharge were conscious of the risk of relapse.[144] In a letter written in 1885, Orange spelled out his personal thoughts about releasing patients. He wrote, "[I] enclose these few lines to say … It is one of the most painful parts of [my] duty to have to listen to piteous appeals for discharge from the unfortunate inmates and at the same time to know that it would not be right to grant what is asked for."[145]

This was particularly relevant to those women who had been diagnosed as suffering from puerperal insanity and other manias related to childbearing.[146] As noted in Chapter 5 and previously in this chapter with regard to husbands, prevention would become the responsibility of the guardians to whom the woman was released. One of the clinicians' prime anxieties was the potential risk attached to any future pregnancy. Former patients were readmitted but, among the cases reviewed, none of the relapses were caused by childbearing. Following the passing of the 1884 Criminal Lunatics Act, the pro-forma *Warrant of Conditional Discharge* specifically stated that "if any of the conditions of discharge appear to be broken … the Secretary of State may by warrant direct … [the Criminal Lunatic] … to be taken into custody and to be conveyed to some Asylum".[147]

The main condition of discharge was that the guardian should submit periodic reports on the progress of the former patient to Broadmoor, countersigned by a person of authority such as a local doctor or minister. In most cases the discharged patients

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[144] Andrews, "Boundaries of Her Majesty's Pleasure", p. 225.

[145] BCLA, D2/2/2/337, Case File: Hannah Shawcross. "Letter dated 25 June 1885 to Mr E Hibbert, Hyde, Cheshire re Hannah Shawcross".

[146] Other "manias" relating to childbearing included lactational insanity and insanity of pregnancy.

[147] 47 & 48 Vict. c.64. Criminal Lunatics Act 1884. Sample Warrant BCLA, D/H14/D2/2/237, Case File: Hannah Shawcross, "Warrant of Conditional Discharge 9 August 1890".

and in later years their guardians, complied with any conditions laid down in their release documentation. Sarah Lancestell's son regularly submitted Annual Reports about his mother's welfare from her release in February 1886 until her death in January 1891.[148] There were those who wished to distance themselves from the stigma of Broadmoor and deliberately moved away. In 1892 Charles Barrow wrote to Dr Nicolson requesting that the conditions of his wife's discharge be dropped as he felt "it is not necessary for our new society to be aware of our circumstances."[149] The request was formally declined but Barrow gave up furnishing the reports anyway. Without informing Broadmoor, he moved his family to Birmingham which action culminated in a police search. Eventually, their whereabouts and circumstances were reported to Broadmoor by the Chief Constable of Birmingham Police. He wrote explaining that "Mr Barrow is in a terrible state of anxiety ... he appeared to think that Mrs Barrow should not be obliged to return to Broadmoor if she lost her reason again."[150] From the lack of further papers in her case file, it would appear Barrow's explanation was satisfactory to the Asylum and Home Office authorities. Kate Barrow remained with her husband and family without any further reference to Broadmoor.[151]

Patients could be readmitted because their guardians felt they were no longer able to manage their charge. In 1885 Sarah Newman was discharged to the guardianship of her husband, Daniel but in 1900 he wrote to Broadmoor saying, "I can

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[148] BCLA, D/H14/D2/2/2/126, Case File: Sarah Lancastell, "Annual Reports 1886-1891".

[149] BCLA, D/H14/D2/2/2/330, Case File: Kate Barrow, "Letter from C. Barrow to Dr Nicolson, 5 January 1892".

[150] BCLA, D/H14/D2/2/2/330, "Letter from Chief Constable, Birmingham Police, 19 August 1895".

[151] BCLA, D/H14/D2/2/2/330, Barrow; TNA, 1901 England Wales & Scotland Census. Class: RG13; Piece: 1809; Folio: 124; Page: 11; GRO, 1909 Death Index. Barrow, Kate (64) Q4 vol.6c. p. 29 Kings Norton (Worcestershire) England & Wales, BMD Death Index, 1837-1915.

no longer be answerable for my wife's safety or my own as I live in fear of my life … her threats and behaviour are past all bounds, she cannot be restrained".[152] Others were readmitted because the women themselves admitted to their guardians that they felt vulnerable and unable to cope with life outside the asylum. On 11 January 1897 Rebecca Bell was discharged from Broadmoor to the care of her sister in Farnham, with whom she lived "well and happy" for three years.[153] In August 1900 her sister wrote to the matron at Broadmoor to say that Rebecca was suffering from depression, could not sleep at night and would not eat properly. She had also become very nervous of others and had "asked me to send her back"; Rebecca Bell returned on 16 August.[154]

Caroline Gardiner was admitted into Broadmoor in 1887 and discharged to the care of her husband in December 1897.[155] He regularly sent the requisite reports to the authorities and she appeared to be in good spirits and health. In November 1905 the Medical Superintendent, Dr Brayn, received an unsigned letter from her home in Dover saying that Caroline "should be sent for at once". He wrote to the Chief Constable of Kent advising him that "An anonymous note believed to be from Mrs Gardiner has been received at this Asylum" and requesting that "quiet inquiry [be made] respecting the present mental state of Mrs Caroline Gardiner". [156] A visit from a local doctor confirmed that Caroline was "furtive & suspicious" and wandering in

[152] BCLA, D/H14/D2/2/2/568, Case File: Sarah Newman, "Letter from Daniel Newman to Dr R. Brayn, 5 January 1900".

[153] BCLA, D/H14 D2/1/2/2, Patient Casebook: Females admitted 1879-1901, Rebecca Bell Reg. no. 575, f. 105. (transcribed by BRO)

[154] BCLA, D/H14/D2/2/2/575, Case File: Rebecca Bell, "Letter from Mrs Sophia Lock 10 August 1900".

[155] BCLA, D/H14/D2/2/2/670, Case File: Caroline E Gardiner, "Warrant of Conditional Discharge 7 December 1898".

[156] BCLA, D/H14/D2/2/2/670, Gardiner, "Letter from Dr Brayn to Chief Constable of Kent. 2 November 1905".

her mind but, he wrote, there was "no evidence of suicidal or destructive tendency".[157] Nevertheless, Caroline was returned to Broadmoor and her Warrant of Conditional Discharge was revoked on 5 November 1905. Whatever the circumstances were surrounding readmission, a patient could be re-released if their physical and mental states were considered suitable. The domestic circumstances and capabilities of the "new" guardians were once again reviewed and assessed to ensure a safe discharge. Not only were the discharged patients effectively policed and watched for the rest of their lives, so were the families and kin who had accepted responsibility for them.[158] Both Sarah Newman and Sarah Bates, as described at the beginning of the chapter, were subsequently re-discharged, Newman to the care of her son with whom she lived until her death in 1905 and Bates to her daughter in July 1904, only to return in January 1905.[159]

Death in the asylum

Despite what was viewed as thorough investigation and assessment by the asylum authorities and government officials, unfortunately not every discharge was successful. Twenty-one of the 106 women discharged were readmitted and then remained in Broadmoor for the rest of their lives. Amongst these were Rebecca Bell, Sarah Bates and Caroline Gardiner who died in 1905, 1911 and 1918 respectively.[160] There were a number, such as Eliza Kirby, whose families unsuccessfully campaigned for release and who died in Broadmoor and there were many for whom discharge and

[157] BCLA, D/H14/D2/2/2/670, Gardiner, "Letter from Dr C A Kent. 2 November 1905".

[158] Shepherd, "The Families of the Criminally Insane", p. 26.

[159] BCLA, D/H14/D2/2/2/568, Newman, "Warrant of Discharge 30 January 1900"; D/H14/D2/2/2/611, Sarah Bates.

[160] BCLA, D/H14/D2/2/2/575, R. Bell. "Death notice 2 November 1905"; D/H14/D2/2/2/611, Bates, "Death notice 12 February 1911"; D/H14/D2/2/2/670, Gardiner, "Death notice 22 May 1918".

release was never considered.[161] When discussing the deaths of those women who died in the asylum, as with the discussion on discharge procedures, my analysis relies mainly on Broadmoor records. Although the casebook notes are available for the other asylums, they contain medical commentary rather than information on interactions with the families or other authorities.

Some of the women who had been incarcerated between 1835 and 1863 in Bethlem or Fisherton House, were transferred into Broadmoor and therefore either died there or were discharged. Table 7:2 shows the percentage of all the women of my sample group admitted between 1835 and 1895 who died in incarceration, broken down by admission pattern. Although 47% of the sample group died in the asylum, it is difficult to ascertain one common factor which determined their retention. Table 7:3 is a breakdown of the causes of death for those who died in the asylum, including the 21 women who were discharged and returned. The table has been compiled from the open case books, open personal case files and newspaper reports.

[161] BCLA, D/H14/D2/2/2/136, Case File: Eliza Kirby; D/H14/D2/2/2/138, Case File: Harriet Goodliffe.

Admissions 1835 to 1895	**Adms**	**Died**	**%**
Non-Broadmoor	37	5	14%
Transferred from Bethlem & Fisherton House to Broadmoor	31	21	68%
Broadmoor only	220	109	50%
Total	288	135	47%

Table 7:2: *Deaths in the asylums; admissions between 1835 and 1895.*[162]

Cause of death in incarceration 1835 to 1895				
	Non-Broadmoor	**Transferees**	**Broadmoor**	**Total**
Apoplexy	1		2	3
Cancer		4	18	22
Cardiac		5	5	10
Cerebral disease		2	4	6
Chest disease	1		3	4
Chronic conditions			3	3
Consumption & pthisis	1		7	8
GPI (syphilis)		1	4	5
Kidney disease		3	4	7
Meningitis			2	2
Senile decay/ dementia		3	5	8
Suicide	1		1	2
Typhus	1			1
Ulceration of gut			2	2
Unknown (not available post-1919 deaths)		5	50	53
Totals	**5**	**21**	**109**	**135**

Table 7:3: *Cause of death in incarceration 1835 to 1895.*

[162] 288 cases admitted to any asylum as a criminal lunatic in the period 1835 to 1895 for murder or attempted murder of their child. Number of deaths for the admissions in the period 1863 to 1895 include the 21 women who were readmitted.

