'Died Today' Introduction

'DIED TODAY'
The Brief Lives of Patients at Claremont Hospital for the Insane 1909-1919

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Thesis submitted in partial fulfilment of a Master of Arts degree in History at the Australian National University.
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January 2015

ABSTRACT

The Case Books of Claremont Hospital for the Insane in Perth, Western Australia, record many cryptically explained patient deaths in the early twentieth century. This thesis explores the reasons for these deaths and how patients came to harm. It examines the expectation of hospital life for the most vulnerable groups of patients, comparing mortality at Claremont with mortality at other institutions. The distinctive economic, political and social conditions in Western Australia, a frontier state, framed the ‘special path’ of the historical development of mental health care in Western Australia. I show that this special path was the overarching factor determining the comparatively brief lives of Claremont patients. While general paralysis of the insane was a major cause of death of male patients at Claremont, I suggest that ‘senile’ patients were the most vulnerable group. Overseas studies show that shortages of food caused the premature deaths of thousands of asylum patients during World War I, particularly in Britain and Germany, but the evidence indicates that average mortality rates at Australian asylums were not significantly affected during the War.

Except as otherwise indicated, this thesis is entirely my own work.
I am specially indebted to my supervisor, Dr Carolyn Strange. She has been more than generous with her time and advice and has been incredibly supportive and understanding during my periods of ill health. I was deeply impressed by Carolyn’s understanding of public health issues and I am grateful for her constant helpful suggestions. I am also especially grateful to Dr Philippa Martyr, Adjunct Senior Research Fellow at the University of Western Australia, and historian at the North Metropolitan Service, Mental Health, for her extremely generous advice and support on all matters relating to Claremont Hospital for the Insane and for her valuable comments on earlier drafts of this thesis. Philippa kindly provided me with numerous copies of primary source material and with drafts of her forthcoming book on Claremont. I hope that my thesis might become a contribution to Philippa’s ongoing work on Claremont’s history. Dr Mary-Anne Jebb, Research Fellow at the Australian Institute of Aboriginal and Torres Strait Islander Studies, also commented on some early drafts of my thesis and was most helpful and supportive with advice on sources. I would also like to express my sincere gratitude to Gerard Foley and his team at the State Records Office of Western Australia for their patience, courtesy and expert advice and for rescuing me at times from my clumsy efforts with the microfilm readers.

I am deeply grateful to my wife Rosemary for putting up with my long hours at the keyboard and for cheerful words when the going was tough. I would also like to thank my daughter Vanessa for providing a home away from home during my research trips to Perth.

I am entirely responsible for any errors or omissions in this thesis.
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**ABBREVIATIONS**

<table>
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<th>Abbreviation</th>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ALF</td>
<td>Australian Labour Federation</td>
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<tr>
<td>Claremont</td>
<td>Claremont Hospital for the Insane, Perth</td>
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<tr>
<td>Death Notice</td>
<td>Form of Notice of Death (Schedule 13 of the 1903 <em>Lunacy Act</em>)</td>
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<tr>
<td>GPI</td>
<td>General Paralysis of the Insane</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases (World Health Organisation)</td>
</tr>
<tr>
<td>Inspector General</td>
<td>Inspector General of the Insane [for Western Australia]</td>
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<td>NLA</td>
<td>National Library of Australia</td>
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<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PPH</td>
<td>Perth Public Hospital (Royal Perth Hospital from 1946)</td>
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<tr>
<td>Report(s)</td>
<td>Report(s) of the Inspector General of the Insane [for Western Australia]</td>
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<tr>
<td>RDI</td>
<td>Recommended Daily Intake (of foodstuff or nutrient)</td>
</tr>
<tr>
<td>Select Committee</td>
<td>Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane [Western Australia, 1919]</td>
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<tr>
<td>SROWA</td>
<td>State Records Office of Western Australia, Perth</td>
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<tr>
<td>TB</td>
<td>Tuberculosis (all forms)</td>
</tr>
<tr>
<td>Trove</td>
<td>Trove Newspaper Database, National Library of Australia</td>
</tr>
<tr>
<td>VD</td>
<td>Venereal disease</td>
</tr>
<tr>
<td><strong>Victorian Report(s)</strong></td>
<td>Report(s) of the Inspector General of the Insane [for Victoria]</td>
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<td>WA</td>
<td>Western Australia</td>
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Abbreviations used in endnotes:

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<tr>
<td>ABS</td>
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<tr>
<td>SROWA</td>
<td>State Records Office of Western Australia</td>
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<tr>
<td>Cons</td>
<td>SROWA consignment number</td>
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My approach in this thesis is to use the terminology of the time, unless I believe that a specific term may appear obscure to a modern reader. For example, I have avoided the word ‘psychiatrist’, because it was rarely used in the early twentieth century. Until the 1920s, ‘alienist’ continued to be used to describe medical practitioners who specialised in insanity. According to the Australian National Library’s Trove newspaper database, there are 209 mentions of ‘alienist’ in the West Australian press between 1900 and 1920 and three mentions of ‘psychiatrist’. Since these distinctions are not germane to this thesis, I have used the terms ‘doctor’ or ‘medical practitioner’. I have not used the modern terms ‘care staff’ or ‘carers’. The terms used in the primary sources are ‘attendants’ or ‘nurses’ or just ‘staff’.

Although Claremont Hospital for the Insane was officially a hospital, in the common parlance of the day ‘asylum’ was used as often as ‘hospital’. ‘Asylum’ was more often used in Britain. ‘Asylum’, in the sense of a place offering a safe refuge, is probably the correct term to describe Claremont at its beginnings. Official definitions and treatment of mental illness have changed very significantly since the early twentieth century and it is clear that many patients admitted to Claremont, such as ‘idiots’, ‘imbeciles’ or alcoholics, would not now be regarded as mentally ill by modern standards. Although ‘idiot’ and ‘imbecile’ had diagnostic meanings a century ago, they are offensive terms today. I use the neutral term ‘developmentally disabled’, unless quoting from original sources. For simplicity, all references to ‘insane’ or ‘insanity’ denote people certified under the 1903 Lunacy Act, except where otherwise indicated.

‘Phthisis’ refers to the pulmonary form of tuberculosis (TB). The term is still in use by medical professionals, but I have used TB as a more intelligible general term, to refer to all forms of this illness, such as bone tuberculosis, scrofula and other tuberculosis-related conditions.

There are technical difficulties in expressing the present day value in dollars of Australian monetary amounts a century ago. Explaining and justifying a particular
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approach to monetary conversion would be a distraction from the thrust of this thesis; therefore I have simply used Australian pound sterling values of the day for comparative purposes.\(^5\) There was no theoretical difficulty in converting Imperial measures to metric measures.

I refer to the Forms of Notice of Death (as mandated under Schedule 13 under the 1903 *Lunacy Act*) as Death Notices, in order to differentiate them from death certificates which would have been issued by the WA Registrar of Births, Marriages and Deaths on request.\(^6\)

**Naming of Patients in the Claremont Sources**

All documents in the State Records Office of Western Australia (SROWA) which are referenced in this thesis are publicly accessible. However, under West Australian government regulations, a 100 year rule still applies to publishing medical information which identifies individual patients or discharged patients. Therefore I have replaced surnames by the initial (for example James S.) unless the patient's (or ex-patient's) full name appears in a public record such as a Royal Commission report. For cultural reasons, I have not given the name of the Aboriginal boy included in my case study.\(^7\)

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\(^1\) Hugh Freeman, 'Psychiatry in Britain c. 1900', *History of Psychiatry*, 21, (2010), 321.

\(^2\) Source: Trove Newspaper Database, National Library of Australia [Retrieved 31/10/2014]

\(^3\) There are 770 mentions of the phrase 'Claremont Asylum' and 764 mentions of 'Claremont Hospital' in *Trove* (Digitised Newspapers) for 1900 to 1920 [Retrieved 31/10/2014]. For use of 'asylum' in Britain ca. 1900, see for example Freeman, 'Psychiatry in Britain c. 1900' or Andrew Scull, *The Most Solitary of Afflictions. Madness and Society in Britain, 1700-1900*, (London: Yale University Press, 1993).


\(^5\) For a discussion of the difficulties, see 'How do I calculate the current value of old money?' [Retrieved 31/10/2014].

\(^6\) Compulsory registration of births, marriages and deaths in WA started in 1841. [Retrieved 6/12/2015].

\(^7\) In many Aboriginal communities it is offensive to refer to a deceased person by name, unless agreed to by the deceased's family. [Retrieved 11/11/2014]
An Early Death, A Brief Life

‘He died in the twenty-eighth year of his age...’¹

Fig 0.1 James S. in his prime.²

27 year old James S. was admitted to the Claremont Hospital for the Insane on 20 July 1914. His introduction card, held in the Case Book, claimed that he was a British lightweight champion boxer and expert in other martial arts. He weighed in at 63 kg (11 stone 7 lb) and had at one time been in excellent physical shape, as his photographs indicate.³ On admission, his heart was 'loud and thumping', lungs healthy and his reflexes normal. There was a tremor of the facial muscles. But the admitting physician found that James was not well mentally.⁴ He was 'morbidly suspicious', had delusions of being followed and was rambling in speech. The standard Case Book categories for 'Diagnosis' and 'Cause' were left blank, but we know from other entries that he had been a fishmonger, that he was a Methodist and that his hair was fairish and eyes grey. From these meagre and unmedical facts, we can surmise that James's illness had ended his sporting career. Two friends were recorded. Their names are illegible, but they do not appear to be family members.

The very brief notes of his weekly reviews over the next month showed little improvement in James’s mental state. Although ‘well behaved’, he could not converse and sat ‘staring in front of him all day’. He was still ‘confused and depressed’ by early September. No treatments or diagnosis are recorded and no reflections were made on the nature of his physical or mental illness. James, a strapping athlete in happier times, had in a relatively short space of time become
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‘very thin’ and his appetite was poor. On 4 October, he had to be force fed, a procedure then known to be risky due to the hazards of choking, heart failure, laceration of the throat and cross-infections from feeding instruments. On 19 November, four months after admission, the Case Book entry simply noted: ‘Died today’. No cause of death was given in the Case Book notes, but the Death Notice states that James died from dysentery and ‘asthema’ (asthma). It is reasonable to suppose that the proximate cause was a heart attack or other organ failure due to the combined effects of malnutrition and the stress of his other medical conditions. But we will never know if his refusal to eat and subsequent death was due to physical or mental illness, the effects of forced feeding, or perhaps the effects of boxing injuries. The passing of the putative boxing champion, far from home, was not recorded in the mainstream West Australian press.

Although few patients could have claimed to have been in such fine physical condition prior to admission, James’s story may stand for many others at Claremont Hospital for the Insane in the early twentieth century. His brief life at Claremont is tersely recorded: ‘Died today’. For the period 1909 to 1919, well over 50 per cent of male patient deaths (20 percent of female deaths) are bluntly recorded in the Case Books as ‘died today’, ‘deceased’, ‘died last night’ or ‘died this morning’. In many cases, the preceding Case Book notes gave no hint of impending death. Some of the official Death Notices are missing from the Colonial Secretary’s files and the causes of death are left blank in others. These puzzling deaths, and my desire to explain them, inspired this thesis, which is an historical study of the life expectancy of patients at Claremont and the causes of mortality.

The Aims of this Thesis and its Contribution to Historiography
Mortality and expectation of life are of increasing concern to mental health care providers to the present day, because the mortality rate of the mentally ill relative to the mortality of the general population of Australia has steadily increased since the Second World War. This seems paradoxical in view of the much broader armoury of treatments now available, advances in medical technology and specialisation of care. The reasons for this decline are unclear – there is a recognised ‘knowledge gap’. While the modern paradigm favours de-institutionalisation, specialisation and care in the community, some scholars, such
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as Stephen Garton, suggest that institutional modes of care, as places of refuge, still have something to offer. Garton claims that well-resourced and maintained colonial institutions in NSW achieved an ‘excellent record of success’ in their heyday, with good rates of recovery and relatively low mortality, suggesting that state provision of a refuge for the mentally ill, shielding them from outside harms and stresses, might achieve better results, in terms of mortality and discharge rates, than community care and improved treatments. But does the evidence support Garton’s broad claim with respect to asylums in the ‘frontier’ state of Western Australia?

The current historiography on Claremont and its predecessor, Fremantle Asylum, indicates that mental health care in WA was neither well resourced nor well run in the colonial period until well into the twentieth century and that results were correspondingly poor. My study goes further - it examines the factors affecting life expectancy of patients at Claremont for the period 1909 to 1919, specifically: management policies; nutrition; standards of care; hygiene; adverse effects of chemical and physical restraints; and lack of social support. The overarching constraints on all these factors in the period of this study were overcrowding and financial stringency. As I will show, overcrowding and limited budgets were universal themes in British, United States (US) and European asylums and Australian institutions were not exempted at a period of worldwide growth in the number and patient population of institutions caring for the insane. But the distinctive characteristics of the development of care for the mentally ill in Western Australia (WA) since the State’s beginnings significantly affected the nature of care at Claremont. My analysis of a case study of a ten per cent sample of patients who died there between 1909 and 1919, and my examination of the available primary sources, gives insight into how the lives of individuals were cut short by the above-mentioned factors and the reasons for the poor performance of the institution. Although condition on admission is clearly a significant determinant of life expectancy, the evidence suggests that it is not the most important factor.

The poor results at Claremont do not refute Garton’s claim that large institutions can effectively cater for the mentally ill. In a sense, they reinforce it. By pointing to
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the faults at Claremont, this study will indicate the straightforward, practical and simple measures which might have brought its results to the level of Garton’s exemplars, namely the better run and better resourced asylums of the most populous States, NSW and Victoria. In drawing attention to the failures and by implication, their solutions, I make the point that the institutional mode of care should not inevitably be associated with deficient standards of care.

Another important claim in this thesis is that mental health care in WA, from its beginnings until 1920 and beyond, followed a ‘special path’. I will show that the unique demography and geography of WA, its frontier society and its delayed social and economic development profoundly affected the nature and scale of harms experienced by patients at Claremont and the composition of the patient population. Evidence from primary sources and the case study indicates that Claremont had exceptionally high numbers of single, male and immigrant patients in relation to the equivalent numbers in other Australian asylums and overseas institutions. I argue that these categories of patients are more likely to be in poor health on admission than other classes of patient. I will also show that people admitted to Claremont were far more likely to be in poor physical health than the general population, as is still the case in WA today.14 This relative poor health and social isolation of single and immigrant persons who became mentally ill meant that they were particularly vulnerable to harm after admission.

As leading historians of mental institutions have established, there was an extraordinary increase of mortality amongst asylum patients in Britain and Germany during World War I. Over half of German patients died during the course of the war.15 This misfortune has been attributed to food shortages caused by submarine warfare and the effectiveness of the Allied blockade of the Central Powers. While Australia did experience shortages of manpower and some food items during the war, my analysis of the primary sources shows that these shortages did not significantly affect the diet or the mortality of Claremont patients over the course of the war. But it seems clear that shortages of labour due to the enlistment of Claremont staff (including one doctor out of a medical team of five) must have adversely affected standards of care.
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Finally, I will contest Gayle Davis’s claim that general paralysis of the insane (GPI), one of the worst manifestations of tertiary syphilis, was the ‘most deadly disease of asylumdom’. Evidence from the case study shows that this was not the case at Claremont. Male patients who did not have GPI had roughly the same life expectancy as patients with this condition (very few female patients had GPI in this period). Statistics drawn from the Reports and my case study indicate that senility (broadly defined) was a more important determinant of higher mortality. This evidence broadly agrees with the results of large scale studies of patient life expectancy in New York for the period 1909 to 1928, which I will discuss in Chapter Three. The typical symptoms of GPI clearly are a ‘cruel madness’, to use Davis’s description. They can include paralysis, dementia, violent attacks on family and friends, bone fragility and crippling sores (gummas). But GPI does not appear to have been the most fatal of patient conditions. My study shows that it was senility.

What is the relevance of this thesis? In exploring and explaining the brief lives of patients admitted to Claremont, it contributes to the historiography of mental health care in WA and it is the first historical study to look specifically at mortality from all causes in an Australian asylum. It is also the first study specifically to compare Claremont death rates with death rates at other Australian asylums at this period. The thesis highlights the distinctive characteristics of the development of care for the insane in WA which differentiate care at Claremont from care at other Australian and overseas institutions. I have been able to put in context the life expectancies of ‘senile’ and general paralysis of the insane (GPI) patients at Claremont with the expectation of hospital life of patients in broadly similar categories in other institutions in Australia and elsewhere. Finally, I show that restrictions on finance and some food items during World War I did not significantly affect the mortality rate at Australian asylums during the war.
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**Historiography of Care for the Insane in WA**

Previous Australian studies of Claremont and its predecessor, the Fremantle Lunatic Asylum (established 1865), have mentioned issues which directly and indirectly affected mortality, but they do not address death rates. Roger Virtue wrote about the legal and political background to the proclamation of the 1903 *Lunacy Act* in WA, which envisaged the replacement of the rundown, irreparable, insanitary and overcrowded Fremantle Lunatic Asylum by a modern and purpose-designed facility. Virtue expanded on his thesis in a 1997 paper, noting the continuing delays in providing adequate facilities due to government impoverishment and labour shortages in the ‘struggling colony’. In the late 1890s, after a series of newspaper reports about alleged brutality at the Asylum and unexplained deaths, mental health reform became a significant political issue. Jill Bavin’s thesis looks at the intention to implement a system of ‘moral management’ in Fremantle (1857-1903). But the severe overcrowding and shortage of funds made this impractical. Bronwyn Harman, in her 1993 study of women incarcerated as insane at Fremantle (1858 to 1908), focuses on the use of lunacy laws as a means of social control of ‘difficult’ women. She claims that many women became depressed and violent as a response to Asylum conditions and were poorly fed and often restrained. However, Harman draws no conclusions about the effects of these factors on mortality.

Lucy Williams wrote about the language used in discussions of insanity in WA from 1903 to 1910 and the social, medical and political context, which illustrated the motives for policy and practice in the treatment of the insane. She also analysed patients’ letters. While the letters reflect both positive and negative experiences, the majority are critical. Williams suggests that letters containing criticisms tended to survive in the Case Books because management did not want to ‘upset’ family and friends and did not pass them to the intended recipients. Restrictions on access at the time of writing (1993) limited her study. They do not now apply to the great bulk of Claremont records for my period.

Philippa Martyr has written extensively on the history of Claremont and its predecessor, the Fremantle Asylum, including mental health care for Aborigines in WA in the period 1870 to 1914. Her forthcoming book on the history of
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Claremont, amongst other things, discusses the setting up official inquiries into alleged poor conditions at the Hospital and the background to poor industrial relations there.\textsuperscript{29} Martyr has discussed in some detail the various harms patients were subject to during their detention at Claremont. Her analysis of oral histories from the ‘Hopeless Hill’ (Claremont) for the period 1933 to 1995 suggests that poor patient management practices persisted long after a series of public inquiries had brought them to light.\textsuperscript{30}

The background to the establishment of Claremont is discussed in detail in A.S. Ellis’s 1984 book \textit{Eloquent Testimony}, which is in part a history of the very different management styles of the two Inspectors General of the Insane in my period of interest – Sydney Montgomery (1901-1916) and Theo Anderson (1916-1926).\textsuperscript{31} Ellis discusses the history of the Fremantle Asylum, the setting up of Claremont and the architecture and fitting out of the new institution. He also describes the establishment of an associated farm at Whitby Falls, 50km distant from Perth, to provide work for some of the fitter ‘quiet and chronic’ male patients. Ellis also discusses significant events in the life of the institution, including the background to the formation of the Select Committee. But it is more of a narrative than a critical study. While Ellis makes some reference to Select Committee evidence and the \textit{Reports}, he does not make use of the Claremont primary source documents, such as Case Books, for the period before 1920. His book is mostly uncritical of asylum conditions, although Ellis does draw attention to the lack of any attempt at treatment. There is no discussion of the lives of patients, other than a brief account of the suspicious death of the patient Francis Andinach, which sparked public outrage and a Royal Commission in 1918.\textsuperscript{32} I will give a fuller account of this incident in Chapter One, drawing from Andinach’s Case Book notes.

These previous West Australian studies give context and background to one of the principal tenets of my thesis: that the development of mental health care in WA prior to 1920 followed a distinctive path, for example Virtue’s mention of ‘government impoverishment’. The studies also show that poor conditions at Claremont were not new developments, but reflected ongoing historical continuities. While these sources do of course mention patient deaths, my thesis
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will relate mortality rates to specific causes. In order to do this, I need to ask new questions about the data, drawing on a wider array of literature.

**Historiography of Care for the Insane in other States**
Cheryl Day’s thesis on the historical development of Kew Asylum in Victoria from 1872 to 1915 suggests that mental health care in this institution was far better resourced and better managed than at Claremont. Day ‘illuminates the private world of the asylum inmate’ and the individual roles of staff, patients and families. The central task of her study is to present ‘an intimate portrayal’ of patient life and the relationships between patients and the wider community.\(^\text{33}\) Unlike WA, the disruption and turmoil of the Victorian gold rushes of the 1850s had transformed into sustained urban growth and the expansion of a vibrant manufacturing sector.\(^\text{34}\) There were therefore fewer single patients and immigrants in Victorian asylums than in WA. Garton’s social history of insanity from 1880 to 1940 discusses developments in care for the insane in NSW.\(^\text{35}\) These historical studies of mental health provision in the most wealthy and populous states mention advances in care which were conspicuously lacking or belately provided in WA, such as specialisation of institutions, specialised medical training, laboratory testing for venereal disease and reception houses. These differences confirm my claim that mental health care in WA followed a ‘special path’ within Australia.

Queensland may also, in similar respects, be regarded as a frontier state. Mark Finnane’s study of Wolston Park Hospital for the period 1865 to 2001 suggests similarities with the early development of mental health care in WA: a large proportion of immigrants and males, official poverty and ‘years dominated by makeshift arrangements’.\(^\text{36}\) There is not much detail of developments in the years 1900 to 1920. Finnane does not explain this lacuna – perhaps the relevant source documents were unavailable. He refers to a ‘very large number of deaths’ as a proportion of admissions, but the figures he quotes are for 1879, 1929 and 1969. He attributed this high mortality rate to not only the alleged higher mortality of the mentally ill, mistreatment and lack of care, but also to the de facto use of the Hospital as a hospice or ‘depot for the senile or abandoned aged’.\(^\text{37}\) While further studies of Queensland asylums ‘on the frontier’ at the period might reveal further similarities with WA developments, the NSW and Victorian studies suggest that the
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character of mental health care in WA was associated with distinctive economic, social and demographic conditions, which contributed to the latter’s higher mortality rate.

The Period of This Study, 1909-1919.

There is an impressive amount of publicly available official documentation for Claremont at this period: the Mable Royal Commission in 1921, the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane (Select Committee) Inquiry of 1919 and the Royal Commission into Lunacy of 1921 to 1922, which all refer to events in 1919 and earlier. But the report of the 1918 Andinach Royal Commission is missing, presumed lost. The press commented freely and critically on all these inquiries and on a number of other notorious cases, such as the Courthope affair, mentioned at the 1921 Royal Commission into Lunacy, and the case of Rudolph Hein. The Courthope and Hein cases were about alleged unlawful detention and not directly about Claremont conditions, therefore I will not discuss them further. These inquiries and the associated press reports provide a great deal of additional insight into the meagre Claremont records – for the Andinach Royal Commission, the press accounts are the only surviving accounts of its proceedings.

There was a long transitional period before Claremont became the main focus of mental health care in WA in 1909. According to Virtue, the decision to start work on the new Hospital at Claremont in 1902 and the supporting legislation in 1903 were political responses to a long period of public dissatisfaction with the existing mental health system. The first Inspector General of the Insane, Dr Sydney Montgomery, had a critical say in choosing the site. On 18 August 1903, the first cohort of twenty male patients was transferred from Whitby Falls (the farming outpost for Fremantle Asylum) to the construction site at Claremont. The initial contingents, chosen for their fitness to work, were to be more part of the Claremont farm operations than patients. Further groups of male patients were transferred from Fremantle or Whitby as more accommodation became available. All female patients were transferred from Fremantle to Claremont during 1908, some males remaining at Fremantle due to space restrictions. The remaining males were transferred in 1909 and Fremantle Asylum was closed.
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This was the de facto opening date of Claremont as the principal mental institution in WA and the starting date of this study.49

During 1919, the recording of case notes was transferred from Case Books to a card system. The card system had been recommended by the Official Visitors and Dr Bentley, one of the medical staff, had been familiar with a similar system in England.50 Unfortunately, the card system has not survived.51 Because the card system had not in fact been fully implemented by the end of 1919, patient records for 1919 remain in the Case Books, perhaps a reflection of the slipshod recording practices so evident in entries for James S. and with those for patient 958. Patient 958, a Chinese man, had been recorded as ‘quiet and orderly’, but ‘showed no improvement’, seven years after he had died.52 Therefore 1919 must be the end point of the case study and this thesis.

Dr Sydney Montgomery was appointed as the first Inspector General of the Insane in 1901, shortly before the decision to build at Claremont. Peter McClelland’s 1997 article on ‘Montgomery’s Claremont’ discusses the management style of this Inspector General and the decline in conditions after an initial promise of enlightened treatment at the new Hospital for the Insane.53 A series of (Perth) Sunday Times articles in early 1911 was severely critical of staff and patient conditions, slack and arbitrary management and the inconsistent enforcement of voluminous regulations.54 Not all of the reportage was critical. The Western Mail wrote effusively about the exemplary conditions at Claremont in 1912.55 Yet the same article has photographs of very close bed spacing, much closer than in wards at PPH, as depicted in Figures 0.2 and 0.3 below. It is evident that patients with longer arms could, while in bed, easily reach patients in the next bed, in violation of legal requirements.56 Ellis’s view of Montgomery was also uncritical. While Ellis explicitly takes Montgomery’s part, in the aftermath of Montgomery’s successful prosecution of a libel case against Mrs Lyons in respect of alleged maltreatment of a patient, Martyr suggests that Mrs Lyons was a reliable witness. Martyr argues that both Lyons and Montgomery may have been acting in good faith and were not aware of maltreatment by junior staff, which indicates a systemic and serious management failure by the Inspector General.57
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Source for Figs 0.2 and 0.3: ‘How the State Cares for the Afflicted in Mind’, *Western Mail*, (Perth: 24 Aug 1912), 6s.

Fig 0.2 Female Dormitory at Claremont 1912

Fig 0.3 Male Dormitory at Claremont 1912

Montgomery died suddenly in February 1916. He was succeeded by Dr Theo Anderson, the assistant medical officer since 1908. There had been no succession plan; Anderson was chosen because he was the next most senior permanent medical officer. The unexpected death of Montgomery left Anderson ill prepared for his new senior role. Ellis claims that Anderson was considerably less charismatic than his predecessor and suggests that the new Inspector General had a ‘rigid’ and
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authoritarian management style. Indeed, Anderson’s management style was the subject of press criticism and industrial disputes, especially in the aftermath of the Andinach affair and two other patient-related controversies, concerning Rudolf Hein, a German immigrant, and Thomas and Georgina Mable, a married farming couple from Ongerup. Hein had twice applied unsuccessfully to the courts for release from Claremont in 1914 and 1916 and Martyr suggests that he had been the subject of virulent anti-German prejudice at a time of war. The Mables, who were committed in 1915, had persistently claimed that they were unlawfully detained at Claremont. While Georgina Mable was discharged in 1917, her husband’s application to the courts for release failed in the same year. As many irregularities with the Mables’ committal process had become public by 1917, a substantial lobby had been built up, critical of Anderson’s inflexible stance on the issue, which pressed for Thomas Mable’s discharge. These disputes and other complaints led to a Legislative Assembly Select Committee of Inquiry in 1919. The report of the Select Committee in November and the discontinuance of Case Books records after 1919 mark the end point of this study, while the starting point is the beginning of Claremont’s function as the main focus of mental health care in 1909.

Primary Sources and Methods

The Reports are my main source of aggregate data on mortality, admissions, financial data and the running of the farms. The Select Committee Report of 1919 provides detailed evidence, much of it contested, over conditions at Claremont. The evidence of ex-patients was entirely ignored or discounted in the report. No current patient was called to testify because individual patient claims of wrongful admission were beyond the scope of the Committee’s terms of reference. It must be noted that the inquiry was a political exercise, but by careful consideration of the plausibility and motivations of different witnesses and reference to other primary sources, I have been able to draw on the ‘most likely’ evidence for insights into risks for patients at Claremont. Some figures and evidence from these documents can be verified against the annual Reports for years ending 1909 through to 1919. The Royal Commission into Lunacy of 1921 took note of poor conditions, such as overcrowding, poor maintenance and a lack of towels and linen. It also found patients’ evidence to be ‘most unsatisfactory'. I have also used
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aggregate mortality data from Commonwealth Year Books, Australian Bureau of Statistics (ABS) historical data and the WA Year Books. Press reports of this period comment on conditions and management at Claremont, the above mentioned official inquiries and the Andinach affair. Details of the official dietary scale for patients and staff as from 1915 are documented in the published General Regulations under the Lunacy Act of 1903. Other primary sources are listed in the Bibliography.

