

# **Secrecy and Denial in Matters of Life and Death: A Critical Analysis of Deaths in Psychiatric Detention, 1845-2018**

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## **Abstract**

Each year detained patients die in psychiatric detention in England and Wales in contentious circumstances. Despite the fact that deaths in psychiatric detention is not a new phenomenon, minimal critical research exists which analyses this problem.

Underpinned by a critical criminological framework focusing on power, marginalisation and resistance, the thesis undertakes a critical analysis of deaths in psychiatric detention in both a historical and contemporary context. This is achieved through combining primary archival research with interviews and questionnaires undertaken with a number of individuals directly involved with this issue. In addition, the thesis utilises and analyses family campaign websites that were set up following the death of their detained relative.

In order to understand the response to patients in death, a critical understanding of the response to them during their lives is also developed, both historically and contemporaneously. Further areas of focus include the official response to patients and their families, inquest and investigation procedures, the issue of accountability and the challenging of dominant discourses surrounding psychiatric detention.

Based upon the findings of the thesis, a number of radical alternatives are outlined. These alternatives would address the issue of deaths in psychiatric detention and transform the current failing systems for the benefit of some of the most vulnerable members of society.

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<sup>1</sup> See Appendix A.

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## **Introduction**

This chapter introduces the issue being critically examined in this thesis, that of the deaths of patients detained in psychiatric detention<sup>2</sup> under the Mental Health Act in England and Wales (and in lunatic<sup>3</sup> asylums historically<sup>4</sup>). First, the nature of the problem will be discussed, including the inquest and investigation processes following the deaths of patients and the response to bereaved families. The chapter will then proceed to outline the aims of the thesis. The methods that will be utilised, along with the methodological and theoretical frameworks of the thesis will be examined, in anticipation of a more extensive discussion surrounding these areas in later chapters. Finally, the chapter concludes with an overview of the structure of the thesis.

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<sup>2</sup> The term 'psychiatric detention' is used throughout this thesis as the overarching term for where patients are detained under the Mental Health Act (in asylums and mental/psychiatric hospitals). This term has also been used by the charity INQUEST in their work. INQUEST are introduced later in this chapter.

<sup>3</sup> Although now considered an offensive term, 'lunatic' is used within the thesis, in line with its use historically.

<sup>4</sup> Whilst in the context of contemporary data gathering, the thesis is concerned with the deaths of patients detained under the Mental Health Act, this Act did not exist during the majority of the time period covered in the archival files that are explored within this thesis. Therefore, for the purposes of the archival research, 'detained' is used primarily in the context of patients who were housed within lunatic asylums.



## **The Problems Being Examined**

### *The Deaths of Detained Patients*

The mental health charity MIND<sup>5</sup> have argued that 1 in 4 people will experience a mental health problem each year in England and Wales (2017: n.p). This prevalence of mental health problems<sup>6</sup> was demonstrated in 2015/16 when detentions under the Mental Health Act were at an all-time high. There were 63,622 detentions in England, an increase of 9% from 2014/15 when 58,399 patients were detained<sup>7</sup>. The 2014/15 figures themselves had increased by 10% from 2013/14, when 53,156 patients were detained (Health and Social Care Information Centre, 2016: 4). Previously, in 2005/06, the number of people detained was 43,361 (Ibid: 4). Therefore, there was a 47% rise in detentions under the Act in England between 2005/06 and 2015/16 (Ibid: 4). In Wales, between 2015/16, there were 2,001 detentions. In 2014/15, the figure was 1,921 and in

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<sup>5</sup> MIND was founded in 1946 and provide support to those with mental health problems. They undertake policy and campaigning work, provide professional training and have local branches in order to provide specialist support (MIND, n.d).

<sup>6</sup> The term 'mental health problems' is used throughout the thesis. There are numerous terms widely used such as 'mentally ill' 'poor mental health' and 'mentally disturbed'. However, after consulting literature from groups such as INQUEST and MIND, the term 'mental health problems' was decided upon for use within the thesis. The term recognises the problematic nature of an individual's condition, not only for themselves but for their families and those they interact with. As Rethink, a mental health charity recognise, certain terms such as 'mentally ill' and 'sufferer' only work to reinforce the alienation and stigma facing those with mental health problems (2018: n.p).

<sup>7</sup> Since the 2015/16 statistics were published, when 63,622 patients were detained, there has been a change in the way statistics are correlated. Therefore, the number of people detained in 2016/17 appears significantly lower at 45,864. However, due to the changes in the collation process, the 2016/17 statistics are 'missing data' and are therefore 'not directly comparable' with previous years (Community and Mental Health Team NHS Digital, 2017: 2). However, the NHS digital team argued that if the statistics were complete it would have shown an estimated 2% increase in detentions since 2015/16 (Ibid: 2).

2013/14, there were 1,692 detentions (Welsh Government Statistics for Wales, 2016: 5).

Between the years of 2000 and 2013, almost 60% of deaths in state custody in England and Wales originated from those detained under the Mental Health Act<sup>8</sup> (Independent Advisory Panel on Deaths in Custody, 2013: 6). In 2015, the Independent Advisory Panel on Deaths in Custody (IAP) published details of the total number of deaths of detained patients that had occurred between 2000 and 2014 in England and Wales. During this time, 4,801 patients died (Independent Advisory Panel on Deaths in Custody, 2015a: 9). The Care Quality Commission<sup>9</sup> (CQC) also examined the number of deaths of detained patients<sup>10</sup>. In 2016/17, there were 247 deaths of detained patients in England (Care Quality Commission, 2018a: 44). Prior to this, in 2015/16 there were 266 deaths in England and in

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<sup>8</sup> It should be noted that the statistics included within this chapter have been outlined in order to provide a context for the issues discussed in the thesis. Although they have been taken from official sources, the 'bad reputation' (Best, 2001: 5) of statistics must be considered. As Best noted, 'we suspect that statistics may be wrong...trying to manipulate us...yet at the same time, we need statistics; we depend upon them to summarize and clarify' (Ibid: 5). With that in mind, the approach adopted was one of 'thinking critically about statistics' (Ibid: 6), recognising that they can be used as 'weapons' in influencing opinion regarding social problems and social policy (Ibid: 10-13). Therefore, the questions to be kept in mind when examining statistics are, 'who created the statistic?' and 'why was this statistic created?' (Ibid: 27-28). It is also important to recognise that statistics do not provide detailed information surrounding deaths, such as whether or not such deaths were preventable.

<sup>9</sup> The Care Quality Commission are the independent regulators of health and adult social care in England.

<sup>10</sup> Prior to 2009, the number of patients who died each year was not published, although the Mental Health Act Commission began to collate yearly statistics in the 1990s. Following 2009, the Care Quality Commission was formed as a merger of the Commission for Social Care Inspection, the Health Care Commission and the Mental Health Act Commission. The Care Quality Commission then began collating the annual statistics of those who died whilst detained under the Mental Health Act in England.

2014/15 the CQC were informed of the deaths of 227 detained individuals (Ibid: 44).

The data provided by the IAP and the CQC illustrates the problematic nature of deaths in psychiatric detention. The CQC has indicated that between 2011 and 2016<sup>11</sup>, 1,202 detained patients died in England (Care Quality Commission, 2016a: 52). Of these, 102 deaths were due to an unknown cause, 200 were due to unnatural causes and 900 were attributed to natural causes (Ibid: 52). This was primarily pneumonia, pulmonary embolisms and heart disease (Ibid: 52). However, as Hardy (2013: n.p) has noted, 'death by natural causes does not necessarily mean it was not preventable'. This raises further concerns surrounding how potentially 'natural cause' deaths may be dismissed without appropriate investigation. The IAP also recognised the issues surrounding the high number of supposedly 'natural cause' deaths. They have argued that the poor physical health of detained patients should be investigated, along with a re-examination of existent data into natural cause deaths in order to uncover patterns and issues (2015b: n.p).

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<sup>11</sup> The number of deaths of patients identified by the Care Quality Commission are related to England only and cover deaths from September of one year through to April of the following year. Therefore, they are different from the statistics collated by the Independent Advisory Panel on Deaths in Custody, which uses data from England and Wales and are collated from January through to December of a single year. The number of patients who die in Wales each year, whilst detained, are not published annually, unlike deaths in England.

The issue of self-inflicted deaths amongst the detained population is also a problem. Of the 4,801 patients who died between 2000 and 2014 in England and Wales, 693 of these were self-inflicted deaths (Independent Advisory Panel on Deaths in Custody 2015a: 25). Linked with this, the CQC has pointed to the prevalence of certain methods used by patients in order to take their own lives. These methods included hanging, jumping in front of a moving vehicle/train (having been allowed out of the ward or absconded), jumping from a building (again, having been allowed out of the ward or absconded), self-strangulation and self-poisoning (2016a: 53). However, it is not just the circumstances surrounding the deaths of patients that are problematic. Post-death procedures, namely investigations and inquests, are also controversial, along with the response to bereaved families during these processes. These issues will now briefly be explored in anticipation of critical examinations of these areas throughout the thesis.

### *The Question of Accountability*

As the thesis will examine, there is a sustained and widespread ignorance shown towards deaths in psychiatric detention. The literature surrounding current failings in the system is limited, with much of the minimal literature in existence

originating from the charity INQUEST<sup>12</sup>. As INQUEST have indicated, there is no independent investigation system in place following the deaths of detained patients (2015a). This is despite the claim that patients detained in psychiatric wards are up to five times more likely to suffer a preventable death than those with mental health problems in prison (Ramesh, 2015: n.p). When an individual dies whilst detained in psychiatric detention, the hospital trust responsible for the individual's care at the time of their death undertakes the investigation into the death. This results in hospital trusts investigating their own potential failings and raises questions surrounding transparency and accountability. For INQUEST, this indicates a 'glaring disparity' between how deaths in psychiatric detention are investigated compared with deaths in police and prison custody, where independent investigation systems exist (2015a: 5). Related to the experiences of bereaved families in the investigation process, INQUEST have also argued that:

Bereaved families often struggle to be involved in internal investigations and face barriers to disclosure of basic information and relevant documents. It does not inspire family or public confidence when an organisation investigates itself over a death that may have been caused, or contributed to, by failures of its own staff or systems (Ibid: 6).

The Equality and Human Rights Commission (EHRC) suggested that the 'families of those who die in psychiatric hospitals are shut out of the care preceding, and the investigation following, a death' (2015: 6). A culture has emerged where

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<sup>12</sup> INQUEST, founded in 1981, is an independent charity which provides an advice service to bereaved families, and other concerned individuals, following deaths in different forms of state custody. In addition, the charity undertakes policy and campaigning work. INQUEST is discussed further in Chapter Four but to provide an insight into their work, in June 2018 the organisation had 878 open cases and in the two years prior to this they had worked on a total of 1,621 cases (INQUEST, 2018a: n.p). Further information can be found at [www.inquest.org.uk](http://www.inquest.org.uk).

those undertaking the investigation into a death are unwilling or reluctant to acknowledge or listen to the voices of families and, as a result, continual opportunities are missed to make the investigation inclusive, comprehensive and an opportunity for learning lessons (INQUEST, 2016a: 9). Similarly, the CQC also noted that learning from deaths is not being given enough consideration, resulting in missed opportunities (2016b: 6).

Families also experience the coronial process negatively and are ‘overwhelmingly excluded’ within the system (INQUEST, 2003: 3). They are:

At the margins of the [inquest] process, not provided with sufficient information for it to be meaningful to them or to be empowered to participate properly...the experience [is] one that adds to, rather than diminishes, distress...it marginalises them leaving them with more questions than answers (Ibid: 3).

INQUEST has described the coroners court as ‘more often than not the only opportunity to discover the truth’ (2015b: 9). However, it has long been recognised that the coronial system is ‘failing’ (INQUEST, 2003: 1). The coroners court, without an independent investigatory body to precede it, is often unable to fully investigate failings or to provide guidance on the prevention of future deaths (INQUEST, 2015a: 6). In 2016, INQUEST noted that between 2011 and 2014, 373 deaths of detained people in psychiatric detention were reported to coroners in England and Wales (INQUEST, 2016b: n.p). However, data gathered by the CQC, and the Health Inspectorate for Wales, over the same period, indicated 1,115 deaths-742 more than had been

reported to coroners (Ibid: n.p). Therefore, there were 'inconsistencies' within official data sets and this suggested that 'hundreds of patients' who died while being detained under the Mental Health Act may have been denied inquests (Ibid: n.p).

The concerns highlighted by groups such as INQUEST, the EHRC and the CQC, have been raised in the context of the sustained neglect of the injustices concerning the issue of deaths in psychiatric detention within critical academic research. Whilst it is not to argue that existent literature surrounding psychiatric detention is not sympathetic to the issue of deaths in psychiatric detention, literature that examines the problem critically, whilst providing radical and meaningful policy alternatives, is extremely lacking. Furthermore, there is no critical academic research which examines deaths in psychiatric detention with a particular focus on post-death procedures, namely inquests and investigations, as well as the experiences of bereaved families.

### **Research Aims**

In order to understand the responses to detained patients in death, it is also important to understand the response to them in life. Furthermore, because this area has been neglected in academic literature for such a sustained period, it is important that the historical context is provided before contemporary issues are examined. In order to contribute towards unsilencing the silence surrounding

deaths in psychiatric detention, and address the significant gaps in knowledge, the thesis has several aims. These aims are as follows:

1. The first aim is to undertake a critical, revisionist, *historical* analysis of the response to patients in psychiatric detention, in both life and death, from 1845 up until 1959. In relation to the deaths of patients, there will be a focus upon three main areas: (a) the investigation process following the deaths of patients (b) the coroners court inquest (c) the response to bereaved families and those who work with these families.
2. The second aim is to undertake a critical, *contemporary* analysis of life and death in psychiatric detention, with a focus on the same three areas identified above, from 1960 up until 2018.
3. The third aim is to explore how accountability has been understood in psychiatric detention, both historically and contemporaneously.
4. Fourth, the thesis is concerned with uncovering and critically analysing the consequences of deaths in psychiatric detention, namely concerning the families of the deceased and their support groups.
5. The fifth aim is to examine how dominant discourses surrounding the response to patients in both life and death have been challenged and contested both historically and contemporaneously.
6. Finally, the thesis, based upon the findings of the research, aims to propose a number of alternatives that could radically transform current systems surrounding psychiatric detention, preventing deaths and promoting accountability.



## **The Structure of the Thesis**

Following this introduction, Chapter One outlines the theoretical frameworks that underpin the thesis. The chapter critically examines the pathologisation, medicalisation and criminalisation of patients in both life and death, alongside analysing the control and labelling that patients, along with their families, have experienced. The role of the asylum and psychiatric hospital as a state institution is also critically analysed. The chapter also theorises the role of both psychiatry and the medical profession.

The chapter also focuses on why the very people who understand the issues concerned, namely patients and their families, are continuously overlooked. As critical thinkers have argued, dominant 'regimes of truth' (Foucault, 1991: 74) have supported the 'negative reputation' of these groups (Scruton and Chadwick, 1987a: 220). A theoretical framework consisting of a Foucauldian influence, along with other critical thinkers including Goffman and Scull, also assists in placing a 'questioning spotlight' (Coggan and Walker, 1982: 11) onto the issue of deaths in psychiatric detention. This approach is concerned with generating knowledge and data that has previously been subjected to 'multiple forms of subjugation' (Foucault, 1980a: 96). The critical analysis is underpinned by concepts of truth, power and knowledge. Power can work to create alternative truths and knowledges which indicates the important relationship between truth and power (Foucault, 1980a: 93). Both the historical and contemporary data gathering involved in this thesis relates to what Foucault would classify as an example of

the 'insurrection of subjugated knowledges' (Foucault, 2003a: 7). The insurrection of these subjugated knowledges results in previously silenced 'stories from below' emerging (Porter, 1987: 231) and the generation of alternative truths.

Chapter Two outlines the methodological underpinnings and methods adopted within the thesis and places these within the broader spectrum of critical criminological research. In order to achieve the aims of the thesis and ensure that multiple layers of subjugated knowledge were uncovered, different methods were utilised to generate historical and contemporary data. First, primary archival research was undertaken in order to critically examine the response to patients in both life and death. Utilising Foucault's concept of writing a genealogical 'history of the present' (Foucault, 1977: 31), the thesis traces the history of psychiatric detention and deaths within these institutions. This approach allows these issues to be analysed through a critical consideration of historical themes and contexts (Cousins and Hussain, 1984: 264). The primary archival research consisted of examining historical reports, newspaper articles, letters and case notes. Drawing upon historical data in relation to both the lives and deaths of patients, as part of a critical, revisionist history, challenges the silence and minimal concern that has surrounded psychiatric detention.

Contemporary data gathering consisted of interviews and questionnaires with numerous groups: bereaved families, coroners, legal practitioners and an MP.

These different groups have experienced being dismissed and marginalised following the death of a detained patient, or had encountered or worked with those who had experienced this dismissal and marginalisation. Contemporary data gathering also involved the critical analysis of campaign websites established by bereaved families, following the death of their detained relative. The chapter discusses how these methods not only link with one another, but also how they link with the theoretical frameworks of the research outlined in Chapter One. Finally, Chapter Two considers the potential ethical issues involved within the research.

Chapter Three undertakes the first half of the critical, revisionist 'history of the present' (Foucault, 1977: 31) and critically examines the growth of psychiatric detention from 1845 and the introduction of both the County Asylums Act and the Lunacy Act, through to 1959 and the introduction of the Mental Health Act. The response to patients in both life and death during this period is analysed. This is achieved through critically examining the data generated from the archival research, and other relevant literature, linking the findings to the theoretical discussions constructed in Chapter One. The investigation system following the deaths of patients is also explored, along with the role of the coroners court. Here, there is a particular focus on the lack of accountability apparent within these processes. Chapter Three also outlines the official response to patients, along with the families of patients and those who raised concerns. The chapter analyses the role of the medical profession, in addition to the regimes of control and silencing that patients and their families were subjected to. Chapter Three also

critically analyses the challenges to this control and silencing, examining the subsequent alternative knowledges and truths that were generated as a result of this contestation.

Chapter Four covers the period from 1960 to 2018. In order to continue to construct a critical, revisionist history, further archival data will be analysed, alongside more contemporary material, again linking these discussions to the theoretical discussions constructed in Chapter One. The chapter analyses the contemporary response to detained patients in both life and death, along with their families and those who raised concerns. As with Chapter Three, there is a focus on the attempts to silence and marginalise any challenge and complaint. This chapter also considers the contemporary official response to the deaths of detained patients, examining the circumstances of these deaths, whilst also focusing on issues within the inquest and investigation processes. As in Chapter Three, the issue of accountability is integral when examining these processes. Chapter Four also draws upon the responses to the deaths of detained patients by counter-hegemonic groups such as INQUEST, the CQC and the EHRC.

Chapter Five critically examines the findings generated by face-to-face and telephone interviews, as well as the data gathered by questionnaires and the analysis of family campaign websites. The chapter outlines the key themes that emerged from the data and links these to the themes that emerged in Chapters Three and Four. This chapter also links the findings to the theoretical arguments

developed in Chapter One. The themes identified within this chapter provide the foundations for the radical alternatives that are proposed in Chapter Six. These alternatives would work to radically transform the failing systems that dismiss and silence the voices of those embroiled within it, as well as helping to prevent future deaths in psychiatric institutions.

Having now introduced the aims of the thesis, Chapter One considers the theoretical frameworks and influences which underpin the thesis.

## **Chapter One: 'A Social, Mental and Metaphysical Death'<sup>13</sup>: Theorising Life and Death in Psychiatric Detention**

Having introduced the issue being critically examined in this thesis, the frequent, yet often hidden problem of deaths in psychiatric detention (Mason-Whitehead and Mason, 2012: 224), this chapter will outline the theoretical approaches, influences and frameworks which underpin the thesis. Whilst a Foucauldian framework surrounding power, truth and knowledge is integral to the theoretical underpinnings of the thesis, the work of other critical criminological theorists, including Goffman and Scull, will also be drawn upon throughout the chapter.

The chapter will analyse a number of key areas including the pathologisation and criminalisation of mental health problems; the rise of the asylum/psychiatric hospital; the role of medical professionals and psychiatrists; the prevalence of marginalisation, subjugation and denial and finally the generation of alternative truths and knowledge. The different theoretical approaches, influences and frameworks will then be drawn upon later in the thesis in order to critically examine and analyse the data uncovered.

### **The Pathologisation and Criminalisation of Mental Health Problems**

A positivist framework has dominated policies, practices and scholarship related to mental health problems and the deaths of patients (Carlton and Sim, 2018: 54).

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<sup>13</sup> Scull (2005: 13).

A positivist approach focuses on the 'pathological deficiencies' of patients (Ibid: 54), with an individualised view of mental health problems (McGuire, 2004: 10). Patients have continuously been viewed through a pathological and dehumanising lens (Cohen, 2009: 13). The dominance of this positivist approach within mainstream knowledge surrounding the official response to patients has resulted in an approach which relies on 'rigid categories of diagnosis to define levels of sanity and madness'<sup>14</sup> (Alvelo, 2009: 33).

The pathologisation of patients was reflected in the animality discourse that has been apparent within mental health provisions (Foucault, 2003b: 68). Foucault noted that viewing patients through an animalistic lens dehumanises and degrades them (Ibid: 69). As a result, patients were often treated 'no better than a beast' (Scull, 1979: 64). This dehumanising response 'robbed madness of all empowering features and reduced it to mere negation, an absence of humanity' (Porter, 2003: 93). The construction of animality contributed to the cage-like design of many early asylums. It was also a common belief that this animality could only be responded to through discipline and brutalising regimes including capturing, confinement and constraint (Foucault, 2003a: 70). Unsurprisingly, the disciplining of patients was apparent in early asylum provisions. For Jones, there was a 'great failure' in the legislation in place as early as the seventeenth century

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<sup>14</sup> Terms such as 'madness', although now considered offensive, will be used within this thesis, in line with their use within the historical literature, in order to demonstrate the response to individuals with mental health problems historically.

which did not distinguish between those with mental health problems and those without (1993: 10).

A focus on the pathologisation and individualisation of those with mental health problems, as opposed to a focus on any external factors, worked to legitimate the suppression of these individuals through policies and practices such as criminalisation, incarceration and institutionalization (Jones, 1993: 6). Those with mental health problems were readily confined in prisons (Seddon, 2007: 2) and were subjected to punishment such as deprivation of food or solitary confinement (Jones, 1993: 10). This further emphasised the link between criminalisation and mental health problems. John Howard, the penal reformer, visited several institutions in 1777 in order to investigate the conditions under which those with mental health problems were being held. He noted:

In some gaols are confined idiots and lunatics. These serve for sport to idle visitants at assizes and at other times of general resort. The insane, where they are not kept separate, disturb and terrify other prisoners. No care is taken of them, although it is probable that by medicines, and proper regimen, some of them might be restored to their sense and to usefulness in life (1777: 16).

According to Foucault, there was 'outrage' at the fact that those with mental health problems were confined with criminals (Foucault, 2003b: 41). The criminalisation of mental health problems was not just a historical issue. It is still apparent, often fuelled through a positivistic 'partly mad, partly bad' dualism (Barham, 1992: 102), The 'bad' aspect focuses particularly on males and the 'mad' aspect upon females (Prior, 1999: 177). Women have often been positioned



within a psychiatric discourse, whereas men have been located within a criminal discourse, regardless of the prevalence of mental health problems (Ussher, 1992a: 10). Women deemed to be mad were viewed as the 'Other' which meant they were 'ill, as outside, as pathological, as somehow second-rate' (Ussher, 1992a: 11). Penfold and Walker viewed the system as protecting males through blaming women for their own victimisation (1983: 244). For Ussher, 'experts' such as doctors 'reinforce[d] women's alienation' through pathologising their behaviour (1992a: 344). There has been a 'continuing conceptualisation of women's madness within a positivist/realist frame' (Ussher, 2005: 28) which further repressed and labelled the already marginalised female patients.

Seddon argued that the 'bad or mad' dualism was an example of positivistic 'dividing practices' (Seddon, 2007: 14). These dividing practices were 'modes of manipulation that combine the mediation of a science and the practice of exclusion-usually in a spatial sense, but always a social one' (Rabinow, 1984: 8). Dividing practices such as labelling, classification and segregation served as strategies that categorised and separated those with mental health problems (Foucault, 1977: 326). As a result of these positivistic dividing practices, patients have been objectified (Foucault, 1982: 208) which has further reinforced their marginalisation and segregation. Due to their status as a deviant, patients have been denied legitimacy as human beings in both life and death (Sim et al, 1987: 15).

The pathologisation and criminalisation of patients closely links with a 'risk-averse and zero-tolerant environment', combined with a climate of 'control versus care' (Cochrane and Gerace, 2014: 106) that has dominated positivistic psychiatric provisions. The apparent risk and dangerousness of those with mental health problems has provided the justification for the exercise of the 'prestige and power' of psychiatry (Schur, 1980: 231), where the threat of punishment and degradation is constant (Walton, 1981: 178). This focus on risk has created an:

Immediate deficit in approaches to care in that a person's level of psychosis, aggression, capacity for self-harm and/or suicidal behaviour becomes a problem to be thwarted or forestalled and not a 'need' to be attended to. Under the umbrella of safety, risks have to be managed, reduced and eliminated despite this being an impossible task that results in increased control and surveillance of psychiatric patients (Cochrane and Gerace, 2014: 94).

A focus on risk and dangerousness has led to social injustice, inequality and a widespread misapprehension regarding the supposed dangerousness and unpredictability of those with mental health problems (Lieberman, 2009: 65). An example of this concerns the intolerance surrounding those with mental health problems co-existing in the community with people who do not have mental health problems, due to the perceived risk and threat that they pose (Cummings, 1999: 59). This intolerance has further contributed to the positivistic Othering of those with mental health problems. This meant that these individuals have been subordinated and excluded which has reinforced the misconception that mental health problems were linked to crime and deviance (Perez, 2014: 198). This response has further pathologised patients and worked to justify their social control (Roshier, 1977: 311).

For Roshier, the process of pathologisation was also a form of 'moral labelling' (1989: 37), where the suggestion that those with mental health problems were the Other and somehow different was reinforced (Ibid: 21). Othering takes the form of negative connotations being applied to these individuals and being measured against what was deemed to be normal (Spandler and Anderson, 2015: 134). Othering has been apparent with labels such as 'dangerous' and 'risky' being applied to patients (Ibid: 134). This has resulted in patients being viewed as 'manipulative, evil, and personality disordered' (Williams and Keating, 1999: 140). This focus on the supposed risk and dangerousness of patients has shown the psychiatric system to be focused on social exclusion and control, masked as care and treatment. This social control of patients has worked to 'promote and protect' the interests of the powerful (DeKeseredy, 2011: 72).

### **Conceptualising the Rise and Role of Asylums and Psychiatric Hospitals as 'Total Institutions'<sup>15</sup>**

It is also important to understand how the emergence and growth of psychiatric detention has been understood by a range of critical thinkers. Rothman questioned why, historically, institutions for 'deviant and dependent' individuals became places of first resort (2002: xiii). For Rothman, the emergence of the asylum was wrongly understood as a reform and a step in the 'progress towards humanity' (Ibid: xiv). If the growth of asylums was a reform, then this meant that there had supposedly been a breakthrough in the understanding of mental health

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<sup>15</sup> Goffman (1961: 11).

problems and how they could be treated (Ibid: xv). However, he questioned whether there had been any progress at all (Rothman, 1980: 9). Similarly, Ignatieff argued that reform could be used in order to 'consolidate' state power within institutions such as the asylum (1978: 260).

Rothman viewed the emergence and growth of asylums as a 'two hundred year history of reform without change' (1980: 9). An example of these supposed reforms was the continuous implementation of programmes and policies related to the governance, care and treatment of patients<sup>16</sup>. These reforms were, in practice, extensions to the control of patients (Ibid: 3-4) and consisted of failings and 'unmitigated disasters' (Ibid: 42). The legitimacy surrounding the emergence of asylums was also questioned by Foucault who argued that confining patients in asylums was designed for the 'elimination' of individuals (2010: 78).

For Scull, progressive reform was ignored in favour of the traditional prejudice aimed towards patients and their treatment. In line with the animalistic discourse discussed earlier in this chapter, he argued that patients were viewed through a positivistic lens as 'creatures, no longer responsible for their actions...non-entities' (Scull, 2005: 13). The asylum was a convenient place to isolate and contain inconvenient people (Scull, 1979: 231). Within the institution, patients were subjected to a 'specialized, bureaucratically organized, state supported asylum

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<sup>16</sup> This is critically examined in Chapters Three and Four.

system which isolated them both physically and symbolically from the larger society' (Ibid: 14). For Scull, institutional management and control became the dominant response to patients (Scull, 1993).

As discussed earlier in this chapter, the treatment of patients within asylums was a disguised form of punishment (Foucault, 1965: 11) which acted as a regulator of the minds of patients (Foucault, 1977: 232). Foucault argued that the 'wheels of power' (1980b: 116) within the asylum operated within a system of power that was secured by a 'multiplicity, a dispersion, a system of differences and hierarchies' (2008: 6). Foucault also argued that the 'asylum machine' (Ibid: 161), like prisons, demonstrated common characteristics of social control. Asylums were structured to be ominous and designed to provide a visible warning and deterrent to the wider public of the consequences of deviating from social norms (Foucault, 1977: 130). With psychiatry often ordering and controlling patients (Smith, 1975: 2), its true aim is exposed as 'public hygiene' (Foucault, 1988: 180), resulting in patients being institutionalised and eradicated from society (Foucault, 2003b: 109). The monotony and routine of asylum life was then designed to encourage normative behaviour (Showalter, 1981: 320).

An example of supposedly therapeutic practices that were instead argued to be extensions to the social control of patients was provided in the growth of moral treatment. The Retreat of York opened in 1796, which was established by William Tuke and the Quaker movement. The Retreat was designed as the first institution

in England and Wales where moral treatment as a therapeutic approach was adopted. The building of the Retreat was inspired by the death of a Quaker, Hannah Mills, who died in squalid and inhumane conditions at York Lunatic Asylum in 1790 (Entwistle, 2010: 37). There were widespread rumours concerning the poor conditions at the York Asylum and this was confirmed by Godfrey Higgins, a governor of the asylum, who uncovered a hidden set of cells.

The cells were:

In a very horrid and filthy situation, the straw appeared to be almost saturated...the walls were daubed with excrement...I then went upstairs...and in to a room...the size of which was twelve feet by seven feet ten inches, and in which there were thirteen women (Higgins, 1816: 2).

Higgins also argued that patients at the asylum were subjected to 'cruelty', 'very great neglect' (Ibid: 5) and 'personal indignity' (Ibid: 6). He claimed that one patient was 'inhumanly kicked down the stairs by the keepers' and was told by them that 'he was looked upon no better than a dog' (Ibid: 6). Furthermore, the staff 'insulted' the same patient's wife with 'indecent ribaldry' (Ibid: 6). Higgins noted that there had been discrepancies in the mortality records kept and this 'had the effect of disguising the mortality [at the asylum]' (Ibid: 8). He also suggested that it may have been the case that, within statistics, numbers were removed from the 'died' figure and instead included within the 'cured' figure (Ibid: 8).

In contrast to the York Asylum, Glover-Thomas argued that patients at the York Retreat were viewed as human beings, with an emphasis on work and leisure

activities (2002: 8). However, for Scull, the label of moral treatment 'disguised a monotonous reality in which the needs of the patients were necessarily subordinated to those of the institution; indeed, where a patient's needs were unlikely even to find expression' (1993: 119). Furthermore, Foucault attacked the idea that state institutions such as retreats became more enlightened and humanitarian (Foucault, 2003b). He stated that the York Retreat served as 'an instrument of segregation' (Ibid: 231) and that a fear of 'great depth' was apparent at the Retreat (Ibid: 233). He also argued that 'we must re-evaluate the meanings assigned to [William] Tukes's work' (Ibid: 234). Work came first in the moral treatment that was practised at the Retreat. This work, Foucault argued, possessed a constraining power due to the regular hours, the attention required by patients and the obligation to produce a result. He also argued that the Retreat viewed madness as a return to childhood as 'everything at the Retreat is organised so that the insane are transformed into minors' (Ibid: 239).

For Jones, Foucault's contention that the fear at the Retreat was of very 'great depth' misunderstood the nature of the institutional regime. Jones maintained that the Tukes and the Quakers were entirely against any system of intimidation or beatings (1993: 30). She argued that this 'purely human gesture[s] of trust was interpreted [by Foucault] as a sinister form of repression' (Ibid: 30). She also stated that the regimes at the Retreat may have been paternalistic, but in comparison to the treatment at other asylums, the family-substitute treatment at the York Retreat was much more favourable (Ibid: 31). Nevertheless, the issue

of deaths was still prevalent as between 1796-1840 there were 139 deaths of patients at the Retreat (Registrar General, 1847: 97).

Goffman argued that asylums and mental hospitals were examples of 'total institutions' (1961: 11). These are institutions where a large number of individuals resided who were cut off from wider society and lead an enclosed, controlled existence (Ibid: 11). The reason for cutting off patients from the wider society was often justified as protecting the wider public from them (Ibid: 16) which worked to justify their constant control and sanctioning (Ibid: 43). Within total institutions, patients were infantilised and treated as children, with every aspect of their lives controlled by others (Larry-Mays and Thomas-Winfree, 2009: 149; Shorter, 1997: 275). Total institutions were also viewed as 'vehicles for social control' (Dain, 1994: 430), with the asylum staff and medical profession carrying out a continual process of exclusion and control. Here, the 'unrelenting gaze of clinical agents seized the mentally ill person from almost every angle' (Jacob, Perron and Holmes, 2014: 3).

As part of the 'degradation and irony' of the asylum regime (Barham, 1992: 2) and the 'breaking of who you are' (Scruton, 2017: n.p), patients have continually been subjected to humiliating regimes which removed their self-identity and esteem (Goffman, 1961: 31-32). Upon admission to these 'storage dumps' (Ibid: 73), patients passed through a 'betrayal funnel' (Ibid: 140) and underwent a 'mortification of [the] self' (Ibid: 31) where they were constantly degraded (Ibid:



14). New patients were subjected to a 'full set of mortifying experiences' (Ibid: 137), such as examination and judgement, following which, a 'kind of contamination occurs' (Ibid: 31) which further worked to marginalise and subjugate patients. This admission resulted in numerous consequences, including 'personal degradation...but not least, incarceration in a mental hospital, possibly for life' (Szasz, 1972: xxvii).

Goffman argued that the asylum, a total institution, could create mad behaviour (1961: 62). The main aim of such institutions was for the patients to accept that they were sick, in contrast to those who treated them, who were well. In order to recover, the patient must then adopt the 'healthy' views of those providing their treatment (Ibid: 64). If a patient was to reject their treatment, this was deemed as the patient demonstrating hostility towards the asylum and that they were not committed enough to their recovery in order to be released (Ibid: 53). Goffman also stated that total institutions frequently claimed to be concerned with rehabilitation (Ibid: 71). However, in practice, this rehabilitation was seldom accomplished (Ibid: 69). Instead, patients were constrained by 'spoiled identities' which meant that a person was subjected to stigma, an attribute deemed by Goffman to be 'deeply discrediting' (Ibid: 3). The stigma represented by mental health problems was a 'blemish of character' (Goffman, 1963: 14) meaning patients were viewed as weak and inferior (Ibid: 9). This contributed to the view of patients as 'second-class' citizens (Harnden, 2008: 33). Patients were

subsequently viewed as 'social junk', a 'costly' burden to society who required controlling and regulating (Spitzer: 1975: 645).

Foucault contended that systems of domination within total institutions depended upon the successful subjugation of bodies where individuals are mastered in order to render them 'docile' and 'obedient' (Foucault, 1977: 138). This status of being docile was achieved by the repressive and restrictive regimes that dominated the lives of patients which attempted to render them as an 'unreachable other' (Parr, 2008: 18). This status was further imposed through the positivistic process of normalization. Foucault understood normalization as corrective, with the aim of producing conformity to what was deemed normal (1977: 184). In an example of normalization in practice, Seddon (2007: 58) drew links with Foucault's notion of 'documentary accumulation' (1977: 189) where those with mental health problems were compared with others (Ibid: 191). Here, the use of medical screening, observations and psychiatric opinion was used to determine the normality of behaviour or the mental state of individuals (Seddon, 2007: 58). These techniques could be viewed as attempts to normalize those with mental health problems, whilst determining the ways in which they could most successfully be managed within the system (Ibid: 59).

The pathologisation and criminalisation of those with mental health problems and the subsequent suppressive and controlling response has resulted in a 'state within a state' emerging (Ignatieff, 1978: 35) where the dismissal, subjugation

and marginalisation of patients was continuously reinforced. A key way in which this has been maintained is through the medical and psychiatric profession. The medicalisation of mental health problems further legitimated the increased use of institutionalizing individuals in asylums (Sinclair, 2007: 58). The role and impact of these professions will now be explored.

### **Theorising the Role of the Medical Profession and Psychiatrists as 'Judges of Normality'<sup>17</sup>**

Despite the fact that medical authority 'functions as power well before it functions as knowledge' (Foucault, 2008: 3), mental health problems came to be managed by the medical profession (Scull, 1979: 16). By the mid-nineteenth century, the medical profession had secured 'powerful support' in relation to the view that 'insanity' was a disease and for that reason was something that doctors alone were qualified to treat (Scull, 1993: 232). However, at this time there was little or no specialist medical knowledge apparent in relation to the treatment of patients (Jones, 1993: 94). Despite this, 'mad doctors' or 'captains of confinement' claimed to possess unique powers to identify and manage those with mental health problems (Scull, 2005: 14). Doctors grew to believe that they held the solution to mental health problems in their power and they could cure patients if they forfeited their rights to govern themselves (Porter, 1987: 41). As Scull et al recognised:

The massive internment of the mad...was intimately bound up with the emergence and consolidation of a newly self-conscious group of people

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<sup>17</sup> Foucault (1977: 304).

laying claim to expertise in the treatment of mental disorder and asserting their right to a monopoly over its identification and treatment (1996: 3).

It was apparent that 'psychiatry captured control over insanity' (Scull, 1975: 218) which resulted in psychiatrists being deemed 'scientifically qualified to be the master' of others (Ibid: 139). The profession argued that the science of psychiatry provided the answer to mental health problems (Davies, 2014: 1). The doctor became the key figure in diagnosing and treating patients (Jacob, Perron and Holmes, 2014: 2) and the medical profession attempted to control individuals with mental health problems through their claims that only they were qualified to deal with this area. This further 'shifted insanity into the medical arena' (Scull, 1993: 41). The medical profession 'had an advantage when it came to justifying their claims to cure insanity, because everybody 'knew' that they possessed powerful remedies whose use demanded special training and expertise' (Ibid: 184). As a result, mental health problems were increasingly seen as something that could be 'treated only by a group of legally recognised experts', experts who were medical men (Scull, 1981: 6).

The asylum 'became almost the sole officially approved response' to treating patients (Scull, 1981: 6). Thus, doctors became 'managers of the mad' (Scull, 1993: 244). Psychiatric expertise aimed to legitimate the exercise of medical power (Foucault, 2008: 175). However, for Foucault, 'mystifications' shrouded supposedly therapeutic practices (2010: 499) and there was a 'dense mystery' surrounding psychiatric treatment (Ibid: 508). He noted:

As positivism imposes itself upon medicine and psychiatry, this practice becomes more and more obscure, the psychiatrist's power more and more miraculous and the doctor-patient couple sinks deeper into a strange world (Foucault, 2003b: 261).

The power entrusted to the medical profession continued to grow due to their 'scientific legitimacy', which consisted of a 'self-reinforcing system' (Scull, 1979: 44). The medical profession, as 'judges of normality' (Foucault, 1977: 304) justified themselves by emphasising that 'order, rationality and self-control could only be attained in an institutional setting' (Scull, 1979: 44). Scull stated that any 'advances' in lunacy reform were 'in many quarters' viewed as scientific, which was a viewpoint that medical professionals were keen to emphasise (1981: 1). This contributed to the view that 'the medical capture of madness' was linked to a 'mysterious advance' in scientific understanding (Scull, 1993: 3-4). This legitimated the male scientific experts and females were further excluded 'through the dominance of the myth of the masculine scientist' (Ussher, 1992a: 66).

Drawing upon the work of Foucault, Cousins and Hussain noted that doctors were central authority figures in the asylum, not because they possessed 'an objective knowledge of madness', but because, in contrast with patients, doctors were men of 'integrity and virtue' (1984: 137). The prospect of a female occupying this role was unheard of as women were 'pallid, pathetic creatures' who were 'incapable of extending treatment or advice to others' (Ussher, 1992a: 68). Therefore, asylums were 'populated by women but supervised by men'

(Showalter, 1987: 54). However, Ussher argued that 'science' was used as a 'smoke-screen' for the 'insidious' role of male professional 'experts' (1992a: 66). This smoke-screen worked to 'neutralise criticism and dissent' (Ibid: 66).

For Ussher, medical professionals and psychiatrists demonstrated an 'almost divine right to exercise control' through their supposed scientific expertise, heralding their 'passport to power' (1992b: 45). Despite its inability to provide adequate care and treatment, the discourse of positivistic scientific credibility provided security for professionals who were 'bolstered by the confidence given by the scientific bag of tricks-a confidence which sometimes results in an exaggeration of one's competencies' (Ibid: 46). The interests of the professionals were served, rather than the interests of the patients. Through the 'insidious' implications of a positivist focus, the role of the doctor as an expert was glorified, with experts protecting a particular set of interests (Ibid: 46). This resulted in:

The impenetrable language of science perpetuat[ing] its illusion of objectivity and expertise, creating a dense, jargonised world which can usually only be understood (or criticised) by those who have undergone the interminable initiation into its elite' (Ibid: 46-47).

As Scull argued, these various elites 'increasingly sought to rationalize and legitimize their control of all sorts of deviant and troublesome elements by consigning them to the ministrations of experts' (1975: 219). Doctors stood 'at the top of the pyramid' (Breggin, 1993: 402) and held an 'inescapable power' (Foucault, 2008: 177). The power of the knowledge of medical professionals

‘constituted a crucial foundation for efforts to secure and sustain professional dominance and control’ (Scull, 1993: 4).

Despite recognising that within ‘institutions of subjugation’ (Foucault, 2000a: 82), it was the dominant view that decisions surrounding care and treatment could only be made by a doctor due to their supposed expert understanding (Foucault, 2010: 124), Foucault questioned:

Why must asylum power be exercised by a doctor? It seems to me that the interior of the asylum is given a medical stamp by the physical presence of the doctor: it is through his omnipresence, the assimilation of asylum space to the psychiatrist’s body. The asylum is the psychiatrist’s body, stretched and distended to the dimensions of an establishment, extended to the point that his power is exerted as if every part of the asylum is a part of his own body (Foucault, 2008: 181).

Similarly to the history of the asylum, it has been argued that the history of psychiatry was not reflective of development (Foucault, 1991: 54; Johnstone, 2000: 145; Cousins and Hussain, 1984: 133). For Donnelly, the history of psychiatry has been presented by many in such a way as to indicate progress (1986: 16). This notion of progress was inaccurate and an example of the mystification which dominates this area (Ibid: 17). Likewise, Scull argued that ‘the history of psychiatry [was] anything but the history of the gradual liberation of the insane’ (1993: 5), arguing against viewing the moving of mental health problems into the medical arena as a reform (Ibid: 2). This was a point also drawn upon by Smart who again emphasised that the medicalisation of mental health problems was not to be viewed as progress (2002: 23).

For Szasz, psychiatry 'accepted the job of warehousing society's undesirables' (1973: 8). Within these warehouses, patients were stored, rather than adequately treated. They were brutalised and their human rights ignored (Ryan, 1983: 124-125). Szasz argued that psychiatrists inflicted a 'literal loss of freedom' upon patients (2014: 27). They demonstrated both moral and professional failure and incompetence, hiding behind a 'cloak of therapeutic neutrality' (Ibid: 7). Whilst psychiatrists viewed themselves as diagnosing and treating patients, in practice they were in fact stigmatising and controlling them (Szasz, 1991: iii). The dominant positivistic ideologies of psychiatry were communicated through diagnoses, prognoses, treatments and the 'concentration camps called mental hospitals' (Ibid: 6). Szasz maintained that there was no medical, moral or legal justification for these treatments (2010: 268). He argued that much of what was deemed 'medical ethics' within psychiatry were in fact examples of paternalistic rules and regulations. This resulted in the persistent infantilisation and domination of patients due to them being viewed as irresponsible children (Szasz, 1974; Szasz, 1994).

Establishing and maintaining a monopoly was integral to the success of the 'capture and control' (Scull, 1993: 3-4) of patients. This power was bolstered through the 'cosy collaborations' (Cohen, 1988: 30) which developed between psychiatrists who confirmed and supported each other's decisions in the face of questioning or complaint. Patients were 'insulated from the world' by the medical profession (Scull, 1979: 96) and were continuously objectified and constrained (Rabinow, 1991: 10). For Szasz, psychiatrists were 'agents of classification' (Szasz,



1991: 73) and through this classification they aimed to legitimate the constraints and social controls placed on those with mental health problems (Szasz, 1973: 213). Psychiatrists possessed a set of value judgements that imposed a particular view of 'bourgeois reality' upon patients (Grob, 1994: 263). Vatz and Weinberg argued that psychiatry consisted of many invalid assertions, used to convince others of the mental health problems of patients (1994: 315). This worked to justify the deprivation of the patient's liberty, supposedly in his or her own interest (Szasz, 1994: 1). Psychiatrists have played a significant role in incarcerating these individuals and, by doing so, authenticated themselves as 'scientifically enlightened physicians and compassionate healers' (Ibid: 1). Doctors and psychiatrists were to be understood as state agents authorized to deprive people of their liberty under the banner of medicine. The more the state empowered doctors and psychiatrists, the more the medical profession strengthened the power of the state (Szasz, 2010: 283). Busfield argued:

It is the state that has acceded to and licensed medical practitioners' claims for professional power and professional autonomy and given them legislative backing; it is the state that has given institutions powers to control and confine lunatics considered dangerous or in need of treatment (1996a: 134-135).

Within the lives of patients the medical profession was a 'constant presence' (Beveridge, 1998: 434), continuously scrutinising them. Furthermore:

Every action could be censored or criticized on the arbitrary whim of an attendant. Inmates often complained that staff abused their position of power and bullied or goaded their charges. This feeling of powerlessness was rendered even more painful if the patient regarded his tormentor as a social inferior (Ibid: 444-445).

Despite the power bestowed on the profession, Foucault argued that:

Expert psychiatric opinion contributes nothing to knowledge, but this is not what matters. Its essential role is to legitimize, in the form of scientific knowledge, the extension of punitive power to something that is not a breach of the law (2003b: 18).

The medical profession was criticised for the way in which they responded to patients (Turner, 1985: 709). They have also been criticised for arguing that patients 'had no feeling' (Wise, 2012: n.p). Furthermore, Scull criticised asylum doctors for exercising disciplinary and management functions under the 'cloak of medical treatment' (1993: 290). He noted how the psychiatric profession attempted to explain away failures by promoting the idea that patients were tainted and hopeless creatures (Scull, 2005: 21) who were considered to have suffered a 'social, mental and metaphysical death' (Ibid: 13). He drew upon the view of Lord Shaftesbury who argued that it was seemingly the case that 'madness constitutes a right, as it were, to treat people as vermin', with the asylum representing the 'deliberate and unceremonious sweeping from sight' of asylum patients (Ibid: 13-14).

Foucault argued that psychiatric power was 'mastery, an endeavour to subjugate' (Foucault, 2008: 174). An example of this subjugation in action was the increased use of psychiatric labels since the inception of the profession (Jacob, Perron and Holmes, 2014: 16). The expansion of psychiatric categorisation worked to increase the power of psychiatry (Szasz, 1972: xxvii). Szasz also contributed to this

argument and stated that the use of labels was stigmatising (2010: 267). For Szasz, the label of mental illness was an attempt to medicalise and legitimate the social control of the labelled groups (1974: 4). Furthermore, once a diagnostic label was applied, this then imparted a 'defective personal identity' onto patients (Szasz, 1973: 203). This correlated with the views of Goldstein Jutel who noted that the 'point which a disorder gets cemented by its institutional recognition as a diagnosis is also the point at which debates are silenced and particular voices privileged' (2014: i).

Being labelled as mentally ill could have devastating consequences for individuals (Grob, 1994: 262). For Porter, despite being viewed as so inferior, individuals with mental health problems had the same hopes, fears and aspirations as those without mental health problems (1987: 2). However, once a badge such as insanity was applied, it then meant that these individuals had 'forfeited their rights to govern themselves, to exercise a voice or veto in their own detention or therapy' (Ibid: 41). Having mental health problems resulted in a lack of power and social standing (Schur 1980: 30). Furthermore, for Plumb, the labels of 'psychotic', 'manic' and 'sick' legitimated the lack of credibility attached to the experiences of those to whom these labels were attached (1993: 177). Once labels were applied, patients were subsequently embroiled in the exercise of 'mental domination' by doctors (Porter, 1987: 43). For Hamilcar, a former patient, this domination of patients by doctors resulted in individuals losing their civil liberties (1982: 188). The application of a label worked to legitimate the official response to patients which led to reactions such as disgust, fear and the distancing of those

individuals from wider society (Scheff, 2009: 47). Subsequently, people who experienced mental health problems were excluded from the debates or had their experiences disregarded or 're-interpreted' (Plumb, 1993: 170). It is unsurprising that it has been argued that 'society blindly regards psychiatry as safe medicine, a position that is very comfortable since those who reject it are likely to wind up with a psychiatric label themselves' (Grobe, 1995a: viii). As Al-issa recognised, psychiatrists were 'notorious in their readiness to impute madness to others. The list of labels they can use is long enough to enable them to apply one to anybody and everybody' (1980: 3).

Psychiatry has been described as consisting of 'envy, competition, collaboration, desperation, greed and narcissism' (Newnes, 1999: 23). For Foucault, psychiatric power was 'the creator of needs and the management of the deprivations it establishes' (2008: 155). It has been argued that psychiatrists were unable to do anything for the vast majority of patients (Scull, 1993: 262). As a result, Szasz argued that institutional psychiatry itself was an abuse (1997: xxix) and, as it was 'inseparable from coercion, psychiatry cannot be reformed. It must be abolished' (Szasz, 2014: 32).