All deaths in Broadmoor were the subject of a county coroner's inquest and a number of these inquests were reported in the local Berkshire newspapers. What is apparent is that, amongst the women of my sample group, there were only two deaths from general paralysis of the insane (GPI or syphilis) and none from causes directly stemming from childbearing. Whether the woman's insanity had, in some cases, been caused by her underlying medical condition, is not within the scope of the research for my thesis but there is a possibility that diseases such as TB or brain disease would have had an impact. Hilary Marland has analysed the deaths of women who suffered from puerperal insanity. She highlights the clinical association of the perceived trauma of childbirth and its aftermath with patients' fear of impending mortality and damnation, suicidal impulses and general clinical depression.[163]

The fragility of a patient's mind and her overall disposition was closely observed in the asylum as an indicator of insanity or, indeed, sanity. If a patient moved towards an improved "cheerful" outlook and more amenable behaviour without delusions, it was taken as a sign that she was recovering from her mental illness. The one common factor for those women retained in the asylum, therefore, may be the lack of these traits. In 1871, on her admittance for her second stay in Fisherton House, Mary Ann Payne was described as "very excited and agitated". One month later she was "more calm and somewhat stronger" and her final entry states that "she is very considerably improved … being now quiet and industrious. Discharged".[164] In contrast, Mary Bennett's medical reports in Broadmoor consistently say that she was not improved in mind and that she was "petulant and troublesome".[165] She was

[163] Hilary Marland, "Under the Shadow of Maternity: Birth, Death and Puerperal Insanity in Victorian Britain", *History of Psychiatry*, vol. 23, no. 1, (2012), pp. 78–90.

[164] FHAA, J7/190/12, Patient Casebook 1871-1875, Mary Ann Payne f. 177.

[165] BCLA, D/H14/D2/2/2/111, Bennett, "Medical report 1868".

admitted in 1866. In 1875 Orange wrote that she "was not improved in mind" and in 1880, she was described as "irascible and very much depressed".[166] Bennett was never released and died in 1884 of pthisis and meningitis.[167]

There were two suicides amongst the group, the first was that of Anne Colley in Stafford Gaol as outlined in Chapter 4 and just one within an asylum, that of Sarah Bull in Broadmoor. As Olive Anderson pointed out, reiterated by Anne Shepherd and David Wright, even if asylum records described the patient as suicidal on entry into the asylum, suicides within the asylums rarely happened.[168] The reasons for this probably lay in the preventative methods used, which consisted of strict surveillance and on occasion, sedation. Dr Orange's report on Sarah Bull's case indicates that observation was not always enough but that some responsibility should lie with the patient. In the four years of her incarceration prior to her death, her husband, George Bull, had made numerous enquiries about possible discharge and visited regularly. Despite being favourably viewed by the staff as coming from a respectable and educated home – George Bull was a Schools Board Inspector – the asylum medical men did not believe that Sarah Bull was in a fit mental state to be released. As a medical report in 1883 stated, "she has been comparatively tranquil yet her mental health is by no means re-established … her release … would be attended with a considerable risk of relapse into a state of active insanity".[169] The last refusal for

[166] BCLA, D/H14/D2/2/2/111, Bennett, "Medical reports 1875, 1880 and 1883".

[167] BCLA, D/H14/D2/2/2/111, Bennett, "Death notice 21 August 1884"; BHFS, Berkshire Burial Records 25 August 1884 St John the Baptist, Crowthorne, Mary Bennett (44). Berkshire Burial Records.

[168] Olive Anderson. *Suicide in Victorian & Edwardian England*. (Oxford: Clarendon Press. 1987), p. 406; Anne Shepherd & David Wright. "Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint", *Medical History*, vol. 46, (2002), pp. 175-196.

[169] BCLA, D/H14/D2/2/2/316, Case File: Sarah Ann Bull, "Medical Report 15 June 1883".

release was one week before her suicide and would appear to have preyed on her mind, as demonstrated in the wording of her suicide note, "I have felt dreadful strange for some days … What good am I here? … What anxiety for my husband. It is far better for him to be relieved of such a burden".[170]

Orange's 1884 report on the case to the Commissioners in Lunacy gives a sense that he believed that the asylum was not at fault for missing the signs that Bull might harm herself. Her case demonstrates that the attendants and medical staff had also relied on patients articulating how they were actually feeling. Orange wrote,

> … No change was observed in her condition until she was found … at 6.30 am … The fact that was stated by her that she 'felt dreadful strange' had been concealed by her and not observed otherwise it is unlikely to say that she would not have been removed to another ward and placed under suitable supervision…[171]

At the inquest into her death, the attendant who had seen her at bedtime said that she had said good night "in the usual way" and that there was no reason to visit her during the night because she had "always seemed very cheerful". Her husband's evidence supported that of the Broadmoor staff saying "she appeared to be in her usual good health and spirits" when he had last seen her on the Tuesday before. [172] Where it might seem that Orange was justifying the non-action of the asylum staff in protecting a patient from self-harm, there is also a sense of disappointment and failure. The asylum existed to safeguard the patients from harm and they had failed to do so. As he

[170] BCLA, D/H14/D2/2/2/316, Bull, transcribed suicide note.

[171] BCLA, D/H14/D2/2/2/316/23, Bull, " Dr Orange to Commissioners in Lunacy 10 June 1884".

[172] "Distressing Suicide At Broadmoor Asylum" *Reading Observer* (14 June 1884), p. 2.

subsequently wrote in his Annual report for 1884, "it would appear that no amount of precaution is capable of guarding entirely against accidents of this nature".[173]

As mentioned earlier in the chapter, it has been suggested that the asylum medical men seem to favour keeping the women in the asylum until menopause as a preventative measure against future pregnancies.[174] There is evidence in the case files that to an extent this was a consideration, although the menopause itself was thought to hold an inherent risk to the female mind. As Dr Orange wrote in Eliza Kirby's notes in 1877:

> … She has not yet passed that period of life when with the … cessation of the female functions of the generative organs there comes to those who are subjects of insanity of a chronic even comparatively mild description, a considerable liability to the accession of attacks of mania, more active and more acute…[175]

It was felt that, in Kirby's case, her mind would never be settled enough to ensure a "safe" discharge. Despite persistent and sustained attempts by her family for her discharge, her release was always resisted by the authorities. It is noted in her file that Kirby refused to write to her husband and that "she herself says, in her insane way,

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[173] William Orange, "Twenty-Second Annual Report of the Medical Superintendent", *Reports upon Broadmoor Criminal Lunatic Asylum with Statistical Tables for the Year 1884* (London: Eyre and Spottiswoode. 1885), p. 4.

[174] Andrews, "Boundaries of Her Majesty's Pleasure", p. 230.

[175] BCLA, D/H14/D2/2/2/136, Kirby, "Draft medical report to the Home Office 12 April 1877.

she will not go to her husband".[176] Eliza Kirby died of heart disease in February 1887, having spent 20 years in Broadmoor.[177]

The asylum medical superintendents and their medical officers had autonomous control of the criminal lunatic patients in death; they could act in what they were believed were the best interests of their patients without reference to the Home Office. The paternalistic, interventionalist attitude applied to the families of the dying too. Families were actively encouraged to visit and communicate with their dying relative, as comfort to both parties.[178] When Bridget Myles was seriously ill in 1903, her sister and surviving daughters were encouraged to visit and correspond with her. This correspondence continued until her death in 1909.[179] In 1885, Dr Nicolson wrote to Ann Goring's husband saying, "[she] is seriously ill with an attack of inflammation of the lungs and thereby she may be visited at any time".[180] On many occasions, families finally accepted that they would not be able to care for or even see their errant member again. Catherine David was discharged to the care of her husband in October 1877 but she requested to return to Broadmoor just one month later. Her husband wrote to Dr Orange in December 1877 in despairing terms saying, "I do intrude upon your patience … [but] … I simply want to know how is my wife? … I

[176] BCLA, D/H14/D2/2/2/136, Kirby, Death notice 6 February 1887. BCLA; BHFS, Berkshire Burial Records, 10 February 1887 St John the Baptist, Crowthorne, Eliza Kirby (56).

[177] BCLA, D/H14/D2/2/2/136, Kirby, " Draft medical report to the Home Office 21 February 1878".

[178] Shepherd, "The Families of the Criminally Insane", p. 27.

[179] BCLA, D/H14/D2/2/2/150, Case File Bridget Myles. "Death notice 3 March 1909"; BHFS, Berkshire Burial Records 8 March 1909 St John the Baptist, Crowthorne, Bridget Miles [sic] (76).

[180] BCLA, D/H14/D2/2/2/318, Case File Ann Goring, "Letter 21 January 1885".

have bidden her farewell for life … [but] … I should like to know how she is … and that is all".[181]

Sarah Patey was admitted to Broadmoor from Fisherton House in 1863 and for the next 27 years there was regular correspondence between the asylum and her husband Richard, who wrote each year asking the same question: "I am very anxious to know of any change in my wife by this time".[182] By 1883 she was described as "very much deranged" and as having "a frail heart"; her family was advised that it had been agreed that they "may visit at any time".[183] In February 1898 Richard Patey was advised that "mentally she is demented, knows nobody and is unable to hold any conversation so she would not appreciate a visit".[184] By June 1900 he was advised that "your wife's health is declining … there is, I fear, little hope of her recovery".[185] Sarah Patey died in September 1900 and the final letter from Richard reads, "I regret I will not be able to attend the funeral as I am now in very poor health … I can only thank you and all at the Asylum for your care for my wife".[186]

As with workhouse deaths, responsibility for funerals and burials lay with the asylums. Julie-Marie Strange writes that workhouse and pauper burials were popularly viewed as "undignified interments". That view does not appear to have been taken by the families of the Broadmoor patients.[187] In the case of Broadmoor, family members

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[181] BCLA, D/H14/D2/2/2/220 Case File: Catherine David. "Letter from John David 21 December 1877".

[182] BCLA, D/H14/D2/2/2/71, Case File: Sarah Patey. Series of letters from Richard Patey.

[183] BCLA, D/H14/D2/2/2/71, Patey, "Letter from Dr Nicolson 20 April December 1883".

[184] BCLA, D/H14/D2/2/2/71, Patey, "Letter from Dr Baker 14 February 1898".

[185] BCLA, D/H14/D2/2/2/71, Patey, "Letter from Dr Baker 12 June 1900".

[186] BCLA, D/H14/D2/2/2/71, Patey, "Letter Richard Patey 18 September 1900"; BHFS, Berkshire Burial Records, 18 September 1900 St John the Baptist, Crowthorne, Sarah Patey (62).

[187] Julie-Marie Strange, *Death, Grief and Poverty in Britain* (Cambridge: Cambridge University Press, 2005), p. 138.

would gratefully accept the Asylum's authority at this time, writing letters of gratitude for the care their family member had received before and after, death. The families were invited to attend the funeral and burial at Broadmoor but their presence was not considered essential. The burial of patients at Broadmoor was also a matter of practicality. The costs of transportation of a body and of a funeral would be beyond the economic capability of many of the patients' families. As the deceased remained a responsibility of the Crown all costs were borne by Broadmoor.[188] This meant that, in most cases, the dead family member would then be interred away from their community, although it would appear that the whereabouts of the grave was of less importance than knowing that their family member had been "decently" buried. As Julie-Marie Strange observes, the families and kin would remember the deceased mother in different contexts without necessarily visiting the cemetery or burial ground in question.[189] The asylum authorities were willing to allow families to visit and personalise the burial site if they so wished.