The Case Books maintained by Claremont medical staff and official Death Notices are my main sources for the case study described in Chapter Two. They give rich, but incomplete, detail about the lives and deaths of patients. As noted above with respect to Williams’s thesis, many restrictions on access no longer apply to the Case Book documents and related records, therefore I have been able to examine many more records held at SROWA. Some Claremont records for the period remain restricted, subject to Freedom of Information (FOI) requests. After having requested and examined some of the restricted records, I decided that they did not add substantially to the more ‘public’ information with respect to my thesis topic. It is important to note that the SROWA-designated start and end dates for a given Case Book refer to dates of the first and last recorded admissions. The dates of post-admission entries for individual patients may extend beyond the end date of the Case Book.

The case study sample was derived as follows. There were 644 deaths of male patients and 272 deaths of females recorded in the period 1909 to 1919. It was impractical to analyse this volume of records. Therefore I recorded the Case Book entries for every tenth patient admitted to Claremont between 1909 and 1919 and who died there in this period. This ensured that these patients were exposed only to conditions at Claremont and not at Fremantle Asylum or Whitby Falls. Some records for this sample had to be rejected because, on closer examination, they did not conform to my selection criteria or the patient details had been incorrectly recorded in the Case Books. The remaining records are for 48 males and 24 females. Thus this is not a random sample, but sufficient for a reasonably accurate picture of life expectancies. To assist with analysis of these data, the related Death
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Notices and for generation of graphs, I built a Microsoft Access 2013 database and set up a number of Microsoft Excel 2013 workbooks.70

As I will show in the following chapters, the standard of patient documentation at Claremont was exceptionally poor in comparison with other Australian mental institutions at the period. Nevertheless, careful analysis of the case study data and relevant primary sources has allowed me to gain productive insights into mortality at Claremont and place those insights within an Australian and international context. There are problems with the Claremont data. An important caveat with respect to discussions of mortality is that the majority of patients had co-morbidities, as evident in the Death Notices and some Case Book records. The ages of case study patients are known, but less than half the males (and only one female) had a recorded diagnosis at admission.71 The available Death Notices – for 358 males and 154 females - only cover the period 1912 to 1918 and the data are incomplete.72 Despite the deficiencies of these documents (the cause of death is blank in some, or the document itself is missing in a few other cases), they provide in the main an invaluable reference and cross reference where the cause of death is either missing or cryptically recorded in the Case Books. The ‘exciting’ and ‘predisposing’ causes of admission recorded in the Case Books are not useful for determining the diagnoses, since in some years ‘exciting’ causes were not recorded in over 75 per cent of cases and over 40 per cent of ‘predisposing’ causes were not stated.73 Despite these problems of incomplete records, these new sources have enabled me to ask new questions about mortality at Claremont.

Mortality in Comparative Perspective

Historical comparisons of aggregate death rates between mental health care institutions in different countries and even within one country are difficult, because it is nearly impossible to standardise the statistics for age, form and stage of illness at admission and the aims and traditions of each institution differ according to social, economic and political factors dominant in the host society. In Chapter One, I will show that the makeup of the patient population, standards of treatment, care specialisation and infrastructure for Claremont, a frontier institution, vary significantly from the corresponding characteristics in mental health care institutions in Australia and overseas.74 The structure, legal
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framework, demography and traditions of mental health care in Australia in the twentieth century have also evolved quite differently from British models. Within Britain, care was less centralised and there were large private asylums for the wealthy, for example, Ticehurst,75 pauper asylums,76 boarding-out,77 and many more outpatient clinics than in Australia.78 In Germany, there was political contention between proponents of clinical care as a focus for research and training and managers of large asylums, the Heil- und Pflegeanstalten,79 and there was also an official system of in-home care, which extended the official definition of insanity beyond hospital and clinic walls.80 In the US from 1900 onwards, state mental hospitals effectively took over the care of the indigent aged and senile from local almshouses, ‘providing long term custody for the poor and disabled’81 In Norway between 1916 and 1933, Ørnulv Ødegård estimated that about 35 per cent of the insane, including most senile patients, idiots and imbeciles, were cared for in private families and colonies: there were no reliable statistics for this group.82 While the provision of mental health care in these Western societies shared common features, there could be no accepted baseline for comparison of outcomes while each country made provision in its own way and had its own criteria for desirable outcomes.

Standards of care, training and admission criteria differed significantly between countries. For example, the scale and depth of organised psychiatric training and research in Germany, Switzerland, France and Austria was far superior to what was offered in Britain at the time, as evidenced by the fact that many British doctors wishing to specialise in mental illness sought training in Zurich, Vienna, Berlin or Heidelberg. British doctors drew heavily on ‘Germanosphere’ models (and to a lesser extent French ideas) in their own professional work.83 In Austria,84 there were different classes of care in the one institution according to ability to pay.85 Differentiation of the standard of care according to race, with much higher mortality for black patients, was a conspicuous characteristic of US asylums in the South at this time.86 It follows that different institutions had divergent admission criteria and treatment policies and catered for varying proportions of aged, the vulnerable and the very ill, with each category having different life expectancies. Moreover, there were fundamental problems with the reliability of disease classifications before 1939.87 As a result, comparing one institution with another in
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terms of aggregate death rates is problematic. Similar difficulties apply when comparing institutions across recent and historical time periods.

Average death rates based on aggregate figures, as quoted in a number of historical studies of mental institution mortality (and in the Reports), may also understate mortality when there is a skewed distribution of deaths by length of stay, and they do not give a true picture of survival times. These points can be demonstrated as follows. As shown in Fig 3.3 (Chapter Three), roughly 70 per cent of male GPI sufferers died in their first year at Claremont. If, counterfactually, no further GPI patients had been admitted after this first year, the average death rate for the survivors in their next year would have been about ten per cent. But assuming a constant rate of admission, the average annual death rate for new patients plus survivors would be about 56 per cent, which considerably understates actual mortality for a given set of patients over time. A similar argument might apply to median death rates. Relative death rates, namely the probability of patient dying from a given cause with respect to the probability of a person in the general population dying from the same cause, are also difficult to use for comparing institutions without also referring to statistics on the relative mortality of their source populations from these causes. Such an exercise would be beyond the scope of this thesis.

A series of studies of North Wales asylums by David Healy, Margaret Farquahar and colleagues have compared mortality between modern and historic cohorts of psychiatric patients. The authors found sufficient detailed information in past records to be able to correlate historic diagnoses with modern classifications of illness and their studies offer useful insights into the changing effectiveness of mental health care over different centuries and the reasons for the changes. One of the measures they use is length of stay before death data, which, as argued above, gives a more accurate picture of mortality over time. Their results will be discussed in more detail below. The outcome of the Welsh studies suggests that useful comparisons might be made between historic institutions if sufficient data is available and if similar methodology is used.
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I was not able to compare specific mortality associated with mental illnesses such as ‘mania’ and ‘melancholia’ with the mortality from similar conditions elsewhere for a number of reasons. There were deficiencies of the Claremont records, with diagnoses often not recorded in the admission notes. The Death Notices do not mention the reason for admission. Another difficulty was the varying standards of classification of mental illness worldwide at a period when international disease classification standards were only beginning to be established.91 I should make it clear at this point that, with very few exceptions, Claremont doctors did not attribute mental illness as a cause of death.92

Structure

In Chapter One, I show that the development of mental health care in WA up to the start of my period has followed a different, ‘special’, path from its sibling Australian asylums because of Western Australia’s distinctive social, economic and political environment. Until well into the twentieth century, WA remained a ‘frontier’ state and the constraints of limited official resources, small population, enormous distances, sex imbalance and isolation forced a series of pragmatic compromises on official welfare provision. This meant that its welfare institutions were less specialised and became end stations for senile, the dying, the alcoholic and the ‘difficult’, as well the actual insane. The mixed blessings of the 1890s gold rush and the arrival of big numbers of mostly male immigrants without family ties increased population and pumped up the state’s budget, but worsened the sex imbalance and challenged regulators and law enforcement. As a result of these factors, the male to female ratio at Claremont was about twice as high as most other Australian and overseas institutions.

Chapter Two looks at a case study sample of 48 male and 24 female patients who were admitted to Claremont between 1909 and 1919 and who died in those years. The evidence from this case study highlights the following five characteristics of Claremont which, while not absent from other Australian asylums, helped to materially shorten the lives of patients. Firstly, the evidence clearly shows that documentation for patients on admission and during their stay was of an exceptionally poor standard in comparison to other Australian institutions, suggesting that doctors gave little time to individual patients. Secondly, patients in
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The case study were exposed to a range of harms, including violence, unsuitable treatments, poor nutrition and a low standard of medical care. The third characteristic is that patients in the sample were admitted for reasons other than diagnosed insanity and for many of these individuals no diagnosis was recorded at admission. The evidence indicates that Claremont had a 'warehousing' role, accommodating senile patients, the very young, developmentally disabled persons and the terminally ill. Two patients in the sample died on the day of admission.

Fourthly, because of the distinctive demographics of WA, most patients were socially isolated and there was a preponderance of single patients and patients with no friends or distant friends. As I will show, there was a clear relation of social isolation to patient morale and therefore mortality. Finally, it is clear that the lives of patients in the case study were tragically brief. About 60 per cent of patients in this case study sample died within their first twelve months at Claremont – 90 per cent in the first five years.

The final chapter, on harms and mortality, looks beyond the case study to the other evidence about the reasons for the short lives of patients in general at Claremont. This evidence includes testimony from public inquiries, newspaper reports and mortality data from mental institutions overseas and in Australia. I expand on the problems of violence and punishment, reflecting on the evidence for abuses by attendants and nurses. I show that from the highest level of management, staff had a punitive attitude to refractory patients, firmly believing that violent or resisting mentally ill individuals would be ‘taught a lesson’ by harsh punishments, such as physical restraint, isolation, ‘bread and water’ regimes and ‘chemical coshes’, such as harmful and disabling laxatives or strong hypnotic drugs, undermining morale and health. Another challenge to health was the patients’ dietary scale which, while adequate in kilojoules, was rather poorer and more monotonous than the daily fare of ordinary working-class people in WA. In the light of modern knowledge about nutrition, we know that there were significant deficiencies in the diet, as compared to a contemporary working-class diet, which particularly affected the health and mortality of vulnerable groups: the aged, GPI patients with fragile bones and menstruating women. Overcrowding, understaffing and inadequate sanitary facilities increased the probability of acquiring fatal infections, such as tuberculosis (TB) or dysentery. Evidence to the 1919 Select Committee about the
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doctors’ daily rounds clearly shows that any sort of treatment involving doctor-patient dialogue was quite impossible, since, on average, doctors ‘saw’ one patient per minute. In fact, as Fig 3.1 (Chapter Three) shows, the rate of officially recorded recoveries declined as the crowding increased and the staff to patient ratio worsened.

The expectation of life was significantly less for patients at Claremont than for patients at overseas institutions and other Australian asylums. My analysis of the evidence indicates that the relative scale of harms and perhaps the composition of the patient population at Claremont (more male, more single and more aged) explain these unfortunate results. I suggest that more spacious facilities and better standards of care, specialisation of treatment, infection control and efficient separation of patient with different illnesses might have considerably improved life expectancy. It is true that some British asylums had shorter life expectancies during the war years due to severe and ill-considered cutbacks to patients’ diet as a management response to wartime restrictions. But I show that wartime constraints did not markedly affect death rates at Australian asylums. Finally, I test Davis’s claim that GPI was the most deadly disease in asylums and demonstrate that senility, rather than GPI, was the greater threat to patients.93

2 Along with the photographs, there was an introduction card, on which was printed: ‘James S. [surname omitted] British Light Weight Champion. Catch as-Catch-Can and Ju-Jitsu.’ Catch as-Catch-Can is a type of wrestling, very popular in the early 20th century. James is depicted without boxing gloves, so he may have been posed as a Catch As-Catch-Can wrestler.
3 SROWA Cons 752, Item 4. There are very few photographs of patients on file in the Case Books.
4 There are no identifying initials for the admitting doctor.
5 Ian Miller, ‘Necessary Torture?: Vivisection, Suffragette Force-Feeding, and Responses to Scientific Medicine in Britain c. 1870–1920’, *Journal of the History of Medicine and Allied Sciences*, 64, No. 3, (Jul 2009), 333-372. As Miller notes, forced feeding was very painful.
6 In anorexia, death from organ failure or myocardial infarction is fairly common. Death tends to happen when the Body Mass Index is about half the normal figure. See Alan Lieberson, ‘How Long can a Person Survive without Food?’, *Scientific American*, (New York: Scientific American, 8 Nov 2004).
7 SROWA Cons 752, Item 3108 /4, folios 150-151. Inserted between these folios are two photos of James in his heyday in fighting gear and a visiting card which lists him as British Lightweight Boxing Champion (no year given or indication of professional or amateur status). I could not find a record of James S. in the British boxing history web pages, in Trove or in UK press archives.
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8 183 out of 300 final (death) entries for males were ‘one-liners’, 47 out of 242 for females. Estimate from study of Claremont Hospital Case Books 1909-1919.
9 A Death Notice (Schedule 13) was legally required for every deceased patient under the WA Lunacy Act of 1903. The Colonial Secretary was the Minister responsible for all lunacy matters (along with lighthouses, harbour maintenance and the racing industry).
11 Ibid, 1.
13 For rapid growth of British asylums since the late nineteenth century, see Edward Hare, 'Was Insanity on the Increase? The Fifty-sixth Maudsley Lecture', British Journal of Psychiatry, 142, (1983), 439-440. The growth is depicted in Fig 1 on p 440.
17 Davis, The Cruel Madness of Love.
18 Ibid, 87-93. See also SROWA Cons 752, Item 3108/2, Folio 421 for the case of Herbert T., a GPI patient, who had terrorised his family and servants until his death on the day of admission to Claremont.
19 Peter Bladin’s 2003 study looked at mortality from epilepsy in early Victorian asylums. See Peter S. Bladin, 'Status Epilepticus, the Grim Reaper of the Mental Health System in early Victoria', Journal of Clinical Neuroscience, 10, No.6, (2003), 655-660.
24 For example, see Harman ‘Out of Mind’ 126.
26 Ibid, 62.
27 See Chapter 3 of Martyr, Us That Live Here. Copyright: North Metropolitan Health Service, Mental Health (NMHS – MH), State of Western Australia.
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29 See Martyr, Us That Live Here.
31 Ellis, A.S. Eloquent Testimony. The Story of the Mental Health Services in Western Australia 1830-1975, (Perth: University of Western Australia Press, 1984).
32 For some criticisms of the lack of training, treatment etc, see ibid 74-75. See Chapter Two for discussion of the Andinach case.
34 ibid, 3.
37 ibid, 54.
38 The Mable Royal Commission of 1920 concerned the circumstances of the alleged illegal detention of Thomas Mable and his wife and did not discuss conditions at Claremont. See Government of Western Australia, Royal Commission appointed to inquire into the continued detention of Thomas Mable in the Hospital for the Insane at Claremont, (Perth:1920).
39 The folder for the Andinach Royal Commission report held at SROWA is empty.
40 W.E. Courthope, a barrister and ex-serviceman, had been detained at Claremont and applied successfully for release. After release, he successfully petitioned the WA Parliament in 1921 to establish a Royal Commission into lunacy governance, which made its final report in 1922. For example of newspaper comments, see ‘Copy’, Sunday Mirror, (Perth:27 Feb 1921), 1. For Courthope’s evidence at the Royal Commission, see Report and Appendices of the Royal Commission in Lunacy, (Perth: 1922), 9-10.
41 Hein, a German national, had sued successfully for release, been released and then forcibly re-admitted on the day of release. See Martyr Us that Live Here.
42 In his evidence to the 1921 Royal Comission, Courthope was highly critical of Claremont conditions.
44 McClelland ‘Contours of Madness’ 66. Whitby Falls was originally purchased in 1897 as the site for a new asylum, but this proposal was rejected by Montgomery. Instead, Whitby Falls became a satellite institution, a ‘work therapy’ farm site for male alcoholics fit enough for farm labour.
45 ibid, 68.
47 Ellis, Eloquent Testimony, 43. 150 males had been transferred from Fremantle by late 1908, see James Thomson, Through Darkened Windows', Western Mail, (Perth: 10 Oct 1908), 14.
49 There was no official opening of Claremont, nor any ceremony associated with the first building, presumably due to the public stigma associated with the institution – Martyr, personal communication.
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50 Select Committee, evidence of Dr James Bentley, question 4364.
51 Advice from SROWA and Philippa Martyr.
52 No diagnosis is recorded for James S., although his eye colour is recorded. For the case of ‘patient 958’, see ‘Vigilans Et Audax’, The Insane Hospital, West Australian, (Perth: 24 Nov 1919), 6. The Inspector General’s evidence to the Select Committee shows that he was not familiar with the card system used by his subordinates. See Select Committee, evidence of J.T. Anderson, Questions 4726-5060.
53 McClelland, ‘Contours of Madness’, 75. For the initial promise, see, for example, Western Mail, (Perth: 11 May 1907), 24 - ‘as one walks through corridor after corridor and [sees] the beautifully kept and clean rooms, one hesitates to believe that this is the residence of the insane; it resembles exactly the ordinary hospital for the sick.’
54 For example, ‘The Claremont Asylum’, Sunday Times, (Perth: 26 Feb 1911), 13. Also discussed in Ellis, Eloquent Testimony, 56-57. It is clear that the asylum information in the articles came from disgruntled attendants.
55 ‘How the State Cares for the Afflicted in Mind’, Western Mail, (Perth: 24 Aug 1912), 6s.
56 As Anderson, the Inspector General, stated to the Select Committee in 1919, Claremont would not meet statutory requirements for air space, see Select Committee, Question 5040. For a photograph of the children’s ward at PPH in 1902 (with much wider bed spacing), see G.C. Bolton and Prue Joske, History of Royal Perth Hospital, (Perth: Royal Perth Hospital, 1982), 68-69.
57 Mrs Lyons claimed that she saw two female patients chained to a bench. Montgomery won a libel action against her for £250. Martyr suggests that nurses may have used home-made restraints without permission. See Martyr, Us that Live Here, Chapter 4. For Ellis’s discussion of the case, see Ellis, Eloquent Testimony, 63.
58 Martyr, personal communication.
60 Ellis, Eloquent Testimony, 79-80.
61 A Royal Commission was eventually held in 1921 to investigate the circumstances of the Mables detention, whose findings reflected badly on Anderson’s professionalism and expertise. As Martyr writes: ‘Royal Commissioner Alfred Kidson was scathing about the doctors’ lack of expertise.’ For discussion of these cases, see Martyr, Us that Live Here, Chapter 3. See also ‘The Case of Francis Andinach’, West Australian, (Perth: 13 June 1918), 4 and ‘Claremont Asylum. Insufficient Accommodation.’, West Australian, (Perth: 30 Aug 1918), 4.
63 Report of Select Committee 1919.
64 Martyr, personal communication.
67 The Andinach affair related to the death of a patient, Francis Andinach, due to the alleged brutality of a orderly. The official records, including the Andinach Royal Commission’s report, are missing, presumed lost. Therefore press reports are the only source. See Chapter 3 for further discussion of the Andinach case.
69 For example, when the date of death was prior to the date of admission.
70 Excel and Access - © 2013 Microsoft Corporation. All rights reserved. All working documents are available on request, subject to an undertaking to observe confidentiality restrictions concerning patients’ names.
71 Rose S. was diagnosed with GPI at admission. See SROWA Cons 752, Item 3107/2, Folio 325.

The Claremont records attribute a few deaths to ‘mania’, ‘acute mania’, ‘exhaustion from acute mania’ or ‘exhaustion from melancholia’. Epilepsy was often fatal but is now regarded as due to a central nervous system disorder or physical injury. See C. Butler and A.Z.J. Zeman, ‘Neurological Syndromes which can be mistaken for Psychiatric Conditions’, *Journal of Neurological and Neurosurgical Psychiatry*, 76, (2005), 131-138.

CHAPTER ONE – Isolation on the Frontier

“When we have wandered all our ways, shuts up the story of our days.”¹

From the first European settlement, Western Australia has been a frontier society and its capital, Perth, was ‘the most isolated city in the civilised world’.² Its geographic and cultural isolation, sparse population, vast distances, extremes of climate and population imbalance have, until recent times, set it apart from other Australian states, with the possible exception of Queensland. WA’s convict past is more recent than in NSW, Tasmania and Victoria and it was the last state to experience a major gold rush and the last to achieve self-government. From the beginning, successive administrations, with limited resources and remote from external support, had to adapt to very different local conditions than those obtaining in Britain or in the larger Australian states. Thus the development of mental health care in WA has much in common with other, much earlier, frontier settlements in the Anglosphere, such as the Californian, Victorian and British Columbian goldfields. In these rough and violent places, officials, and not doctors, became the front line decision makers between gaol, asylum or hospital, with the gaol often filling all three functions.³ We can see a similar lack of differentiation of care modalities and pragmatic problem solving in WA, profoundly differentiating the structure and provision of official welfare services there from the types of care provided in the major centres of western Europe and the United States. In this chapter, I will discuss the distinctive social, economic and demographic factors affecting the historical evolution of mental health care in WA and their influence on patient mortality.

The Development of Mental Health Care in WA – Continuities, Discontinuities, Differences

The history of official mental health provision in WA began with a makeshift solution when mentally ill Dr Nicholas Langley, along with ordinary prisoners, was confined in the wreck of the Marquis of Anglesey in 1830. No suitable public buildings were yet available, as Perth and Fremantle had very recently been settled by Europeans in August 1829. Limited resources again forced a compromise when the Round House at Fremantle was established as a combined gaol and lunatic
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asylum and holding centre for 'fringe folk'. The Round House was soon overcrowded, with four inmates to a small (4m by 1.9m) cell by 1837. This combined accommodation might be contrasted with the establishment of separate facilities for the insane in the much larger colony of NSW in 1811. The first dedicated provision for the mentally ill in WA, and yet another hasty stopgap arrangement prompted by a crisis, was the conversion of Scott's Warehouse in Fremantle to a temporary asylum for mentally ill convicts transferred from the Round House in 1857. About 10,000 convicts were transported to WA during the years 1850 to 1867. By 1857, 4,500 convicts, all male and predominantly single, had arrived, outnumbering the 4,300 free male settlers. The pressure of numbers and scant resources had forced another expedient on the authorities: the shifting of the mentally ill to temporary quarters, before a permanent building was available, to make space for prisoners at the Round House.

Before transportation, most of the convicts sent to WA had been held at Pentonville and Portland prisons in England. These prisons (and others) practised the strict ‘Separate System’ of confinement. As Bill Forsythe describes the regime:

> there was a total ban on communication between prisoners, with severe punishment for infringement of this. But association with very severe limitation on communication also invited single-cellular isolation for periods such as night...

Prisoners had to wear hoods on the way to religious services and, when in chapel, sat in separate boxes to minimise any form of communication. The adverse effects on prisoners’ mental health of this system, which would be regarded now as an (illegal) form of sensory deprivation, were well recognised at the time by prison reformers, including Charles Dickens. Given this unhealthy background and the additional stresses of the long uncomfortable voyage to WA, it was quite likely that many new convict arrivals were either already mentally ill on disembarkation or particularly vulnerable to deviant behaviour once on shore. It seems probable, therefore, that increasing problems of convict lunacy taxed the limited accommodation at the Round House. To address these problems, the Fremantle Lunatic Asylum was opened as a permanent facility in 1865, not far from the Convict Establishment at Fremantle Gaol. It also admitted female patients in a separate ward. In the public mind the Asylum was a useful auxiliary to its near neighbour, the
Gaol, since its patients, whether convict or free, were required to wear prison garb. The government’s intentions for the Asylum had been for ‘moral management and to rehabilitate patients in a serene atmosphere’, but within a few years overcrowding defeated these aspirations. Fremantle accommodated 45 patients ‘in relative comfort’ in 1865, but by 1870 held 75 patients. By the time of the 1890s gold rushes, despite additional building works, Fremantle continued to be overcrowded. Thus, almost from the start, increasingly crammed accommodation was characteristic of official mental health facilities in WA.

Individuals without local family and social ties were most likely to come under notice of the authorities. The majority were low status males who transgressed official norms, whether free or unfree. All the convicts were male, most were single, and many of the wives of the married convicts refused to emigrate (or contracted new relationships) despite Government offers to fund their travel. The free male colonists outnumbered free females and were also mostly single. The resultant ratio of males to females in the colony was about 1.6 to 1 in 1870, which correspondingly reduced the chances of family formation. Indirect evidence for the latter is the low birth rate in WA with respect to other states, which remained relatively low almost until the end of the century.

Rootless men with few social supports were the most likely to have unsettled lives, often marked by loneliness, violence, venereal disease, alcohol and antisocial behaviour, as exemplified by some cases in the case study sample of Claremont patients. To be fair, hard drinking was the general rule in Australia for married and unmarried alike in the late nineteenth century. In their history of alcohol in Australia, Ross Fitzgerald and Trevor Jordan claim that heavy drinking, as a unique feature of Australian national identity, is a myth. But it was certainly high in remote or predominantly male contexts. Jack Blocker identifies three factors which determine the level of alcohol consumption in the US: ‘gender, marital status and distance from family’. Fitzgerald and Jordan stress that these three factors had particular application in WA in the late nineteenth century. In 1889, WA consumed more than twice as much proof alcohol as any other Australian colony. And this ratio increased markedly during the gold rushes of the 1890s with the sudden arrival of masses of single men in remote places. By 1896, while drinking in the more settled
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Australian colonies had declined, WA’s alcohol consumption had risen by more than 50 per cent and was ‘higher than most European countries’.24

Thus the stresses of lonely living, for which alcohol was both an escape and a slow poison, could bring on, or exacerbate, symptoms of mental illness. Although some women, particularly prostitutes and homeless women, experienced similar stresses, males were evidently more vulnerable to the health risks of social isolation, since by 1870 the ratio of males to females at Fremantle was about 2.4 to 1.25 Females were less at risk because they were far more likely to have partners and families to care for them. Family support was in many cases sufficient to allow mentally ill family members to recover from short episodes of aberrant behaviour without outside assistance. Families tended to shield and protect their sick loved ones as long as they could cope with the financial, physical and emotional demands of restraint. In 1854, 83 per cent of females aged over 21 in WA were married.26 But, as with the males, single females without family support could easily end up in Fremantle. Megahey attributes this result to the low status and restricted employment options of single women. Most were domestic servants, there being few other employment opportunities for single women. If they left their employment, they were more likely to become homeless, or be forced into prostitution, and therefore come under the notice of authorities as ‘difficult’ and refractory.27 Thus the majority of Fremantle patients were either male, single or socially isolated, or all three. As we shall see, this continued to be the case at Claremont.

In many cases, the family ties of married and widowed women who came to Fremantle were also fragile or broken. For some of them, the Asylum was a refuge from domestic violence, family strife, postpartum illness and poverty.28 Other women were removed from home when their families could not cope with their behaviour or when husbands seeking new partners rejected them.29 Under the colony’s first Lunacy Act of 1871, relatives could request committal for troublesome relatives, as private patients paying full fees.30 This was the case in 1888 with the ‘difficult’ Sophie C., whose mother said that ‘a short stay in the [Fremantle] Asylum may so impress her...’.31 ‘Failure to fulfil domestic responsibilities’ or ‘unacceptable behaviour’ were standard charges in committal proceedings.32 There is evidence from both the Fremantle and Claremont patient records in the Case Books that
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Women were easier to commit, at least as private patients, than men. In many cases of admission of private patients, the admission notes show that one of the certifying persons was a male relative. For admission of males, who were more likely to be paupers, convicts or otherwise paid for from the public purse, the persons signing the Certificate of Lunacy were always doctors.