### **‘Confined’ and ‘Controlled’<sup>18</sup>: The Experiences of Females**

When examining the power of the medical profession the issue of gender becomes apparent. For Ussher, the Victorian era was a vital time regarding the regimes that ‘confined’ and ‘controlled’ women, due to the emergence of the association between madness and femininity (1992a: 64). Showalter argued that women were subjected to a process of being ‘defined’ and ‘confined’ by the medical profession within the asylum (1987: 5). They were victims of repressive doctors and asylum regimes (Houston, 2002: 310).

Historically, ‘normal’ women were associated with femininity, respectability and domesticity (Barton, 2005: 1), in addition to possessing a ‘help-seeking’ nature (Chesler, 1996: 46). For Showalter, female madness possessed a ‘dual image’ where, within ‘dualistic systems of language and representation’, women were ‘situated on the side of irrationality, silence, nature and body’ (1987: 3-4). In contrast, men were ‘situated on the side of reason, discourse, culture and mind’ (Ibid: 4). If women defied their gender roles, Victorian doctors ‘imposed cultural stereotypes of femininity and female insanity’ upon them (Ibid: 86). However, as Ussher argued, ‘is it that women *are* mad or that they are merely *diagnosed* as such because of the discourse associating femininity and psychological infirmity?’ (1991: 164 emphasis in original).

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<sup>18</sup> Ussher (1992a: 64).

Women's subordinate position in society continued to be maintained and controlled by psychiatric treatment, where their 'debilitating femininity' was reinforced (Allen, 1986: 93). Female patients were 'caught in the contradictions of the traditional female role' (Johnstone, 2000: 14) due to transgressing their gendered feminine expectations (Ibid: 118). Therefore, women were viewed as 'biologically inferior', and were 'prey to all manner of disorders' (Ussher, 1992a: 248).

Asylums themselves were designed to 'not only house feminine irrationality but also to cure it through paternalistic therapeutic and administrative techniques' (Showalter, 1987: 17-18). These techniques and regimes directed attention away from 'women's real oppression, merely defining their distress as personal, as symptoms which fit[ted] within the positivistic philosophy, rather than examining the wider issues facing each individual woman' (Ussher, 1992b: 56-57). Women were encapsulated in 'patriarchal mental asylums' (Chesler, 2005: 91) where 'madness as one of the wrongs of women' unveil[ed] itself before scientific male rationality' (Showalter, 1987: 3).

For Ussher, patients, particularly females, were the 'ultimate scapegoats, burdened with the ills of society; categorized, castigated and separated' (1992a: 7). 'Madness' was positioned as a 'deadly secret, a fear, a means of dismissing and controlling women, and as a means of pathologising distress' (Ibid: 13). Ussher highlighted how these negative discourses surrounding women became

dominant and viewed as the 'truth' due to them benefiting those in position of power (Ibid: 12). This ensured that the patriarchal model of mental health provisions remained largely unchallenged (Blanch and Levin, 1998: 7; Chesler, 1996: 46). Female patients have been particularly vulnerable to the prescription of drugs (Busfield, 1996b: 3). As female patients have been deemed 'tainted stock' (Showalter, 1987: 18), they have been considered 'prime subjects' for shock treatment, psychosurgery, psychotropic drugs (Ibid: 19) and lobotomies (Ibid: 209), all exercised through the 'ubiquitous male authority' apparent within asylums (Ibid: 78). The 'powerless' status of females was particularly apparent when attempting to refuse 'drastic therapies' such as ECT (Al-Issa, 1980: 46).

Females have been particularly silenced within psychiatric detention. As Ussher argued, the labelling of women as 'mad' worked to 'silence' their voices and the subsequent oppression of women was 'misogynistic torture' (1992a: 7). Therefore, there has been a resounding failure when acknowledging the voices of female patients (Ibid: 344). There has also continued to be a 'gaping hole in existing scholarship' related to women and mental health (Menzies et al, 2005: 1). Here, 'standard sources' of psychiatry, such as medical journals and hospital records, continued to ignore women's voices regarding madness, to the point of silencing them (Showalter, 1987: 6). Showalter argued that in the history of psychiatry, 'little attention' had been paid to questions of gender, even from critical authors including Foucault (Ibid: 5-6). This point was also argued by

Menzies et al who noted that the literature related to women and psychiatry was 'distressingly devoid of feminist influence' (2005: 10).

The omission of gender issues within literature has contributed to a 'gender blindness' emerging within the psychiatric system (Barnes and Maple, 1992: 139), where the needs of women had not been recognised 'or worse, derided' (Ibid: 141). The system almost entirely ignored women's existence in relation to mental health (Walsh, 1987: 1). Gender differences were not readily acknowledged until the 1970s (Busfield, 1996b: 1). This was demonstrated by the fact that up until 1975 no studies had been undertaken regarding why women as 'shadowed citizens' were suffering such high rates of mental health problems (Carpenter, 1980: xiii).

### **Subjugating and Denying the Patients' Experiences**

The processes surrounding the formulation of truth and knowledge is integral to a critical understanding of psychiatric detention. Official bodies possess the power to reinforce the marginalisation of opposing viewpoints (Ballinger, 2000: 55). This works to ensure that their legitimacy remains intact (Scull, 1985: 331), coupled with the maintenance of dominant power structures (Mills, 2005: 72). Complaints surrounding psychiatric treatment have been repeatedly dismissed due to patients having mental health problems (Newnes, 1999: 20). A patient attempting to take action against psychiatrists was seen as the 'final proof of



madness' (Cohen, 1988: 30). As Mills asked, how can patients speak out and challenge when their care and treatment lies in the hands of these doctors? (2005: 102).

Foucault argued that patients have been subjugated to an 'arsenal of negative concepts or mechanisms of exclusion', including disqualification and rejection (2003b: 44). The voices and experiences of individuals with mental health problems often become subjugated and dismissed as 'hierarchically inferior' (Foucault, 2003a: 7). In the face of the scientific knowledge of medical practitioners, patients are subjected to 'formulas of exclusion' (Foucault, 2003b: 5) which have attempted to disqualify alternative discourses. This has resulted in those with mental health problems being categorised, labelled and their views marginalised. The inequalities that have faced these subordinate groups have been supported, legitimated and reproduced through dominant 'regimes of truth' which were developed and sustained within dominant power structures (Foucault, 1991: 74; Scraton, 2002a: 116).

Chadwick and Scraton recognised that the dismissal and labelling of certain groups worked to protect and reproduce the political and social interests of established social orders (1991: 172). This legitimatises the discrediting, dismissal and 'defining out' of individuals and groups, such as patients and families (Mathiesen, 1980: 286). The state is under a constant threat from these groups who question and challenge their 'definite place' (Foucault, 2008: 6). These

groups propose negative reforms 'that chip away at the system' (Sim et al, 1987: 17). However, those who propose negative reforms face being co-opted (Ibid: 17) and have to consistently resist their alternatives becoming converted into 'net-widening add-ons...rather than real alternatives' (Mathiesen, 2006: 193). This co-option demonstrates an 'absorption of attitudes and actions: attitudes and actions which, if they were supported on a mass basis, would transcend and threaten smaller or larger parts of the prevailing order' (Mathiesen, 2004: 15). The process of co-option attempts to render certain individuals and groups powerless (Mathiesen, 2006: 141). Any criticism directed towards the psychiatric system has, and continues to be, met with various forms of denial and, at best, 'superficial endorsement' (Ibid: 27). In summary, the more the state can define in, the more valid their defining out of those who do not conform appears to seem (Mathiesen, 1980: 288).

The process of denial can also be utilised in order to understand the marginalisation and subjugation of patients, families and those who speak out. For Cohen, denial takes several different forms and these can be utilised in order to reinforce both the inferior and superior positions of particular groups, in this case psychiatric patients and the medical profession. First, there is literal denial where the accused flatly denies accusations and complaints in relation to the lives and deaths of patients (Cohen, 2001: 7). Second, there is interpretive denial which is when the accused attaches a different meaning to accusations made. This works to downplay these accusations (Ibid: 7). Third, there is implicatory

denial which also downplays the seriousness of any accusations by denying their 'psychological, political or moral implications' (Ibid: 8). Fourth, official denial involves 'collective and highly organised' efforts, usually involving cover-ups (Ibid: 10). Historical denial is achieved through the convenient forgetting of any events related to accusations (Ibid: 12), whereas contemporary denial involves claims that there is no awareness of what is happening (Ibid: 13).

Cohen also argued that there is the 'denial of injury' where the seriousness of any incident is minimised by the accused (Ibid: 95). The denial of the victim can also be a strategy utilised which again attempts to minimise the seriousness of any incident (Ibid: 96). A further denial strategy is the 'condemnation of condemners' where attention is diverted back to the complainants in an attempt to avoid accountability (Ibid: 97-98). Furthermore, literal denial is simply the outright denial that anything has gone wrong (Ibid: 104). Interpretive denial takes place through the admission of the 'raw facts' (Ibid: 105) but the extent of the events and any harms are denied. Finally, partial acknowledgement takes place when some claims are acknowledged, combined with a 'mixture of blatant lies, half-truths [and] evasions' (Ibid: 112-114). For Cohen, 'there are no limits to the methods that are used to deny, cover up, explain away or lie' (Ibid: 104). These various forms of denial will be apparent as the thesis progresses.

The work of Sykes and Matza could also be used to understand official attempts to marginalise and neutralise the failings in both the lives and deaths of patients.

A 'technique of neutralisation' can be seen through the continued denial of responsibility, where the state and individual asylums and hospital trusts have attempted to minimise disapproval from others (1957: 667). Furthermore, even if official responsibility was acknowledged regarding failings, official attempts at neutralising events were then made, also denying that there was any real victim, injury or serious harm involved (Ibid: 668-669). For Sykes and Matza, responsibility and accountability was also avoided through the 'condemnation of the condemners' (Ibid: 668), where those who raised concerns were labelled 'hypocrites, deviants in disguise or impelled by personal spite', with their criticism denied (Ibid: 668). Again, these techniques will become apparent as the thesis progresses.

Jupp et al's (1999) 'contours of invisibility' can also be used to understand the often invisible plights of patients and their families. The first of these contours was no knowledge (Ibid: 5). Here, the lack of public knowledge surrounding the issue of deaths in psychiatric detention has continuously worked to minimise both the seriousness of the problem and the public awareness of these deaths (Ibid: 7). Furthermore, the misconception that deaths were simply 'one-offs' has meant that systemic failings have been repeatedly downplayed (Ibid: 23). Second, the invisibility of the problem has been compounded by the lack of critical research into the area, again minimising public awareness (Ibid: 15). This links with the third contour, that of the lack of theory surrounding the issue of deaths in psychiatric detention (Ibid: 12). Fourth, the lack of statistics related to the

deaths of patients, and the circumstances surrounding these deaths, further works to mystify the prevalence of deaths (Ibid: 8). Fifth, minimal political interest into the issue has meant that there have been very few effective political interventions put in place. Sixth, the lack of control apparent has resulted in non-existent or ineffective mechanisms governing the issues surrounding the deaths of patients (Ibid: 18). Finally, the lack of panic surrounding deaths in psychiatric detention again reinforces the invisible nature of the problem (Ibid: 23).

Scruton and Chadwick have further argued that the 'type' of people who die in custody has serious implications at two associated levels, related to marginalisation and subjugation. It promotes an attitude that the deaths of such people remain non-controversial as 'it assumes that people who choke on their own vomit [or] hang themselves in a distressed state....are not controversial so long as they are checked every half-hour' (Scruton and Chadwick, 1987b: 220). The subsequent 'easy processing' of these cases through the coroners court (Ibid: 220) indicates the lack of official concern or interest in patients which results in the marginalisation of those who die in the care of the state (Scruton and Chadwick, 1987a: 233). As a result, their deaths are dismissed as of lesser importance and significance (Ibid: 233).

Due to constant silencing and subjugation, the views of those who have experienced mental health problems, and the power exercised in institutions, have largely remained ignored. This has further suppressed the already

marginalised and often invisible patients (Box, 1998: 13-14). Their experiences and voices have been, and continue to be, dismissed as 'subjugated knowledges' (Foucault, 2003a: 7). Subjugated knowledge is knowledge that has been suppressed and buried (Foucault, 1980c: 81). These subjugated knowledges are 'disqualified as non conceptual, as insufficiently elaborated, naïve knowledges, hierarchically inferior knowledges' (Foucault, 2003a: 7). The psychiatric patient is deemed as possessing a 'directly disqualified [form of] knowledge' (Foucault, 1980c: 83).

The powerlessness of being a psychiatric patient has dominated their experiences (Hart, 1995: 57), with the 'solitude and silence' driving some to madness, and others to suicide (Ignatieff, 1978: 9). However, many patients 'did not suffer their immiseration quietly' (Ibid: 85), despite it being recognised that it was a 'radical act' for subordinates to challenge dominant voices (Morrison, 2013: 17). Therefore, although the voices of patients have been suppressed, ignored and misinterpreted (Porter, 1987: 33), attempts to silence patients have been consistently challenged (Johnstone, 2000: 58). As a result, the 'indignities of power and control' are exposed (Hart, 1995: 11).

As Ballinger argued, one way to challenge marginalisation and subjugation was to speak out (2000: 123). However, by doing so, patients were further labelled and marginalised, a vicious cycle revolving round the silencing of alternative truths. Interventions, often 'driven from below' (Ryan, 2004: 25), have contested

the degradation that patients have been subjected to (Scruton, 2007: 38). These interventions demonstrated that those who are subject to power can exercise it too (Foucault, 1980c: 98; Foucault, 2003b: 29).

Foucault recognised that asylums were not totally dominating, where power was simply exerted by one group over another (Foucault, 1978: 92). The exercise of power does not always have negative connotations. Power should cease to be viewed as solely negative in the sense that it excludes, represses, censors, masks and conceals (Foucault, 1977: 194). As a result, power should not be viewed as purely repressive or coercive (Foucault, 2007: 155). Through the exercise of power, new knowledges, information and truths can be generated (Foucault, 1980d: 51). Despite attempts to objectify and categorise patients, these categories have often been rejected and contested. This reflects the view that 'where there is power there is resistance' (Cousins and Hussain, 1984: 242). This resistance is indicative of the 'battleground' related to the production of truths (Ibid: 250).

For Porter, it is important to understand what it was like to be mad or thought to be mad, along with recognising the hopes, fears and the injustices suffered by the detained (1987: 1). Their voices provide a direct challenge to the frequent 'excommunication from human society' that the detained have experienced (Ibid: 233). Patients have been denied a 'vocabulary of their own in which to frame their predicament without paying homage to a psychiatric perspective that

diminishes man as a person and oppresses him as a citizen' (Szasz, 1973: 5).

Examining the voices and experiences of patients, not only acknowledges the 'view from below' (Scruton, 2007: 17) but can also indicate:

How much sense the voices of the mad commonly made, in the desperate attempts of isolated, troubled and confused people to grasp their actual situations, their own urges, impulses, memories. They form the struggles of the despairing and powerless to exercise some control over those who had them in their power (Porter, 1987: 5).

Even within the most oppressive and constraining regimes, new and alternative knowledge can emerge (Mills, 2005: 33). This knowledge may ordinarily be discredited due to the threat such knowledges pose to dominant power structures (Houston, 2002: 311). Through the 'insurrection of subjugated knowledges' (Foucault, 2003a: 7) the 'struggles against the privileges of knowledge' are revealed (Foucault, 2000b: 331). The emergence of these 'knowledges of resistance' (Scruton, 2001: 2) is vital due to the lack of official interest and concern in patients (Foucault, 2003b: 33). Through 'demystifying and exposing the workings of state power' (Sim et al, 1987: 10), alternative knowledges also challenge the negative perception of psychiatric patients in both life and death.

Through questioning the systems and structures that dominate, constrain and oppress (Sarantakos, 2005: 51), the often invisible actions of the powerful can be analysed (Tombs and Whyte, 2003: 5). In turn, this indicates how hegemony is never secured and is always susceptible to challenge and resistance (Ibid: 41). This



is vital due to state institutions continuously avoiding accountability (Scruton and Chadwick, 1987a: 232).

## **Conclusion**

This chapter has examined the key theoretical approaches, influences and frameworks that underpin this thesis. The chapter first examined the pathologisation and criminalisation of mental health problems and how patients have been subjected to dehumanising treatment. The confinement of patients, and the links between mental health problems and criminalisation were also critically analysed. The chapter then analysed the role of the asylum/psychiatric hospital and what being embroiled in these institutions meant for patients, including being constantly controlled and managed. The asylum as a total institution was also critically examined, along with the degrading and humiliating regimes that patients were governed by.

The role of medical professionals as 'judges of normality' (Foucault, 1977: 304) was then critically analysed, with a focus on how the supposed expertise of the profession legitimated their authority and control over every aspect of the lives of patients. The chapter examined the processes of marginalisation, subjugation and denial, with a focus on the prevalence of power and control over patients and their families and the processes that have attempted to dismiss, silence and deny their experiences. Finally, the chapter analysed how subjugation and

marginalisation has been contested in order to form alternative truths and knowledge.

The theoretical underpinnings of the thesis discussed in this chapter will be drawn upon in the subsequent chapters of the thesis in order to critically analyse the data gathered. These underpinnings also influence the methodological approaches and methods adopted within the thesis, as the following chapter will now explore.

## **Chapter Two: Methodology and Methods**

Chapter One outlined the theoretical approaches, influences and frameworks that underpin this thesis. This chapter will examine the methodology and methods involved in the thesis. First, it will discuss the role of critical research and the critical researcher, before examining the methodological underpinnings of the research. Second, the chapter will then explore, in line with the Foucauldian underpinnings of this thesis, the role of a genealogical approach in writing a 'history of the present' (Foucault, 1977: 31). Third, there will then be a consideration of why the thesis places significant importance on historical data gathering. Fourth, the sampling techniques utilised in the thesis are then outlined, followed by the methods of contemporary data collection and data analysis utilised. Here, there is a focus on the appropriateness of these methods in researching the issue of life and death in psychiatric detention and how these methods link with the theoretical perspectives outlined in Chapter One. Finally, the chapter undertakes a critical consideration of the ethical issues involved in the research, along with a discussion of the ways in which these issues were addressed.

### **Critical Research and the Critical Researcher**

Traditional social science research has been concerned with generating conventional knowledge, where the views of those in positions of power were seen as rational (Smith, 1987: 65). This traditional research has often worked to increase the status and power of elite groups, whilst reinforcing the

powerlessness of subordinate groups (Becker and Horowitz, 1972: 48). In line with its theoretical underpinnings, the thesis drew attention to power relations, along with the marginalisation and attempts to silence those who challenge dominant power relations, in relation to life and death in psychiatric detention (Savigny and Warner, 2015: 10).

The research for this thesis was 'driven from below' (Ryan, 2004: 25). This meant that recognising and analysing the processes and regimes that silence, subjugate and marginalise in relation to psychiatric detention were central to the research. Gathering the different perspectives of participants surrounding life and death in psychiatric detention allowed for widely unacknowledged issues to be 'illuminated' (Medlicott, 2001: 24).

Critical criminological research views the world as being divided by a 'constant tension', where individuals are 'dominated by the powerful' and oppressed through the use of institutions (Sarantakos, 2005: 51). Adopting a critical approach meant that the research aimed to challenge false beliefs and misconceptions (Ibid: 51) in relation to life and death in psychiatric detention. Critical criminological research places questions of power, knowledge and the state at the centre of its focus and argues that structures of oppression should be challenged (Rubin and Rubin, 2012: 20). Therefore, in line with a critical criminological approach, this research did not follow a conventional history surrounding psychiatric detention and deaths within these institutions. It has

been recognised that undertaking critical research into state institutions which are 'obsessive over secrecy and obstructive over accountability' is extremely challenging (Scruton, 1987: ix). Despite this, the thesis questioned the processes which oppress and control (Harvey, 1990: 6) and an approach was adopted of being doubtful, sceptical and critical towards official discourse (Thomas, 2013: 124).

Critical research highlights abuses of power, inadequacy of investigations and the silencing of alternative accounts through condemnation, vilification and the institutional denial of responsibility (Scruton 2002b: 36). Furthermore, critical social research focuses on uncovering the 'view from below' (Scruton, 2007: 17), discussed in the previous chapter. Here, there is an emphasis on ensuring that the voices and experiences of those who are marginalised and silenced, and those who work with these groups, are heard and represented (Ibid: 10). Furthermore, critical social research:

Challenges the portrayal of the marginalised, the excluded and the oppressed as helpless or hopeless victims of circumstance. It recognises the collective strength and formidable articulation of people galvanised to resistance by the insensitivity, recklessness and neglect of state institutions (Ibid: 10).

Adopting a critical stance means questioning official statistics and definitions, coupled with challenging social control (Stubbs, 2008: 7-8). A critical stance also emphasises the effects of power and promotes social and political change, with a focus on social justice and human rights (Ibid: 7-8). The thesis was concerned with examining the official discourses that reproduced inequalities through the

promotion of 'acceptable' state-defined knowledges and truths in relation to life and death in psychiatric detention (Berrington et al, 2003: 131). This approach allowed alternative historical and contemporary discourses to be uncovered (Jupp and Norris, 1993: 46), discourses that had often been dismissed as 'hierarchically inferior' (Foucault, 2003a: 7).

With the challenge to state hegemony, a 'constant struggle' emerges (Fiske, 1987: 41). Absolute hegemony is never achieved (Ryan and Sim, 2007: 708) due to 'individual and collective acts of subversion, refusals and confrontations' (Sim, 2009: 157). However, limited information exists on this resistance due to a lack of attention paid within research to how power and control is challenged (Crossley, 2006: 2). As discussed in Chapter One, this research aimed to explore the different ways that challenges to official discourses and regimes around deaths in psychiatric detention emerged and how these challenges developed historically and contemporaneously.

This examination demonstrated how individuals on their own, or collectively, can oppose power, whilst questioning its authority and legitimacy (Moore and Scraton, 2014: 31). Therefore, the research sought to examine how the 'self-serving degradation of truth and denial of justice' has been challenged, along with exploring the avoidance and denial of responsibility and accountability that has dominated this area (Scraton, 2007: 239-240). Chronicling the subjective and often subjugated knowledges in the area of psychiatric detention aimed to

generate alternative truths which challenge dominant knowledge (Berrington et al, 2003: 131). This allowed for new knowledge to emerge (Danaher et al 2000: 35). Therefore, the thesis is based on a 'criminology from below' (Sim et al, 1987: 7). This approach focuses on the perspectives of those whose voices have been dismissed and subjugated, along with those who have worked with these groups.

As Scott has argued, as a critical researcher, a number of research values should be adopted (2015: 185). These values include being independent as a researcher and not 'justifying or sympathetically evaluating existing policies' (Ibid: 195). Scott also noted that within critical research it is vital to 'uncover exploitation and/or empower those who are suffering' (Ibid: 196). Furthermore, researchers should recognise that they are in a privileged position, as visitors in the world of participants, and should accurately portray within the research the experiences of participants by uncovering their truths and 'real experiences' (Ibid: 196). Within this process, the critical researcher should not reproduce dominant discourses (Ibid: 197). Finally, critical researchers should not simply interpret the findings of their research, they should also aim to facilitate change in relation to marginalised groups (Ibid: 197).

However, critical researchers have been accused of over-identifying with those being studied, along with 'idealising the view from below' (Scruton, 2007: 17). Nevertheless, Scruton stated that it is vital in critical research to 'bear witness to the depths of people's pain and suffering and the consequences on their lives of

the uphill struggle for truth, justice and acknowledgement' (Ibid: 17). It has also been argued that research cannot be value-free and researchers should make explicit their own personal values in relation to their research area (Bryman et al, 2012: 96). It could be said that by adopting a critical approach, the research 'took sides' with participants, particularly due to the 'underdog' status of some of them, namely families, who have been ignored and silenced (Rubin and Rubin, 2012: 20).

Becker argued that it is not possible to remain neutral as a researcher as it is impossible to undertake research without being contaminated by prior knowledge of an issue (1967: 239). For Becker, it is not whether researchers should take sides, but rather, whose side the researcher is on (Ibid: 239). He argued that a 'hierarchy of credibility' exists and, within this hierarchy, those at the top define, control and exercise power, where their views and knowledge 'intrinsically deserves to be regarded as the most credible account obtainable' (Ibid: 241). Thus, the members of 'higher' groups in society, in this case psychiatrists and medical professionals, define the way things 'are' (Ibid: 241). In contrast, members of 'lower groups', patients and their families, are only entitled to 'partial information and their view of reality will be partial and distorted in consequence' (Ibid: 241). As a result, 'credibility and the right to be heard are differentially distributed through the ranks of the system' (Ibid: 241).



As Porter has argued, there has been an 'extraordinary deafness towards the communications of the disturbed and in particular a discounting of their reactions to, and complaints against, the psychiatric treatment meted out to them' (1987: 5). Because of this, 'the protests of the mad have been interpreted as symptoms of their madness' (Ibid: 5). Researchers may possess some sympathy towards groups who possess a lower position in the hierarchy as whilst the wider society may regard them as inferior sources of knowledge, critical researchers instead believe that they are credible sources (Ibid: 239-240). Becker argued that the accounts of subordinates work to challenge official truths (Ibid: 243) and have as much right to be heard as superordinates (Ibid: 241).

As critical researchers refusing to accept the hierarchy of credibility, accusations of bias emerge, which seemingly only occurs when the side of the subordinate is taken (Ibid: 243). Scott (2015: 190) argued that it is more important for a researcher to have empathy with whoever is researched, as opposed to automatically identifying with the underdog. For Gouldner, it was important to recognise the 'unknown suffering' of certain groups (1968: 106), in this case patients and their families, whilst focusing on those who experience 'needless' suffering (Ibid: 106). However, for Silverman, by taking the underdog perspective, there is a risk of emerging from the research with an 'outsider's view of an outsider's account of what is going on' (1985: 19). Despite this, understanding the experiences of these groups is vital due to the fact that their suffering is less likely to be recognised by wider society (Gouldner, 1968: 106).

The thesis was influenced by the standpoint that the researcher was someone who could empower people (Silverman, 1985: xi). However, the researcher as an empowering individual leads to the question of 'who has the authority to speak?' (Smith and Wiegman, 1995: 4). Those with knowledge and experience in this area, such as patients and bereaved families, are often marginalised because their knowledge is not deemed expert. This is despite it being argued that these groups are indeed unrecognised experts (Chesler, 2005: 8). Those with alternative knowledges have often been ignored in policy, whilst being 'swept aside and overwhelmed by other views, often ones that have no grounding whatsoever in serious research' (Currie, 2007: 177).

The issue of speaking 'for' and 'about' others has also been raised (Smith and Wiegman, 1995: 100). Smith and Wiegman have argued that those from dominant groups who speak for others 'does nothing to disrupt the discursive hierarchies' (Ibid: 99). Alcoff (1991: 7) also questioned whether it was acceptable for researchers to speak for those with different backgrounds and circumstances than themselves, due to the risk of researchers reinforcing the oppression of the group being researched. Thus, if patients and families cannot be viewed as authoritative figures due to their experiences related to life and death in psychiatric detention, is the critical researcher, arguably in a 'privileged position', the next-best option in order for these suppressed voices to be heard? As a researcher, this poses a further question: 'If I don't speak for those less privileged than myself, am I abandoning my political responsibility to speak out against

oppression, a responsibility incurred by the very fact of my privilege?’ (Ibid: 8). Careful consideration was given to ensuring that existing injustices and inequalities (Scott, 2016: 197) surrounding psychiatric detention were not exacerbated, whilst also ensuring that the meanings and truths behind the perspectives of participants were not lost (Alcoff, 1991: 6). Through engaging with ‘estranged other[s]’ (Scott, 2016: 185), and those who work with these groups, their hidden experiences were visibilised (Ibid: 185).

### **Methodology: Approaching the Research**

An inductive approach was adopted in the research which meant that the research did not commence with an existing hypothesis to test. Rather, conclusions emerged based on the findings of the research (Blaikie, 2010: 154). However, as Gray has argued, when adopting an inductive approach, it is impossible not to hold some pre-conceived ideas or judgements surrounding the research topic, as these ideas and judgements influence the decision to initially research a particular topic (2014: 18). It was therefore important to acknowledge that this research was influenced by the findings of my Masters research in this area which critically analysed the problematic nature of deaths in psychiatric detention, particularly surrounding post-death investigations and inquests. It was this research which also indicated the gaps in research and knowledge related to deaths in psychiatric detention. The thesis aimed to build upon this previous research, as opposed to testing any hypotheses generated from this research, hence the employment of an inductive approach (Babbie, 2010: 58).

Like the issue of deaths in prisons, a positivistic approach has dominated the generation of knowledge in relation to life and death in psychiatric detention, with an official resistance to other methodological approaches (Medlicott, 2001: 33). For Medlicott, a positivist approach was too 'blunt' to examine sensitive issues such as the institutionalisation of individuals (and the deaths of those institutionalised) and, instead, an approach was adopted that focused on the interpretations of individuals caught in power relationships (Ibid: 35-36). The research for this thesis aimed to critically analyse the patterns and themes associated with the deaths of detained patients, both historically and contemporaneously (Gray, 2014: 18). Therefore, positivist ontological and epistemological frameworks were avoided (Power, 2003: 147). This was a point reiterated by Stubbs who argued that positivist methodologies should be rejected within critical criminological research (2008: 7).

In order to move away from a positivist approach, the research adopted an epistemological position of interpretivism. An epistemological position is concerned with the 'nature of knowledge' and the way in which reality is known to us (Sarantakos, 2013: 29). Interpretivism is an approach that promotes the importance of understanding the individual circumstances of those being researched (Blaikie, 2007: 124). This approach also focuses on understanding rather than simply explaining the issues being examined (Kasi, 2009: 96). Adopting an interpretivist approach allowed for the consideration of how the social order surrounding the regimes and hierarchies related to psychiatric

detention were created and maintained (Sarantakos, 2005: 40). An interpretative approach meant that when examining both the historical and contemporary issues around deaths in psychiatric detention, an exploration of how power and dominance had been utilised in order to avoid accountability could be undertaken (Davies et al, 2014: 11).

The methodological approaches adopted allowed for the recognition of the subjective nature of the interpretations and meanings that individuals attached to particular events (Walliman, 2006: 15). This was beneficial in developing an understanding of the experiences of different groups surrounding life and death in psychiatric detention and to avoid attempting to construct 'universal' truths (Ibid: 21). As a result of critically analysing the subjective experiences of the participants, the research was able to present alternative knowledges that challenged dominant truths sustained within dominant structures of power (Scruton, 2002a: 116). This was in line with the Foucauldian theoretical influences of the thesis which was sceptical of dominant truths. Alternative truths emerged as a result of adopting this standpoint which also allowed different perceptions of the same issues to be uncovered (Schwartz-Shea and Yanow, 2012: 82).

The ontological position of constructivism was adopted within this research. Ontology is concerned with 'the nature of reality' (Sarantakos, 2013: 29). Constructivism is defined as an approach that focuses on research participants being 'meaning makers' (Hammond and Wellington, 2013: 32). Constructivist

research draws upon the subjective meanings that individuals attach to their experiences, based on their understanding of particular situations (Creswell, 2014: 8). Again, adopting this position allowed the research to be unrestricted by a search for 'absolute truths' (Sarantakos, 2005: 37) surrounding deaths in psychiatric detention. Instead, through developing an understanding of the 'lenses through which people view events' (Rubin and Rubin, 2012: 19), an emphasis on subjectivity allowed the research to present various different subjective versions of the research topic, both historically and contemporaneously, as opposed to 'definitive' versions (Bryman, 2008: 19).

### **Gathering the Historical Data**

A critical, revisionist trajectory was adopted within the thesis as no critical, revisionist history currently exists surrounding life and death in psychiatric detention in England and Wales. Revisionist histories, as Gutting argued, work to challenge liberal interpretations of history (2005: 35) which argued that various forms of state custody had become more progressive (Ignatieff, 1981: 153; Laing, 1992: 25). Instead, revisionist histories highlight the increased state control of 'deviant' populations, resulting in segregation, classification and marginalisation (Cohen, 2007: 13). Conducting a critical, revisionist history allowed for the 'distortions or illusions introduced or sustained by conventional histories' to be revealed (Donnelly, 1986: 17).

In order to undertake this critical, revisionist history, this thesis focused on 'the lived experience of people', as opposed to 'expert opinion' (Holmes and Dunn, 1999: 3). The emergence of alternative knowledges, discussed in Chapter One, challenge the 'ex-communication' (Porter, 1987: 233) of those who speak out. This acknowledgement of these voices has ensured that those who have been marginalised are viewed as 'full human subjects' (Medlicott, 2001: 34).

In an area that has been so widely neglected in critical research as that of life and death in psychiatric detention, it was important to 'make sense of the past' (Fulbrook, 2002: 195). Therefore, before commencing contemporary data gathering, significant archival research was undertaken. Archival material, as primary sources, provided direct evidence from the time periods covered by the thesis (Finnegan, 2006: 142). As Dean argued, examining historical documents helps to understand contemporary data (1994: 14). Therefore, it was vital to 'capture the historical movement in which the present is caught' (Ibid: 8).

Over 200 files were accessed at the National Archives<sup>19</sup>. The contents of each file ranged from a small number of documents, to hundreds of documents. Most of these files were easily accessed, which eliminated the issue of non-response and refusal that could happen in the other forms of primary data collection, discussed

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<sup>19</sup> Some files, once accessed, did not match the file description, were duplicates of other files, were in too poor a condition to read or were missing documents and were therefore unable to be included in the thesis.

later in this chapter (Sarantakos, 2005: 298). Files concerning issues in both life and death were of most interest, along with issues of accountability, as outlined in the introduction to the thesis. Search terms used in the 'Discovery' search engine at the National Archives included 'asylum/mental hospital/psychiatric hospital deaths' 'asylum/mental hospital/psychiatric hospital complaints' and 'asylum/mental hospital/psychiatric hospital allegations'. File descriptions were then read and those deemed most relevant based on these descriptions were selected<sup>20</sup>. This ensured that the research retained focus and avoided becoming a 'blindly accumulated pile of facts' (Samuel et al, 1985: 10). Another technique used during the archival research was snowball sampling, discussed later in the chapter in relation to other primary data gathering (Gray, 2014: 223). Search terms such as those discussed above were utilised initially, however, as files were accessed, other cases that were discussed within the original files were then accessed themselves.

During the archival research, the role of 'detective' was adopted (Harvey, 1990: 28). This involved 'seeking out clues, following trails and leads, and gradually getting a feel of what is going on' (Ibid: 28). Seal has argued that whilst undertaking archival research, the experience of closely reading and analysing documents can mean coming into close contact with the 'wreckage of human suffering' and can be extremely emotional (2012: 689). A stance of 'disciplined

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<sup>20</sup> In an example to indicate the magnitude of undertaking research at the National Archives, if 'asylum deaths' is typed into the Discovery search engine, 1,540 supposedly relevant files are returned from the search.



empathy' (Medlicott, 2001: 39) was adopted when examining the archival files which meant that as reading the files was undeniably an emotional experience, boundaries were drawn in order to avoid being overwhelmed by the research process (Ibid: 53). This was a difficult task as when reading the archival data, a number of cases stood out as particularly emotive. The research embraced what Johnson called the 'kaleidoscope' of feelings and emotions experienced, including euphoria, jubilation, anger and frustration (2009: 195). As Johnson also argued, acknowledging these emotions can result in a greater understanding of the research area which can enrich and enhance the research (Ibid: 195).

The files accessed dated primarily from the mid-nineteenth century through to the 1990s and consisted of letters, case notes, admission, discharge and death registers and newspaper articles. Many of the files were concerned with allegations made against staff, the investigation of complaints surrounding the treatment of patients and the issue of contentious deaths. Reports and inquiries into conditions and allegations were also uncovered. Despite the dismissal and subjugation faced by patients, and those who challenged the system, the similarity of their responses 'demands that their claims are considered seriously' (Beveridge, 1998: 461). Photographs were taken of every document in each file accessed and, as each file was examined, the issues considered included what the data represented and what questions the data raised (Lofland and Lofland, 1995: 75). Extensive notes were also made surrounding the contents of each file, along

with 'key quotes' and themes that became apparent such as 'lack of accountability' and 'marginalisation of complaints'.

As Barton has noted (2005: 163), when a piece of data is being examined retrospectively, it is difficult to be entirely sure that a researcher understands and interprets the piece in the way it was originally constructed. Therefore, a number of areas were considered when selecting and examining documents, including the authenticity, credibility and comprehensibility of the evidence (Flick, 2009: 257). When reading the documents it was important to consider whether they were factual or opinion-based and how this may have influenced the data. Furthermore, it was also judged if the documents were intended to be viewed by the public, a more private audience, or to remain confidential, along with whether the documents were meant to be argumentative, pressurising or persuasive (McDowell, 2002: 111-112).

Whilst undertaking the archival research, a number of issues emerged, the first being that the majority of correspondence from patients and relatives did not survive over time (Smith, 2008: 238). Many of the documents were handwritten and were in a poor condition due to their age (May, 2011: 203). This meant that analysing these files was extremely time-consuming. However, as Scraton has acknowledged, uncovering and recovering truth requires time and patience (2017: n.p). Another issue that emerged from examining the archival files was that, on several occasions, documents within the file would not be in

chronological order or would end abruptly, without any indication of the final outcome of the case. In addition, files were missing documents, an issue highlighted by Sarantakos as being problematic (2005: 299).

Another issue was the varying length of files, meaning that information surrounding some cases was much less detailed than others, resulting in cases of varying lengths being presented in Chapters Three and Four. A final issue was that there were files that were still closed under the Public Records Act 1958, a problem identified by May as being restrictive when undertaking archival research (2011: 203). This meant that from 1999, hundreds of files which potentially could have been utilised within the thesis were inaccessible. Eight Freedom of Information requests were submitted to The National Archives, in order to view some of these closed files. Three requests were granted, although data were redacted in all three files. The further five requests were rejected.

Once the archival research at the National Archives was complete, the thesis turned to more contemporary archival material by accessing the ProQuest Historical Newspapers online archive. Accessing the ProQuest archive meant that more contemporary cases were uncovered that, if they were included in the files at the National Archives, would have been closed due to date restrictions. The digitization of newspapers means that researchers can now very quickly ascertain if the newspapers contain relevant material through the search tools available (Bingham, 2010: 227). The same search terms were used here as were used at

the National Archives. It had to be considered that the newspaper articles were also intended for public viewing, often unlike the material accessed at the National Archives. It was also recognised that only the most newsworthy aspects of each case would have been published. Nevertheless, accessing the newspaper archive allowed for the broadening of the scope of the research. Consulting the digital archives also corroborated information gathered from other sources (Allen and Sieczkiewicz, 2010: 2).

Undertaking archival research allowed a 'history from below' to emerge, which concentrated on the 'marginal who have been least visible' (Tosh, 2010: 71). The research for the thesis focused on personal accounts including autobiographies, letters and the work of counter-hegemonic groups that are often missing in official accounts. This contrasted with official accounts which rely on official documents, papers and political statements. These sources create accounts of history from the perspective of those in power (Sim, 2009: 3). For Porter, 'if we are to understand the treatment of the mad, we must not listen only to pillars of society, judges and psychiatrists' (2006: 314). It was also important to explore 'beyond the explanations so readily and easily offered by the experts who say they *know*' (Ussher, 1992a: 9 emphasis in original). Wood argued that there is a scepticism surrounding the history of the asylum that relies primarily on the voices of asylum staff (1994: 3). Similarly, for Beveridge, the history of the asylum, written only from a physician's perspective, was 'seriously incomplete as it

ignored the experience of the great number of men and women' who were detained (1998: 461).

Beveridge did acknowledge that the testimonies of patients could be problematic, for example due to issues surrounding interpreting their accounts as they were constructed for various 'personal, polemical and literary purposes' (Ibid: 461). Also, due to their mental health problems, questions surrounding the accuracy of their statements was also an issue (Ibid: 461). However, for Beveridge, to dismiss these statements because of the mental health of patients was unfair. For example, patient correspondence utilised in Chapters Three and Four provides a unique and previously hidden insight into the world of psychiatric detention. They present 'a virtually unique record of asylum life' and are 'less tidy, less considered...and, because of that, they give a richer, more compelling picture of asylum life' (Ibid: 461).

Salvatore has argued that in order to understand historical data, researchers should act sensitively in order to acknowledge the 'otherness' of the past (2004: 191). The research for this thesis recognised that instead of being considered 'objects of domination', those whose voices were considered 'knowledge from below' were actually valid and credible forms of knowledge (Foucault, 1997: 179). Furthermore, undertaking a critical, revisionist history 'demonstrated the usefulness-and indeed the priceless quality-of whole classes of documents which were previously held in low esteem' (Samuel et al, 1985: 6). These accounts from

below constructed alternative truths to that of official truths (Sim, 2009: 3). As Pilgrim and Rogers also argued, these critical accounts challenge dominant versions of history, which protect the powerful (2014: 89). As a result, within this thesis, those in power, such as asylum staff, were no longer considered authoritative, they were instead considered as sources to be critically analysed (Van Der Dussen, 1981: 286).

Critically examining the experiences and struggles of those embroiled in the system meant that previously accepted, conventional histories were challenged. Chamberlayne et al (2000: 23) stated that social history research should consider the wider social situations and problems which faced those being researched. Furthermore, as Wright Mills argued, in order to understand the experiences of individuals, the researcher should understand the wider social and historical structures that influenced the experiences of those being examined (1959: 158). For Wright Mills, it was also important to link individual issues with wider public issues (Ibid: 8) which rarely occurs in relation to failings in psychiatric detention where cases are dismissed as one-offs. As will be demonstrated in Chapters Three and Four, by critically examining what at first appears to be personal problems in relation to single cases, these problems are often revealed to be indicative of more widespread public issues involving failures in both the lives and deaths of patients.

## **Archival Research as a Genealogy**

Linking the archival research with the theoretical underpinnings of this thesis, a 'history of the present' (Foucault, 1977: 31) in relation to life and death in psychiatric detention was undertaken through the archival research. This was an example of a 'genealogy', defined by Foucault as an approach which aims to 'desubjugate historical knowledges' (2003a: 10). Roth stated that 'writing a history of the present means writing history *in* the present' (1981: 43, cited in Garland, 2014: 373 emphasis in original). This approach uses history as a source (Tazzioli et al, 2015: 3) and a full 'decomposition' (Rose, 1999a: 50) of the issue of life and death in psychiatric detention was undertaken. The approach provides an example of using the past to 'illuminate the present' (Cohen, 2007: 15), whilst giving a voice to 'submerged voices' which lie 'a little beneath history' (Sawicki, 1991: 28). As Castel noted, 'the present bears a burden, a weight that comes from the past, and the task of the present is to bring this burden up to date in order to understand its current ramifications' (1994: 238).

A genealogy 'is motivated not by a historical concern to understand the past...but instead by a critical concern to understand the present' (Garland, 2014: 373). This 'critique of the present' (Crowley, 2009: 341) is undertaken within the existence of contemporary problems (Dean, 1994: 35). Therefore, a problem is posed, in this case the issues of deaths in psychiatric detention, from the perspective of the present and then its genealogical history is traced (Kritzman, 1988: 262, cited in Garland, 2014: 367). A genealogical approach shows how any issue emerged

(Bevir, 2008: 263), whilst also aiming to trace the relationship between the past and the present (Garland, 2014: 372). The genealogical analysis also 'traces how contemporary practices and institutions emerged out of specific struggles, conflicts, alliances and exercises of power, many of which are nowadays forgotten' (Ibid: 372). This history of the present is therefore critical and recognises the consequences of the repressive aspect of power and knowledge (Ibid: 376).

The genealogical approach results in a 'critical history' emerging from the research (Ibid: 372). For Smart (1983: 76) a genealogical approach 'is disruptive of traditional historical analyses employing conceptions of uninterrupted continuities in history', thus giving critical consideration to the 'series of subjugations' apparent. This results in discontinuities being revealed, thereby challenging the dominant truths (Tamboukou, 1999: 203), surrounding the lives and deaths of those in psychiatric detention.

For Foucault, an 'effective critique' can be developed through 'historical contents [which] allow us to see the dividing lines in the confrontations and struggles that functional arrangements or systematic organizations are designed to mask' (2003a: 7). Therefore, the emergence of historical data allows for the rediscovery of the effects of these conflicts and struggles (Foucault, 1980c: 81-82). Counter-hegemonic truths emerge from the historical data which are powerful in the fact that they are 'different from all the knowledges that surround it' (Foucault, 2003a:



8). It is through the 'reappearance of these knowledges from below, of these unqualified or even disqualified knowledges' that official discourses are critiqued (Ibid: 7) and 'hierarchising knowledges' (Dean, 1994: 12) are challenged.

Genealogies are concerned with critically examining knowledge and power (Elden, 2017: 110), alongside the processes behind the generation of truth and knowledge (Tamboukou, 1999: 202). For Foucault (1980c: 85), a genealogy should aim to draw attention to suppressed knowledges that can be used to oppose and challenge dominant power structures. Therefore, genealogies 'entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges' (Ibid: 83). The approach recognises that these knowledges offer a 'valuable, effective and uniquely important practice of philosophical-historical critique of the present' (Koopman, 2013: 5). Rose argued that genealogies also:

Aim to help maximise the capacity of individuals and collectives to shape the knowledges, contest the authorities and configure the practices that govern them...revealing the lies, falsehoods, deceptions and self-deceptions which are inherent within these attempts to govern us for our own good (1999b: 282)

The buried and subjugated knowledge which emerges from historical data (Hook, 2005: 6) has often been unrecognised and unrecorded in mainstream history (Tamboukou, 1999: 207). The genealogical method also exposes how institutions, regimes and practices that are taken for granted are deeply problematic (Garland, 2014: 372). A genealogical approach promotes scepticism, questioning, suspicion and critique (Hook, 2005: 4-7). Dominant knowledge surrounding care and

treatment often go unquestioned (Danaher, Schirato and Webb, 2000: 17). This has resulted in mental health problems being 'owned' by psychiatry and thus psychiatrists often have the 'final word' (Ibid: 22). The passage of time has worked to reinforce this dominance. However, knowledge is also susceptible to change (Ibid: xi). Through constructing a history of the present, this thesis has aimed to trace the prevalence of power and control in this area, again creating alternative knowledges which are 'capable of opposition and struggle against the coercive power of social scientific discourse' (Hook, 2005: 7).

In summary, through undertaking a critical genealogical analysis of life and death in psychiatric detention, 'submerged problems' (Koopman, 2013: 1) emerged, along with an alternative body of knowledge surrounding the struggles faced by patients and their families (Foucault, 1980c: 83). The struggles engaged in by these groups were therefore exposed (Tamboukou, 1999: 203). By working to ensure the 'genealogical recovery of subjugated voices' (Hook, 2005: 7), the thesis sought to give a voice to marginalised knowledges, as opposed to reinforcing the exclusion and subjugation of psychiatric patients and their families (Smart, 1983: 80). In line with the methodological approaches of the research, discussed earlier in this chapter, undertaking a genealogy did not aim to construct 'the truth' surrounding deaths in psychiatric detention, recognising that people had different experiences of the issues being critically examined. Instead, it aimed to construct multiple 'truths' (Hook, 2005: 8), through the desubjugation of knowledges (Foucault, 2003a: 10).

The findings from the archival research assisted in ensuring that one of the aims of the research was fulfilled, that of undertaking a critical examination of historical data related to psychiatric detention and deaths within these institutions. Furthermore, the archival data assisted in increasing the understanding of the background to the contemporary psychiatric detention system. Therefore, this 'new world' of information (Hill, 1993: 1) not only provided a comprehensive insight into the historical system, but also provided the basis for the contemporary exploration of both pre-existing and newly-emerging issues.

### **Gathering the Contemporary Data**

#### *Sampling in Interviews and Questionnaires*

With the Public Records Act restrictions in place at the National Archives, the research turned to accessing material such as reports and investigation findings after 1999<sup>21</sup>, as will become apparent in Chapter Four. However, the next consideration was how contemporary voices could be accessed in order to continue the revisionist history of the present. The research utilised a non-probability, purposive sample consisting of individuals and groups who were hand-picked as the most appropriate participants for the research (Denscombe, 2010: 17). Because of this, the findings of the research could not be generalised to all those with experience in this area.

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<sup>21</sup> When the most recent relevant archival file was accessed.

Participants were sourced through online searches into cases of deaths in psychiatric detention and from prior knowledge of cases in this area. Utilising a purposive sample meant that individuals were chosen who would provide the most relevant data in order to achieve the aims of the research (Kumar, 2014: 244). This was in addition to ensuring that an extensive amount of relevant data was gathered (Gray et al, 2007: 105). As has been argued, utilising a purposive sample can result in a plethora of 'information-rich' data emerging from participants (Patton, 1990: 169).

The number of participants who were interviewed or completed a questionnaire was fourteen. This consisted of eight legal practitioners, three family members, two coroners and one MP. Utilising a number of different groups who all possessed knowledge of the issue of deaths in psychiatric detention allowed for a triangulation approach to be utilised. This meant that the research was strengthened by gathering data from those with different experiences of the issue (Patton, 1990: 187). Furthermore, examining the experiences of a number of different participant groups allowed examples of 'multiple forms of subjugation' to emerge (Foucault, 1980c: 96). Whilst coroners, legal practitioners and MPs do not experience the same overwhelming marginalisation and subjugation as patients and bereaved families, they often find themselves subject to constraint, attempted silencing and dismissal after attempting to speak out about the systems they work within. Therefore, their experiences were also vital to this research.

Participants were approached personally as their contact details were in the public domain. Existing contacts were also utilised in order to gain access to other participants, especially as this was an example of a research topic where it was often the case that it was difficult to recruit participants (Hall and Hall, 1996: 17). As the research progressed, several participants suggested further suitable participants for the research and a snowball sampling technique was also used. This was particularly useful as the research topic was a sensitive and 'hidden' area where the knowledge of 'insiders' was vital (Gray, 2014: 223). As a result, potential participants who had remained 'underground' (McIntyre, 2005: 105) were identified by 'key informants' (Patton, 1990: 176). This indicated the importance of 'networks' (Kumar, 2014: 214) and 'connections' (Lofland and Lofland, 1995: 37) which allowed previously hidden participants to become visible (Davies et al, 2011: 355).

As Kumar (2014: 245) has noted, a snowball sample can result in possible bias due to the circumstances of the potential participants being recommended by the original participants. As an example, one family member with a negative experience of psychiatric detention may suggest another family with a similar experience. Despite this, a positive aspect of adopting the snowball sampling technique was that upon contacting those who had been recommended by other participants, their participation was agreed almost immediately. This was due to being able to use the original participant as a 'reference' to ensure the credibility

of this research, as opposed to contacting potential participants unannounced (Denscombe, 2010: 18).