In 1879, William Greenwood requested that he and his surviving children be allowed to visit the grave of his wife, Emma, in order to plant shrubs in her memory, which request was granted.[190] On occasion the deceased's family claimed the body for private burial, which was readily accepted by the hospital authorities. In the case of Jewish patients, the Broadmoor authorities had a connection with the Burial Society of the United Synagogue in St James Place, Aldgate, who would collect the deceased for interment in the Jewish cemetery in east London.[191] Throughout the final illnesses

[188] Shepherd, "The Families of the Criminally Insane", p. 28

[189] Strange, *Death, Grief and Poverty*, p. 193.

[190] BCLA, D/H14/D2/2/2/147, Case File Emma Greenwood, "Letter from William Greenwood 31 August 1879"; BHFS, Berkshire Burial Records. 8 August 1879 St John the Baptist, Crowthorne, Emma Greenwood (53); Photograph; Appendix 4.

[191] BCLA, D/H14/D2/2/2/168, Case File: Adelaide Freedman "Telegram from United Synagogue. 16 May 1902".

of the patients, if the asylum authorities were able to contact the families and kin, they kept them informed at all times of progress and treated them with professional sympathy. In all cases after the death, the asylum authorities afforded the deceased patients dignity in death in accordance with their creed, whatever their social background.[192] The overall impression from records is that any claims to the dead by their family and friends were met with approval and help. If the funeral and burial did take place at Broadmoor, it was considered respectable and acceptable, unlike pauper burials which Strange described as being viewed as an offence to the dignity of the dead and the bereaved.[193]

Conclusion

The integrity of the family and home were always considered of importance in the decisions to release of the infanticidal mothers. Family involvement was always a part of the decision-making process in the release of these mothers from the custody of an asylum. The existence of good social bonds and strong extended family units, such as those of Sarah Jackson (1859) and Sarah Newman (1885 and 1900), led to positive responses from the authorities to discharge requests. Family and friends were always examined to confirm that they were willing and able to provide a home for the discharged woman. The economic condition and to a lesser extent the respectability, of a family was always significant to the Home Office officials. Prior to Broadmoor's opening, the importance of respectability to the discharge procedure was less evident. Records from Fisherton House and Bethlem indicate that the social status of a patient's family had an influence on release decisions. The opening of Broadmoor as an asylum dedicated to the treatment of criminal lunatics was a major contributor to the changes in discharge procedures and protocols between 1835 and 1895. Increasingly, in the

[192] See Appendix 4: "Burials at Broadmoor Criminal Lunatic Asylum".

[193] Strange, *Death, Grief and Poverty*, p. 159.

thirty years after Broadmoor opened familial, domestic and economic social circumstances were more closely examined to ensure that the proposed care would safeguard vulnerable patients.

The majority of the mothers who had murdered their children were from a working-class background and social status played a part in the way the women and their home circumstances were perceived. Occasionally, the educational background of the family and husband was questioned and references from employers and other community figures were required, to confirm the family's suitability to be carers. Officials at the Home Office sought reassurances that the respectability and moral circumstances of families and friends were suitable to ensure a safe future for the discharged patient. The concepts of acceptable social behaviour differed between classes but respectability was always a shared point of reference. Educated middle-class men such as Thomas Sanderson and Charles Barrow were able to use their social connections to enlist the help of well-known political figures to assist in their petitioning for their wives' release. Their social background was recognisable to the officials at the Home Office and would aid their cause. A strong element of middle-class culture was a belief in an obligation to look after the welfare of the "less fortunate" members of society. This perceived paternalistic responsibility is demonstrated by interplay in the discharge procedure between the asylum clinicians, the personal referees for the guardians and the officials at the Home Office.

Although the medical officers at Broadmoor placed a value on the emotional bonds of a family, there was on occasion an apparent lack of appreciation for the socio-economic situations of poorer families. As with the discharge arrangements for ordinary lunatics, the authorities were concerned with the quality of the homes to which the discharged mothers would return.[194] Increasingly, particular emphasis was

[194] Dobbing, "The Family and Insanity", p. 150.

placed on the future comfort and welfare of the discharged patient rather than on a return to her former role. For women whose crimes had been closely related to familial and gynaecological problems, the capability of family and kin to provide a reputable, comfortable home was a key factor in evaluating release from an asylum. If it were shown that the husband and the patient's extended family were offering a respectable domestic environment, together with caring companionship, discharge would be recommended. For the women who remained in the dedicated criminal lunatic facilities for the rest of their lives, families were only involved with them as visitors and correspondents and in their deaths at the behest of the asylum authorities. Whatever happened to the women, whether they were released or died in the asylum, control over their futures lay in the hands of the Home Office and the asylum authorities and that control grew over the sixty years in question. In the earlier years of the period, particularly with releases from Bethlem, if the women received a Royal Pardon then their lives no longer fell under the purview of the Home Office. Royal Pardons fell from use and, increasingly, the releases were conditional. Conditions of discharge became more formal and stringent until, by the end of the nineteenth century, the discharged patient remained ostensibly always a responsibility of the Crown, wherever they were. None of the women, including those who remained in Broadmoor until their deaths, lost the status of being held at her Majesty's pleasure as criminal lunatics.

Conclusion:
"One of the very gravest of crimes"[1]
Reflections on "Mad Mothers, the Law and the Asylum".

On her release from Broadmoor in 1870, after seventeen years in confinement, Amelia Burt wrote that she was "truly sensible of the care and the kindness I have received for so many years".[2] She had been originally committed to Bethlem in 1852, then, in May 1863, transferred to Broadmoor as one of the first patients. Amelia Burt's history, between 1852 and 1870, is an illustration of one woman's experiences of the court and asylum systems in mid-nineteenth century England. She was tried at the Old Bailey on 13th December 1852 for the wilful murder, by drowning, of her nine-month-old baby, Annie Philadelphia.[3] The witnesses' descriptions of her behaviour at the time of the crime led the judge, Mr Justice Wightman, to conclude that she must have been insane and he advised the jury to acquit her on those grounds.[4] Amelia was sent into Surrey County Gaol (Horsemongers Lane), then, on 27th December, she was admitted into Bethlem as a criminal patient.[5] The casebook notes explain that once in the Hospital, she was a model patient, being "very good-tempered and obedient … and her intellect is clear". This was despite the fact that she "continued in a low state of mind" and "only in this way [shows] any symptom of insanity." In her first seven months in Bethlem Amelia had never been seen to smile and the medical officers were

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1 "Infanticide in England", *Morning Chronicle,* (10 September 1852), p. 4.

2 TNA, HO18/350 Criminal Petitions: Series II, Amelia Burt. "Letter to Secretary of State at the Home Office 28 February 1870".

3 OBP, *Old Bailey Proceedings Online*, January 1884, Trial of Amelia Elizabeth Burt (30) (t18521213-149).

4 "Murder of an Infant", *Lady's Own Paper*. (27 November 1852), p. 3, col 2.

5 TNA, HO18/350, Criminal Petitions, II, "Application for Removal to Bethlem 27 December 1870".

concerned that she could be suicidal. By April 1854, she had become "almost cheerful … and frequently smiles", still working with her needle and in "excellent bodily health." [6] Amelia was not removed to Fisherton House, despite appearing to be a "less dangerous" patient but was transferred, on 30th May 1863, to Broadmoor.[7] In 1870, she was allowed to write to the Home Secretary to petition for her release. In her letter, she described her husband as "being of unsteady habits" and claimed that she had "not seen or heard of [him] for the last 16 years."[8] If released, she wrote, she "would endeavour to earn my living as a machinist or domestic servant."[9] On their medical certificate, Dr John Meyer and Dr William Orange confirmed that they found "her [Amelia Elizabeth Burt] to be Sane and in good bodily health."[10] In turn, in their covering letter to the Certificate, the Governors of Broadmoor confirmed that Amelia's mother and sister were willing to receive her after discharge.[11] She was duly discharged on 2nd April 1870.[12] By April 1871, she was living with her mother in Bermondsey, under her maiden name of Gibson.[13]

I have opened each chapter of this thesis with a brief case-study of individual mothers who had killed their children and who were found insane by law. Each story was selected to illustrate the main topic under discussion and to lend substance to the argument within the particular chapter. It was a more difficult task to find one history to illustrate this final chapter and conclusion. For this purpose, I selected Amelia

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6 BHRA, CBC-03 Criminal Patient Casebooks 1850-1857, Amelia Elizabeth Burt f. 50.

7 BCLA, D/H14/D2/2/2/11, Case File: Amelia Elizabeth Burt.

8 TNA, HO18/350, Criminal Petitions, II, "Letter to Secretary of State at the Home Office 28 February 1870".

9 TNA, HO18/350, Criminal Petitions, II, "Letter 28 February 1870".

10 TNA, HO18/350, Criminal Petitions, II, "Medical Certificate, 7 March 1870".

11 TNA, HO18/350, Criminal Petitions, II, "Letter, 15 March 1870".

12 BCLA, D/H14/D2/2/2/11, Burt.

13 TNA, 1871 England Census. Class: RG10; Piece: 628; Folio: 123; Page: 25.

Elizabeth Burt's case because we have clear records of her experiences of the medico-legal system over the middle two decades of the sixty-year period reviewed in this thesis. Her trial was documented in the Proceedings of the Old Bailey and her Bethlem casebook notes are available, as is her casefile from Broadmoor.[14] Additionally, Home Office files available for research contain her petition for release, together with official correspondence detailing her discharge.[15] Amelia Burt was one of the first tranche of patients admitted to Broadmoor and she was one of the few early cases to be discharged unconditionally, following her personal request and petition. The seventeen years of her detention was a period of both consolidation and change in the protocols and procedures surrounding incarceration of criminal lunatics. Her seven years in Broadmoor covered the time when the new, dedicated criminal lunatic asylum became a firmly established part of the medico-legal and asylum landscape.

In my Introduction, I suggested that this chapter would, as the conclusion to my thesis, draw together the various arguments of the preceding chapters. In bringing the different topics and threads together, I would document the "typical" life-journey of a married mother who had killed her children to, potentially, find a coherent pattern to the treatment meted out in both legal and medical contexts. There was not, however, one archetypal or standard case; each woman's case-history in my 288-strong dataset was unique. There were many similarities in their diagnoses, treatments and social circumstances, as there were in the responses of medical and legal authorities, families, the press and, through their offices, the general public. But equally, there were many differences, the reasons for which can be attributed to other factors, such as views on social behaviours and respectability, inter-class relationships and identifications and evolving medical knowledge of insanity and its perceived causes.

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[14] OBP, January 1884, Burt; BHRA, CBC-03 Burt f. 50; BCLA, D/H14/D2/2/2/11, Burt.

[15] TNA, HO18/350, Criminal Petitions, II, Amelia Elizabeth Burt.