For poor women whose family life had been disrupted by poverty, desertion, physical or mental abuse, illness or death, the Poor House was the standard refuge. But ‘difficult’ behaviour or dissent was punished by expulsion to Fremantle. While the Poor House may not have been the appropriate place for mentally ill women, women who were not mentally ill but defiant, critical or obstreporous suffered the same sanction. Nora F., whose husband was terminally ill at PPH, stated that her children ‘are obliged at the [Poor] House in Perth to live in filthy rags and sleep on damp beds’. For expressing these ‘delusions’, she was sent to the Fremantle Asylum. A press report of a few years later concerning complaints from the Sisters of Mercy suggests that Nora’s ‘delusions’ may have been well founded, given that there was an officially acknowledged shortage of mattresses for both Poor Houses and that children there were in a ‘pitiable condition’. Thus for many of WA’s ‘difficult’ women, Fremantle served as the last stop.

The sex ratio of the source population has a disproportionate effect on the sex ratio of mental institutions, as shown in Table 1.1. Fremantle represents one extreme, with a male to female patient ratio of 2.5 to 1 in 1870. In the settled ‘home’ country, Britain, the proportion of men to women for the whole population was 1.06 to 1 and the ratio in asylums was 1.2 to 1 in 1871. For WA, the marked disparity in male to female ratios continued until World War I, reinforced by the huge migration of mostly single men to the gold rushes of the 1890s and the arrival of 30,000 migrants, also predominantly single men, in the five years before the War. The historical continuity of the disparity is reflected in the ratio of males to females at Claremont, which was always above 2.5 from 1909 to 1919. Another continuity is the far higher ratio of single to married patients as compared to that for the general population of WA. For example, in 1919, 62 per cent of males and 34 per cent of females admitted to Claremont were single. In 1921, 30 per cent of males over 15 in
WA were single and 21 per cent of females. This suggests that lack of family support was a key factor in official perceptions of mental illness, particularly amongst males.

Table 1.1 Sex ratio in Asylum Population vs Sex Ratio in General Population

Sources: See endnotes in table.

<table>
<thead>
<tr>
<th>Asylum</th>
<th>Males to Females - Patient Population</th>
<th>Males to Females - General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fremantle (WA) 1870&lt;sup&gt;59&lt;/sup&gt;</td>
<td>2.5 to 1</td>
<td>1.6 to 1</td>
</tr>
<tr>
<td>Claremont (WA) 1909-1919&lt;sup&gt;40&lt;/sup&gt;</td>
<td>2.6 to 1 (1913)</td>
<td>1.3 to 1 (1913)</td>
</tr>
<tr>
<td></td>
<td>2.4 to 1 (1917)</td>
<td>1.05 to 1 (1917)</td>
</tr>
<tr>
<td></td>
<td>2.3 to 1 (1919)</td>
<td>1.14 to 1 (1919)</td>
</tr>
<tr>
<td>Kew (Vic) 1880&lt;sup&gt;41&lt;/sup&gt;</td>
<td>1.3 to 1</td>
<td>1.1 to 1</td>
</tr>
<tr>
<td>All public asylums (Vic) 1919&lt;sup&gt;42&lt;/sup&gt;</td>
<td>1.0 to 1</td>
<td>1.0 to 1</td>
</tr>
<tr>
<td>Goodna (Qld) 1880&lt;sup&gt;43&lt;/sup&gt;</td>
<td>1.6 to 1</td>
<td>1.4 to 1</td>
</tr>
<tr>
<td>All public asylums (NSW) 1900&lt;sup&gt;44&lt;/sup&gt;</td>
<td>1.5 to 1</td>
<td>1.1 to 1</td>
</tr>
<tr>
<td>All asylums (Britain) 1871&lt;sup&gt;45&lt;/sup&gt;</td>
<td>1.18 to 1</td>
<td>1.06 to 1</td>
</tr>
<tr>
<td>All asylums (Canada) 1891&lt;sup&gt;46&lt;/sup&gt;</td>
<td>1.15 to 1</td>
<td>1.03 to 1</td>
</tr>
<tr>
<td>Toronto (Canada) 1891&lt;sup&gt;47&lt;/sup&gt;</td>
<td>1.1 to 1</td>
<td>1.03 to 1</td>
</tr>
<tr>
<td>All mental hospitals in Stockholm (Sweden) 1924-1936&lt;sup&gt;48&lt;/sup&gt;</td>
<td>0.9 to 1</td>
<td>0.76 to 1</td>
</tr>
<tr>
<td>Bel-Air Asylum, Geneva (Switzerland), 1900-9&lt;sup&gt;49&lt;/sup&gt;</td>
<td>1.1 to 1 (admissions)</td>
<td>0.9 to 1 (1900 for Canton of Geneva)</td>
</tr>
</tbody>
</table>

There was also a difference in the racial composition of the asylum population between Claremont and Fremantle. In the 1890s, Fremantle Lunatic Asylum started to be used as a convenient quarantine facility for ‘coloured’ men whose behaviour offended the authorities or the public. About a third of the 56 ‘colonial’ inmates were Asian males in 1891, mostly Chinese.<sup>50</sup> ‘Colonial’ inmates were paid for by the colony of WA, whereas ‘Imperial’ inmates (transported convicts) were a charge to the British government.<sup>51</sup> As doctors (with limited language skills) admitted, the mental state of Asian patients could rarely be determined. Correspondence between the Colonial Secretary and the Fremantle superintendent, Dr Hope, suggests that these men were confined for expediency and not for proven insanity.<sup>52</sup>
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About 30 Aborigines who had 'behaved wildly' were also admitted to Fremantle or Claremont between 1870 and 1914. Generally speaking, they fitted the profile of European admissions: labourers, vagrants, the elderly, females without support, but not alcoholics. As Martyr points out, language and cultural differences made diagnoses of mental illness for indigenous people dubious. When Claremont became fully functional in 1909, twenty per cent of its resident male patients were born in Asia. But as from 1909, the Reports show that far fewer Asian and Aboriginal persons were admitted. And, as Martyr suggests, authorities became reluctant to admit Aborigines unless it was the last available option. The considerable expense and political fallout of keeping 'Asiatics' at considerable public expense in overstrained facilities appears to have been a factor in this changed policy. The WA Government had already deported seventeen Asian-born patients in 1897 in response to public anger at overcrowding. This may not at first sight have seemed successful as a cost-cutting exercise, since the colony still paid for the transport and maintenance of the deported patients while overseas. But three quarters of the repatriated men were dead and off the books in less than three years after their deportation. Thus, almost from its inception, Claremont became predominantly European in character, with most patients born in Australia, Britain or Ireland.

Another discontinuity from the early years of mental health care is the comparative longevity of patients at Fremantle. From 1857 to 1865, a quarter of 'colonial' male patients died within two years of admission to Fremantle, whereas about half of Claremont patients in my case study sample died in their first year. In 1879, the typical stay of 'colonial' males at Fremantle was 6.5 years, for females 13.5 years, whereas 'Imperial' males had an average stay of 13.5 years. In 1896, there remained eighteen 'Imperials' at Fremantle. They had been confined there for an average of 30 years. We can see in the Fremantle figures for the colonial years that treatment outcomes, in respect of longevity at least, may well have been comparable with the 'excellent' outcomes discussed by Garton in respect of contemporary institutions in NSW and Victoria. But there was a marked decline at Claremont as from 1909. Based on the annual death rates stated in the Reports for 1909-1919, roughly 90 per cent of male patients at Claremont were either dead or discharged after six years. That does not necessarily preclude the presence there
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of cohorts of longer-lived patients, with similar life spans to the hardy Imperials. The evidence for or against that may be in the Case Books, but the work required to extract it would be beyond the scope of this thesis. Nevertheless, it is clear that patients, on average, lived briefer lives at Claremont than in sibling institutions in Australia.

An important change in the early twentieth century was a reversal of the long term decline in the official insanity rate from 1880 to 1903, expressed as a proportion of the population. As Fig 1.1 indicates, the officially defined insanity rate after 1880 until 1900 was in long term decline. The rate fell from about 330 per 100,000 in 1880 to about 120 per 100,000 in 1896, having been ‘diluted’ by the mass immigration of hopeful prospectors and miners in the gold rush years of the 1890s. But in the years 1903 to 1919, the insanity rate rose steadily, roughly in step with the growth in population, from about 200 per 100,000 to about 350 per 100,000, a 175 per cent increase in seventeen years. One explanation for this turnaround may be the lesser statistical reliability of the earlier insanity figures, which are based on much smaller numbers of patients – there were only 85 in 1870. Other explanatory factors may be the net effect of changes in legal definitions of insanity, changes in the social role of the asylum and the use of alternative institutions. The first Lunacy Act of 1871 allowed persons certified as insane to be counted in official statistics. The Government’s intentions with respect to the second Lunacy Act of 1903 were to strengthen safeguards for the civil rights of persons alleged to be insane. However, under the new Act, the patient advocacy powers of Official Visitors were weakened. The number of Official Visitors was reduced from three to two and they now required the approval of a doctor before they could discharge patients. But these claimed enhancements did not prevent a rapid increase in the insanity rate after 1903. It does seem plausible, as argued above, that authorities increasingly looked to Claremont, rather than poor houses, gaols or homes for the aged, as a short term catchall for a wide range of social problems. But we now need to look at the unique circumstances of Claremont which distinguish it from other mental health care institutions in Australia and elsewhere.
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Sources for Fig 1.1: 
*Reports* for 1909-1919. Patient numbers at Fremantle (daily averages) taken from Harman, ‘Out of Mind, Out of Sight’, Table One, 104; WA historical population statistics appear in ABS 3105.0.65.001 Table 1.

Source for Fig 1.2: *Report* for 1919.
Frontier Conditions in the Twentieth Century

At the start of the new century, WA had only just begun to enjoy sufficient resources to enable the development of health and welfare infrastructure towards the scale and breadth of provision which had already been available for some decades in other states. Before the gold rushes and massive population increases, the exigencies of finance and labour had made even a modest expansion politically impossible. The convicts had increased the labour supply, but at some cost in additional provision of detention facilities, as we have seen. While the settled and wealthier states of Victoria and NSW had long had specialised care for the developmentally disabled, clinics, reception houses and multiple large institutions, mental health care in WA was distinctly less specialised and much more centralised. Although a few ‘quiet and chronic’ patients were sent to Whitby Falls after 1897, all official care for ‘imbeciles and idiots’ in WA took place at Claremont, and a fifteen-bed mental ward at PPH was only established in 1908. The PPH ward was staffed by Lunacy Department attendants and nurses and was in effect a reception facility.

Apart from Claremont, mental health facilities in WA were small at this period. Whitby Falls had only seven male patients in 1912, increasing to 22 in 1919. Greenplace had been opened in 1916 to accommodate voluntary, fee paying, female patients. But by 1918 it was no longer used for this purpose due to lack of demand. There were only thirteen female patients at Greenplace in 1920. As noted, PPH had a fifteen bed mental ward cum reception facility and there was a smaller mental ward on the goldfields at Kalgoorlie Hospital. In contrast, Victoria had seven asylums with over 200 patients in each, and two Receiving Houses by 1919. And the developments in care in wealthier states still lagged behind the breadth and expansion of mental health services in Britain.

A brief look at the development of mental health care in Britain from Victorian times might serve to underline and emphasise the different path of the same services in Australia. The rate of growth of the registered insane in Britain increased markedly from the last half of the nineteenth century, at a much greater rate than the increase in general population. At the same time, there was a
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‘remorseless’ rise in the size and number of British asylums. For many
contemporary critics of the asylum system, this unmanageable growth meant a
corresponding decrease in the effectiveness of therapy.73 In 1855, the British
Commissioners in Lunacy put forward three reasons for the growth of asylum care
and patient numbers. Firstly, inmates lived longer in hospital than if they were
cared for in the community. Secondly, changes in legislation and official policies
had changed definitions of insanity and moved insane persons away from other
official forms of care, such as work houses and hospitals, to asylums. Finally,
improvements in diagnostic standards meant more accurate detection of
previously unrecognised cases of insanity.74 The reasons for the rapid growth of
British asylums at this period have been debated by a number of scholars,
including Edward Hare and Andrew Scull.75 Scull has claimed that these reasons
included considerations of professional prestige and material reward for asylum
doctors.76 While these incentives cannot be ruled out, Hugh Freeman’s explanation
is much more plausible: if there is a demand for the provision of services to people
with chronic disability, and these services are provided, they will be used,
especially if there is a general perception that patients might live longer as a
result.77 There was no charge for paupers, who were the vast majority of the
insane in public institutions.78 At the same time, social and legislative changes
encouraged transfer of most of the insane from workhouses, where most were
previously held, to asylums.79

Although Australia had fewer institutions, different welfare provisions,
administrative arrangements and legislation, and more centralised care than
Britain, there was marked long term growth in the numbers of officially defined
insane relative to population in the wealthier Australian states after 1850,
reaching a steady maximum for the period 1903 to 1919. For example, the official
insanity rate in NSW was about 280 per 100,000 in 1880, temporarily declining in
1891 to 270 per 100,000, but increasing to a roughly constant rate of about 350
per 100,000 after 1902. Victoria reached a higher maximum rate of around 400
per 100,000 in the same period.80 WA echoed these changes in the insanity rate,
but at a much later period, since the larger scale development of mental health
care came much later than in other states, a contrast which is clearly seen in Figs 1.1 and 1.2.81 Thus the increase in the rate of official defined insanity in WA was
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not due to epidemiological factors, but instead reflected, as it did in Britain, social, political and economic changes in the modalities of welfare provision.

While WA’s insanity rate moved quickly towards the Australian average in the early twentieth century, the ratio of male to female patients of about 2.5 to 1 remained by far the highest of all the states, as shown in Table 1.1. This ratio was barely affected by the moderate decrease in the male to female ratio after 1870. But there was a slight decrease in the proportion of male patients during the war years, when 32,000 young men had enlisted, ten per cent of the total WA population.\textsuperscript{82} There are some plausible, but speculative, explanations for this unique feature of Claremont. Firstly, there may be a quasi-quantum or ratchet effect in operation: above a given level of the ratio of males to females in the general population, the ratio of male to female patients may jump to a new, semi-fixed level. Above this level, small or even moderate decreases in the composition of the general population will not significantly affect patient sex ratios, as seen in Table 1.1.

Another explanation for the sex imbalance at Claremont, which can be firmly based on the available evidence, is the increased mental health risks incurred by people without social ties or family networks, which fell more heavily on males. I have already discussed these risks and their differential impact on men and women in the context of admissions to Fremantle. As Coleborne remarks, ‘...the patient is not infrequently a stranger in the land; kindred and home are far away’.\textsuperscript{83} This was the rule at Claremont. After the arrival of mostly single men in the gold rushes of the 1890s, 30,000 assisted or nominated migrants, mainly hopeful young single men from the British Isles, arrived between 1909 and 1914. The new migrants formed about ten per cent of the total WA population in 1911.\textsuperscript{84} As a result, WA had far more unattached single males than other States.\textsuperscript{85} Therefore the same factors which had marked earlier life in WA remained in operation in the early twentieth century: isolated lives punctuated by hard drinking and violence, unsafe and commercial sexual relationships, lack of material assets and living in quarters rather than homes.
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In the WA goldfields, where large bodies of unattached males were gathered, we can safely assume an echo of the high alcoholism rate and violent behaviour of the eastern states goldrushes of the 1860s. As K.C. Powell describes the earlier diggings in eastern Australia: ‘…..frequently the normal civilised standards were forgotten. ... it was a journey back into primal behaviour with barbarism on the march.’ As Powell shows, alcoholism in the eastern states declined rapidly after the 1860s, as they became more settled and the male to female ratio became more even. Therefore it is reasonable to assume that alcoholism was more frequent in WA while males remained in the majority. One telling symptom of risks to health from this sex imbalance was WA’s much higher rate of GPI, relative to population: the death rate for GPI for WA was more than twice as high as the Australian average. As confirmed by admission reports on patients in the case study data, discussed in the next chapter, males who died at Claremont were much more ill on admission than either males in the general population or female patients who died. Therefore I suggest that patients, particularly males, were more vulnerable to harms than patients at other Australian mental institutions.

In this chapter, I have identified the unique factors affecting the provision of health care in WA ‘on the frontier’ in the early twentieth century and the effects of these factors on the nature and composition of the patient population. Isolation and lack of funds for most of the nineteenth century had meant a lack of differentiated official infrastructure for the management of disruptive individuals. Therefore Fremantle Lunatic Asylum and its successor, Claremont Hospital for the Insane, had to serve many purposes beyond their ostensible function of caring for the insane. Because of the surges of predominantly male immigration in the late nineteenth and early twentieth century, the patient population was heavily biased towards males and immigrants. Lack of alternative provision for the more difficult to manage elderly and the dying meant that Claremont was also a nursing home and hospice. In the next chapter, I will discuss the evidence from the case study, throwing further light on the conditions at Claremont and the health of patients.
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6 See also Margaret McPherson, 'Utterly Useless Men. Convict Lunatics in Western Australia.', *Studies in Western Australia History*, 24, (2006), 64.
7 'Assessment of Convicts Transported to Western Australia', Reading 168, L. Evans and P. Nicholls (eds), *Convicts and Colonial Society 1788-1868*, (South Melbourne: MacMillan, 1984), 259. See also Sandra Taylor, 'Who were the Convicts? a statistical analysis of the convicts arriving in Western Australia in 1850/51, 1861/62, and 1866/68', *Studies in Western Australian History*, 4, (Dec 1981), 20.
8 ABS 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 1. Population by sex, states and territories, 31 December, 1788 onwards .
11 Herbert Franke, 'The Rise and Decline of Solitary Confinement. Socio-historical Explanations of Long-term Penal Changes', *British Journal of Criminology*, 32, No.2, (Spring 1992), 126, 141. The 'Separate System' was also practised at Port Arthur in Tasmania, where the cellular boxes in the prison chapel are well preserved (personal observation).
12 Forsythe, 'Loneliness and Cellular Confinement', 761.
13 See Edgar, 'The Convict Era in Western Australia'.
14 McPherson, 'Utterly Useless Men', 63-64.
15 See discussion in ibid, 69-70.
16 ibid, 70 and Ellis, *Eloquent Testimony*, 27.
17 Roger Virtue, 'Lunacy and Social Reform in Western Australia', *Studies in West Australian History*, No. 1, (Jun 1977), 38.
18 In 1852, the Emigration Commissioners offered to fund the travel of the wives and families of 60 ticket-of-leave men who might ask for them. But none took advantage of the offer. See Warren Bert Kimberly, *History of West Australia*, (Melbourne: F.W. Niven, 1897), 165.
19 ABS, 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 102. Population, sex and marital status, WA.
20 The ratio had not improved by 1896, when it was about 2.3. For WA, see ABS 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 1. Population, by sex, state and territories, 31 December 1788 onwards.
21 ABS 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 42. Crude birth rates.
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24 Fitzgerald and Jordan, Under the Influence, loc 1338.

25 For the proportion of males to females in Fremantle, see Megahey, ‘More than a Minor Nuisance’, 54. See also Harman, ‘Out of Mind, Out of Sight’, 104.

26 ibid 54.

27 ibid 54-55.

28 See for example Mark Finnane, ‘Asylums, Families and the State’, History Workshop, No. 20, (Autumn 1985), 138-139. ‘The asylum ….was acting quite simply as the protector of the abused and intimidated.’ See also Coleborne, ‘Insanity, Gender and Empire’, 90-91.

29 Insanity, being grounds for divorce, was one way to dispose of an unwanted partner. For example, see ‘The New Divorce Act. Cases before the Chief Justice. A Wife’s Insanity’, West Australian, (Perth: 17 May 1912), 8.

30 WA Lunacy Act 1871, Schedule B.


32 ibid, 55.

33 The male and female Case Books for the period 1903 to 1909, SROWA Cons 752, Items 3108/1 and 3107/1 respectively, have entries for both Claremont and Fremantle patients.

34 Hetherington, Paupers, Poor Relief and Poor Houses, 37, 56-61.

35 Megahey, ‘More than a Minor Nuisance’ 56. No surname is given for Nora.


38 Bolton, Land of Vision and Mirage, locs 1961, 3755

39 For Fremantle, see Harman, ‘Out of Mind, Out of Sight’, 104. For WA, see ABS 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 1.1, Population, by sex, state and territories, 31 December 1788 onwards.

40 Reports 1909-1919; Commonwealth Year Book 1925.


42 Victorian Report 1919; ABS 3105.0.65.001 Table 1, Population.

43 Mark Finnane, ‘Wolston Park Hospital 1865-2001: A Retrospect’, Queensland Review, 15, No. 2, (2008), Fig 7, 52; For Qld - ABS 3105.0.65.001 Table 1, Population.

44 Peter Shea, ‘One Hundred Years Ago in New South Wales’, Australasian Psychiatry, 9, (2001), 31. For NSW, see ABS 3105.0.65.001 - Australian Historical Population Statistics, 2006 - Table 1.1.


49 Jacques Gasser and Genevieve Heller, ‘The Confinement of the Insane in Switzerland, 1900-1970: Cery (Vaud) and Bel-Air (Geneva) Asylums’, Chapter 2 in Roy Porter and
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Wright (eds), *The Confinement of the Insane*, 57; *Schweizer Statistik, Eidgenössischer Volkszählung von Dezember 1900*, (Bern: Gustav Grunau, 1905), 134-135.

50 *Ibid* 53. See also Ellis, *Eloquent Testimony*, 35.
51 See McPherson, 'Utterly Useless Men', 69.
52 Megahey, 'More than a Minor Nuisance', 53, 59.
54 Admissions for Asian born males were about one to two per cent of asylum population from 1909 to 1919, females zero to one per cent. See *Reports* Table 8. The 1909 *Report* shows nationality statistics for all resident patients, subsequent *Reports* show nationality of admissions only.
55 Martyr, 'Behaving Wildly', 331.
57 Megahey, 'More than a Minor Nuisance', 50. For Claremont see Fig 3.4, Chapter Three.
59 Based on an average death rate of nine per cent and a broadly similar discharge rate. See *Report* for 1919, Table 2. The actual net discharge figure would be lower due to re-admissions.
60 Comparison of the *Reports* with the *Commonwealth Year Book* figures for WA indicates that the official rate of insanity in WA was based on the numbers at Claremont, the private asylum within Claremont and at Whitby Falls. These statistics did not include patients at other private asylums or other hospitals or estimates of insane persons living outside these institutions.
61 Patient numbers at Fremantle (daily averages) taken from Harman, 'Out of Mind, Out of Sight', Table One, 104; WA population statistics appear in ABS 3105.0.65.001 Table 1.
62 For example, two (instead of formerly one) certificates were required for committal and a period of 'reception' was required before certification. See Roger Virtue, 'Lunacy and Social Reform in Western Australia 1886-1903', *Studies in Western Australian History*, No. 1, (Jun 1977), 29-65. For press report of the Government's intentions, see 'Parliament. Legislative Council. Wednesday, August 13', *West Australian*, (Perth: 13 Aug 1903), 3. discussion of the enhancements in the 1903 *Lunacy Act*.
63 Under the 1871 Act, Visitors could order the discharge of patients on their own responsibility. Compare Section 30 of the 1871 Act and Section 104 of the 1903 Act.
65 For Whitby Falls, see Ellis, *Eloquent Testimony*, 38-39.
66 There were four asylums in NSW in the 1880s – see Garton, *Medicine and Madness*, 38-39. The NSW and Victorian asylums were also less centralised. There were asylums at Beechworth and Ballarat in Victoria and Goulburn in NSW. For the PPH mental ward, see Ellis, *Eloquent Testimony*, 53-54. For a description of the NSW reception house, see Shea, 'One Hundred Years ago in NSW', 30.
67 Martyr, personal communication.
68 *Report* for 1912, 1 and *Report* for 1919, 1.
69 Ellis, *Eloquent Testimony*, 56.
72 Hare, 'Was Insanity on the Increase?', 439-440. The growth is depicted in Fig 1 on p 440.
74 Hare, 'Was Insanity on the Increase?', 439-440.
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77 Hugh Freeman, 'Psychiatry in Britain, c. 1900', History of Psychiatry, 21, (2010), 313.
79 Miller, ibid.
80 Garton, Medicine and Madness, 37. The 1903 figures for NSW and Victoria are from the 1919 Report.
81 The source for Fig 1.2 is the 1919 Report.
82 For enlistment figures, see Bolton, Land of Vision and Mirage, loc 2201.
83 Coleborne, ‘His Brain was Wrong’, 50, quoting the Manning Report on NSW Asylums, 1868.
87 About 25 deaths per year from GPI occurred in WA between 1909 and 1919, about a sixth of the total of 159 in 1919 for all of Australia. WA’s population in 1919 was about a fifteenth of the Australian population. Source: Government of Western Australia, Statistical Registers for Western Australia, 1909 to 1919; Commonwealth of Australia, Commonwealth Year Book 1920, 81, 206.
CHAPTER TWO – The Case Study – The Brief Lives of Patients at Claremont

‘He seemed therefore to die rather for want of the fuel of life...”¹

Irish-born Denis T., formerly a labourer and miner, was aged 52 when admitted to Claremont on 8 May 1912.² The 'friend' entry in the Case Book, which was intended to list next-of-kin or a contact person, lists a Sergeant T. (possibly a relative) at Cue, a gold mining town.³ On admission, Denis was very weak and needed assistance with walking. He appeared to have cardio-vascular problems, with thickened arteries and heart murmurs. He was checked for symptoms of possible neurosyphilis.⁴ Only some of the standard tests were performed: he had a tremulous tongue and unequal pupils. The other standard tests at Claremont for neurosyphilis were the Argyll Robertson test (also known as ‘prostitute’s pupil’) and Babinksi’s sign, but there is no record of these in this case. The tests were not necessarily specific for neurosyphilis, but could indicate other neurological conditions.⁵ The Wasserman test, which was to become a standard diagnostic tool for syphilis, had been used in Australia since at least 1908, ⁶ but there is some indirect evidence that it was not used at Claremont at this time. Dr Bentley testified before the Select Committee in 1919 that: ‘The fact that a man might react to a blood test does not prove that he is in an infective condition’.⁷ Despite some positive indications for GPI, Denis’s diagnosis was left blank.

Denis was unable to answer questions rationally and was delusional. He believed that the hospital food was poisoned – four other patients in the case study sample made similar claims.⁸ A week after admission, the observations note that he was ‘wet and dirty’, the standard euphemism for doubly incontinent.⁹ In the following week, the notes say that he was still ‘demented and childish’. He was confined to bed in June and on 8 July he ‘died today’, with no cause recorded in the Case Book. The official Death Notice recorded that Denis T. died of GPI and dysentery.¹⁰

Eighteen year old NSW born Emily M. died less than a year after she was admitted on 26 February 1914.¹¹ She was not examined immediately on admission, because Dr Bentley’s admission notes say that before his examination she had had to be strapped down because of her attack on another patient. Bentley noted that Emily was delusional, exposed herself and was ‘very erotic’. Her physical health was good.
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Her heart, lungs, abdomen and reflexes were normal and the Argyll Robertson test for possible neurosyphilis was negative. Subsequent observations noted that she was ‘noisy and troublesome’ and doubly incontinent at times. We know that Emily had a lung condition in May, because she was injected with terebene, which was then a standard treatment for chest conditions, including pulmonary TB. On 27 August, the Case Book noted that she was seven months pregnant, meaning that she had probably conceived about a month prior to admission. Previous Case Book observations did not mention the pregnancy and the birth of a child in October was not recorded until December. The December notes also record that she was getting much weaker. On 11 February 1915, she ‘died today’ from TB. It is possible that this infectious disease was acquired at Claremont, although it may be that she had a latent form which expressed itself after admission, perhaps exacerbated by conditions at Claremont and her pregnancy. There is no mention of the fate of her child.

These two cases illustrate most of the institutional shortcomings which patients faced in their brief lives at Claremont. For both patients, the standard of care and documentation was poor. Denis’s notes and examination are incomplete and no cause of death was given in the Case Book. Emily’s pregnancy, which must have become obvious at some point, was not mentioned until two months after she gave birth. Both patients were probably victims of poor hygiene and overcrowding, since they died from infectious diseases. While Emily was apparently in good health on admission, Denis was clearly very ill on arrival, with serious heart issues, suggesting that the authorities regarded Claremont not only as a place of care for the mentally ill, but as a hospice for the dying. It appears that Denis was sent to Claremont rather than the Home of Peace either for being disruptive or because the Home was full.

While there is much evidence, some conflicting, from contemporary press reports, the Select Committee and Royal Commissions about poor record keeping, exposures to harms, the multi-function role of Claremont and the effects of isolation on patients’ health, the evidence from my sample gives much more direct insight into the reasons for the short and bleak lives of patients in the sample, which will be discussed in the last section of the chapter. While focussing on the case study, I will
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draw on evidence from other sources, such as the Death Notices, to give context to
the analysis and allow comparisons to be made with practices elsewhere.