Originally, the research for the thesis wished to speak to a larger number of families. However, as bereaved families were an example of a hidden population, it was difficult to establish contact with them, a recognised 'struggle' within research (Walters, 2003: 3). Family Member One, when interviewed, stated that he thought a factor which might deter individuals from participating in research such as this was the different groups and individuals who contact families, such as the media and researchers, and come into their lives before leaving after collecting what they need. This was a point echoed by MP One<sup>22</sup> who described the 'nightmare' that faced him when he attempted to contact families in order to conduct a piece of research on deaths in custody. He stated that it was often the case that 'we take what we need [as researchers] and then move out' which resulted in families, who initially have feelings of hope, feeling disappointed and frustrated. However, he stated that this 'was not a reason for you or I not to research this topic'. The issue of family involvement and how it was negotiated is discussed later in this chapter.

According to Medlicott, statistics are of greater value and significance than words to policy makers (2001: 33). This is a 'trap' which researchers can fall into (Ibid: 33). Here, 'much political comfort [is] gained by denying the validity' of qualitative

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<sup>22</sup> Quotations are taken from primary data gathering undertaken with participants.

research due to it lacking 'scientific credibility' (Ibid: 43). Gathering quantitative data would have allowed a certain level of statistical analysis and understanding surrounding life and death in psychiatric detention to emerge. However, in line with the interpretivist, constructivist approach adopted in this research, the thesis aimed to move beyond structured numerical data in order to uncover rich and deep contextual data (Bryman, 2008: 393). These were complexities that a statistical, numerical analysis would struggle to address. As Holliday has argued, it is insufficient to rely solely on quantitative data. Instead, it is necessary to critically examine the subjective experiences of individuals (2007: 7). Gathering qualitative data allowed participants to feel unrestricted when providing their responses (Yates, 2004: 33). In a topic as sensitive and under-researched as deaths in psychiatric detention, it was important that participants could express, in words, the subjective nature of their experiences (Rothe and Kauzlarich, 2016: 34).

#### *Undertaking Interviews and Questionnaires*

The first and preferred method of qualitative data collection was face-to-face, semi structured interviews. A total of six face-to-face interviews were undertaken and lasted an average of one hour. The purpose of the interview was outlined to participants in the participant information sheet (See Appendix B) and the informed consent form (See Appendix C).

Questions were based upon prior knowledge developed concerning deaths in psychiatric detention and the themes that had emerged from the findings of the archival research. Depending on the participant, for example, a family member or a coroner, different questions were asked which ensured that the questions were most suited to the background of participants (See Appendices D, E, F and G). The questions were grouped together by theme or topic, such as accountability, to ensure that data collection flowed from one topic to another (McIntyre, 2005: 170). Questions were designed to include enough detail to allow participants to understand the question, but were also short enough to maintain interest (Hall and Hall, 1996: 123). In addition, care was taken to avoid using technical terminology, as well as ensuring that the wording of the questions was not leading, thus risking the possibility of influencing the responses provided (Ibid: 164). Utilising semi-structured interviews allowed the list of questions generated to be expanded upon, with the possibility of following up and probing particular points made by the participants (Thomas, 2013: 198; May, 2011: 134). The questions were not always asked in the order contained within the interview schedule, due to the participants responding to questions in ways that moved the interview away from the original order (Thomas, 2013: 198).

A stance was adopted of being an 'open and non-judgemental listener' (Medlicott, 2001: 39). This was part of a standpoint discussed by Medlicott deemed 'disciplined empathy' (Ibid: 39), drawn upon earlier in this chapter in relation to archival research. As Medlicott argued, it was important that judgement was not



passed by myself or that I became overwhelmed by the experiences of participants (Ibid: 39). This ensured that the 'multi-layered' experiences of the participants emerged from the data through not only listening to them but also hearing them (Ibid: 34). Participants were able to answer as freely as they wished and this allowed the subjective, rich and complex views they held to be uncovered (Denscombe, 2010: 166). Where appropriate, clarification and elaboration of the responses was sought through probing, thus broadening the scope of the data (May, 1999: 110). This ensured that the 'richness' of the data was strengthened and gave participants an indication of the level of detail desired in responses (Patton, 1990: 324). At the end of the interview, participants were debriefed and given the opportunity to ask any questions (Kvale, 1996: 128). As Kvale has noted, participants are keen to talk to an attentive listener and to learn more surrounding the background and dissemination of the research (Ibid: 128). This was apparent as all participants engaged in further conversation related to the research topic following the interview.

Notes were also made during interviews, which included any key points made by participants (Patton, 1990: 351). In order to avoid losing rapport whilst these notes were being written, they were kept brief but contained enough detail in order to ensure that they made sense when examining them after the interview (Hall and Hall, 1996: 162). Notes were typed up immediately after each interview and this assisted in ensuring that they were as comprehensive as possible (Newing, 2011: 113). Typing up field notes, and transcribing the interviews,

meant that the data became familiar and that themes were identified (Gray, 2014: 604).

The methods utilised in the research were tailored to meet the circumstances of the participants. Therefore, for four participants who wished to be interviewed, but not in person, telephone interviews were used. Here, consent forms were returned in advance and participants were briefed and debriefed in the same manner as the face-to-face interviews, with the same questions asked. As with the face-to-face interviews, the answers provided by participants could be probed further and notes were made throughout the interview. As Denscombe argued, people are as honest in telephone interviews as they are in face-to-face interviews (Denscombe, 2010: 10). This was apparent throughout the telephone interviews, where participants were open and talked about their experiences at great length. Whilst it was not obvious, it may have been the case that some participants felt more comfortable discussing the sensitive topic of the research by telephone rather than in person (Bryman, 2008: 457).

For four participants, it was not convenient to be interviewed in person or by telephone. Questionnaires were sent to them, which they returned at their convenience, along with their signed consent forms. The same open questions were included from the interviews, allowing participants to answer as freely as they wished, but without the possibility for probing and following up on any of the points made (Denscombe, 2010: 161). For Hall and Hall, questionnaires

provide the opportunity for some participants to answer more truthfully, particularly with respect to sensitive issues, than they would in an interview (1996: 100). Furthermore, the use of questionnaires minimised the possibility of 'interviewer effects', where the responses of participants may have been affected by the presence of the researcher (Bryman, 2008: 218). However, in contrast, Lee argued that sometimes it is the case that some participants are more forthcoming in the presence of an interviewer, particularly in the case of sensitive topics (1993: 98). Through utilising interviews and questionnaires, both possibilities were taken into account.

#### *Examining Family Campaign Websites*

The twenty-first century, fuelled by advances in technology, has allowed for the voices of bereaved families and friends to be heard through online campaigning forums and websites. These sites, established by families following the death of their relative, have provided another way for families to generate alternative truths surrounding deaths in psychiatric detention, whilst campaigning for justice surrounding their relative's case. Seven of these sites were accessed and utilising these sites widened the research sample. Again, a purposive sample was utilised in order to include families most suited to the areas being critically examined. These sites were sourced through online searches, as well as becoming aware of them through the work of organisations such as INQUEST. When seeking out campaign sites it was important to bear in mind that if a family had an acceptable experience within the coroners court and investigation system following the

death of a relative, it was unlikely that they would set up a campaign website. Therefore, the sample used could not be viewed as representative of all families bereaved by a death in psychiatric detention (Robson and McCartan, 2016: 379). However, as will be argued later in this chapter, it was not an aim of the research to provide a representative, generalisable sample.

The campaign websites were examples of 'sites of resistance who collectively seek to reflect, discuss, plan and act on events, cases or issues which expose injustice' (Clarke, Chadwick and Williams, 2017: 9). The emergence of these sites was vital as:

With deflection of blame and denial of liability foremost in the legal and media strategies of those in authority, grieving close relatives were impelled into initiating and defending campaigns for greater transparency while protecting the reputations of loved ones (Scruton, 2007: 13).

Robson and McCartan noted that certain groups with specific interests and concerns, such as bereaved families, can be more easily reached via the internet (2016: 379). Additionally, Gaiser and Schreiner argued that the emergence and growth of the internet has allowed individuals and groups to express themselves to a wide audience, without the need for a mediator such as a book publisher. This has resulted in the empowerment of individuals who share their experiences (2009: 83).

Cohen has argued that there is a misconception that blogging sites are 'too personal, too detailed...too apparently unconcerned with the topics we tend to think are worthy of public talk' (2006: 165). Furthermore, Hookway has raised the issue of how a researcher can be sure that what he/she reads on personal websites and blogs is truthful (2008: 97). In answer to this, he responded 'how can the truth be ensured in any research scenario...how do you know, for instance, if someone is being honest in an interview?' (Ibid: 97). It was also important to recognise that the data gathered from online sites had been thought about before being written and posted online, whereas participants who were interviewed gave impromptu responses.

The content of the sites was repeatedly read and extensive notes were made surrounding the cases. These sites were a further example of knowledges and voices from below which contest dominant knowledge and state-defined truths. Cohen has argued that blogging through these sites gives individuals and groups 'a new and powerful voice' (2006: 163). Similarly, for Hookway, these sites are a 'revolutionary form of bottom-up news production and a new way of constructing [ones] self' (2008: 91). However, as Family Member One noted, families can become 'worn out' and cease their campaigning roles. As a result, the chronicling of these sites, on occasion, ended without any indication of the outcome of their case.

### **Data Analysis: Reliability, Validity and Credibility**

Utilising archival research, face-to-face interviews, telephone interviews and questionnaires, alongside analysing family campaign websites, meant that a triangulation approach was adopted. The use of these different methods strengthened the reliability and validity of the research (Thomas, 2013: 146) and resulted in a 'complementary compensation of the weaknesses and blind spots of each single method' (Flick, 2009: 26-27). This resulted in a fuller and more complete analysis emerging surrounding the issue of life and death in psychiatric detention (Denscombe, 2010: 138).

Following completion of the data collection, transcripts of interviews were made. These were then read repeatedly, along with the questionnaire responses and the extensive notes made from examining the campaign sites. This allowed for a familiarisation with the data to develop, along with the identification of any themes that were apparent (King and Wincup, 2008; Denscombe: 2010). Inductive and deductive codes were applied to the data, related to events, themes, actions, opinions and key terms (Denscombe, 2010: 294). The data was then processed through NVivo. Combining these different forms of analysis ensured that all of the key themes were identified (Rubin and Rubin, 2012: 192). As data analysis progressed, codes and themes that appeared to be very similar were condensed, amended, or it was decided that some themes were actually sub-categories within main categories (Gray, 2014: 604). Shared experiences and

patterns emerged which connected the individual stories into collective narratives (Merill and West, 2009: 133).

In order to strengthen the validity and reliability of the research, a reflexive approach was adopted throughout the research process. Here, there was a continual awareness of the limitations of the research concerning factors such as the sampling methods used (Mason, 1997: 6). Also considered was how external influences or personal circumstances may have affected any data gathered (Creswell, 2009: 233). Hall and Hall (1996: 43) stated that validity could be assessed through an examination of how the research was carried out, along with a consideration of whether any factors could have influenced the way in which the research was undertaken. For Noble and Smith (2015: 34-35) a number of key strategies adopted by qualitative researchers could assist in improving the credibility of qualitative research, several of which were adopted within this research. The first was actively acknowledging any personal bias that may have influenced findings. The second was an awareness of how sampling and other methods utilised may affect the findings of the research. Third, meticulous records were kept, including detailed quotes. Finally, data triangulation methods were utilised. The use of triangulation enhanced the validity of the data due to the consistency and similarities of findings arising from the different methods (Denscombe, 2010: 138).

As the research sample was purposive, it could not be assumed that the findings of the research could be generalised to others outside of the sample (Crow and Semmens, 2008: 49; Thomas, 2013: 122; Hall and Hall, 1996: 131). However, the thesis did not aim to produce results that could be generalised to populations outside of the research sample, in line with the critical, interpretative approach adopted. As Thomas argued, in interpretative research such as this, one could not expect another researcher to have the same findings. Therefore, generalisability should not be of great concern in interpretive research (2013: 139). This was also a point reiterated by Maykut and Morehouse who stated that research such as this should not aim to generalise its results. Instead, the research should focus on achieving a deeper understanding of experiences from the unique perspectives of the participants (1994: 44).

In line with the critical approach adopted, this thesis was an example of 'discovery' research (Denscombe, 2010: 29). The thesis aimed to uncover 'stories from below' (Porter, 1987: 231) and previously hidden issues, whilst generating new and alternative truths surrounding the issue of life and death in psychiatric detention. This was most of concern, as opposed to producing results that could be generalised to all those in a similar position as that of the participants in this research. Therefore, the research gathered exploratory data on a highly underdeveloped area (Hall and Hall, 1996: 116). This provided a unique approach to a problematic, yet largely ignored issue. There was a focus on exploring old problems in a new way, discovering new themes and explanations (Rubin and



Rubin, 2012: 16). This worked to challenge dominant forms of knowledge around life and death in psychiatric detention both historically and contemporaneously.

### **Ethical Issues**

Ethical approval was granted by the Research Ethics Committee at Liverpool John Moores University and their researcher guidelines were followed throughout. Extensive consideration was given to potential ethical issues due to the sensitive nature of the research (Kalmbach and Lyons, 2003: 671). It was also kept in mind that participants were not simply to be viewed as 'data' for the research (Woliver, 2002: 677). A 'framework of trust' was promoted that allowed participants to discuss, in some cases, potentially painful issues (Lee, 1993: 98). As Rubin and Rubin noted, participants should be no worse off following data collection, but ideally better off, primarily through making their experiences and problems more visible (2012: 89).

Participant information sheets included significant details surrounding what the research entailed, why they had been chosen as participants and what was asked of them. No pressure was put on individuals to participate. However, the potential benefits of participating were made clear, such as the opportunity to contribute to a research topic that had been significantly neglected (Morton-Williams, 1993: 15). It was also explained to participants that they could withdraw their participation at any point during the research, at which point their data

would be destroyed (Ruane, 2005: 19). How the data was to be stored was also included in the participant information sheet, along with the measures in place to protect confidentiality and anonymity. Finally, the participant information sheet detailed how confidentiality would be broken if there was an instance where there was a legal or moral duty to report a participant risking harm to themselves or others (Thomas, 2013: 48).

Prospective participants were asked to read the participant information sheet before reading and signing the informed consent form. This form summarised the main points included in the participant information sheet. It was also ensured that participants understood all aspects of the content of the informed consent form. Participants were advised that should they become distressed during the interview, then the interview would cease immediately, or they should cease completing the questionnaire immediately before contacting myself. This scenario did not occur.

In terms of family campaign websites, it has been noted that informed consent is not required when analysing data contained on publicly accessible websites (Vannini, 2008: 278; Monette et al, 2011: 70). Similarly, Hookway argued that these sites are located within the public domain and, should they not need to be accessed via a login/profile page, meaning that a simple online search could access these sites without restriction, then the need for consent was not necessary (2008: 105). Furthermore, as Hookway (2008: 105) stated, these sites

are 'personal but not private' as families are actively informing others about their case online, asking for support and assistance.

To ensure confidentiality and anonymity, and that data was collected and stored in line with the Data Protection Act (Hughes, 1998: 103), all consent forms sent electronically were encrypted and stored on my password-protected Liverpool John Moores University account. All hard copies of consent forms, and gathered data, were stored in a secure filing cabinet. Furthermore, the contact details of participants, and any data gathered from them, were also stored separately. Identifying information was removed from the data and replaced with pseudonyms such as 'Family Member One' and 'Coroner One'. Anonymised questionnaires and transcripts were stored for future research and this was outlined in the participant information sheet (Johnson and Bullock, 2009: 216). Personal data will be destroyed five years after the viva, in line with Liverpool John Moores University's guidelines.

A vital ethical consideration was debriefing participants following the collection of the data (Israel and Hay, 2006: 97). Debriefing consisted of thanking individuals, asking if they had any questions and once again providing my contact details, should they have had any questions at a later date. With questionnaires, debriefing took the form of an email sent to participants thanking them for their participation and asking if they had any queries. With the analysis of family

campaign sites, debriefing was not necessary, as data had been obtained from publicly available sources.

Finally, there was an awareness surrounding the potentially distressing data that may have been shared with myself. Had this become an issue, advice would have been sought from my supervisors. Also linked with researcher welfare, a mobile phone was taken to every interview and a family member was always made aware of the time and location of the interviews (Jamieson, 2000: 70).

## **Conclusion**

This chapter has detailed the ways in which this research was undertaken by discussing the methodological underpinnings of this thesis, in addition to outlining the methods utilised. First, the importance of critical research and the role of the critical researcher was discussed. The critical research approaches outlined worked to ensure that the research uncovered the structures and regimes that dominate the topic of deaths in psychiatric detention, whilst challenging conventional knowledge in this area. A discussion of the methodological underpinnings of the research indicated how the research was approached, ontologically and epistemologically. There was also a focus on how the research aimed to uncover rich, detailed and subjective data, whilst creating new and alternative knowledges, in line with the theoretical approaches outlined in the previous chapter.

It was discussed how and why archival research was undertaken, along with the methods employed in order to uncover this material, before moving on to discuss how these approaches linked with the theoretical and methodological underpinnings of the research. The chapter then discussed the role of a genealogical approach and the formulation of a history of the present, in line with the theoretical framework discussed in Chapter One.

A justification of the sampling techniques was then discussed, including how several different participant groups were chosen, in order to allow a broad range of experiences and alternative views to be uncovered. The chapter then moved on to discuss the chosen methods of contemporary data collection and how this data was analysed. Here, the benefits of utilising a number of different methods was outlined, focusing upon how these methods were appropriate in researching the issue of deaths in psychiatric detention. Furthermore, how the methods linked with the theoretical underpinnings of the research was also discussed, along with how these various methods allowed alternative forms of knowledge to emerge from the research. Utilising historical archival data, alongside contemporary interviews, questionnaires and the analysis of family campaign websites, worked to ensure that a comprehensive history of the present was undertaken, which would not have been possible if historical or contemporary data had been gathered on their own. Measures implemented in order to strengthen the reliability, validity and credibility of the research were then outlined. Finally, the chapter then considered potential ethical issues, and the measures adopted, to prevent any issues arising.

The thesis will now move on to Chapter Three. This chapter presents the first of two critical, revisionist histories which will analyse the data uncovered from primary archival research. The chapter covers the period from 1845 and the introduction of the County Asylums Act and the Lunacy Act, through to 1959 and the introduction of the Mental Health Act.

### **Chapter Three: ‘An Outrage so Gross and Barefaced’<sup>23</sup>: A Revisionist History of Life and Death in Psychiatric Detention in England and Wales, 1845-1959**

Having explored the theoretical and methodological frameworks which underpin this thesis, along with the methods utilised to gather data, this chapter will provide a critical, revisionist history of the lives and deaths of patients within the asylum and mental hospital system. This begins in 1845 with the introduction of both the County Asylums Act and the Lunacy Act, and will end in 1959 with the introduction of the Mental Health Act.

As discussed in Chapter One, the thesis focuses on uncovering knowledge that has been subjugated and silenced. In order to construct a ‘history from below’ (Tosh, 2010: 71), discussed in Chapter Two, extensive primary archival research was undertaken. The findings of this archival research will be presented in this chapter, alongside other relevant material. As noted in the introduction to the thesis, this chapter is influenced by Foucault’s concept of a ‘history of the present’ (Foucault, 1977: 31). This means that the contemporary problem of inadequate psychiatric provisions, in addition to deaths in psychiatric detention, will be critically examined by using history ‘to rethink the present’ (Garland, 2014: 373).

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<sup>23</sup> The National Archives (1863a, MH 51/53).

The chapter is constructed chronologically and critically examines the growth of psychiatric detention, in addition to the regimes within these institutions and the treatment that patients were subjected to. The dominance of the medical profession within the asylum will also be analysed, as will the issue of the deaths of patients. How these deaths were explained and responded to by official bodies is also critically examined. Issues surrounding the subsequent inquest and investigation procedures are analysed, with a particular focus on the question of accountability.

The theoretical frameworks discussed in Chapter One will be drawn upon within this chapter in order to critically examine and analyse the issues surrounding the lives and deaths of patients in psychiatric detention. A number of theoretical issues will be of particular interest within the chapter. These include the pathologisation and criminalisation of those with mental health problems, including their incarceration and institutionalisation. Also of interest is the individualisation of problems and the association of patients with risk, dangerousness and deviance. An area of concern is the role of the total institution and how patients (and their families) were segregated, managed and controlled, as well as how the supposedly superior status of the medical profession worked to legitimate interventions and 'treatment'. A further theoretical influence that was outlined in Chapter One, and will be drawn upon within this chapter, is the issue of subjugation and marginalisation of patients and their families. In line with the critical approach outlined in Chapter Two, throughout the chapter there will



be a focus upon the 'insurrection of subjugation knowledges' (Foucault, 2003a: 7) and the importance of making visible the voices and experiences of those who have been marginalised, silenced, subjugated, or lost in history.

### **Psychiatric Detention: The Emergence of Challenge and Complaint**

In 1845, two significant Acts were passed, the County Asylums Act and the Lunacy Act. The provisions in the Acts made it compulsory for every county in England and Wales to provide asylum provisions for all patients (Bewley, 2008: 7). This was nearly forty years after the 1808 County Asylums Act recommended that asylums should be built in every county (Ibid: 7). However, this was not compulsory and, as a result, only twenty asylums were built in the United Kingdom (Moon et al, 2015: 61). The Lunacy Act established the Lunacy Commission. The Commission was responsible for overseeing the effectiveness of asylums and for making 'detailed' inspections of all public, private and charitable institutions (Scull, 1993: 165).

As the construction of county asylums was now compulsory, the 'rapid expansion' that took place was justified by reformers who stated that the asylum 'could do more than merely provide a safe refuge for lunatics; they could also cure them' (Walton, 1981: 167). However, Packard, a former patient, argued that asylums represented nothing more than 'corruption' and 'evil' (1868: iii). Furthermore, by calling the asylum an asylum, it actually masked the reality of their existence as

prisons (Ibid: iv). For Packard, the asylum was a place that created 'insane' behaviour (Ibid: 123).

Prior to the introduction of the two Acts in 1845, asylums existed in an 'almost unbelievable state of filth and neglect' (Shaw et al, 2007: 14). This point was reiterated by Porter who argued that asylums varied in quality, where many were 'abominations, riddled with corruption and cruelty' (2003: 99). Also prior to the introduction of the Acts, an article in *The Lancet* argued that patients were:

Imprisoned by society; they [were] confined under the authority of Acts of Parliament. Their keepers and superintendents have over them almost unlimited power; they may place them in solitary confinement, bind them hand and foot and deprive them of food and air to almost any extent. This discretionary power may be indispensable; but it will not be denied that it should be exercised under the strongest safeguards and the strictest supervision. Now do these safeguards exist? We unhesitatingly reply that they do not (1840: 897).

During the mid-nineteenth century, common causes of deaths in asylums were 'exhaustion following insanity', 'debility', 'diarrhoea', 'exhaustion', 'general debility', 'serious effusion in the brain', 'worn out constitution', 'general decay of nature', 'exhaustion following mania', 'softening of the brain' and 'exhaustion following idiocy' (The National Archives, 1845, MH 51/745)<sup>24</sup>. However, during

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<sup>24</sup> When archival files are referenced throughout this thesis, no page numbers are used due to no page numbers being used within the files themselves.

early asylum provisions, no centralised records were kept surrounding the number of deaths<sup>25</sup>.

### *The Alleged Lunatics' Friend Society*

In 1845, the same year the County Asylums Act and Lunacy Act were introduced, the Alleged Lunatics' Friend Society was formed to provide support and guidance to asylum patients. The Society was recognised as 'the first organised manifestation of public apprehension about the operation of the lunacy laws' (Hervey, 1986: 274). One of the founding members of the Society was John Thomas Perceval, the son of the assassinated British Prime Minister, Spencer Perceval. Perceval was committed to asylums in Bristol and Sussex in the 1830s. He argued:

I was never asked, do you want anything? Do you wish for, prefer anything?  
Have you any objections to this or to that? (1838:106).

Perceval was controlled by medical men whose 'habitual cruelty, and worse than ignorance-*charlatanism*-became the severest part of my most severe scourge'

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<sup>25</sup> Despite there being no centrally held mortality records, individual asylum mortality figures did emerge during the early nineteenth century. An example of this was at York Asylum when it was found that between 1807 and 1813, sixty-one deaths had been concealed from official records (Digby, 1986: 18). This was further compounded in 1813 when there was a total discrepancy of 131 deaths between deaths reported by the asylum and the actual figure (Ibid: 18). At Cheshire Asylum, between 1829 and 1835, there were 288 admissions in total. During the same period, there were 71 deaths. At Lancashire Asylum, there were 2,222 admissions between 1817 and 1835, with 856 deaths. At Middlesex Asylum 1,183 individuals were admitted between 1831 and 1835. There were 326 deaths during this time (Hawes, 1836: 4). Furthermore, mortality rates were discussed by Browne who noted that the mortality rate at both the Wakefield and Lancaster Asylums was one in four during the 1830s (Browne, 1991: 75). It was also noted in 1840 that there had been 2,739 admissions at the West Riding of York Pauper Lunatic asylum since the asylum opened in 1819, with 868 deaths. At Hanwell Asylum, between 1831 and 1840, there were 56 deaths for every 100 patients (Farr, 1841: 19).

(Perceval, 1840: 3 emphasis in original). He suffered 'great cruelties, accompanied with much wrong and insult' (Ibid: 3). It was noted that 'Perceval's hospitalizations were gruelling trials for him. At various crucial stages of his recovery he proclaimed his sanity but each assertion was met with distrust, ridicule and doubt' (Podvoll, 1854: 112). On his release, and having founded the Alleged Lunatics' Friend Society, Perceval then dedicated the next thirty years of his life to reforming asylums (Ibid: 111). He attempted to prove 'with how much needless tyranny they [patients] are treated' (Perceval, 1840: 3). Perceval said, 'who shall speak for these [patients] if I do not-who shall plead for them if I remain silent? How can I betray them and myself too by subscribing to the subtle villainy, cruelty and tyranny of the doctors?' (Ibid: 115).

Richard Paternoster, a member of the Alleged Lunatics' Friend Society, wrote of his own treatment as a patient and compiled accounts of others (Paternoster, 1841). For Paternoster, the 'whole system [was] one of coercion and cruelty' (Ibid: 16). He drew upon a case where a patient had been wrongly detained for thirty years and would have continued to have been incarcerated had it not been for the interventions of the public. Furthermore, he detailed the case of an epileptic patient who was confined in Hereford Asylum in 1838. He apparently showed no evidence of insanity. The patient's wife was denied access to see him and fought for six weeks for him to be released. On arriving home, it was discovered that he was 'covered in sores, wounds, bruises and filth, and in a state of exhaustion and disorder, bodily and mental' (Ibid: 44). He subsequently died, however no action

was taken. Paternoster also recalled the 'murder' of a fellow patient, allegedly as a result of violence of a keeper (Ibid: 55). He drew upon another case of a patient who attempted to hang himself and had to be saved by another patient:

Had he died, none outside would have heard of it; there would have been no inquest...a report would have been sent into the Commissioner's office that such a patient had died a natural death, or as the favourite expression amongst these madhouse people is, 'died from exhaustion' (Ibid: 23).

Paternoster, in a seemingly uphill battle to raise concern regarding these issues, and encourage official acknowledgement and accountability, asked:

Will *no one* support me in the arduous and important task I have undertaken of exposing the horrible enormities and atrocities...I handed up to the coroner, soon after my liberation, the case of a man who was murdered...no notice was taken (Ibid: 17 emphasis in original).

Paternoster argued that complaints were readily dismissed as delusion (Ibid: 19) and patients were punished for complaining (Ibid: 6). There was also a:

Total absence of any power to which the unfortunate victim [patient] can appeal...inviolable secrecy in which every transaction is wrapped from beginning to end, whereby the most revolting cruelties, and the most atrocious outrages upon all law and justice are committed with perfect impunity (Ibid: 5).

He also questioned what treatment female patients experience 'if these horrors can occur with regard to the male patients' (Ibid: 6). He concluded, 'if it were desired to form some system by which persons of sound mind [and] intellect might be driven mad, and those who are insane kept so, I could conceive no means more adapted to the purpose than the present [asylum system]' (Ibid: 5).

The Alleged Lunatics' Friend Society campaigned for changes in lunacy laws, assisted discharged patients, attracted public attention and examined matters that Commissioners<sup>26</sup> would overlook (Hervey, 1986: 253). The majority of the Society's work was concerned with assisting 'defenceless groups, who were unable to obtain help for themselves' (Ibid: 262). Between 1845 and 1863, they 'bombarded' parliament and the government with literature and petitions (Ibid: 257). The Society 'attracted gratuitous abuse' from the press and medical journals (Ibid: 245). Its members were 'constantly treated with disdain by those authorities responsible for the care and treatment of lunatics' (Ibid: 245). The Society took up the cases of more than seventy patients between 1845 and 1863 (Ibid: 262).

Whilst they may have often failed to obtain compensation for the patients they assisted, they did cause the authorities 'acute embarrassment' (Ibid: 261). A case undertaken by the society was that of Dr Edward Peithman. He was detained at

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<sup>26</sup> The term 'Commissioners' relates to the Metropolitan Commissioners in Lunacy, established under the Madhouses Act of 1828. The Commissioners could revoke, or refuse to renew, asylum licenses and during visits to asylums patients could be discharged by the Commissioners if it was believed that they were improperly detained (Hervey, 1985: 101).

Bethlem<sup>27</sup> in 1840 and was not properly examined by staff until 1854 (Podvoll, 1854: 109). Perceval was convinced of Peithman's sanity and he was subsequently released. However, when he appealed for compensation as a result of being illegally detained, Peithman was arrested and certified as insane. Perceval once again intervened and Peithman was released, on the condition that he immediately left the country (Ibid: 110).

It was argued in 1854 that 'all the issues Perceval made his discoveries about [in the 1830s] are the same ones we face today' and this served as a further 'uncomfortable reminder of how much we have forgotten, or have never learned' (Podvoll, 1854: 112). However, the Society ceased in the mid-1860s following the deaths of a number of its key members. Given the lack of public interest in lunacy, it was 'doubtful whether the Society could ever have attracted widespread support' (Hervey, 1986: 275). Despite this, it was noted that numerous suggestions made by the Society were 'plagiarized' and officially adopted, with

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<sup>27</sup> Bethlem, following opening in 1330, became a key tourist attraction and patients were displayed to visitors on a pay-to-view basis (Andrews et al, 1997: 2). Foucault noted that this 'exhibition' amassed around 96,000 visits a year (2003b: 64). In 1403, a Royal Commission investigated allegations of scandals and malpractice at Bethlem. There were later accusations of physical and sexual abuse, corruption and murder at the institution (Chambers, 2009: 8). Andrews et al (1997: 340) argued that prior to 1683 it was difficult to gauge the mortality rate within Bethlem. Burial registers recorded the deaths of 43 patients between 1680 and 1690, and 89 deaths between 1690 and 1694. Furthermore, between 1694 and 1718, there were 1,841 admissions and 355 deaths (Ibid: 340). However, it would later be argued that suicides sometimes went unrecorded on registers at Bethlem (Ibid: 341), as between 1846 and 1855, there were only four suicides or strangulations recorded (Hood, 1856: 112). This was despite the fact that during the same nine-year time period, 964 patients were deemed to have contemplated or attempted suicide (Ibid: 112).

the state 'afraid to acknowledge the origin of these contributions [as originating from the Society]' (Ibid: 257).

### *Issues and Failings*

Accounts continued to emerge regarding inadequacies within asylums. An example of this was in 1846 when complaints were raised surrounding issues at Haydock Lodge, including 'general mismanagement, cruelty, neglect and an excessively high mortality rate' (Mellett, 1982: 114). A member of staff was forced to resign and was replaced by another individual who was 'less idle and corrupt' (Ibid: 114). A further example of asylum inadequacies was apparent in 1846 when an article in *The Lancet* described asylums as 'markets trafficking in humanity in its worst condition, in most of which those prudent, judicious, and rational means which ought to be adopted for the recovery of the patients [were] entirely and designedly neglected' (1846: 516). Furthermore, it was thought that 'too much confidence was placed in the integrity of those who [had] the management of these places' (Ibid: 516). Despite this, asylum doctors were seen to have 'established a monopolistic claim' over patients' lives (Cohen, 2007: 101).

In 1846, the *Further Report of the Commissioners in Lunacy* argued that:

For many years the insane poor in this country must have altogether escaped the observation both of the government and the public. Their numbers were not known, with any degree of correctness, even in their own counties or parishes; their condition apparently creating no inquiry or interest, except amongst a few benevolent individuals (Commissioners in Lunacy, 1847: 66).



The *Further Report of the Commissioners in Lunacy* noted that medical superintendents in asylums were 'a most zealous, able, and intelligent body of men, whose services in the cause of the unfortunate persons afflicted by mental maladies, it is difficult to over-estimate' (Commissioners in Lunacy, 1847: 62). However, it was also argued that 'medical men were deeply implicated in the beatings and maltreatment of patients, even in their deaths' (Scull, 1991: xviii).

A case that did emerge from the secretive system, which demonstrated the importance of holding a post mortem in every case when there was doubt regarding the cause of death, was that of John Cottingham. Cottingham was a patient at the Lincoln Lunatic Hospital when he died in 1847 (The National Archives, 1847, MH 51/41). There was a difference of opinion between medical officers regarding the cause of death. Furthermore, there was reason to expect that Cottingham was injured in a struggle between himself and his attendant. In an investigation into the death, it was found that the attendant had been drunk at work on more than one occasion and this had been overlooked by the hospital. A former attendant provided a statement related to the case and 'went to some extent' to implicate the accused attendant (ibid). However, it was decided that the evidence was not strong enough for any charges to be brought.

Similarities regarding the silencing of allegations were apparent in the alleged abuses and neglect of patients at the West Malling Asylum in 1850 (The National Archives, 1850, MH 51/44A). An informant, a previous superintending keeper,

stated that he ceased work at the asylum partly due to witnessing the neglect and ill-treatment of patients, including the 'most abominable' use of restraint. He also heard 'blows and screeching' from patients (Ibid). Again, the case was closed despite further evidence later emerging of the alleged mistreatment of patients at the asylum.

Unease about the efficiency of asylums continued to grow and in 1851 a report was published concerning the 'unsatisfactory state' of Hull Asylum (The National Archives, 1851, HO 45/3510). The Asylum had been visited four times by the Commissioners in Lunacy and on every occasion it had been deemed defective. In 1865, a committee appointed to inspect the asylum was denied access (The National Archives, 1865, HO 45/7709). Despite being persistently informed of the issues at their asylum, the management failed to implement effective improvements. There was little meaningful questioning of asylum managers, and a 'degree of complacency' had occurred (Smith, 1999: 276).

In 1851, a letter from an asylum attendant sent to the authorities stated that a patient, named only as 'Burrows', had gone to bed at an unnamed asylum in good health and the following morning was found dead. It was noted that no inquest had been held and the matter had been 'hushed up' (The National Archives, 1850, MH 51/44A). The letter ended with the claim that investigating the matter 'will disclose more than you are aware of' (Ibid). Despite this, no follow up regarding this letter was chronicled. In 1853, a letter from a former patient at Bethlem

provided an equally damning account of asylums<sup>28</sup>. The author, Alfred Owen, stated that the 'most hideous tragedy [had] been enacted within the walls of Bethlehem [Bethlem] Hospital' (The National Archives, 1853a, HO 45/4995). Owen claimed that he had been detained for a further three months at Bethlem after he complained about the 'barbarous scenes' and 'horrid manner' in which he was treated at the hospital. He believed that the 'unfortunate' patients in the institution were still being treated in the same 'cruel and diabolical manner' (Ibid). Owen also claimed to have seen patients, who had done nothing to deserve such cruel treatment, being:

Struck by most powerful men, with all the force they could command, in the most vital parts of their bodies and then I saw the poor unfortunate patients fall down on the floor and then scream...most horridly and fearfully, and when I looked at them...The agony they seemed to suffer was truly dreadful to behold and which I shall never forget! (Ibid)

Again, no action was taken regarding these claims. This further emphasised the 'unfortunate legacy' of the asylum, that of 'silencing' the patient (Pietikainen, 2015: 145). Whilst the voices of the medical profession became increasingly prominent, the voices of the patient 'signified nothing' (Ibid: 145). Wise (2014:

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<sup>28</sup> Alfred Owen's account of Bethlem was not a unique one. William (James) Norris was confined within Bethlem under 'horrifying' conditions (Parry-Jones, 2007: 257). An iron collar was placed around his neck, his feet were manacled and a harness was fitted over his shoulders. He was only able to take one step away from the wall (Jones, 1993: 41). It was also reported that his arm was broken by an intoxicated keeper (Paternoster, 1841: 42). He was released after twelve years and subsequently died three weeks later. Further failures at Bethlem were also reflected in the autobiography of Urbane Metcalf who was a patient at the hospital between 1804 and 1806 and later between 1817 and 1818. Staff described him as a difficult patient who was 'full of complaints' (Metcalf, 1818: 76). His hospital records stated that he was confined to his room and no explanation was forthcoming as to why this was the case. However, Metcalf's writings offered an insight in to why this occurred. He had complained about the abuses apparent at the hospital to staff and to visitors of a committee from the Houses of Commons. This was his attempt to 'acquaint them with the cruelties and abuses' he suffered (Ibid: 76). However, he was ignored and, seemingly as punishment, was then confined to his room until he was discharged.

226) noted that letters of concern or petitions in relation to the care of the patients would be stamped by the authorities with statements such as ‘no answer, he is half crazy himself’. Further statements of dismissal included ‘point out to him that the mere fact of such an application having been made casts a serious doubt upon the soundness of the gentleman’s mind’, and even simply: ‘nil—mad’. The stigma associated with mental health problems resulted in potentially valid arguments being dismissed. This was due to the complainant possessing this ‘deeply discrediting’ attribute, which worked to taint and discount their complaints<sup>29</sup> (Goffman, 1961: 3).

Despite the silencing and marginalisation they faced, patients and former patients continued to fight for their voices to be heard. As Pietikainen stated, ‘the mad had a voice, an agonised and confused voice perhaps, but nevertheless a voice’ (Ibid: 145). For Clarke, Chadwick and Williams the ‘resistance of dominant narratives or classifications, which are used to construct stories about those

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<sup>29</sup> In an indication of the historical prevalence of dismissing patient complaints, in 1822 a former asylum patient, Throphimus Fulljames wrote to Robert Peel, then Home Secretary, detailing his concerns surrounding the ‘unauthorised human misery’ and ‘unparalleled cruelties’ apparent at asylums in London and Bristol (Wise, 2014: 226). Fulljames detailed thirty-one cases, including his own experience at Brislington House Asylum, where he alleged that patients were mistreated. He noted that many of the individuals he encountered were sane. He also provided details of doctors subjecting patients to cold-shower shock treatments, detention in dark stone cells and shutting patients in coffins. He was contacted by numerous former members of staff who all corroborated the original stories and provided examples of new cases (Ibid: 226-227). However, his account was discredited due to him being prone to bouts of ‘delusionality’ and, as a result, ‘every part’ of his testimony was ‘invalid’ (Ibid: 226). His letter detailing his complaints, also signed by three former keepers at the asylum, was sent to Dr Fox of Brislington House. Fox’s subsequent self-exoneration related to the complaints was then accepted in full by the authorities. Fulljames received correspondence which stated that ‘Mr Peel has inquired into some of the cases of grievance stated and finding them not to be well founded, he does not deem it necessary to pursue the inquiry further’ (Ibid: 226).

communities, issues or events experiencing injustice, can be understood as a process of challenging silencing techniques' (2017: 16). Therefore, those who spoke out worked to challenge not only their own subjugation and marginalisation but also worked to challenge the silencing and concealment that dominated the system.

### **'Hushing up What Looks Like a Very Black Affair'<sup>30</sup>: Contentious Deaths and Their Investigation**

In 1853, William Windsheffel died at the Colney Hatch Asylum (The National Archives, 1853b, HO 45/4552), an asylum that would later be described as being 'a byword for neglect and misery' (Taylor, 2014: 104). Windsheffel's sister said she was 'shocked beyond measure' to receive an 'abrupt' official document regarding his 'accidental' sudden death (The National Archives, 1853b, HO 45/4552). She was informed that an inquest had already been held and the verdict had been death caused by fractured ribs and other internal injuries. The family visited the asylum and they all agreed that Windsheffel had been 'murderously assaulted' and were informed that an incident had occurred involving another patient 'when the keeper's eyes were not on them' (Ibid). The family felt 'disgusted' that the inquest was held without their involvement and that they were unable to pose questions to the asylum staff. A 'strict' inquiry was 'immediately instituted' into the circumstances of the case. However, after

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<sup>30</sup> The National Archives (1863a, MH 51/53).

‘anxious consideration’ of the matter, it was concluded that however much the incident was to be deplored, blame could not be attributed to an attendant (Ibid).

Further issues concerning the uncertainty and lack of clarity surrounding post-death procedures was reflected in April 1854 when the coroner for North Somerset wrote to the Secretary of State seeking clarification regarding his role (The National Archives, 1854, HO 45/5349). The coroner was concerned that information regarding deaths was provided by the management of the asylums who gave ‘their version’ of events and, generally speaking, were most reluctant for an inquest to be held (Ibid). He questioned whether he should hold inquests in all cases, as was the case in prisons. Replying, the Secretary of State explained that it was not necessary to hold inquests into the deaths of all patients in asylums and they should only be held ‘in cases where there were questions regarding the cause of death’ (Ibid). However, this in itself was problematic due to the possibility of concealing evidence when identifying whether there were ‘questions’ surrounding a cause of death in the first place.

The concerns raised in 1854 were not new ones. Prior to this, the ‘tangled and contradictory’ politics of coroners inquests in the nineteenth century (Sim and Ward, 1994: 262) was indicated in 1830, when an article in *The Lancet* asked:

Who is the non-medical coroner that can discover whether the sudden death of a miserable patient is caused by an accidental fall or a blow from a keeper? Do you ever hear of an inquest in any of those institutions? (The Lancet, 1830: 47).

It was also noted in 1840 that inquests had previously been held on every person who had died at Wakefield asylum. However, this practice had ceased due to it being 'unnecessary', 'useless' and 'expensive' (House of Commons Select Committee, 1840a: 91). In the case of Middlesex Asylum, it was revealed in 1840 that no inquest had been held at the asylum in a nine month period, despite there being more than eight hundred patients housed at the institution at the time (House of Commons Select Committee, 1840: 141). It was also argued by the authorities at Middlesex that inquests in asylums in all cases of death were a 'mere unnecessary expense' (Ibid: 140).

An article in *The Lancet* noted how the death of every imprisoned criminal was investigated by the coroner. However, the 'same regard' had not been shown for the imprisoned asylum patient (The Lancet, 1840: 897). Instead, this had left the inquest into their deaths:

Contingent upon certain accidental circumstances...It will not be denied that the checks which the wisdom of parliament has devised for the care of criminals are necessary; is there any just reason, then, why the innocent lunatic should not enjoy the same merciful protection? (Ibid: 897).

It was also suggested that 'it would be better for the cause of humanity, and the ends of public justice, if inquests were taken on all persons who die in lunatic asylums, whether they be public or private institutions' (House of Commons Select Committee, 1840b: 106). It was recognised that the coroners court provided the opportunity to 'challenge the practices of disciplinary institutions

and the medical profession' (Sim and Ward, 1994: 263). However, despite the possibility of the coroners court exposing abuses of power, it was instead the case that the court frequently failed to 'represent the interests of the powerless against those of state institutions' (Ibid: 263). This emphasised the 'unwillingness' and 'inability' of the coronial system to critically examine the often complex circumstances surrounding the deaths of those confined in asylums (Ibid: 248). This ensured that asylum management remained largely unchallenged and already marginalised voices were repeatedly silenced.

A further contentious death occurred in 1863 when George Stapleford, a 'certified lunatic', was found dead in the Regent's Canal after jumping from a bridge<sup>31</sup> (The National Archives, 1863b, MH 51/55). Prior to his death, there had been some confusion regarding whether he should be housed in an asylum or a workhouse. As a result, his case was considered by a number of different officials, including a local chemist who stated that Stapleford was 'very likely' to commit suicide. Furthermore, the case was brought before one of the relieving officers of the local parish<sup>32</sup> who was 'very angry' at it being referred to him. Stapleford was also visited by one of the medical attendants of the parish who, after 'about a

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<sup>31</sup> Whilst Stapleford was not housed in an asylum at the time of his death, this case has been included within the thesis in order to highlight the issues and failings related to timely and adequate provisions being made for individuals who require care and treatment but did not receive it.

<sup>32</sup> The role of a relieving officer was to provide support to the local community, whilst also being responsible for arranging admissions into workhouses.



quarter of an hour' was satisfied that he was insane (Ibid). He took his own life before he was admitted to an asylum.

'After the least possible enquiry' a verdict was returned stating that Stapleford's death was caused by drowning, but no evidence was put before the jurors regarding how he came to end up in the water. The medical attendant who had visited Stapleford attended the inquest and put himself forward as a witness but was not called by the court. Despite some members of the jury asking for evidence to be heard regarding Stapleford's state of mind, the coroner argued that it was not relevant to examine the circumstances prior to the death (Ibid). Due to the contentious nature of this case, it was considered by the Commissioners in Lunacy. It was found that if it had not been for the deviation from duty of the relieving officers, the deceased 'would probably still be alive' (Ibid). They noted that if the evidence sufficiently warranted it, there was a case to be brought before a magistrate with a view to 'having the law authoritatively promulgated and the relieving officers taught their duty' (Ibid). However, this did not occur.

In 1863, Thomas Henry died at Lancaster Asylum, following a struggle with an attendant (The National Archives, 1863a, MH 51/53). Reporters at the *Lancaster Gazette* attended the inquest but the coroner indicated that 'the reporters must be excluded' (Ibid). Subsequently, the attendant in question was charged with manslaughter. It was stated that this decision was made not because there were

sufficient grounds for conviction, but because the inquest was not held publicly and action was needed to be taken in order to indicate that the authorities were taking the case seriously (Ibid).

The *Lancaster Gazette* published several stories regarding the case. The newspaper indicated its disdain at being turned away whilst attempting to observe proceedings. An anonymous letter was also sent to the newspaper which argued that the case ought to be enquired into, as 'an outrage so gross and barefaced as that which you describe must not be tolerated' and 'this arbitrary and insolent attempt at hushing up what looks like a very black affair will not do in this country' (Ibid). As a result of the case, nothing had been done to improve public confidence in the system and there were 'reasons to fear that the inquest may have been a farce' (Ibid). The letter continued:

Here is a poor man, Thomas Henry, bereft of reason, the inmate of a large public lunatic asylum, come to a violent death, as far as one can judge, killed by one of the keepers employed in the institution. However far it may have been from the intention of the attendant to do any harm to the patient entrusted to his care, I think there can be little doubt that the patient died in consequence of injuries inflicted upon him by the hand of the attendant. If this be so, there ought to have been an investigation, the most searching and complete as well as the most public and above-board. A post mortem examination ought to have taken place, conducted by skilful surgeons unconnected with the institution (Ibid).

The views reflected in this anonymous letter were also shared by James Robertson who wrote to the Earl of Shaftesbury, the Chairman of the Commissioners in Lunacy. Robertson argued that there were suspicions that the

truth regarding the case was being concealed from public view in order to ‘gloss over’ the matter (Ibid). Robertson suggested that a very different investigation would have taken place if the death had not been of a pauper lunatic and that those charged with his death would have faced a trial by jury. He also posed a list of questions for the Commissioners, including:

1. Were they aware that the press had been excluded from the inquest?
2. Were they aware that when the attendant was charged with the ‘killing and slaying’ of Thomas Henry, nobody was employed on the prosecution side of proceedings?
3. Did the Commissioners think it proper that the post mortem examination was conducted by the medical officer of the asylum? (Ibid).

The actions of the *Lancaster Gazette*, and the anonymous author, demonstrated their refusal to accept the secrecy and concealment surrounding the case. As a result of their actions, they drew attention to the inadequacies in the inquest and investigation processes following asylum deaths. The case also highlighted the prevalence of issues identified in Chapter One concerning the exercise of power, secrecy and lack of accountability apparent within these systems.

### **‘Secrets of the Prison House of Lunacy’<sup>33</sup>: Accusations, Dismissals and Denials**

Whilst individual cases such as that of Thomas Henry occasionally gained wider interest, the number of patient deaths received little attention. This was despite it being argued that death-rates were around 40% of admissions within Victorian asylums (Russell, 1988: 297). Statistics which covered the period from 1861-1870

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<sup>33</sup> Merivale (1879: 4).

indicated the continued prevalence of deaths within asylums (Registrar General, 1875: ccx). Here, it was reported that at Surrey Asylum, the average number of patients per year during the above period was 912, with an average of 61 deaths. At Kent Asylum, there was a yearly average of 768 patients, with 87 deaths, while at Hanwell Asylum there was 1,631 patients on average, with 166 deaths per year. Finally, at Colney Hatch asylum there were 1,976 patients on average each year, with 188 deaths (Ibid: ccx).

In 1870, it was reported that a patient at Hanwell Asylum and another at Carmarthen Asylum had died from broken ribs and other injuries (Anon, 1870: 251). The Commissioners found no information to confirm how the patient at Hanwell ascertained their injuries but did find multiple defects at the asylum. The patient at Carmarthen was believed to have been injured following a struggle with an attendant. Both deaths were explained by asylum staff to the Commissioners as falls. However, the Commissioners questioned how symmetrical fractures could manifest as a result of a fall and instead stated that 'we cannot help thinking that they are sometimes due to the violence of attendants' (Ibid: 252). Despite this, no action was taken in both cases.

In 1874, the Lunacy Law Reform Association reported that brutality and cruelty was apparent in asylums, including criminal negligence by staff (Lunacy Law Reform Association, 1874: 11). However, little action ensued and contentious deaths continued to be a problematic issue. An example of this was

demonstrated in 1879 when a patient, Benjamin Harrison, died at South Yorkshire Asylum. The inquest verdict was that he had died from 'inflammation of the lungs accelerated or caused by a fractured sternum and three broken ribs but as to where and when the injuries were inflicted there is not sufficient evidence before the jurors' (The National Archives, 1879, HO 144/45/86384).