By describing and discussing these different aspects of the passage of the dataset of criminally insane mothers through the legal and institutional systems of Victorian England, I have found explanatory rationales for the benevolent and sympathetic legal and medical treatment received. Chapter by chapter, I have assessed the influence that prevailing social and collective principles could have on the interpersonal dealings between the mothers and the male legal, medical and governmental authorities. The detailed examination of the women's individualities, their life experiences and their ultimate outcomes in the system supports the hypothesis that considerate humanity frequently drove societal attitudes. Notwithstanding the fact that the mothers had carried out an ostensibly socially unacceptable deed, they were not inevitably censured.

In exploring the women's lives, I show that individual experiences and social background impacted on all aspects of their passage through the Victorian medico-legal system group. The discrete group of mothers who had killed their children were not necessarily condemned by the male-led medical and legal authorities, nor by Victorian society. This would appear to run contrary to present-day understanding of nineteenth-century concepts of motherhood, respectability and female violence. The perpetration of the crime of child-homicide by a female, was an act which did not fit into any conventional portrayal of a Victorian woman, let alone one of Victorian parenthood.[16]

It is apparent from my research and reading for this thesis, inter- and intra-class perceptions of respectability played a powerful role in the dynamics of the

[16] Barbara Leonardi, "Introduction: The Family Metaphor", in in Barbara Leonardi (ed), *Intersections of Gender, Class and Race in the Long Nineteenth Century and Beyond* (Basingstoke: Palgrave Macmillan, 2018), pp. 1-14, p. 4.

mothers' life-journeys. They also impacted upon the emotional engagements and relationships between the women of my dataset and all men in authority. I have found that some ideas of behaviour and outlook, were entrenched in class perceptions. Others were more nuanced, depending on situation and persons involved. Concepts of respectability and reputation were important to all levels of Victorian society. From my research for the thesis as whole, it has become evident that different principles of behaviour and respectability played a significant part in determining the quality of the women's passage through judicial and medical processes. The authorities' reactions were impacted by their cultural perceptions of other classes' expectations of respectable domestic and personal behaviour. Those reactions were tempered by the social backgrounds of each of the parties, as different classes had varied ideals and expectations of family and family duty.

The cases where homicidal mothers were charged with killing or assaulting their legitimate children, presented a problem to Victorian England and Wales. The marital status of a female defendant impacted upon cultural, legal and medical views of all mothers who murdered their legitimate children.[17] One problem was that the existing legislation, was focussed upon illegitimacy. As married women, the larger group within in my dataset would not be impacted by the legislation. A prevailing, perhaps essentially middle-class, "moral" view was that mothers with legitimate offspring had no obvious explanation for committing this crime, except, perhaps, insanity. Like other historians, I conclude that puerperal insanity provided a rational explanation for socially unacceptable behaviour, with sympathy being extended even to those mothers who had killed their offspring. Admissions to county and private asylums, together with those into criminal lunatic facilities, show that puerperal mania

[17] Anne Marie Kilday, *A History of Infanticide in Britain. c1600 to the Present* (Basingstoke: Palgrave MacMillan, 2013), p. 172-178.

did not just happen amongst the poorer mothers in society; it could affect anyone.[18] Its occurrence could not necessarily be attributed to "hereditary degeneracy", which was popularly believed to exist amongst the lower classes. The incidence of any historical insanity within a family was relevant to the legal and medical authorities, whatever the woman's social status and would be noted in records and statements.

Cases tried under the existing infanticide legislation, frequently received what were deemed lenient verdicts, including verdicts of insanity. There was a judicial reluctance to pass a capital sentence for infanticide, in its meaning of the killing of infants under twelve months old. The charge would more frequently be concealment of birth or manslaughter. The lenience or benevolent concern would stem from a sympathy for a young, single mother's desperation and possible violation by the father of the child. The accused would be viewed as more sinned against, than a sinner herself. Katherine Watson states that from her research, she has found that cases of possible madness, if verified by medical opinion, were not heard at assizes and "diverted from the criminal justice system" or faced a lesser charge.[19] From my research I have found that this hypothesis, while maybe applicable to new born murder, is not strictly true in cases of older infants and children. The single mothers considered to be insane, received the same sympathy for such circumstances, together with the added suggestion of mental derangement, caused by their physical health.

As I stated in my introductory chapter, a diagnosis or a suggestion of puerperal mania gave the medico-legal world a viable rationalisation for an inexplicable crime, whether the mother was single or married. My research and thesis adds to this

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[18] Catherine L.Quinn, "Include the Mother and Exclude the Lunatic. A Social History of Puerperal Insanity, c1860-1922" (unpublished PhD thesis, University of Exeter, 2003), p. 341.

[19] Katherine D. Watson, *Medicine and Justice: Medico-Legal Practice in England and Wales, 1700-1914* (London & New York: Routledge, 2020), p. 163.

scholarship by focussing on the condition in a legal and criminal context, when it manifested itself in the most tragic of circumstances.The majority of asylum admissions discussed in this thesis were said to be suffering from insanity, classified as puerperal in origin. Others had conditions associated with a woman's life-cycle and physiology. Such reasons were presented as having the ability to have a profound effect upon a woman's behaviour, even pushing her to the destruction of her child. There was compassionate concern amongst the medical profession towards affected mothers and the same compassion was apparent in the legal world. In accepting that the puerperal state could have a drastic impact on a woman's mental health, the medico-legal world and the general public were able to view maternal child murders committed under its influence as deserving of special consideration.

The male authority figures with whom the mothers came into contact, were invariably from the middle class and their personal lives did appear to impact upon their perceptions of the women. One factor which was common to all classes was the belief that that a home and family needed a mother at its centre. The lack of interest in caring for the home and for her children was sometimes given as evidence of insanity. If such evidence was given, it was as "proof" of abnormal behaviour, not as a criticism of the accused's abilities as a home-maker. The women were rarely described as "bad" mothers, and, including working mothers, they were frequently described as a loving and hardworking, despite their crime. A respectable, working-class Victorian home would have the mother at its heart but expectations of respectable domesticity differed from middle-class ideals. For a family to be thought respectable and "happy", the husband and father should be hard-working, prudent, affectionate and non-violent towards his wife and children.[20] The wife and mother should have good housekeeping

[20] Joanne Begiato, *Manliness in Britain, 1760-1900. Bodies, Emotion and Material Culture* (Manchester: Manchester University Press, 2020), p. 21.

skills, manage the family economy and be a fond and protective mother. Offence against such criteria, by the husband or by the mother, was frequently accepted in mitigation of the mother's crime. The idea of the defendant being found insane, offered an acceptable explanation to the essentially middle-class male authorities.[21]

Middle-class ideals of the home and family relationships informed the opinions of the male authority figures and, at times, would colour their views of a working-class household. This, in turn, had an impact on the reactions to the accused mothers in courtrooms and again in institutions and asylums. With regard to asylums, Anna Shepherd and Lorraine Walsh, separately, assert that certain socially acceptable behaviours by patients, were important determinants of management and treatment.[22] Any patient, whatever their class, would command favourable attention if they were seen to be respectable in habits. [23] In this thesis, I determine much the same response from the asylum clincians and staff.

Throughout my thesis, within each topic covered, it is clear that emotionally-driven responses from all parties impacted on the lives of the criminally insane mother. The death of a child carries with it an inherent poignancy and a raft of different emotional reactions. When that death is a violent one at the hands of the child's mother or father, the emotional responses to the case, at any level, whether legal, medical, family or public, are varied and mixed. This is as true in the present day as it was in Victorian Britain. Although I would not categorise this thesis as a study within the field of the history of emotions, the existence of emotional influences on the life-

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[21] Watson, *Medicine and Justice,* p. 84

[22] Lorraine Walsh, "A Class Apart? Admissions to the Dundee Royal Lunatic Asylum. 1890-1910", in Jonathan Andrews & Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam & New York: Rodopi, 2004), pp. 249-270, p. 250.

[23] Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 173.

journeys of the 288 women must be recognised. Emotional language engendered sympathy for the both the woman and her family in court. Barristers, expert witnesses and judges would openly express their personal reactions to cases, which impacted directly on a woman's future.

The interactions between the criminally insane mothers and their families and kin, while they were in the asylums, demonstrate the emotions existing within a familial unit. Letters and other ephemera illustrating dealings between the families and the asylum staff, reveal some aspects of the emotional relationships between the infanticidal and homicidal mothers and their families. Close and extended family played a very important part in the women's lives. Their support and continuing contact could ensure the women's futures outside institutional life and assist with their comfort within the asylum, if discharge was thought inappropriate. Familial disapprobation and estrangement equally, although more negatively, could impact the women's lives. Once again, ideas of respectability were important to the lives of the asyluum patients. The circumstances of family and kin played a crucial part in discharge and retention decisions.

The mothers' individual histories contribute to the wider histories of medical and legal treatment of insanity under the law and in the institutional systems of nineteenth-century England and Wales. In taking a micro-historical, narrative approach to my researched material and sources, I have analysed the experiences of my dataset of women, to explain the circumstances of the women and their crime and for the legal and medical treatment they received. Research into the personal biographies illustrate, and sometimes, clarify the impact of contemporary ideals. I believe that the Victorian expectations of motherhood coupled with social class ideas of respectability, influenced decisions made about all maternal child-homicides. These ideals of motherhood were rooted in one basic premise, that a mother should always

look after and care for her children. This was nuanced across the different class cultures. From the middle-class ideal of the "angel in the house" to the industrious housewife and working mothers of the lower classes, all were expected to nurture their children to the best of their abilities.

This hypothesis, that society's views of motherhood and ideals of respectability played a crucial role in the nineteenth century view of a female criminal, has been expressed before. Lucia Zedner describes such views as judgements against a "highly artificial notion of the ideal woman – an exemplary moral being."[24] Zedner also continues that, towards the latter end of the century, the view changed with the development of criminology and ideas of hereditary mental inadequacy.[25] Despite the view that the middle-class ideologies of women's behaviour and of motherhood, were unobtainable, "highly-artifical" objectives, they *were* influential on Victorian class conceptions and interactions. I am aware that the size of the studied group is relatively small in terms of child homicide and female crime, and that my research is very focussed on this singular set. I contend that the social judgements and views held by all sections of society is key to answering the questions asked in my introduction. What made these women so different? And why were they treated as they were?

Respectability of behaviour and backgrounds impacted on the professional and personal relationships. It was important to the way they were viewed by their own society, by the legal fraternity and the medical world. Analysis of the social background of all parties, including the women, their families and kin and the men from medical and legal authorities, highlights this importance. To be seen as "well-thought-of" and decent or to always act in an appropriate manner, was a dominant

[24] Lucia Zedner, "Women, Crime and Penal Responses: A Historical Account", *Crime and Justice,* vol. 14 (1991), pp.307-362, p. 308.