**Poor Record Keeping**
The generally poor quality of record keeping and observation, not only for Denis T.
and Emily M., but for all patients in the case study sample, is immediately apparent.
It is also evident in the other Case Books entries which I examined. With few
exceptions, the medical histories for the sample patients are documented in two or
three lines, if at all, although the taking of a medical history on admission was a
recommended practice of the day. It was also a legal requirement that the ‘mental
state and bodily condition’ of patient should be entered in the Case Book on
admission. But for the case study sample, the patient’s condition and status were
recorded haphazardly at best, with no diagnosis being given for 60 per cent of
women and 96 per cent of men. There is very little documentation of treatments and
an absence of extensive observation notes, in contrast to standard practice in British
institutions, where all the Claremont doctors were trained. These doctors wrote
observations infrequently and their notes were often terse to the point of obscurity.
Emily’s final observation did record a clear cause of death. But for Denis and many
other patients, the last file note was simply 'Died today' or ‘Died last night’, or just
‘Died’. Half of the admission form entries for Emily were left blank. Possibly her
mother (the recorded ‘friend’) was unwilling to provide much detail of her
background, and she may have been too violent for her height and weight to be
noted. But violence would not have prevented the recording of Emily’s hair and eye
colour. The medical staff did not record the birth of her child until two months after
the event. Emily’s treatment with terebene is one of the very few instances in the
Case Books or observations where any specific medication is recorded, but the
dose or duration of treatment was not given. In only two other cases was there
mention of a medicine, dosage or treatment regime. Coleborne’s work on detailed
case notes in Australian and New Zealand asylums also shows that Claremont’s
record keeping was of an exceptionally poor standard. For example, she writes
that the Gladesville (NSW) records had voluminous marginal notes, information
from the certifying doctors and family observations drawn from medical certificates.
This level of documentation is rarely seen in Claremont records.
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In contrast to the sketchy Case Book records, the aggregate financial and patient statistics published in the Reports were fairly extensive, suggesting that financial administration took priority over medical care. The Reports contained detailed statistics on mortality by age and sex, causes of death, discharges, causes of admission and many other measures of claimed effectiveness, giving a false impression of efficient administration. But the official reports for the larger states, such as Victoria, presented much more information and give an impression of greater transparency. The Victorian Reports had a low percentage of ‘unknown’ exciting or predisposing causes, and expanded on topics never discussed in the Claremont Reports, such as the dismal pass rates in attendant and nurse examinations, the occurrence of various illnesses by age group, tasks of working patients, individual reports for the seven public Victorian asylums, private asylums, reflections on causation of mental illness and details of accidental deaths at the asylums.

The poor quality of the patient documentation ignored the clear intention, if not the letter, of the state’s lunacy legislation. The Inspector General of the Insane was required to:

Enter, or cause to be entered, in a book to be called the case book, as soon as may be after the admission of any patient, the mental state and bodily condition of every patient at the time of his admission, and the history of his case whilst he continues in such hospital.

Table 2.1 shows the categories of data collected in the Case Books at admission. Post mortem notes were also recorded for some deceased patients. The top half of the Case Book form had specific ruled boxes for all these categories except ‘Medical Certificate’, ‘Physical and Mental Condition’ and ‘Post Mortem’. The latter categories were filled in in free format by the admitting doctor or the doctor attending the death. What is immediately apparent from the table is a relaxed approach to form filling. Examination of other related records kept by doctors shows a similar style.

This may have been a form of quiet resistance to bureaucratic regulation, but Select Committee evidence suggests that it was a response by medical staff to time pressures and excessive workloads. There were only four full time doctors and one part time doctor during the war years (Dr Bentley had enlisted) to care for over 1000 patients and the Inspector General had to supervise Whitby Falls (50 km
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distant) and Greenplace as well. But if workload was the cause of slack
documentation, it is not clear why doctors often recorded non essentials such as eye
colour and left out more useful data such as the ‘Result’ (the diagnosis). Sometimes
these missing entries were scrawled casually in free format in the Physical or
Mental Condition reports, which must have hindered statistical collection. These
rushed, incomplete and casual observations in the Case Books cast some doubt on
the accuracy of the aggregate statistics in the Reports and their implicit claims of
efficient administration.

Table 2.1 – Data collected on admission from patients in the case study
sample

Sources for Table 2.1 : Claremont Case Books

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>% in Sample who have this entry filled in the Case Book form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>First names and surname</td>
<td>Male</td>
</tr>
<tr>
<td>Admitted</td>
<td>Date admitted</td>
<td>100</td>
</tr>
<tr>
<td>Sex</td>
<td>M or F</td>
<td>100</td>
</tr>
<tr>
<td>Religion</td>
<td>If Australian, state of origin. Else country of origin.</td>
<td>94</td>
</tr>
<tr>
<td>Nationality</td>
<td></td>
<td>94</td>
</tr>
<tr>
<td>Age at admission</td>
<td></td>
<td>91</td>
</tr>
<tr>
<td>Marital Status</td>
<td>M(arried), S(ingle), W(idowed) or U(nknown)</td>
<td>91</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td>89</td>
</tr>
<tr>
<td>Friends</td>
<td>Name and address of relatives or friends</td>
<td>85</td>
</tr>
<tr>
<td>Relatives Insane</td>
<td>[Hereditary influences?]</td>
<td>30</td>
</tr>
<tr>
<td>Attack And Duration</td>
<td>Type of attack and the duration of the attack</td>
<td>67</td>
</tr>
<tr>
<td>Age 1st Attack</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Cause</td>
<td>Cause of illness</td>
<td>60</td>
</tr>
<tr>
<td>Epileptic</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>Suicidal</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Dangerous</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Result/ Diagnosis</td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Order By</td>
<td>Persons issuing detention order</td>
<td>91</td>
</tr>
</tbody>
</table>
According to the Chief Attendant, James McKeown, the examination data were normally recorded on the day after admission, unless the patient was seriously ill, when they would be medically examined ‘straight away’.\(^{29}\) The credibility of McKeown’s claim, and his implicit view that attendants could accurately judge the severity of a patient’s condition, is undermined by the facts of the Andinach affair, which had resulted in a Royal Commission.\(^{30}\) Francis Andinach was seriously injured in a struggle with a Claremont attendant at the mental ward of Perth Public Hospital (PPH). In contravention of regulations, an attendant (Robert Eacott) had single handedly attempted to fit a strait jacket onto Andinach, who was injured during the resulting struggle. According to a fellow patient’s testimony at the subsequent Royal Commission, Andinach was ‘savagely’ beaten by Eacott. When admitted to Claremont on 21 May 1918, Andinach had many visible and extensive injuries and he died on 29 May from ‘acute mania, pulmonary congestion following trauma, [and] exhaustion’.\(^{31}\) Appendix Three is a transcript of the Case Book entries listing his injuries.\(^{32}\) These records show that Andinach was not medically examined
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until the 24th of May, three days after admission, when he was found to have two rib fractures which were the probable cause of his fatal ‘pulmonary congestion’.\textsuperscript{33} Attendants with limited medical knowledge had been left to care for him and to make their own assessments of the seriousness of his injuries.

The extraordinary fullness of Andinach’s Case Book notes suggests a panicky response to impending public scrutiny of this management failure. It is impossible to prove, but the atypical depth of detail of the Andinach Case Book notes (and several crossings out) as compared to other Case Book entries suggests retrospective completion after the matter had become a public scandal. It is also extraordinary that the Colonial Secretary told the \textit{West Australian} that Dr Moxon, who he claimed ‘saw’ the deceased when admitted, reported that Andinach showed no indication of serious injuries.\textsuperscript{34} Even if attendants or nurses considered that the patient was not seriously ill, the practice of deferring medical examination on admission flouted the intention of the \textit{Lunacy Act} and exposed the new patient to the risk of further injury by other patients or self harm, compromising the accuracy of the admission notes.

There was scant regularity or method in the intervals between observations for the patients in the case study sample. Generally speaking, more frequent notes were taken on seriously ill patients, but for many patients who died at Claremont, their penultimate observation was made months prior to their deaths. There was a seven month gap between Annie B.’s deathbed observation and her previous observation.\textsuperscript{35} Observations were generally made weekly on female patients in the first month of residence or more often if they were seriously ill. After that, observations were made monthly for the next three months and three monthly after that. But for some patients, there were gaps of six months or a year, with no apparent explanation for these discontinuities. Longer-term patients who experienced severe illness over a protracted period as they approached death tended to be seen more often. Therefore it is probable that patients in the sample, who were all deceased, had more observations on average than patients who did not die at Claremont. There were also more observations for patients in their first year at Claremont, which might be explained as follows. The aggregate discharge statistics show that 80 per cent of females (and 60 per cent of males) at Claremont
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were discharged in the first twelve months. Broadly similar figures were noted by Garton for NSW and by Cathy Smith in England.\textsuperscript{36} Since discharges were a very public measure of success or failure,\textsuperscript{37} this evidence suggests that Claremont doctors, challenged by the overcrowding of the institution and limited staffing, would have concentrated their observation efforts within the first year when their work was more likely to effect an improvement in a patient’s condition.\textsuperscript{38}

Generally speaking, female patients received more attention. Observation notes for patients in the sample were fuller and more frequent for females than males. The pattern of observations for males was more irregular and variable and the observation intervals after the first few weeks tended to be longer than for females. There are a number of plausible reasons for these marked differences in practice between sexes and between individuals. In respect of these disparities, the different management style of the doctors in each ‘side’ of Claremont, and fewer patients per doctor on the female ‘side’ - allowing more frequent observations there – as well as differences in training between nurses and attendants, may have all been relevant.\textsuperscript{39}

There are no available statistics on the nurse to patient ratio, but other evidence indicates similar staff shortages to the male ‘side’.\textsuperscript{40} Nevertheless, Coleborne and Marietta Meier emphasise the important role of cultural attitudes to gender in treatment policies. They also claim that social class played a role in determining treatments and the language used to describe them. This work suggests that perceptions of lower class and lower status and prevailing conceptions of gender roles meant a closer supervision of females within institutions than was the case for males.\textsuperscript{41} Another plausible factor in differentiation of treatment for females is the role of the patient’s family and friends. Coleborne claims that family interactions with asylum staff were effective in securing more attention to individual patients and influenced treatment strategies and quality.\textsuperscript{42} As shown in Chapter One, female patients were more likely to have such family support than males, hence their welfare was more likely to be reported on.

The observation notes, then, were useless as a reliable record of the progress and medical history of patients, presumably as a result of the time pressures and a failure of management to enforce consistent recording standards.\textsuperscript{43} The majority of observations are very short and uninformative: such as ‘dull & stupid’, ‘no change’,
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‘much the same’, ‘does a little work’ and other stock phrases. ‘Dull and stupid’ and its various cognates were part of the standard medical shorthand of the day.\textsuperscript{44} In many cases, there was no indication in the observations preceding death that the patient was in poor health. Patients were evidently weighed at intervals, but their weights were not recorded in the observations or in the Day and Night Books.\textsuperscript{45} There is conflicting evidence about the observation process. The Chief Attendant, James McKeown, claimed that observations were made after personal examination by the doctor, whereas William Flanagan, an attendant of 29 years experience, claimed that the observations were written up by the doctor every two or three weeks on the advice of attendants, relying on notes in the Night and Day Books.\textsuperscript{46} The reliance on stock phrases suggests the latter. For many patients, there could be six or nine month intervals or more between observations. There was no observation for James H. between June 1918 and July 1919.\textsuperscript{47} The alleged dates of two observations for Dorothy B. were prior to her date of admission.\textsuperscript{48} According to the \textit{West Australian}, Case Book entries for one Chinese patient continued to be made for six years after his death at Claremont, during which time he was said to be ‘quiet and orderly’.\textsuperscript{49} As shown in Table 2.1, only 50 per cent of observations at death gave the cause of death for males, 75 per cent for females. To sum up, observations were unreliable, often uninformative and in many cases, relied on post hoc impressions and attendants’ opinions rather than medical examination.\textsuperscript{50}

The lack of attention to detail is not restricted to the Case Books. It is mirrored in the Death Notices issued at Claremont. There are missing certificates, causes of death which do not match the Case Book entry, blank causes of death, and dates of death which precede admission dates. For three patients, including, William G., the date of death precedes the date of admission.\textsuperscript{51} Only 29 of the 44 case study patients admitted between 1912 and 1918 had Death Notices.\textsuperscript{52} For nine patients (not in the case study), no cause of death was given in the Death Notice. There is no record on the Lunacy Department file containing the Notices of any query by the Department concerning these deficiencies.

\textbf{Exposure to Harm}

Violence at Claremont was both physical and mental. There was patient on patient violence and rough handling by attendants, as mentioned in the Andinach case.
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Verbal violence, often mentioned in the observations, or low level violence such as spitting, could stress or infect vulnerable patients with TB and other communicable diseases. Although there is no record of either Emily or Denis having been physically harmed, the observations show that Emily and other patients in the sample were often violent, to each other and to staff. Ann B. was killed by another patient. But, except for Ann, the records do not indicate which patients in the sample had been attacked. Some patients were violent to staff, for example James B., who assaulted a doctor, and William W., who struck an attendant. Emily M. chased and tried to kill another patient. Notes for other patients in the case study sample mention quarrels, disturbances and fighting and many more patients were likely to have been harmed by others. Some patients were feeble, weak or bedridden and would have been particularly vulnerable to violence. Even an accidental jostle against patients with fragile bones, especially the elderly or GPI sufferers, could result in a quickly fatal injury. Edward C., a GPI patient and therefore vulnerable to bone breaks, was found to have a fractured sternum and died five days later. He was not medically examined until he had been in bed for four days. The cause of the break may have been the natural progress of his disease or an accidental fall, but violence may have played a part since we know that Edward was ‘frequently quarrelsome’. The Andinach affair shows that attendants could also be brutal and violent. Violence at Claremont was poorly controlled due to crowding, lack of separation and poor management.

Some of the treatments at Claremont were known at the time to have harmful side-effects and cause distress to patients. But in only three cases are treatments recorded for patients in the sample. Emily M. was injected with terebene, a turpentine-based treatment for cough or TB, when about three months pregnant. Elisabeth R. was given 0.65g (ten grains) of chloretone daily for an unspecified period. Chloretone was widely used as a sedative, for chorea and as a sea-sickness remedy, but was known to have harmful symptoms when taken for too long a period or in higher doses. As little as two grains taken three times daily caused alarming symptoms such as ‘imbecility’, ‘stupor’ and ‘twitching’. Elisabeth’s treatment regime falls into this range. The infant Dorothy B. was treated with mercury for seizures with unhappy results. Her seizures stopped, but she remained immobile, incontinent and developmentally disabled until her death at the age of seven.
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Mercury was a standard treatment of the day for epilepsy and syphilis, but by the 1920s, it was increasingly understood to be ineffective and toxic and was replaced by less toxic treatments such as salvarsan. While the treatments clearly did affect patients’ health and morale, the lack of documentation makes it impossible to make any quantitative estimate of the harmful effects.

The nutritional deficiencies and lack of variation in the diet at Claremont affected particular categories of patients in the sample, as will be discussed in more detail in Chapter Three. Patients with brittle bones, such as the elderly or people with GPI were vulnerable to calcium and Vitamin D deficiency. The GPI patient Edward C., as we have seen, died from a broken bone. Several patients in the sample had eating disorders or suffered from wasting illnesses, which would have been exacerbated by deficiencies in the diet. Some patients refused to eat, for example James S., Gladys H. and Frank T. died from ‘general inanition’, a wasting condition caused by malnutrition. Maud A. died from mania and ‘exhaustion’, the end result of inanition. According to Margaret Harris and her co-authors, early twentieth century asylum deaths due to ‘exhaustion’ might be attributed to complications of depression, including eating difficulties and resultant inanition. Similarly, deaths attributed to ‘senility’ or similar diagnoses, may also have been due to inanition. Ironically, the aggressive measures used to prevent death by starvation may have shortened lives. Forced feeding for patients who refused food, as in the case of James S., was known have health risks and was certainly painful. While the effects are impossible to quantify, the poor diet at Claremont, as I will show, was a significant contributing factor to deaths among patients in the sample.

The 'Multi-Function' Role of Claremont

From 1909, Claremont took over Fremantle Asylum’s integral role in the welfare system for the sick, the aged, the poor, the alcoholic and the disabled in WA, as described in Chapter One. Claremont was the final stop for the unruly poor, drunk, homeless and aged in the WA welfare system. Violent or ‘difficult’ inmates of the crowded homes for the poor and aged were removed to Claremont, for example 73 year old Ann B., who was expelled for ‘unruly behaviour’ from the Home of Peace. The jobless Robert C. and the failed farmer Michael B. were alcoholics known to be violent. Kellie Abbott and Celia Chesney cite a number of ‘contested admissions’
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for ‘difficult’ women in the WA welfare system. But some quiet and inoffensive people were also removed to Claremont, such as the ‘feeble’ and elderly Eleanor G. Thus decisions to certify patients as ‘insane’ were often made on non-medical criteria. The evidence suggests that the first Inspectors General of the Insane had limited control over who was admitted. As Montgomery, the Inspector General, complained in 1909, these admission practices served to ‘swell our death rate and decrease our recovery rate’. Clearly, the fact that he made this complaint indicates that he could not refuse admission to certified patients and that he had little or no input into certification decisions.

As we have seen, a defining characteristic of welfare provision on the periphery, with its limited resources, is a lack of specialisation of care as compared to more populated and better funded centres. In addition to caring for people rejected by other institutions, Claremont had to care for the demented aged, alcoholics, the terminally ill and the developmentally disabled. It also functioned as a de facto ‘Lock Hospital’ for GPI patients, such as Edward C., but Claremont doctors knew that these patients were not very infectious. About a third of males in the sample and only one female died of GPI.

Very young patients were also admitted, for example, the unfortunate Dorothy B., who became severely disabled after mercury treatment. Bertha Baskerville, a charge (senior) nurse, stated that 30 children were held at Claremont in 1919. While admitting that children should ideally be kept apart from other patients, she told the Select Committee that some children could be left alone with trusted female patients. The hospital records do not indicate how many of these children were developmentally disabled or how many were mentally ill. Upon reaching maturity at about age fifteen, male children were placed in male wards. The Royal Commission into Lunacy of 1921 acknowledged that this system of mixed care and the placing of vulnerable young people in adult wards was far from optimal for their care and development needs and exposed them to harm from other patients.

Thus Claremont, while ostensibly an institution for the care and rehabilitation of the mentally ill, was required to admit many patients for whom its staffing and limited resources were not well suited, partly because of the deficiencies of provision of
care and financing in 'feeder' institutions, such as homes for the aged. Other Australian asylums and many institutions overseas had these additional responsibilities. About ten per cent of admissions to Victorian mental hospitals in 1919 were due to 'old age' and twelve per cent were due to 'congenital defects' (presumably the developmentally disabled). In public asylums in the US state of New York from 1909 to 1928, about eight per cent of first admissions were 'seniles' and there were similar percentages of alcoholics and 'arteriosclerotics'. But I would argue that because of the longtime persistent lack of specialisation of social provision in WA, Claremont had a much higher proportion than its sibling institutions of patients who could not be formally classified as insane under the medical criteria of the day. These patients were at higher risk than patients who were actually mentally ill from unsuitable treatments. The resultant overcrowding and lack of separation degraded the standard of care, compromised hygiene and increased the possibility of acquiring transmitted infections for all Claremont patients.

**Isolation on the Frontier**

Hard drinking, social isolation, commercial and risky sex relationships, and violence were an established part of WA male culture 'on the frontier'. There were twice as many males as females in the case study sample. Of the 21 single males in the sample, few of whom were born in WA, four had no 'friends' and three had contacts living interstate or overseas. Some immigrant single patients had had hard, remote and lonely lives in WA which must have affected their mental state. The admission notes for Arthur P., a failing farmer whose nearest 'friend' lived in England, mentioned 'hard living and financial worry'. The delusional and friendless Irish prospector James B., aged 60, had never married. The cause of his illness was recorded as 'hardship and bad food'. Denis T., a miner from the remote and declining Murchison goldfields, had also emigrated from Ireland and was still single at 52. His only 'friend' was his putative relative, a police sergeant stationed at these goldfields. Edwin Q., also single, was a self-confessed alcoholic.

Although comparatively fewer and more confined to settled areas, the relative isolation of female patients is also striking. Only about 30 per cent of females in the sample were married, whereas about 65 per cent of females older than fifteen and
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resident in WA were married. In 1911, about 40 per cent of female WA residents were born there, but less than twenty per cent of female patients in the sample were born in WA. Thus single female immigrants were more than twice as likely to be confined at Claremont as married local women. Coleborne made similar observations with respect to female patients at Yarra Bend, Victoria, and Auckland, New Zealand for the period 1870-1910. She claims that single low status working-class women, without the protection of family and local ties, who challenged authority or employers or who lived ‘loose lives’ evoked institutional responses. Coleborne analyses the interactions of the authorities with those women who lived ‘marginal lives’, many of whom were immigrants, namely women officially documented as ‘dissolute’ or as prostitutes. They were seen as ‘a threat to the social order’. Similar official responses to prostitutes and ‘marginal’ women were evident in WA. Raelene Frances, in her history of prostitution in Australia, writes about the use and abuse of coercive legislation in WA before and during World War I to restrict the civil liberties of ‘loose’ women and to effect, and in some cases profit from, venereal disease control. The patient Victoria B. was registered as a prostitute and her admission notes indicate a troubled record with the police. The other single females in the sample were nearly all domestic servants, as had been the case previously at Fremantle, which suggests that they were predominantly working class and had low status. As with the males, social isolation, low status, hard lives and resistance to dominant norms often led to more harsh and arbitrary confinement of low status females than in more settled societies where a wider range of welfare infrastructure was available.

**Brief Lives**
Irrespective of their state of health at admission, all patients faced similar hazards at Claremont. Most patients, more often males, were already in poor physical health when admitted, but a sick patient’s greater vulnerability to bad conditions and infections could prove fatal. Denis and Emily were probably exposed to infection: Denis was dead after two months, having succumbed to GPI and dysentery; Emily did not last a year before succumbing to TB. Quantitative analysis of the ‘life spans’ for all patients in the sample shows that about 55 per cent of both males and females died within a year of admission, which roughly conforms to Finnane’s 1929 figures for first year mortality at Wolston Park in Queensland.
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Between 1909 and 1919, the aggregate annual death rate for males was seldom below eight percent; the female rate was slightly lower except in 1912 and 1916. The death rate exceeded the discharge rate in most years.93

After the hazardous first year, there was a marked difference in mortality rates, indicating that males were more ‘fragile’ than females. Only one tenth of males survived for more than six years, as shown in Fig 2.1. There is also a marked ‘flattening’ of the survival curves after twelve months: the rate of decease falls off. If conditions determined life expectancy, the relative longevity of patients who survived their first year could be explained by their greater toughness and resistance to harms. Another explanation might be the better health status on admission of the ‘first year survivors’. But the underlying factors were more complex than this simple picture might show.

As discussed above and as evident in Fig 2.1, Claremont admitted patients of very different ages and health status and therefore with different life expectancies. The admission notes for case study patients show that they had a wide range of physical and mental conditions with varying prognoses: dementia, epilepsy, GPI, heart conditions, mania and melancholia. Two thirds of males had a heart condition, but only a few females, which might explain the greater ‘fragility’ for males. Some fatal illnesses were probably acquired in the hospital: dysentery, pneumonia and other infectious diseases, such as TB of the lungs. This form of TB might have a long latency period or have been caught from another patient. Some patients in the sample suffered from multiple concurrent morbidities, for example heart disease and dementia. And there were significant year to year variations in aggregate death rates, suggesting a complex interplay of natural variations, external influences, changes in staffing, care practices and admission policies. These factors will be discussed in more detail in Chapter Three.
This complex weave of factors can only be unpicked to a limited extent, due to small, less statistically significant, numbers in the various categories. It is possible with GPI, which was the most common physical illness for males and the diagnosed cause of about a third of male deaths in the sample. About a third of males in the sample had GPI on admission. Yet, as shown in Fig 2.2, fewer GPI deaths than non-GPI deaths occurred in the first twelve months, and the death rates after 18 months are quite similar. Four fifths of GPI patients in the sample had died after three years, somewhat less than the three year death rate of 90 per cent for patients with GPI in British asylums in 1913. Davis’s view of GPI as ‘the most deadly disease of asylumdom’ is not confirmed by the sample of male Claremont patients. ‘Senility’ was far more ‘deadly’. I will discuss this surprising result in the next chapter.
The death rates in the sample of patient records broadly reflect, with variations from year to year, the death rates seen in the aggregate statistics from the *Reports*. The aggregate death rate fell after the first years, but up to 90 per cent of patients did not survive five years at Claremont. A crude calculation can be made which underlines these mortality rates. If they survived until the age of five, males born in WA between 1901 and 1910 had an average life expectancy of about 53 additional years, females 56 years. Subtracting the age at death for each person in the sample from these life expectancies gives an average ‘loss’ of twelve years for males and nineteen years for females, probably more, given that life expectancies improved after 1910, except for young adult males during the war. Therefore it is clear that the sample patients were either significantly more ill than the general population of WA or they incurred fatal harms at Claremont, or both. Another possibility is that the mental and physical state of the patients on admission made them particularly vulnerable to harms. Nevertheless, for all but a few hardy souls, a failure to secure a discharge meant certain death in four or five years.
Outside Support

Although mental illness would have strained family and social ties, supportive friends, visitors and family could be important factors in patient’s physical and psychological well-being, as Coleborne and others have emphasised, providing treats, pocket money, food and outings, influencing treatments, and making release possible. But for highly stigmatised diseases, such as GPI, families often ‘forgot’ the patient and invented sanitised cover stories for their absence. When Ann B.’s husband visited, she was much quieter, although we do not know if this was from fear or affection. We do not know if patients always received their food parcels. Thomas Smith, a charge attendant, said that food brought in by visitors was put in a cupboard and given out ‘at discretion’. Given the punitive mindset of some staff, it is possible that ‘bad’ patients received little or nothing. According to the evidence of an ex-patient, Patrick O’Meara, one patient refused to eat hospital food and was fed by relatives. O’Meara testified that: ‘No-one offered him [the patient] food’ and he subsequently died from ‘paralysis’. Outings could provide relief from hospital stresses and social contact. Sufficiently trusted patients were allowed out on day release under the supervision of a relative, a friend or an attendant – a financially successful day at the nearby race meeting for a lucky few. Such treats were less likely for the difficult and the isolated.

Family and friends also provided an external and independent check on maltreatment and abuses. In theory, the official Board of Visitors appointed under the Lunacy Act performed this auditing role and were required to ‘see every patient’. Under the 1903 Lunacy Act, two Official Visitors were to be appointed to every establishment caring for the insane, or suspected insane. The Visitors were required to inspect the institution, its books and its grounds and to see every patient at least every three months. They were required to report to the responsible Minister on each visit. The Visitors for most of this period were Mrs Susan Casson (née Holmes), a legal practitioner, social reformer and member of the Australian Labour Federation, and Dr William Birmingham, a Fremantle medical practitioner. But, as I will show in Chapter Three, the Select Committee evidence suggests that the Visitors relied on hearsay and were clearly reluctant to criticise management. Family and friends could effectively instigate political
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pressure. After the suspicious death of Francis Andinach, a popular owner of a Fremantle café, the demand for a proper investigation was taken up by the local Labor member, Walter Jones, soon to be a member of the Select Committee, who, according to Ellis, successfully demanded a Royal Commission. In contrast, those without family or friends, people who had lived hard isolated lives on the frontier, had to pay further penalties when they became ill and institutionalised: lower standards of care and attention, less protection from abuses and a diminished quality of life. Their despair and isolation is poignantly expressed in letters to the Inspector General and other government officials filed in the Case Books.

There were other sources of outside support and comfort. Some of these activities provided additional checks on abuses and relief from isolation. Claremont held regular concerts and dances and fielded a regular cricket team in the metropolitan competition. Attendants and nurses were required to dance with patients and to take part in their games and amusements. Religious services were held and clergy regularly attended sick or dying patients. For men without family ties or close friends, previous war service provided continuing comradeship and a social network. Ex-servicemen’s organisations were politically influential postwar and provided advocacy and support for members fallen on hard times. Evidence for this is the marked sensitivity of medical staff and carers to repeated questions from Select Committee members about the standard of care for Martin O’Meara VC. Some attendants and doctors had also served in the war and might have been expected to be sympathetic to the needs and welfare of a disabled war hero.