A Commissioners' inquiry was subsequently held at the asylum in relation to the death. A discharged patient, Pinlott, swore that he saw a violent assault on the deceased by an attendant. It was also noted by the Commissioners that Harrison had fallen on another occasion when it was 'certainly possible' that he suffered the fractures of his sternum and ribs. However, little, if any, blame was attributed to the attendants (Ibid). A subsequent letter from Dr Glover at the Home Office emphasised the laxity of the asylum's administration. In his view, there was 'too much discretionary power on the part of the inferior attendants' (Ibid). Glover stated that the post mortem was 'brief and unsatisfactory' and claimed that the death resulted from an incident that would not have been likely to have occurred in an asylum 'managed in the best manner' (Ibid).

In 1879, the autobiographical account of Herman Charles Merivale was published. Merivale discussed the 'secrets of the prison-house of lunacy' (1879: 4) and said that 'for five fearful months' he was housed in an asylum where his 'morale of heart and mind [was] being more played upon and shattered every day' (Ibid: 45). He argued that 'the house-doctor, whose business it was to cure us, and above

all to set us free, was one of the most remarkable madmen in the place' (Ibid: 22). He also argued that existing within the asylum was a 'death-in-life' (Ibid: 3) and stated that 'the man who comes sane and safe out of the hands of mad-doctors and warders...and Heaven knows what our law has woven round the unlucky victim...is very sane indeed' (Ibid: 4). He also drew attention to the attempts to control and silence patients where 'all letters, written or received, pass[ed] through the doctor's hands...there lies another royal road to the discovery of truth' (Ibid: 58). The letters from patients was an area of contention also drawn upon by Berveridge. He noted that letters were held back if they were felt to display mental disturbance on the part of the writer, or were critical of the asylum, with notes attached by the authorities such as 'a mad letter' and 'showing several delusions' (1998: 434).

Another case that reinforced the persistent concerns regarding the treatment of asylum patients was demonstrated in 1895 when the Commissioners in Lunacy issued an order to prosecute an attendant following the ill-treatment of a patient at an unnamed asylum (The National Archives, 1895-1896, MH 51/795). It was alleged that the management took no steps to prevent the ill-treatment after complaints were made to them (Ibid). Evidence provided by another patient claimed that he had witnessed the attendant's 'brutality' towards the patient and the treatment was 'continuously of a rough and bullying kind', involving 'gross acts of violence' (Ibid). This included the tightening of restraints overnight so that the patient could not move. However, official case notes stated that 'one must be very cautious' in accepting statements from patients (Ibid). As Rosenhan noted,

there is a dominant perception that 'staff are credible witnesses [and] patients are not' (Rosenhan, 1973: 257).

It was later stated that no proceedings could be taken against the attendant, due to the vague wording of the legislation in this area (The National Archives, 1895-1896, MH 51/795). In addition, there was not enough evidence for any charges to be brought against the managers of the asylum. This case shed light upon the lack of clarity and uncertainty in the legislation that governed asylums. Furthermore, it also indicated how, because of this uncertainty, the law could be interpreted in different ways which protected the accused and prevented legal action being taken against them. This ensured that the dominance of asylum professionals remained in place, to the detriment of the patients who faced the negative consequences of being labelled and categorised as 'mentally ill' (Goode, 2016: 451). This categorisation, classification and control was even more concerning as asylums were being used as places of first resort in order to treat individuals. This was despite the introduction of the Lunacy Act in 1890 which argued that these institutions should actually be used as a last resort (Andrews et al, 1997: 246).

### **‘Sheer wanton cruelty’<sup>34</sup>: Into the Twentieth Century**

As the twentieth century approached, questions were again being asked regarding the necessity of holding inquests into asylum deaths (The National Archives, 1897, HO 45/9925/B24719). In 1900, policies were introduced regarding the procedures that were to be followed if a patient died. Notices regarding deaths were to be sent to the coroner by asylum managers within forty-eight hours of the death occurring. Optimistically, an article in *The Lancet* described this as ‘an excellent innovation’ that worked to ‘reassure the public in a very real and practical manner that everything that is possible is being done for a sadly afflicted class’ (The Lancet, 1900: 1517).

It was recognised at the turn of the century that ‘no patient should be entrusted to any attendant that is not known for his humanity, patience and skill’ (The National Archives, 1895-1896, MH 51/795). However, in 1902, concerns were raised when Joseph Lambert was admitted in a bruised condition to the Derbyshire Asylum. The patient had previously been a boarder at Portland Grange<sup>35</sup> managed by Mr Hurd and it was suspected that he had been subjected to violent treatment whilst there. The Lunacy Commission instructed Dr Macphail to visit and report on conditions at Portland Grange (The National Archives, 1902, MH51/71). Florence Cohen, one of ‘Hurd’s lunatics’, claimed that he had once

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<sup>34</sup> The National Archives (1922, MH 58/222).

<sup>35</sup> Portland Grange was not an asylum. However, those housed there were all deemed ‘lunatics’. Individuals housed at Portland Grange were named ‘boarders’ as their families paid varying amounts of money for their relatives to live there.



struck her across the face and on another occasion she had seen a fellow boarder, Herbert Wood, struck with a whip (Ibid).

Another boarder, Slocock, was said to look like 'a wreck physically and mentally' and was, 'like most of his class, untruthful' (Ibid). Beken, another boarder, was described by Macphail as speaking in a 'furtive suspicious manner' (Ibid). During a conversation with Macphail, Beken became very suspicious and went to the door to check that nobody was listening to his conversation. In Macphail's opinion, Beken had been insane and had only partially recovered. Beken later wrote to Macphail and said that he had additional things to say but did not want Hurd to know about this as he was 'too much in their power' (Ibid). He claimed that the boarders were given a meat called 'spiced beef' but was believed by the patients to be horse flesh. Furthermore, the Hurds were 'cruel, brutal and violent' to them and used threats 'needlessly and senselessly'. Macphail dismissed Beken as 'insanely suspicious if not actually insane' (Ibid). Each boarder's account of their experiences at Portland Grange was discredited and disqualified based on their inferior status as patients, despite the recognition that 'few mental illnesses make a person dishonest' (Herring, 2015: 135).

Questions regarding the appropriate supervision of patients were raised in January 1907 when Frederick George Torvell killed a fellow patient, George Legg, at Dorset County Asylum (The National Archives, 1907, HO 144/1012/147976). Torvell had been thought to be 'perfectly harmless' and for the previous ten years

both men had worked together during daily duties. On the day of the incident, an attendant left the group to work alone, something he 'constantly' did. Torvell was described by staff as a 'grinning idiot' who did not appear to understand anything said to him (Ibid). The Medical Superintendent of the Asylum indicated that Torvell was 'so acutely insane and deluded' that he considered it 'most undesirable' that he should be brought to trial (Ibid).

The coroner in the case maintained that the jury had no right to entertain any question regarding the sanity and insanity of the person who committed a murder. He advised that the correct action to take was to return a verdict of murder in the same way they would if the case had not involved a patient. He thought it important that something definite was agreed in cases where a 'demented idiot' was involved, in order to avoid further confusion, and the police and asylums should be instructed on this (Ibid). This clarification was required as fatal or serious attacks within the asylum received little attention from the public and were 'soon forgotten' (Commissioners in Lunacy 1872: lviii). A criminal lunatic certificate of insanity was subsequently issued for Torvell and he was moved to Broadmoor, which had opened in 1863 as the first criminal lunatic asylum in England and Wales<sup>36</sup>.

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<sup>36</sup> The construction at Broadmoor was deemed essential as the 'mentally disordered offender fitted poorly and without harmony into either the prison system or that of the mental hospital or asylum' (Gordon, 1992: 108). Therefore, the purpose of Broadmoor was to provide treatment and not punishment (Ibid: 108). It was hoped that Broadmoor would transform the 'intersection' between punishment and madness. However, this was not the case (Seddon, 2007: 26) and the majority of individuals with mental health problems who had committed crimes were still contained within prisons (Garland, 1985: 7).

## **Confessions of an Asylum Doctor**

Historically, 'the voices of mental patients could be heard only when amplified by someone more powerful' (Hornstein, 2009: 161). An example of this was provided in the writings of Dr Montagu Lomax in 1922. Lomax served as an asylum medical officer and worked for two years at Prestwich Asylum (The National Archives, 1922, MH 58/222). He raised a number of concerns:

1. Patients 'herded together' with no attempt at individual treatment;
2. Medical staff wholly inadequate;
3. Medical superintendents 'snowed under' with administrative tasks and 'subordinate' medical officers 'over-worked and underpaid';
4. 'Indiscriminate' prescribing of opiates and sedatives, alongside a 'habitual' use of excessive doses of croton oil as a means of 'taming refractory patients';
5. 'Harsh' treatment of violent patients with some made to exercise 'in the pen' which was essentially a wire cage;
6. Absence of facilities required for 'proper' hospital treatment;
7. Abuse of solitary confinement and mechanical restraint;
8. Asylum buildings and exercise grounds resembled 'barracks or prisons';
9. Food 'monotonous and badly cooked';
10. Deaths from 'senility' were actually caused by starvation;
11. Patients employed on 'unhealthy' work such as cleaning out latrines;
12. Failure of the Visiting Committee to carry out their statutory functions;
13. Patients 'unsuitably clad' and overcoats not allowed;
14. Statutory inspection by the Commissioners of the Board of Control was 'too cursory to be of any value' (Ibid).

Lomax thought that attendants did not 'really care twopence' if a patient took their own life, provided that they could not be blamed (Ibid). In response, the hospital board stated that his claims were 'exaggerated' and 'impossible to believe' (Ibid). They argued:

One would have thought that any decent man, with the interests of the insane at heart, would have felt it his duty to report the circumstances at once to the superintendent and then if necessary to the Board of Control.

Instead of taking the honourable action he lies low for over two years and then publicises to the world a lurid account of his experiences (Ibid).

The hospital board stated that every patient had the opportunity to speak to the Commissioners regarding any 'real or imaginary' issues (Ibid). This in itself presented an infantilised view of the patients, with the powerful, level-headed Commissioners listening to the 'imaginary' issues of already stigmatised and marginalised patients. Lomax claimed that former asylum attendants were prepared to give evidence of cruelty. He wrote an article for the *Daily Telegraph* in which he stated:

The ill-treatment in question is always inflicted by attendants upon patients and no one else ever witnesses it. The attendants naturally never tell upon each other, except in the rarest instances, and the only other source from which the information can come is the patient themselves. And it is rarer still for a patient to make a complaint. Why? For the all-sufficient and unanswerable reason that he knows he will never be believed. His evidence is always 'tainted'; the mere whisper of the word 'delusions' is sufficient to damn it altogether (Ibid).

He indicated that he did not believe that the only cases of ill-treatment within asylums in 1920 were the five cases that the Board of Control had reported. He claimed that he had personally interviewed former patients who held the 'most important information' and he was convinced of their 'complete credibility' (Ibid). He found the attitude of those 'caring' for patients to be one of 'indifference, callousness, neglect, gross brutality and in some instances, sheer wanton cruelty' (Ibid). Lomax stated that his witnesses had no agenda for not speaking the truth; former patients had regained their liberty and did not wish to risk losing it. He argued that the 'old fiction' that the statements of patients and former patients

were 'delusions' could no longer be sustained. Such an assumption meant that no abuses, however true, could ever be detected and the authorities 'must no longer be allowed to shelter themselves under this absurdity' (Ibid).

Subsequently, a committee was formed to examine the claims and it was found that the committee at Prestwich 'did not know what [was] going on in their own institution' (Ibid). Despite this, it was 'obvious' that 'nothing' would be done until the medical superintendent retired. The committee found that Lomax had opened 'the sluice-gates of hundreds of bitter memories', whilst also uncovering 'a vast underworld of misery and despair' (Lomax, 1922: 5). The 'scathing attack' by Lomax 'painted a picture wholly at odds with the gleaming medical projections of the Board of Control' (Fennell, 1996: 108). However, it was the 'horrified public reaction' that actually resulted in official investigations taking place (Ibid: 108). As a 'whistleblower', the labels of 'rogue' and 'troublemaker' could be applied to Lomax, with no protection from reprisals (Louw, 2011: 61). Those associated with the asylum undertook 'aggressive attempts' to damage his reputation (Dix and Betteridge, 2008: 107). In an attempt to discredit him, it was argued that he must have been 'mentally disturbed' himself (Nolan, 1993: 82). Nevertheless, Lomax's case was described as 'shaking up' psychiatry (Ibid: 83) and worked to successfully draw attention to the 'shadowy underside of a complex network of shifting relations that situated officers, staff and patients within a hierarchical structure' (Hide, 2014: 40).

Lomax contributed to the autobiographical account of a patient, Grant-Smith who detailed her twelve-year confinement. During this time, she was forced to change the content of her letters to her family regarding her care and treatment (1922: 80). Furthermore, on numerous occasions she had urine thrown over her head (Ibid: 84). She also alleged that she was locked in the toilet whilst doctors visited, in order to prevent them from seeing her bruises (Ibid: 84). Grant-Smith continued to raise complaints but was regularly moved to other asylums, which, for her, was an attempt to divert attention away from the issues she had raised (Ibid: 72). It has been argued that women's voices were 'silenced behind asylum walls' (Geller and Harris, 2004: xi) and that 'we do not hear the voices of female lunatic patients' (Showalter, 1987: 60). However, by speaking out Grant-Smith challenged the supposed 'expert knowledge' possessed by the medical profession (Smith, 1975: 7).

### **Further Deaths and Failings**

In 1927, more questions were raised regarding coronial procedures following the death of a patient, Edward Chilcott, at Dorset Mental Hospital (The National Archives, 1927, RG 48/403). Mr Kendall, the registrar, stated that the cause of death in the coroner's report did not match the notice from the hospital. Kendall also noted the difficulties in obtaining paperwork in cases where the coroner did not consider an inquest necessary. In order to indicate the persistent nature of this issue, Kendall drew upon a letter written in 1914 from a coroner concerning the problem. The letter stated that the coroner did not see why he 'should be

troubled' to fill out a certificate every time a person died in an asylum as that would result in 'some 60 or 70 in the course of the year'. Therefore, it appeared to be 'a waste of time' (Ibid). The same coroner noted that up to 400 people died each year in large mental hospitals and work would be 'thrown upon' coroners if they were required to fill in a certificate every time a death occurred. He also argued that 'coroners should not be put to such unnecessary trouble and the relatives of patients dying in a mental hospital should not be delayed in obtaining certificates for burial' (Ibid).

In 1930, a case emerged which demonstrated the issue of 'discrepancies' in patient records (Marland, 2005: 137). Warwick county coroner, Mr Hadow, stated that the circumstances in the case of Florence Alice Neale were so unusual that he had felt compelled to inform his colleagues (The National Archives, 1930, RG 48/437). Following Neale's burial, Hadow found that there were discrepancies in the paperwork regarding the cause of death. Hadow thought that the case was 'so unsatisfactory' that he should have taken steps to exhume the body, but did not do so as he was sure that the death was attributable to natural causes. He stated that if this case had been presented correctly he would certainly have held an inquest and argued that the disposal of the body without his knowledge and consent 'betray[ed] a laxity that cannot be too strongly condemned' (Ibid).

In 1930, the Mental Treatment Act was passed. This Act aimed to modernise mental health provisions, whilst providing full legislative support to make

voluntary treatment available to all patients, regardless of their income (Coppock and Hopton, 2000: 34). The Act also proposed increased patient empowerment in order to develop understanding around mental health problems (Cherry, 2003: 172). A number of changes regarding the terminology used in relation to those with mental health problems was also introduced. As an example, it was stated that the use of the term 'lunatic' should cease (Eldergill, 1997: 61). The Act also replaced the term 'asylum' with 'mental hospital' (Turner et al, 1999: 578). Whilst these changes signified a move away from the 'negative connotations' of the labels of 'lunatic' and 'asylum' (Bryan, 2014: n.p), the introduction of new labels ensured that the categorisation of patients remained. This meant that the 'convenient but largely meaningless label' of 'mental illness' could still be applied (Eysenck, 2008: 94).

Cases of patient mistreatment continued to emerge. In 1933, at Meanwood Park Hospital in Leeds, an attendant was dismissed for ill-treating a patient and 'striking him' with his fist. Staff then failed to report the incident and there was no prosecution (The National Archives, 1933-1956, MH 51/411). In 1935, Thomas Boller claimed that an attendant had knocked him down and kicked him in the mouth at the same hospital (Ibid). The evidence of a number of other patients concerning the incident was deemed 'tainted' due to them indicating that they had been waiting to 'catch' the attendant acting improperly (Ibid). The attendant said that he took full responsibility for Boller's condition. He said he had hit him with a stick as he was teasing other patients and the stick had caught him in the mouth, however he denied kicking him (Ibid). The attendant's employment was



terminated with a view to pursuing legal proceedings against him. However, there was an absence of any 'reliable' corroborative evidence due to 'only low grade patients being present' (Ibid). As a result, the evidence of the attendant was accepted.

Later discussions indicated that it was 'difficult to understand' how there was a lack of evidence, when in fact there was sufficient evidence to justify a prosecution. Despite this, a prosecution did not materialise (Ibid). This case drew attention to the ways in which the statements of patients were discredited due to the perception of them being incompetent and untrustworthy (Link et al, 1992: 88). Regardless of the fact that the attendant had taken responsibility for the injury to Boller, he was 'knowledgeable' and 'competent' due to him being a member of staff, whereas, in contrast, patients were 'inadequate' and 'untrustworthy' (Hatfield and Lefley, 1993: 92).

Ellen Ruddle died at the Frome Road Institution in August 1937. No inquest or post mortem was held following her death (The National Archives, 1939, RG 48/1158). Members of the public enquired why this had been the case. An 'astonishing' development occurred when it was found that there were discrepancies in the certificates sent to the registrar and the coroner. The notice sent to the coroner noted the cause of death solely as toxic myocarditis, with no mention of chronic morphine poisoning which had been included in the original certificate (Ibid). It was argued that if the causes of death had been fully reported

to the coroner then it was probable that he would have at least ordered a post mortem, and possibly an inquest. Furthermore, concerns were raised that similar errors may have occurred at other institutions. Ruddle's body was later exhumed due to 'outstanding mysteries' regarding the case (Ibid). The findings of these additional enquiries were not documented.

Unhappy with the treatment they were receiving, patients continued to complain to the authorities. John Mark Nash, a patient at Rampton, wrote to the Home Secretary in May 1938. He stated that 'this mental hospital is no good to me, I would have capital punishment any time for what I have done' (The National Archives, 1933-1956, MH 51/411). Nash claimed that an attendant had hit him in the mouth, tripped him and then punched him in the face, before telling another attendant that Nash 'went for him'. As the attendants 'had their own way' with the patients, Nash argued that he would never have acted in this way (Ibid). An internal investigation dismissed the allegations and stated that Nash had 'attacked' the attendant, and there was no evidence of ill-treatment or unnecessary force being used towards him. Further allegations regarding patient mistreatment emerged and in 1938 another patient, Frederick George William Howell, alleged that a patient named Baker was struck by two members of staff who had both made it a common practice to 'use their boots' on patients. The letter requested that the authorities 'put an end to the brutality against patients' as the doctors had 'closed their eyes' to it (Ibid). Again, no further action was deemed necessary regarding these allegations.

Additional cases of abuse continued to surface. In 1941, there was an alleged assault on Violet May Hoskins at Llwyn Hryr Certified Institution (The National Archives, 1933-1956, MH 51/411). It was argued that she was held down by the matron and given a 'good thrashing'. However, the Mental Deficiency Committee enquired into the case and were not satisfied that an assault had occurred. Allegations were also made about an incident involving the ill-treatment of an unnamed patient at Rampton in 1944 by the patient's mother, Janet May Clift. In a response which reflected the infantilisation of patients, the hospital board stated that Clift should encourage her daughter to be of 'good behaviour' and avoid a re-occurrence of any incident (The National Archives, 1947, MH 51/422).

### **The Introduction of the National Health Service and Beyond**

Following the introduction of the National Health Service (NHS) in 1948, the number of asylums began to fall and there was an increased focus on new drugs and social welfare policies. This led to an 'awakening of social psychiatry' and the realisation that many patients in mental hospitals 'did not need to be there' (Jones, 2009: 3).

In 1948, admission and discharge registers were gathered from different mental hospitals in England. The records were then updated when a patient died or was discharged (The National Archives, 1948, MH 94/104). Each hospital's entry

consisted of either 30 or 31 patients<sup>37</sup>. At Farnborough Hospital, 19 of the listed patients had died by the end of 1953. 22 patients had died by the end of 1959 at St Martin's Hospital in Bath and 24 patients died by the end of 1960 at Birkenhead Hospital. The register contained three pages related to Tooting Bec Hospital, all ranging from 1948 through to 1960. On the first list of 31 patients, 20 had died by the end of 1960. On the second list, 27 of 31 patients had died. On the final list of 31 patients, 21 had died by the end of 1960 (Ibid).

The interest from pharmaceutical corporations during the mid-twentieth century in manufacturing new drugs to treat mental health problems drew attention to the emerging 'corporate' nature of psychiatry. The so-called 'drug revolution' of the 1950s (Johnstone, 2000: 145) resulted in drug companies possessing a 'vested interest in selling the chemical solution to mental distress' (Ibid: 166). Jones noted how the free prescription of drugs resulted in a 'totally different atmosphere' within mental hospitals (1993: 150). It was also argued that psychiatric hospitals 'revolve[d] around the various rituals of drug treatment' (Moncrieff, 2006: 115). Here, it was difficult to ascertain the level of harm caused by the over subscription of drugs due to the 'virtual monopoly on the production of publicly available and officially sanctioned information' (Ibid: 132).

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<sup>37</sup> This file consisted of a page of a register dedicated to each hospital. It was highly unlikely that the 30/31 patients listed on each page was the entirety of their admissions for 1948, however it was unclear as to why the files only contained this select number of patients.

In 1951, concerns were raised at Menston Hospital after visitors complained that patients were 'treated like dogs' (The National Archives, 1951-1959, MH 137/381). An internal committee investigated the claims and found them to be untrue. The committee said that unless an allegation was withdrawn which described the institution as a 'concentration camp', the hospital would take action against the complainant (Ibid). The complainant subsequently withdrew the allegation. However, an associate of the Friends of Menston Hospital contributed to the investigation and stated the hospital had acted in a way that had 'undermined human dignity and self-respect' (Ibid).

Concerns would later again be raised at the same hospital when the Friends of Menston Hospital wrote to the physician superintendent stating that they had received a complaint regarding a member of staff who had previously had complaints made against him (The National Archives, 1961, MH 137/382). The physician superintendent at Menston stated that the claims were a defamation of character and the staff member would be sure to take legal action. In the face of this threat, the Friends group requested that the matter be dropped (Ibid). Subsequently, an independent examination of the case found the behaviour of the physician superintendent to have been 'monstrously overbearing' and 'deliberately threatening' (Ibid). This led the independent investigation team to question what treatment the patients received if the Friends were met with such hostility (Ibid).

In March 1956, a letter was sent to Dr Wilson<sup>38</sup> from 'all B2 ward patients' at Rampton Hospital concerning their treatment (The National Archives, 1933-1956, MH 51/411). Rampton had become known as the 'rag-bag' of the system (Roxan, 1958: 94) where patients were beaten 'day after day, week after week' (Ibid: 150). The patients stated that they had been 'pushed in a wet room in the nude with no bedding' and had also been 'bashed up' (The National Archives, 1933-1956, MH 51/411). The authors claimed that if something was not done officially then there would be 'trouble' (Ibid). It was alleged that the nursing sister in the isolation ward allowed the patients out of their rooms in order for them to assist in the 'bashing up' of patients in B2 Ward (Ibid). The patients said they could not sign their names individually in the letter as they thought they would be punished. Another letter to Dr Wilson said that patients had been 'half starved' and stated 'you would not think we were human beings' (Ibid). Furthermore, the patients argued that the staff 'were sly, acting appropriately when official visitors were around' (Ibid). At the time of writing their letter, the patients claimed that there was a fellow patient lying on the isolation ward in a 'mental state' with no action being taken (Ibid).

The Acting Medical Superintendent (AMS) stated that he had investigated the claims and that there was no truth in them. It was argued by the AMS that the sister concerned was a 'very straightforward, level headed, reliable, mature person and a good nurse' (Ibid). In the AMS's opinion, minimal official notice

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<sup>38</sup> It was unclear who Dr Wilson was.

should have been taken of the complaints. As a result, the patients were seen as dishonest and their views discredited. This suggested that the sister was acquitted of these charges based on the judgement that she was 'level headed' (Ibid). This was in contrast to the B2 patients who were 'irrational' and 'abnormal' due to their mental health problems (Horwitz, 2002: 6).

Small instances of accountability occurred periodically and in 1956, a ward orderly was dismissed from Botleys Hospital for striking a patient (The National Archives, 1933-1956, MH 51/411). In the same year, a female patient absconded from Delapole hospital and was found at the home of a male nursing assistant. He was dismissed and prosecuted. He received two nine month sentences which ran concurrently after being found guilty of having sex with the patient (The National Archives, 1956-1957a, MH 51/344). The following year a patient at Hellingly Hospital in Sussex had a baby with one of the porters. He pleaded guilty and received an absolute discharge (The National Archives, 1956-1957b, MH 51/342).

Also in 1957, several different accounts from former patients at different hospitals surrounding their experiences of control, subjugation and silencing were published in the book, *The Plea for the Silent* (Johnson, 1957). The accounts indicated the 'other side' of truths in this area (Ibid: 9). The group formed a 'grievance committee' but were unable to obtain a hearing as they had 'been up against a closed ring of authority' (Ibid: 8). As former patients, 'a conspiracy of

silence surrounded them' (Ibid: 8). One of the anonymous authors stated that he had been detained in a mental hospital following his petition for improved treatment for his wife who had received inferior treatment following an operation (Ibid: 11). He detailed his experiences of the widespread censorship of her mail, the poor attitudes of staff and invasive treatments. Another former patient noted how, after she had left the Women's Auxiliary Air Force following the war, she had struggled to reintegrate back into normal life and had been found sleeping rough. After being taken to the police, she was given three options: to return home at her own expense, become a voluntary patient, or failing either of these, become certified as insane (Ibid: 32-33). The author asked if she was well enough to be given the option to return home, how could she be deemed appropriate for treatment in a mental hospital? (Ibid: 33).

Having refused to comply with the first two options she soon became aware of the harm she was doing to what remained of her 'shattered life' and, still more to her relatives 'who would henceforward be obliged to admit the stigma of one official certification in the family' (Ibid: 33). She continued, 'I had unthinkingly laid a handicap upon the lives of generations of my relatives' (Ibid: 34). The author also commented on the censorship of correspondence and the 'genuine horrors' that added to her 'sense of terrified unreality' (Ibid: 34). She recalled an incident where the ward sister, who had a 'passionate temper', called her a 'lying bitch' (Ibid: 35). This incident led her to believe that 'anything could happen in an institution where the sister in charge of a ward appeared to have no more self-



control than the patients' (Ibid: 35). For her, 'no one other than a mental patient knows the terrifying feeling of utter physical and directional helplessness' (Ibid: 37).

Another anonymous author explained how she had attempted to alert the police to a problem she had by breaking a window in front of a passing police car at the hostel where she lived. She was subsequently taken to a mental hospital and was told by a doctor that she would be in need of treatment for 'all her life' (Ibid: 52). She expressed her 'horror' at hearing this and questioned how this could be the case when less than a week before she had been earning her own living. She was met with dismissive comments by the doctor such as 'you see, you have no insight into your illness' and 'you broke a window...you lost control of yourself' (Ibid: 52-53). Another patient was:

Convinced that, had I not made strenuous efforts to regain my freedom, writing to all who could in any way help, worrying the doctor, asking to go before committees, and even compromising in many respects, I would still be within those walls, eating out my heart and becoming daily more hopeless, less able to cope with life (Ibid: 80).

Penfold and Walker argued that the medical profession organised and controlled patients (1983: 243) and this was particularly apparent in the response to, and treatment of, females where classification and categorisation were crucial strategies utilised (Ussher, 1992b: 43). The accounts discussed here highlighted how the medical profession emphasised the low-status and discrimination of female patients (Al-Issa, 1980: viii). This was in the interests of medical men who

aimed to further secure their professional standing (Ehrensreich and English, 1978, cited in Busfield, 1996b: 2).

In 1957, the *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (Percy Report) reported that the running of psychiatric hospitals should mirror the running of general hospitals as closely as possible. It was also stated that mental illness should be regarded in the same way as physical illness. It was argued that once an individual had reached the point where they could safely return home, they should no longer be detained as a patient (Percy, 1957: 44). Two years later, the 1959 Mental Health Act was introduced. The Act was viewed as the start of a new approach to managing mental health provision in England and Wales. It linked with the recommendations of the Percy Report and created a framework which aimed to ensure that the treatment of mental illness mirrored the treatment of physical illness as closely as possible (Branford, 2011: 207). The Act also laid down 'strict guidelines' regarding involuntary treatment (Beer et al, 2008: 3) and introduced mental health review tribunals to act as 'watchdogs' (Gittins, 1998: 67).

Fennell argued that the Act moved power from the hospital administration directly on to the physicians (Fennell, 1996: 168). However, the power bestowed upon these physicians was increasingly questionable as it had become apparent that medical remedies for mental health problems had proved 'almost wholly ineffective' (Scully, 1979: 171). This left doctors in a 'distinctly vulnerable position'

as they had 'gained their monopoly in the treatment of insanity without a knowledge base which would have given them a rationally defensible claim to special expertise in this area, though they had convinced others that they possessed one' (Ibid: 171). As a result, medical professionals were 'victims of their own propaganda' (Porter, 2003: 199) as in truth, they 'remained as far as ever' from possessing any genuine skill to care and treat patients (Scull, 1979: 171).

## **Conclusion**

The perception that 'locking up the mad was best for everyone' (Porter, 1987: 17) was used to justify the growth of asylums and the growth of 'institution[s] where those deemed 'unproductive' could be 'housed, controlled and conveniently forgotten' (Mathiesen, 2006: 141). However, as the number of asylums grew, problems associated with them also continued to grow. By undertaking the first half of a 'history of the present' (Foucault, 1977: 31), the chapter has contributed towards fulfilling a number of the main aims of the thesis. The first of these aims was to undertake a critical examination of historical data related to the response to patients and their families in both life and death. The chapter also addressed the aim of examining the emergence of issues surrounding the inquest and investigation systems following the deaths of detained patients. Analysing the issue of accountability in both life and death has also contributed towards addressing the aims of the thesis.

Through examining documents such as letters from patients and their families, the chapter was able to allow previously hidden and ignored knowledge to emerge. This was in addition to critically analysing how 'established reputations' were threatened, along with the challenge to the 'hegemony of the status quo' (Hill, 1993: 6). As Grobe argued, 'the psychiatric institution is built on the assumption that the experiences of 'mad' people don't count-and most of the world has no problem with that' (1995a: xi). Therefore, 'first-person accounts of psychiatric treatment constitute a largely untapped set of sources' (Hubert, 2002: 16). Despite attempts to 'deny and disallow' (Wood, 1994: 1) alternative and subordinate experiences, the presenting of them within this chapter has worked to 'rupture a prescribed narrative' (Ibid: 12). This has worked to legitimate these dismissed voices (Ibid: 2), whilst offering new 'truths' surrounding psychiatric detention and deaths within these institutions.

Undertaking the first part of this critical history has resulted in the history of psychiatric detention and deaths within these institutions being presented in a new light, along with a number of key themes emerging. The first theme was that of the negative official response to patients within the asylum. As the chapter noted, patients were degraded and disregarded within asylums, with a continual lack of official interest in their care and treatment. This failure to respond appropriately to patients was also apparent following their deaths, with these deaths dismissed and concealed. This links with the second theme that emerged from the chapter which was the lack of accountability apparent in both the lives

and deaths of patients. Here, there was minimal accountability and transparency apparent following the mistreatment and abuse of patients, in addition to the lack of post-death accountability. This issue was compounded by the seemingly endless ways in which secrecy worked to conceal the actual circumstances surrounding cases, including dismissal, marginalisation, punishment, discrediting and silencing.

Another theme to emerge was the different ways in which power was exercised over asylum patients by the state, and more specifically by the 'mad-doctors' who aimed to gain a monopoly of control over patients (Kopans, 2006: 124). Here, issues of power, control and regulation were apparent. However, as the chapter identified, it became apparent that although doctors acquired a dominant position in governing asylum patients, they were continuously challenged by the refusal of individuals and groups to 'take the asylum authorities' proclamations at face value' (Scull, 1981: 2). This was demonstrated by the complaints of patients, families and those who spoke out, including 'disaffected' medical professionals (Ibid: 2). This was also indicative of the 'contradictions, contingencies and contestations' surrounding psychiatric power which worked to deny the 'dominant voices' of the asylum an 'all-embracing hegemony' (Sim, 2009: 156). As a result of this contestation, patients, families and those who spoke out ensured their voices were heard, which in turn worked to challenge the secrecy and lack of debate in this area.

The identification of these themes raised issues concerning the evolution of asylum regimes and the motivations behind the 'progress' of these regimes. For example, whether this evolution actually demonstrated any real progress or whether constant changes within the system worked to further legitimise the categorisation, subordination and disqualification of those with mental health problems. Another issue that this chapter has raised is how power has been utilised to avoid accountability regarding failings within the system and how the control of patients ensured that the 'disciplinary network' in asylums remained in place (Foucault, 2008: 93). This linked with a further issue surrounding how dominant truths were constructed, enforced and maintained. Furthermore, the chapter raised the issue of how the subjugated voices of patients, their families and others who resisted dominant truths worked to challenge their imposition and created new realities and narratives.

The next chapter will pick up a number of these themes through a contemporary, critical revisionist history of psychiatric detention and deaths within these institutions, beginning in 1960 and ending in 2018.

## **Chapter Four: 'We Are Waving, Yet We Are Still Drowning'<sup>39</sup>: Detained**

### **Patients in Life and Death, 1960-2018**

The previous chapter of this thesis constructed a critical, revisionist history of life and death in psychiatric detention in England and Wales, from 1845 through to 1959. This chapter continues to undertake this 'history of the present' (Foucault, 1977: 31) and will be particularly concerned with providing a critical examination of a number of areas in both life and death between 1960 and 2018. These areas include the role of the medical profession, the prevalence of deaths and the response to these deaths. Also of concern is the inquest and investigation processes, along with how accountability was understood within these systems. The secrecy and lack of accountability within the system is also critically explored. Issues of complaint will be analysed, along with the strategies that were used to subordinate and oppress those who spoke out. How this subordination and oppression has been challenged will also be critically examined as the chapter progresses.

As noted in Chapter Two, primary archival data originating from the National Archives and the ProQuest Newspaper Archive will be critically analysed. However, following the archival data gathered in 1999, no further relevant archival material was able to be accessed at the National Archives due to restrictions in place under the Public Records Act 1958. As the chapter

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<sup>39</sup> Parkinson (2015: n.p).

progresses, other material such as reports and investigations will be drawn upon, in order to bring the chapter into 2018.

### **'The Death Knell for the Asylum Pastoral'<sup>40</sup> and the Emergence of Community Care**

Following the introduction of the Mental Health Act in 1959 it was believed that the 'shameful stigma' associated with asylums and mental hospitals would only subside when the 'secrecy' associated with the system was 'swept away' (Roxan, 1958: 9). Although psychiatric detention 'was problematic from its inception', it was not until the late 1950s and early 1960s that the system was subjected to a 'sustained analysis and critique' (Pilgrim and Rogers, 2014: 147). It was argued that the work of psychiatrists had not resulted in any progress being made. In fact, they had contributed to a 'nightmare of breathtaking proportions' (Shorter, 1997: ix). An example of this was demonstrated by the mortality rates at Broadmoor where, by the end of 1960, there had been a total of 5,336 male admissions, along with 1,537 female admissions. Of these admissions, 1,671 males and 415 females had died (Gordon, 2012: 153).

In the face of concerns surrounding the care and treatment of patients, the anti-psychiatry movement became prominent in the 1960s and assisted in raising a 'sceptical consciousness' in relation to psychiatric practice (Cohen, 2007: 160).

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<sup>40</sup> Barham (1992: 1).



The anti-psychiatry movement signified a move 'away from the expert' and the 'deprofessionalisation' of the system (Ibid: 31). This further reinforced the 'field of contestation' that emerged within psychiatry (Crossley, 2006: 1). The movement argued that people recovered despite, rather than because of, the treatment they received (Johnstone, 2000: 39). The movement also challenged the view that the psychiatric system was 'largely benign' and that there has been continual progress towards the effective care and treatment of patients (Holmes and Dunn, 1999: 3). As Grobe argued, the 'psychiatric institution was not about healing but about oppression, the oppression of the human spirit...being terrorized, tortured, tormented and traumatized' (1995a: vii). Grobe continued, 'in a society that relies on scapegoats in order to function, [the] view of 'madness' is very convenient. It assures the dominant power group's staying in power since it is they who decide what is 'normal' in the first place' (Grobe, 1995b: 167). While psychiatrists 'possess the ultimate power' (Scull, 1975: 221), they were also viewed as 'well-paid administrators whose minimal and prima donna presence lends a paternal air of scientific and legal efficiency' (Chesler, 2005: 123). It was therefore unsurprising that it was argued that 'mental asylums rarely offer asylum' (Ibid: 95).

With a clear failure to adequately care and treat patients, attention grew on deinstitutionalisation and how patients could be treated outside of hospitals (Barham, 1992: 12). A focus on deinstitutionalisation developed in 1961 when Enoch Powell, the Minister of Health, predicted that mental health beds in hospitals would be reduced by 50% in the following years, with patients instead

being treated in the community (Cohen, 1964: 141). For Barham, this 'sounded the death knell for the asylum pastoral' (1992: xi) and 'dirty, scruffy, rotten' asylums (Ibid: 1). In an example of the contradictions (Sim, 2009: 156) within psychiatric power, the emphasis on deinstitutionalisation resulted in an:

Ironical affinity between those for whom liberation from the asylum meant a liberation from psychiatric conformity and those for whom psychiatric progress was now able to promise the return of the mental patient to social conformity (Barham, 1992: 12).

The 1960s subsequently saw a move 'away from the state' and this was demonstrated by 'non-interventions' including community based provisions (Cohen, 2007: 31). For Cohen, a move 'away from the institution' signified a 'lack of faith in traditional closed institutions' (Ibid: 31). This was unsurprising when it was considered that 'a large number of people [had] unnecessarily spent many years away from ordinary living' (Ramon, 1992: xiv). Ramon also argued that 'a large number of professional workers [had] unnecessarily spent their professional life in not providing the best available intervention and in reinforcing the controlling element of their work instead of the caring element' (Ibid: xiv). There was also a continued feeling from the relatives of patients that they had been 'let down' (Ibid: xv), indicative of the lack of official interest in families that was apparent historically, as discussed in Chapter Three.

In 1962, the government's Hospital Plan encouraged a move away from large mental hospitals to new district general hospitals. This was due to an apparent

decline in the number of chronic patients in mental hospitals due to new drugs that allegedly halted mental health problems in their early stages (Godin, 2003: 22). However, there was 'no professional or public consensus' regarding what provisions should replace hospitals (Ramon, 1992: xv). For Scull, 'decarceration, deinstitutionalization, diversion-under whatever name the process currently masquerades' was supposedly more humane and effective (Scull, 1977: 41). However, this 'miracle of miracles' approach (Ibid: 41) was 'built on a foundation of sand' (Ibid: 1). Scraton stated that with the closure of mental hospitals in the 1960s came reassurances that stories of failings, mis-treatment and abuse 'would pass quietly into oral history-contemporary testimonies of a bygone era' (2002a: 108). However:

Behind the high walls of special hospitals [and] the bolted doors of psychiatric units...those imprisoned continue to be subdued by a lethal mix of tranquillising and anti-psychotic drugs, supervisory neglect, staff brutality and defensive managements...[they form] closed worlds (Ibid: 108).

Barham argued that it became apparent that Powell was 'unduly optimistic' in his aspirations for the mental hospital system (1992: xi-xii). Whilst it may have been argued that the move away from large mental hospitals to smaller district hospitals was to benefit patients in terms of care and treatment, it could also be argued that it was an attempt to ensure that their 'constant control and regulation' remained in place, albeit in a more localised setting (Larkin, 2011: 130). Discrepancies soon emerged surrounding the number of hospitals that were actually closing. Barham referred to an incident when the opposition health

spokesman requested a list of mental hospitals for which there were no closure plans, only to find that the list included four hospitals which had already closed and two that were due to close (Ibid: 20-22).

A new emphasis on community care aimed to develop 'a policy of inclusion' (Ibid: 34). However, following leaving hospital, patients were 'debriefed and quarantined', drawing comparisons with the return from a leper colony (Johnson, 1985: 3). The results of community care were typically in contrast with official aims, as what was delivered was actually a policy of exclusion 'under the banner of inclusion' (Barham, 1992: 34). Because of this, 'most community-based provision' mirrored 'the all-too-familiar relationships of institutional life' (Davis, 1988: 35).

### **Same Problems, Different Era: Continued Dismissal and Subsequent Challenges**

In 1965, *The Guardian* published an article by a consultant psychiatrist regarding 'the scandal of the British mental hospital' (The Guardian, 1965a: 9). The psychiatrist worked in a hospital near London, which housed around 1,800 patients. He spoke out regarding the condition of the hospital and argued that the treatment of the patients compared unfavourably with the treatment of animals (Ibid: 9). The psychiatrist also stated that the quality of the staff left 'much to be desired' and claimed that in an average hospital, around a quarter of

the doctors themselves had a major psychiatric disorder (Ibid: 9). Furthermore, he argued:

Who is there to complain? The patients who know [how bad things are] are often too incapacitated to talk. Articles on community care, therapeutic community, wonder drugs, and the supposed advances of the recent Mental Health Act have little meaning to the wretched individual suffering from chronic schizophrenia, and abandoned in a cheerless Victorian mausoleum with ninety fellow sufferers and one nurse to keep an eye on them all. Once a year, of course, he may see a junior doctor (Ibid: 9).

Following the publication of this article, another letter was sent to *The Guardian* from a senior social worker who criticised the attitudes of staff in mental hospitals and stated that it was common practice for standards of care to be inconsistent (The Guardian, 1965b: 10). The letter also claimed that a doctor at one hospital had attempted to set fire to the institution and a nurse who had been dismissed had regularly threatened a patient with physical injury if he did not hand over money (Ibid: 10). Another letter from a former student nurse noted that she had been 'haunted' by what she had witnessed during her time training on a psychiatric ward (The Guardian, 1965c: 8). The psychiatrist's initial article, along with the additional letters, demonstrated how 'institutions and their regimes [were] not unshakeable nor beyond challenge, particularly where they fail to serve needs, contain conflicts, or answer troublesome questions in a way that is perceived as satisfactory' (Garland, 1991: 4). The cases also demonstrated, as was the case in Chapter Three, that it was not always the 'powerless' who spoke out. Here, various members of staff also challenged wrongdoing.

Members of staff raising complaints was also apparent in 1965 when Sister Inglis of St Crispin's Hospital complained after witnessing the rough treatment of a patient by a doctor (The National Archives, 1966-1976, MH 159/238). However, the doctor also complained about her and she was moved to another ward. Sister Inglis questioned why reprisals were taken against her for complaining. She also questioned why the hospital management committee refused to enquire into the allegations she made or the reprisals she had suffered. She also asked why the doctor was cleared of wrongdoing without any witnesses being called. St Crispin's would later be criticised for 'allowing a patient to deteriorate into a condition which contributed to her death' (Ibid).

Further issues were raised by McCarthy who, in his attempt to 'break through the wall of silence' (2009: 5) surrounding the psychiatric system, detailed his experiences as a trainee mental nurse in the 1960s. 'Sadistic' names were given to the different brutal methods used on patients, including 'Thump Therapy', 'The Warder's Lock', 'The Drops', 'The TTT' (Terrible Towel Treatment), 'The Water Works' and 'The Zigzag' (Ibid: 38). He noted an occasion where a 'blind and tiny' old male patient was given a 'resounding smack across the back of his head' by a member of staff (Ibid: 13). He described the medical superintendent as a 'complete cuckoo' (Ibid: 71). Regarding complaints, he noted, 'even in those instances where patients are injured by staff we all know how easy it is to record these occurrences as self-harm, an accident...the system here is watertight' (Ibid: 71). Later in his career, McCarthy was informed by the chief executive of the

health authority for whom he was working that he had not heard of any abuses, nor did he have access to any central records. Within an hour, McCarthy had telephoned senior nursing colleagues and chronicled their responses, including proven cases of staff stealing from patients, assaults and sexual relationships between staff and patients. After being presented with the information, the chief executive 'nearly had a fit' (McCarthy, 2016: n.p).

Contentious deaths and allegations of mistreatment continued to plague the mental hospital system and in 1968 a verdict of 'death by misadventure' was recorded at the inquest into the death of a patient at Normansfield Hospital patient (The Times, 1968: 2). The deceased patient, Peter Oakley, was a 'severe spastic' and died from a fractured skull when another patient tipped him out of his chair (Ibid: 2). The medical superintendent of the hospital, when asked by the coroner how many staff there were in a ward of seventy patients, stated that there were usually three or four nurses, to which the coroner replied, 'is that all?' (Ibid: 2).

In the late 1960s, John Bell's parents died within weeks of each other when he was fourteen. Bell's GP referred him to a psychiatrist. On arriving at Tone Vale Mental Hospital, Bell believed that he should have been placed in a special unit due to his age. However, he was held in the main hospital, which was a 'very terrifying experience' (Bell, 1996: 106). Over the next seven months, Bell 'went through hell', was mocked by nurses and given excessive doses of drugs, to the

point where he could not stand up (Ibid: 106). He alleged that he had been assaulted by nurses on more than one occasion, sexually abused and beaten up by another patient. A new doctor at the hospital would later argue that the institution was no place for a boy of his age and stated that there appeared to be nothing wrong with him. He was subsequently discharged.

However, on his release, as a victim of the stigma surrounding psychiatric patients, Bell was ostracised in the community and subsequently attempted to take his own life. He was re-admitted to Tone Vale and diagnosed as schizophrenic. He was told by a charge nurse that the only way he would leave the ward was when they transferred him to the geriatric ward or 'in a coffin' (Ibid: 107). Bell stated that there were seventy patients on the ward and it was 'impossible' to talk to any of them as 'their minds had been destroyed' (Ibid: 107). For Bell, his care and treatment was of such an inferior nature that he argued that the RSPCA treated stray dogs better than the nurses on the ward treated patients (Ibid: 107).

He maintained that the diagnosis of schizophrenia 'destroyed his life' and caused damage that would never be repaired or reversed (Ibid: 107). He was again discharged but was later re-admitted to Tone Vale. In an example of challenging the perception that 'mere lay people have no right to challenge medical opinions' (Banton et al, 1985: 29), Bell continuously fought against the diagnosis he



received. He was eventually informed by a different psychiatrist that there was no evidence that he was schizophrenic and this diagnosis was made in error.

### **Issues at Broadmoor**

In 1965, Peter Thompson attempted to take his own life in a local mental hospital. He was informed less than twenty-four hours later that he could return home. Following an incident where two people were injured, Thompson was detained in Broadmoor, with the period of his detention 'to be decided by other authorities' (Thompson, 1972: 85). Thompson bypassed the hospital authorities and contacted the police regarding a complaint related to the razor-slashing of his coat. He felt that the staff 'got their own back' for him bypassing them when they suggested he use anti-freeze to keep frost out of his garden patch. Thompson did this, not understanding at the time that this would kill the patch. For Thompson, the response to him demonstrated 'the indifference of some of the staff to their patients' (Ibid: 115). The dismissal of Thompson's complaints also linked with the view of the Mental Health Act Commission that patients in special hospitals often felt that raising a complaint would not only serve no purpose but would hinder their progress in the hospital (1987: 16).

A number of patients at Broadmoor received anonymous threatening letters, Thompson included. Again, he contacted the police, rather than the hospital authorities. The police were unable to help and their attitude 'appeared to be that in a mental hospital you should expect to receive sick letters from sick people' (Thompson, 1972: 119). The Chief Constable of Berkshire Police

subsequently wrote to the Ministry of Health asking that no letters or complaints from Broadmoor patients be sent to him (Ibid: 119).

During Thompson's time at Broadmoor, the *Daily Express* published an article that described the hospital as 'the Berkshire institution for 900 insane criminals' (Ibid: 125). Thompson wrote to the newspaper to complain about this description, but no apology or correction was published. Undeterred, he contacted the Press Council who found that the correction should have been published. BBC radio news also made a similarly inaccurate reference to Broadmoor. When Thompson complained, his letter was read on air (Ibid: 125-126). In 1969, he was released following a mental health tribunal (Ibid: 133). His case provided an example of how 'stories from below' (Porter, 1987: 231) emerged. These stories demonstrated how, 'despite suffering from the most hair-raising, sometimes completely incapacitating illnesses, people's determination to rise from the abyss was utterly remarkable' (O'Donnell, 2012: 340).

Another patient who spoke out regarding the regime at Broadmoor was Alan Reeve who, during the 1960s, was first sent to the adolescent unit at St Augustine's Hospital. He described the institution as 'grossly overcrowded, understaffed, not particularly clean, in short, a dumping ground' (Reeve, 1983: 51). Reeve subsequently killed another patient housed in the unit (Ibid: 77). As a result, he was sent to Broadmoor and was warned by a fellow patient that he would 'probably see more 'strange' behaviour from the screws than any of the

patients [and] he was correct' (Ibid: 83-84). Another patient asked Reeve to kill him, but he refused. Reeve said that he later found the patient dead (Ibid: 96-97). Despite staff naming another patient as the killer, Reeve stated that he had killed him but later retracted his statement. *The Times* published an article regarding this 'mystery death' at the hospital. However, neither the Ministry of Health, nor the police, would release any details regarding the circumstances surrounding the death (The Times, 1967: 2). Reeve was convicted of manslaughter on the grounds of diminished responsibility (The National Archives, 1967a, ASSI 6/439).