[25] Idem., p. 309.

cultural and social aspiration for most levels of society. Despite holding differing views and an occasional apparent lack of appreciation for the socio-economics of poorer families, the middle-class legal, medical and governmental officials accepted many of the domestic values of lower classes, as "respectable". In the main, mothers of the dataset were not viewed as morally deviant or degenerate. Their lives and characters were publicly and medically, scrutinised. Frequently they were described as respectable women in all aspects and loving, fond mothers. A plausible explanation of their violent, out of character, behaviour lay in mental illness.

During my research, I have been drawn to examining the experiences of postnatal psychiatric conditions in present-day sufferers, to briefly compare them with those of Victorian mothers. In her 2002 chapter, *"Nothing in between"*, Julie Wheelwright states that contemporary cases of women who kill their children should be and are rightly, first dealt with by the criminal justice system, because they have committed a criminal act.[26] She submits that such crime needs sympathy, not condemnation, which compassion is afforded by present-day tolerant society. [27] This modern social tolerance accepts that post-partum mental instability can cause devastating despair in mothers, which can lead to child murder. She suggests this consideration understands that the impaired judgment and reasoning of mothers suffering from psychological illnesses and psychoses, can be mentally overwhelming and, thereby, their "fragile sense of humanity" can be broken.[28] I would argue that my thesis shows that similar sympathetic and compassionate views existed within

[26] Julie Wheelwright, "'Nothing in between': modern cases of infanticide" in Mark Jackson (ed.), *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot: Ashgate, 2002), pp. 270-285., p. 285.

[27] Idem., p. 285.

[28] Idem., p. 285.

Victorian society and it is not a phenomenon confined to the twentieth or, indeed, the twenty-first century.

My thesis adds to scholarship within the fields of medical, psychiatric and legal history. It adds a new aspect to the scholarship of nineteenth-century by a detailed investigation of an unique dataset of women, in a sixty-year time-frame of social change in the Victorian England and Wales. By taking an singular and different approach to the subject of infanticide and child homicide, it supplements and complements the extant historiography on the subjects. My reflections on Victorian masculinity and femininity fall within the category of gender history. My exploration of the women's lives includes analysis and comment on marital status and familial relationships as well as on intra-class ideals of respectability. This cultural and social historical analysis clearly demonstrates that individual experiences and social background impacted on all aspects of the mothers' journeys through the Victorian medico-legal system.

Appendix 1: Class Designation by Occupation.

Women's Occupations

Occupation	**Class**
Bridle stitcher	Lower Class Unskill
Charwoman	Lower Class Unskill
Cook	Lower Class Unskill
Domestic servant	Lower Class Servant
Dressmaker	Lower Class Unskill
Farm Servant	Lower Class Agric
Field labourer	Lower Class Agric
Hatter	Lower Class Unskill
Housekeeper	Lower Class Unskill
Household duties - Housework	Lower Class
Applicable all classes	Middle Class
Labourer	Lower Class Unskill
Lacemaker	Lower Class Unskill
Laundress	Lower Class Unskill
Lodging housekeeper	Lower Class Unskill
Mantle maker	Lower Class Unskill
Market hawker	Lower Class Unskill
Milliner	Lower Class Unskill
Needlewoman	Lower Class Unskill
Packer in a factory	Lower Class Unskill
Pauper	Lower Class Unskill
School teacher	Middle Class Lower
Servant	Lower Class Servant
Silk weaver	Lower Class Unskill
Tailoress	Lower Class Unskill
Wet nurse servant	Lower Class Servant

Appendix 1 (cont'd)

Men's Occupations

Occupation (Spouses)	Class
Accountant	Middle Class
Ag labourer	Lower Class Agric
Asst overseer of h'ways	Middle Class Lower
Baker	Lower Class Skill
Bank Official	Middle Class
Barometer maker	Middle Class Lower
Blacksmith	Lower Class Agric
Bookseller	Middle ClassTrade
Boot finisher	Lower Class Skill
Bootmaker	Lower Class Skill
Boots at hotel	Lower Class Servant
Bricklayer	Lower Class Skill
Bricklayer's labourer	Lower Class Unskill
Builder	Lower Class Skill
Butcher	Lower Class Skill
Cabinet maker	Lower Class Skill
Carpenter	Lower Class Unskill
Carrier	Lower Class Unskill
Cart driver	Lower Class Unskill
Carter	Lower Class Unskill
Chemist & druggist	Middle Class Trade
Chemist's assistant	Middle Class Lower
Clerk	Middle Class
Coachmaker	Middle Class
Coach painter	Lower Class Skill
Coachman	Lower Class Servant
Coal miner	Lower Class Unskill

Coal porter	Lower Class Unskill
Collier	Lower Class Unskill
Commercial Traveller	Middle Class Trade
Cork cutter	Lower Class Agric
Cotton weaver	Lower Class Unskill
Customs clerk	Middle Class
Dock labourer	Lower Class Unskill
Draper	Middle Class Trade
Draper & tailor	Middle Class Trade
Dressingcase maker	Lower Class Skill
Dressmaker	Lower Class Skill
Druggist/chemist	Middle Class Trade
Engine driver	Lower Class Skill
Engine fitter	Lower Class Skill
Engine fitter(marine)	Lower Class Unskill
Farm bailiff	Middle Class Agric
Farm labourer	Lower Class Agric.
Farmer	Middle Class Agric.
Fishmonger/carpenter	Lower Class Unskill
Foundryman	Lower Class Unskill
Furrier	Middle Class
Gamekeeper	Lower Class Agric
Gardener	Lower Class Servant
Gas fitter	Lower Class Skill
Gas stoker	Lower Class Unskill
Gentleman's servant	Lower Class Servant
Grocer	Middle Class Trade
Grocer & draper	Middle Class Trade
Grocer's assistantt	Lower Class Skill
Harness maker	Lower Class Unskill
Hatters manager	Middle Class Trade
Horse dealer	Lower Class Agric

Housepainter	Lower Class Skill
Invalid chairkeeper	Middle Class Trade
Ironstone miner	Lower Class Unskill
Ironworker	Lower Class Unskill
Journeyman saddler	Lower Class Unskill
Labourer	Lower Class Unskill
Linen draper	Middle Class Trade
Lithographic printer	Middle Class Lower
Master Maltster	Middle Class Lower
Master Mariner	Middle Class
Merchant's clerk	Middle Class Lower
Militia soldier	Lower Class Unskill
Millworker	Lower Class Skill
Miltia	Lower Class Unskill
Miner	Lower Class Unskill
Miner's labourer	Lower Class Unskill
Nail cutter	Lower Class Unskill
Navvy	Lower Class Unskill
Ostler	Lower Class Skill
Painter	Lower Class Skill
Plumber	Lower Class Skill
Police (super)	Middle Class Lower
Police constable	Lower Class Unskill
Publican	Lower Class Unskill
Railway clerk	Middle Class Lower
Railway engineer (India)	Middle Class Lower
Railway guard	Lower Class Unskill
Railway platelayer	Lower Class Unskill
Railway pointsman	Lower Class Unskill
Railway porter	Lower Class Unskill

Railway shunter	Lower Class Unskill
Railway signal man	Lower Class Unskill
Railway worker	Lower Class Unskill
Riverboat messenger	Lower Class Unskill
RN Engineer	Middle Class
Roller coverer	Lower Class Skill
School Board Inspector	Middle Class
Seaman (ordinary)	Lower Class Unskill
Seaman (petty officer)	Middle Class Lower
Seed & manure merchant	Middle Class Agric.
Servant royal household	Lower Class Servant
Servant	Lower Class Servant
Ships architect	Middle Class
Shoemaker	Lower Class Unskill
Soldier	Lower Class Unskill
Stableman	Lower Class Unskill
Station master	Middle Class Lower
Stone mason	Lower Class Skill
Store foreman	Middle Class
Straw hat manufacturer	Middle Class
Tailor	Lower Class Skill
Telegraph clerk	Middle Class Lower
Tobacco Dryer	Middle Class
Warehouseman	Middle Class Lower
Warehouse Manager	Middle Class
Waterworks labourer	Lower Class Unskill

Weaver	Lower Class Skill
Whitesmith	Lower Class Skill
Woodturner	Lower Class Skill
Workman	Lower Class Unskill

Appendix 2. Geographical Location – Region/Country & County.

North-west

- Cheshire
- Cumberland
- Lancashire
- Westmorland

North & North-East

- Co Durham
- Northumberland
- Yorkshire

Midlands

- Derbyshire
- Herefordshire
- Northamptonshire
- Nottinghamshire
- Shropshire
- Staffordshire
- Warwickshire
- Worcestershire

East

- Essex
- Lincolnshire
- Norfolk
- Suffolk

West & South-West

- Devon
- Gloucestershire
- Somerset

Appendix 2. Geographical Location – (cont'd).

South & South-East

- Hampshire
- Oxfordshire
- Sussex

London

- CCCourt
- Middlesex

Home Counties

- Berkshire
- Bedfordshire
- Buckinghamshire
- Hertfordshire
- Kent
- Surrey

Wales

- Caernarvon
- Carmarthenshire
- Flintshire
- Radnor
- Montgomery.

Appendix 3: Liverpool cases 1835-1895. Maternal child-homicide cases.

Name	**Married Widow Single**	**DoB**	**Year of crime**	**Attributed cause of Insanity (& other given circumstances/ information)**	**Area of Liverpool**	**Occupation/spouses occupation (Class)**
Agnes Bradley	married	1824	1856	Religious delusions	Toxteth Park	Ships architect (MC)
Ann Coultas	single	1825	1858	Intemperance	Eccleston	Charwoman (LCUnsk)
Sarah Rylands	widow	1839	1864	Grief at death of husband (fear of destitution)	Bolton	Station Master (MC)
Catherine Dawson	married	1835	1864	Imbecility (poverty: Irish)	Lavrock Bank, Toxteth (courts)	Labourer (LCUnsk)
Sarah Eccles	married	1825	1866	Domestic Abuse	Frank St Courts, Toxteth	Labourer (LCUnsk)
Bridget Myles	married	1833	1868	Intemperance (Domestic abuse: Irish)	Vauxhall	Seaman(LCUnsk)
Margaret Davenport	married	1842	1872	Depression	Warrington	Carter (LCUnsk)
Martha Birkenhead	married	1848	1876	Destitution	Little Sankey	Labourer (LCUnsk)
Agnes Morris	widow	1834	1877	Grief at death of husband (fear of destitution)	Great Crosby	Bank Official (MC)
Jane Allender	married	1854	1882	Domestic Abuse (Irish)	Vauxhall	Engine fitter (marine) (LCSk)
Annie Jackson	married	1842	1882	Religious Delusions (Depression)	Toxteth Park	Ship’s captain (MC)