The official concern about the quality of care for O’Meara VC suggests that public dissatisfaction with the treatment of ex-soldier patients in general had been brewing for some time before this inquiry. The Select Committee revelations and recommendations did not mollify the complainants. A month after the Committee had investigated O’Meara’s treatment, the Returned Soldiers Association (RSA) petitioned the Government to have all ex-servicemen withdrawn from Claremont and removed to a convalescent home. Correspondence in 1924 between the Inspector General and the Lunacy Department mentions representations by RSA to the Colonial Secretary to allow relatives to choose their own ‘medical men’ to treat

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Ex-soldier patients. This privilege was already in effect in other WA hospitals, but was firmly resisted by the Inspector General.\textsuperscript{115} In the event, all ex-serviceman patients were transferred to ‘Lemnos’, a dedicated and federally funded hospital for mentally ill ex-military, in 1926.\textsuperscript{116} While the RSA lobbying may have some effect, much of the cash strapped state government’s motivation for this change was probably financial, in that the Commonwealth paid for the maintenance of patients at Lemnos.\textsuperscript{117}

The poor record keeping at Claremont is strong evidence of inefficient administration, deficient standards of care and in some cases, dishonest misrepresentation. Patients in the case study sample were exposed to a number of mental and physical health risks and Ann B. was killed. Francis Andinach received very serious injuries before admission, but was neglected by doctors for the first three days after his admission. The multi-function role of Claremont caused overcrowding. The consequent pressures on staff and unsatisfactory separation and differentiation of care for patients with different illnesses, ages and propensity to violence, compromised the health of all. The marked social isolation of patients in the sample with respect to the source population foreshadows two issues discussed in more detail in the following chapter. Firstly, friendless and isolated people were likely to be in poorer health upon admission. Secondly, the standard of care and provision of comforts at Claremont was improved by the interventions of family, friends and organisations such as the Returned Soldiers Association. Isolated patients would have had worse morale and shorter lives than patients who had regular social contacts. All these contributing factors explain much of the disturbingly brief lives of patients in the study sample. Finally, I have established that the case study statistics are by and large representative of the aggregate statistics for deceased patients, apart from year-to-year fluctuations in the latter. The case study provides useful insights into the incidence and causes of mortality at Claremont, the reasons for admission and the composition of the patient population, which I will draw on in the next chapter.

\textsuperscript{1} Aubrey, \textit{Brief Lives}, life of Thomas Hobbes, 155.
\textsuperscript{2} SROWA Cons 752, Item 3108/2, Folio 241.
\textsuperscript{3} ’(W)’ next to the entry denoted wife, ’(H)’ husband, ’(M)’ mother, etc. There was no such suffix on Denis’s ‘friend’ entry.
\textsuperscript{4} See Introduction for discussion of neurosyphilis.
medications were vague, e.g. ‘laxatives’.

New Zealand, 1860 were recorded.

headings such as ‘Medicine’, ‘Cough Mix’, ‘Hypo In

Montgomery’, 65 (Anderson), 81 (Bentley).

The Cruel Madness of Love, 130-146 for the history of this test. For use in NSW in 1908, see Garton, Medicine and Madness, 169.

Select Committee, evidence of James Bentley, medical superintendent, Question 4437.

Elisabeth R., Thomas C., Gladys H., Ann B. and Elisabeth B.

At Claremont, ‘wet’ meant incontinent of urine, ‘dirty’ meant incontinent of faeces – Philippa Martyr, personal communication.

SROWA Cons 752, Item 1912/0105, Folio 24.

SROWA Cons 752, Item 3107/4, Folio 65.


The Home of Peace in the Perth suburb of Subiaco had been founded in 1898 as a hospice, with 30 beds initially. Most state welfare facilities were chronically overcrowded – see Hetherington, Paupers, Poor Relief and Poor Houses, 47,73.

The taking of an extensive medical history – anamnesis – was recommended by standard medical texts of the time. For example, Georg Klemperer, The Elements of Clinical Diagnosis, (London:Macmillan, 1904), 1-4; Charles Arthur Mercier, Lunatic Asylums: Their Organisation and Management, (London: Charles Griffin, 1894), 253-254.

WA Lunacy Act 1903, paragraph 72.


For British training of Claremont doctors, see Ellis, Eloquent Testimony, 42 (Montgomery), 65 (Anderson), 81 (Bentley).

The Claremont Day and Night Books do record treatments, vaguely, under non-specific headings such as ‘Medicine’, ‘Cough Mix’, ‘Hypo Injection’, or ‘Aperient Mix’. No dosages were recorded.

See Dorothy B., SROWA Cons 752, Item 3107/2, Folios 239 (mercury) and Elisabeth R. (chloretone), SROWA Cons 752, Item 3107/2, Folio 73.


Clause 39, paragraph (2) of the WA Lunacy Act of 1903.

I found at least ten Death Notices (Schedule 13s) on file which left the cause of death blank. In contrast, the Day and Night Books, which were kept by the attendant or nurse in charge, were meticulously filled out in neat handwriting although the descriptions of medications were vague e.g. ‘laxatives’.

For the doctors’ daily schedule, see Chapter 4.
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25 Ellis, Eloquent Testimony, 63-64, 72. There were 1090 patients in 1918 – see Report for 1918. See Introduction for description of Whitby and Greenplace. Whitby Falls was about 50km from Claremont.

26 The Aboriginal boy had only one name.

27 This category was omitted from forms after 1910.

28 Two male patients in the sample died on the day of admission (Herbert T. and John W.). See SROWA, Cons 752, Item 3108/2, Folio 421 and Cons 752, Item 3108/4, Folio 362 respectively).

29 Select Committee, evidence of James McKeown, Chief Attendant, Questions 2927-3336.

30 The report of the Andinach Royal Commission of 1918-1919 is missing from its folder in the SROWA files. See Martyr, Us that Live Here, Chapter 3.

31 SROWA, Cons 752, Item 1916/0369, Folio 113. According to the notes, Andinach had a large area of subcutaneous emphysema, which can be a symptom of very dangerous underlying conditions.

32 The Case Book notes, SROWA Cons 752, Item 3108/5, Folios 226-227, contain clippings of the relevant article from the West Australian (Perth: June 22, 1918). See also Martyr, Us That Live Here, Chapter 3, for details of the Andinach Royal Commission. Claremont regulations specified that at least two staff were required when a strait jacket was to be fitted.

33 The Case Book notes state that Andinach had a 'well marked subcutaneous emphysema on the whole of left chest', indicative of a punctured lung. See also Select Committee, evidence of Thomas Cox, former attendant, Questions 3812-3837. Cox witnessed the reception of Andinach and claimed to have seen some of his external injuries. See also Martyr, Us that live Here, Chapter 3. For the background to the Royal Commission, see Martyr, Us that Live Here. As Martyr writes, the official report of the Royal Commission has been 'lost' and she had to reconstruct the details from press reports. Eacott was exonerated by the Commission.

34 'Andinach Case. Ministerial Statement', West Australian, (Perth: 22 Jun 1918), 7. There is no record of any medical examination having taken place until three days after Andinach's admission. It is not clear if Moxon made the Case Book notes.

35 SROWA Cons 752, Item 3107/4, Folio 25.


37 The discharge rate was prominently featured in every Report and poor discharge rates were the subject of Parliamentary criticism, see 'Hospital for the Insane: The Select Committee’s Ministerial Statement', West Australian, (Perth: 29 November 1919), 11.

38 For complaints about overcrowding, see for example the introduction to the 1909 Report. See also Select Committee, conclusions Page ix.

39 Female staff were always termed 'nurses', 'charge (senior) nurse' or 'matron', male staff were 'attendants', 'charge attendant', 'charge (senior) attendant' or 'chief attendant'. Patients on the female 'side' had their own dedicated doctor – Martyr, personal communication.

40 Select Committee, evidence of Lilian Whiteside, nurse, Question 4305.

41 See Catherine Coleborne, 'Insanity, Gender and Empire: Women Living a 'Loose Kind of Life' on the Colonial Institutional Margins, 1870-1910', Health and History, 14, No. 1, (2012), 77-99. See also Marietta Meier, 'Creating order. A quantitative analysis of psychiatric practice at the Swiss mental institutions of Burghölzli and Rheinau between 1870 and 1970', History of Psychiatry, 20, (2009), 145. Meier emphasises the role of gender, but class was also important with respect to disciplinary measures.

42 For example, see Catherine Coleborne, “'His Brain was Wrong, His Mind Astray': Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880s-1910', Journal of Family History, 31, (2006), 45-65. Also Richard Adair, Joseph Melling and Bill Forsythe, 'Migration, family structure and pauper lunacy in Victorian
See entry for ‘Inanition’ in circulating blood. Starvation, malnutrition or intestinal disorders are among the causes.

211. Epilepsy, 1990, 392

Chorea', valid dosage and usage, see W. Essex Wynter, ‘Chloretone and its Uses, Especially in
also Donald E. Core, ‘Chloretone Overdosage', (London: Oct 22, 1881), 666.

General, Questions 4804 page great Cons 752, Item 3107/2, Folios 239.

name of the Chinese patient is not given.

brevity of examinations is discussed in chapter 3.

For William G, see SROWA Cons 752, Item 1912/0105 (no Folio number).

Death Notices issued before 1912 and after 1918 have not survived in the extant records at SROWA.

For example, see Select Committee, evidence of John Iliffe, junior attendant; Questions 937-939, evidence of Francis Day, attendant, Questions 1284-1288; evidence of Martin Kerins, Charge Attendant, Questions 2314-2350.

SROWA Cons 752, Item 3108/2, Folio 166; for William W, see SROWA Cons 752, Item 3108/5, Folio 134.

The Select Committee report gives more detailed examples of violence.


[Retrieved 2/7/2014]. See also Select Committee, evidence of J T Anderson, Inspector General, Questions 4804-4806.

SROWA Cons 752, Item 3108/2, Folio 226.


See SROWA Cons 752, Item 3107/2, Folio 73. (10 grains = ca. 0.65 grams)


SROWA Cons 752, Item 3107/2, 239.


Inanition is defined as: ‘exhaustion caused by lack of appropriate nutrients in the circulating blood. Starvation, malnutrition or intestinal disorders are among the causes.’ See entry for ‘Inanition’ in Marcovitch, Black’s Medical Dictionary.

SROWA Cons 752, Item 3107/4, Folio 139.
First Admission, Australia, nurses’ quarters due to overcrowding. See Martyr, ‘Wolston Park Hospital 1865-1922’, 55.

For Robert C, see SROWA Cons 752, Item 3108/5, Folio 172. The Home of Peace was a hospice at Subiaco, a suburb of Perth.

SROWA Cons 752, Item 3108/5, Folio 173.

Kellie Abbott and Celia Chesney, ‘I am a poor Woman’: Gender, Poor Relief and the Poorhouse in Late Nineteenth and Early Twentieth-Century Western Australia’, Studies in Western Australian History, 25, (2007), 35-36.

SROWA Cons 752, Item 3107/3, Folio 115.

Report for 1909, 4.

Compulsory treatment and detention of persons infected with VD was introduced under the 1911 Health Act.

Based on the evidence of Dr James Bentley, medical superintendent, Questions 4435-4436. A.J. Casselman wrote in 1921 that the tertiary stage was only ‘slightly infectious’ – see A.J. Casselman, ‘The Diagnosis and Treatment of Syphilis and Gonorrhea’, Public Health Reports (1896-1970), 36, No. 16, (Apr 22, 1921), 854.

Select Committee, evidence of Bertha Baskerville, charge nurse, Questions 3961-4029.

Baskerville evidence, ibid. A separate children’s ward was created in 1922 out of the existing infectious diseases block at the Hospital, which had also been used as ad hoc nurses’ quarters due to overcrowding. See Martyr, Us that Live Here.


Victoriaan Report 1919, Table VIII, 10.

Raymond G. Fuller, ‘Expectation of Hospital Life and Outcome for Mental Patients on First Admission’, Psychiatric Quarterly, 2, (1930), 297.

Bolton, Land of Vision and Mirage, loc 1782.

SROWA Cons 752, Item 3108/4, Folio 254.

SROWA Cons 752, Item 3108/2, Folio 166.

SROWA Cons 752, Item 3108/2, Folio 59.


Coleborne, ‘Insanity, Gender and Empire’, 80-81.

ibid, 79, 92.

Raelene Frances, Selling Sex. A Hidden History of Prostitution, (Sydney: University of NSW Press, 2007), 207-209. Notoriously, Dr Blanchard, the Government Medical Officer, abused his position to enforce a huge fee of £1 1/- a visit for women in brothels, every fortnight, when the weekly wage for a factory worker was perhaps £2. Blanchard was tried before a Royal Commission for improper conduct, but the charges were dismissed and the Commissioner said he was only guilty of an ‘error of judgement’ – see ‘The Blanchard Inquiry’, West Australian, (Perth: 24 Jul 1915), 8 and Frances, Selling Sex, 209.

Victoria B. had threatened a female friend with an axe, alleging that the friend was a police informer. See SROWA Cons 752, Item 3107/4, Folio 202.

Meghey, ‘More than a Minor Nuisance’, 55.


See Reports 1909-1919.


ibid.
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97 Coleborne, 'His Brain was wrong'; Coleborne, 'Families, Insanity and the Psychiatric Institution in Australia and New Zealand'; Mary-Ellen Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915', Journal of Family History, 19, (1994), 177-193. Patients with pocket money could purchase small treats, including tobacco, from Chinese patient Ben Way, see Select Committee, evidence of Charles Hames, storekeeper, Question 3451.
98 Martyr, personal communication.
99 SROWA Cons 752, Item 3107/5, Folio 24.
100 Select Committee, evidence of Thomas Smith, charge attendant, Questions 3300-3301.
101 See discussion above on 'bread and water'. For examples of punitive attitudes, see Select Committee, evidence of Martin Kerins, charge attendant, Questions 2315-2352; evidence of Susan Casson, official visitor, Questions 3720-3721.
102 Select Committee, evidence of Patrick O'Meara, former patient, Questions 1980-1984. There is no evidence to indicate that Patrick O'Meara was related to Martin O'Meara, VC, a current patient at Claremont.
104 WA Lunacy Act 1903, para 94.
105 WA Lunacy Act 1903, para 94.
106 Casson served on the bench of the Childrens Court. Under the 1903 Lunacy Act, Visitors had to be medically qualified or legal practitioners. For details of the Official Visitors, see Chapter 4 of Philippa Martyr, Us That Live Here: A History of Claremont, Swanbourne and Graylands Hospitals (in press). Copyright: North Metropolitan Health Service, Mental Health Section (NMHS – MH), state of Western Australia. My sincere thanks to Dr Martyr for providing a pre-publication extract. Dr Birmingham is well known as the original owner of WA motor vehicle licence plate No. 1. http://historicplates.com.au/sale-wa-historic-plate-wa-57-0 [Retrieved 17/11/2014].
107 See discussion of Susan Casson’s misleading and hearsay evidence in Chapter Three. See also Select Committee, evidence of Benjamin Darbyshire, Official Visitor, Questions, 4556-4621.
108 Ellis, Eloquent Testimony, 66. But Ellis gave no evidence for Jones’s demand - see Martyr, Us that Live Here, Chapter 3. For Andinach’s popularity and family circumstances, see Daily News, (Perth: 4 Mar 1899), 4 and ‘Strange Circumstances of Fremantle man’s death’, Sunday Times, (Perth: 2 Jun 1918), 1. For Case Book notes on Andinach, see SROWA Cons 752, Item 3108/5, Folios 226-227.
109 Arthur P., a single failed farmer with no local relatives or friends, the victim of ‘hard living and financial worry’ wrote a letter to the Inspector General asking for cyanide to end his suffering - see SROWA Cons 752, Item 3108/4, Folios 254-255. Claremont policy until the 1920s was that letters to state officials were not delivered to their addressees.
111 Government of Western Australia, ‘Rules and Regulations for the Government and Management of the Hospitals for the Insane of Western Australia’, (Perth:1911), 1509.
112 O’Meara had to be kept in a strait jacket at night because of his strength and violence (and staff shortages). There are 16 mentions of him in Select Committee evidence. For example, see evidence of James Bentley, medical superintendent, Questions 4416-4420.
113 For example, James Bentley. See Ellis, Eloquent Testimony, 72.
114 For example, see ‘Claremont Asylum. Inspector General Condemned. Removal of Soldier Patients Demanded.’, West Australian, (Perth: 27 Nov 1919), 4. For ex-soldier
attendants, see Select Committee, evidence of Thomas Anderson, former attendant, Question 4261.

115 ‘Claremont Hospital for the Insane – Returned Soldier Patients – Right of Relatives to Choose their own Medical Men’, SROWA Cons 752, Item 1924/0205, Letter from Inspector General of the Insane, J. T. Anderson, to Under Secretary, Colonial Secretary’s Office, 4 Feb 1924 and associated correspondence.


117 Martyr, personal communication.
CHAPTER THREE — Harms and Mortality — ‘How the State Cares for the Afflicted in Mind’¹

‘Twas a pity to use such a sweet swan so inhumanely.’²

In the previous analysis of the case study and relevant sources, I have foreshadowed the major health risks which all patients experienced at Claremont. I have also established that particular groups of patients were vulnerable to these risks at admission: the aged, the very young and the physically ill. In this chapter, I will discuss these risks in more detail, as exposed through public inquiries, official records, contemporary press reports and criminal prosecutions of Claremont staff. The Select Committee testimony is my main source of evidence. As I will show, the Committee’s findings indicate that there was a general punitive approach with respect to the use of restraints, endorsed at the highest level of management. Another source concerning harms suffered by patients is their own testimony of mistreatment in letters written to friends, relatives and petitions to public officials and politicians. The Select Committee was ‘inundated’ with patients’ letters.³ We know that patients in the NSW system and overseas typically wrote ‘thousands’ of letters, but there are only a few surviving letters written at Claremont, interleaved in the Case Books, far fewer than the extant letters in the Fremantle Asylum records.⁴ The small sample of letters I have examined do not detail specific abuses. From the beginnings of Claremont, all letters from patients were opened and the evidence suggests that many, if not all, of these letters were not delivered to the official addressees and that many were simply discarded.⁵ Therefore much confirmatory evidence, like the ‘lost’ report of the Andinach Royal Commission, and the missing and incomplete Death Notices, is no longer available. And, as the 1921 Royal Commission into Lunacy noted, there was no official documentation or log of patients’ complaints against staff.⁶ Although many of the claims about harms at the Select Committee inquiry were contested, there is enough consistency and confirmation from other sources to allow me to give a fair account of contemporary perceptions of the harms to patients. The inquiry exposed very disturbing evidence, particularly in respect of the harsh chemical restraints that were used frequently and in some cases, vindictively.
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There were a number of harms which shortened patients’ lives. There was much
evidence of violence and brutality, not only by patients, but by staff. I will discuss
the methods used to restrain violent patients, both chemical and physical, which
had severe and cumulative effects on health. I will also analyse the patient diet,
which was adequate by the institutional standards of the time, but was
monotonous and deficient in nutrients, deficiencies which significantly affected the
prognoses of specific groups of patients: the sick, the aged and menstruating
women. Overcrowding, time pressures and inadequate facilities increased the risks
of infection with fatal illnesses and the same underlying factors contributed to the
poor standard of patient care: it was physically impossible to provide therapeutic
care which required patient-doctor interaction. Finally, I will discuss the health
risks of the standard medicinal treatments at Claremont. But since the Select
Committee report is my main source of evidence, I need to first look at the
reliability of the testimony.

Contested Evidence at the Select Committee Inquiry
The Select Committee inquiry was an attempt to address a substantial breakdown
in staff and management relations. During the 1919 influenza pandemic in Perth,
Claremont was quarantined and resident staff were not permitted to leave the
grounds for four months. The Inspector General was exempted, since he was
required to visit other institutions, but, according to Martyr, he made social visits
to the exclusive Weld Club as well. At the same time, ministers of religion and
various carters and drivers were allowed to freely enter and leave. As described
in Select Committee evidence and reports in the West Australian, several
attendants left the grounds in defiance of the rules and were dismissed. Some
attendants were also dismissed for talking to their wives through the hospital
fence. Following these dismissals, the Australian Labour Federation (the ALF)
inquired into conditions at Claremont and a number of serious allegations about
patient violence were aired in the press. The secretary of the ALF, E. Lewis Driver,
was particularly critical of the Inspector General’s responses to the ALF inquiry. Dr
Anderson had denied the existence of venereal disease at Claremont when it had
been noted in his own publicly available Reports as a leading cause of death.
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The Select Committee inquiry was intended to calm down this acrimonious dispute and the continuing public concern about these dismissals, the disturbing ALF report and the Andinach Royal Commission. The newspaper accounts of conditions at Claremont leading up to the inquiry suggest that by late 1919 the limits of public tolerance for evident management shortcomings and its misleading claims had been reached. Some of the sacked attendants gave evidence to the committee. The bitter tone of some evidence and the mutual recriminations between management and attendants shows a serious breakdown in industrial relations.

The following exchange provides a sense of this hostile atmosphere:

Q: We have been told that frequently you [Dr Anderson] do not go around the Hospital on Saturdays?
A: That is a deliberate lie.
Q: Do you know a man called Underwood?
A: Yes.
Q: Would you be prepared to say that he is not infectious?
A: I say that he has not syphilis and the man who is saying so is telling a deliberate lie.

William Berry and other attendants claimed that Anderson had been ‘the worse for drink’ at public social events and while on duty. This was strongly contested by senior staff and other doctors. The Inspector General also denied the allegation, but admitted that he was not a teetotaller. Irrespective of the truth of the matter, mutual hostility was not concealed. At least some of the attendants’ animosity was caused by a perception that Anderson’s dismissals and management style were arbitrary and unfair, a view implicitly accepted by the Select Committee when they recommended the re-instatement of some attendants.

Given this background, I have tried to apply tests of plausibility and consistency to Select Committee evidence and have also referred to independent sources, where available, with respect to evidence about harms. I have discounted clearly evasive or misleading evidence based on what witnesses were told by interested parties and not what they had observed themselves. The following testimony by Susan Casson, an Official Visitor, is an example of both.

A: [Casson] The matron told me that breakfast and tea consists of bread and butter...

- And -

A: ...Sometimes I have seen the patients being bathed by the nurses...
Q: On your surprise visits, have you seen the patients bathed?
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A: Yes.
A: ....Of course I do not go into the room where the women undress. It would hurt their feelings...
Q: You have never seen the patients actually getting their bath?
A: No.15

Violence and Punishment

Documented cases and allegations of staff brutality and other abuse around this period were not rare and isolated events. Garton lists a number of serious incidents of staff brutality in NSW mental hospitals. He says that an average of two to three staff were dismissed each year from the 1880s for ill-treatment of patients, including sexual molestation. Other staff received reprimands, but in other cases management turned a blind eye to abuses in the interests of industrial harmony. Garton mentions a ‘thousand’ letters containing patients’ complaints of brutality.16 It is unlikely that all these allegations were groundless. In Feldhof, Austria, between 1905 and 1914, there were fourteen cases of fatal injury which could not be explained after a judicial enquiry. In some years, there were over 100 severe patient injuries. Watzka suggests that the high rate of dismissals indicates that many of these injuries were caused by staff, rather than patient on patient violence.17 But some of the latter incidents might well have been the result of negligence. Geoffrey Reaume discusses a long series of patient allegations of abuse by attendants at Toronto Hospital in Canada from 1883 to 1937. He argues that while it is impossible to quantify the number of incidents of abuse or compare these statistics with statistics for other institutions due to difficulties with the data, a strong narrative about patient experiences at Toronto can nevertheless be constructed.18 Some doctors claimed in the British Medical Journal in 1870: “‘rib-crushing’ was ‘the favourite ... mode in which lunatics [were] hurried out of existence”.19 But since staff rarely testified against colleagues and patients’ evidence was by default at a discount, the true incidence of abuse at Claremont must have been higher than the reported rate. It is apparent that the 1921-1922 WA Royal Commission into Lunacy made no serious attempt to assess the veracity of patients’ evidence or letters. They rejected every claim by patients or ex-patients with respect to staff misconduct.20

My examination of the Claremont Case Books and Select Committee evidence suggests that there was considerable under-reporting of abuses. The Case Books
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record much violence, verbal and physical, amongst patients. The killings of Ann B. and Francis Andinach were extreme cases, but there are many accounts of quarrelling, fighting, aggressive behaviour and violent language.Emily M. chased and tried to strangle a fellow patient. The Case Book notes for James M. record that he attempted an unusual form of self-harm: he attacked bigger patients ‘so that they will hit him back and kill him’. And there was suicide: Edwin Q., one of the case study patients, cut his throat in the dining hall with a table knife. Oddly, this death was not recorded as a suicide in the 1910 Report, but as a ‘cut throat’. The Report of the Select Committee complements the Case Book evidence about violence and other issues, since it would be unlikely that doctors might register critical or professionally embarrassing observations in the latter, where they were not under oath. For example, nurses and attendants might be reluctant to record attacks by patients on staff, since that might be taken as a sign of weak or negligent management. And Select Committee evidence does show that staff were also the targets, or potential targets, of patient violence. The former Inspector General had been struck by a patient. The attendant John Iliffe told the Committee that he had lost his thumb after a patient attack. Albert Milsted, an attendant stationed at PPH, testified before the Committee that he had been ‘half murdered’ by patient Cody. He had to be rescued by another attendant. Milsted continued: ‘We strapped the patient down for two or three days. He died’. Some patients, such as O’Meara VC, had to be restrained every night because of repeated attacks on staff and lack of personnel on night shift. Because of his great strength, O’Meara had to be kept in a strait jacket when only one attendant was on duty in his ward.

The Committee’s report contains many allegations by ex-patients and staff of cruel, arbitrary and harsh treatment. Former patients made claims of staff-on-patient violence. Patrick O’Meara, an ex-patient, alleged that attendant Tucker had knocked down and kicked a defenceless old patient, who subsequently died. O’Meara testified that the attendant who reported the incident ‘got the sack’. Ex-patient Bertha Hinson claimed to have seen cruelty and experienced brutality herself. She stated that nurses dragged a dying patient across the floor. Bertha had suffered from a ‘fallen womb’ (prolated uterus) while at Claremont, which she claimed was caused by a nurse kneeling on her. For obvious reasons, there was little staff or management testimony about staff on patient violence. An exception
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to this unwritten rule was the case of John Taylor, who was convicted of assault on
a patient while drunk and on duty in 1916. Taylor’s assault was witnessed by other
attendants and the chief attendant and he was immediately dismissed. The court
rejected Taylor’s claim that such assaults on patients were a daily occurrence.32
The Taylor case was not mentioned in Select Committee evidence. While assaults
on patients were perhaps not daily events, it seems plausible that they were not
rare or isolated occurrences, given the evidence of unsavoury experiences at other
contemporary institutions in Australia and elsewhere.33 And evidence from other
studies suggests that patients with influential social or family ties were less
frequently assaulted by staff.34

What measures were taken to prevent or minimise violence? There were
‘refractory’ wards for violent patients on each ‘side’ of the hospital.35 The male
violent ward had the highest staff to patient ratio: about one to seven. In contrast,
the ‘chronic and quiet’ male ward had a staff to patient ratio of one to sixteen.36
There was much Select Committee evidence about physical and chemical
restraints. Montgomery had been reluctant to use strait jackets,37 but a number of
Select Committee witnesses testified to their use under Anderson’s management.
Fitting a strait jacket to a resisting patient was arduous and time-consuming and
could not be done without assistance or chemical restraint.38 An attempt by a
single attendant to fit a strait jacket on Francis Andinach resulted in the death of
this patient.39 Some refractory patients were tied down with sheets, as in the case
of James M. and Emily M., but this must have been at best a short term solution for
moderately strong persons.40 Therefore seclusion rooms were probably preferred
as a means to restrain aggressive patients. There was a legal requirement to log
the reasons for either isolation or use of a strait jacket in a journal.41 The medical
journals have survived, but the recording of these restraining measures was
haphazard.42 The logging requirement was also evaded by defining ‘seclusion’ as
having a patient in a single room without an attendant or nurse in the adjacent
room.43 Chemical restraints, such as laxatives, sedatives and hypnotics were also
used as a means of achieving patient docility and will be discussed below under
‘Treatments’. The incidence of injury and violent deaths already discussed suggests
that restraint and separation were of limited effectiveness at Claremont.
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The Select Committee evidence indicates that the objective of all these restraints was not simply a pragmatic response to limit self-harm or harm to others. The same measures which were used to prevent violence were also used to ‘educate’ recalcitrant patients and perhaps as a salutary warning to others. Punitive measures, such as isolation and deprivation of food in response to a violent attack were justified by staff as moral, deterrent and educative punishments. The testimony of Martin Kerins, a senior attendant, was an example of this mindset. When patient P. struck Dr Prince,44 P. was confined to a cell for seven days on a bread and water diet with doses of the violent purgative, croton oil, placed in P.’s food. Kerins explicitly denied that this was a punishment, contradicting himself a few questions later:

A: If we allowed them to carry on, knowing what they were doing, they would commit the same offence over and over again.
Q: Then what effect would the punishment have on him?
A: It would bring to his memory that he had done wrong...45

Dr Hugh Montgomery, brother of Sydney, the late Inspector General, testified: ‘You must punish these people when they misbehave. They are like children’.46 The Official Visitors were unlikely to object to these punitive measures, because they shared the professed beliefs of staff with respect to the positive effects of punishment. Susan Casson, an Official Visitor, told the Select Committee: ‘Discipline is everything. There must be some punishment....I have seen patients come in very violent and a few weeks of discipline have made a great difference to them’.47 Dr William Birmingham, Casson’s colleague, believed that: ‘The great bulk of patients know they are doing wrong and on them punishment acts as a deterrent.’48 The Inspector General, Anderson, had been attacked by patient M. and claimed that the consequent punishment may have had a deterrent effect on other patients.49 The moral hazard of these attitudes, endorsed at the highest level of management, is that irresponsible staff could euphemise their revenge for patient attacks, and brutal misconduct or arbitrary abuse, as moral education and salutary deterrents.