During his time at Broadmoor, Reeve, in an attempt to challenge the regimes at the hospital, compiled a dossier of complaints and allegations, including drug peddling amongst staff, distribution of pornography, abuse, assaults, brutality used as 'a method of control', medication used as punishment and misuses of treatment including electro-convulsive therapy (The National Archives, 1972a, MH 150/878). Reeve argued that the staff 'didn't know what they were doing'. An example of this was apparent on one occasion when a patient collapsed and subsequently died and 'the time that was wasted was ridiculous' as staff 'fumbled around' (Ibid). Reeve, in his role as spokesman for the patients' 'Revolutionary Action Committee', commented that he expected the investigation into their dossier to be a 'whitewash' (Ibid). He detailed a number of cases within his dossier, yet many of these were marked 'no further action necessary' by management and his concerns were dismissed. He was accused of possessing 'anti-authority' values (Ibid) which worked to discredit his complaints.

The Revolutionary Action Committee claimed that Broadmoor was a prison, not a special hospital (The National Archives, 1972-1975, MH 150/872). This was a comparison that had been made by others (Women in Special Hospitals, 1986: 23). The Committee argued that upon entry, individuals lost their right to 'dignity and human rights' (The National Archives, 1972-1975, MH 150/872). They called for 'an immediate, truly impartial review' into decisions that had been made regarding whether patients were released or not. They also called for an independent, public inquiry into the hospital 'where each prisoner may testify with guaranteed immunity from victimisation' (Ibid). They argued that patients should be allowed to sit on hospital committees, along with demanding an end to drug abuse and 'brutality' at the hospital. (Ibid). The allegations and demands outlined by the Committee were dismissed as 'fairy tales' by the hospital and there were even threats to ban 'rebel' relatives from visiting (Ibid).

Papers were submitted recommending Reeve's release in January 1978 and he was interviewed by a member of the Aarvold Committee<sup>41</sup> before a decision was made by the Home Secretary. During this interview, he was asked whether he intended to be 'politically active' upon his release, to which he replied yes (Reeve, 1983: 159). Reeve questioned why this was of any relevance. As Hornstein noted, 'why are doctors so interested in silencing mental patients? What might they say

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<sup>41</sup> The Aarvold Committee was established in order to examine cases which required additional consideration. The Committee was described by Reeve as being 'shrouded in secrecy' (1983: 159).

that psychiatrists find so troubling?’ (2009: 162). The recommendation for release was subsequently rejected with no reasons provided.

In 1980, Reeve was interviewed by another Aarvold representative, and again the recommendation for release was rejected (Reeve, 1983: 168). In preparation for a tribunal, he met with an independent psychiatrist who argued that there was nothing wrong with him and that he should be released immediately (Ibid: 174). However, following the tribunal, Reeve’s release was again blocked by the Home Secretary (Ibid: 183). Instead, it was recommended that he should be transferred to another hospital. Reeve subsequently escaped from Broadmoor. He travelled to Amsterdam and, following a shoplifting, killed a policeman (The National Archives, 1972-1975, MH 150/872). He was sentenced to fifteen years in prison and released on parole in 1992, during which time Britain attempted to extradite him in order to return him to Broadmoor. He challenged this attempted extradition through the European Commission on Human Rights (Cruickshank, 1993: n.p). However, he was returned to Broadmoor in 1997 where he was held for a further five months, before being released.

Cohen argued that each patient at Broadmoor was aware that their fate rested ‘entirely in the hands of the authorities’ (1982: 74). He noted that there was ‘far too little therapy, that the hospital [was] too isolated and that it [was] still too much like a prison’ (Ibid: 51). He also maintained that as psychiatrists working in the hospital were ‘so incompetent’, they had little right to make crucial decisions

regarding the care and treatment of vulnerable individuals (Ibid: 11). The regime at the institution was described as 'crushing' for the patients (Ibid: 83). One relative claimed she was banned from visiting the hospital after she made a list of the drugs her son was being given. If the staff at the hospital were subjected to any criticism, they reacted extremely defensively (Ibid: 71), with the psychiatrists resenting any questioning of their power (Ibid: 87).

Cohen also discussed an incident where a patient attempted to strangle himself at Broadmoor. A group of patients went to his assistance and raised the alarm. However, there was no staff intervention for eight minutes. The following day, the patients timed how long it should have taken staff to arrive, and found it to be around forty-five seconds. This led them to believe that a patient summoning help was not viewed as an emergency (Ibid: 82). Cohen stated that whilst there had been, at the time of writing, eight official reports on special hospitals, no former patients had ever been asked to contribute (Ibid: 73). This was justified through the dismissive view that 'psychiatric patients, in general, [were] not supposed to know what [was] best for them' (Ibid: 73). For Cohen, neglecting the views of patients was 'not just morally wrong-it [was] therapeutically blind' (Ibid: 73). Continuing to disregard their views only worked to further compound the marginalisation that patients were subjected to.

### **‘The Voices of These People Deserve to be Heard’<sup>42</sup>**

Davis and Kidd (2013) detailed the case notes of thirty-seven patients at the West Riding Pauper Lunatic Asylum between 1890 and 1969, where 2,861 patients died. The thirty-seven patients spent over 680 years in the asylum between them. These patients were ‘often without hope of release and not able to speak for themselves’ (Swan, 2013: 3) and it was maintained that ‘the voices of these people deserve to be heard’ (Davis, 2013: 6). It was recognised that there had been an emphasis on ‘containment, management and administration’ within the asylum (Ibid: 7) and that being admitted into an asylum during the nineteenth century was ‘fraught with danger and certainly for some, the beginning of what was in effect an arbitrary life sentence on a locked ward’ (Ibid: 7).

One case examined by Davis and Kidd was that of Thomas Edmondson. Edmondson was regarded as a ‘dangerous and irritable man’ (Davis and Kidd, 2013: 17). He experienced ‘delusions’ and ‘excitement’ and this determined that he would spend the rest of his life in the asylum. He died aged seventy-one, after spending thirty-nine years in the institution (Ibid: 17). Cecily Sedgwick was observed by the medical officer at the asylum to be ‘really quite insane and restless’ and walked around ‘in an insane manner’ (Ibid: 29). She died in the asylum, having spent fifty-nine years incarcerated. John Constantine was both deaf and dumb from birth and was labelled as a ‘dummy patient’ and ‘a fairly good imbecile’. His efforts to speak were noted as ‘rather amusing to observe’ by

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<sup>42</sup> Davis (2013: 6).

staff (Ibid: 31). Constantine spent fifty-five years at the asylum before he died in 1927, aged sixty-five.

Another patient who spent over half a century at the asylum was John Longthorn. It was written in his case notes, 'since the last note this old man has completed his fiftieth year of residence under care and treatment. He shows no change mentally' (Ibid: 47). Longthorn lived in the institution for sixty-one years before he died aged ninety-six (Ibid: 47). Finally, three years into his admission, it was claimed that another patient, Ernest Austin was much brighter and had improved considerably. However, instead of being released, he remained in the asylum for a further fifty years before he died aged eighty (Ibid: 79).

Another case was that of Ethel Wilson. Wilson was admitted into the asylum aged six. It was argued that she was an 'idiot from birth' but that her intelligence levels were 'little less than that of an ignorant child of her years' (Ibid: 23). She would spend twenty years in the asylum before passing away aged twenty-six. Robert Cort spent sixty-nine years at the institution. He was described by staff as 'stupid' and a 'much-demented epileptic', although he only suffered three fits (Ibid: 69). Another patient was George Brewer who spent twenty-seven years at the asylum where it was argued that he 'did not stand a chance. He was there for life and there was not the slightest attempt to treat him...[it] was simply custodial care' (Ibid: 77).



Although the voices of asylum patients have been largely ignored, an insight was provided into what it was like to be part of the 'human wreckage' within the system (Davis, 2013: 7). The cases of these patients provided a 'history of injustice, abuse and denial of basic human rights' (Swan, 2013: 3). They also posed the question of how effective the care and treatment in asylums could really be, when so many patients spent decades of their lives detained within them, supposedly unsuitable for release.

### **Further Allegations and Contentious Deaths**

Following the publication of the book *Sans Everything* in 1967, which alleged that elderly patients were mistreated in both psychiatric and general hospitals, it was argued that an 'intolerable situation' had developed in hospitals (The National Archives, 1967b, MH 150/350). Here, there were 'thousands of ways in which nurses can be made to pay dearly if they dare to raise their voices in criticism' (Ibid). This was apparent in 1969 where, following allegations made in the *News of the World* by a former member of staff at Ely Hospital in Cardiff, an official report was published in 1969 (Department of Health and Social Security, 1969). The allegations involved six members of staff and included 'inhumane and threatening' behaviour, pilfering of items and a lack of concern regarding complaints (Ibid: 1). The report focused on the background of the individual who made the accusations, known as 'XY'. XY was described as an 'outsider' who was 'something of a rolling stone' and held 'a grievance against the world' (Ibid: 8). This response reflected the analysis by Jones (1993: 189) who noted that those

who made accusations were usually labelled as 'outsiders' and thus, a 'pattern was set'. This pattern consisted of former members of staff or relatives of patients accusing staff of 'cruelty and brutality', followed by the accuser being labelled as an 'outsider'. This meant that they could be discredited and their views dismissed (Ibid: 189). As Becker (1963: 1) recognised, an 'outsider' is someone who supposedly cannot be trusted.

XY was also discredited through the suggestion that he/she<sup>43</sup> possessed a questionable work ethic, along with being described as a 'natural critic' (Department of Health and Social Security, 1969: 8). Despite this attempt at discrediting XY, their concerns were not unfounded. It was discovered that one patient 'probably was teased and assaulted' by a member of staff (Ibid: 3). However, due to the 'confused state of evidence', the report recommended that those accused should be acquitted of any charges. It was found that another patient had been subjected to 'undue roughness' and 'struck in the face', however this was not 'out of malice' (Ibid: 122). It was also found that food intended for the patients had been consumed by the staff. A number of other allegations were not investigated as members of staff refused to give evidence. The report recommended the 'complete reconstruction' of the hospital, in addition to relieving the over-crowding apparent within it (Ibid: 13). It was also recommended that sudden deaths within the hospital should be more thoroughly investigated (Ibid: 13).

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<sup>43</sup> It was unclear if 'XY' was a male or female.

Jones (1993: 188) argued that public attention and concern grew regarding the treatment of patients due to cases such as XY. However, by the early 1970s this concern 'subsided as quickly as it had arisen' (Ibid: 190). This again drew attention to the apparent disregard for those who carried the stigma of mental health problems (Cohen et al, 2002: 4). In contrast with the short-lived concern surrounding the inferior treatment of patients, concern surrounding the 'dangerousness' and potential risk of patients to the wider population was significantly longer lasting (Alaszewski, 2003: 195).

Following allegations regarding patient mistreatment at Farleigh Hospital in 1969, the bodies of two former patients were exhumed (The Guardian, 1969a: 1). One of the patients was alleged to have been punched, kneed in the groin, had his head banged against a door and been hit on the head with a piece of wood (Ibid: 6). During a double inquest, it emerged that one had been tied to a toilet and not fed. The same patient had also been given another patient's drugs and had his head 'rammed into a wall' (The Guardian, 1969b: 4). During the subsequent trial of three nurses, it was claimed that they had 'kicked, punched and thrown things' at patients (The Guardian, 1970a: 6). Another patient had been dropped on his back and was kicked as he had gone to bed without washing. It was claimed that one of the nurses involved said that the patients were 'animals' (Ibid: 6). In a rare display of the claims of patients being taken seriously, the three nurses were found guilty of some of the charges brought against them and were each sentenced to between two and three years in prison (The Guardian, 1970b: 5).

In a subsequent public inquiry, a former student nurse claimed to have witnessed the 'slave labour' of patients (The Guardian, 1970c: 4). The nurse resigned due to the treatment of patients. She had attempted to treat the patients with sympathy and kindness but was mocked by other staff members for doing so (Ibid: 9). It was argued by the chief nursing officer at the hospital that the events described at the trial did not happen as outlined in court (The Guardian, 1970d: 5). Even though the accusations had been proven in court, the hospital management still denied them. It was later advised following an inquiry into the ill-treatment of patients at Farleigh that procedures for reporting deaths at the hospital should be reviewed (The National Archives, 1970-1971, BN 13/238).

On February 20<sup>th</sup> 1969, a patient died at South Ockendon Hospital. In March of the same year, the bereaved family's MP, Norman Atkinson, raised concerns regarding the death in the House of Commons. He took this course of action as it was thought that the patient had died as a result of violence and was still unburied (Ezard, 1969: 1). Mirroring issues reflected in the previous chapter, Atkinson noted that the patient's mother had been unable to gather information from the hospital regarding her son's death and she was 'continuing to suffer' (Ibid: 1). She had also not been informed where the inquest was being held. In order to obtain any news or updates regarding the case, the bereaved family was having to follow the local press (The National Archives, 1969-1972, MH 150/359). This, for Atkinson, was 'most inhuman' (Ibid). It emerged that another patient

was to be brought before the 'hospital court' regarding the manslaughter of the patient (The Guardian, 1969c: 6).

It was found that only one nurse was on duty on a ward of fifty-two patients at the time of the death (The National Archives, 1969-1972, MH 150/359). In the light of the media attention following the death, the mother of another patient wrote to the local newspaper and detailed how her son had suffered several injuries whilst at South Ockendon. She asked, 'don't you think it is about time that some sort of inquiry was set up as to the manner in which the patients are treated?' (Ibid). She continued:

I confess I am becoming extremely nervous as to what will eventually happen to my son; after all he was taken to Ockendon to receive special care and attention and it is heartbreaking for all mothers in a similar situation to know that their sons and daughters similarly incapacitated are not treated in a manner in keeping with a civilised country (Ibid).

A third case at the hospital was raised by the mother of another patient who stated that her son had been assaulted by nurses and argued that 'no one takes notice of violence' at the institution (Ibid). A nurse also resigned following allegations of hitting a patient with a brush and whipping patients with a belt (The National Archives, 1972b, MH 150/700). However, it was decided that there was not enough evidence to prosecute the nurse.

In 1972, Peter Dawkins was admitted to South Ockendon. His mother was 'appalled' with the conditions in which her son was held (The National Archives,

1972c, MH 150/704). However, her son's complaints were dismissed as 'the ramblings of a mentally disturbed person' (Ibid). Having attempted to complain to the hospital with no avail, Mrs Dawkins contacted the Recorder of Southend who, when processing Peter through the court system for a prior incident, had recommended he received treatment and not punishment. The Recorder said he had been 'impressed' by the conduct of Mrs Hawkins. He argued that the case was an 'appalling state of affairs' and Mr Dawkins and his mother had been subjected to 'utterly inhumane treatment' (Ibid). Allegations of inadequate care and treatment continued to emerge and the mother of a patient raised complaints that her son had been turned into an animal after his treatment at the institution (Ibid). Further concerns were raised when a patient died at South Ockendon after being found to be covered in bruises. The case was closed, despite 900 people being interviewed (The National Archives, 1972d, MH 150/703).

In an indication of the lack of official interest surrounding suicides within psychiatric hospitals, the Welsh Hospital Board wrote to all Welsh psychiatric hospitals in 1971 and enquired as to their provisions for dealing with suicidal patients (The National Archives, 1971, BD 18/158). One hospital replied stating that they were only aware of one case in the previous thirty years and another replied saying that they could not recall any suicidal patients (Ibid). The physician superintendent at another hospital simply replied, 'I regret to say I have no facilities whatsoever to deal with suicidal or potentially suicidal patients' (Ibid). Another noted that his hospital currently held an eighteen year old suicidal

female. However, the only way they could care for her was to 'regrettably...lock her in the side room'. Whilst acknowledging that this was poor practice, they said that they were 'unable to do anything else' (Ibid).

In 1972, Sophie Greene died at Napsbury Hospital. A post mortem found 'severe and extensive' injuries' (Department of Health and Social Security, 1973: 5). Four nurses were suspended, however no further action was taken against them (Ibid: 5). In the same year, a report was published from a committee of inquiry into allegations made by staff at Whittingham Park Hospital regarding the ill-treatment of patients, fraud and the 'suppression of complaints' (The National Archives, 1969-1973, MH 160/792). The inquiry team heard evidence of 'dishonesty, ill-treatment of patients and disgraceful behaviour on the part of senior and junior members of the staff...but all this was denied by the alleged offenders' (Ibid). Despite this, the inquiry found that the allegations made were 'justified' (Ibid).

An acknowledgement of the fact that those experiencing mental health problems could 'comment meaningfully on their care and surroundings' (Dale, 1972: 5) was reflected in the publication of *Psychiatric Hospitals Viewed by Their Patients* in 1972 (Raphael and Peers, 1972). The views of 2,148 patients were analysed. Patients raised concerns regarding the frequency in seeing their doctor, the lack of information provided by these doctors, the inadequacy of nursing care and their lack of freedom (Ibid: 21). However, these views were explained away by

hospital management as patients having a 'great dependency' on their doctors, while those who stated that they had not been told enough information by their doctors were dismissed as 'forgetting' what had been explained to them (Ibid: 21-22).

It was argued that psychiatric hospitals were being run 'in a country club fashion' during the 1970s (The National Archives, 1973-1976, MH 160/1160) and in 1972, a crown court case was held following an assault on a patient at Farleigh Hospital by two nurses. Both nurses admitted to having drunk large amounts of alcohol in the hours before the incident (The National Archives, 1972-1974, MH 150/821). Both were imprisoned, one for six months and the other for nine months. However, they appealed against their convictions and they were subsequently quashed (The National Archives, 1971-1973, DPP 2/5070).

In 1973, it was claimed that there was a 'conspiracy of silence' surrounding the deaths of ten elderly female patients at Rossendale Hospital (The National Archives, 1975-1976, MH 160/1214). Officials refused to name the staff involved, leading to media interest which questioned why they were not named. Further concerns were raised in 1974 when two members of staff at St Augustine's Hospital spoke out regarding a number of issues including the degrading and humiliating treatment of patients, over-medication, assaults by staff and patients being reduced into 'passive' and 'submissive' beings (South East Thames Regional Health Authority, 1976: 150). However, the two members of staff were met with



‘ridicule’ and ‘dismissive remarks’ by management, including the comment that ‘the contents [of the complaints] are immature’ (Ibid: 149).

In the same year, a coroner requested police intervention related to the suicides of three patients in a week at Warlingham Park Hospital (The National Archives, 1972-1979, MH 160/1333). A year later, two patients were found hanged on the same day at the institution. A subsequent inquiry examined twenty-one suicides over a sixteen-month period at the hospital. During one sitting, a patient travelled to the inquiry and interrupted proceedings to inform them that all of the consultants were present at the inquiry when at that very moment there was an ongoing suicide attempt taking place (Ibid). A former patient said that there were filthy conditions at the hospital and it was a ‘living hell’, with a nurse claiming that the treatment of patients was ‘pitiful’ and ‘pathetic’ (Ibid). The inquiry found that nurses feared being victimised for speaking out which effectively ‘gagged’ them (Ibid).

The inquiry also found that the statistics published regarding the number of deaths of patients were inaccurate and underestimated their actual number (Ibid). The subsequent report into the hospital made fifty-four recommendations including additional staff, improved communication and better record keeping (The National Archives, 1975-1979, MH 154/902). A doctor at the hospital was later suspended after disagreeing with the treatment of patients. Colleagues

alleged that he was mentally ill, however relatives of his patients were reportedly outraged at this suggestion which they believed was a tactic used to discredit him (The National Archives, 1972-1979, MH 160/1333).

In 1975, the report of the Committee on Mentally Abnormal Offenders (Butler Committee) was published. Regional psychiatric secure units were recommended as a 'matter of urgency' throughout England and Wales (Department of Health and Social Security, 1975: 18). Despite the emphasis on hospital closures and community care, £14 million was earmarked for the development of these psychiatric secure units in every region. It was suggested that these units would remove 'mentally disordered individuals' from prisons, relieve open wards of the pressures associated with containing individuals who needed to be in secure facilities and eliminate the overcrowding that was apparent in special hospitals (Bean, 1986: 105). Due to the introduction of these units being a 'matter of urgency', dominant discourses of risk and dangerousness surrounding patients were amplified (Ibid: 105). This further contributed to a 'custodial feel' surrounding mental health provisions (Easton and Piper, 2012: 153).

### **Cover-Ups and Dismissals**

In 1975, Mr S.W. Fish raised concerns regarding the psychiatric department at Bolton General Hospital and the treatment of his partner Mrs Sarah Elizabeth

Ashton, a patient at the hospital (The National Archives, 1975-1978, MH 160/1157). In a letter to the Prime Minister, Fish stated:

She has complained to me each time I have visited her since the 20<sup>th</sup> May 1975 that the staff have assaulted her continually, putting judo on her, dragging her by the neck and hair and slapping her...She shouldn't be in that closed ward at all for incurables. The staff have insulted me continually each time I visit her (Ibid).

Ashton alleged that she had suffered 'barbaric, inhumane and degrading' treatment, which included a member of staff threatening to poison her (Ibid). In response, the hospital found 'no substance' to the allegations and that she was 'mistaken due to her mental condition' (Ibid). Ashton was subsequently released and Fish decided that he would drop the complaints against the staff, due to not wishing to undo the progress made by Ashton since her release. Despite this, planning began for a formal inquiry. In addition, internal investigations were undertaken which resulted in 'some degree of disquiet' (Ibid). Mrs Ashton subsequently attempted to take her own life.

The inquiry was held in private and Mr Lawson, the North-West Regional Secretary of the Confederation of Health Service Employees, criticised the decision to make the inquiry a closed and private affair. A 'private and confidential appendix' to the report contained a consultant psychiatrist's opinion on Mr Fish, despite him not being a patient himself. The report found that there was 'no cause for public anxiety' and there was 'no evidence whatsoever of any

cruelty, violence or other deliberate malicious behaviour towards patients' (Ibid).

It was also found that Mr Fish's evidence was:

Completely unreliable. Not only was there no corroboration of his many allegations but also by reason of the matters set out in a private and confidential appendix attached hereto, we were completely unable to accept his sole testimony. Even though we find that Mr Fish completely and honestly believed what he told us, we have to reject his evidence. In fact, we found that Mr Fish's own conduct during 1975 contributed to the problems into which we were inquiring (Ibid).

Fish's views were subsequently discredited. As Goffman argued, as the 'loyal spouse of a mental patient', he was 'obliged to share some of the discredit' of the stigmatised person to whom he was related (1963: 30). Johnson has also argued that families share the stigma and discrediting felt by their 'down-trodden' relatives (1998: 19). Undeterred, Fish presented a case to the European Commission on Human Rights who found that there was no substance to the allegations, based on the findings of the inquiry (The National Archives, 1975-1978, MH 160/1157).

However, in 1976, it was reported by the *Manchester Evening News* that the police were investigating serious allegations regarding the treatment of patients at the psychiatric department of Bolton General Hospital, some of which occurred on the same ward where Mrs Ashton was held (Ibid). A nurse resigned having refused to work with another nurse who was alleged to have hit two patients. Allegations were also made in relation to the inappropriate administration of medication (Ibid). An internal investigation was unable to uncover anything

definitive regarding the allegations. As a result, the accused nurse was issued with a formal verbal warning regarding his administration of medicine and 'warned to be extremely careful as to his conduct to patients' (Ibid).

In the same year, the hospital management at Prestwich, discussed in Chapter Three, faced further criticism following three 'unusual deaths' in five days. One patient was found hanging, another was found dead in a bath and a further death was caused by a patient striking another patient (The Guardian, 1976: 24). In 1978, an inquiry into the conditions and the standard of patient care at Normansfield Hospital formed a 'very disturbing view' (The National Archives, 1978, HO 343/119). Concerns included open and unattended treatment rooms, a custodial atmosphere and dirty conditions. The issues were all encountered on the final visit by members of a committee of inquiry who had made several previous visits to the hospital due to ongoing concerns. These issues had also been encountered during these prior visits.

The inquiry found that due to the behaviour of some staff, and mismanagement at every managerial level, a 'deeply disturbing' situation had arisen (Ibid). It also found that certain clinical decisions made by staff members should be referred to the General Medical Council and a number of staff members from both Normansfield and the responsible health authorities should be dismissed. In the case of two members of staff, it was recommended that they should not be re-employed in the National Health Service. It was stated that the majority of nurses

were devoted to their tasks and there were 'very few rotten apples' (Ibid). However, no mention was made of attempts to eradicate these rotten apples. Finally, it was noted that prompt publication of the 'unusually forthright' final report was advisable in order to avoid allegations of a cover up (Ibid).

The idea of a 'cover up' was also drawn upon by Townsend who trained as a psychiatric nurse in the 1970s. During his training, he spoke with a patient who was confused about her location. He informed her that she was in hospital, to which the patient replied, 'God. Has it come to this?' (Townsend, 2012: 3). Townsend felt he had announced a death sentence to her within a hospital that 'was the embodiment of evil in bricks and mortar' (Ibid: 3). He noted that by 1978 many patients were being diagnosed as having institutional psychosis which increased their difficulties in being discharged. He also recalled two patients receiving an engraved medal for sixty-five years of 'service'. Townsend noted, 'they were, sadly, delighted. They should have sued' (Ibid: 29).

On one occasion, he maintained that a charge attendant was drunk and the staff resorted to locking him in a side room. He destroyed the room and it was decided by the staff that the blame would be placed on a Ukrainian patient who could not speak English (Ibid: 33). He also recalled staff drinking alcohol on their shift and noted how many different 'corrupt systems' were in existence, including staff stealing money from patients and labelling it as 'tax' (Ibid: 126-127). As has been demonstrated in other cases within this thesis, by speaking out, Townsend risked

becoming 'professionally isolated [where] rumours are circulated about their mental health and counter accusations are made (and often invented) about them' (Hammond, 2014: ix),

John O'Donoghue, a patient in the 1970s and 1980s, first received electro-convulsive therapy when he was sixteen. Writing of his experience as a patient, he noted that 'broken minds' could be made worse by the cures prescribed and that 'the state is not always a place of refuge and protection. Sometimes the state is out to get you' (2012: 98). Furthermore, he recognised that he carried a stigma and a diagnosis, 'a destiny that isn't mine but which has been assigned to me. I'm marked by events, by comments from others and files I have no right to see' (Ibid: 98). O'Donoghue's views were reflected in the work of Banton et al who argued that psychiatric hospitals were 'oppressive, controlling, brutalising, inhuman institutions in which the individuality of patients [was] systematically destroyed' (1985: 20).

Further failings were apparent in 1979 when George Black, an individual with a 'long history' of suicide attempts, took his own life at Saint Clements Hospital and lay undiscovered for ten days (Rusbridger, 1979: 1). A confidential report criticised the hospital's management, along with inadequate staffing levels, whilst also drawing attention to failings surrounding the death of another patient from the same ward (Ibid: 1). In the same year, Charles Mitchell visited his wife at the Severalls Psychiatric Hospital in Essex. He was informed that his wife had

died a month earlier and had been cremated (The Guardian, 1979: 2). Two days later, he was informed that there had been a mistake and his wife had actually died two weeks earlier and had not been cremated (Ibid: 2).

As noted in Chapter One, females were particularly subjugated and marginalised within the mental hospital system. For Ussher, the labelling of female patients as mad silences their voices (1992a: 7). Furthermore, 'speaking out' could further reinforce the label of madness as 'intelligent educated men' used the threat and the label of madness 'very cleverly with no shame' (Ibid: 6). This resulted in females being ignored as 'the rantings of a mad woman [were] irrelevant' (Ibid: 7). However, despite attempts to silence women, the accounts of their detention which emerged were 'lucid, brilliant heartbreaking accounts of their confinements. Incredibly, these heroic women were not broken or silenced by their lengthy sojourns in hell' (Chesler, 2005: 4). An example of this was provided during the 1970s by Jane Pole-Jones who was treated in a psychiatric unit.

Pole-Jones argued that patients found their needs subordinated and were subjected to degrading and humiliating regimes, masked under the cloak of 'treatment'. She stated that she was given 4000mg of Largactil daily, a drug used to treat psychotic disorders, when the normal dose was 400mg for larger men (Pole-Jones, 2006: 20). She noted:

The drugs made me very dry, and I used to ask for water and they used to pour it down the sink in front of me to make me plead and beg for the



water. They used to do the same thing with food. They used to throw it at me and make me grovel on the floor for it. They tried to force you into a position where you have to acknowledge that you are wrong. At one time they got two or three members of staff to rub mashed potato in my hair- it's absolutely unbelievable when you think about it now, and it was cruel. The whole thing was like a nightmare (Ibid: 22).

She also claimed that the doctors often failed to turn up, were not interested or 'looked completely bored' (Ibid: 26). She continued:

When you are in the bin [the hospital] most of the time is spent trying to get to see the doctor, because you go in and then don't see a doctor for weeks and weeks and weeks, and sometimes you actually wonder if you are ever going to see one again (Ibid: 26).

As a 'female giver of knowledge' (Chesler, 2005: 352), Pole-Jones indicated how the female patient was 'rarely treated with kindness or expertise' (Ibid: 5). However, by speaking out, Pole-Jones provided an example of how women's madness narratives could interrupt and challenge psychiatric discourse (Hubert, 2002: 142).

### **'Lifting the Veil'<sup>44</sup> of Oppression**

'Lifting the veil' was the aim of a 1979 television film surrounding the ill-treatment of patients at Rampton (The National Archives, 1979-1980, HO 343/115). The film discussed a patient being kicked down stairs by staff and then subsequently being beaten up as they slept. Further incidents included a patient

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<sup>44</sup> The National Archives (1979-1980, HO 343/115).

who had excrement mixed into their food and another who was made to mop up vomit with their own hair (Ibid). It was alleged that 146 nurses were involved in the mistreatment of patients. A subsequent inquiry found that around 130 of the patients should not have been housed at Rampton and that the lack of public insight into the workings of the institution contributed to the problems (Ibid).

A consultant psychiatrist previously employed at the hospital spoke to *The Observer* in 1980 regarding why he chose to resign from his post after witnessing poor medical care and the mis-treatment of patients (Hawkes, 1980: 4). Dr Neville Hills stated that the hospital did not offer adequate psychiatric care and the atmosphere was closer to a prison than a hospital (Ibid: 4). Following the 1979 documentary, Hills claimed that rather than attempting to reform procedures, staff focused on improving the image of the hospital through favourable publicity and 'carefully controlled' visits from newspapers (Ibid: 4). The 'final straw' for Hills came when he saw a nurse strike a patient. The incident was reported but charges were not brought. Hills stated, 'this made me feel totally useless. If I am not to be believed when I see ill-treatment-and I was one of the six consultants in the hospital-what chance does an ordinary patient have of a complaint being taken seriously?' (Ibid: 4).

The subsequent *Report of the Review of Rampton Hospital* found overcrowding, a lack of professional leadership and 'inflexible' regimes that placed too much focus on 'rigid disciplinary rules' (Department of Health and Social Security, 1980:

18-22). Rampton was described as 'a closed and secretive institution' that was in need of a more open management style (Ibid: 22). It was suggested that a higher level of priority should be given to meeting the needs of the relatives of the patients, with easy access provided to any information they required (Ibid: 132).

Following these findings, the press focused repeatedly on the hospital, asking 'how we can call ourselves a civilised nation' when such levels of 'beatings, torture and humiliation' can be inflicted on some of the most vulnerable members of society (The National Archives, 1979-1980, HO 343/115). It was later revealed that *The Observer* had successfully challenged a judge's order which had banned all reporting related to allegations of abuse at the hospital. A nurse was convicted of four counts of ill-treatment, which included punching patients and threatening to lock up a patient if he complained. This nurse was given a suspended sentence. Another nurse at the hospital was also given a suspended sentence after being convicted of three counts of striking patients (State Research Bulletin, 1982: 164). It was also revealed that twenty nurses were originally charged with the ill-treatment of patients. However, the only publicly reported case was a nurse who was convicted of breaking a patient's jaw (Ibid: 164).

The Prison Officers Association twice attempted to prevent reporting on the convictions. *The Observer* revealed that Rampton subsequently punished the patients by restricting their privileges, including visits from relatives. This was

designed to 'remind patients of the consequences of lodging complaints or testifying against nurses at the hospital' (Ibid: 164). It therefore appeared that the regimes at Rampton were as 'militant, powerful and as violent' as those at Broadmoor (Ibid: 165).

The aftermath of the case 'tightened the grip of the state on information coming out of the special hospitals [and] mental hospitals' (Ibid: 164). As a Rampton patient argued, 'nothing ever seems to happen to the staff: they can humiliate you, make your life a misery but nothing ever happens to them' (Lloyd, 1995, cited in Lloyd, 2005: 227). The patient continued, 'they say if you can survive Rampton, you can survive anything' (Ibid: 227).

In 1980, a nurse at Brookwood Hospital was struck off after being found to be overdosing patients (The National Archives, 1978-1981, DT 16/604). A report was published by Surrey Area Health Authority in the same year following an investigation into the care and treatment of patients at Brookwood, including staff physically and verbally abusing the patients (Ibid). A nurse had also been struck off for assaulting patients (Ibid). In the same year, a verdict of unlawful killing was also recorded after a patient at Chase Farm Hospital was put in a bath of scalding water by two nurses (The Guardian, 1980: 3). The patient, Catherine Bell, died from bronchial pneumonia caused by burns. There were inconsistencies in the evidence provided by the two nurses involved and half-way through the inquest there was an adjournment when the coroner advised that the nurses

should be informed about the dangers of perjury and 'then maybe we can find out the truth about this matter' (Ibid: 3). The two nurses were charged with manslaughter and with making false statements at the inquest and it was argued that the incident had been covered up (Chorlton, 1981: 4). However, both nurses were cleared of the charges.

### **Challenges From Below**

In the 1970s there was further growing criticism of psychiatry and this helped to promote the development of a psychiatric survivors movement (Busfield, 2011: 118). This movement was influenced by the criticisms of the system put forward by anti-psychiatrists. The aim of the movement was for the better treatment of patients and for their voices to be heard (Ibid: 118). There was also a growth in organisations that aimed to give a 'voice' to those who had been oppressed, based on the 'strong civil and human rights movement' that had emerged which was 'appalled at the often inhumane and corrupt psychiatric services' (Hudson, 1999: 136). In 1981, INQUEST was founded. The formation of INQUEST was the 'product of a particular radical moment' (Ryan, 2004: 23). The organisation was 'driven from below' (Ibid: 25) and undertook policy and campaigning work, whilst focusing on assisting families 'piece together the circumstances that surrounded the death that has transformed their grief into anger' (Ibid: 1).

A further group established was Women in Special Hospitals (WISH) in 1987, which aimed to challenge the 'appalling and degrading' treatment of women (Women In Special Hospitals, n.d). They argued that women were 'incarcerated unjustly and inhumanly incarcerated' in special hospitals, whilst aiming to promote the voices of females at both local and policy level (Women in Special Hospitals, 1986: 23). The group has worked to ensure that women have ceased to be 'invisible' within special hospitals (McCabe, 1996: 28), in addition to challenging the 'long silence over the unspoken 'she' of psychiatry' (Allen, 1986: 87). Other groups that would later be established included the United Family and Friends Campaign which was founded in 1997 and 4WardEver in 2006 who assist family campaigners in their fight for justice. For Ryan and Sim:

The radical orientation of these groups, and, crucially, their adoption of a theoretical and political perspective that focused on issues of power and powerlessness, ensured that a different, more challenging and more critical series of questions began to be asked about deaths in custody (2007: 704).

Similarly to the Alleged Lunatics' Friend Society, discussed in Chapter One, as a counter-hegemonic organisation INQUEST had a 'precarious existence', they were 'always in danger of being confined to the margins, of being defined out' (Ibid: 135). Despite this, INQUEST, and other groups such as WISH, through their campaigning, research and policy work 'forced into the public arena' issues that had been widely neglected (Sim et al, 1987: 14). In turn, they:

Made clear the lack of redress afforded to relatives both because of the unsatisfactory and largely unaccountable practices of the coroners courts and because it has proved impossible to obtain even the most basic information about how their relative or friend died (Ibid: 14-15).

In 1981, it was reported that the rate of suicides involving detained patients was rising rapidly, with the rate of patient suicide doubling since the 1950s (Durisch 1981: 5). In the same year, a coroner called for the closure of the psychiatric unit at the Queen Elizabeth Hospital following the deaths of a number of patients (The Guardian, 1981a: 4). It was found that resources were so inadequate that, at times, only one student nurse had been on duty (The Guardian, 1981b: 3). The family of one of the deceased patients threatened legal action unless an inquiry was conducted into the deaths (Cook, 1981: 3). It was later decided that no inquiry would be conducted, and instead, consideration was to be given into re-opening the unit in order to save money (The Guardian, 1982: 3).

Ingleby noted that in Great Britain, before the introduction of the Mental Health Act in 1983, one in nine men and one in six women could expect to enter a mental hospital (Ingleby, 2004: 7). This was indicative of the link between 'madness and womanhood' (Ussher, 1992a: 64), where women were at the bottom of the asylum hierarchy and were 'primary victims of the asylum' (Breggin, 1993: 399-403). As Coppock argued, the mental health system is designed by men. This poses the question of 'how it is possible for mental health services to be truly gender sensitive when such an imbalance exists' (2008: 99). Lloyd noted the numerous subtle ways in which the gender imbalance was also apparent such as the tendency for males to be included first in documents that detailed the numbers of patients. This was indicative of the wider response to females within the system (1995: 229). Changes in areas such as psychiatric theory and public

policy also failed to challenge this imbalance of gender and power 'that has kept madness a female malady' (Showalter, 1987: 19).

With the introduction of the Mental Health Act in 1983, the Mental Health Act Commission was established which was responsible for monitoring its operation in England and Wales. Commissioners could conduct unannounced visits to mental health facilities in order to check compliance with the Act. They could also interview detained patients, conduct checks on their records and examine their care (McMurrin et al, 2012: 182). The Act was praised for reducing the discrimination that had 'dominated' mental health law in the past (Glover-Thomas, 2002: 36). However, Szumukler argued that the Act actually discriminated against people with mental health problems, assuming that these individuals were dangerous, whilst emphasising the negative stereotypes and labels already in existence (2010: n.p).

In 1985, the issue of race in relation to deaths in psychiatric detention was the focus of an inquiry into the death of Michael Martin, a black patient at Broadmoor (Ritchie, 1985). On the day of his death in 1984, he was described by staff as appearing depressed and began to abuse other patients before attempting to assault a nurse. Several nurses restrained him. A charge nurse decided that he should be moved to another ward and given a sedative injection. Subsequently, a member of staff noted that his position had not moved for fifty minutes. On entering the room, he was found to be lifeless (Ibid: 6-7). The post-mortem



examination found deep bruising around his neck, which the inquiry believed was from a nurse holding his arm across his neck when he was being restrained. The cause of death was the aspiration of vomit (Ibid: 7).

The inquiry into his death found that Martin had a history of mental health problems and had attempted to attack staff and patients between twenty and thirty times. The inquiry found that his move from a local hospital to Broadmoor had been a 'shattering experience' for both him and his mother (Ibid: 2). Furthermore, the inquiry noted that the responsible medical officer had 'avoided communication' with his mother (Ibid: 2). It was also recognised that she was distressed by the 'impersonal and formal' way that condolences were offered to her by the hospital (Ibid: 3). She found staff to be 'hostile' towards her and had been left feeling bitter and resentful (Ibid: 3). During the inquest it was claimed that Broadmoor beatings were routine (The Guardian, 1984: 2).

In 1987, it was found that Nottingham District Health Authority failed to provide adequate management at the Mapperley Hospital where seven patients had committed suicide over a three-month period (The Guardian, 1987: 6). In the same year, the Mental Health Act Commission's Second Biennial Report found that in some responses to complaints made by patients there was a:

Disturbing tendency to portray the patient's perception of events as tainted by emotional disturbance, undue sensitivity or mental disorder. Such attitudes prejudice any chance of a fair enquiry by treating complaints

as probable figments rather than justifiable grievances worthy of full investigation (1987: 14).

Again, this was not a contemporary issue as similarities could be drawn here with the case of Throphimus Fulljames, discussed in the previous chapter, whose concerns were dismissed due to his 'delusionality' (Wise, 2014: 226). Further examples of the negative response to patients was revealed by the Community Psychiatric Nurses' Association (CPNA) in 1988. A patient argued, 'we are treated like sheep, not thinking human beings' (1988: 8). Another patient noted, 'I read a notice once which said 'how to deal with awkward patients'. I've never seen one which said 'how to deal with nurses who get awkward'. Being treated like this makes you feel worse, staff get away with it but we can't' (Ibid: 8).

Penfold and Walker recognised that 'psychiatry is an institution in a society in which women are oppressed' (1983: vi). This response resulted in psychiatric hospitals being 'very unsafe places for women to be' (Johnstone, 2000: 117).

Therefore:

Where women are concerned, most psychiatric theories and practices validate the male as prototype, legitimize women's second-class status as male property, validate dominant-subordinate relationships between men and women...Thus, psychiatry is a very powerful force towards preserving a situation which works for the material gain of men (Ibid: 244).

The autobiographical account of Barbara Taylor challenged the oppression of women that psychiatry practice has contributed to (Smith and David 1975: v).

Taylor, who was a patient during the 1980s, found wards ‘crackling with tension’ and patients who ‘hadn’t had a conversation in thirty years’ (2014: 128). She detailed cases of both the abuse and rape of patients (Ibid: 161-162) and also claimed that friendships between patients were discouraged by staff (Ibid: 149). Through her account, Taylor challenged dominant discourses surrounding the psychiatric system and contributed to alternative truths and knowledge emerging regarding the experiences of patients within the system.

#### **Into the 1990s: ‘A Transparent Attempt to Deflect Concerned Public Scrutiny’<sup>45</sup>**

In the new decade, cases continued to emerge regarding failings following the deaths of patients. An example of this was seventy-year-old Bridget Brosnan who died at the psychiatric ward at the Lister Hospital in 1990. The coroner found that she died as a result of unlawful killing, with the cause of death being asphyxiation (Boseley, 1991: 3). She had bruises consistent with being forcibly restrained, with defence marks on her face and neck. She had been heavily sedated, with enough of the drug Prothiaden in her system to have caused her death (Ibid: 3). A murder inquiry ensued and three nurses were arrested. It was later decided that there was not enough evidence to charge them with murder or manslaughter, however two nurses pleaded guilty to conspiracy to pervert the course of justice (Ibid: 3). Both nurses received suspended sentences. The court heard that the nurses had changed their stories, from finding the patient in bed having suffered a heart

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<sup>45</sup> Brindle (1992a: 2).

attack, to finding her hanging. The following year, an inquest into the death of another patient at the same hospital demanded 'big improvements' regarding staffing and security (Linton, 1992: 10). It later emerged that the hospital had called in two mental health experts to assist with the number of suicide attempts at the hospital (Boseley, 1992: 6).

Broadmoor found itself subject to more criticism in 1991 when an inquiry into the death of another black patient, Orville Blackwood, argued that there had been little change in the way the hospital handled the unexpected deaths of patients. Blackwood was the third black patient to die in contentious circumstances in seven years at the hospital. The inquiry team expressed their concerns regarding the reaction of the Prison Officers Association who put 'considerable pressure' on the nursing staff not to take part in the inquiry (Prins, 1993: 3). The family felt there was a lack of remorse shown by staff and that there had been a 'cover-up' (Ibid: 32).

On the day of his death, Blackwood voluntarily went to a seclusion room. It was decided by staff that he should be medicated. When the doctor entered the room (along with other staff), Blackwood allegedly attempted to punch him and was restrained by nursing staff (Ibid: 29). The inquiry team attempted to determine whether any warning was given before the group entered the room, or if any reassurance was offered, but this was unclear. It was concluded that it was potentially the case that a large group of staff had unexpectedly entered the

room. The decision was made to inject the patient with two drugs. It was noticed that he was not moving and appeared to have stopped breathing. Attempts to resuscitate him followed, with no success (Ibid: 30).

Arriving at the mortuary, Blackwood's mother was shown her son's body and claimed that she could see other bodies clearly within the refrigerator. The inquiry team felt this sounded 'like the stuff of fictional television drama' and decided to visit the mortuary themselves. The team were 'disturbed' to find it exactly as she had described (Ibid: 32). They argued that this was 'unbelievably insensitive' and suggested that the guidelines should be reconsidered urgently (Ibid: 32). The inquiry team stated, 'we have heard as many theories as we have seen experts. The worrying aspect of this is that so many distinguished authorities simply did not *know*; they were simply speculating' (Ibid: 43 emphasis in original). It was suggested that one of the drugs may have accidentally been injected into a vein, instead of muscle, and a drug that was supposed to take effect over one to four weeks had actually been given in minutes (Ibid: 43-44).

The inquiry recommended that when a member of staff had been assaulted or attacked by a patient, they should not be involved in making immediate decisions to change the patient's treatment. Furthermore, urgent action was recommended regarding the introduction of training related to the control of violent incidents, without using physical restraint as a first resort (Ibid: 77-78). It

was also recommended that the hospital develop clear procedures regarding informing relatives of the death of a patient (Ibid: 79).

Another contentious death was that of Paul Merrell who hanged himself in 1991 at the Littlemore Hospital in Oxford. He was one of four patients who had died suddenly in hospitals in the area over a nine-month period (Brindle, 1991a: 3). Before his death, he was regarded as being in the highest risk group of suicide. However, he was not placed on even the lowest of four levels of observation and his movement was unrestricted (Ibid: 3). An inquiry into this spate of deaths found that there needed to be more support in place for patients (Brindle, 1992a: 2). The father of one of the patients stated that the decision to publish the findings of the inquiry on the government's 'budget day' was 'a transparent attempt' to deflect and divert attention away from the failings and issues apparent, thus avoiding public scrutiny (Ibid: 2).

In 1992, Bryan Marsh, a patient at Rampton, died. Marsh suffered a heart attack following an incident with a nurse where he was restrained. Five nurses were later suspended and nine were arrested, following a second post-mortem arranged by the family's solicitor (Mills, 1992: n.p). However, a prosecution was not successful (Gunn and Maden, 1999: 8). Despite this, an inquiry into the circumstances surrounding this incident found that it had been 'badly handled, that staff were evasive in giving evidence, that training for, and use of control and restraint techniques were deficient and that senior managers had mishandled the

aftermath of the incident' (Kaye and Franey, 1998: 232). However, Rampton and Broadmoor were not be the only special hospitals to be criticised for their inferior practices, as the 1992 Ashworth Hospital inquiry would expose.

### **The Ashworth Inquiry**

In 1992, an inquiry into the care and treatment provided at Ashworth hospital examined the cases of several patients where there was 'failure upon failure to care for, and treat [them] properly' (The National Archives, 1992a, JA 7/62). Sean Walton, who had been admitted to the hospital in 1983 aged fifteen, died unexpectedly in seclusion in 1988, following an assault by a member of the nursing staff. The inquiry found that the member of staff 'acted disgracefully' (Ibid). Furthermore, there was a lack of observation and communication, and the inquiry team found it 'lamentable' that one of those involved in performing CPR was not adequately trained. The inquiry also criticised the doctor who undertook the post-mortem for producing a 'remarkably uninformative' post-mortem report (Ibid). The inquiry argued that 'every death in custody should be treated with suspicion', and that each death should be examined with 'meticulous care and thoroughness' (Ibid).

The second case concerned was that of Geoffrey Steele who was 'physically abused and maltreated' (The National Archives, 1992b, JA 7/72). Nursing staff were criticised for acting unprofessionally and for participating in assaulting Steele and then blaming him for easily bruising (The National Archives, 1992c, JA

7/73). The inquiry stated that the nursing staff had acted in an 'inhumane and degrading way' (The National Archives, 1992a, JA 7/62). They also 'felt quite unable to accept the accounts by staff' (The National Archives, 1992c, JA 7/73). Furthermore, one of the nursing staff involved had attempted to 'cover up his unprofessional conduct', while another who had 'participated' in the assault 'was not a very convincing witness' (Ibid). The inquiry found that a nurse who did not participate in the inappropriate behaviour 'ploughed a lonely furrow in her determination to act professionally'. She was 'ostracised' by the other staff and was moved away from ward duties by management (Ibid).

Another patient was Gary Harrington who hanged himself at the hospital (Ibid). The inquiry found Harrington was one of a number of patients who had hanged himself in similar circumstances and that his death was both predictable and preventable (The National Archives, 1992a, JA 7/62). The inquiry criticised the fact that his family was only informed of his death when a family member telephoned the hospital to enquire about him (The National Archives, 1992c, JA 7/63). The inquiry uncovered notes from a doctor which claimed that 'the family, especially the mother, are a problem, very demanding and may make allegations of neglect and seek legal action against the hospital' (The National Archives, 1992b, JA 7/72).

There was an 'almost overwhelming' list of complaints provided by the patients at Ashworth (The National Archives, 1992d, JA 7/68). The concerns that



repeatedly arose included physical abuse and assault, seclusion, intimidation, victimisation and the theft of possessions (The National Archives, 1992b, JA 7/72). Certain wards and staff members were referred to multiple times within letters from patients. The inquiry also examined the way in which complaints were managed, including a case where a patient alleged that staff had made his life 'a misery' and another case related to allegations of racial abuse (ibid). There was 'a flawed system for handling patient-complaints' and complaints were 'mishandled from start to finish' (ibid). There was an attitude of 'disbelief' towards patient complaints, coupled with a 'total denial' demonstrated by nurses (The National Archives, 1992e, JA 7/64). In some cases, the management of complaints failed to protect the human rights of the patient (ibid). It was also found that of six-hundred complaints made by patients over the previous ten years at Ashworth, not one had been upheld (Lloyd, 2005: 228). Newspaper coverage of the inquiry also provided examples of the 'repressive and intimidating culture' at Ashworth (Brindle, 1992b: 1). One such example was a pigs head being used by staff to scare patients. It was also reported that staff at the hospital who spoke out risked death threats (Brindle, 1992c: 3).

It was found that the hospital delayed, rather than encouraged, family members to participate in their relative's care (The National Archives, 1992a, JA 7/67). Furthermore, there was an 'abundance of evidence' concerning the disadvantages families faced when attempting to obtain information about how

and why their relative had died (The National Archives, 1992f, JA 7/67). Deborah Coles of INQUEST gave evidence to the inquiry. She argued that:

Families' experiences are characterized by lack of information, secrecy and often what they feel is indifference by the authorities and by the institution in which the deceased has died. They have a desperate desire to know the circumstances of the death and to find out what has actually happened. What they feel is that they face a wall of silence. The system of finding out what happened is totally inaccessible...the other key thing about deaths in custody is that because the nature of custodial institutions families often have very limited access to people in special hospitals and are often kept at arm's length throughout that person's detention. This causes tremendous distress and confusion, to find out that somebody has died and to be given no information. They find they have little information during the period of detention and this is made worse after the death when they are told absolutely nothing (Coles, 1992, cited in Ryan, 2004: 94).