Mary Anthony	married	1846	1887	Illness (convalescent from brain disease, hereditary)	Kirkdale	Marine Engineer (MC)
Leah Charlton	married	1862	1890	Delusions of persecution (isolation)	Toxteth Park	Customs officer (MC)
Catherine Groarke	married	1861	1891	Delusions (Unhappy marriage: Irish)	Toxteth Park	Draper (MC)
Mary J Kavanagh	married	1861	1891	Fear of retribution (Irish)	Toxteth	Publican (LCSk)
Mary Lascelles	married	1855	1892	Influenza (Exhaustion)	Bootle	Railway clerk (MC)
Lucy Mallett	married	1861	1893	Puerperal Insanity	Litherland	House painter (LCSk)
Mary Ann Hayes	married	1842	1894	Intemperance (Drunkard)	Pitt Street Courts, Toxteth	Docker (LCUnsk)
Mary Winchester	married	1863	1894	Puerperal (lactation & delusions)	Walton	Engine fitter (railway) (LCSk)

Appendix 3: "Liverpool cases 1835-1895." (cont'd)

Image 1: *Bostock Street Court, off Scotland Road, Liverpool, 1900*

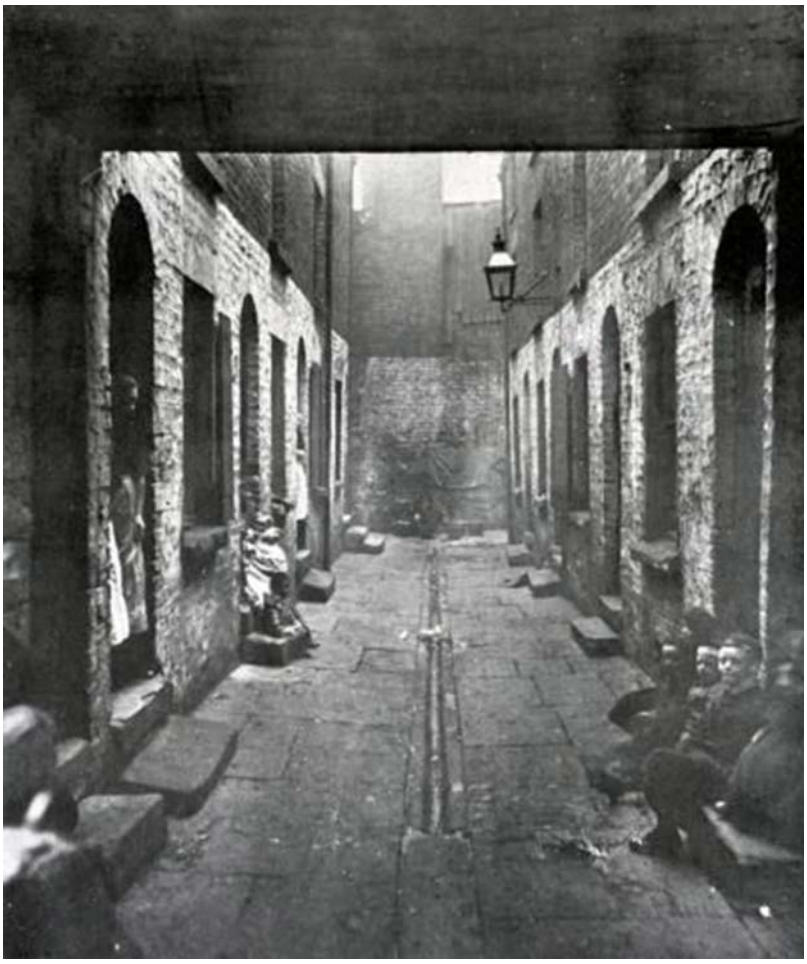

Image 2: *Beresford Road, Toxteth, Liverpool 1890.*

Images 2 & 3 courtesy of Liverpool Record Office (©LVRO)

Appendix 4: Burials at Broadmoor Criminal Lunatic Asylum.

Burials at Broadmoor Criminal Lunatic Asylum for admissions between 1863 and 1895.

Unless otherwise desired by family and friends, patient funerals took place in the chapel at Broadmoor and subsequent burials were in the cemetery opposite the main gates. Despite the chapel and burial ground being consecrated, as Broadmoor was not an ecclesiastical parish, the patient interments in the asylum precincts were recorded in the registers of local parish churches. Between 1863 and 1873 the burials of deceased patients were recorded in the parish registers of St Michael & All Angels Parish Church, Sandhurst. Subsequently, they were recorded in the parish registers of St John the Baptist Parish Church, Crowthorne which was opened in 1873. Seventy-five (75) women of my dataset of 288 criminally insane mothers were buried at Broadmoor Criminal Lunatic Asylum between 1864 and 1917.

Image 3: *Burial Ground, Broadmoor Hospital, Crowthorne, Berkshire.*

Patient name		**Year of Birth**	**Year of Death & Burial**	**Age at Death**	**Parish Burial Register**
Ann	Amess	1835	1900	65	St John
Martha	Armstrong	1851	1905	54	St John
Emma Elizabeth	Aston	1849	1912	63	St John
Martha	Bacon	1830	1899	69	St John
Sarah	Bates	1853	1911	58	St John

Mary	Beal	1834	1906	72	St John
Eleanor	Bell	1812	1884	72	St John
Rebecca	Bell	1853	1905	52	St John
Mary	Bennett	1840	1884	44	St John
Mary	Bowen	1862	1914	52	St John
Susan	Burfield	1853	1892	39	St John
Mary	Butcher	1831	1879	48	St John
Ann	Byrom	1803	1871	68	St Michael
Elizabeth	Carr	1842	1891	49	St John
Emily	Clegg	1851	1915	64	St John
Mary	Coleman	1829	1902	73	St John
Ann	Coultas	1825	1884	59	St John
Johanna	Culverwell	1856	1917	61	St John
Elizabeth	Daunton	1845	1877	32	St John
Catherine	David	1835	1898	63	St John
Ellen	Davis	1822	1885	63	St John
Catherine	Dawson	1835	1876	41	St John
Sarah Elizabeth	Dobbins	1862	1931	69	St John
Sarah Eliza	Drew	1830	1893	63	St John
Louisa	Durrant	1836	1880	44	St John
Sarah	Eccles	1825	1866	41	St Michael
Sarah	Fletcher	1838	1890	52	St John
Emma	Greenwood	1826	1879	53	St John
Catharine	Groocock	1840	1903	63	St John
Mary Ann	Hamilton	1828	1910	82	St John
Mary Ann	Hanner	1833	1913	80	St John
Elizabeth	Harris	1861	1888	27	St John
Mary Ann	Hathaway	1842	1916	74	St John
Elizabeth	Hizzit	1819	1864	45	St Michael

Patient name		Year of Birth	Year of Death & Burial	Age at Death	Parish Burial Register
Charity	Hoskins	1824	1864	40	St Michael
Annie	Ingham	1842	1903	61	St John
Eliza	Kirby	1828	1887	59	St John
Louisa	Knight	1864	1887	23	St John
Ann	Lacey	1813	1884	71	St John
Elizabeth	Lane	1863	1894	31	St John
Jane	Langton	1850	1903	53	St John
Maria	Laughton	1828	1902	74	St John
Rebecca	Law	1835	1915	80	St John
Emily	Lee	1859	1910	51	St John
Rose	Levesley	1849	1917	68	St John
Harriet	Lilley	1838	1897	59	St John
Mary Ann	Maddock	1856	1908	52	St John
Elizabeth	Marchant	1849	1915	66	St John
Mary	McNeill	1831	1886	55	St John
Mary Susannah	Millington	1865	1913	48	St John
Agnes Martha	Morris	1834	1901	67	St John
Bridget	Myles	1833	1909	76	St John
Anne	Noakes	1844	1887	43	St John
Sarah	Norman	1860	1907	47	St John
Amy	Oakes	1843	1913	70	St John
Mary Ann	Ogden	1816	1890	74	St John
Catherine	Oliver	1814	1870	56	St Michael
Mary Ann	Parr	1829	1900	71	St John
Sarah	Patey	1838	1900	62	St John
Mary Ann	Payne	1824	1889	65	St John
Jane	Petheridge	1837	1882	45	St John
Sarah	Price	1831	1903	72	St John

Patient name	Year of Birth	Year of Death & Burial	Age at Death	Parish Burial Register	Patient name
Margaret	Rees	1863	1903	40	St John
Sarah Ann	Rippin	1860	1890	30	St John
Mary Ann Day	Savile	1815	1867	52	St Michael
Annie Berry	Sidney	1850	1909	59	St John
Hannah	Smith	1795	1870	75	St Michael
Margaret	Tate	1848	1900	52	St John
Elizabeth	Thompson	1823	1907	84	St John
Mary	Titley	1815	1866	51	St Michael
Priscilla	Utting	1841	1901	60	St John
Hannah	Walker	1833	1876	43	St John
Eliza	Whorlow	1847	1893	46	St John
Edith	Willimont	1864	1902	38	St John
Mansfield	Woolfit	1815	1912	97	St John

Image 4: *Memorial stones – Broadmoor Burial Ground.*

(Photographs taken 20th March 2020 ACP.)

Appendix 5: Dataset - Complete List by name

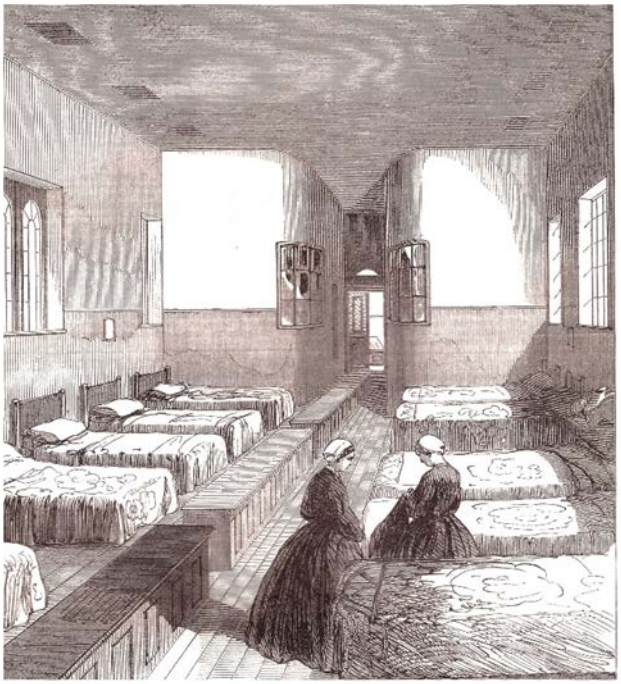

Image 5: *Female Dormitory, Broadmoor Criminal Lunatic Asylum, 1866.*
(Illustrated London News, 24 Aug 1866. Author's own print).