The Diet

The dietary scales for patients and staff were specified under the Regulations of the Lunacy Act of 1903.50 They were much more generous but less varied than the
asylum diet recommended by Charles Mercier, an influential British specialist on insanity, in 1894. Mercier thought that ‘idle persons’ should receive only 140g meat daily, whereas the Claremont scale in 1915 for all non-workers was 340g.51 According to my calculations in Appendix One, patients received in theory an adequate diet, by modern Australian standards, in terms of kilojoules.52 Patients who worked received a small portion of cheese (28g) and extra bread and milk.53 Sick patients might get eggs, beef tea and more bread and milk.54 But while the diet may have been adequate in energy, I will show that it was deficient in nutrition and that the published amounts were a statement of intent, rather than the actual quantities received.

While the patient diet was a lifeline for the destitute, the alcoholic, the very poor and the homeless, it was poorer than the diet of the ‘respectable’ working-class in Australia.55 The superior scale of provision for the diet of nurses and attendants is some evidence for that.56 The 1913 Heydon Inquiry in NSW accepted the Commonwealth Statistician’s estimate that a family of four people (presumably with two children) consumed about 1400g of bread per day, possibly more generous than the Claremont ration for male adults of about 450g.57 Some of the eighteen working-class families discussed by Robin Walker in his summary of the Inquiry ate meat three times a day and fed eggs to their working men. Mr Poole, a farrier, regularly ate 450g of steak at a single meal. Some mothers questioned by Heydon were well aware of nutritional concerns, believing that cabbages and fruit were especially nutritious. That is not to deny the scanty diet of poor and large families revealed by the Inquiry.58 Thus while the well-being and longevity of pauper patients and alcoholics may have improved after admission to Claremont due to better and more regular meals, the health of in-work working-class and middle-class patients may well have been compromised.

While adequate in energy content, the diet was unbalanced and nutritionally deficient. The current recommended daily intake (RDI) for iron for menstruating women is more than 20mg, if they are to avoid anaemia, but the Claremont meat ration contained less than half this amount.59 Until 1915, females received less meat than males, who required less iron.60 Lack of dietary fibre could lead to constipation and other bowel conditions and require resort to potentially harmful
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laxatives. There was no allowance for fresh fruit, although we know that patients were given an unspecified amount of fresh fruit in season from Whitby Falls and by visitors and benefactors.\textsuperscript{61} A lack of Vitamin C over time can affect wound healing and vulnerability to infections. Of special concern, given the numbers of the elderly and GPI sufferers, was the deficiency of calcium and Vitamin D. The daily ration of 118ml of milk, plus a smaller allowance of milk for oatmeal, contained at best 150mg calcium. And there were claims that the milk was watered down.\textsuperscript{62} Only the workers got a small amount of cheese (28g) and an extra 250ml milk, perhaps totalling 400mg of additional calcium.\textsuperscript{63} There is no indication that other sources of calcium, such as sardines and green leafy vegetables, appeared on the menu, whereas there is good evidence that these items were a regular part of the working-class diet in WA at this time.\textsuperscript{64} The RDI for calcium for Australian adults is ca. 1000mg, 1300mg for people over 70 at higher risk of brittle bones.\textsuperscript{65} We know now that smoking, vitamin D deficiency and alcohol abuse are also associated with reduced bone mass density and fracture risk.\textsuperscript{66} While most of these nutritional factors, now generally accepted by the medical profession, were only just beginning to be recognised at this time, Claremont management did recognise that better food was important for sick patients and to retain staff,\textsuperscript{67} but financial considerations took priority.

The monotony of the diet must have done little for patient morale. For breakfast and the evening meal, the daily menu was always two slices of bread with jam and butter, with oatmeal three times a week for breakfast.\textsuperscript{68} Economy and no doubt labour saving were the rationale for the frugal regime.\textsuperscript{69} Some attendants and nurses tried to gloss over these depressing facts. A former Chief Attendant, William Flanagan, said: ‘If a man wants an extra slice, it should be there for him......If patients do not like jam, they can have butter’.\textsuperscript{70} The main meal, dinner, was an unvarying seven day cycle of the same dishes, broken only on the King’s Birthday and Christmas, when a glass of beer plus pudding was offered. The main meal on Monday and Wednesday was always ‘meat pie’. While patients working at the farm helped to raise pigs and poultry for sale and staff had regular eggs and bacon, pork was on the patient menu only three times a year.\textsuperscript{71} This depressing monotony, in particular the eternal bread and jam, was adversely commented on in the Select Committee conclusions in 1919, but had still not been addressed by 1921.\textsuperscript{72}
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Claremont was still consuming 60,000lb (about 27,000kg) of jam per annum in 1935, evidence of the continuing priority of economy over health in institutional care in WA.  

A number of witnesses at the 1919 Select Committee testified to shortages and deficiencies of distribution at mealtimes. Attendants claimed that in Ward M5, the violent male ward, patients got little food, the worst quality meat and fought over scraps at mealtimes. James Illife, a junior attendant in the ward, spoke of a Darwinian ‘scramble for food’, the slow and weak ‘going without’. This was confirmed by the attendants Francis Day and Thomas Russell. For the hospital generally, Martin Turner and James Illife, some former attendants and an ex-patient said that butter was often not provided, milk was watered down, and meat was of poor quality. William Flanagan testified that if patients missed out on meals, they got ‘make up meals’, bread and butter and tinned vegetables, suggesting that this was a common practice for less assertive patients. It is true that some of these witnesses may have had grudges, as discussed in the Introduction, but their evidence seems mutually consistent.

There was other evidence for shortages, diversions and bad distribution of food. The storekeeper, Charles Hames, testified to substitutions and shortages, attributing some of them to wartime conditions. Susan Casson, an Official Visitor, contested the claims of shortages and adulteration, but her evasive evidence and reliance on hearsay makes her an unreliable witness. For example, she had never seen patients having breakfast, but testified that they got bread and jam. She had never seen patients bathing, but was able to say that she did not see naked patients queuing for baths. It is probable that some of the shortages were caused by thefts of food by staff. In 1922, James McKeown, the Chief Attendant, was searched by detectives on leaving the hospital and was found to have hospital food and tobacco on his person. A large amount of tobacco and some tins of hospital food were found at his home and he was charged with a number of offences. The court did not believe McKeown’s claim that he was holding the tobacco for ‘safekeeping’ and he was sentenced to two months gaol for unlawful possession. Dr Anderson told the magistrate that he hoped that the sentencing would ‘effect a big improvement in the institution’, suggesting that he was aware of thieving by other staff.
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Evidence that a Chinese patient, Ben Way, was somehow able to make 'fancy cakes' for the attendants’ morning and afternoon teas suggests that there were other unauthorised diversions from the official supplies. Given the evidence of shortages, stealing and ‘scrambles for food’, it is implausible that the official dietary scale was achieved for most patients. The published dietary scale was an aspiration, rather than fact.

Another cause of shortages of food for patients was the commercial orientation of the Claremont farm operations, which used patient labour. Farm milk was supplied on a commercial basis to other hospitals in Perth. Livestock, meat and vegetables were also sold at a profit. Thus the needs of other hospitals and commercial considerations in respect of milk supply had priority over the needs of patients. The storekeeper said that: ‘other institutions have first claim on the milk’. Patients often had to make do with tinned condensed milk - nine days out of ten, according to attendant James McGowan. Staff received farm produce which was denied or supplied in very modest quantities to patients: eggs, bacon, pork, possibly cheese, and generous amounts of milk and butter. While farm workers received a meagre portion of the product of their work, whose main feature was a small lump of cheese, their labour was accounted for at the inflated book value of £250 per annum, £175 more than the rate for a first year attendant. In the Reports, Claremont management, while acknowledging the therapeutic value of farm labour, were quite explicit on the overriding importance of farm income.

As the Financial Report sections of the Reports make clear, farm receipts were intended to offset operating losses, given that only a fraction of patients paid full maintenance. Patients’ food was a lower priority. From my examination of the reported farm receipts and expenditure, the claimed book value of food supplied to patients and the published prices of food in the West Australian, I found that there was much more creative accounting over and above the implausible ‘paper’ wages for working patients. These wages were obviously book entries and never actually received by these workers. The only material reward for their labour, other than fresh air and exercise and an escape from the crowded asylum, was a small supplement of extra food and tobacco (for the men). The Select Committee failed to exercise due diligence in not questioning the financial records, especially the
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wage accounts, more closely. On paper, the high wages, even if never actually paid, must have worsened the reported financial position as compared to the real financial position. But the Committee did not question it. Another example of possible questionable accounting practice is representation of costs per patient. The 1919 Report claims that the cost per head was £69, whereas a simple calculation based on the Victorian Report for the same year shows that the average maintenance cost per patient was roughly £52. But the unflattering financial story is material for another thesis. Despite the questionable financial statements, we can accept that money constraints limited the patient diet.

What conclusions can be drawn about harm and mortality arising from dietary issues? Elderly patients and GPI patients, with brittle and damaged bones, were more likely to be affected by calcium and Vitamin D deficiency, increasing their vulnerability to rough handling and falls. Menstruating women were more likely to develop anaemia, and the health of already anaemic women was put at risk. Fractures could prove fatal, as perhaps in Edward C.’s case, or lead to immobility and consequent morbidity. On considerations of diet alone, previously well nourished persons from middle and upper class backgrounds may have lived shorter lives in Claremont than if cared for at home. But, all that said, the patient diet at Claremont was much more generous and nutritious than the meagre diet at Buckinghamshire Asylum during the war, the scene of the ‘extraordinary deaths’ due to malnutrition. For example, the daily bread ration at Claremont was about 450g for males. At Buckinghamshire in 1916 it was about 200g – perhaps three slices. The average daily energy intake for males at Buckinghamshire was roughly 6,600Kj – males at Claremont theoretically received 13,000Kj. The modern estimated energy requirement for less active adults varies from about 6000 to 10,000Kj depending on height, weight and sex. Therefore, while the Buckinghamshire diet was at or below the lower limit for most adults, the Claremont diet was sufficient in terms of energy intake, provided that patients actually received it. But it was far from nutritionally ideal and depressingly monotonous.

These deficiencies clearly did hasten death for vulnerable groups, particularly the elderly, GPI sufferers, the anaemic and the ailing in general, but the data are
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insufficient to allow for any quantitative estimates of the effects. But it would be anachronistic to say that Claremont management or its Lunacy Department overseers were aware of these nutritional issues. While staff did acknowledge the monotony and parsimony of the diet, patients were reasonably well fed by contemporary institutional standards. There was not the official indifference which Crammer so roundly criticised at Buckinghamshire. And as I will show, shortages of some foodstuffs during the war years did not significantly affect the mortality rate in Australian asylums.

**Hygiene and Infection**

According to the *West Australian*, no expense had been spared in the construction of the new Hospital at Claremont. In 1907, it reported that the sanitation and fittings were provided ‘according to the latest methods’, that septic tanks were to be installed and the water supply would come from a new bore.95 The modern design and equipment of the kitchen would ensure ‘scrupulous hygiene’.96 Drawing on the latest British designs, the intention of the pavilion system was to allow for the separation of patients by category and reduce the spread of infection.97 From Select Committee and *Reports* evidence and the official hygiene regulations, it is clear that staff were well aware of, and trained in, standard hygienic precautions required to minimise patient-to-patient and patient-to-staff disease transmission.98 The principles of antisepsis had been well accepted in hospital environments since the pioneering work of Ignaz Semmelweis in the 1860s, who (ironically) died from a blood infection after being severely beaten by attendants on admission to a mental asylum.99 But it was difficult for staff to follow good practice at Claremont because of insufficient provision of the appropriate facilities and supplies, notwithstanding the fulsome praise of the *West Australian* for Claremont’s ‘scrupulous hygiene’ and ‘latest methods’.

In a crowded asylum, the facilities and available supplies could not cope with the numbers and the staff did not have the time to do their job. There were repeated complaints by attendants and former patients about staff shortages, time pressures, lack of running water and hot water for cleanup, lack of towels, gloves, bedding and clothing, lack of separation of infectious patients and insufficient toilets. This evidence was disputed by some staff and the Inspector General, but
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the number and consistency of adverse reports tell a clear story. There is a long list of critical testimony about hygiene issues in Appendix Two. Martyr’s review of press reports on conditions at Claremont confirms the criticisms. These shortcomings, unconvincingly denied by management, must have had effects on morbidity. An additional infection risk factor was the close spacing of beds, due to pressure of patient numbers, in violation of English and WA health regulations. This illegal practice was noted by the 1921 Royal Commission on Lunacy. Another sacrifice of hygiene to economy was the use of patient labour in the preparation of food. Most infections acquired at Claremont were a consequence of the inherent risks of hospitalisation under cramped and rushed conditions and inadequate resources, namely the close contact of the infectious and their effluvia with the general patient body and staff.

**Standard of Medical Care and Treatments**

Given the ratio of doctors to patients – four resident doctors to 1148 patients in 1919 – it was impossible to give adequate therapeutic care for either physical or mental conditions. From the facts of the Andinach case and the medical neglect of Edward C., we can infer that on some occasions doctors did not monitor the Claremont hospital ward for days at a time and delegated care in this ward to attendants. At the asylum in Feldhof, Austria, at the turn of the century, which had roughly the same ratio of doctors per patient, Carlos Watzka calculated that doctors could give at most two to three minutes attention to each patient per day, assuming twelve-hour shifts. There was conflicting Select Committee evidence about the time spent on doctors’ rounds. Dr Bentley, the medical superintendent, gave the following description of his workday:

A. On an ordinary work day my routine is that I start in ‘X’ Block (the open wards) about 9:30. I then see the ‘X’ Block report books. I then ....deal with patients’ letters.... Then I read the report books, male and female. There are frequently interviews with friends of patients... Then I start round the wards.

Q. Approximately what time would that be?
A. It varies. I would be approximately between 11 and half past...

Q. What time do you get back to the office again?
A. Between a quarter and half past one. ...Sometimes I go into the dining hall.

Q. We are up to 1:30 pm now?
A. I go home for lunch....About 2 o’clock I go around....I get finished there any time between 5 and 6:30.
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On Bentley’s schedule, it was impossible for patients to receive much more than a greeting. If he ran his eye over perhaps 250 patients in five or more hours on his rounds, as this evidence suggests, then he might perhaps have ‘seen’ an average of one patient per minute. The Inspector General, Anderson, thought that the one and a half hour morning round was sufficient, because ‘very few are sick’. He thought that ‘we spend as much time as is necessary with patients....not more than one minute is given to a whole row of seniles’.107 Dr Tymms, an independent witness and former Chief Medical Officer of PPH, thought otherwise: ‘I do not see how it could be done’.108 The Chief Attendant’s claim that doctors wrote up the Case Book on the basis of personal examination is therefore unbelievable.109 Psychotherapy was in its pioneering stages in 1914,110 but it is unlikely, given these restrictions of time and attention, that there could be any sort of treatment regime for mental illness at Claremont which involved doctor-patient dialogue. Moreover, as the patient population grew, the ‘dilution’ of medical care and attention must have been an important factor in the declining rate of patients discharged as recovered, as can be seen in Fig 3.1.111

Fig 3.1 source: Reports 1909 to 1919.

From the Select Committee and Case Book evidence, it is clear that doctors relied much more on attendants’ reports, and not their own observations, for detailed information about patients’ conditions. Dr Bentley testified that ‘we are constantly asking the charge (senior) attendants of the wards in regard to the mental
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condition of the patients’. They also relied on attendants to dispense routine medications and to transfer patients to the hospital ward when ill. The Day and Night Books, containing observations by attendants, had few details of treatments. Patients received ‘Medicine’, ‘Cough Mix’, ‘Hypo[dermic] Injection’ or ‘Aperient Mix’. No dosages were recorded. There were notes on who had diarrhoea, who was restless and who refused meals. Attendants were allowed to give laxatives, such as ‘white draught’ (Epsom salts) or castor oil, and cough medicines on their own authority. They also transferred patients to the hospital ward on their own responsibility, as was the case with Edward C., who, as we have seen, was not medically examined until he had been confined to bed for four days. Thus attendants and nurses clearly had much more discretion for treatments than doctors were prepared to publicly acknowledge.

There was a great deal of evasive and misleading testimony about the use of croton oil, a powerful purgative. The evidence strongly suggests, despite equivocal management denials, that the administration of this medication was slackly controlled, mostly unrecorded and possibly punitive and might serve as a paradigm of negligent management. The Inspector General admitted that there was no specific written rule for the issue of croton oil, but nevertheless expected attendants to know that issuing this purgative without medical authority would be grounds for dismissal. Although attendant William Berry testified (misleadingly) that the use of croton oil was logged in the ‘daily report’, and Dr Anderson mentioned a specific date when it was given to patient Maffetti, I can see no specific mention of croton oil in the Day or Night books; there were only entries for ‘laxatives’. There were few controls on access to this medication. It was kept in a locked cupboard, but all staff had keys to it, therefore it was possible for attendants or nurses to administer croton oil without the permission or knowledge of management. The storekeeper testified that 156 ml of croton oil (about 150 doses) had been consumed since 1913. Given this rate of consumption, it is remarkable that some attendants and nurses told the Select Committee that they had never seen it used. It is also remarkable that Anderson and Bentley, presumably knowing in advance that they would be questioned on the subject, and knowing that the storekeeper would testify, apparently did not seek to inform themselves on how much croton oil had been used. The Colonial Secretary,
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presumably on advice from the Inspector General, misled Parliament when, in the debate of 24 September 1919 which led to the setting up of the Select Committee, he claimed that croton oil had been used only three times since 1909. In its conclusions, the Select Committee rejected the misleading testimony, noting the conflicting evidence about croton oil, and the claims of the Inspector General and Bentley that it was ‘rarely given’. But in specifically noting the storekeeper’s evidence on the rate of croton oil usage, the Committee rejected the veracity of the doctors’ claims. The Committee implicitly criticised Anderson’s careless management of this powerful medication when it recommended: ‘Your Committee is of opinion that attendants should be instructed that Croton Oil shall not be given to patients at any time without a special order from the Doctor’. The use of laxatives, including croton oil, as a calming therapy on ‘excited’ patients was widely accepted at this time, as the Select Committee noted in its conclusions. This treatment had been a ‘tradition’ in British asylums since the eighteenth century. Despite the transparently euphemistic language employed by management and senior staff, harsh or frequent purges must have caused suffering. Some staff hostile to management exaggerated the bad effects of croton oil – patient Mafetti was alleged to have lost an implausible 28kg in a week. But anodyne evidence about slight or even positive effects and infrequent usage was also questionable. Dr Bentley testified that croton oil ‘produces a slight congestion of the intestine’ which drew blood away from the brain. Martin Kerins, a senior attendant, claimed that patients were ‘slightly griped’ and that croton oil made them ‘better in every way’. Susan McLean, the Matron, said she had seen croton oil used only ‘once or twice’. Thomas Smith, another senior attendant, said he had never seen it used in his 22 years at Claremont. Yet these senior staff seemed unaware that over 150 doses had been used over the last six years. And it seems implausible that a purgative which was widely recognised as drastic and which some attendants viewed as a medium of revenge would not cause suffering. Therefore there was a clear moral hazard, given lax management and its tacit endorsement of disciplinary measures, that vindictive staff might use laxatives or other unpleasant medication as retribution for a violent patient under the excuse of relieving constipation, enforcing ‘discipline’ or calming the patient.
The longer term harmful effects of laxatives were known at the time and doctors and staff could hardly have failed to observe the bad effects over time when they were used as a standard treatment. In a 1910 *Lancet* article, Herbert French, a senior doctor at Guys Hospital, a leading British hospital, and author of several medical textbooks,¹²eight recommended great caution for long term administration of purgatives. He believed that habitual and indiscriminate usage could cause constipation.¹²nine H. B. Beatty, a Surgeon Captain in the Royal Navy, wrote in 1892 that constipation was ‘a very frequent annoyance for purgatives soon lose their usual effect and when given stronger bring on troublesome diarrhoea’.¹³° Staff were of course not aware of the adverse effects of laxatives on gut nerves, electrolyte imbalance and malabsorption of nutrients and medications, but the long term results of these effects were nevertheless real.¹³¹ Therefore it is not surprising that dysentery, also known as the ‘bloody flux’,¹³² was noted as a contributing cause of death for about five per cent of males and fifteen per cent of females at Claremont between 1912 and 191⁹.¹³³ Admittedly, some of these deaths may have been directly due to acquired infections and not laxative abuse. The common practice of giving croton oil (and possibly other medications) in food to unaware patients, resulting in painful gastric cramps after eating, may well have contributed to anxiety, delusions of persecution and depression.¹³⁴ Perhaps some of the accusations by patients about ‘poisoned food’ were well founded in experience.¹³⁵ In short, the loosely supervised use of laxatives as a ‘cure-all’, in food and as a punishment damaged health and lowered patient morale.

The Select Committee evidence also exposes the frequent use of chemical restraints at Claremont, which, as discussed above, is scantily and seldom recorded in the Case Books or Day and Night Books. While there are some records about chemical restraints (other than laxatives) in the Case Books, such as in the case of Elisabeth R., a case study patient, who received chloretone, a hypnotic,¹³⁶ there is a lot more detail in the Select Committee report. Albert Bishop, a former attendant, stated that bromide and ‘chloral’ (chloral hydrate, another hypnotic) was given to noisy patients.¹³⁷ Bertha Hinson, an ex-patient, testified that she had been given bromide while suffering from a uterine prolapse.¹³⁸ This medication was commonly used for epilepsy and for calming patients, but was known at the time to produce dementia-like symptoms and a rash. In 1909, the British doctor James
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Taylor favoured Epsom salts over bromides as a safer alternative. Even though the adverse effects of bromide administration were well known, and safer substitutes were available, bromides continued to be used in some US institutions as a standard sedative and antiepileptic up to as late as 1940. Chloral hydrate (not to be confused with chloretone) was regarded as a ‘living death’ by 1899. The well known German pharmacologist, medical author and expert on psychotropic drugs, Louis Lewin, thought that chloral was ‘the most dangerous of all hypnotics’. Nevertheless, chloral hydrate continued to be sold over the counter until late in the twentieth century and is still in use as a prescription medication. Barbiturates, for example veronal, were coming into use by 1903 but there is no record of their use at Claremont in this period. Paraldehyde was used as a sedative at Claremont and in other Australian institutions. British and European asylums had been using it as a hypnotic since the 1880s. Paraldehyde is known to cause dependency, but is still in use for treatment of epilepsy. Andinach was ‘quiet’ after being given morphine. As with laxatives, permissive and punitive management policies increased the risk that ‘chemical coshes’ would be used vindictively or for the convenience of staff rather than the welfare of patients. The long term harmful effects of these restraints on physical and mental health were well recognised at the time.

The Expectation of Hospital Life – Some Comparisons with Claremont

It is apparent from Fig 3.2 that ‘senile’ patients in New York hospitals in the period 1909 to 1928 lived longer lives than ‘seniles’ at Claremont. Raymond Fuller’s detailed 1930 study examined the expectation of hospital life for patients diagnosed with mental illness in New York State from 1909 to 1928. He identified six groups, each containing 600 patients, for analysis: manic-depressive, dementia praecox, senile, arteriosclerotic, alcoholic and general paralysis. About 70 per cent of deaths of Claremont male ‘seniles’ and 50 per cent of female ‘seniles’ occurred in their first year in the Hospital, whereas about 30 per cent of males and 20 per cent of females died in that category in their first year at New York. It is also instructive to compare the Claremont figures for ‘seniles’ with the death rate at Buckinghamshire, scene of ‘extraordinary deaths’, apparently exacerbated by malnutrition, where 60 per cent of all patients admitted in 1918 died in the first six months. Nearly all deaths of Claremont ‘seniles’ took place in

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the first five years, but after ten years, nearly twenty per cent of New York patients were still alive. But there are some important caveats. Substantial percentages of New York ‘seniles’ were permanently discharged: very few Claremont patients aged over 60 were discharged, which might account for the better survival chances of the former group.153 Secondly, it is not clear that the New York and Claremont definitions of ‘senility’ were the same; for Claremont, I have defined patients who died from ‘senility’, ‘senile dementia’ or ‘senile decay’ as ‘senile’.

GPI sufferers in New York also appeared to have better survival chances, as shown in Fig 3.3. Females lived longer than males in New York, but at Claremont their chances were better only in the first three years. But, as with senility, there are some important caveats. We do not know if diagnoses for GPI at New York were based on the criteria used at Claremont, or if the more accurate Wassermann test for syphilis was used: this test was probably not used at Claremont.154 Fuller does not specify the treatments that were used for GPI, but Horatio Pollock states that newer treatments, including malarial cures, were not used at New York until 1926.155 Pollock also claims that Fuller’s sample of GPI patients could be considered as ‘untreated cases’, since they were admitted before the introduction of salvarsan.156 It is unlikely that malaria treatment was used at Claremont, since it was only in the experimental stage by 1918.157 As with ‘seniles’, about 70 per cent of Claremont male patients with GPI died in the first twelve months, about 90 per cent were dead after five years, while roughly twenty per cent of New York males with GPI remained alive after ten years. Figure 3.4, which represents deaths in all categories, shows that about 50 per cent of all male or female deaths occurred in the first twelve months at Claremont, in contrast to less than half that number of deaths occurring in New York.158 Thus GPI and ‘senility’ were high risk categories at both Claremont and New York, but ‘senile’ patients were at greater risk of dying in both institutions.
Fig 3.2 sources: Fuller, ‘Expectation of Hospital Life’ and Claremont Death Notices

Fig 3.3 sources: Fuller, ‘Expectation of Hospital Life’ and Claremont Death Notices
Despite the noted difficulties in drawing comparisons, there are plausible explanations for the marked differences in lengths of stay for deceased patients between New York and Claremont. Fuller's detailed and extensive study would not have been possible without a far higher standard of patient documentation than was practised at Claremont, implying a correspondingly higher level of care and treatment. The greater resources available to a wealthier and far more populous US state would indicate more specialisation of care, better doctor and staff ratios, improved separation and better infrastructure, but the roles of these factors cannot be proven without a detailed study of conditions in New York institutions.

Given these statistics on GPI and ‘all categories’, it is appropriate at this point to ask if GPI was indeed ‘the most deadly disease of asylumdom’, in Davis’s phrase. Davis, quoting George Robertson’s 1913 lecture on GPI, notes that in Scottish asylums, 50 per cent of sufferers died in the first year, 75 per cent by two years and 90 per cent in three years. J.G. Smith, in an 1899 paper, analysed 700 cases of GPI patients at the Glamorgan Asylum. He found that for the period 1887 to 1896, eighteen per cent of males died in their first year, whereas about 80 per cent had died after three years. But, as shown in Fig 3.3, GPI was far less virulent in New York, with twenty per cent of males dying in the first year and a lower
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percentage of females. After ten years, twenty per cent of New York males were still alive.

As GPI deaths registered in the Claremont Death Notices constitute a much bigger sample (451 males, 184 females) than the case study sample, I will base my length of stay estimates on the former. In their first three years at Claremont, males with GPI were far more ‘fragile’ than female GPI patients: around 70 per cent of males died in their first year, more than double the figure for female deaths. It should be noted that there was only one recorded female death from GPI, that of Rose S.\textsuperscript{162} After three years, the survival curves for Claremont males and females were almost identical. Very few GPI patients lived longer than ten years. While GPI patients died sooner than the ‘average’ patient at both New York and Claremont, it is clear from comparison of Fig 3.2 (‘seniles’) with Fig 3.3 (GPI) and 3.4 (all categories) that ‘senility’ was ‘the most deadly disease’ at both institutions.