As a result of the concerns raised, the inquiry suggested that a more 'participatory role' should be developed regarding the involvement of families in the coroners court (The National Archives, 1992f, JA 7/67). The inquiry stated that it had held back on further suggestions for reform due to legislative changes that were ongoing at the time. It was envisioned that families would have greater access to records and be able to 'probe' inquest evidence (Ibid). This meant that 'no longer can it be said that the veil of secrecy will attend the antiquity of the jurisdiction of coroners courts' (Ibid).

The Ashworth inquiry also provided an insight into the continued subordination, marginalisation and silencing of female patients. This was particularly the case for women who, in special hospitals, were 'powerless, infantilised [and]

degraded' (Lloyd, 1995: 199). The inquiry found that the environment at Ashworth was 'macho' and the needs of female patients required 'thorough review' (The National Archives, 1992g, JA 7/63). It also indicated that the regime for women at Ashworth was 'demeaning and anti-therapeutic' (Ibid). Women at the hospital were 'almost constantly emotionally abused and at times physically abused...they [felt] chronically frightened and overwhelmingly powerless' (McCabe, 1996: 28). As a result, 'special hospitals [were] not appropriate places for treatment for the overwhelming majority of women' (Ibid: 29). In medium secure units where men and women lived together, there was constant harassment and fear and, in at least one unit, women were issued with rape alarms (Ibid: 29).

For McCabe, 'women rapidly become institutionalised and can expect to be in a special hospital for several years; this and the inevitable stigma, makes rehabilitation extremely difficult' (Ibid: 29). This stigma did not end when a woman left hospital as, 'in the eyes of the public, simply having been in a special hospital makes a woman very dangerous' (Ibid: 29). Therefore, until services met the needs of women, they would continue 'to have their needs only partially met; at worst, to be further harmed by the very system that is set up to help them' (Ibid: 30).

### **Further Disillusionment and Ashworth Revisited**

In 1993, Mary O'Hagan examined the experiences of psychiatric patients in various parts of the world. O'Hagan had been a patient and during her time in psychiatric detention felt that her hospital bed was her 'raft to nowhere' (1993: 7). Speaking with other patients, she found that many had been 'neglected and oppressed' (Ibid: 10). She drew upon the experience of a patient who had been told that the hospital where he was detained had an open-door policy. However, on numerous occasions, the staff refused to see him. He subsequently removed the door and took it to staff 'to ensure the ward had a genuine open door policy' (Ibid: 13). He was told by staff that he had taken this course of action because he was mad. The patient found this 'very demeaning' (Ibid: 13).

O'Hagan argued that all of the individuals she had spoken to felt 'devalued' by the psychiatric system which resulted in them being placed into a 'very passive, disempowered role', with the use of drugs rendering patients into 'internal straitjacket[s]' (Ibid: 14-15). She argued, 'we get the message from the system and society that our psychiatric experience has no value' (Ibid: 10). Rogers et al also examined the views of patients. Numerous examples of poor nursing practice were uncovered. Nurses were described as 'evil' and 'dictators' (1993: 44), whilst patients were treated in a 'sub-human' manner (Ibid: 44-45). Of 463 patients surveyed, nearly 40% found their psychiatrist's attitude to be 'unhelpful' or 'very unhelpful' (Ibid: 48). Psychiatrists were also described by patients as 'godly' and 'condescending' (Ibid: 149).

In 1993, a nurse was suspended after a patient jumped into a bath and suffered burns at Stallington Hospital (Clouston, 1993: 4). Seven members of staff were either dismissed or disciplined following the death of another patient on the same ward who drowned in her own vomit after being tied to a toilet (Ibid: 4). Two nurses were charged with ill-treatment and attempting to pervert the course of justice and another with conspiracy to pervert the course of justice (Ibid: 4). They were later acquitted. The following year it was reported that managers of psychiatric hospitals within the North West London Mental Health Trust ignored 'disturbing' shortcomings involving patient care which may have contributed to the deaths of fourteen psychiatric patients (Brindle, 1994: 2). It was also reported that one death a week was caused by powerful tranquillisers and other drugs being given in psychiatric wards and in the community, yet the issue remained largely unchallenged (Mihill, 1994: 4). As Crepaz-Keay argued, few doctors were prepared to acknowledge that the negative effects of drugs were as likely to occur as the 'so called' therapeutic effects (1999: 91).

It was also reported in 1994 that there had been two deaths within a six-week period at the private Kneesworth House Hospital, amid allegations of staff brutality and the excessive use of drugs (Gould, 1994: 3). The first of these deaths was a patient who had allegedly choked to death during a struggle with staff. The second death was said to have been caused by an over-prescription of drugs (Ibid: 3). It was later noted that there had been more contentious deaths at Kneesworth House and inspectors had raised serious concerns surrounding the hospital,

including the use of drugs as a 'management tool' (Gould, 1995: 6). In 1996 a further patient died, leading the then Shadow Health Secretary to call for a public inquiry into the hospital (Gould, 1996: 4). This did not occur.

The 'prejudice and oppression' related to women's treatment within the psychiatric system continued, as did the challenges to this negative response (Stang Dahl and Snare, 1978: 11). This challenge was achieved, in part, due to the continued emergence of first-hand accounts. Lloyd drew upon the experience of a female patient who, after setting her clothes on fire, heard the paramedic say, 'she can't even do this properly. She'll be out in a couple of hours to try again' (Lloyd, 1995, cited in Lloyd, 2005: 235). A further example of the oppression of patients was demonstrated by Grobe who argued:

In addition to surviving our 'madness' we've had to survive the 'treatment' of our 'madness': The solitary cells, the padded rooms, the restraints, the jackets; the forced injections, treatments without consent, commitments against our will; the drugs, electric currents, brain damage; the side effects, broken teeth, spinal injuries, disabilities, deaths, unclaimed bodies buried under numbered plates; the sexual assaults, physical abuse, rapes; the patronizing attitudes, stigmatizing labels, discrimination, invasions of privacy, ostracism, isolation, alienation. The coercion. The scapegoating. The lies that are told against us, the truths that go unheard because we are 'paranoid'; the absence of civil rights, human rights, justice. The mangling of mind, body spirit; the broken parts that never get fixed, the broken lives, the parts forever lost. The pain. The suffering. The world's rejection (1995b: vii).

In 1995, the Mental Health Act Commission found that 'too little' had been done to prevent patient suicides at a number of different hospitals and a 'good many'

could have been prevented (Brindle, 1995: 10). The Commission recommended increased training in risk assessment and management. They recommended that there should be an increased focus on the risks faced by patients, as opposed to a focus on the risk that patients posed to others (Ibid: 10). It was also noted that when a patient died, hospital trusts had failed to conduct investigations and, in the case of contentious deaths, appoint an independent assessor to examine the case (Ibid: 10).

Claims by former patients that drugs and alcohol were being misused in the Personality Disorder Unit at Ashworth, along with financial irregularities, paedophilia and pornography were the catalyst to a second report into the hospital. Prior to the publication of this report in 1999, a negative reputation had already emerged regarding the hospital. This was in part due to the 1992 report discussed earlier in this chapter, coupled with newspaper reports of the hospital, one of which branded doctors at the hospital 'revolting' (The National Archives, 1997-1998, JA 2/12). The report found that the accusations were 'largely accurate' (The National Archives, 1999, JA 2/82) and that there were unsatisfactory structures of accountability (The National Archives, 1999 JA2/82; Fallon, 1999: 10). The role of the patient care team was 'inconsistent, vague, fragmented, uncoordinated [and] poorly recorded' (Fallon, 1999: 110). Additionally, 'incident recording and reporting was poor and in many cases non-existent and therefore gave a misleading view that all was well' (Ibid: 111). Disturbances that had taken place were a result of the inappropriate mix of

patients, along with a lack of direction from the management team and poor staff morale at the hospital (Ibid: 112).

The report made fifty-eight recommendations. This included Ashworth reviewing its controls over prescribed drugs to ensure that the risk of nurses becoming involved in their illegal distribution was avoided (Ibid: 216). It also recommended that the institution should be closed at the earliest opportunity, as there was 'no confidence in the ability of Ashworth Hospital to flourish under any management' (Ibid: 10). Finally, it acknowledged that 'now [was] the time to grasp the nettle and replace the system we have found to be so fundamentally flawed with one which will serve patients, staff and the public far better' (Ibid: 10).

### **Controversies and Contentions in the Twenty-First Century**

Following the second report on Ashworth, Holmes and Dunne (1999: 2) argued that:

The current system [had] come to be characterised by treatments that can harm rather than help, by 'experts' who seem to be on a different planet to the 'patients', by systems that sometimes crush people who are different, by categorising, monitoring and removing people, and by coercion rather than care (1999:2).

Furthermore, it was also stated that:

It [was] an indictment of the present mental health system that many emerge feeling weak, flawed or that our opinions are no longer trusted. We



feel stigmatised and judged by the system. We are seen as different from normal people and will always be treated this way (Hudson, 1999: 146).

Unless improvements occurred related to inequalities within mental health services, it was argued these services would remain 'unsafe, ineffective, oppressive and wasteful of human and financial resources' (Williams, 1999: 29). For Beresford and Croft, 'contradictions and complexities' dominated mental health policy and provisions at the beginning of the new millennium (2001: 12). During this time, psychiatry was described as being in a state of 'transition and confusion' (Johnstone, 2000: 163). Despite this, psychiatrists and the medical model still dominated treatment. However, it also continued to be widely contested. Busfield argued that this was for a number of reasons, including the fact that psychiatric practice had been 'inhuman and inappropriate-seeking to control individuals rather than help them' (2011: 106).

For Johnstone, the 'biggest challenge' to traditional psychiatry was the service user/survivor movement that was growing in strength, campaigning not only for an improved system but for a radically new one (2000: 164). An example of this was the National Survivor User Network for Mental Health (NSUN) which aimed to 'bring mental health service users and survivors together to communicate, feel supported and have the power and the platform from which to have direct influence at every level' (National Survivor User Network, n.d). Organisations such as NSUN, along with groups including patient councils, 'challenge[d] the psychiatric empire' and the prevalence of the 'I am God' syndrome possessed by

doctors (Hudson, 1999: 144-145). In turn, they attempted to create alternative truths which challenged dominant voices within the system. These challenges were vital as it was found in 2001 that approximately 1,300 psychiatric patients had killed themselves between 1995 and 2000 which could have been prevented (Carvel, 2001: 6).

Despite a five-year campaign by the Royal College of Psychiatrists aimed at increasing public and professional understanding of mental health problems, there were still significant levels of discrimination within the system (Crisp et al, 2000: 7). The enduring stigma attached to those with mental health problems was apparent, with patients often being viewed as 'violent, irresponsible, incapable of making meaningful decisions, or unable to care for themselves' (Linhorst, 2005: 300). It was therefore still apparent that the attitudes towards those with mental health problems were characterised by fear, hostility, aloofness, suspicion, and dread...the mentally ill [were] society's lepers' (Rosenhan, 1973: 255).

In an example of the 'insurrection of subjugated knowledge' (Foucault, 2003a: 7), a video was released in 2000 which contained extracts from fifty interviews<sup>46</sup> with former asylum patients from 1925-1985 (Mental Health Media, 2000). Patients provided harrowing accounts of their time in detention:

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<sup>46</sup> Over two-hundred hours of footage is available at the British Library (Shelfmark: C905 Mental Health Testimony).

- One of the former patients interviewed noted, '[they are] experiences I would rather have not had...but I want to use them...if they are of value to anyone else'.
- Another said that 'nothing prepared them' for asylum life. A further former patient argued that life within the asylum was 'just existing...no other word for it'.
- A former patient noted, 'you was just put down what the psychiatrists thought you was...an imbecile, a mental defective and feeble-minded'. However, another argued, 'I know more than any psycho-surgeon or neurosurgeon...they might know what it is to operate on someone but I know what it feels like to be operated on'.
- Another argued, 'if someone would have sat me down and said 'look...what I want to do is drill two holes in your skull, shove needles in your brain, rods in your brain, electric shock and burn it out...'. I don't think there's any lunatic that would say yes to that is there?'.
- Another former patient said, 'they [the staff] get a wet bath towel, put it under [the] cold water tap, twist it and hit you with it...another one is to get the key chains round your throat and throttle you with it...but they know how far to go'.
- For another, 'they kill people inside the building and landscape the outsides to make it look like heaven'.

- With regards to what could have been done to improve their care and treatment, 'a lot of understanding, a lot of care and talking...compassion, care, understanding' was the suggestion.
- One of the former patients concluded, 'some people today, when I tell them about it, they say 'you want to try and forget about it'...but you can't forget 46 years of your life' (Ibid).

### **Race, Racism and Death**

In 2003, the *Independent Inquiry into the Death of David Bennett* was published (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003). Bennett was Afro-Caribbean and had been receiving treatment for mental health problems for eighteen years before his death at the Norvic Clinic in 1998. On the evening of his death, he had been involved in an incident with a fellow patient and was removed to another ward. He hit a nurse, and during a struggle he was held down on the floor and died (Ibid: 2). The inquiry examined a number of areas, including the care and treatment that he received, the compliance with statutory obligations and communication with his family. It found that the decision to move him from his ward following the incident was not 'handled with sufficient care and sensitivity' (Ibid: 25). There were also 'errors and misjudgements' on the part of the staff (Ibid: 27). Furthermore, the restraint used was deemed to have been 'mishandled' (Ibid: 28).

His death was reported to the police at 00:40 on October 31st 1998. The police advised the clinic staff not to inform the family of his death, which they heard about nine hours later. The inquiry stated that 'we regard the behaviour of both the Trust and the police with dismay' (Ibid: 31). It also found that there was 'no coherent pattern' or plan for treating his needs, including ethnic, cultural, social and spiritual requirements (Ibid: 30). This led the inquiry to argue that if 'the National Health Service does not look at the whole man or woman, as the case may be, it is failing in its duty' (Ibid: 30).

The inquiry made twenty-two recommendations, including that all of those who worked in mental health services should receive training in cultural awareness (Ibid: 67). It also recommended that 'under no circumstances' should patients be restrained for longer than three minutes (Ibid: 67). It was argued that the Department of Health should collect and publish annual data on the number of deaths of psychiatric patients and that procedures surrounding the internal inquiries by hospital trusts following deaths should be reviewed (Ibid: 67).

As Patel and Fatimilehin argued, the lack of understanding regarding the experiences of black and minority ethnic people was an indication of the positioning of these groups within the system (1999: 62-63). Furthermore, the 'overwhelming bias' regarding the use of traditional, western methods of practice was 'a testimony to one of the most blatant, yet often covert, forms of racism in the mental health system' (Ibid: 63). The issue of race is not just apparent in

death. As Browne argued, in life, there is a common perception that black people with mental health problems are 'dangerous' (1996a: 199). Fernando argued that black/ethnic minorities were more likely to be detained under the Mental Health Act, given high doses of medication and 'suffer from unmet need' (1996: 34). Furthermore, for O'Hagan, black patients received 'second class treatment' within the psychiatric system (1993: 14). This rendered these patients doubly disadvantaged as, not only were they marginalised due to their mental health problems, they also faced 'the most alienating experience of all', that of being a black patient in a white mental health system (Ibid: 14).

Browne found that 75% of professionals interviewed stated that black patients were more likely than white patients to be viewed as 'dangerous' (1996a: 199). It was also argued by Dr Sashi Sashidharan that black people were seen as 'intrinsically madder' than white people and, once admitted to hospitals, only possessed a minimal chance of satisfactory care and treatment (Sashidharan, 1991, cited in Brindle, 1991b: 4). For Ussher, psychology's refusal to examine factors such as racism 'allow[ed] it to be used for more insidious purpose[s]' (1992b: 51). The positivistic nature of psychology 'acts to mystify the conditions of those deemed in need of psychological assessment or intervention, at the same time as it reifies the power of the expert' (Ibid: 51). As a result, psychiatric services for black people were primarily concerned with control (Browne, 1996b: 67).

## **Deaths of Detained Patients: Ongoing Areas of Concern**

There had been a 'collective failure of agencies and government to act earlier on the well-documented and recognised evidence of a failing system' involving the coroners court (INQUEST, 2003: 1). INQUEST have raised a number of issues regarding the coronial system:

The coroners inquest has become an arena for some of the most unsatisfactory rituals that follow a death-accusations, deceit, cover-up, legal chicanery, mystification: everything but a simple and uncontroversial procedure to establish the facts (Ibid: 4).

The charity criticised what it saw as the key failings within the coronial system that caused unnecessary stress for bereaved families, including a lack of information or no information provided to them (Ibid: 15). They also indicated their concern that families could be persuaded by hospital trusts and coroners that they did not require legal representation when in reality, 'families can face barristers from the Home Office, police authority or health authority' (Ibid: 36-37). As a result:

The failure of the state to ensure [an] equality of arms at inquest hearings is one of the major problems of the inquest system that perpetuates a view that the system is biased towards the interests of organisations that may be criticised (Ibid: 36).

In 2005, an inquest took place into the deaths of eleven patients during the 1990s at the Kingsway Hospital in Derby. There had been accusations of patients being deliberately starved. However, the Crown Prosecution Service decided not to pursue criminal proceedings at the time (Britten, 2005: n.p). As the patients had

been suffering from dementia, some witnesses argued that it was actually beneficial to withhold food and water from those who experienced difficulties chewing and swallowing food (BBC, 2005a: n.p). Despite this, a witness who had worked as a healthcare assistant said she had continued to feed patients, despite the risk of being dismissed if she had been seen doing so (Ibid: n.p). The coroner ruled that food and drink had been deliberately withheld, but also stated that the eleven patients died from natural causes. The management at the hospital was also criticised and in 2005 the ward manager and his deputy both resigned, having been suspended on full pay since 1997 (BBC, 2005b: n.p).

Despite the recommendations of the Bennett inquiry, restraint-related deaths continued to be a problem. An independent inquiry was held in 2006 into the restraint-related death of Geoffrey Hodgkins at St James's Hospital in Portsmouth. He died in 2004 after being held face down on the floor until he stopped breathing (Carvel, 2006: n.p). The inquiry found that Hodgkins had thrown a plastic cup at a patient who was behaving inappropriately. He was not threatening anyone when seven nurses, security guards and support workers overpowered him. There were also allegations that the staff passed cigarettes to each other 'as they squeezed the life out of him' (Ibid: n.p). The inquiry criticised staff for restraining him for longer than the recommended time (Hampshire and Isle of Wight Strategic Health Authority, 2006: 86). In 2008, an inquest took place into another restraint-related death, that of Kurt Howard who died at the Cefn Coed Hospital in Swansea. It was held six years after his death and his family



demanded to know why he had been restrained for at least fifty-five minutes, despite the risks of such long-lasting restraint. The family also wanted to uncover why the staff involved failed to report the death as restraint-related (Garden Court Chambers, 2008, n.p). The jury at the inquest found that the use of restraint was 'excessive' (INQUEST, 2008, n.p).

Also in 2008, twenty-five year old John Paul McLaughlin died at the Psychiatric Intensive Care Unit of the Queen Elizabeth Hospital in Gateshead, a hospital discussed earlier in this chapter. On the day of his death, he was sedated and was placed in the 'seclusion room' under 'constant observation' (Borrill and Hamblin, 2012: 23). Staff notes stated that he had placed a pillow over his head. The next note indicated that he was still lying down with the pillowcase over his head. The staff later claimed that they did not enter the seclusion room for several minutes as they believed that he was 'pretending to be calm in order to attack them' (Ibid: 24).

The inquest heard that the 'fish-eye lens' used to conduct observations of the patients was 'uncomfortable to look through and was at an awkward height'. As a result, supposed 'constant observations' were actually undertaken every two to three minutes (Ibid: 24). The jury found that the viewing point itself, along with the failure of the staff to react to the patient placing the pillow over his head, contributed to his death (Ibid: 23).

Consequently, plastic pillows and pillowcases were no longer used at the intensive care unit and the seclusion room was renovated, along with the introduction of an observation room that allowed a clear view of the room. The coroner also made two Rule 43 reports<sup>47</sup>. The first of these was that 'constant observations' should mean precisely that, with the patient in clear view at all times, with no interruption. The second stated that a patient placing an object on or over their head or face, whilst subject to constant observation, should be viewed as an emergency and immediate attention should be taken to prevent this (Ibid: 24). The use of the seclusion room within this case was also concerning as it was deemed a 'degrading' and a 'medieval practice' (McCarthy, 2015: 1). McCarthy also argued that seclusion had a 'strong undercurrent of punishment', and questioned, 'when a patient has been through this process, how much dignity and personal power do you think they have left?' (Ibid: 6).

Further concerns were raised in 2009<sup>48</sup> when the Mental Health Act Commission was notified of 392 deaths of detained patients between 2005-2008 (The Mental Health Act Commission, 2009: 201). The report drew attention to an incident where a patient had strangled himself and it was suspected that records had been falsified (Ibid: 221). In another incident, a patient who was supposedly subject to fifteen minute observations was found hanging and was reported to have shown

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<sup>47</sup> Under Rule 43 of the Coroners Rules 1984 a coroner has the power, following a death, to contact any individual or body and instruct them to take action regarding the prevention of future deaths (these have subsequently been replaced by Regulation 28 Reports).

<sup>48</sup> These concerns were raised a time when there had been a further amendment to the Mental Health Act in 2007 which implemented changes in relation to definitions surrounding mental health problems and the appointment of a named nearest relative for patients.

signs of rigor mortis, which was not usually visible until around three hours after death (Ibid: 221).

In 2011, it was argued that patients were ‘as powerless as ever’ and ‘resigned to their fate’ (Allan, 2011: n.p). It was noted that, ‘as far back as 2004’ there had been calls for an independent body to be introduced in relation to the investigation of deaths in psychiatric detention (Leach, 2012: 14). However, as Chapter Three indicated, the discrepancies in the investigation system between asylum deaths and other forms of state custody was being raised as early as 1840 (The Lancet, 1840: 897). Two centuries later, the same questions were being asked regarding the lack of accountability following the deaths of detained patients. However, it was also recognised that it was likely to be the case that there would be ‘insufficient political will in the foreseeable future’ to create an independent system to investigate deaths in psychiatric detention (Leach, 2012: 15). It was argued that the Care Quality Commission could act as the body to investigate patient deaths (Ibid: 15). However, this prospect was problematic as inadequacies within the Commission had previously been highlighted, with the Commission described as ‘not fit for purpose’ (The Guardian, 2013: n.p). The British Medical Association stated that they had no confidence in the Commission to be able to independently regulate health and social care services (Ibid: n.p).

In 2013, a judicial review was held in relation to the lack of an independent investigation system. The review was a result of the interventions of the family

of Jane Antoniou, a patient who died at Northwick Park Hospital in London in 2010. The day before her death she had expressed her wish to die (Murphy, 2012: 21). Despite this, observations were not increased and she continued to be allowed to leave the ward alone, at the discretion of the nurses. The following day, during an hourly check that was ten minutes late, Antoniou was found lying on the floor in her room, with her dressing gown cord around her neck. There were delays in the internal, non-independent investigation and the hospital trust reportedly refused to provide evidence as well as their report into Antoniou's death to her husband or to the coroner (Ibid: 22). For the Antoniou family, the internal investigation lacked independence, was superficial, failed to secure evidence, did not involve the family and failed to follow policy and guidance. The family argued that this was a breach of Article 2 of the European Convention on Human Rights (Ibid: 22). Article 2 is the right to life and states that every individual's right to life should be protected by law. If, however, an individual dies in state custody, an effective investigation should be undertaken (Equality and Human Rights Commission, 2012: 25). Furthermore, the investigation should be 'independent, prompt, and open to an element of public scrutiny and should involve the family of the deceased' (Ibid: 26).

The judicial review questioned whether Article 2 obliged the state to conduct an 'immediate' and 'independent' investigation into the circumstances of a patient's death (R (Antoniou) -v- Various, 2013: 2). Furthermore, it examined whether the lack of independent investigation 'constitute[d] a difference' between other deaths in state custody, such as those in police and prisons (Ibid: 2). The review

found that despite the existence of the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission<sup>49</sup> (IPCC), in relation to prison and police custody deaths, the law did not require an independent investigation system for the deaths of patients detained under the Mental Health Act (Ibid).

Despite the refusal to implement an independent investigation system, cases continued to emerge which indicated the need for this provision, particularly when the same hospital trusts experienced multiple deaths. An example of this was in 2013 when there were calls for a public inquiry following the deaths of four patients at St Andrews Hospital in Northampton (Doward, 2013: n.p). There were concerns that the use of antipsychotic drugs may have contributed to their deaths and that an internal report which identified these concerns was not passed to the coroner or bereaved families. The Care Quality Commission argued that they did not believe an investigation was necessary (Ibid).

A further example occurred in 2013 when there were calls for greater transparency following ten suicides that had occurred since 2010 at the Bradgate Unit in Leicester (Champion, 2013: n.p). One of these deaths was that of Kirsty Brookes who absconded from the Unit and hanged herself. The coroner stated that she had taken her own life partly because of neglect at the Unit (BBC, 2011: n.p). In the case of Michael Coltman at the Unit, the coroner found that his

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<sup>49</sup> In 2018, the Independent Police Complaints Commission (IPCC) became the Independent Office for Police Conduct (IOPC).

bedding had been removed after a previous suicide attempt but it had been returned to him by staff who had not been briefed on his case. He then took his own life by hanging himself with his bed sheet (BBC, 2012: n.p). It was also stated that paperwork had not been completed properly and observation checks had been a mere 'tick-box exercise' (Ibid). Another patient, Sally Ann Vye, also went missing from the Unit and took her own life. Police were not informed until eight hours after her disappearance (BBC, 2013a: n.p). Her parents would later argue that changes promised by the Unit had not taken place and numerous issues had been identified by the Care Quality Commission involving inadequate patient care (BBC, 2013b: n.p).

### **'Serious Mistakes Have Gone On For Far Too Long'<sup>50</sup>: Historical Failings in a Contemporary System**

The issue of restraint has been highlighted throughout both this Chapter and Chapter Three. In 2013, MIND noted that there was a 'huge variation' regarding the use of physical restraint across England and this was 'unacceptable' (2013: 3). In a single year, one trust reported thirty-eight restraint-related incidents, whilst another reported over three thousand (Ibid: 3). Between 2000 and 2014, patients detained under the Mental Health Act accounted for 46% of all restraint-related deaths across the different custodial sectors (Independent Advisory Panel on Deaths in Custody, 2015a: 15). The Independent Advisory Panel on Deaths in

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<sup>50</sup> Equality and Human Rights Commission (2015: 3).

Custody also noted that between 2011 and 2012 restraint-related deaths of patients detained under the Mental Health Act had increased by 75% (Ibid: 15).

Furthermore, Agenda<sup>51</sup> found that females were more likely to be restrained face-down than males in mental health units and one in five female patients had been restrained. Within some trusts, this was as many as three in four (2017: n.p). For Agenda, this was extremely problematic due to the prevalence of a history of abuse within the female population with mental health problems. Therefore, 'not only is being restrained frightening and humiliating, it also risks re-traumatising women and girls' (Ibid: n.p). The organisation called for an end to face-down restraint and argued that other forms of restraint should only be used only as a last resort (Ibid: n.p).

In 2015, the Equality and Human Rights Commission (EHRC) reported the findings of its inquiry into the deaths of adults with mental health problems in different forms of state custody. Of interest to the EHRC was compliance with human rights legislation, particularly Article 2, the right to life. The inquiry found that 'despite reports and recommendations, serious mistakes have gone on for far too long. The same errors are being made time and time again, leading to deaths and near misses' (2015: 3). For the EHRC, some of the deaths investigated were avoidable (Ibid: 36). The inquiry also found that much of the information related to the non-

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<sup>51</sup> Agenda are an organisation who work to ensure that all females receive the support they need in various areas such as mental health, poverty and abuse.

natural deaths of patients detained in hospitals was unavailable and noted that the investigation system following deaths in psychiatric detention was 'opaque' (Ibid: 6). The Commission recommended the introduction of an independent investigation body as 'an immediate opportunity to reduce the deaths of detained patients' (Ibid: 6).

The EHRC recommended that there should be a 'statutory obligation on institutions to respond to recommendations and publish these responses' (Ibid: 6). The Commission also recommended that there needed to be increased transparency and scrutiny, whilst also ensuring that individuals were held to account for failings or wrongdoing (Ibid: 6). The EHRC, in collaboration with INQUEST, identified issues surrounding the lack of family involvement following the detention of a relative (2015: 15). Here, families stated that they felt excluded from decision-making, not included in care-plan discussions and 'were surprised at how little advice or information was sought on their relative's previous mental health history' (Ibid: 15). Unsurprisingly, the 'progress review' of the initial EHRC inquiry concluded that the Commission was 'disappointed to have to report some areas where little or no progress has been made' (Equality and Human Rights Commission, 2016: 7). They recommended a 'full government review' into the adequacy of post-death investigations (Ibid: 29).

Mirroring the concerns of the EHRC, INQUEST also published a report into the inadequacy of the investigation system following deaths in psychiatric detention



(INQUEST, 2015a). It revealed a number of persistent issues, which included poor record-keeping, inadequate staffing levels, poor clinical oversight and unsafe environments. As a result, many key issues risked being 'glossed over and the opportunity for critical learning lost' (Ibid: 33). The charity pointed to the 'superficial nature' of investigations which were often speedily conducted, with little opportunities for families to establish the circumstances surrounding their relative's death, including whether or not the death was preventable (Ibid: 33). Furthermore, families had minimal or no access to medical records and other basic information, and there were failures in passing on the findings of internal investigations to them and to coroners (Ibid: 30). There were also issues around the struggle of families to obtain legal funding or representation at inquests, as well as delays in the disclosure of key evidence, with NHS representatives 'pushing' for settlements before inquests (INQUEST, 2016c: 9). This resulted in families feeling 'threatened' and this placed them 'at a disadvantage from the outset' (INQUEST, 2016a: 9). The charity recommended that inquests should be more robust, with increased attention paid to ensure that recommendations were implemented (INQUEST, 2015a: 7).

INQUEST argued that it was very much 'a lottery' in relation to how well families were involved in post-death procedures (2016a: 8). There was a lack of information provided to them, and there was little or no opportunity to raise questions or concerns. If families were involved in investigations, it was often the case that this was due to the interventions of their lawyers or INQUEST (Coles,

2012: 16). It was unsurprising that the lack of independence and transparency within the investigation system had a:

Deleterious impact on bereaved relatives and public confidence in the ability of the current system to ensure the learning of lessons to safeguard the lives of an extremely vulnerable group of people (Ibid: 16).

As there had not been a single, independent investigation following a self-inflicted death in psychiatric detention, INQUEST recommended the introduction of a fully-independent system for investigating deaths in psychiatric detention, along with increased 'proper and meaningful' involvement of families in the investigation system (Ibid: 7).

In 2015, an independent review was held into the deaths of patients at Southern Health NHS Foundation Trust's Mental Health and Learning Disability services between April 2011 and March 2015. The review found that there was a lack of leadership and focus, along with inadequate time being spent investigating these deaths (Mazars LLP, 2015: 14). The timeliness of investigations was a 'major concern' and Southern Health 'could not demonstrate a comprehensive, systemic approach to learning from deaths', resulting in 'missed opportunities for learning' (Ibid: 16-17). This was particularly concerning as it was recognised that 'learning from deaths, done well, can be powerful and can lead to improvement in patient care' (Ibid: 26). However, there had been an 'insufficient transparency' within investigations (Ibid: 17). The systems in place 'provided no evidence that the Trust had fully reported or investigated unexpected deaths or taken remedial

action where appropriate' (Ibid: 18). The review also found that Southern Health had 'not been accurately categorizing deaths...One consequence of this reporting practice [was] to lessen the transparency around deaths' (Ibid: 55).

Sixty-Four percent of investigations undertaken by Southern Health had not involved families (Ibid: 16). Their concerns were not responded to and there were extensive delays in producing reports, along with careless reporting, with several different names being used for one patient within a single report (Ibid: 32). The review also found that Southern Health had been informed on a number of occasions that the procedures for 'Serious Incident Requiring Investigation' were inadequate, but no effective action was undertaken (Ibid: 14). Southern Health would later be served a warning notice which ordered them to take immediate action to guarantee the safety of patients in certain wards, along with a demand to put in place 'effective governance arrangements to ensure robust investigation and learning from incidents, including deaths, to reduce future risk to patients' (Care Quality Commission, 2016c: n.p). The CQC stated that it had concerns regarding the safety of patients and Southern Health had not put in place effective arrangements to identify, record or respond to these (Ibid: n.p). They had missed opportunities to learn from these incidents and to take action to reduce the likelihood of similar events happening in the future (Ibid: n.p). Furthermore, the management of complaints was 'superficial and appeared rushed' (Ibid: 7).

Only 0.3% of deaths over a four year period at Southern Health's mental health services for older people were investigated as a 'serious incident', again demonstrating a 'lack of interest in patient safety and learning from deaths' (Julian, 2016: 4). The Trust was fined £2 million due to 'systemic failures' following the deaths of two patients (BBC, 2018a: n.p). The judge acknowledged that one of the victim impact statements from a bereaved family made for 'almost unbearable reading' (Ibid: n.p). A consultant psychiatrist who was the lead clinician for one of the two patients admitted twenty-eight failings concerning his care and treatment before his death. It was argued that the psychiatrist showed 'no remorse' following the patient's death and had not apologised to the bereaved family (Press Association, 2017: n.p). She was subsequently suspended from work for twelve months (Halliday, 2018: n.p).

In 2014, it was noted that as little as 6.6% of NHS budgets was being spent on mental health provisions and this resulted in the claim that the NHS treated mental health as a 'second-class service' (Campbell, 2014: 8). Furthermore, it was reported in 2015 that mental health trusts were subjected to further budget cuts and 'the impact of these cuts [fell] squarely on patient care' (MIND, 2015: n.p). O'Hara argued that cuts in mental health services were 'driving people to the edge' (2015: n.p). It was unsurprising that an inquiry by MPs into mental health funding resulted in an 'unprecedented display of anger over the state of the NHS' and received 96.000 individual submissions (Boffey and McVeigh, 2016: n.p). In 2016, Farmer and Dyer (2016: 3) maintained that:

For far too long, people of all ages with mental health problems have been stigmatised and marginalised...mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

Alexander (2016: 3) highlighted that some hospital trusts had received as many as 22 coroners' warning reports<sup>52</sup> since 2008 (Ibid: 4). For Alexander, these warning reports were the 'tip of an iceberg' due to coroners not being provided with the full facts of cases or not detecting problems themselves (Ibid: 5). However, problems in the coronial system were only compounded by the continued problematic nature of the investigation system following the deaths of detained patients. In 2016, the CQC published a report into the way NHS trusts investigated the deaths of patients in their care (Care Quality Commission, 2016b). INQUEST critiqued this report by pointing out that their own call for an independent investigation framework to 'tackle long standing, dangerous systems and practices to prevent future deaths' was not one of the recommendations made by the Commission (2017a: 4).

### **A 'Litany of Failures'<sup>53</sup>: Recent Patient Deaths**

Contentious deaths continued to occur and, in 2016, at the inquest of fifteen-year-old Christopher Brennan who died at Bethlem Hospital in 2014, it was found

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<sup>52</sup> As noted earlier in the thesis, coroners can construct Regulation 28 Reports where, following a death, they contact any individual or body and instruct them to take action regarding the prevention of future deaths.

<sup>53</sup> Private Eye (2016a: 15).

that neglect had contributed to his death. Due to a high number of self-harming incidents, the staff had become 'desensitized' to apparent dangers (BBC, 2016: n.p). Another inquest was held in 2016 into the death of thirty-one year old Mohammed Mansoor Elahi in 2013. He had a history of self-harm and had previously tried to take his own life a number of times. He subsequently drowned during a hospital canoe trip (Yarwood, 2016: 7). Pennine Care NHS Foundation Trust pleaded guilty to two breaches of health and safety regulations, having carried out no risk assessment for the activity, despite it being a regular activity for the previous two years. He was subject to fifteen-minute observations and should not have been taking part in outdoor activities. Pennine Care's own health and safety manager was not aware that the canoeing activity was taking place (Ibid: 7).

Also in 2016, Mersey Care NHS Foundation Trust was blamed for a 'litany of failures' following the death of a patient, Paul Hiron, who hanged himself at Broadgreen Hospital. His death took place three months after another patient strangled herself at the same hospital (Private Eye, 2016a: 15). In another case in 2016, that of Helen Millard, it was found that she was able to hang herself at the Westlands Mental Health Unit, after previously attempting to take her life in the same way. She had been making ligatures up to five times a day. However, no action was taken to prevent her from doing so (Private Eye, 2016b: 39).

Adam Withers, a twenty year old patient also died in 2016. He fell 130ft to his death after climbing a chimney at Epsom Hospital (Private Eye, 2016c: 37). The inquest found that he had informed staff of his intention to climb the chimney. Despite this, and the fact that other patients had previously climbed the chimney, no preventative measures were implemented (Ibid: 37). Epsom and St Helier University Hospitals Trust and Surrey and Borders Partnership Trust were both found guilty of 'systemic failures', including lack of proper risk assessments, poor-record keeping and care planning and the 'almost complete lack of effective communication' (Ibid: 37). The Surrey and Borders Partnership Trust was subsequently fined £300,000 (Surrey Live, 2017: n.p).

A coroner in Wales removed herself from proceedings in 2016 concerning the death of Mark Williams who had died in 2015, having been treated both in the community and as an in-patient. His family fought to be furnished with his medical records and the internal investigation report into his death. The coroner removed herself from proceedings after being accused of being too 'cosy' with the health board that was responsible for his care (Private Eye, 2016d: 37). Lawyers acting for the family were accidentally copied into an email from the coroner which was sent to the police asking them to investigate the family, having found out that Mr Williams was the son of a patient who had died due to neglect whilst in hospital (Ibid: 37). In her email, the coroner appeared to have already 'made up her mind' regarding the case (Ibid: 37). She indicated that she wanted to uncover information from sources such as Facebook 'which may indicate that

the family are so affected by what happened [to the mother of Mr Williams] that they may be unable to see the distinction of what happened here' (Ibid: 37).

Numerous issues discussed earlier in this chapter, and in Chapter Three, have continued to be identified, indicative of the lack of improvement surrounding the official interest in patients. For example, black people were the ethnic group most likely to have been detained under the Mental Health Act in 2016/17 (GOV.UK, 2018: n.p). This reinforced the view that 'black people are treated in a more coercive and punitive way within the psychiatric system' (Pilgrim and Rogers, 2014: 75), whilst also noting that a 'discriminatory backdrop exists in the mental hospital' (Ibid: 76).

A further issue which indicated the longevity of problems was apparent in 2018 when the CQC argued that there was a shortage of nurses at Rampton and Broadmoor, limiting patient's freedom and care and putting their lives at risk (Care Quality Commission, 2018a: 28). Also in 2018, the Parliamentary and Health Service Ombudsman found failures in the diagnosis and treatment of patients, inappropriate hospital discharge procedures and inadequate after-care of the patients. They also found poor risk assessment and safety practices (2018: n.p). They noted that patients had not been treated with dignity and their human rights had been infringed. This was coupled with poor communication with the patient and/or their family and carers (Ibid: n.p). An inquest held in 2018 also indicated the continued lack of official interest in patients and their families.



Following the death of Anne Roberts in 2017, following choking to death whilst detained at Prospect Park Hospital, the jury at her inquest found that the inadequate care and treatment she had received contributed to her death, six days after a previous choking incident (BBC, 2018b: n.p). During the inquest, her family were asked to pay £1,000 for the use of a private room to discuss their case with their legal representatives (Bowcott, 2018: n.p).

In the same year, it was announced that the Joint Committee on Human Rights backed a call by INQUEST for non-means tested funding for families to be represented at inquests as part of a 'better access to justice' approach (INQUEST, 2018b: n.p). The Ministry of Justice also launched a call for evidence regarding experiences of the inquest system. Here, INQUEST encouraged families to submit evidence to encourage an end to the current 'inequality of arms' (Ibid: n.p).

As indicated in the introduction to this thesis, deaths in psychiatric detention have remained high. Duncan claimed that at least 271 mental health patients had died between 2012 and 2017 following 'failings' in NHS care, with 136 legal warnings given to NHS bodies (2018a: n.p). It was also found that between 2012 and 2017 there had been 706 failures recognised by coroners in relation to 271 deaths of mental health patients, including 'errors, misjudgements, flawed processes, a lack of staff or beds and poor training' (Ibid: n.p). Persistent cases of poor communication were also uncovered, along with non-adherence to protocols, lack of appropriate care, poor record-keeping, insufficient risk

assessment, family and friends being ignored, insufficient training and delays in treatment (Duncan 2018b: n.p). These were all issues that were apparent decades and centuries earlier, as examined in Chapter Three.

## **Conclusion**

By continuing the critical, revisionist history from 1960 to 2018, this chapter has demonstrated how the present-day has been shaped by 'complex power relations and struggles' (Garland, 2014: 373). This has indicated how 'the past is not dead...but living in the present' (Johnson, 1998: 81). The chapter has chronicled the 'institutionalisation of inhuman and degrading treatment' (Scruton, 2002a: 108) displayed against patients and their families. As Martin previously asked, 'how is it that institutions established to care for the sick and helpless can have allowed them to be neglected, treated with callousness and even deliberate cruelty?' (1984: x).

As with Chapter Three, this chapter has contributed to fulfilling a number of the aims of the thesis, including critically analysing the contemporary response to patients in both life and death, along with the response to their families. The chapter contributed to the aim of analysing the inquest and investigation systems, thus focusing on the issue of accountability. The chapter also addressed the aim of critically examining contestations and challenges and the alternative knowledge that emerged as a result of these challenges.

The themes identified in this chapter mirrored many of those identified historically in Chapter Three. The first of these themes was the inferior treatment of detained patients, in both life and death. This has remained as prominent as it was historically, with patients and their families being continuously disregarded and silenced. The second of these themes was the continuation of the exercise of power and control over patients and their families. These groups have continually suffered the same 'lamentable experiences' (INQUEST, 2017a: 1), namely marginalisation and subordination that those in their position experienced centuries earlier, as discussed in Chapter Three.

The third theme was the continued lack of accountability in both life and death, with continuous official attempts at denial and concealment. An example of this was the lack of accountability and family involvement following the death of William Windsheffel in 1853, and the same lack of accountability and family involvement in the case of Jane Antoniou in 2012. The persistent marginalisation and dismissal of bereaved families was also a key theme. As Shaw and Coles argued:

In seeking to condemn and vilify both those who die and their families, the state has sought to marginalise and dismiss alternative accounts...the dead and their families are to blame, which has allowed a long term institutional and governmental denial of responsibility (2007: 11).

However, another theme apparent was how, through resisting their silencing and subjugation, those who challenged the dominant voice of the state, and the

mental health system, have created alternative truths. Their continual emergence has resulted in a 'diverse range of resistance to dominant discourses' (Ballinger, 2000: 125) being constructed. Without these contestations, it was likely that dominant truths would have remained unchallenged, thus working to reinforce the secrecy and lack of debate in the area. Again, these contestations were apparent in both the historical and contemporary system.

The issues examined in this chapter indicated how little accountability there was within the system, coupled with secrecy, inadequate post-death provisions and the failure to learn lessons. This further exposed the ever-present 'complex interweaving of power relations that characterise the mental health arena' (Banton et al, 1985:35). As noted, many of the issues apparent in Chapter Three were also apparent within this chapter. This raises the question as to whether there has been any significant, meaningful progress within the system, in both life and death. Why are patients, their relatives and those who speak out still continuously marginalised? Furthermore, why are patients still dying in contentious circumstances every year? Why are investigation systems still private, with minimal transparency and family involvement? As Porter stated, we are in modern times, yet ancient problems remain (2003: 215). It would appear that many vulnerable people still face 'a lifetime of increasingly inadequate and exclusionary care' (Prior, 1999: 116). Furthermore, for Parkinson:

There is no compassion. We are waving-the activists; the mental health service users and their friends and families; the doctors and nurses and social workers and carers; and yet still, *still*, we are drowning (2015: n.p emphasis in original).

Having now further contributed to a 'history of the present' (Foucault, 1977: 31) and explored the growth of asylums through to the modern psychiatric hospital, in addition to deaths in these institutions, Chapter Five will analyse the findings of the interviews and questionnaires undertaken with bereaved families, coroners, legal practitioners and an MP. This is in addition to an examination of online family campaign websites which were established following the death of patients in psychiatric detention.

**Chapter Five: ‘Fight for Justice, Accountability and Change’<sup>54</sup>: Interviews, Questionnaires and Family Campaign Websites**

The historical data critically examined in Chapters Three and Four provided the foundations for a critical examination of the relationship between historical and contemporary events (McDowell, 2002: 4). These two chapters constructed a ‘history of the present’ (Foucault, 1977: 31) in relation to life and death in psychiatric detention. This chapter presents the findings of face-to-face interviews, telephone interviews and questionnaires conducted with bereaved families, coroners, legal practitioners and an MP, as well as an analysis of online family campaign websites.

The chapter critically examines the key themes identified from these forms of data collection, linking the data with the theoretical frameworks employed within the thesis, and the historical themes examined in Chapters Three and Four. A number of themes will be explored. First, the official negative response to deaths in psychiatric detention, critically focusing on the blaming of patients, and their families. Second, the lack of accountability following the deaths of patients, particularly in the investigation system and coroners court. Third, the power of silencing and marginalisation and fourth, the resistance, contestations and challenges of those who were marginalised by official discourse and practices. It is to these themes that this chapter now turns.

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<sup>54</sup> Campaign Website Four.

## **The Official Response to Deaths in Psychiatric Detention**

As indicated in the earlier chapters of this thesis, the historical official response to the deaths of patients was extremely problematic, with constant failures dominating this area. Participants also identified the prevalence of contemporary failings, including:

Issues that come up time and time again-a complete lack of communication and adequate undertaking of risk assessments. Alongside this, you have a lack of listening to what families have to say, a lack of care planning...wholly inadequate and incorrect administration of medication and poor security in wards (Legal Practitioner Six).

This perspective was reflected in the views of Legal Practitioner One who argued:

There are constant failings with no legitimate reason for these failings. Here, I mean the lack of patient follow up and review, poor record keeping, problems involving the administration of medication, lack of communication internally and externally, non-adherence to policies, missing documentation and certain individuals undertaking important roles who don't have a clue.

As indicated in Chapters Three and Four, the same institutions often have repeated failings occurring surrounding the deaths of patients. This was also apparent contemporaneously, with Coroner One stating that the same trusts come before his court but usually 'slightly different things have gone wrong'. Coroner Two noted his view that there were 'trends where there can be a cluster of deaths over a relatively short period of time, involving similar cases'. Despite that 'most patient deaths can be attributed to a failure within the hospital setting' (Coroner Two), the official focus appeared to be more on blaming patients for

their own deaths, rather than acknowledging any systemic failings. This resulted in blame 'more often than not being placed on the deceased regardless of the circumstances' (Legal Practitioner Seven). The official abdication of responsibility was also apparent historically as identified in Chapters Three and Four. As Legal Practitioner Eight noted, 'if blame [regarding a death] can be diverted elsewhere then it will'. Legal Practitioner Five also argued that trusts:

Shift the blame onto the deceased as they claim that they could not have been expected to know as the patients hadn't said they needed help and therefore things couldn't have been that bad. Not only are these people not recognising that they missed something, they are also blaming the patient for their own death. For families this is a real source of pain and suffering because it heaps misery onto the grief they already have.

This persistent denial of blame and responsibility was indicative of the state constructing 'a reality of their choosing' (Davies et al, 2014: 11), where the circumstances of patient deaths became lost in mystification. It was not just patients who were blamed for their deaths. Legal Practitioner Six noted that there had also been a growing trend in trusts blaming families for their relative's death:

I have noticed an increase in the blaming of families for the death of their relative. The trust will say that the families did not raise concerns or they weren't strong enough in letting the trust know of any concerns, but families say they were never asked. One case I worked on, the witness statements presented by the trust in question all contained a section on the deceased's mother. This was astonishing-of what relevance is a section on the mother? It was an attempt and a tactic to deflect attention away from their own failings.

This was a point also raised by Family Member Three:



From the moment we were told he had died, I thought, wait up here, are you trying to say we could have done something to stop this? Because if you are, then you absolutely should have yourselves. It makes you doubt yourself and your actions, when you know deep down that you have tried all you can.

A number of participants discussed the most common methods used by patients when taking their own lives, which was primarily the use of hanging (Legal Practitioner Two). However, official recognition of these dominant methods appeared minimal. For Legal Practitioner Seven, 'they know [the staff], they've seen it all before, the way they [patients] take their own lives, but you would never guess'. Instead of focusing on preventing deaths, Legal Practitioner Seven argued that the official response by the medical profession to patients was 'pull yourself together'. For Legal Practitioner Six:

The excuse often used is 'the patient presented fine so how were we to know?' But, many people with mental health problems pretend to be fine and it is the job of skilled clinicians to understand this.

It was argued that it was 'often the case that procedures are not followed, particularly surrounding patient observations' (Legal Practitioner Two). The issue of observations was discussed in Chapter Four in the cases of John Paul McLaughlin and Jane Antoniou. This was an area of concern also drawn upon by the Equality and Human Rights Commission and INQUEST who argued that patient observations were viewed as a 'tick box exercise', with minimal official importance attached to the need for these observations (2015: 18). A case which demonstrated issues surrounding patient observation was detailed by Campaign

Website One<sup>55</sup> whose relative died in 2006, alone in a ward bathroom. On the night of her death, she should have been supervised during bathroom visits. However, ‘mysteriously, the hospital staff claimed that [she] no longer needed constant observation as she had been cured of incontinence, falling and risks from other patients’ (Campaign Website One). The deceased lay on the floor for ten minutes before anyone noticed. Staff did not have the skills or equipment to resuscitate her and a security guard who should have allowed the ambulance access to the building was sleeping (Ibid).

Further cases involving failings were highlighted by participants. Coroner Two discussed an incident which involved a ‘vulnerable location’ (toilet) with ligature points being left unlocked. A patient, who had previously expressed suicidal tendencies regarding ligature points, was able to enter the toilet and take her own life. Another example of failings was detailed by Legal Practitioner One where a patient went missing from his ward and was found hanging, a week later, thirty metres from the hospital entrance. The care team consisted of individuals with poor English. Furthermore, there were ‘unreadable’ notes regarding the patient’s care and treatment, which those who had written could not read themselves. The location where the individual took his own life was a ‘no-go zone’ for patients and when the hospital representative was asked at the inquest how patients should know this, the representative replied that the patients should

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<sup>55</sup> The families behind the campaign websites are not the same families who were interviewed for this thesis. Therefore, there is no link between ‘Campaign Website One’ and ‘Family Member One’ and so on.

know because ‘they [the hospital] let the weeds grow there’ (Legal Practitioner One). Furthermore, when the patient initially went missing, procedures were not followed and the member of staff sent to look for him had sight difficulties.