Last Name	**First Name**	**DoB**	**Age**		**Year of Crime**	**<u>Asylum/Institution</u> Bethlem Fisherton House** (FH) **Broadmoor**(Brdmr) **Rainhill** (LCLAR)
Clarke	Ann	1799	35	M	1835	Hoxton House/ Bethlem
Smith	Hannah	1795	42	W	1837	Bethlem/Broadmoor
Avenall	Ruth	1802	35	M	1837	Bethlem
Colley	Ann	1802	35	M	1837	Other (Prison)
Hodges	Elizabeth	1817	21	M	1838	Bethlem
Byrom	Ann	1803	36	S	1839	Bethlem/FH/Brdmr
Dickenson	Sarah	1809	35	M	1844	Bethlem /FH
Huntsman	Eliza	1825	21	S	1845	Bethlem

King	Mary Ann	1822	24	M	1846	Bethlem
Scuffam	Ann	1823	27	S	1846	Bethlem
Beveridge	Mary Ann	1802	39	M	1847 1849	Other (Prison) Bethlem
Hatfield	Caroline	1827	20	S	1847	Other (Prison)
Pegg	Eliza	1822	31	S	1847	Bethlem /FH/Brdmr
Prior	Martha	1812	37	M	1847	Hoxton Hse/Essex
Grout	Sarah	1818	31	M	1848	Hoxton Hse/Essex
Beveridge	Mary Ann	1802	39	M	1849	Bethlem
Ogden	Mary Ann	1816	34	M	1849	Bethlem/Broadmoor
Robinson	Mary	1822	27	S	1849	Bethlem
Jackson	Sarah	1809	40	W	1849	Bethlem
Goddard	Elizabeth	1802	47	M	1849	Bethlem
Higgins	Elizabeth	1825	25	M	1850	Other (Prison)
Sanderson	Emma	1820	30	M	1850	Bethlem
Scuffam	Ann	1830	22	M	1850	Bethlem
Playle	Esther	1828	23	M	1850	Hoxton Hse/Essex
Drake	Sarah	1814	36	S	1850	Bethlem
Page	Milicent	1809	42	M	1851	Hoxton Hse/Essex
Clarke	Maria	1830	21	S	1851	Other (Prison)
Burt	Amelia	1823	30	M	1852	Bethlem/Broadmoor
Chitty	Maria	1807	45	M	1852	Bethlem
Clark	Eliza	1822	30	M	1852	Bethlem/FH
Good	Ann	1835	18	S	1852	Other (Prison)
Lewis	Emma	1818	35	S	1852	Bethlem
McNeil	Mary	1831	21	S	1852	Bethlem/Broadmoor
Raven	Ann	1819	33	S	1852	Bethlem
Thew	Elizabeth	1830	22	M	1850	Bethlem/FH
Allen	Sarah	1830	26	M	1853	Bethlem/Broadmoor
Borley	Maria	1831	23	M	1854	Bethlem/FH
Parr	Mary Ann	1829	25	S	1854	Bethlem/Broadmoor

Savell	Catherine	1824	30	M	1854	Bethlem
Bacon	Martha	1830	26	M	1856	Bethlem/Broadmoor
Bradley	Agnes	1824	35	M	1856	LCLAR
Payne	Mary Ann	1824	32	M	1856	Bethlem/Broadmoor
Ryder	Emily	1834	22	M	1856	Bethlem
Clarke	Maria	1818	39	S	1857	FH
Jukes	Martha Rebecca	1826	30	M	1857	Other (Prison)
Price	Sarah	1831	26	W	1857	FH/Broadmoor
Woolfit	Mansfield	1815	43	M	1857	FH/Broadmoor
Coultas	Ann	1825	38	S	1858	Bethlem/Broadmoor
Lacey	Ann	1813	54	M	1858	FH/Broadmoor
Newell	Mary	1837	22	S	1858	Fisherton House
Williams	Elizabeth	1828	30	M	1858	Bethlem/Broadmoor
Lewis	Martha	1835	24	M	1859	Bethlem
Titley	Mary	1815	45	M	1860	Bethlem/Broadmoor
Leaver	Jane	1826	34	W	1860	Bethlem/Broadmoor
Salmon	Harriet	1835	26	M	1861	Bethlem/FH/ Brdmr
Oliver	Catherine	1814	47	M	1861	FH/Broadmoor
Hoskins	Charity	1824	37	W	1861	FH/Broadmoor
Wilson	Ann	1822	39	M	1861	Bethlem/Broadmoor
Torkington	Jane	1832	29	M	1861	Bethlem/Broadmoor
Hamilton	Mary Ann	1824	38	M	1861	Bethlem/Broadmoor
Law	Rebecca	1835	27	W	1862	FH/ Broadmoor
Simpson	Catherine	1836	26	S	1862	FH
Hocken	Martha	1840	22	S	1862	FH
Savile	Mary Ann Day	1815	47	M	1862	FH/ Broadmoor
Vyse	Ann Cornish	1829	33	M	1862	FH
Harris	Mary Ann	1825	37	M	1862	FH/ Broadmoor
Cole	Adelaide	1832	30	M	1862	FH
Patey	Sarah	1838	25	M	1863	FH/ Broadmoor

Goodliffe	Harriet	1832	31	M	1863	FH/ Broadmoor
Payne	Mary Ann	1842	21	M	1863	FH
Thomas	Elizabeth	1830	33	M	1863	FH/ Broadmoor
Mitchell	Sarah Emily	1839	24	S	1863	Broadmoor
Lancastell	Sarah	1824	39	M	1863	FH/Broadmoor
Dawson	Catherine	1835	31	M	1864	LCLAR /Broadmoor
Howard	Emma Pudney	1841	23	S	1864	Broadmoor
Rylands	Sarah	1823	42	W	1864	Broadmoor
Dyson	Mary Ann	1841	23	M	1864	Broadmoor
Driver	Ruth	1834	30	S	1864	Broadmoor
Thompson	Lucy	1844	20	S	1864	Broadmoor
Pryce	Elizabeth	1842	23	S	1864	Broadmoor
Thompson	Elizabeth	1823	41	M	1864	Broadmoor
Webb	Ann	1827	39	M	1865	Broadmoor
Lack	Esther	1824	41	M	1865	FH/ Broadmoor
Drew	Sarah Eliza	1830	36	M	1865	Broadmoor
Eccles	Sarah	1825	41	M	1865	Broadmoor
Butcher	Mary	1831	35	M	1866	Broadmoor
Rowe	Harriet	1837	30	M	1866	Broadmoor
Bennett	Mary	1840	26	M	1866	Broadmoor
Kirby	Eliza	1828	38	M	1866	FH/ Broadmoor
Edwards	Jane	1842	25	S	1866	Broadmoor
Lyons	Mary	1833	34	M	1866	Broadmoor
Bell	Eleanor	1812	55	M	1867	Broadmoor
Coleman	Mary	1829	38	M	1867	Broadmoor
Gathercole	Mary Ann	1837	30	M	1867	Broadmoor
Greenwood	Emma	1826	42	M	1867	Broadmoor
Fletcher	Sarah Elizabeth	1838	30	M	1868	Broadmoor
Myles	Bridget	1833	35	M	1868	LCLAR / Broadmoor
Coleman	Clara	1842	26	S	1868	Broadmoor
Sherwood	Elizabeth	1834	36	M	1868	Broadmoor

Nattrass	Margaret	1830	38	M	1868	Broadmoor
Holmes	Jane Elizabeth	1836	33	M	1868	Broadmoor
Freedman	Adelaide	1840	30	M	1869	Broadmoor
Ingham	Annie	1842	29	M	1869	Broadmoor
Messer	Ann	1824	46	M	1870	Broadmoor
Daniels	Mary Ann	1836	35	M	1870	Broadmoor
Ryan	Hannah Maria	1837	34	M	1871	Broadmoor
Beal	Mary	1834	37	M	1871	Broadmoor
Weedon	Susan	1841	30	M	1871	Broadmoor
Nicholls	Annie	1841	30	M	1871	Broadmoor
Hanner	Mary Ann	1833	39	M	1871	Broadmoor
Harris	Elizabeth	1836	36	M	1871	Broadmoor
Petheridge	Jane	1837	35	M	1871	Broadmoor
Utting	Priscilla	1841	31	W	1872	Broadmoor
Davenport	Margaret	1842	30	M	1872	LCLAR / Broadmoor
Groocock	Catharine	1840	32	M	1872	Broadmoor
Marchant	Elizabeth	1849	25	S	1872	Broadmoor
Best	Avis	1845	38	S	1873	Broadmoor
Cooke	Fanny	1844	30	M	1873	Broadmoor
David	Catherine	1835	38	M	1873	Broadmoor
Bland	Martha	1849	24	M	1873	Broadmoor
Crumpton	Jane	1844	30	M	1873	Broadmoor
Orton	Ann	1847	32	M	1873	Broadmoor
Walker	Hannah	1833	41	M	1873	Broadmoor
Armstrong	Martha	1851	23	M	1873	Broadmoor
Grant	Jane	1848	26	S	1874	Broadmoor
Newman	Sarah	1832	42	M	1874	Broadmoor
King	Emma	1849	25	S	1874	Broadmoor
Dowling	Louisa Fanny	1847	27	M	1874	Broadmoor
Ellis	Caroline	1850	24	M	1874	Broadmoor

Ashley	Louisa Elizabeth	1830	45	M	1874	Broadmoor
Holford	Ann	1855	20	M	1875	Broadmoor
Daunton	Elizabeth	1845	31	S	1875	Broadmoor
Hillier	Elizabeth	1852	23	M	1875	Broadmoor
Beck	Mary Ann Elizabeth	1853	23	M	1875	Broadmoor
Luke	Emma	1855	21	M	1875	Broadmoor
Baines	Martha	1842	33	M	1875	Broadmoor
Killen	Martha	1845	31	M	1876	Broadmoor
Carr	Elizabeth	1842	35	M	1876	Broadmoor
Cole	Elizabeth	1841	35	M	1876	Broadmoor
Morris	Agnes Martha	1834	43	W	1876	Broadmoor
Birkenhead	Martha Ellen	1848	28	M	1876	Other (Prison)
Hirst	Mary	1849	28	M	1876	Broadmoor
King	Charlotte	1835	42	M	1877	Broadmoor
Maddock	Mary Ann	1856	23	S	1877	Other (Prison)
Bushby	Elizabeth	1843	34	M	1877	Broadmoor
North	Amelia	1845	32	M	1877	Broadmoor
Lilley	Harriet	1838	39	M	1877	Broadmoor
Bell	Rebecca	1853	25	M	1877	Broadmoor
Taylor	Eliza	1838	40	M	1877	Broadmoor
Harper	Ellen	1861	17	M	1877	Broadmoor
Laughton	Maria	1828	48	M	1877	Broadmoor
Keary	Lucy	1850	28	M	1878	Broadmoor
Amess	Ann	1835	43	M	1878	Broadmoor
Oldman	Ellen	1847	31	M	1878	Broadmoor
Carr	Ann Elizabeth	1851	27	S	1878	Broadmoor
Brown	Emma	1845	33	M	1878	Broadmoor
Sidney	Annie Berry	1850	28	M	1878	Broadmoor
Jones	Catherine	1845	33	M	1878	Broadmoor