A series of studies on the expectation of life in North Wales asylums found that historical survival rates for all categories were far better than survival rates at Claremont. These studies examined mortality for the two periods 1870s-1920s and 1990s-2000s.\textsuperscript{163} For the historical cohorts, the survival rates (the chance of not dying in a given year) for each category of illness were similar in the short term, although the mortality for schizophrenia was rather higher after the first five years. In the first year, 95 per cent of patients in the historical cohort survived. After five years, the survival rate for schizophrenics in this cohort was just under 85 per cent, while the rate for patients with other psychoses was roughly two per cent lower.\textsuperscript{164} About 78 per cent of patients in the historic sample survived after five years and 68 per cent after ten years. These survival rates are far superior to the rates for all categories of patient at Claremont, where there was about a 60 per cent chance of dying in the first year for either males or female patients.\textsuperscript{165} The authors of the Welsh studies thought it unlikely that patients from the historic cohorts were significantly more ill during their stay than contemporary patients because the ‘malignant’ psychoses evident in past times (for example, catatonic schizophrenia) were now almost extinct. Moreover it was now much easier for less severely ill individuals to be admitted.\textsuperscript{166} The authors suggest that physical morbidity is a much more significant indicator of higher mortality than mental
illness and the New York and Claremont statistics for ‘senility’ deaths would tend to confirm that.

Peter McCandless’s study of the South Carolina Lunatic Asylum in the US is relevant because he discusses the causes of the deteriorating death rates between 1890 and 1915 and the effects of inferior standards of care on a specific group of marginalised and vulnerable people: poor black patients. By 1915, there was a 27 per cent annual death rate for blacks and eleven per cent for whites, as compared to the average death rate for Claremont between 1909 and 1919 of around nine per cent for both males and females. A 1904 report by a State legislature investigative committee found that the average death rate for all US mental institutions was about seven per cent. The same report also showed that the death rate at South Carolina for all patients was about double the regional average and that the mortality rate for blacks was more than double the rate for black patients elsewhere in the nation. But it should be noted that some US institutions with few or no black patients also had death rates well above the US average. In 1910, the Oregon State Hospital had an annual death rate of over sixteen per cent. The rate of recovery at South Carolina compared to other US institutions was also dismal. The conditions for blacks were such that even the all-white investigative committee of 1909, in a deep South State, was moved to comment that the hospital was ‘a menace to the health and life’ of black patients.

McCandless did not attribute all of the excess mortality of black patients to substandard conditions at the Asylum. Most blacks (and many whites) lived in great poverty and the death rate for blacks in the general population was much higher than for whites. The Asylum fed black patients essentially the same deficient and cheap diet which the poor might afford in South Carolina: ‘a diet heavy in cornmeal, molasses and fatback’ which probably contributed to the high incidence of pellagra amongst patients and in the general population. Pellagra is a potentially fatal vitamin deficiency disorder and can cause dementia, dermatitis and diarrhoea. It can be cured by proper diet. In the cash-strapped asylum, overcrowding was severe and made therapy almost impossible. Ventilation was poor, more so in the older and unsafe buildings housing black patients, and, as at Claremont, this contributed to the possibility of contagion. Due to financial
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stringency, most traditional forms of recreation were not available for either blacks or whites. For black male patients, there was a ratio of 1 attendant to 36 patients, about half the ratio for white male patients. The latter ratio was comparable with the attendant to patient ratio for the ‘quiet ward’ at Claremont, which was slightly better at 1 to 16. Of course there were few non-Europeans at Claremont, but the fate of blacks at South Carolina suggests that the effects of poor diet, over-crowding and lack of staff attention are the three most important factors which affect the death rates of the least powerful and the most marginal. At Claremont, the poor, the demented and single immigrants may have filled that role.

The Effects of Wartime Restrictions on Asylums
In Britain, the average annual mortality rate for all asylums between 1859 and the eve of the First World War had declined marginally from about 10.5 per cent to about 9.5 per cent, while the recovery rate had also dropped, from 35 per cent to 30 per cent.174 Between 1915 and 1920, the average death rate rose from twelve per cent to twenty per cent, with some asylums, such as Northumberland, reaching the extraordinary level of 38 per cent mortality per year and Buckingham losing 60 per cent of its newly admitted patients with the first six months. After the war, mortality rates soon returned to prewar levels.175 Crammer claimed that TB was the cause of about a quarter of all patient deaths in 1918 in Buckinghamshire and that these patients were particularly susceptible to malnutrition and underfeeding. Therefore it is probable that the effects of wartime stringencies and financial restrictions, particularly on food, but also on levels of care, had shortened the lives of tens of thousands of British patients. At the same time, the working class in Britain had maintained its kilojoule intake and did not go hungry despite the effects of submarine warfare on food imports.176

In Germany and the other Central Powers, the same wartime restrictions, on a much harsher level due to the more effective Allied blockade,177 had affected the civilian population en masse, and asylums in particular, and had led to mass starvation of patients and populace.178 ‘Death gathered his harvest’ in German asylums – the patient population fell by 50 per cent.179 Patients also suffered from wartime food shortages in neutral countries such as Norway.180 There was a lot of year-to-year fluctuation in the Claremont death rate during World War I. The
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average rate for both sexes was about nine per cent, with the male rate reaching
nearly fourteen per cent in 1910, declining to about ten per cent in 1919. The
general trend for males was downwards during the war years, but there was no
clear tendency in the female rates of death, as shown in Fig 3.5. There is no single
factor which stands out as a cause for the year to year variations. While there
certainly were wartime shortages, including issues with some non-essential food
items and their distribution at Claremont, there is no evidence that food
availability declined significantly over the war years. The revised dietary
regulations of 1915 appear to be marginally more generous than the preceding
dietary scale of 1911. The worldwide influenza pandemic of 1918-1919 did not
significantly affect the death rate: there were only four deaths from influenza in
1918 and none were reported in 1919. The evidence indicates that the death rate
of patients at Claremont was not appreciably increased by the effects of the war.

Fig 3.5 source: Reports 1909-1919.

Mortality Statistics at other Australian Institutions

The mortality rates for the seven Victorian asylums and two Receiving Houses at
this period confirm my conclusion that wartime constraints had little effect on
health. Except for Victoria, I was not able to obtain detailed statistics on death
rates for other Australian asylums at the period within the timeframe of this thesis,
because the relevant reports are not available online and are held in the respective
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State Libraries. As Fig 3.6 shows, there was much less year to year fluctuation in the year to year death rates in Victoria for 1909 to 1919 than at Claremont. The male death rate remained within the range eight to ten per cent, averaging at nine per cent, whereas the female rate ranged from six to eight per cent. The lower variability of the Victorian death rates suggests that the much larger patient numbers in Victoria (in 1919, about 5300 versus 1100 at Claremont), tended to ‘smooth out’ normal statistical variations. Although there were many more influenza deaths in Victorian asylums in 1919 than at Claremont (60 in Victoria versus 4 at Claremont), this did not much affect the death rates in Victoria for that year. Because of the fluctuations in the Claremont male death rates, it is difficult to say that conditions were better or worse long term than for Victorian males. What is clear is that Victorian female patients were healthier than their West Australian cousins over most of the period. I have already pointed out plausible factors for the more favourable treatment of females at Claremont in Chapter Two and it is reasonable to assume that similar causes applied in Victoria: better staff ratios, more contact with family and friends, and less crowding. Although overcrowding was also a problem in Victoria, it is plausible that the greater separation of classes of patient and increased specialisation of care available in Victoria significantly reduced the probability of contagion of infectious diseases and improved treatment results.

Fig 3.6 source: Victorian Reports 1909-1919
Summary

My analysis of evidence about Claremont (relating to the period 1909 to 1919) from public inquiries, official records, contemporary press reports and criminal prosecutions of staff has shown how the health, and therefore life expectancy of patients was adversely affected by the conditions and how specific groups of patients were more vulnerable to harm, both physical and mental. About 50 per cent of patient deaths were from conditions which could be exacerbated or caused by dietary issues. Transmission of infectious diseases, such as dysentery, pneumonia and TB also contributed substantially to the death rate. Lapses of hygiene were inevitable given the overcrowding and inadequate toileting and washing facilities for staff and patients. The standard of medical attention was poor and treatments unsystematic and tardy. Doctors had little to offer for treatment of mental illness other than chemical and physical restraints which were often intentionally punitive and harmful rather than therapeutic. As overcrowding increased, the standard of care and the rate of recovery diminished. Fig 3.1 above shows a clear relationship between overcrowding and the rate of recovery. After 1911, recoveries per annum for male patients declined from a peak of about twelve per cent to less than five per cent by 1919. The rate of female recoveries started from a higher base – about twenty per cent in 1913, and declined to about eight per cent by 1919. About half of the patients who died at Claremont died in the first twelve months after admission. By 1919, the death rate was twice the recovery rate.

Historical studies of overseas asylums show that the expectation of hospital life was significantly longer than at Claremont in the same period, especially for senile and GPI patients. However, contrary to Davis's claim that GPI was the most ‘deadly disease of asylumdom’, it appears than senility was the greater threat. World War I constraints did not much affect mortality rates in Australian asylums, unlike the tragic experiences of ‘extraordinary deaths’ in German institutions and some British asylums. If senility is considered as a disease (or more accurately as a set of co-morbidities), Davis’s claim that GPI was the most deadly disease is not supported by the evidence – aged patients died more quickly. Comparisons with Australian and overseas institutions suggest that more spacious facilities and
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better standards of care, specialisation of treatment, infection control and efficient separation of categories of patient might considerably extend life expectancy. At Claremont, these needful things were sadly lacking.

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1 'How the State Cares for the Afflicted in Mind', Western Mail, (Perth: 24 Aug 1912), 6.
2 Aubrey, Brief Lives, life of Edmund Waller, 312.
3 Select Committee, ix.
5 See Martyr, Us that Live Here, Chapter 3 and Government of Western Australia, Report and Appendices of the Royal Commission in Lunacy, (Perth: 1922), 14.
6 Royal Commission in Lunacy, ibid, 15.
7 Martyr, Us that live Here, Chapter 3.
8 'Isolation of Claremont Asylum', West Australian, (Perth: 26 Jul 1919), 7.
10 The ALF inquiry and related press reports are well summarised by Martyr in Us that Live Here, Chapter 3. See also 'Claremont Asylum – Labourists' Investigations – an Overcrowded Institution – Dangers Faced by Attendants,' West Australian, (Perth: 31 Aug 1918), 8. For criticism of Anderson’s claims about the absence of VD, see letter to the editor from Lewis Driver, West Australian, (Perth: 29 Oct 1918), 4.
12 Select Committee, evidence of Dr Anderson, Inspector General, Questions 4432, 4452-4456.
13 Select Committee, evidence of William Berry, attendant, Questions 1609-1614; evidence of Alexander Grimalid, employee, Questions 1094, 1099-1102; evidence of John Iliffe, junior attendant, Questions 1048-1054; evidence of Albert Milsted, attendant, Questions 836-838.
14 Select Committee, evidence of John Anderson, Inspector General, Question 4806.
15 Select Committee, evidence of Susan Casson, Official Visitor, Questions 3657, 3664-3668. Casson had been questioned in respect of the claim that up to 10 female patients had had to queue in the nude while waiting for a bath. She denied the claim even after admitting she had never seen patients undressing or having a bath.
16 Garton, ibid, 174-175.
17 Watzka, 'Die Landesirrenanstalt Feldhof bei Graz', 152 and endnote 45.
18 Reaume, 'Accounts of Abuse of Patients at the Toronto Hospital for the Insane', 95-96.
19 Quoted in Wallis, 'The Bones of the Insane', 197.
21 For killing of Ann B, see SROWA Cons 752, Item 3107/4, Folio 25 and 'An Asylum Tragedy', West Australian, (Perth:10 May 1918), 8. The Andinach case is discussed in Chapter 2.
22 See Chapter Two.
23 SROWA Cons 752, Item 3108/5, Folio 216.
24 SROWA Cons 752, Item 3108/2, Folio 59. The 1910 Report does not list any suicides, therefore the 'cut throat' statistic in this Report must relate to Edwin Q.
25 The Andinach case was a significant exception. The reasons for the very detailed recording of Andinach's case are discussed in Chapter One.
26 Select Committee, evidence of Theo Anderson, Inspector General, Questions 4867-4868.
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27 Select Committee, evidence of John Iliffe, junior attendant, Questions 937-939. Attendant Hendrie lost a finger after an attack in 1913 – see ‘An Asylum Incident’, West Australian, (Perth: 8 May 1913), 7. The thumb had to be amputated.

28 Select Committee, evidence of Albert Milsted, attendant, Question 842.

29 Select Committee, evidence of Alexander Watt, attendant, Questions 4150-4152. See also entry for Martin O’Meara, VC, in the Australian Dictionary of Biography.


30 Select Committee, evidence of Patrick O’Meara, former patient, Question 1972-1973. There is no evidence that Patrick was a relative of Martin O’Meara VC.

31 Select Committee, evidence of Bertha Hinson, former patient, Questions 1644-1646.


33 For example, see Garton, Medicine and Madness, 173-175 or Watzka, ‘Die Landesirrenanstalt Feldhof bei Graz’, 152 or Geoffrey Reaume, ‘Accounts of Abuse of Patients at the Toronto Hospital for the Insane, 1883-1937’, Canadian Bulletin of Medical History, 14, No. 1, (1197), 65-106.

34 For example, Coleborne, “His Brain was Wrong, his Mind Astray”.

35 Martyr, personal communication.

36 Select Committee, evidence of Robert Roe, former attendant, Question 463.

37 Ellis, Eloquent Testimony, 5.

38 Martyr, personal communication.

39 See Chapter One for a description of the Andinach affair.

40 SROWA Cons 752, Item 3108/5, Folio 216.

41 Select Committee, evidence of Dr William Birmingham, Official Visitor, Question 4650-4651. Sections 36, 37, 54, 55 and 73 of the 1903 Lunacy Act set out the legal requirements. The format for the journal was specified in Schedule Ten. SROWA advice is that the Schedule Ten records for 1909-1919 are now lost.

42 Martyr, personal communication.

43 Ibid. See also Select Committee, evidence of Hugh Montgomery, former doctor at Claremont, Questions 3644-3646.

44 ‘P’s first name is not recorded.

45 Select Committee, evidence of Martin Kerins, Charge Attendant, Questions 2314-2350.

46 Select Committee, evidence of Susan McLean, Matron, Questions 2721-2723; evidence of Hugh Montgomery, (formerly on medical staff of Claremont), Question 3624.

47 Select Committee, evidence of Susan Casson, Official Visitor, Question 3721. As noted above, Casson’s evidence has limited credibility, but I think she can be believed on this matter.

48 Select Committee, evidence of William Birmingham, Official Visitor, Question 4672.

49 Select Committee, evidence of J.T. Anderson, Inspector General, Questions 4867-4868.

50 Sources: Government of Western Australia, Rules and Regulations for the Government and Management of the Hospitals for the Insane of Western Australia, (Perth:1911), 9-11. This booklet is enclosed in SROWA, Cons 752, Item 1920/0186.

Also Government of Western Australia, ‘Lunacy Act 1903’ (revised regulations replacing 1911 regulations), Government Gazette, (Perth: May 14, 1915), 1600-1601.

51 Charles Mercier, Lunatic Asylums: Their Organisation and Management, (London:Charles Griffin, 1894), 63-64. For influence and writings, see:


53 Select Committee, evidence of Herbert May, steward, Questions 2546-2554.

54 Select Committee, evidence of Charles Lockyer, first cook, Question 1732; evidence of William Flanagan, former Chief Attendant, Questions 2072-2074.

See Appendix One for dietary scales of patients and attendants.

The Heydon Inquiry figures are quoted in Walker, ‘Aspects of Working-Class Life’, 36, 43.

See discussion in ibid, 42-43.

The RDI assumes that the women are not taking oral contraceptives, which is irrelevant to the early twentieth century.

Australian Department of Health and Aging, ‘A Modelling System to Inform the Revision of the Australian Guide to Healthy Eating’, loc cit., 48. The published 18mg RDI for iron assumes 17% oral contraceptive usage. Therefore, for women not using these contraceptives, the RDI must be over 20mg. For 1915 revisions, see Government of Western Australia, ‘Lunacy Act 1903’ (revised regulations), *Government Gazette*, (Perth: May 14, 1915), 1600-1601.


Evidence of Martin Turner, attendant, Questions 724-730.

Select Committee, evidence of Charles Hames, storekeeper, Questions 3502-2723.

For sardines, see for example advertisement by Howard Kemp, Grocers, *West Australian*, (Perth: 1 Jan 1910), 5. For spinach, lettuce, cabbage etc see for example advertisement by Cheney & Co, Kalgoorlie, *Kalgoorlie Miner*, (Kalgoorlie: 11 Jul 1912), 4.


Select Committee, evidence of Charles Lockyer, first cook, Question 1732; evidence of William Flanagan, former Chief Attendant, Questions 2072-2074.

Bread and butter, oatmeal and a little milk were the major components of the diet for the very poor in Sydney. See R. Walker, ‘Aspects of Working-Class Life in Industrial Sydney in 1913’, 42-43.

Select Committee, evidence of Hugh Montgomery, former doctor at Claremont and brother of Sydney Montgomery, Questions 3758-3759. Patients helped with the preparation of the bread, butter and jam – see Select Committee, evidence of Herbert May, steward, Questions 2507-2508.

Select Committee, evidence of William Flanagan, former Chief Attendant, Questions 2126-2128.

Select Committee, evidence of John Anderson, Inspector General, Question 4834.

Select Committee, viii; Government of Western Australia, *Report and Appendices of the Royal Commission in Lunacy*, (Perth: 1922), 11 – ‘...the jam supplied at tea time becomes distasteful.’ (Commissioner’s conclusions on the dietary scale).


Select Committee, evidence of James Illife, junior attendant, Questions 999-1008; evidence of Francis Day, attendant, Questions 1284-1288; evidence of Thomas Russell, attendant, Question 588.

Select Committee, evidence of Frank Coyle, former attendant, Questions 2186, 2200-2203; evidence of Patrick O’Meara, ex-patient, Questions 1995-1996, evidence of Reginald Edwards, former attendant, Questions 522-532; evidence of Martin Turner, attendant, Questions 724-730, 744; evidence of James Illife, junior attendant, Questions 999-1008; evidence of William Berry, attendant, Questions 1580-1585.

Select Committee, evidence of William Flanagan, former chief attendant, Question 2023.

Select Committee, evidence of Charles Hames, storekeeper, Questions 3478, 3485, 3493-3500.

Select Committee, evidence of Susan Casson, Official Visitor, Questions 3657, 3665-3668.
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79 Martyr, Us that Live Here. The arrest was part of an elaborate surveillance operation in response to constant loss of stock.
81 Select Committee, evidence of Thomas Smith, charge attendant, Questions 3249-3253. Smith said that he had purchased flour and eggs from outside sources on Ben Way’s behalf, but was clearly evasive on the question of how the butter was obtained. Ben Way also traded in tobacco, allegedly not from the Claremont supply.
83 Select Committee, evidence of Charles Hames, storekeeper, Questions 3493-3500.
84 Select Committee, evidence of James McGowan, attendant, Questions 1473-1480. Also evidence of Charles Hames ibid.
85 See ‘Lunacy Act 1903’ (revised regulations replacing 1911 regulations), Government Gazette, (Perth: May 14, 1915), 1600-1601.
86 Select Committee, evidence of Richard Kerr, farm and dairy manager, Question 4046. The wages were only an accounting entry. It is highly unlikely that working patients actually received any money wages.
87 Report for 1909, 6.
88 SROWA, Cons 752, Item 1920/0186, (no Folio Number). Undated, unsigned, Minute to the Undersecretary on the the Lunacy Act Amendment Bill 1911. According to the minute, only 238 patients (out of 818 in 1911) paid any maintenance. Only 50 paid full maintenance. During 1909-1919, Claremont always ran at a deficit.
89 It is unlikely that female patients would have received tobacco. There is no evidence that female patient labour was used on the Claremont farm.
90 The Victorian figure is calculated from Table XII in the Victorian Report. (Expenditure – Receipts) / Patients.
92 SROWA, Cons 752, Item 3108/2, 226.
93 See Crammer, ‘Extraordinary Deaths’, 434. See Appendix One for Claremont kilojoule estimates.
98 For example, Select Committee, evidence of Thomas Cox, former attendant, Questions 3812-3813. For hygiene regulations, see Government Gazette, (Perth: May 14, 1915), 1600-1603. For an example of staff examination questions on hygiene, see Report for 1910, 5.
100 Martyr, Us that Live Here, Chapter 3.
102 Select Committee, evidence of Herbert May, steward, Questions 2507-2508.
103 Ellis, *Eloquent Testimony*, 72. The Inspector General (Dr Anderson), Dr Bentley, Dr Benson and Dr Prinz.

104 The hospital ward accomodated physically sick patients requiring bed rest and bedridden patients. Andinach had visible and serious injuries and wasn't medically seen for three days.

105 Watzka, ‘Die Landesirrenanstalt Feldhof bei Graz’, 155. The calculation included time for administration etc. There were about 240-300 patients per doctor at Feldhof.

106 Select Committee, evidence of Dr Bentley, Medical Superintendent, Questions 4370-4376.

107 Select Committee, evidence of Dr Anderson, Inspector General, Questions 4967-4972.

108 Select Committee, evidence of Dr Tymms, medical practitioner, Questions 5076-5078.

109 See Chapter One for discussion of the sloppy maintenance of Case Book entries.


111 Based on recoveries data in *Reports* 1909-1919. The actual recovery rate was somewhat less, as the rate of re-admission was roughly 10% over the same period.

112 Select Committee, evidence of Dr Bentley, Medical Superintendent, Questions 4389-4391.

113 Select Committee, evidence of Dr Anderson, Inspector General, Questions 5002-5004.

114 SROWA, Cons 752, Item 3108/2, 226.

115 Select Committee, evidence of Dr Anderson, Inspector General, Questions 5002-5007.

116 Select Committee, evidence of William Berry, attendant, Question 1602.

117 Select Committee, evidence of Dr Anderson, Inspector General, Questions 4760-4765. No first name is recorded for Mafetti.

118 For example, see Select Committee, evidence of James McGowan, former attendant, Questions 1431-1432. The evidence of the only attendant who mentioned logging of croton oil administration, William Berry, was discounted by the Select Committee (Question 1602).

119 Select Committee, evidence of Charles Hames, storekeeper, Questions 3464, 3473-3474. See also Select Committee, Conclusions, viii.

120 For example, Select Committee, evidence of Thomas Russell, attendant, Questions 609-611.


122 Select Committee, Conclusions, viii.


124 Select Committee, evidence of Robert Roe, former attendant, Questions 481-489.

125 Select Committee, evidence of James Bentley, Medical Superintendent, Question 4401.

126 Select Committee, evidence of Martin Kerins, Charge Attendant, Questions 2324, 2353-2361; evidence of Susan McLean, Matron, Questions 2763-2769; evidence of Thomas Smith, former Charge Attendant, Questions 3273-3274.

127 Select Committee, evidence of Reginald Atkinson, Medical Officer (PPH), Questions 4546-4554; evidence of Dr William Birmingham, Official Visitor, Questions 4667-4669 – ‘in excess, croton oil is an irritant poison’. For use as revenge, see evidence of Duncan Stewart, former attendant, Questions 2293-2305.

128 For example, Herbert French, *An Index of Differential Diagnosis of Main Symptoms*, (Bristol: J. Wright & Sons, 1910).


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132 Dysentery is characterised by the passage of blood and mucus in the stool – see entry for 'Dysentery' in Black's Medical Dictionary.
133 Based on examination of Death Notices for Claremont patients held at SROWA; Const 752, Item 1914/0145, Item 1916/0369, Item 1915/0179.
134 Select Committee, evidence of Martin Kerins, Charge Attendant, Question 3321.
135 For example, admission notes for Thomas Copeland, SROWA Cons 752, Item 3108/2, Folio 381.
136 SROWA Cons 752, Item 3107/2, Folio 73.
137 Select Committee, evidence of Albert Bishop, former attendant, Question 333.
138 ibid also Select Committee, evidence of Bertha Hinson, former patient, Questions 1644-1645. See also Martyr, Us that Live Here, 'Drugs, Restraint and Exclusion'.
144 For Claremont - Martyr, personal communication. For NSW ca. 1900, see Shea, ‘One Hundred Years Ago in New South Wales’, 31.
148 See Appendix Three for Case Book entries for Francis Andinch.
149 Henry Rollin uses the term ‘chemical cosh’ to describe the use of bromides, paraldehyde and chloral hydrate in Britain around 1900. See Henry R. Rollin, ‘Psychiatry in Britain One Hundred Years Ago’, British Journal of Psychiatry, 183, (2003), 297.
150 Fuller, ‘Expectation of Hospital Life and Outcome for Mental Patients on First Admission’, 295-323. The mortality statistics are taken from Table 3 on page 306.
151 There was also an ‘all causes’ group of 1200 patients.
152 Crammer, ‘Extraordinary Deaths’, Table 3, 432.
153 Fuller, ‘Expectation of Hospital Life’, 318; Claremont Reports 1912-1918.
154 See Chapter Two for a description of the tests used at Claremont. Gayle Davis recommends caution in interpreting the advent of the Wassermann test as a definite improvement, because: ‘it did not lead to either great changes in the numbers diagnosed or the way in which the diagnosis was made’. See The Cruel Madness of Love, 140-141.
156 Pollock, ibid, 195.
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158 About the same proportion of deaths occurred in the first twelve months in Victorian asylums as at Claremont – see Victorian Report 1916, Table VII, 9.
159 Davis, ‘The Most Deadly Disease of Asylums’. See also George M. Robertson, ‘The Morison Lectures, 1913 – General Paralysis of the Insane’, British Journal of Psychiatry, 59, (1913), 221. The period in which the Scottish GPI mortality figures were collected is not specified in Robertson’s paper.
160 Ibid, 267.
161 J.G. Smith, ‘Seven Hundred Cases of General Paralysis of the Insane; being an Analysis of all the Cases which have occurred in the Glamorgan County Asylum from 1867 to 1896’, British Journal of Psychiatry, 45, (1899), 441.
162 Rose S. was diagnosed with GPI on admission. See SROWA Cons 72, Item 3107/2, Folio 325. The ratio of female GPI sufferers to males was much lower than that in Britain – see Davis, The Cruel Madness of Love, 228-229.
163 D. Healy et al, ‘Mortality in Schizophrenia and Related Psychoses’
164 Calculated from ibid, Fig 1, 6.
165 Based on Claremont Death Notice figures for 1912 to 1918. The death rate for the first twelve months for case study patients 1909 to 1919 was rather higher at 70%.
167 McCandless, ‘South Carolina Lunatic Asylum’, Table 7.4, 189.
168 Source of Claremont death rates: Reports 1909-1919. There were significant year-to-year variations in the Claremont averages. There was a 13.5% death rate for males in 1910 and an 11.8% rate for females in 1918.
169 McCandless, ‘South Carolina Lunatic Asylum’, 191. The South Carolina aggregate death rate (around 13% in 1905) was about double the national rate.
171 See McCandless, ‘South Carolina Lunatic Asylum’, 187, 191. We can safely infer that the investigative committee of Southern state legislators was all white because most blacks had lost their civil rights, including the vote, since the 1890s
173 ‘Fatback’ is a cheap and very fatty cut of meat from the back of a pig.
174 See entry for ‘Pellagra’ in Black’s Medical Dictionary.

Ødegård, ’The Excess Mortality of the Insane’, Table 6, 363.

For further comments on wartime stringencies, see the conclusions of the 1921/1922 Royal Commission in Lunacy - Government of Western Australia, Report and Appendices of the Royal Commission in Lunacy, (Perth: 1922), 15.

There were shortages of rice, clothing and bedding attributed to wartime shortages – Select Committee, evidence of Charles Hames, storekeeper, Q 3482-3484, 3515-3516.


Calculated from ‘Causes of Death’ (Table 4) in Reports 1909-1919.