A further case was drawn upon by Family Member Two whose relative took their own life:

Things were getting worse and we tried to tell them [the hospital] but it all fell on deaf ears. For us, there was no other way she would have tried to take her own life and sure enough, that was the way she did [hanging]. If it was obvious to us, why wasn’t it to them? When our team said this at the inquest, they [the hospital] acted surprised, like we had never warned them.

The cases discussed here provided further evidence of an official lack of concern or interest in patients, banishing them to the ‘bottom of the pile’ (Campbell, 1996: 58-59). Legal Practitioner Two did acknowledge the difficulties in providing care and treatment to individuals who ‘often have a desire to end their life or may never fully recover’. However, as was the case historically in Chapters Three and Four, individualising the deaths of patients worked to continuously ensure that attention was deflected away from systemic failures, thus minimising official liability and accountability surrounding these deaths.

The level of importance attached officially to learning lessons from previous deaths was also identified by participants as inadequate. MP One stated, ‘we’ve

had plenty of time to learn-I'm bored of hearing that lessons have been learned'.

This was a point also referred to by Family Member Two:

It's every time, you hear the same rehearsed lines [that lessons have been learned], but they clearly haven't or we wouldn't have been put in the position we were in and in ten years families will be saying the same as me. That's the sad reality of it.

The official contemporary response to deaths in psychiatric detention consists of failures, blaming of patients and their families and a lack of learning lessons. As identified, these were also all historical issues. All of these issues were compounded by a continuous lack of accountability, as the chapter will now explore.

### **Culture of Secrecy**

Chapters Three and Four focused on the different ways in which secrecy was apparent following the deaths of detained patients historically, where 'one of the key features and effects of power [was] the ability to operate beyond public scrutiny and thus accountability' (Tombs and Whyte, 2003: 4). A contemporary example of this lack of transparency was noted by Legal Practitioner Eight who stated, 'I would bet that the number of deaths [of detained patients] we are told of is not the true number'.

The closed and secretive nature of the post-death system was part of a much larger 'struggle for justice' (Campaign Website One). As Julian<sup>56</sup> recognised, 'knowing how and why they [their relative] died is the very least a family should be able to expect' (2016: 4). However, the reality was very different, as Family Member Two noted:

We wanted to know everything, as anyone would, but we were made to feel a nuisance [by the hospital]. Even down to what she used [to hang herself]. It made no difference really, it was done, but we wanted to get everything straight in our heads. They [the hospital] didn't seem to understand that.

As was argued in Chapter Two there has been a 'deafness' (Porter, 1987: 5) to the voices of patients, and in turn, their relatives and those who raised concerns. Family Member Two pointed out that 'anything we said, if it was different to what they [the hospital] said, it went straight in one ear and out the other...is that how they treated her? [their deceased relative]'.

A number of participants discussed how the closed hospital system was dominated by the avoidance of official responsibility and accountability in both the lives and deaths of patients. This reflected the issues raised in Chapters Three and Four, concerning how there were 'minimum mechanisms for guaranteeing transparency' (Scruton, 2002a: 109). According to Legal Practitioner Four:

Hospital in-house legal teams and complaints teams are not what they should be and are far from promoting a stance of accountability.

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<sup>56</sup> Special Advisor on family and carer experience at the Care Quality Commission.

Similarly, for Legal Practitioner One:

Different organisations and agencies cover their backs against people attempting to uncover circumstances, in order to protect their staff, but this is at the expense of others.

Legal Practitioner Four stated that 'some trusts are more defensive' than others.

A trust identified as particularly defensive was Southern Health (discussed previously in Chapter Four). Southern Health were responsible for the care of the patient behind Campaign Website Three. The deceased drowned in 2013 and Southern Health claimed that the death was a result of 'natural causes'. However, the coroner involved in the case dismissed this claim immediately (Campaign Website Three). The family were then embroiled in 'a year of murk, buck passing, of cover up, of redaction, of bluff and excuses' (Ibid). This case was part of a string of failures, as only two months after the patient's death, an unannounced CQC inspection found that the ward where the patient had died was completely unsafe and was closed down (Ibid). Despite this, Southern Health continuously attempted to minimise or deny the seriousness of its failings.

Campaign Website Four's case provided another example of a lack of accountability. The deceased died in 2015 and his family claimed that he 'suffered abuse, neglect, over medication, restraint and torment' (Campaign Website Four). Through sharing their story online, the family chronicled their 'fight for justice, accountability and change' and argued that 'any one of us could be next...if we don't do something now' (Ibid). The family maintained that the public outcry

would have been greater had it been an animal that had died and questioned 'why the battle for accountability and justice should be so hard'. They also questioned how their relative's death could be so easily 'dismissed' and asked 'why don't they care about the wellbeing of a family left devastated and a mother completely destroyed by the actions and decisions made by people with power?' (Ibid). When the inquest into the death was delayed<sup>57</sup>, a family member wrote that she was:

Struggling to continue the fight. Emotionally I am a wreck...there are no clues as to when the inquest will take place and I know the many people involved will be busy covering their backs...How do I deal with waiting to find out how he died...why was [he] naked and covered in his own excrement when the paramedics came...I'm not sure how I deal with waiting and I'm not sure how I'll deal with the answers if I ever get them...to the powers that be that are trying to block and prevent the fight for justice and accountability instead of acknowledging the massive failings. Come on! You failed [him], you made the last four years of his life a living nightmare. Hold your hands up! Do the right thing! (Ibid).

The secrecy and lack of accountability experienced by Campaign Website Four's family was also apparent in the case discussed by Campaign Website Five. The deceased was found hanged in 2012, with mysterious needle marks in his groin, only seven days after he was admitted. Three days into his admission, he rang the police and claimed that he had been drugged and raped on the ward. Despite this, the police 'failed to secure the scene, interview vital witnesses and even destroyed evidence' (Campaign Website Five). Suicide could not be confirmed.

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<sup>57</sup> At the time of submission, the inquest had not taken place.

The family found that when a doctor called them to inform them that things were 'not looking good' following an incident, their relative was in fact already dead. When the family arrived at the hospital, they overheard a member of staff 'very disrespectfully' saying 'she's here' in relation to the deceased's mother (Ibid). The family said that 'since that first lie [that things were 'not looking good' when their relative was already dead]...so many more have followed' (Ibid). The family also argued that they had been 'fighting bureaucracy and denied the truth as to what really happened', whilst the authorities had:

Sent a grieving mother round and round in circles...in an effort to hide the inadequacies of a failing system and to conceal the truth of their own organisation[al] inadequacies...each one covers for the other at the expense of patient safety (Ibid).

An inquest failed to provide answers and nobody was held accountable for the death. For the family there was:

Months and months of denial. Avoidance, the pile of lies being put under the carpet must be lifting it by now. Shameful inadequacies and failure of senior management. Resignations and no accountability (Ibid).

Both the coroner and the family called for a public inquiry into deaths within the trust concerned, yet these calls were ignored. The family behind Campaign Website Five argued that their relative was 'only one of a very long list of beautiful souls' that the trust in question had failed. This was reflected in Campaign Website Six, which involved the death of a patient within the same hospital as Campaign Website Five. Their relative died three weeks after being admitted. The family alleged that during this time their relative was 'bullied by



staff [and] wrongfully restrained' (Campaign Website Six). This was admitted to by staff but no disciplinary action was taken. The deceased was also over-medicated because 'the staff couldn't read the notes properly' (Ibid). Again, this was admitted to by staff but no action was taken.

The family behind Campaign Website Six were not informed until the following day that their relative had died. In the view of one of the parents of the deceased, 'he [the deceased] didn't stand a chance and I wish to God I'd never trusted them with my son's life' (Ibid). The circumstances surrounding the death changed repeatedly, from the deceased hanging from a bedroom door, to hanging from a wardrobe door, leading the family to argue that their thirteen stone relative 'hung himself from a wardrobe handle that was GLUED on. REALLY?????' (Ibid). Already 'confused and distressed beyond belief', the family was presented with a 52-inch belt which they had never seen before. Their relative had a waist of 28 inches, yet they were informed that the belt had belonged to their relative and was used to hang himself. The family noted that there were no bends or creases in the belt that would indicate the weight or stress of a thirteen stone person hanging from it. Their relative had blood around his neck yet the belt had no blood on it. However, the police refused to undertake any tests on the belt 'on the basis of expense' (Ibid). A family member wrote:

I am literally shaking and my heart is banging...writing what I have done has worn me out...I will put statements [online], photos of the wardrobe, the bloody lot. This has been such a hard journey. I'm now ready to share...all I wanted was the truth because with the truth will come the justice and I told them I wouldn't stop fighting until I [got] it (Ibid).

The issue of repeated failings within the same hospital trust was again apparent following the death of the patient behind Campaign Website Seven who died at the same trust as that involved in Campaign Websites Five and Six. Their relative died from an accidental overdose in 2012. He had expressed his desire to harm or kill himself, yet was repeatedly discharged, on one occasion the day after a suicide attempt (Campaign Website Seven). The family took their case to the Parliamentary and Health Service Ombudsman (PHSO) who found failings in the care provided to the deceased and stated that the trust missed opportunities to prevent his death. The PHSO found that risk assessments were not appropriately undertaken. They also found that the trust could have done more in respect of providing an individualised response to the family, with assurances as to how the issues that occurred in their relative's case would be prevented from reoccurring in the future (Ibid). For one family member:

I can't put into words what [the] death has done to myself and the family...I cannot put to rest how he was let down...having to go through the PHSO to get some answers because of lies and poor excuses...not being able to trust anyone...and everyday I'm reminded that I'm sadly not the only one going through this and the ways things are going I don't think we will be the last (Ibid).

The family later received a written apology from the trust, which was 'pitiful'. They asked 'how many more must die before action plans actually get actioned?' (Ibid). The relentless campaigning demonstrated by the families behind Campaign Websites Five, Six and Seven in their involvement with the same trust came to fruition in 2017 when the police launched an inquiry into seven deaths

within the trust<sup>58</sup> (Campbell, 2017a: n.p). In 2018, it was revealed that the police were investigating the deaths of twenty-five patients within the same mental health trust, with a view to prosecutions under the Corporate Manslaughter and Homicide Act<sup>59</sup> (Private Eye, 2018: 38). However, it was also revealed that three nurses at the trust would not face charges despite admitting to falsifying records (Ibid: 38).

Cohen's work on denial, discussed in Chapter One, could be applied to the cases discussed so far in this chapter when examining the avoidance of accountability. Literal denial was evident, where the trusts argued that issues raised by patients, families and those who complained 'did not happen or [were] not true' (Cohen, 2001: 7). Interpretive denial was also apparent where the accused admitted basic facts regarding complaints, but would then downplay the magnitude of the complaints (Ibid: 7). Furthermore, implicatory denial was used by trusts who did not deny the accusations made but instead denied their 'psychological, political or moral implications', whilst minimising the seriousness of the accusations (Ibid: 8). Official denial was also evident and involved 'collective and highly organised' efforts, usually involving cover-ups (Ibid: 10). There were also persistent denials regarding the existence of victims, with a continual minimisation of the effect that 'insignificant' events could have on these supposed victims (Ibid: 96). This was in addition to the continual blaming of the deceased and their families (Ibid:

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<sup>58</sup> At the time of submission, this investigation had not reported its findings.

<sup>59</sup> Again, at time of submission, this investigation was not complete.

97-98). As Family Member One argued, 'we [family campaigners] are made to feel as though we shouldn't be fighting. We are made to feel guilty'. This condemnation of victims seeking justice sought to further marginalise and silence them. As Scraton argued, families are:

Silenced through their pathologisation, and alternative accounts are disqualified through vilification, there is a profound (almost obsessive) refusal by state institutions to acknowledge responsibility...it prevents the bereaved and survivors from coming to terms with the pain of their loss (2007: 235).

As was also the case historically, as critically examined in Chapters Three and Four, It is apparent contemporaneously that a culture of secrecy and lack of accountability dominates the post-death system following the deaths of detained patients, consisting of concealment, denial and avoidance. This lack of accountability has been particularly apparent within the investigation process, as this chapter will now explore.

### **The Lack of Accountability in the Investigation System and the Coroners Court**

The lack of an independent investigation system following the deaths of detained patients has been a long-contested issue, as demonstrated in Chapters Three and Four. Contemporaneously, participants noted their concern regarding the issue. As Campaign Website One argued, 'it cannot be right that our society ignores some of the most vulnerable members of our society in such a deplorable way

[through the lack of an independent investigation system]’. This was supported by MP One:

It has been a mistake to view the NHS as inherently good and therefore it is OK for them to investigate themselves following the deaths of detained patients. This should not be the case. Instead of massaging away the uncomfortable truths, the NHS should be demanding an independent investigation system themselves, in order to be on par with the police and prison service. The state, and those under that umbrella, asks us to trust it. Therefore, when it fails, it is very serious and we need to find out what went wrong promptly, which is not happening due to the lack of independent investigations. It’s a life and requires a greater sense of urgency and a call to arms.

Despite the apparent benefits of an independent system, such as increased accountability and transparency, Coroner Two stated that he could not envision an independent system being introduced. This viewpoint was shared by Legal Practitioner Five who added that ‘it is unlikely to occur, but there is potential in politics and lobbying’. For Legal Practitioner Six:

The government would push back incredibly hard on an independent investigation system, but why should people with mental health problems be differentiated from other individuals in different forms of custody?

This ‘inequality’ led to the belief that it was the official view that:

Detained persons are less worthy and the NHS has something to hide. This has led to a culture of certain types of death not requiring attention, combined with deliberate attempts to miss things in investigations. This is an inadequate mind set in investigating one’s self (Legal Practitioner Five).

Family Member Three agreed:

You go through life as someone irrelevant because you have poor mental health. Then in death, you don’t even warrant an independent

investigation. It really needs to change. How can this ever improve otherwise?

The lack of an independent investigation system was an area also discussed by Campaign Website Five. Here, the family argued that 'independent investigations of deaths of psychiatric patients must be the norm. There is too much room for cover-ups and lies when organisations investigate themselves'. The family continued:

There must be an independent review of any recommendations made after a patient's death. As already proved, it is too easy for senior management to say 'yes we have addressed all issues raised after the death of xyz...lessons have been learned' (Campaign Website Five).

Coroner Two found that when he commissioned independent witnesses beyond those named in investigations by trusts, this procedure revealed 'issues that had not been identified in the original submissions to the court'. Problems surrounding the disclosure of evidence were also identified. Legal Practitioner Two stated:

Solicitors often have to press hospitals for information. There is a continual fight for disclosure and access to documents within a system that should not be adversarial but is. This results in issues being swept aside.

Similarly, Legal Practitioner Eight noted:

You can try telling a family that certain documents don't exist, they might believe you. We don't. It's insulting to think that we don't know our jobs well enough to know what documents they [the trusts] are sitting on.

In a display of the persistent avoidance of official accountability and transparency, Legal Practitioner Four also discussed how he had to 'push all the time' for disclosure of documents and evidence from hospital trusts and their representatives. Furthermore, Legal Practitioner Four noted how he had been forced to ask coroners to use their powers to compel the disclosure of documents from other parties, particularly when trusts claimed that certain documents did not exist. He stated: 'they won't give them up [the documents] unless you ask for them'. As Campaign Website One recognised, it was 'appalling' that trusts operated systemic 'delaying tactics' in disclosing vital information. The secrecy apparent highlights the 'powerful discretion' within the system (Scruton, 2007: 38). However, examples such as the cases discussed by Legal Practitioner Four indicates that this veil of secrecy could be lifted, often by 'more powerful' people (Hornstein, 2009: 161), such as legal practitioners acting on behalf of families.

Even when documents were provided by trusts to the coroners court, Legal Practitioner Five stated that he had to press for 'a more rigorous analysis of the information received, as often the conclusions made by the hospital don't stack up with the evidence'. An example of this was illustrated by Legal Practitioner Four who recalled an incident where a patient had been released from psychiatric care, only to take her own life days later. An independent consultant, in an early draft of a report into the death, 'came to a critical conclusion that it was completely inappropriate for the patient to have been discharged'. Nevertheless:

What started as a critical report went round the houses and by the time

the final draft was produced, a benign, non-critical report was sent to the family. The family and I were later given access to the prior drafts and were able to see how watered down the report had become.

The family argued that this editing of the report was a breach of Article 2 of the European Convention on Human Rights<sup>60</sup>. However, the judge overseeing the family's challenge did not give them permission to appeal. For Legal Practitioner Four, 'this was an indication of what can go on' and was a further example of the 'shameful hypocrisy [that] has become normalized within an intolerant regime of denial, cover-up and dismissal' (Walters, 2007: 16).

Legal Practitioner Six detailed how a case she had worked on became well-documented in the media and was subsequently subject to an independent examination<sup>61</sup>. This external investigation was a rare occurrence and resulted in an:

Incomparable quality and depth to an internal investigation, with family engagement, focusing on revealing what happened, not avoiding accountability and promoting meaningful change.

Despite the potential of independent investigations following the deaths of detained patients, some participants also argued that an independent system would not necessarily be problem-free. They noted the issues apparent in the

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<sup>60</sup> As discussed in Chapter Four, Article 2 is the 'right to life'. If an individual dies in state custody, an independent and prompt investigation must be undertaken which is transparent, open to public scrutiny and involve the bereaved family (Equality and Human Rights Commission, 2012: 25-26).

<sup>61</sup> The independent examination was undertaken by Verita, an independent investigative agency.



independent investigation systems in place to examine the deaths of individuals in police and prison custody. An example of the 'cosy collaborations' referred to in Chapter One (Cohen, 1988: 30), was discussed by Coroner Two:

Prior to the introduction of the PPO [Prison and Probation Ombudsman], other prisons would independently examine cases from other prisons, but that turned into 'you scratch our back and we'll scratch yours'. Now we have the PPO we have different issues, they are woefully inadequately funded.

Similarly, Legal Practitioner Two stated:

Having the IPCC [Independent Police Complaints Commission] and PPO does not make that much difference, as they have no obligation to call witnesses and ask nicey nicey questions.

Participants expressed their disdain towards the investigation system, yet also recognised that the introduction of an independent system remained unlikely and not without issue. The issues discussed concerning the investigation system results in a coroners court inquest often being held in the aftermath of an investigation that has been internally-held, is far from wide-reaching and lacks criticality and transparency. Despite this, Legal Practitioner Six argued that there had been some 'small' improvements in the 'unpredictable' coronial system. However, for Legal Practitioner Five more was required:

It is true that coroners now have more powers, including being able to order disclosure, compel witnesses and ensure that critical questions are asked, whilst allowing public scrutiny. However, these powers are not always used as many coroners feel they need to stay on side with trusts.

Coroner Two also pointed out that after July 2013 only lawyers could become new coroners. It was no longer the case that this role could be undertaken by a doctor. As a result:

You could become a coroner with no knowledge of mental health...you have to learn on the job. There has been the promise of medical examiners to add the medical expertise to coronial teams, however this has not followed through and coroners feel they have been cast adrift.

Legal Practitioner Two indicated that there were a number of cases where, following the deaths of detained patients, hospital trusts admitted liability for the patient's death shortly after it had occurred. However, trusts admitting liability was in fact a further indication of the 'blurred accountability' (Jacob, Perron and Holmes, 2014: 7) apparent in the coronial process and was viewed as a 'tactical' decision (Legal Practitioner Two). This was explained by Legal Practitioner Two who argued that there was 'most definitely an ulterior motive' behind taking this action:

Upon admitting liability, trusts then attempt to persuade families that they no longer require legal representation themselves, despite the fact that the trust themselves would still have legal representation. In one case, when the trust took this course of action, it was then a fight to be able to call witnesses at the inquest because of the trust admitting liability, although I succeeded in the end.

Coroner Two stated that it would help the whole process if families were legally represented. Families could be put at an 'unfair disadvantage' without legal representation as, 'despite what trusts say, they will be almost universally be represented themselves'. Coroner Two continued:

It does not make much difference to the findings of the inquest, but having representation for families means that issues raised can be explored in further depth and questions can be asked, as opposed to statements which is what families have a tendency to do if they are representing themselves.

For Legal Practitioner Nine, the only time a family would not need legal representation was when a coroner undertook such a thorough examination that all of the evidence was gathered. However, this was a 'very rare' occurrence. Legal Practitioner Nine also pointed to a case when a coroner, due to the 'extremely thorough' approach adopted:

Found that nurses had been signing the names of other staff members on documents and case notes. We hadn't even noticed this ourselves. It was only because of her really quite meticulous approach that this was uncovered.

Another route through which accountability in the coronial system was avoided was 'obstructive defence solicitors who work to conceal the flaws and failings of the trust who had instructed them' (Legal Practitioner Three). As Legal Practitioner Two noted, 'hospital trusts are known for instructing the same solicitors to represent them'. Family solicitors are then forced to act 'bullish and push hard for the truth' (Legal Practitioner Five). Legal Practitioner Four, who now represented families but had previously represented trusts, noted:

I was told 'the less you say the better' and if families were not represented or had a lawyer who did not know what they were doing you had to hope that issues you didn't want touching on were not brought up.

Legal Practitioner Eight maintained that 'the way other legals act towards us, it's classroom antics, whispering secrets, belittling requests. We know how to handle

it, but families don't'. It was not only legal practitioners who were deemed obstructive. Coroner One noted how:

Some witnesses [representing or employed by trusts] are evasive during questioning at the inquest. I continue to ask the question until it is answered, however long that might end up taking.

Furthermore, Legal Practitioner Eight argued that the representatives of hospital trusts questioned family members in the coroners court:

As if they were being cross-examined in a criminal court rather than giving evidence about their loved one at an inquest (Legal Practitioner Eight).

Legal Practitioner Five also discussed the defensive nature of hospital trusts whom:

In their desire to avoid civil claims for damages turn the process of the inquest into a twisted and warped experience and the people who suffer most because of this are families. This is in complete contradiction with the NHS's claims that they want to learn from previous deaths.

Family Member Two stated that during his relative's inquest, the family felt that they had entered 'a world of secrecy and denial' and:

It felt as though we were getting somewhere with the questioning but then nothing. Nobody wanted to answer the questions, or answer them in any depth. There was so much more we wanted to know but it was as though nobody wanted to rock the boat for the sake of a psych patient.

As Family Member Three also noted, 'it felt like that at every turn there was a block, a gate closed. On our own we would have had no chance [of challenging the hospital]'. Legal Practitioner One pointed to a case where, on the first day of

the inquest a hospital trust disclosed additional evidence and then continued to do so throughout the inquest. For Legal Practitioner One this was a sign of a 'cover-up where there was clearly something to hide'. Similarly, Coroner Two noted that he was due to hold two hospital-death inquests (from different hospitals) the following day and had only been furnished with the trust's paperwork that day. This linked with the views of Legal Practitioner Four who stated that 'due to things staying in-house longer, documents were being disclosed at the last minute before inquests and this results in a mess'.

The experiences of bereaved families in the coroners court was discussed by Legal Practitioner One who noted how relatives were encouraged to think that all parties in the inquest were 'all in it together', yet this was rarely the case. Despite their negative experiences, Legal Practitioner Five stated:

Families are keen to attribute blame but they would actually not wish to blame as much if they believed the system was more open and forthright regarding mistakes, with people acknowledging that lessons will be learned.

In order to improve the experiences of families, Coroner Two stated that he asked relatives to outline their issues beforehand in order to prepare witnesses regarding the questions they would be asked. However:

This has led to families feeling suspicious that if they set their questions and concerns out in advance, then it will result in the trust having time to scheme their way out of the issues, and if they had been able to ask the questions on the day of the inquest, without prior warning, they may have been able to catch them out (Coroner Two).

Legal Practitioner One stated that some coroners complained that families had produced 'bucket lists' of questions for which they wanted answers. This raised the question of 'whether the voices of families were genuinely welcomed within the courts or whether lip service was being paid to them' (Legal Practitioner One). Regarding the 'quest for accountability' demanded by families, Coroner One argued:

It is sometimes the case that families bring a case to prove into the court and because of this they will never be satisfied as the inquest is a journey of discovery where the purpose is inquisitorial and not to prove one set of events against any other views. Families who continue to campaign for justice and accountability following the inquest verdict must be aware that the evidence will not change over time.

Further problems in the coroners court were highlighted by Legal Practitioner Three who noted the lack of 'consistency' within the coronial process:

Much depends on which coroner is overseeing the case and whether it can be argued that Article 2 of the European Convention on Human Rights is engaged. If we can engage Article 2, it allows a broader scope to be focused on within the inquest. This means we increase the likelihood of a more thorough examination of the case and the possibility of attaining accountability.

The discretion of coroners was described as problematic and 'most definitely an issue that can hinder families getting the answers they require' (Legal Practitioner Seven). As Scruton and Chadwick recognised, 'the use by coroners of their lawful discretion can be crucial not only in discovering the circumstances of deaths (or hindering their discovery) but also in affecting subsequent judicial and policy decisions' (1987b: 11).

Legal Practitioner Five noted that it was also very difficult to persuade coroners to focus attention on previous deaths within the same trusts. This was an area of concern also identified by INQUEST who have argued that it is vital to situate individual deaths within the context of other deaths, either within the same institution, regionally or nationally in order to identify persistent issues, patterns and failures (2016c: 6). Furthermore, Legal Practitioner Six argued:

The majority of coroners use their discretion to limit the scope of an inquest to that death alone, when we, as family representatives, may want to discuss an incorrect diagnosis or previous deaths that may highlight that a particular trust had not changed and had not learned lessons. Most coroners resist and only a handful of coroners would be interested in looking at patterns with previous deaths.

Another issue identified was when certain questions were not put to the jury or issues were rejected or misunderstood (Legal Practitioner Five). This was in addition to the ‘nonsense of excessively long waits for inquests’ for families (Ibid). Despite the issues within the court, Legal Practitioner Three also noted that there were some ‘very critical conclusions from coroners and some very good Regulation 28 Reports’<sup>62</sup>. However, the lack of response from official bodies counteracted the potential for lessons to be learned and ‘unfortunately there is no mechanism for the coroner to force the hand of the organisation to actually effect the changes that they set out in their responses’ (Legal Practitioner Three). This was also discussed by Coroner One who stated, ‘I have no power to enforce any suggestions made and I can’t really believe that this is likely to change’. For

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<sup>62</sup> Regulation 28 reports have replaced Rule 43 reports, discussed in Chapter Four. Regulation 28 reports are issued by a coroner when there are opportunities for changes to be implemented that would prevent future loss of life. The recipient is then given 56 days to respond.

Coroner Two, 'public shaming is often enough to encourage action by trusts, primarily as a result of Regulation 28 reports. But, if not, the CQC are hovering in the background'. However, Coroner Two also argued:

Even when Regulation 28 reports are produced we find that the responses are often poor and do not give families the satisfaction that lessons will be learned. However, they are always responded to, eventually, sometimes just a generic response by a civil servant.

Coroner One referred to a further limitation placed on coroners by their governing bodies. He stated that if a hospital trust said that they wished to make improvements, but could not do so due to a lack of funding, then he would not criticise this, as it would mean 'criticising the politicians'. Legal Practitioner Five argued that 'the overall inquest process, and conclusion of the inquest, doesn't go far enough'. The comments from participants reflected the analysis of Scruton and Chadwick who referred to the:

Official secrecy, lack of access to primary evidence and official inquiry reports, unfair procedures at inquests and the selective and discriminatory use of permissive powers by coroners, all adding up to a system which was heavily weighted against the interests of a deceased's family and friends (1987b: 166-167).

The views of participants were also indicative of families who had been involved with INQUEST who argued that they 'were under the impression that an inquest was an impartial investigation-not a game of advocacy/opposition' (INQUEST, 2003: 23). The contemporary examples outlined in this chapter also emphasise the positioning of the coroners court as a site of a contradictory power struggle,



as discussed in Chapter Three. On one side, truths can be suppressed, and on the other side, truths can be revealed that would have otherwise remained hidden. This indicates the capabilities of the court in 'providing alternative accounts to official discourse' (Sim and Ward, 1994: 260).

### **The Power of Silencing and Marginalisation**

As discussed in Chapters Three and Four, the families of detained patients were repeatedly subjected to marginalisation and dismissal in both the lives and deaths of their relatives. Their 'constant control and regulation' (Larkin, 2011: 130) was discussed by Family Member One:

The often slow progress made by official bodies is a deliberate tactic to wear families out. 2011 and the riots showed us that things can move quickly if they want, if it suits the interests of certain people. The tactic of slow progress results in families giving up, getting tired and ceasing communication with each other, not forgetting mental health problems [experienced by families].

The views of Family Member One reflected what had happened within his own family where 'communications had broken down'. He thought that more immediate family members were keen to accept damages. He had attempted to persuade them not to, as that would leave the investigation 'dead in the water'. Despite this, he did understand why families chose to accept damages, although it also angered him, as 'due to this ploy, those involved in the death can carry on with their lives due to the acceptance [by the family] of damages'.

For MP One, the lack of regard and official interest in families was promoted by the 'misconception that deaths in custody does not affect a lot of people'. It was also a common misconception that bereaved families were 'unfortunate aberrations' (Scruton, 2002a: 110). The lack of public awareness can be explained by attention being diverted to the undesirable 'social characteristics' of patients (Box, 1998: 13). It is a strategy of social control which further marginalises already marginalised groups, whilst also attempting to render them 'invisible' (Ibid: 13). As a result, these deaths 'do not elicit public sympathy' (Shaw and Coles, 2007: 11). For Coroner One:

Historically, society learned over decades not to care about asylum patients and not to be understanding. I have always been of the view that it would take many generations to lose this lack of caring attitude.

This attitude to patients was apparent in Coroner One's courtroom where he had to remind the court, on occasion, 'not to label and use certain terms'. Labelling, stigmatising and discrediting<sup>63</sup> was discussed in Chapter One, along with how this response works to reinforce the marginalisation and subjugation which dominates this area. This response was also drawn upon by Family Member One, who, when trying to organise a fund-raiser in memory of their relative, 'found potential venues to be quite dismissive, assessing whether my event was worthy of them'. The family were so aggrieved that they submitted a formal complaint

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<sup>63</sup> This labelling, stigmatising and discrediting was also apparent during a deaths in custody awareness event attended during the course of the thesis. Here, the organiser noted the difficulties in finding a venue willing to accommodate the event. Venues had cancelled once they knew the nature of the event as it was 'controversial and likely to provoke debate' (Naphtali, 2016: n.p).

to one of the venues concerning their attitude. Family Member One's case provided an example of the 'quiet structural forces [that] are in operation, silencing criticism and protest' (Mathiesen, 2004: v). By speaking out, Family Member One contested this 'silent silencing' (Ibid: vii) and ensured that alternative truths and knowledges continued to emerge.

Within the investigation system, silencing and subjugation was again apparent, as had been the case historically in Chapters Three and Four. Legal Practitioner Three stated that families felt that being asked by the trust to participate in the investigation was:

Merely paying them lip service, and as a result, families often find it hard to gain a real involvement and often feel as though they are not being listened to.

Legal Practitioner Two argued that families were included in investigations as a 'token gesture' and that their opinion 'was not really required'. For Legal Practitioner Five, 'families feel the entire process is stacked against them'. However:

It is now much rarer to encounter trusts who have completely failed to engage with families at all following the deaths of detained patients but it can be the case in private settings. However, the engagement is often not genuine on the part of the trust, it is a cursory engagement demonstrating a lack of quality and an engagement that is not meaningful...if families meet with trusts at the beginning and end of the process they often feel that they were not listened to, their issues dismissed or not acknowledged and have no means to challenge their findings...it is a case of 'our report, our conclusions...that's the end of it' (Legal Practitioner Six).

Legal Practitioner Two recalled an occasion when a family met with a hospital trust at her office following the death of their relative. Despite the fact that the family 'really pressed for answers', she believed that 'they would not have got these answers without our presence'. For Legal Practitioner Three:

Families are frustrated that their questions are not being answered. There is a lack of openness and families who were enthusiastic at the start of the process regarding the possibility of change become cynical and develop a lack of faith in the system.

With the issue of silencing and marginalisation following the deaths of patients so prevalent, the dominance of a post-death system based on secrecy and control was emphasised, with this response being particularly apparent within the coroners court. MP One noted that when attempting to uncover the circumstances surrounding a death in the coroners court, and ensure that justice was attained, families 'were always the weaker party, up against the power of the state' and received little support. This resulted in relatives being faced with 'an inequality of resources that often led to feelings of disempowerment' (Ibid). An example of this disempowerment was the 'nightmare' Legal Aid Agency (Legal Practitioner Four). Legal Practitioner Two noted her concern regarding the lack of legal funding for bereaved families to be represented at an inquest. She argued:

When trusts admit liability regarding a patient's death, funding for families is less readily available, so why, if trusts are open, honest and transparent, don't they fund the cost of the families' representation?

Reflective of the widespread disregard for bereaved families, Legal Practitioner Two continued:

On occasion I receives phone calls from families, sometimes via INQUEST, who are about to go into the inquest without legal advice. I inform them that they should not have been allowed to go without legal advice for so long and they should attempt to postpone the inquest and seek proper legal assistance.

Coroner Two argued that:

There should be increased funding for families and this is something the current chief coroner has suggested. The current chief coroner is also keen on full disclosure to properly interested persons. However, when a new chief coroner takes up the role, I'm not sure if these will be followed through. I am a little dubious.

Ryan has noted previously that this lack of resources was a continuing issue for families (2004: 5). This resulted in unrepresented families having to confront lawyers representing various different official bodies. As he recognised, 'this is hardly a level playing field' (Ibid: 5). This lack of regard and official interest in families again reflected that it was not just patients who were designated to 'second-class citizenship status' (Harnden, 2008: 33). Families were also subjected to this marginalisation when attempting to uncover the circumstances surrounding their relative's death.

The varying standards of coroners was also highlighted by participants as an area in which families experience marginalisation. For Legal Practitioner Four:

Different coroners within the same jurisdictions can have very differing approaches. One example was a young patient who took his own life after numerous attempts. Despite his history, he had very limited mental health care. The assistant coroner issued a highly critical verdict with a then rule 43 report. I know that if the senior coroner had dealt with that case, it

would not have been dealt with in the same way, and most definitely with less criticality or regard for the family. The senior coroner does not like lawyers being involved and tells families they don't need representation, even though all other interested parties will be represented. It is his view that solicitors and barristers acting for families are a nuisance, an interference, meddlers and are only there to make his life hard.

The views of Legal Practitioner Four were also shared by Legal Practitioner Five:

Some coroners are more critical towards family representatives than the representatives of other interested parties due to the number of critical questions they ask. I think this is often down to some coroners feeling it is their job alone to ask questions.

For Legal Practitioner Two, some coroners needed 'pushing' to treat families appropriately and some were 'absolutely in the wrong job'. This was a point reflected by Legal Practitioner Five:

It is around 50/50 if a coroner recognises the importance of the family. There are still a lot of coroners who treat the families as if they are anyone else

Similarly, Legal Practitioner One noted:

There are coroners who do not make eye contact with families, possess a mind made-up attitude, indiscriminately distribute documents to different interested parties, possess pitiful record-keeping skills, dehumanise the deceased and talk about them as if they were not a person, all whilst cutting off questions prematurely in the court-room. This leads to family disbelief and on one occasion, this actually led us to judicially review a coroner resulting in a new inquest taking place.

Legal Practitioner One noted that it was 'the luck of the draw' if a family ended up with a 'good' or 'bad' coroner. She continued:

Families should be at the heart of the process and many coroners do respect this. Some coroners allow more questions as the inquest process continues, along with allowing family impact statements which humanises the deceased.

As Legal Practitioner Six indicated, 'unless it is a coroner we know, it is hard to advise families on what their experience may be like'. Coroner Two, in recognising that families felt 'overwhelmed' by the inquest process, attempted to make his court 'as informal as possible'. Furthermore, Coroner One stated that he tried to 'make the room feel smaller for families'. Coroner One was also discussed by Legal Practitioner One who said that he put families first, had an understanding of mental health, was thorough and asked many questions. However, the family-centered approach of Coroner One was not adopted by all coroners and Family Member One highlighted his family's fight to change the coroner involved in his relative's case. The inquest took four years to be held as the family:

Point blank refused to have the local coroner undertake the case as he was known to be insensitive regarding mental health. He refused to step aside but we persevered and got rid of him.

Campaign Website One also discussed their experience of the coroner assigned to their case and pointed out that he appeared to believe that their relative's death was 'not worth proper consideration' (Ibid). The family claimed that he refused to hear all of the evidence regarding the 'systemic' neglect of their relative, including the fact that the deceased had regularly fallen and was untreated by the staff for a number of medical issues. The family also alleged that the deceased had been given extremely high doses of medication, as the staff had claimed she had the 'constitution of an elephant'. According to the family, the

coroner was not interested in hearing that the deceased's 'dignity was frequently trampled upon' as a result of 'numerous' attacks by patients and staff. The coroner also failed to call a jury, dismissed the evidence of the family as 'irrelevant', while 'patronising' and 'bullying' them and refusing to acknowledge that they required legal representation.

The family were so dismayed at the attitude and behaviour of the coroner that they walked out of the inquest (Campaign Website One). Delivering his judgement in an 'aggressive' and 'rushed' manner, due to, in his own words, having 'more pressing cases' to deal with, he 'refused to look at [the] family once' and passed down a verdict of death by natural causes which, for the family, was a miscarriage of justice. The family noted that he displayed 'an arrogance for the position which he holds' and was 'incredibly disrespectful to the memory of a mother who, for over 40 years of her life, suffered the indignities and discrimination associated with a mental illness' (Ibid).

It was not just coroners who were criticised. Coronial offices and administrative staff were also discussed. Legal Practitioner Two stated that she had experienced a lack of correspondence by some coronial offices, resulting in her having to actively seek information regarding court listings. This view was mirrored by Legal Practitioner One who detailed two cases where her office enquired about the date for a particular inquest, only to be informed by the coronial office that a date had already been set, without checking if interested parties could attend at that



time. She argued that this was a breach of the 2013 Coroner's (Inquests) Rules, 'but was unfortunately not uncommon'.

As Scraton and Chadwick argued, there is an expectation within the inquest process that 'liability [was] on the agenda' (1987a: 214). However, families were repeatedly left disappointed and frustrated due to failures in gaining access to vital information (Ibid: 214-215). As a result, they became 'disillusioned and embittered by a procedure which [relied] on the effective building of negative reputations of the deceased in often unsubtle attempts to justify acts of negligence or brutality' (Ibid: 215). The views of Scraton and Chadwick were apparent in the experiences of participants. For Legal Practitioner One, the period following an inquest for families was often a 'roller coaster of emotions' and it was a 'mixed bag' regarding how families felt. Legal Practitioner Four indicated that:

Some families feel there are unanswered questions, with the minority feeling they have been given no answers at all. Cases such as this result in families leaving court thinking 'what was that about? We didn't understand any of it', particularly for those without legal representation.

Legal Practitioner Five maintained that families felt that they had asked 'most of their questions and received an answer for most'. However, he also noted that, on occasion, relatives argued that 'questions were avoided by witnesses or questions they had wanted answers to were dismissed by the coroner as irrelevant'. Legal Practitioner Six argued that families, following the inquest:

Often feel vindicated. However, any family satisfaction is undermined by the fact they have had to fight incredibly hard and wait incredibly long for answers.

For Legal Practitioner Four:

It was more often the case that families did not sing the praises of the coroners court inquest. However, others feel they have an increased understanding because they hear witness statements in person and this can help families understand where the witnesses were coming from when they made their statements, which can often appear very cold.

This point was reflected by Legal Practitioner Two who recognised that it was vital that families saw witnesses and did not just read their witness statements. She described how families struggled to 'let go' following an inquest. However, for some families, there was a 'personality change' when she contacted them after the process to see how they were. For her, families seemed more 'relaxed' and 'less stressed' following the inquest (Ibid). However, Legal Practitioner Five argued that families could also experience 'post-traumatic stress, mental illness and complete breakdowns' following their bereavement. This was indicative of the views of Scraton who argued that people's lives are 'fractured by events that may only take minutes but effects last a lifetime' (2017: n.p). Compounded by the lack of accountability and transparency in the post-death system, bereaved families were, and continue to be, subjected to continual silencing, marginalisation and subjugation. However, this silencing and marginalisation has continuously been challenged, as will now be explored.

## **Resistance, Contestations and Challenges**

This chapter has provided numerous examples of families and their representatives contesting and challenging their attempted marginalisation and subjugation. The chapter will now proceed to explore this contestation in more depth. As Campaign Website One argued, it was vital for bereaved families to 'get things changed, once and for all, so that no family ever has to go through the tragedy that we have'. This was also reflected by the family behind Campaign Website Four who argued that 'we who fight for the truth will not be silenced any more'. An example of this resistance was demonstrated in the case of Campaign Website Three. As noted earlier, the trust involved attempted to dismiss the death due to natural causes. The family launched a sustained campaign against the trust, where they faced 'tortuously slow progress'. During the course of their campaign, the Chief Executive Officer of the trust resigned, only to be reinstated into a 'new role that didn't exist before'. For the family, this drew attention to the 'peculiar works at senior NHS levels around regulation [and] accountability (Ibid). They stated that they had been subjected to a 'tale of atrocity, rage deceit and bullying...the dark side of public bodies remain hell bent on crushing us with no whiff of remorse, commitment to change or any demonstrable positive action' (Ibid). Despite this, they argued that they 'have not given up and we are not going away, [we will] continue our fight for the people that now have no voice' (Ibid).

A subsequent inquest found that not only was the death entirely preventable but it was partly as a result of neglect. The jury also found a lack of leadership, failures

in risk assessment and training, along with a lack of contact with the family. Despite this, the family saw little accountability for their relative's death and continued their campaign in the face of abuse directed towards them from those within the trust (Ibid). This perseverance paid off and in 2017 it was revealed that the trust was to face charges related to the death. For INQUEST, this case was an example of what could happen when families 'never give up their struggle for truth and justice' (2017b: n.p). The trust released a statement indicating that it was responsible for the death and that it was the result of 'multiple systemic and individual failures' (Southern Health NHS Foundation Trust, 2017: n.p). The trust also acknowledged that they violated both the patient's right to life and the human rights of the bereaved family and it was to pay them compensation for its 'unlawful acts and omissions' (Ibid). As a result of their campaign, the family hoped that no family would have to 'search quite so deep, for quite so long, to get answers and find the humanity they deserve' (Ibid).

Further examples of what could happen when families continuously contested their marginalisation was indicated by Campaign Website Two. Their relative died after being restrained by up to eleven police officers after they were called to an incident on the ward the patient was being treated in, only hours after his admission. The family stated that they were 'determined to ensure that all of the circumstances of his tragic death are brought under proper scrutiny' but had to wait for seven years for an inquest which took place in January 2017. The inquest found that excessive force had been used and the restraint was disproportionate

and unreasonable, resulting in a 'litany of failures' (INQUEST, 2017b: n.p). Following the inquest, the family said: 'when [he] became ill, we turned to the state in our desperation...we shall always bear the cross of knowing that, instead of the help and care he needed, [he] met with his death' (Ibid). The family, through years of campaigning argued that 'now is the time to say NO MORE-WE DEMAND JUSTICE AND ACCOUNTABILITY' (Campaign Website Two). Six officers were later cleared of any misconduct following an internal investigation which was closed to the public and the press. Although the hospital trust apologised to the family, no one was held accountable for the death. In 2017, three police officers stood trial on charges of perjury in relation to the death. The officers were found not guilty (Ibid).

The family behind Campaign Website One also fought to challenge their dismissal and marginalisation. Unhappy with the coroner's ruling of natural causes, discussed earlier in this chapter, they brought a case against the coroner at the High Court, with the aim of quashing the initial inquest verdict and for a new inquest to be heard by a 'less biased coroner who is able to make his decisions in line with the law' (Campaign Website One). The family was made to wait for a transcript of the 'discredited proceedings' to be sent to them which for them was unsurprising as the coroner had been 'disrespectfully slow' on numerous occasions (Ibid). They continued:

The wheels of justice turn extremely slowly...it is in her memory-and those in mind who have, are and will suffer the tragedies of our present system-that we will continue this fight for justice, even though the odds are

definitely against us (Ibid).

A High Court judge found that although there had been issues in the initial inquest, there was no need for a new inquest. The judge did not agree that detained patients should be afforded the same protection by the state as prisoners, by means of an independent investigation system. For the family, it was 'shocking that the deaths of vulnerable people...and in such appalling circumstances do not attract the same safeguards as granted to prisoners' (Ibid). The family argued that it was unfortunate that in the modern day, 'we are still having to make such basic demands for human dignity, and even more saddening that most people are completely unaware of the situation...has anything really changed since the Victorian asylums closed?' (Ibid).

Unhappy with the ruling, the family took the case to the Court of Appeal, arguing again that detained patients should automatically receive the same form of investigation as the deaths of prisoners as 'people who die in mental health detention are just as important as anyone else' (Ibid). The family were stuck within the system, 'grinding on without any end in sight' due to the multiple 'delaying tactics' used (Ibid). The Court of Appeal indicated that the High Court judge had made an incorrect judgement and in fact, the deaths of detained patients should be subjected to an increased level of investigation, in line with human rights legislation. For the family this was not enough and led them to argue that 'lessons will continue to remain unlearnt [without a fully independent

investigation system]. Mental health patients will continue to be unsafe and future deaths will continue to be dealt with in a cursory manner'<sup>64</sup> (Ibid).

Indicative of the campaigns of bereaved families, discussed throughout this thesis,

Legal Practitioner One argued:

Families do not want others to experience what they have. It might be too late for them but they always want the truth out, the system to change and to protect others, even if that means working with groups who they may hold responsible or blame for the death of their relative.

This was a point also drawn upon by Scott who noted that the state should be worked with and against in order to challenge it (2013a: 320). As Family Member One argued:

Positives have come from the death and despite all of the grief we have been through, there could not be a better legacy than that of preventing the deaths of others (Family Member One).

Despite these achievements, Family Member One discussed how fellow family campaigners and organisations had, on occasion, 'let families down and done nothing for families'. He continued, 'It's not enough to 'like' on Facebook, tweet revolutionary phrases, wave banners and shout in the street. That is absolutely not enough'. Instead, he established a campaigning and networking group,

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<sup>64</sup> It would later emerge that the coroner involved in Campaign Website One's case had resigned from his role. He faced sanctions from the Solicitors Regulation Authority (SRA) after he employed his unqualified wife as a deputy assistant coroner. He was found to have breached six key principles governed by the SRA and was fined £495. No other action was taken as he coroner had already resigned and moved out of the country (Hyde, 2014: n.p).

‘where different campaign groups could come together and encourage change’. In addition to this, he regularly contacted other bereaved families to inform them of what to expect, such as ‘letting them know that they can push for the coroner to make Prevention of Future Deaths Reports’ (Ibid). He also established a family funding and campaigning group where families could apply for funding in order to cover the costs of producing material to distribute regarding their case.

Linked with the vital role of campaign groups, several participants discussed the work of groups such as INQUEST as possessing an integral role in challenging the silencing and subjugation surrounding deaths in psychiatric detention. Coroner Two stated that following the establishment of INQUEST, they were ‘considered a nuisance but, over time became respected and appreciated’. Links can be drawn here with the work of the Alleged Lunatics’ Friend Society, discussed in Chapter Three. The Society was dismissed by official bodies, despite the fact that a number of their suggestions were later implemented.

The cases discussed in this chapter provided further examples of families rising above the marginalisation that they faced while challenging the state’s attempts to silence them (Moore and Scraton, 2014: 31). This has resulted in the ‘insurrection of subjugated knowledges’ (Foucault, 2003a: 7) and alternative truths. The cases provided examples of how state practices have also been challenged, whilst influencing policy and practice (Sim et al, 1987: 37).



## **Conclusion**

This chapter has examined the findings of primary data collected from those with direct experience of deaths in psychiatric detention, through undertaking interviews, using questionnaires and analysing campaign websites. The chapter has contributed towards achieving a number of the key aims of the research. First, it highlighted the contemporary response, or lack of response, to deaths in psychiatric detention. Furthermore, it also identified the issues apparent in the inquest and investigation processes and the response to bereaved families, with a focus on the lack of accountability. The chapter also critically examined the contestation to a system that attempted to silence challenge and contestation.

A number of themes were discussed. First, the chapter highlighted the negative official response to deaths in psychiatric detention, consistently blaming both patients and their families, coupled with a lack of official interest in preventing and learning from these deaths. Second, the chapter recognised the lack of accountability following the deaths of patients, based on concealment and denial, resulting in a veil of secrecy dominating post-death procedures. Third, it discussed the silencing and marginalisation of relatives which attempted to render bereaved families, and those who spoke out, silent. Finally, the chapter analysed the resistance and challenges to the exercise of power demonstrated by these groups in order to create alternative truths and knowledge. The themes identified have indicated that the 'personal' problems experienced by patients and their families, were actually 'public' issues (Scruton, 2007: 14-15). Therefore,

the data generated was able to link the experiences of participants with the broader issues and concerns around deaths in psychiatric detention (Rubin and Babbie, 2010: 37). Despite patients and their families being deemed 'hierarchically inferior' (Foucault, 2003a: 7), these groups ensured that the state and its institutions have been continually challenged. As has been argued, 'it is the system that is mad and not the people caught up in it' (Naphtali, 2016: n.p).

By drawing upon the experiences of participants, this research has not only drawn attention to the ways in which the interests of the state, hospital trusts and their staff have been protected, it has also highlighted examples of resistance and opposition to power. These examples have directly challenged the denial of truth and justice which dominates this area (Scruton, 2007: 239). The experiences analysed within this chapter, and those examined in Chapters Three and Four, are testament to the viewpoint that it is 'vital to campaign for change' (Campaign Website One). For Campaign Website One:

Anything less would be disrespectful to the memories of all who have not survived the mental health system in this country. [It is] literally a matter of life and death.

The themes identified in this chapter, together with the themes identified in Chapters Three and Four, provide the foundations for the development of a range of radical alternatives to policy and practice that will now be discussed in the final chapter of this thesis.