Cornford	Mary	1856	24	M	1878	Broadmoor
Donegan	Emma Eliza	1845	34	M	1878	Broadmoor
Freeman	Sarah	1849	31	M	1878	Broadmoor
Barker	Louisa	1844	35	M	1879	Broadmoor
Howell	Annie	1849	29	M	1879	Broadmoor
Hammond	Elizabeth	1849	30	M	1879	Broadmoor
Durrant	Louisa	1836	44	M	1880	Broadmoor
Bates	Sarah	1853	27	M	1880	Broadmoor
Butler	Elizabeth	1831	55	M	1880	Broadmoor
Bull	Sarah Ann	1848	32	M	1880	Broadmoor
Noakes	Anne	1844	36	W	1880	Broadmoor
Godding	Fanny Stow	1841	40	S	1880	Broadmoor
Goring	Ann	1839	42	M	1880	Broadmoor
Norman	Sarah	1860	21	M	1880	Broadmoor
Chalker	Mary Ann	1849	32	M	1881	Broadmoor
Giles	Emily	1858	23	S	1881	Broadmoor
Jackson	Annie	1842	40	M	1881	Broadmoor
Barrow	Kate	1845	36	M	1881	Broadmoor
Haynes	Jane	1856	26	M	1881	Broadmoor
Millett	Mary Ellen	1856	26	M	1882	Broadmoor
Allender	Jane	1854	28	M	1882	Broadmoor
Shawcross	Hannah	1840	50	M	1882	Broadmoor
Tate	Margaret	1848	34	M	1882	Broadmoor
Lee	Emily	1859	23	M	1882	Broadmoor
Beagley	Sarah	1844	38	M	1882	Broadmoor
Coakes	Sarah	1862	20	S	1882	Broadmoor
Loveridge	Rebecca	1845	39	M	1883	Broadmoor
Langton	Jane	1850	33	S	1883	Broadmoor
Walmsley	Emily	1848	35	M	1883	Broadmoor
Davenport	Mary Ann	1847	36	M	1883	Broadmoor
Lawrence	Hannah	1854	29	M	1883	Broadmoor

Culverwell	Johanna	1856	27	M	1883	Broadmoor
Morgan	Mary Ann	1848	35	M	1883	Broadmoor
Player	Annie	1858	25	M	1883	Broadmoor
Agar	Eliza Matilda	1852	31	M	1883	No incarceration
Holmes	Lucy	1846	38	M	1884	Broadmoor
Levesley	Rose	1849	35	M	1884	Broadmoor
Dickinson	Louisa	1861	23	S	1884	Broadmoor
Clegg	Emily	1851	33	M	1884	Broadmoor
Rippin	Sarah Ann	1860	24	M	1884	Broadmoor
Thompson	Mary Ann	1859	26	M	1884	Broadmoor
Homard	Martha Elizabeth	1858	27	M	1885	Broadmoor
Dobbins (Robbins)	Sarah Elizabeth	1862	23	S	1885	Broadmoor
Hanson	Sarah Ann	1858	27	M	1885	Broadmoor
Hibbert	Margaret	1846	39	M	1885	Broadmoor
Hewson	Isabella	1862	23	S	1885	Broadmoor
Lane	Elizabeth	1863	26	S	1885	Broadmoor
Harris	Elizabeth	1861	25	M	1885	Broadmoor
Burfield	Susan	1853	32	M	1885	Broadmoor
Bicknell	Mary Catherine	1857	28	M	1885	Broadmoor
Perry	Anne	1845	40	M	1885	Broadmoor
Base	Esther	1854	32	M	1885	Broadmoor
Medlin	Mary Spargo	1857	29	S	1886	Broadmoor
Nelms	Emma	1838	48	M	1886	Broadmoor
Knight	Louisa	1864	22	S	1886	Broadmoor
Williams	Maria Jane	1866	20	S	1886	Broadmoor
Buckingham	Mary Ellen	1850	36	M	1886	Broadmoor
France	Mary Jane	1847	40	M	1886	Broadmoor
Crean	Elizabeth Ann	1848	39	M	1886	Broadmoor
Hathway	Mary Ann	1842	45	M	1887	Broadmoor

Witting	Elizabeth	1844	43	M	1887	Broadmoor
Gardiner	Caroline Emma	1854	33	M	1887	Broadmoor
Laity	Rowena Vawdrey	1849	38	M	1887	Broadmoor
Cherry	Annie	1865	22	S	1887	Broadmoor
Rushton	Harriet	1849	38	M	1887	Broadmoor
Anthony	Mary	1846	41	M	1887	Broadmoor
Millington	Mary Susannah	1865	22	S	1887	Broadmoor
Cooke	Sarah	1850	38	M	1888	Broadmoor
Osteler	Louisa	1863	25	M	1888	Broadmoor
Aston	Emma Elizabeth	1849	39	S	1888	Broadmoor
Robinson	Ann	1858	30	M	1888	Broadmoor
Armstrong	Mary	1847	41	M	1888	Broadmoor
Spickernell	Julia Georgina			M	1888	Broadmoor
Reynolds	Mary Ann	1855	33	M	1888	Broadmoor
Wilson	Mary	1853	36	M	1889	Broadmoor
Smyth	Ada	1856	33	M	1889	Broadmoor
Farnell	Mary Edith	1859	30	M	1889	Broadmoor
Whorlow	Eliza	1847	43	M	1889	Broadmoor
White	Elizabeth	1851	39	M	1889	Broadmoor
Taylor	Mary Ann	1845	45	W	1889	Broadmoor
Tremlett	Catherine Elizabeth	1854	36	M	1890	Broadmoor
Jacobs	Eleanor Sarah	1865	25	S	1890	Broadmoor
Jauncey	Elizabeth Williams	1855	35	S	1890	Broadmoor
Charlton	Leah	1862	28	M	1890	Broadmoor
Mitchell	Elizabeth	1860	30	M	1890	Broadmoor
Oakes	Amy	1843	47	M	1890	Broadmoor
Higgs	Rosetta Julia	1849	41	M	1890	Broadmoor
Lonnon	Eva Mary	1866	25	S	1891	Broadmoor

Kavanagh	Mary Jane	1861	30	M	1891	Broadmoor
Groarke	Catherine	1861	30	M	1891	Broadmoor
Hensman	Amy	1861	31	M	1891	Broadmoor
Wilcox	Matilda	1868	23	S	1891	Broadmoor
Horsfall	Mary Ann	1850	41	M	1891	Broadmoor
Onions	Emma	1860	31	M	1891	Broadmoor
Heathcote	Mary Jane	1862	29	M	1891	Broadmoor
Fowler	Mary Ann	1863	32	M	1891	Broadmoor
Hinton	Grace Alice	1854	37	M	1892	Broadmoor
Lascelles	Mary Ryland	1855	37	M	1892	LCLAR/Broadmoor
Armstrong	Elizabeth	1863	29	M	1892	Broadmoor
Dyer	Ellen Elizabeth	1847	45	M	1892	Broadmoor
Greenham	Sarah	1858	34	M	1892	Colney Hatch
Proud	Louisa Constance	1861	31	M	1893	Broadmoor
Thompson	Esther	1868	25	M	1893	Broadmoor
Wilson	Emily Harriett	1875	18	S	1893	Broadmoor
Gilyeat	Rose	1872	21	S	1893	Broadmoor
Box	Elizabeth	1859	33	M	1893	Broadmoor
Suckling	Emily	1858	35	M	1893	Broadmoor
Attewell	Julia	1867	26	M	1893	Broadmoor
Mallett	Lucy	1861	32	M	1893	Broadmoor
Winchester	Mary	1863	31	M	1894	Broadmoor
Turner	Ada Sophia	1871	23	M	1894	Broadmoor
Holding	Sarah	1867	24	S	1894	Broadmoor
Willimont	Edith	1864	30	M	1894	Broadmoor
Tucker	Sarah	1864	30	W	1894	Broadmoor
Jenkins	Margaret	1854	40	M	1894	Broadmoor
Smith	Hannah 2	1857	34	M	1894	Broadmoor
Hayes	Mary Ann	1842	52	W	1894	Broadmoor
Harrison	Mary	1853	41	M	1894	Broadmoor

Lofthouse	Elizabeth	1858	36	M	1894	Broadmoor
Wilkes	Harriet	1856	38	M	1894	Broadmoor
Barton	Mary Ann	1859	36	M	1894	Broadmoor
Hopkins	Harriet Rose	1876	19	S	1895	Broadmoor
Hayes	Emma	1858	37	M	1895	Broadmoor
Wright	Charlotte	1851	44	M	1895	Broadmoor
Kendrick	Sarah Jane	1871	24	M	1895	Broadmoor
Fowler	Elizabeth	1860	35	M	1895	Broadmoor
Bowen	Mary	1862	33	M	1896	Broadmoor
Rees	Margaret	1863	32	M	1895	Broadmoor
Rich	Annie	1857	39	M	1896	Broadmoor

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BHRA CBC-01 Incurable & Criminal Patient Casebooks 1778-1840.
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DDR 04 Register of Discharges & Deaths 1868-1877.

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Management and Administration (A)

- D/H14/A2/1/1/1 Reports of the Superintendent and Chaplain of Broadmoor Criminal Lunatic Asylum for the Years 1864-1875 with Statistical Tables.
- D/H14/A2/1/1/2 – 12 (10 vols) Reports of the Superintendent and Chaplain of Broadmoor Criminal Lunatic Asylum for the Years 1876-1885 with Statistical Tables.
- D/H14/A2/1/1/12 Reports of the Superintendent and Chaplain of Broadmoor Criminal Lunatic Asylum for the Years 1886-1895 with Statistical Tables.
- D/H14/A2/1/3/1 Superintendent's Journal, 1863-1870.

Personnel (B)

- D/H14/B1/2/2/1 Rules for the Guidance of Officers, Attendants and Servants of Broadmoor Criminal Lunatic Asylum.

Patients' Records (D)

Administrative records (D1)

- D/H14/D1/1/1/1 Admissions Register: males and females 1863-1871
- D/H14/D1/1/1/2 Admissions Register: males and females 1868-1900
- D/H14/D1/15/1 Discharge Register: males and females 1863-1900

Clinical records (D2)

- D/H14/D2/1/2/1 Patients: Casebooks: females admitted 1863-1879 (closed to 2034).
- D/H14/D2/2/2 Female Patients' Case Files:- (55 files referenced)

Allen, Sarah, D/H14/D2/2/2/2.
Amess, Ann, D/H14/D2/2/2/276.
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Baines, Martha, D/H14/D2/2/2/251.
Bates, Sarah, (1) D/H14 D2/2/2/303
Bates, Sarah, (2) D/H14/D2/2/2/398.
Bates, Sarah, (3) D/H14/D2/2/2/606
Bennett, Mary, D/H14/D2/2/2/111.
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