## **Chapter Six: Recognising the Past, Understanding the Present and Building**

### **Towards the Future**

The previous chapter critically examined the data from interviews, questionnaires and family campaign websites. These findings consisted of personal accounts which offered a critical alternative to official discourse (Scruton, 2007: 39) whilst aiming to 'visibilise hidden human experiences' around life and death in psychiatric detention (Scott, 2016: 185). This chapter will conclude the thesis. A number of radical alternatives will be proposed, based directly upon the findings and themes of the thesis. These radical alternatives would work to improve the numerous failing systems identified throughout this thesis.

As argued in the introduction to this thesis, the research aimed to undertake a critical examination of both historical and contemporary data related to psychiatric detention and deaths within these institutions, particularly within the inquest and investigation processes. The thesis also aimed to develop a critical understanding of the historical and contemporary official response to patients and bereaved families, whilst also understanding the issues that these groups have faced following deaths in psychiatric detention. Another area of concern was the issue of accountability, both historically and contemporaneously, and how dominant truths and knowledge have been challenged surrounding the deaths of patients.

A Foucauldian framework, influenced by a number of other critical theoretical frameworks, shaped the critical examination of issues in both the lives and deaths of patients. By undertaking a genealogical history of the present, issues from both the historical asylum system and contemporary psychiatric detention have emerged. As such, how the past has shaped the present could be critically analysed (Garland, 2014: 371). This was in addition to providing a 'disturbance' and challenge to the discourse of progress concerning psychiatric detention (Dean, 1994: 3).

In line with the critical theoretical approaches adopted, the thesis analysed the enduring silencing, subjugation and marginalisation which has dominated and continues to dominate psychiatric detention and deaths within these institutions. By doing so, the measures that have been taken to suppress counter-hegemonic truths have been recognised (Gotkin, 1995: 116; Kinchloe et al, 2013: 341). Also in line with the theoretical underpinnings of the research, the thesis examined the confrontations and challenges to this negative official response which has resulted in dominant voices being challenged, alongside the creation of alternative truths and knowledges. In the face of the 'abiding oppression' demonstrated by psychiatric institutions (Foucault, 2000c: 283), the emergence of these alternative truths and knowledges exposed how the 'totalising' effects of power could be challenged (Foucault, 2000b: 332). This also indicated how power is 'multi directional, operating from the top down and also from the bottom up' (Dreyfus and Rabinow, 1982: 185). Through the 'rediscovery of

struggles' (Foucault 2003a: 8), the thesis argued that many of the cases examined were examples of systemic issues. Therefore, having considered the past and present, it is to the future that this thesis now turns.

### **Facing the Future: Developing Radical Alternatives**

Having 'interrogated' and 'rethought' the history of deaths in psychiatric detention (Davis, 2003: 6), the longevity of the issues surrounding this area have emerged. Despite this, deaths in psychiatric detention remain largely invisible. Attention has been continuously diverted away from the treatment of detained patients in life and death. An official focus on the 'hierarchically inferior' (Foucault, 2003a: 7) nature of patients has seemingly been used as a justification for their continual subjugation and marginalisation. As Legal Practitioner Eight argued, despite the quality of the recommendations and alternatives proposed by those who spoke out, both historically and contemporaneously, 'there is no real intention [by the state] of introducing them. That would mean admitting that previous policy and practice initiatives were ineffective'. To create alternatives in the face of this long-standing 'continuum of dismissal' (Sim, 2018: n.p) involves a continuous struggle.

This concluding chapter is concerned with developing alternative strategies (Davis, 2003: 107). Rather than recommend various reforms that could be co-opted by the state into an existent 'hierarchization of knowledges' (Foucault,

1980c: 85-86), critical alternatives will be proposed. This is an approach that has also been adopted by INQUEST in their own work when challenging the negative construction and portrayal of those who die in state custody, thus demonstrating the power of counter-hegemonic contestations (Sim, 2009: 7). The radical alternatives proposed in this chapter include the prospect of viewing the issues identified as part of a 'psychiatric continuum' (Sim, 2018: n.p) of social harm and social death, applying an abolitionist perspective to the issues identified in the thesis and a consideration of social justice. Further radical alternatives concern the prevention of patient deaths, the prospect of an investigation system following the deaths of detained patients and radically transforming the coroners court system for the benefit of patients and their families.

### **A 'Psychiatric Continuum'<sup>65</sup> of Social Harm and Social Death**

This thesis has critically examined how psychiatric detention consists of degrading, isolating and repressive regimes. The institutionalisation of patients works to further alienate and marginalise them. The psychiatric system can be compared with the carceral system where a 'carceral continuum' exists (Foucault, 1977: 303). Here, patients are oppressed, isolated and dominated within institutions which exist to supervise, transform, correct and improve those housed within them (Ibid: 303).

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<sup>65</sup> Sim (2018: n.p).

Throughout this thesis, the systemic nature of social harms experienced by patients and their families has become apparent, yet these harms receive little official acknowledgement. Adopting a social harm perspective when examining psychiatric detention and deaths within these institutions recognises the sustained, yet often unacknowledged, harms that face both patients and bereaved families. This approach also recognises that the most damaging harms are actually often state-inflicted (Davies, Francis and Wyatt, 2014: 16). Adopting a social harm perspective would consider physical harm, death and injury, financial and economic harm, along with emotional and psychological harm (Hillyard and Tombs 2004: 19-20). This would allow for a much wider understanding of the range of acts and experiences that remain hidden and unacknowledged to be considered (Francis et al, 2014: 246). This perspective would focus on reducing the level of harm inflicted upon patients and their families (Hillyard and Tombs, 2004: 22). As Hillyard and Tombs argue:

Adopting a social harm perspective would work to challenges the dominant structures of power which impose these harms upon subordinates and, instead of 'bolstering' dominant power structures surrounding psychiatric detention, a social harm approach would 'implicate' them and highlight their failings (Ibid: 21).

An increased emphasis on the hidden social harms affecting patients, along with their families, would also work to challenge the failure to prioritise the deaths of patients and the failure or lack of concern in learning lessons from these deaths (Carlton and Sim, 2018: 4). In turn, the foundations would be set for dismantling the power structures that have allowed this negative response to continue for

such a sustained period of time. A social harm approach would also highlight the opportunity for 'developing inclusive and progressive responses to the harm and suffering endured by patients and their families' (Francis et al, 2014: 251).

The findings of this thesis would suggest that a psychiatric continuum exists surrounding the harms inflicted upon patients in psychiatric detention. This allows the issues uncovered to be understood as part of a 'continuum of violence and terror' (Carlton and Sim, 2018: 59-60). Here, regimes of death and trauma are 'structured by axes of domination and subordination' (Ibid: 54). The harms which encapsulate the lives of patients should be viewed as violence, not just of the physical sense, but emotionally and mentally (Ibid: 54). Patients are pathologised and their issues are individualised. They are further marginalised through regimes of exclusion, dismissal and censorship (Gane, 1986: 5). This continuously results in a 'bleak continuum where reputational management overrides public interest' (Coles, 2018: n.p). As part of this continuum, patients are incarcerated in silence and are continuously degraded and dismissed. Their voices and experiences are denied, thus rendering them disempowered. Attention is diverted away from the psychiatric system, similarly to the prison, as a 'death machine' (Foucault, 2000d: 419) by focusing on the individual patients and not systemic failings.



In order to understand deaths in psychiatric detention as part of a psychiatric continuum, there should be a move beyond understanding these deaths as a result of:

Rogue individuals working within the state, or those contracted by the state, nor through classifications around degrees of risk and vulnerability, nor through individualised discourses of victim blaming (Carlton and Sim, 2018: 57).

Viewing psychiatric detention as part of a wider continuum of failures allows for an acknowledgement of the issue of state incompetence to be examined. This is coupled with the recognition that state institutions, such as psychiatric hospitals and coroners courts, are often places of dehumanisation, isolation and pain, where systemic failures traumatise and terrorise the already vulnerable patients (Ibid: 57-61). This 'systemic and routine neglect' (Ibid: 62), such as a lack of adherence to coronial and investigative recommendations, and the neglect of the voices of patients and families, can have fatal consequences.

Viewing deaths in psychiatric detention as part of a wider psychiatric continuum of degradation, pain, suffering and control also allows for a consideration of how, even before their physical deaths, patients suffer a social death (Scott, 2018). Patients are viewed as 'irrelevant' and of 'little social significance' (Ibid: 164). There is also a failure to view these institutionalised individuals as fully human, coupled with a denial of their needs and human rights (Ibid: 167-168). Similar to prisons, patients are therefore treated as if they were non-existent (Borgstrom, 2017: 5) and become 'ghosts' (Scott, 2008: 176) within the psychiatric system.

This renders these individuals invisible and, coupled with the various forms of denial discussed throughout the thesis, they are viewed as 'less eligible subjects whose views, opinions and voices can be refused and ignored' (Ibid: 168). A social death is a permanent condition (Price, 2015: 5) and it is unsurprising that like prisons, psychiatric detention becomes an 'abyss' (Scott, 2018: 164). Here, the process of mortification, discussed in Chapter One, results in the breaking-down of the identity of patients (Henley, 2018: 64). Patients are repeatedly degraded, humiliated, marginalised and subjugated within these total institutions. The negative labels and stigma does not stop once a patient has died, it is transferred to the families who face the same discrediting, control and dismissal. Due to their dismissal, the challenges of these families are often silenced and suppressed in favour of repressive and destructive policies and practices (Clarke, Chadwick and Williams, 2017: 3).

Thinking about social death allows for an understanding of how the identity of patients is lost, coupled with a loss of their social connections (Kralova, 2015: 235). These losses result in patients being viewed as inadequate, coupled with consequences that are likely to be 'devastating' (Ibid: 239-240). For Scott, there are three aspects of a social death which underpin a critical understanding of how this concept applies to psychiatric detention. First, there is estrangement. This has been apparent throughout this thesis through the removal from society and social isolation of those with mental health problems, with minimal or no acknowledgement of their voices (2018: 168). This isolation legitimises their

estrangement from wider society, leading to the perception that a patient is 'not to be trusted, welcomed or recognised as a rights bearing individual' (Ibid: 168).

Second there is 'un-naming' which not only further denies the dignity of patients but also works to dehumanise them, making them a 'thing' (Ibid: 169). This reinforces the negative labelling, pathologisation and categorisation of patients, rendering them less eligible beings in both life and death (Ibid: 169). Third, there is institutionally-structured violence which, according to Scott, is not just of a physical nature but also a 'silent, invisible, yet potentially deadly form of violence' achieved through repressive rules and regimes (Ibid: 170-171). Institutionally-structured violence also occurs when:

Autonomy and choices are severely curtailed; human wellbeing, potential and development are undermined; feelings of safety and sense of security are weak; and human needs are systematically denied (Ibid: 171).

When a social death status is imposed upon a patient, they 'no longer count' (Ibid: 173) and the consequences for these individuals, in the eyes of the state, are minimal or irrelevant. Recognising that patients suffer a social death allows for the prospect of 're-humanising the 'Other'' (Clarke, Chadwick and Williams, 2017: 1). In turn, this provides the opportunity for the contestation of this Othering (Scott, 2018: 174). Gathering the narratives of those with experience of psychiatric detention and deaths within these institutions allowed for the uncovering of the consequences for these people and how this links to social death (Price, 2015: 19). Throughout this thesis, the alternative truths offered by

the subjugated and silenced, and those who work with these groups, has allowed for 'new social alliances, bonds and meanings to be built' (Scott, 2018: 174). This approach can promote a new way of viewing psychiatric detention and deaths within these institutions, recognising psychiatric detention as institutions of dehumanisation and subjugation (Ibid: 164).

### **An Abolitionist Perspective on Psychiatric Detention**

Despite the multitude of failings critically examined in this thesis, psychiatric detention is still repeatedly used in treating some of the most vulnerable members of society. An abolitionist approach argues that state institutions, such as psychiatric hospitals, do very little to protect those in their care (Sim, 2009: 3). Instead, these institutions direct attention away from their own failings by blaming others, thus legitimating their confinement and control. Adopting an abolitionist perspective towards the issue of deaths in psychiatric detention would allow taken-for-granted assumptions and knowledge in this area to be reconsidered (Hudson, 1993: 5). Adopting this approach would also expose the inadequacy of psychiatric detention as an example of a 'toxic environment' where 'all humans placed in such a degrading and damaging place are vulnerable to its structured harms' (Scott and Codd 2010: 9). It is apparent that we take these institutions for granted and it is difficult to imagine where thousands of patients could be treated elsewhere. However, at the same time, and extremely problematically, there is a 'reluctance to face the realities hidden within them [and] a fear of thinking about what happens inside them' (Davis, 2003: 15).

Adopting an abolitionist perspective in this area would not simply call for the eradication of psychiatric institutions, as this approach would recognise that there are patients who pose too much of a risk to themselves, and others, to not be detained in a secure setting. It would instead question why these institutions are taken for granted as the first response to treating those with mental health problems (Hudson, 2003: 179), when the system fails them so readily in both life and death. This abolitionist framework would consist of breaking with the 'established order' (Mathiesen, 1980: 233), coupled with adopting 'the attitude of saying 'no'' (Mathiesen, 2015: 31) to the persistent and unnecessary use of psychiatric detention. This perspective would focus on the introduction of sensible regimes (Coggan and Walker, 1982: 15) which first considers whether individuals need to be detained at all, and second, how psychiatric detention can be radically transformed. This abolitionist perspective would allow for a greater recognition of the needs of patients, whilst also locating issues within wider social contexts (Scott and Codd, 2010: 21). It would also allow for an increased focus on the issues faced by bereaved families. This approach would emphasise the importance of increased support and interventions for them and for greater visibility regarding their cases (Ibid: 149).

As part of the abolitionist alternatives proposed as this chapter progresses, it is important that the seemingly private troubles experienced by patients and their families are viewed as public issues (Scott and Codd, 2010: 9). For example, individual cases dismissed as one-offs and unconnected can instead be

recognised as reflective of wider systemic issues, such as a lack of accountability. This is indicative of 'turning cases into issues' (Sivanandan, 1983: 9; Scraton and Chadwick, 1987a: 213). Here, institutions are critically examined, focusing on the accounts of patients and their families and contrasting their experiences against official accounts. This approach would stand in stark contrast to current approaches of dismissing and silencing the accounts of those who challenge and contest dominant discourses. The resistance and contestation shown by patients, families and those who spoke out have attempted to make the psychiatric system accountable. These challenges link with the abolitionist perspective of developing a 'criminology from below' (Sim et al, 1987: 7). This approach acknowledges the voices of the marginalised and subjugated, in addition to breaking the silence around deaths in custody and highlighting that these deaths are not simply one-offs but are often indicative of systemic failings.

This challenge and contestation can also be viewed as part of a wider 'criminology of resistance' (Walters, 2003: 166) where critique is promoted, power and social order is challenged and dominant truths are questioned. As part of this movement of resistance and contestation, those who challenge have to be conscious of being co-opted and defined out (Mathiesen, 1980: 287; Scott and Moore, 2014: 259). For the state and its agencies, the absorption of counter-hegemonic voices is a key strategy due to the threat these challenges pose (Mathiesen, 2004: 15). It is a contradiction that groups such as bereaved families are encouraged to share their views and alternatives, yet then face a constant

battle to avoid being defined out (Ryan, 1978: 1). Mathiesen acknowledged that it was a recognised official strategy to implement 'a new order which softens the criticism against the old order for a while, while being structurally like the old order' (1980: 233). An abolitionist approach would move away from the current dominance of 'positive reforms', which work to further legitimise the power of the state. Instead, an increased focus on 'negative reforms' would allow for the state and its legitimacy to be questioned (Mathiesen, 2004: 20).

For abolitionists, reform, in general, has served to reproduce dominant discourses (Ryan and Sim, 2007: 701). Psychiatric detention is reflective of a system which, at first glance, has been continuously reformed. However, this thesis uncovered how these reforms have resulted in very little positive change or improvement. Instead, the findings would indicate that radical change has been ignored in favour of reforms which further control and reinforce the marginalisation and subjugation of patients and their families. It is not to say that all reforms have failed to improve the position of the confined. However, it is important to note that not all change equates to progress (Ryan and Sim, 2016: 716).

### *Social Justice*

The issue of social justice is integral to an abolitionist perspective. As the thesis has demonstrated, there is significant harm, dismissal, struggle and exclusion

facing those who fight for social justice, official acknowledgement and for their voices to be heard (Scruton, 2002b: 35). Issues hindering the attempts by families to obtain truth, justice and accountability<sup>66</sup> include abuses of power, inadequacy of investigations, lack of disclosure and the pathologising of victims. This is coupled with the subjugation of survivors and campaigners. Other issues include the silencing of alternative truths, blaming already marginalised individuals for incidents, the denial of responsibility demonstrated by institutions and the manipulation of the media (Ibid: 36).

The lack of social justice experienced by subjugated and marginalised groups (Barton et al, 2007a: 17), and the struggle faced by them, is often compounded by ‘officially sanctioned and sealed version[s] of the ‘truth’’ (Clarke, Chadwick and Williams, 2017: 35). An example of this lack of social justice in practice was related to the supposed risk that patients pose. As discussed in Chapter One, a focus on the risk and dangerousness of patients leads to social injustice, where the negative response to patients, consisting of control and exclusion, is justified by focusing on their supposed risk and dangerousness. However, adopting a social justice approach would instead focus on the risk and danger posed *to* patients, as opposed to the risk and danger posed *by* them.

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<sup>66</sup> These are the guiding principles of INQUEST.



A way in which social justice could be achieved is through challenging the 'lamentable complacency around accountability' (Coles, Sim and Tombs, 2018: n.p) that exists within various forms of state custody, and in the case of this thesis, psychiatric detention. Coles et al have also proposed the use of the Corporate Manslaughter and Corporate Homicide Act 2007 as a starting point when challenging the continuous lack of accountability following the deaths of patients (Ibid: n.p). The use of this Act would result in the rectification of health and safety breaches, financial implications and the publicising of failings. The persistent lack of prosecutions and convictions highlighted throughout this thesis would indicate that the use of this Act in relation to the deaths of patients could have a positive impact on promoting accountability following these deaths. Therefore, adopting a social justice approach in this area would encourage the development of research and policy initiatives that would challenge, rather than reinforce, dominant structures of power (Barton et al, 2007b: 211). The approach would also question current levels of accountability and allow for a wider understanding and definition of accountability to be developed. However, a framework focused truly on learning and social justice could only be effective if it was entirely independent of the state and its agendas.

A social justice approach would also address how patients and their families have been marginalised and subjugated, in comparison with hospital trusts and the medical profession, whose position of power has been continuously reinforced (Clayton and Williams, 2004: 1). This approach would focus upon fairness

(Hudson, 2006: 20) and would provide humanistic alternatives (Scott, 2013b: 98) to the marginalisation and subjugation experienced by these groups. An example of the capabilities of adopting a social justice approach can be viewed in the response to bereaved families. Following the death of their relative, families are 'at best, marginalised and ignored and, at worst, excluded and abused' (Scruton, 2007: 13). As INQUEST have argued, families continue to feel that they are 'always trumped by the 'experts'' (INQUEST, 2016a: 9). Hospital trusts and the medical profession should value the contributions and experiences of families, as opposed to regarding them as a threat or inconvenience (Ibid: 32). There is a continual official denial to view these families as victims. There is also a need for wider support for families as, not only are they 'entering a completely new world of sustained battles' (Naphtali, 2016: n.p), they are also 'indefinite victims' (Rigg, 2016: n.p).

With the incorporation of a social justice perspective, there would be a recognition that patients, along with their families and those who raise concerns, are groups who possess a wealth of knowledge. It is family members who are the experts when it comes to understanding their relative's needs and not a source to be dismissed. In turn, this recognition would further work to emphasise that the supposedly private issues experienced by these groups were actually indicative of wider, yet concealed, issues.

Despite the fact that ‘bereaved families are plunged into a process where they have to negotiate a maze of different official bodies’ (INQUEST, 2003: 16), there are very few places where they can obtain impartial advice or support, from individuals entirely unconnected to their relative’s death. This is where groups such as INQUEST have been integral in providing advice, support and promoting social justice. As has been argued, INQUEST has sought to ‘re-balance the power relationship for families, enabling them to find a voice in a system that should ultimately be serving their needs and interests’ (Equality and Human Rights Commission and INQUEST, 2015: 33). INQUEST, and other organisations such as 4WardEver, have also assisted families in challenging the attempts to silence them through ensuring that the truth emerges regarding their relative’s death and that their voices are heard. These groups:

Represent the voices of all the other bereaved families...ensuring these are not reported as ‘one-off’ deaths. Each family statement read outside court, each critical jury narrative, each Prevention of Future Deaths report is holding the state to account and a collective step closer to change and justice for bereaved people we work with (INQUEST, 2017b: 3).

Groups such as INQUEST and 4WardEver rely entirely on donations and funding independent from the state and have been able to resist being co-opted. They are able to campaign, research and share their own radical alternatives, without being limited by constraints such as state funding and limitations placed on their organisational agendas by the state (Copperman and McNamara, 1999: 169). It is vital for these groups, and any new groups, to obtain funding from non-state

sources such as The Big Lottery Fund<sup>67</sup> and The Edge Fund<sup>68</sup> in order to avoid being co-opted by the state. This would work to ensure that their stances and policies are not absorbed into dominant power structures in such a way that would work to reinforce hegemonic regimes (Mathiesen, 2004: 15).

### **Preventing Deaths**

In 2017, it was reported that £800 million earmarked to improve mental health services in England and Wales was instead used to ‘shore up hospitals’ finances’ (Campbell, 2017b: n.p). Also in 2017, the BBC’s *Panorama* programme covered a number of cases where the families of individuals with mental health problems raised their concerns surrounding budget cuts (BBC, 2017). The consensus from this programme was that if individuals were given a psychiatric bed then it could prevent deaths, suggesting that the deaths of patients in the community could be remedied through an increase in hospital beds. Whilst the issue of budget cuts has an undeniably negative impact on the mental health system, an increase in beds would not simply solve the problem. The patients discussed throughout this thesis *were* detained in a hospital and yet there were still systemic failures in their care and treatment. An increase in bed numbers does not simply equate to the prevention of deaths.

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<sup>67</sup> The Big Lottery Fund award grants to charities and organisations.

<sup>68</sup> The Edge Fund provide grants to individuals and groups who fight for social justice and an end to inequality.

Instead, whilst acknowledging the lack of funding within the mental health system, there should be a move away from focusing on budget cuts as the core contributing factor regarding the deaths of detained patients. If this is to be believed, what was the reason for the large number of deaths detailed historically, before austerity was an issue? There are a number of strategies, unrelated to funding, that have the potential to contribute towards radically reforming the current system. These include changing the attitude of trusts, the medical profession and coroners, coupled with transparency and accountability in both the lives and deaths of patients.

The official focus on the risks posed by patients, as opposed to an emphasis on recovery, dominates the system (CQC, 2018b: 8). This results in an inevitability when patients do take their own life. This sense of inevitability works to minimise the magnitude of self-inflicted deaths, with a focus on individualising the death and blaming the patient for their own death. However, the evidence gathered within this thesis would suggest that the only inevitability around these deaths is the persistent failures of asylums and hospitals to provide adequate care and treatment to patients.

Rather than individualising the deaths of patients, a radically new approach to understanding self-inflicted deaths is urgently needed. Whilst the focus remains on the pathology of the deceased individual, as opposed to systemic failings, the seriousness of any failings will be continuously minimised. There should be an

increased focus upon the identification of persistent failures, coupled with increased staff training, communication and improved record-keeping and care planning. Linked with the numerous cases discussed in this thesis, more thorough patient observation, along with increased security on wards, would also work to prevent the self-inflicted deaths of patients. In a system dominated by dismissal, subjugation and silencing, simply *listening* to patients and their families could prove an invaluable resource in understanding the complex needs and requirements of patients. This approach would work to promote a culture which values, rather than devalues, the lives of all patients.

Another area of concern is natural cause deaths. As discussed in the introduction to this thesis, it is important to emphasise that just because a death is described as being due to natural causes does not always mean that it was not preventable (Hardy, 2013: n.p). Similarly, Legal Practitioner Seven also noted that deaths as a result of natural causes ‘were often preventable and involved just as many failings as unnatural deaths’. With hospital trusts focusing on deaths resulting from natural causes, or supposedly unpreventable deaths, attention is diverted away from any potential failings related to these deaths.

In order to assist in improving this grey area related to deaths from natural causes, it is important that published statistics do not simply detail the number of deaths. They should instead present the circumstances surrounding deaths, whether they were deemed to be from natural or unnatural causes and whether the deaths

were considered preventable or not. This itself could be problematic due to the lack of accountability and transparency in the inquest and investigation systems, as to whether the actual circumstances of individual deaths had actually emerged. However, at present, trusts can avoid accountability through the shield of ‘natural causes’ and ‘unpreventable deaths’. For trusts to know that greater measures have been put in place to uncover just how many deaths could have been prevented could encourage them to improve their systems, in turn preventing patients dying in the first place. Improvements involving the collation of statistics and information surrounding the deaths of patients has also been an area of concern for INQUEST who have encouraged ‘increased visibility’ within the publication of statistics (2016a: 4).

As to who would undertake the task of collating these complex and probing statistics, at present this would most likely be the Independent Advisory Panel on Deaths in Custody or the Care Quality Commission. However, the issues raised in Chapter Four regarding the Commission, in relation to their potential inadequacies, could prove problematic if they were to undertake this role (The Guardian, 2013: n.p). With the introduction of an independent body related to examining complaints and allegations, proposed later in this chapter, this could also be a strand of work undertaken by this body. This would ensure that the circumstances surrounding whether or not a death was preventable could be accurately uncovered.

Whilst some deaths cannot be prevented or predicted, the continued reluctance by the state to implement effective measures to prevent deaths is indicative of a persistent lack of official interest in the lives of vulnerable patients. Instead of relying on the often-unfounded defence that ‘nothing more could be done’, trusts should instead aim to continuously address what more *can* be done to prevent deaths. Whilst issues may be identified within investigations or by inquests, trusts should attach more weight to the importance of preventative measures, particularly as the same issues and failings emerge repeatedly. There should be an increased recognition of patterns and trends within institutions and more widely throughout the entire system. As both INQUEST (2016c: 6-12) and this thesis has also pointed out, the same issues arise time and time again, both in the same institutions and on a regional and national level. These deaths should be recognised as part of much wider systemic issues.

This emergence of persistent systemic issues raises questions surrounding the efficiency of investigation systems within psychiatric detention and it is to these investigation systems that this chapter now turns.

### **Independent Investigation Systems in Both Life and Death**

As this thesis has indicated, since the inception of the asylum, only a minority of allegations and complaints, in relation to both the lives and deaths of patients, have resulted in any accountability. Does this mean that the continuous stream of complaints and allegations were *all* fabricated? Whilst the state response may



argue this, the evidence uncovered in this thesis would suggest that this was far from the truth. There have been cover-ups, a sustained avoidance of accountability and endless blame attached to the complainants.

Chapters Three, Four and Five examined a number of cases where complaints and allegations were made regarding the improper care and treatment of patients. As these chapters established, it is often the case that complaints related to patients, in life, are investigated internally and are dismissed. As the CQC have indicated, patients should be supported when they make complaints, and should not be fearful of repercussions (2015: 19). Whilst the CQC, and other external bodies, may, on occasion, examine allegations and complaints, the adequacy of the CQC has been criticised publicly, as discussed earlier in this chapter and in Chapter Four. The inadequacy of the CQC would suggest that there is a need for an entirely new and entirely independent body to investigate the complaints and allegations made in relation to psychiatric care and treatment. With the introduction of an entirely independent body to investigate complaints and allegations in the lives of patients, there would be a genuine prospect of real change regarding the continued dismissal of allegations and complaints. This investigative body would possess the potential to increase transparency and accountability in this area and could consist of representatives from INQUEST and family campaigners to ensure that counter-hegemonic voices are included.

In relation to the lack of independent examination following the deaths of detained patients, although establishing such a system has been repeatedly denied by the state, the evidence would indicate that there is a genuine need for an independent system to be introduced. An example of the consequences of a lack of independent investigations was indicated in Chapter Five by Legal Practitioner Six who worked on a case where the trust in question argued that the deceased had died of natural causes. However, the case was then independently investigated where numerous failings within the trust were found, along with the death being found to be entirely preventable. This raises the question of just how often this scenario takes place within the closed, secretive investigation system. Investigating oneself regarding allegations of wrongdoing does not promote transparency and accountability and does not correlate with claims of hospital trusts wanting to learn from previous mistakes. Instead, it suggests that the key focus of trusts is damage limitation (INQUEST, 2016c: 5). As INQUEST has argued:

Hospital trusts must not investigate themselves or employ staff involved in the care and treatment of the relative. Anything other than independent investigations produces an inherent conflict of interest and does not inspire family confidence (2016b: 32).

The introduction of an independent investigation system would also work to challenge the perception that the NHS and hospital trusts 'close ranks' (INQUEST, 2015a: 41) and that internal investigations are dominated by secrecy and cover ups (Shaw and Coles, 2007: 69; INQUEST, 2016a: 5). An independent system would challenge the lack of robustness within investigation reports, again

promoting transparency and accountability within the investigation process following the deaths of patients.

As with the prospect of an independent investigation system to examine complaints in the lives of patients, discussed above, the prospect of the CQC undertaking investigations into deaths is problematic. It has been argued that the CQC fails to operate a clear system for gathering information following deaths, with families expressing anger about the inadequate role of the Commission (INQUEST, 2016c: 12). The EHRC and INQUEST have also argued that the CQC has given a 'clean bill of health' to hospitals and units when failures have been identified (2015: 31). An independent post-death investigation system should be exactly that, truly impartial and independent. Again, representatives from INQUEST and bereaved family members who wish to sit on investigation panels would work to promote a stance of accountability and transparency. All investigation reports should also be made publicly available in order to end the defensive culture of secrecy and denial which currently dominates family experiences of internal investigations following the deaths of detained patients (INQUEST, 2016a: 5).

An independent investigation system alone following the deaths of detained patients may not be enough to guarantee transparency and accountability. Linked with this, INQUEST has proposed the introduction an independent national body which would oversee and monitor the implementation of

recommendations made within investigation reports (2016b: 33). This body would also possess the power to commission urgent reviews when patterns and persistent failures are identified (INQUEST, 2016c: 13). The findings of this thesis would suggest that this would be beneficial in ensuring that lessons are learned and changes are enforced as there has been a deep-seated reluctance to change the system. Hospital trusts should endeavour to accept that lessons need to be learned if future deaths are to be prevented. They should display an active engagement with the recommendations made in reports and investigations, recognising patterns and trends with other deaths and sharing these findings widely in order to assist others in preventing future deaths. This would be in stark contrast to the 'self-protective interests of bureaucratic institutions' that currently prevails (Edwards, 2002: 73).

The analysis in this thesis has demonstrated how bereaved families experience minimal meaningful involvement during the investigation process, with their voices marginalised and ignored. They often found themselves having to try and uncover the actual circumstances surrounding their relative's death themselves, due to the lack of transparency and accountability shown by hospital trusts. This is an area of concern also identified by INQUEST who have argued that families complain of having to be the primary drivers of the investigation process (2016c: 9). This should not be the case. Investigations should aim to include the views of families as much as possible which would form part of a genuine commitment to learn lessons and eradicate failing systems. This is an area also examined by the

CQC and INQUEST who recommended that the NHS should work to provide guidelines regarding what level of involvement families can expect (CQC, 2016b: 58), including the level of communication and information-sharing that they should receive (INQUEST, 2016a: 10). Families should be considered as 'important sources of information and evidence' (INQUEST, 2016c: 8). Until families are acknowledged and treated with increased respect there will not be a genuine focus on real change and the prevention of deaths (Shaw and Coles, 2007: 133).

Despite the potential of an independent post-death investigation system, the likelihood of this system being introduced is minimal, particularly as the issue was raised as early as 1840, as indicated in Chapter Three. It is unsurprising that it has been argued that there has been a 'deep-seated, long standing and widespread resistance within the NHS to arranging early independent scrutiny of deaths' (INQUEST, 2015a: 41). It is difficult to envision how many of the issues identified related to deaths in psychiatric detention could be remedied without the introduction of an entirely independent investigation system.

The introduction of this independent system, if it was entirely independent of the state and hospital trusts, would work to increase accountability and transparency within the system. Most crucially, it would work to uncover the circumstances surrounding the deaths of patients, which, at present, often remain hidden. Therefore, not only does an independent investigation system have the capability

of moving away from the trend of blaming patients for their own deaths, it also has the capability of uncovering the circumstances surrounding deaths and preventing future deaths. The capability to prevent future deaths also extends to the coroners court system, as the chapter will now discuss.

### **Radically Transforming the Coroners Court**

As the thesis has identified both historically and contemporarily, there are significant failings within the coronial system. The varying approaches adopted by different coroners to the deaths of detained patients would suggest that some coroners are seemingly unaware of the importance of their own role, with minimal recognition of the consequences for bereaved families. It should not be the case that it is 'luck of the draw' if a 'good' or 'bad' coroner oversees a case of a detained patient, as was noted by Legal Practitioner One. The attitude of some coroners in fundamental areas such as addressing families directly within the courtroom, making eye contact with them and listening to their concerns were also problematic areas identified by participants in Chapter Five. Increased training around attitudes and personal skills, which should already be integral to their work ethic, would aim to remedy what can be an extremely negative experience of the system for bereaved families. Bereaved families should be given the opportunity to contribute to this training.

In Chapter Five, Coroner Two recognised the importance of all coroners possessing a sound knowledge of mental health problems. However, coroners in

2018 now no longer need any expertise in mental health in order to fulfil the role. They now have to 'learn on the job' about mental health problems (Coroner Two). This can result in coroners not understanding the complexities that mental health problems may add to a case. It is apparent that there are a number of areas for further training opportunities within the coroners court, including training on how to produce comprehensive and critical reports (Coles and Shaw, 2012: 23). This would work to promote a culture of understanding and learning surrounding the inquests of detained patients. Coroners should also attach significant weight and importance to ensuring that the defensive nature of trusts and their representatives within their courts is challenged promptly in order to ensure that the actual circumstances of cases emerge.

As INQUEST has argued, the organisation was not aware of a single inquest into a death in custody where the state has not had legal representation (2015b: 11). Yet, as recognised in Chapter Five, families are informed by trusts that they do not require legal representation. It should not be the case that families are able to enter the complex world of the coroners court without being legally represented. The evidence of this thesis would reinforce INQUEST's argument that bereaved families should be entitled to non-means-tested legal aid in order to be represented within the coroners court (2015a: 45). Families should also receive much more information and support surrounding what the inquest process involves and what to expect.

Due to the multiple issues identified in this thesis in relation to the coroners court, it should also be the case that coroners should be subject to further increased external inspection by an independent body. This would work to ensure that all coroners are fully accountable for their actions, in turn potentially reducing the number of families who have a negative experience of the coronial system. The introduction of this independent body to oversee the work of coroners would also aim to increase transparency surrounding the coronial system. The implementation of this independent body could prove to be a major investment in potentially limiting the likelihood of the persistent mistakes examined in this thesis from reoccurring.

There is no mechanism currently in place to monitor and scrutinise action taken by hospital trusts following the findings of an inquest (Coles and Shaw, 2012: 11). This is despite the recognition that inquests are a vitally important source of learning (INQUEST, 2016c: 11). INQUEST has also argued that there should be a national body introduced which oversees and monitors recommendations made by coroners, and this body should also possess the power to compel compliance with recommendations made within the court (2016b: 31). The required monitoring could be a strand of work undertaken by the independent body proposed in this chapter. It is important that a mechanism is in place to ensure trusts and other associated bodies act upon the findings of inquests. Linked with this, a publicly accessible database should be introduced which chronicles and follows up the recommendations and reports made within the coroners court



(Coles and Shaw, 2012: 23). Whilst some prevention of future death reports made by coroners are published online, the subsequent action taken by the recipients of these reports is not chronicled. Publishing all responses would be another step towards preventing the findings of inquests and investigations 'disappearing into the ether' (Ibid: 25) which has been the case both historically and contemporaneously.

## **Conclusion**

By undertaking a critical analysis of archival material, coupled with interviews, questionnaires and the examination of family campaign websites, this thesis has revealed lamentable failures related to both the lives and deaths of detained patients over hundreds of years. Here, regimes and failings that are 'so institutionalised, so accepted, so routine, yet hidden from the world outside' have been exposed (Scruton 2007: 4). Through critically examining both historical and contemporary data, this thesis has chronicled the 'history of injustice' (Swan, 2013: 3) related to some of the most vulnerable members of society. The fact that many of the contemporary issues raised in Chapter Five were similar to the historical issues raised in Chapters Three and Four indicates 'unbroken pattern[s]' (INQUEST, 2017b: n.p) related to psychiatric detention and deaths within these institutions. However, as Scruton has argued, all truths should be uncovered, however long that may take (2017: n.p). This is what this thesis has attempted to achieve.

The thesis has presented the issue of deaths in psychiatric detention through providing insights from below. These insights have challenged dominant discourses, whilst creating new and alternative ones. This has allowed a critical analysis to develop which highlights the longevity of the issues examined. The thesis has also drawn attention towards how the resilience of those who were marginalised and subjugated was often matched by the 'dogged, uncompromising and brutal resilience [of] the powerful' (Moore and Scraton, 2014: 31). Despite this, the state has failed to claim a monopoly of truth over the issue of deaths in psychiatric detention, due to the 'small victories' (Fero, 2016: n.p) achieved through sustained challenges and campaigning.

As Prior has argued, 'new knowledge raises new questions' (1999: 3). The thesis raises questions regarding why reforms in the psychiatric system have been so limited. Whose interests does this serve? What benefit has come from changes such as no longer using the word 'asylum' when the same silencing, subjugation and abuse occur within the new labels of 'mental hospitals' and 'psychiatric hospitals'? Where is the change that eliminates silencing, subjugation and abuse, regardless of what the institution is called? Why are patients and their families still continuously marginalised and dismissed? Why are patients still dying in high numbers and in contentious circumstances each year? Why is there still minimal transparency and accountability in both the lives and deaths of patients and why is there such a reluctance and official resistance to change this?

The radical alternatives proposed within this chapter have attempted to move away from previous official recommendations that have been co-opted. They are practical, potentially life-saving and possess a real capability for a radical transformation in the system and in the prevention of future deaths. However, it is ultimately the responsibility of the state, and policy makers, to take responsibility for implementing such changes.

Within a system where different bodies and agencies persistently claim to place great importance on accountability and transparency, along with a supposed willingness to learn from past errors, these radical alternatives should be welcomed. The relentless failures critically examined throughout this thesis would indicate that the likelihood of them being implemented is extremely unlikely. Doing so would mean recognising the inferior response to the deaths of detained patients over several centuries. However, when the matter in question is as serious as life or death, it is now finally time, in the name of those who have previously contested the psychiatric system, and for those who will continue to do so, for the obscure, concealing and crushing regimes to be replaced by alternatives which promote a new legacy that emphasises equality, transparency and accountability.

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## Appendix A: List of Prior Publications

- Speed, C. (2014) 'Making the Invisible Visible: A Critical Analysis of Deaths in Psychiatric Detention', *European Group for the Study of Deviance and Social Control*, Summer Newsletter II, 38-42.
- Speed, C. (2014) 'Degradation and Death: Psychiatric Detention in England and Wales', *European Group for the Study of Deviance and Social Control*, Autumn Newsletter III, 17-21.
- Speed, C. (2017) 'As Little Regard in Life as in Death: A Critical Analysis of Subjugation and Accountability Following Deaths in Psychiatric Detention', *Illness, Crisis and Loss*, 25, (1), 27-42.
- Speed, C. (2017) 'Deafening Attempts to Silence: Critically Exploring the Deaths of Patients Detained in Psychiatric Detention' in H. White and S. Fletcher, (eds.) *Emerging Thinkers*, Bristol: European Group for the Study of Deviance and Social Control.
- Speed, C. (2017) 'Deaths in Psychiatric Detention' in S. Morley, J. Turner, K. Corteen and P. Taylor, (eds.) *A Companion to State Power, Liberties and Rights*, Bristol: Policy Press.
- Speed, C. (2017) '“They Cannot Speak Anymore-We Will Make Their Voices Count”: Critically Examining Deaths in Psychiatric Detention' in K. Atkinson, A. Huber and K. Tucker, (eds.) *Voices of Resistance: Subjugated Knowledge and the Challenge to the Criminal Justice System*, Liverpool: Centre for the Study of Crime, Criminalisation and Social Exclusion.

## Appendix B: Participant Information Sheet



# LIVERPOOL JOHN MOORES UNIVERSITY

## PARTICIPANT INFORMATION SHEET

**Research Title:** Secrecy and Denial in Matters of Life and Death: A Critical Analysis of Deaths in Psychiatric Detention, 1845-2018.

**Name of Researcher:** Carly Speed, PhD student in the School of Humanities and Social Science

*The following sheet will enable you to understand the nature of this research study. Before you decide to participate, it is important that you read this sheet very carefully. If you have any questions, now or at any point during the research process, I can be contacted at [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk). My director of studies, Professor Joe Sim can be contacted at [j.sim@ljmu.ac.uk](mailto:j.sim@ljmu.ac.uk).*

### The purpose of this research

The research aims to conduct a critical exploration into deaths in psychiatric detention. This will be achieved through gathering the views of those who have experience of this issue.

### Your participation- what does it involve?

Firstly, you are reading this as you have been identified as a prospective participant for this research. This is because you have personal experience of having had a relative who has died whilst in psychiatric detention or have worked with individuals who have experienced bereavement through a death in psychiatric detention. Participation in this research is **completely voluntary** and you are free to withdraw your participation and data from the study at any point.

If you do choose to participate, you will be asked to fill in a questionnaire or take part in a short interview with myself, either

in person or over the telephone, lasting approximately thirty minutes to one hour, or longer if you wish to discuss your experiences in more depth. This interview will be conducted at a date, time and place most suitable for you. During the interview, I will ask questions regarding your experience or knowledge of deaths in psychiatric detention.

Please note that if you are participating through an interview I will ask if I can record this. It is no problem if you do not wish for me to do so.

### **Your confidentiality and anonymity**

To ensure your confidentiality and anonymity, pseudonyms will be used unless otherwise requested by yourself. If you do choose to waive your right to anonymity I will ask you to contact me on the email address above stating that you do not wish to remain anonymous and you are happy for your name to be published within the research. Electronic data will be encrypted, password protected and stored on my LJMU IT account, which is only accessible to myself. Any non-electronic data will be stored in a secured filing cabinet at LJMU. All data gathered from interviews and questionnaires will only be accessible to myself but may be shared with my supervisors. However, personal, identifiable information will not be shared with anybody. All data will be held for five years after the PhD Viva in accordance with LJMU Research Ethics Committee guidelines. However, anonymised interview transcripts and questionnaires will be saved and may be used for future research in this area.

### **Important**

It is **very important** here to acknowledge that it is my stance that I will break confidentiality if I believe somebody to be at serious risk of harm, whether that be to themselves or others. Any criminal disclosures made will not be acted upon unless I believe somebody to be at serious risk of harm.

If at any point you become distressed, I will cease the data collection immediately or, for questionnaires, you should cease completing this straight away. It can then be decided at a later point if you still wish to participate in this research. I will be following the ethical guidance of Liverpool John Moores University. This will ensure I act ethically and ensure your physical, social and psychological well-being is not adversely affected by the research.

### **Benefits of participating**

The main potential benefits for yourself as a participant is that your voice is being heard regarding your experience of deaths in psychiatric detention. In addition to this, you will be contributing to a body of knowledge which at present is highly under-researched.

### **After the research is completed**

Once the research is completed, a copy will be available to all participants. The research findings will also be available to INQUEST, a charity whose casework priorities include deaths in psychiatric detention. The findings in the thesis may also be presented at conferences, as well as being sent to journals for publication. It is also hoped that the research may be published as a monograph. Please note again that the final thesis will not contain any personal, identifiable information unless otherwise agreed with yourself.

After providing your data, you will be given the opportunity to raise any issues you may have. The contact details of any help/support organisations such as Cruse and the Samaritans will be given if it is deemed appropriate. I am always contactable via the email address [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk).

Thank you for taking the time to read this participant information sheet. If you now wish to confirm your participation then please fill in the informed consent form.

Note: One copy to researcher, one copy to participant.

## Appendix C: Informed Consent Form



### LIVERPOOL JOHN MOORES UNIVERSITY CONSENT FORM

If you have thoroughly read the participant information sheet and agree to all that is detailed within this sheet then please read this consent form, ticking each numbered point if you understand and agree, before signing below.

Research Title: Secrecy and Denial in Matters of Life and Death: A Critical Analysis of Deaths in Psychiatric Detention, 1845-2018

Researcher Name: Carly Speed

Researcher Contact: [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk)

Supervisor Contact: [j.sim@ljmu.ac.uk](mailto:j.sim@ljmu.ac.uk)

1. I confirm that I have read and understand the entire participant information sheet, which contains the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered appropriately. ☐
2. I understand that my participation is voluntary and that I am free to withdraw my participation and data at any time, without giving a reason and that this will not result in any negative consequences. ☐
3. I understand that any personal information collected during the study will be anonymised, pseudonyms will be used, unless otherwise specified by yourself, and all data will be stored securely and remain confidential. ☐

4. I understand that parts of our conversation may be used verbatim within the thesis and in publications or presentations relating to this research but that such quotes will always be anonymised.

☐

5. I agree to take part in the above study through being interviewed or completing a questionnaire.

☐

6. I give permission for my interview to be recorded (only for participants being interviewed).

☐

7. I understand that five years after the PhD Viva, all identifiable information will be destroyed. However, anonymised interview transcripts and questionnaires will be stored and may be used for future research in this area.

☐

Please note that if you do not wish to remain anonymous and would like your name to be published within the research then please contact me on the above email address and confirm that this is your wish.

Name of Participant:

Signature:

Date:

Name of Researcher:

Signature:

Date:

*Note: When completed one copy for participant and one copy for researcher.*

## Appendix D: Family Interview Questions



### Family Questions for Interview and Questionnaire

1. Can you tell me about your relative?
2. Can you detail the circumstances surrounding the death of your relative?
3. What were your experiences regarding the promptness and manner in which you were informed of your relative's death?
4. Following being informed of the death, were you provided with sufficient information, such as what would happen next, opportunities to view evidence and legal advice?
5. How well were you informed about the inquest process?
6. How well do you feel that you were listened to during the inquest and investigation processes? Please discuss.
7. What were your views regarding the outcome/verdict of the inquest and investigation into your relative's death? Please discuss.
8. What was the impact on you and your family following your relative's death?
9. Was there anyone held responsible for your relative's death? If no, what are your views on this?
10. Is there anything, not already discussed, which you felt has particularly influenced your experience of inquest and investigation systems?
11. Have you received any support or assistance of any organisations such as charities? If yes, from whom and what assistance have they provided/have you received?

12. What changes, if any, would you like to see implemented in the future which could assist families whose relative also died in psychiatric detention?
13. Is there anything else you wish to discuss which is relevant to the issue of deaths in psychiatric detention?

Thank you for your co-operation

Contact: [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk)



## Appendix E: Coroner Questions



### Coroner Questions for Interview and Questionnaire

1. Can you detail your professional background, for example, how long you have been a coroner?
2. What training have you undertaken specifically regarding mental health?
3. Can you detail your experience in the area of deaths in psychiatric detention?
4. Can you detail some of the recommendations you have made within your role related to the deaths of detained patients?
5. In your experience, how have the recommendations made in your court related to the deaths of detained patients been received and acted upon?
6. Are there any limitations on your power as a coroner in relation to recommendations made following the deaths of detained patients?
7. How would you characterise the issue of responsibility and accountability within the inquest and investigation system?
8. What, if any, are the challenges you have faced when working in this area?
9. What are your thoughts regarding the lack of an independent investigation system following the deaths of detained patients?
10. In what ways, if any, does this lack of independent investigation effect the coroners court proceedings following the death of detained patients?
11. In your experience, what are the main issues raised by bereaved families during the inquest process?
12. What do you think the wider impact/consequences are for bereaved families following the death of their relative?

13. Are there any changes you could suggest regarding deaths in psychiatric detention?
14. Is there anything else you wish to discuss which is relevant to the issue of deaths in psychiatric detention?

Thank you for your co-operation

Contact: [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk)

## Appendix F: Legal Practitioner Questions



### Legal Practitioner Questions for Interview and Questionnaire

1. Can you detail your experience of working in the area of deaths in psychiatric detention?
2. Based on your experience, how effective do you think the coroners court system is in examining these deaths?
3. Based on your experience, how effective do you think the current investigation system is following the deaths of detained patients?
4. How would you characterise the issue of responsibility and accountability within the inquest and investigation system?
5. During your work in this area, what has been your view on the outcomes of the inquest and investigation processes following these deaths?
6. During your work in this area, have there been any issues which have consistently arisen? If so, what are they?
7. What, if any, are the challenges you have faced when working in this area?
8. In your experience, how are bereaved families responded to during the inquest process?
9. In your experience, how are bereaved families responded to during the investigation process?
10. What do you think the wider impact/consequences are for bereaved families following the death of their relative?
11. Are there any changes you could suggest regarding deaths in psychiatric detention?

12. Is there anything else you wish to discuss which is relevant to the issue of deaths in psychiatric detention?

Thank you for your co-operation

Contact: [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk)

## Appendix G: Member of Parliament Questions



### Member of Parliament Questions for Telephone Interview

1. Can you detail your experience of working in the area of deaths in psychiatric detention?
2. Based on your experience, how effective do you think the coroners court system is in examining these deaths?
3. Based on your experience, how effective do you think the current investigation system is following the deaths of detained patients?
4. How would you characterise the issue of responsibility and accountability within the inquest and investigation system?
5. During your work in this area, what has been your view on the outcomes of the inquest and investigation processes following these deaths?
6. During your work in this area, have there been any issues which have consistently arisen? If so, what are they?
7. What, if any, are the challenges you have faced when working in this area?
8. In your experience, how are bereaved families responded to during the inquest process?
9. In your experience, how are bereaved families responded to during the investigation process?
10. What do you think the wider impact/consequences are for bereaved families following the death of their relative?
11. Are there any changes you could suggest regarding deaths in psychiatric detention?

12. Is there anything else you wish to discuss which is relevant to the issue of deaths in psychiatric detention?

Thank you for your co-operation

Contact: [c.speed@2009.ljmu.ac.uk](mailto:c.speed@2009.ljmu.ac.uk)