See Figs 3.1 and 3.5.
‘Died Today’ Conclusions

CONCLUSIONS – The ‘Special Path’ of Mental Health Care in WA

I have established that mental health care in WA from its beginnings until at least 1920 followed a ‘special path’. While problems of overcrowding, harmful, unsuitable and punitive treatments, unsatisfactory documentation, lack of medical care and nutritional and hygienic deficiencies were of course shared to some degree by other institutions discussed in this thesis, the distinctive demography and geography of WA, its frontier society and its belated economic and social development profoundly affected the scale and nature of these factors and the composition of the patient population. As compared to other asylums, Claremont had exceptionally high proportions of single patients, immigrant patients and male patients whose unsettled life styles, alcohol abuse, vulnerability to VD and lack of social support had damaged their health well before admission. Lack of family and social support while at the asylum meant that patients in these groups were more vulnerable to arbitrary, punitive treatments, neglect and poor morale. But a series of very public scandals and resulting official inquiries in between 1918 and 1922 suggests that the problems of Claremont’s ‘special path’ had exceeded the limits of public and political tolerance.

A feature of this ‘special path’ was a lack of specialisation in welfare provision, which meant that many patients who were not in fact mentally ill by the standards of the day were assigned to Claremont. These patients, who might have received specialised care in other, wealthier states, were assigned to Claremont by default. For example, there was a substantial number of mentally and physically disabled children. People who transgressed the rules at the state’s crowded poor houses and aged persons homes also found themselves forcibly transferred to the asylum. From the high proportion of ‘seniles’ at Claremont, we can deduce that it was the place of first resort for accommodating demented patients. Importantly for the death rate, it was clear that Claremont was used as a hospice for the terminally ill – two patients from the case study sample died on the day of admission. Thus the multi-function role of Claremont, by worsening overcrowding, compromising hygiene and making separation of patients by clinical category difficult, lowered the life expectancy of all patients.
‘Died Today’ Conclusions
My analysis of the case study has shown that length of stay statistics for deceased patients give a much clearer picture of the vulnerability of specified groups than the figures for average death rates which are typically found in historic annual reports of mental institutions in Australia and elsewhere. There are a limited number of comparable studies which look at the expectation of hospital life, but the evidence suggests that ‘seniles’ and GPI patients fared far less well at Claremont than comparable groups elsewhere, particularly in their first year after admission. This was also the case for the Claremont patient community as a whole, with male patients dying earlier than females. But the evidence clearly shows that GPI was not ‘the most deadly disease of asylumdom’ – old and demented patients died sooner. The earlier mortality at Claremont and other evidence suggest two things. On admission, patients were far more physically ill on average than persons in the source population, which has been demonstrated in a number of historic studies, mentioned in this thesis, which examine relative patient mortality. Secondly, patients’ health was more at risk at Claremont than elsewhere as a consequence of its ‘special path’, with at risk groups such as ‘seniles’, TB patients, GPI patients, socially isolated patients and the very ill being particularly vulnerable to the above-mentioned exogenous harms.

The evidence from Claremont’s own documentation, public inquiries, newspaper reports and the annual reports of asylums in Victoria show that it was exceptionally poorly managed. Even after the inquiries brought this mismanagement into very public focus, the responsible Minister and Department took no strong action until the mid 1920s and some poor practices persisted well into the 1930s, when bread and jam was still a staple. Management did not keep up to date with medical developments elsewhere in Australia and even in WA, such as the Wassermann test and the use of salvarsan which were then being tested at the Aboriginal Lock Hospitals in WA and on private patients in Perth. There were extenuating circumstances for management failings. They could not choose their patients and had to accept people certified as lunatics. They had too many patients to deal with in too little space and there were labour and supply shortages, particularly in the war years. While the farm operations had a recognised therapeutic value for patients, management was forced to run the farms and dairy as commercial operations because of government parsimony and the fact that the
'Died Today’ Conclusions
great majority of patients could not pay maintenance fees, thus adding to
administrative burdens. Having said that, many of the priorities of successive
Inspectors General were questionable.

There were many poor practices which might have been remedied with little
additional expense or effort, such as a stricter discipline with respect to recording
essentials, such as diagnoses, on admission forms rather than non-essentials, such
as eye colour, or proper recording and authorisation of treatments. As mentioned
with respect to croton oil, the Inspectors General did not maintain a responsible
control of dangerous medications and were quite unaware of how much was used,
to the extent of causing the Minister to mislead Parliament with incorrect
information. These management failures, and public disasters as the Andinach case
strongly suggest that management appeared to have almost a laissez faire attitude,
often and irresponsibly delegating their responsibilities to medically untrained
attendants and nurses, with unfortunate results, for example the apparently
unrestricted use of laxatives. While the arbitrary and ill-considered actions taken
by Dr Anderson during the Hospital’s isolation during the influenza pandemic of
1919, such as his attendance at outside social functions and vindictive dismissals
for trivial transgressions, certainly worsened industrial relations, there is much
evidence from newspaper reports and the Select Committee that he had not got
along with many of his staff for a long time. To be fair, not all the blame for this
unfortunate situation should be sheeted home to Anderson, but his history of poor
judgement, intemperate language and lax supervision was not helpful.

During the First World War, restrictions on food, labour and transport caused the
premature deaths of thousands of asylum patients in Britain and possibly
hundreds of thousands in mainland Europe, including neutral countries such as
Norway. Patients with TB were particularly affected. In Britain, we know that
unnecessarily harsh rationing during the last years of the War, when the civilian
food supply was reasonably well maintained, caused an ‘extraordinary’ number of
excess patient deaths, with nearly 60 per cent of the patients admitted to
Buckinghamshire in 1918 dying in the first six months after admission. Australia,
as an agricultural country, did not suffer from wartime shortages of food. There
‘Died Today’ Conclusions

were shortages of labour and some imported supplies, such as rice, but I have shown that the mortality rate at Australian asylums was not affected by the war.

Is this history of mortality at Claremont a ‘usable past’? The poor results at Claremont exemplify the role of contingency in the successes and failures of large asylums of the period. It was not pre-determined that the existence of a large institution necessarily meant a high death rate, overcrowding, patient abuse and low rates of recovery. As Garton argues, conditions in NSW asylums in colonial times were relatively humane. They had high rates of recovery and low rates of re-admission. Their solutions to bad conditions were neither infeasible nor obscure. Adequate financing, good infrastructure, proper recording standards, sound management, sufficient and well-trained staff and proper attention to hygiene and nutrition had been possible in the NSW system and elsewhere. And they had been able to provide separately for people with ‘special needs’ and venereal disease, rather than packing them in with the mentally ill. But these conditions for good results were lacking on the frontier, as discussed in Chapter One. The financial means for better public provision, in the form of gold revenue and a substantial population came late to WA. And it seems that, even after the very critical public inquiries of 1919 and 1921-22, the political will was lacking for substantial reform.¹ In a sense, Claremont provides a ‘control’ for what was achievable (and what could go wrong) within the limits of the medical knowledge and the political constraints on public funding of the past.

For economic, social and political reasons, there was a movement after 1920 away from large public institutions towards private practice or clinics. As doctors moved to the private sector, they persuaded governments and the public that asylum care was not in patients’ best interests and resources were increasingly diverted into other forms of care.² As a result, large asylums became more rundown, decrepit and moribund by the 1960s. Garton suggests that these more recent failures and abuses are now a fixed image in the public mind, an image shared by some historians such as Scull, who claims that the failures of large institutions were ‘endemic and inherent’.³ It would not be an exaggeration to say that many people still see the classic fictional film One Flew Over the Cuckoo’s Nest as quasi-documentary, based on factual events and real characters.⁴ Hence modern systems
'Died Today’ Conclusions

of care are seen as a liberation of the mentally ill from overpowering state paternalism, harmful and sadistic treatments and systematic abuse.

Over the last century, there has been a sea change in provision of psychiatric care towards community treatment, clinics and crisis facilities. There is now far more therapeutic care available and a much broader spectrum of medications and other treatments available. Yet, as the North Wales studies show, historical recovery rates for the mentally ill were comparable with present rates and the mortality rates for patients with mental illness were better. Doessel’s long term study of mental illness in Australia found that the mortality of mentally ill persons with the respect to mortality in the general population has continued to worsen since 1916. Jeffrey Geller and the North Wales studies have noted the modern problem of increased and expensive recidivism (the ‘revolving door’) at state institutions. The obvious conclusion is that treatment of the mentally ill has become much less cost effective. Moreover community care ‘hides’ the true costs, because the social and economic cost of this care is now distributed non-transparently over homeless shelters, gaols, criminal courts, police patrols, hapless neighbours, distressed families and over-taxed social workers.

Why then should we see the more transparent practices of the past through a prism of failure? This thesis shows that failures at Claremont and elsewhere, while certainly influenced by local conditions, were not inherent to institutional care. The contemporary successes of some sibling institutions are evidence that the problems in WA might have been remedied, or at least substantially amelioriated, by straightforward measures, not necessarily costly, and sufficient political will. A wholesale return to large institutions for the long term care of selected groups of patients might well be economically and politically unfeasible, but in exploring ways to overcome the present impasse, we should seek guidance from objective historical analysis and not fictional stereotypes.

1 See Martyr, ‘Hopeless Hill’, and Us that Live Here, for the history of Claremont after 1920.
2 Garton, ‘Seeking Refuge’, 42.
3 Garton, ‘Seeking Refuge’.
4 The author of the book on which the film was based, Ken Kesey, did work for a time as an orderly in a mental institution.
5 Doessel et al. 'The Trend in Mental-health Related Mortality Rates in Australia 1916-2004'.
'Died Today’ Conclusions

‘Died Today’ Appendix One

Appendix One – Diet Scales for Patients and Staff 1911.\(^1\)

Sources:
Government of Western Australia, ‘Rules and Regulations for the Government and Management of the Hospitals for the Insane of Western Australia’, (Perth:1911), 9-12. This pamphlet is enclosed in SROWA, Cons 752, Item 1920/0186.


Patients - Daily

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity for Males</th>
<th>Kj males(^2)</th>
<th>Quantity for Females</th>
<th>Kj females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread</td>
<td>454 g</td>
<td>4771</td>
<td>397 g</td>
<td>4171</td>
</tr>
<tr>
<td>Meat, uncooked</td>
<td>340g</td>
<td>3600 (if no bone)</td>
<td>284g(^3)</td>
<td>3007 (if no bone)</td>
</tr>
<tr>
<td>with bone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td>284g(^4)</td>
<td>1435</td>
<td>284g</td>
<td>1435</td>
</tr>
<tr>
<td>Sugar</td>
<td>43g</td>
<td>702</td>
<td>43g</td>
<td>702</td>
</tr>
<tr>
<td>Milk</td>
<td>118 ml</td>
<td>345(^5)</td>
<td>118 ml</td>
<td>345</td>
</tr>
<tr>
<td>Tea</td>
<td>7g</td>
<td>-</td>
<td>7g</td>
<td>-</td>
</tr>
<tr>
<td>Butter</td>
<td>28g</td>
<td>-</td>
<td>28g</td>
<td>-</td>
</tr>
<tr>
<td>Jam</td>
<td>64g</td>
<td>671(^6)</td>
<td>64g</td>
<td>671</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>11524</strong></td>
<td></td>
<td><strong>10331</strong></td>
</tr>
</tbody>
</table>

*Note: In evidence to the Select Committee in 1919, the steward stated that the meat ration was 113g.*\(^7\)

Patients - Once a Week (male ration same as female ration)

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Kj</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>28g</td>
<td>407(^8)</td>
</tr>
<tr>
<td>Barley</td>
<td>28g</td>
<td>407(^9)</td>
</tr>
<tr>
<td>Fish (Friday)(^10)</td>
<td>284g</td>
<td>1760(^11)</td>
</tr>
<tr>
<td>Peas or Split peas</td>
<td>57g</td>
<td>288</td>
</tr>
<tr>
<td>Flour for puddings</td>
<td>57g</td>
<td>840</td>
</tr>
<tr>
<td>Suet (beef or mutton fat)</td>
<td>28g</td>
<td>1100</td>
</tr>
<tr>
<td>Sugar for puddings</td>
<td>28g</td>
<td>457</td>
</tr>
<tr>
<td>Raisins or Currants</td>
<td>43g</td>
<td>217</td>
</tr>
<tr>
<td><strong>Total/7</strong></td>
<td></td>
<td><strong>782</strong></td>
</tr>
</tbody>
</table>

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‘Died Today’ Appendix One

Patients - Three Times a Week (male ration same as female ration)

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Kj</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oatmeal</td>
<td>57g</td>
<td>814</td>
</tr>
<tr>
<td>Sugar for oatmeal</td>
<td>21g</td>
<td>342</td>
</tr>
<tr>
<td>Milk for oatmeal</td>
<td>59ml</td>
<td>172</td>
</tr>
<tr>
<td>Total *3/7</td>
<td>-</td>
<td>569</td>
</tr>
</tbody>
</table>

Plus 43g flour (633 Kj), for both males and females, for pies twice a week. And salt and pepper. Daily equivalent = 181 Kj.

Approximate daily Kilojoules = 10331 + 782 + 569 + 181 = 13056 (males) and 11863 (females).
(assumes that all food is eaten and evenly distributed)

Dinners:
- Sunday – Roast meat and pudding
- Monday – Meat pie
- Tuesday – Roast mutton
- Wednesday – Meat pie
- Thursday – Roast mutton
- Friday – Fish
- Saturday – Curry

Actively employed patients doing at least four hours work a day were allowed, in addition to the above:
- 57g bread
- 28g cheese
- 237ml lemonade or oaten water (a bit less than a standard cup of 250ml).
- Plus 236ml beer or lemonade for the King’s Birthday and 473ml for Christmas.

Patients on special diets received extra mincemeat, beef tea, bread, milk and eggs.\textsuperscript{12}
‘Died Today’ Appendix One

Staff Daily

(male ration same as female ration)

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread</td>
<td>454 g</td>
</tr>
<tr>
<td>Milk</td>
<td>473 ml</td>
</tr>
<tr>
<td>Meat, uncooked with bone</td>
<td>454 g</td>
</tr>
<tr>
<td>Vegetables</td>
<td>454 g</td>
</tr>
<tr>
<td>Cheese</td>
<td>14 g</td>
</tr>
<tr>
<td>Sugar</td>
<td>113 g</td>
</tr>
<tr>
<td>Butter</td>
<td>57 g</td>
</tr>
<tr>
<td>Tea</td>
<td>12 g</td>
</tr>
<tr>
<td>Coffee</td>
<td>4 g</td>
</tr>
<tr>
<td>Flour</td>
<td>49 g</td>
</tr>
</tbody>
</table>

Staff Weekly

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barley</td>
<td>113 g</td>
</tr>
<tr>
<td>Rice</td>
<td>113 g</td>
</tr>
<tr>
<td>Suet (beef or mutton fat)</td>
<td>57 g</td>
</tr>
<tr>
<td>Raisins, dates or currants</td>
<td>113 g</td>
</tr>
<tr>
<td>Jam</td>
<td>198 g</td>
</tr>
<tr>
<td>Oatmeal</td>
<td>198 g</td>
</tr>
<tr>
<td>Bacon</td>
<td>198 g</td>
</tr>
<tr>
<td>Eggs</td>
<td>3 eggs</td>
</tr>
<tr>
<td>Cornflour</td>
<td>35 g</td>
</tr>
<tr>
<td>Tapioca or Sago</td>
<td>113 g</td>
</tr>
<tr>
<td>Fruit (preserved)</td>
<td>113 g</td>
</tr>
<tr>
<td>Fish (Fridays)</td>
<td>454 g</td>
</tr>
</tbody>
</table>

Plus salt, pepper and various condiments.

Note: Some items in the ‘weekly’ table for staff in the original pamphlet have been converted to daily equivalents for better comparison with patient’s rations.
Recommended Daily Kilojoules - Australian Department of Health Guidelines – Low to Medium Activity, Average Height

<table>
<thead>
<tr>
<th>Group</th>
<th>Kj</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men 19-30 years</td>
<td>12400</td>
</tr>
<tr>
<td>Men 31-50 years</td>
<td>11700</td>
</tr>
<tr>
<td>Men 51-70 years</td>
<td>10700</td>
</tr>
<tr>
<td>Men 70+ years</td>
<td>9800</td>
</tr>
<tr>
<td>Women 19-30 years</td>
<td>9800</td>
</tr>
<tr>
<td>Women 31-50 years</td>
<td>9500</td>
</tr>
<tr>
<td>Women 51-70 years</td>
<td>9000</td>
</tr>
<tr>
<td>Women 70+ years</td>
<td>8600</td>
</tr>
</tbody>
</table>

1 For ease and consistency of reference, I have converted all Imperial measures to metric and rounded them to the nearest unit. 1 oz = 28.35g, 1 gill = 118 ml, 1 pint = 473ml.
3 Increased to 340g in 1915.
4 Taken from Crammer *ibid*, Mills gives data only for potatoes.
5 250ml whole milk = ca. 733 Kj
7 *Select Committee*, evidence of Herbert May, steward, Questions 2536-2541.
8 From the Mills figure for ‘cereals’.
9 *ibid*
10 Meat was allowed to be substituted for fish
12 *Select Committee*, evidence of Herbert May, steward, Questions 2468-2541.
Appendix Two – Summary of Select Committee Evidence about Hygiene.


<table>
<thead>
<tr>
<th>Witness</th>
<th>Questions</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Smith, former attendant</td>
<td>375</td>
<td>Dogs seen in kitchen</td>
</tr>
<tr>
<td></td>
<td>411-417</td>
<td>No proper washing facilities. 8 towels for 125 patients. Towels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>are only changed when ‘dirty enough’.</td>
</tr>
<tr>
<td></td>
<td>419</td>
<td>No gloves supplied for handling syphilitic patients</td>
</tr>
<tr>
<td></td>
<td>420-421</td>
<td>Only 1 toilet in ward with up to 20 dysentery cases. Excrement on floor.</td>
</tr>
<tr>
<td>Thomas Russell, attendant</td>
<td>543-552</td>
<td>Attendants use same toilet as patients. 50 patients per toilet.</td>
</tr>
<tr>
<td>Martin Turner, attendant</td>
<td>705</td>
<td>Lavatories insufficient. Ward is marked ‘top to bottom’ (with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>excrement) when dysentery is rife.</td>
</tr>
<tr>
<td></td>
<td>706-707</td>
<td>Lack of sheets</td>
</tr>
<tr>
<td></td>
<td>719-721</td>
<td>Lack of towels. 24 sick patients, 3 towels.</td>
</tr>
<tr>
<td></td>
<td>750-753</td>
<td>Vermin in every ward. Bedbugs and ‘crabs’.</td>
</tr>
<tr>
<td></td>
<td>756-761</td>
<td>Gloves not provided for TB or VD cases.</td>
</tr>
<tr>
<td></td>
<td>765</td>
<td>Patients with contagious disease use same toilets as other patients.</td>
</tr>
<tr>
<td>Albert Milsted, attendant</td>
<td>850</td>
<td>Jug and basin only used by doctors for cleanup, never attendants</td>
</tr>
<tr>
<td>Alexander Grimaldi, employee</td>
<td>1102</td>
<td>Some patients with TB are not isolated</td>
</tr>
<tr>
<td></td>
<td>1108</td>
<td>Patient C. died from typhoid</td>
</tr>
<tr>
<td></td>
<td>1110</td>
<td>No hot water after 6pm, only warm water available is in kitchen</td>
</tr>
<tr>
<td>Joseph Maddigan, attendant</td>
<td>1774</td>
<td>No towels</td>
</tr>
<tr>
<td>Francis Day, attendant</td>
<td>1311</td>
<td>Doctor's jug can be used by attendants for cleanup. Basin with lysol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>is kept locked in a cupboard because it can not be left unattended.</td>
</tr>
<tr>
<td></td>
<td>1313-1314</td>
<td>Wash basins are in patients lavatory. Have to leave ward to wash. Can</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not do this if he is the</td>
</tr>
<tr>
<td>Witness</td>
<td>Questions</td>
<td>Evidence</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>James McGowan, retired attendant</td>
<td>1329-1330</td>
<td>Shortage of clothing and sheets</td>
</tr>
<tr>
<td>Patrick O’Meara, former patient</td>
<td>1964, 2197-2199.</td>
<td>6 towels for 100 men. Had to use shirt to dry himself.</td>
</tr>
<tr>
<td>Frank Coyle, former attendant</td>
<td>2197-2199</td>
<td>Patient had to use shirt as towel.</td>
</tr>
<tr>
<td>Susan McLean, Matron</td>
<td>2724</td>
<td>Sufficient towels</td>
</tr>
<tr>
<td>Chrissie McKenzie, nurse</td>
<td>2868-2870</td>
<td>Shortage of towels at times – can not give every patient clean towel.</td>
</tr>
<tr>
<td>James McKeown, Chief Attendant</td>
<td>3107-3108</td>
<td>Shortage of sheets during the war</td>
</tr>
<tr>
<td>Thomas Fletcher, former attendant</td>
<td>3558</td>
<td>During isolation (for influenza epidemic) in Wards X2 and X3, only 24 towels for 46 patients for drying hands and face.</td>
</tr>
<tr>
<td>Thomas Cox, former attendant</td>
<td>3812-3813</td>
<td>Attendants can not wash hands unless they leave ward.</td>
</tr>
<tr>
<td>Norah Collins, nurse</td>
<td>3868-3871</td>
<td>Antiseptics provided with several (non-fixed) washing basins.</td>
</tr>
<tr>
<td>Mary Crowther, former nurse</td>
<td>3916-3918</td>
<td>Shortage of towels</td>
</tr>
<tr>
<td>Richard Kerr, farm and dairy manager</td>
<td>4037</td>
<td>March to April is ‘typhoid season’ at the Hospital.</td>
</tr>
<tr>
<td>James Bentley, Medical Superintendent</td>
<td>4411</td>
<td>Adequate washing facilities</td>
</tr>
<tr>
<td></td>
<td>4473</td>
<td>Does not know any cases of TB who are not isolated. No infectious cases of VD.</td>
</tr>
<tr>
<td></td>
<td>4461, 4473</td>
<td>Attendants too lazy to wash hands after handling infectious patients.</td>
</tr>
<tr>
<td>J.T. Anderson, Inspector General of the Insane</td>
<td>4799</td>
<td>Special clothes and gloves provided for handling body lice and VD cases.</td>
</tr>
<tr>
<td></td>
<td>5041</td>
<td>5 roller towels in lavatory. Plenty of towels in bathroom.</td>
</tr>
</tbody>
</table>
Appendix Three – Transcript of Case Book Entries for Francis Andinach.¹

[Note: Text details in square brackets are my comments]
[Struck through text represents crossed out text in original]

Admission: 21.5.18
Age: 50
Religion: R.C.
Nationality: Spain
Late Residence: Madrid Restaurant, High St, Ftle
Male or Female: M
Occupation: Restaurant Keeper.
Friend: W. Mrs Andinach ([address] as above)
Order By: [illegible] Craft & Brickhill
Certified By: Dr Barker & [illegible]
Relatives Insane: [blank]
Attack and Duration: [blank]
Epileptic: [blank]
Suicidal: [blank]
Height: 5’ 4” [ca 163 cm]
Weight: 8st 11 ½ [ca 56kg]
Diagnosis: Tabes dorsalis, GPI. Error – vide patient on [illegible].
Hair: Black.
Eyes: Grey [illegible]. Dark -> Grey.

Medical Certificate: Very wild unkempt in appearance wearing only a shirt. Very noisy shouting laughing & singing songs in a foreign language. Either cannot understand the questions put to him or refuses to answer. Very violent & attacks those who approach him. Has to be restrained. Delusional. Thinks he is to be crucified for his sins. At times refuses nourishment.

Physical Condition (24.5.18 – 28.5.18)
Thin, short, spare, man - not well nourished. Heart [illegible]. Pulse thin weak.
Abdomen [illegible] scar of recent [illegible].
Patient is a well nourished man of short stature. There are many signs of injury violence about his body as follows:-
'Died Today’ Appendix Three

(1) Two slight skin abrasions just below L[eft] knee.
(2) Slight bruising on inner side of R[ight] knee.
(3) Two bruises outer side left hip (a) over [illegible] the anterior superior spine.
(4) Bruising skin abrasions over both elbows.
(5) Four bruises over the top of the chest.
(6) Left eye – sunken discoloured with abrasion at [illegible]
(7) Right eye – discoloured
(8) Large extensive bruising over region left lower ribs [illegible] the mid-axillary line

Fractures:

(1) Fourth rib on right side just internal to the anterior border of the [illegible] a little above level of nipple.
(2) Fourth rib on left side 1½" [3.75 cm] above [illegible] the outer side of the outer fragment appears to be over riding the [illegible].

Chest: There is a well-marked subcutaneous emphysema on whole of left chest in front – extending above the [illegible] down to the inner [illegible] margin, [illegible] to the posterior axillary line. The breath sounds are unimpaired. No heart sounds can be detected at the mitral [illegible]. Those at the aortic are normal. The pulse is fairly good.

Special note:

None of the bruising is quite recent, [illegible] appears to be 7 days old & possibly more. [illegible]. The discolouration is advanced & widely diffused, & no where has the characteristics of a bruising which has been caused within 48 hours.

Mental Condition:

This is not such as to permit of a satisfactory examination. The patient has been restless & noisy, talkative at intervals since admission; he has not been in any way violent or required active restraint [but see the ‘Medical Certificate’ note above that Andinach was ‘very violent’]. He is rambling incoherent in his speech does not appear to grasp what is said to him. I cannot understand a word of what he says.
‘Died Today’ Appendix Three

25.5.18 Patient's condition is very unsatisfactory. He is restless delusional shows no improvement. Is getting weaker, can only take [illegible] milk. Has quietened down with morphine. Is having [illegible] daily.

26.5.18 Seemed a little better this morning, but to-night is weaker. Low, delirium. Pulse fairly good.

27.5.18 Patient very weak. Temp. rising. Dyspnoea. Cyanosed.

28.5.18 Condition unchanged.

29.5.18 Weaker. Died this morning.

Deceased 29.5.18 [red ink].

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1 SROWA Cons 752, Item 3108/5, Folios 226-227.
Appendix Four – Case Study Patients recorded in Database

Source: Claremont Case Books, sample of patients admitted to Claremont 1909 to 1919 and deceased between 1909 and 1919.

[n/a] = not stated.

S=Single M=Married W=Widow or Widower

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Bibliography

Primary Sources

Archival Collections
State Records Office of Western Australia:
  Case Books 1903-1918.
  Notices of Death 1912-1918.
  Medical Journal.
  File 1918/068: Papers relating to Francis Andinach (empty).
  File 1912/2717 v1 and v2: Perth Public Hospital Mental Ward.

Government Publications


Government of Western Australia, *An Act to Amend the Law relating to the Insane*, No. 15 of 1903.


Government of Western Australia, *Year Book*, 1910.


Medical Texts and Articles

'Died Today' Bibliography


French, Herbert, *An Index of Differential Diagnosis of Main Symptoms*, (Bristol: J. Wright & Sons, 1910).


Smith, J.G., ‘Seven Hundred Cases of General Paralysis of the Insane; being an Analysis of all the Cases which have occurred in the Glamorgan County Asylum from 1867 to 1896’, *British Journal of Psychiatry*, 45, (1899), 434-446.


'Died Today' Bibliography

1375.


**Newspapers**

(Trove online newspaper database, National Library of Australia.)
*Sunday Times* (Perth)
*Kalgoorlie Miner* (Kalgoorlie)
*West Australian* (Perth)
*Western Mail* (Perth)

**Secondary Sources**

‘Montgomery, Sydney Hamilton Rowan’ and ‘O’Meara, Martin’.

Abbott, Kellie and Celia Chesney, “I am a poor Woman': Gender, Poor Relief and the Poorhouse in Late Nineteenth and Early Twentieth-Century Western Australia’, *Studies in Western Australian History*, 25, (2007), 24-39.


'Died Today' Bibliography


Bolton, G.C. and Prue Joske, History of Royal Perth Hospital, (Perth: Royal Perth Hospital, 1982).

Bolton, Geoffrey, Land of Vision and Mirage. Western Australia since 1826, (Perth: University of Western Australia Press, 2008).


Byles, Julie et al, ‘Psychological Distress and Comorbid Physical Conditions: Disease or Disability?’, Depression and Anxiety, 31, No. 6, (Aug 2013), 524-532.

Casselman, A.J. ‘The Diagnosis and Treatment of Syphilis and Gonorrhea’, Public Health Reports, 36, no. 16 (Apr 22, 1921), 851-921.


'Died Today' Bibliography


'Died Today' Bibliography


Fröshaug, Harold and Aagot Ytrehus, ‘A Study of General Paresis with special Reference to the Reasons for the Admission of these Patients to Hospital’, Acta Psychiatraca Scandinavica, 31, No. 1, (Mar 1956), 35-60.


Fuller, Raymond G., ‘Expectation of Hospital Life and Outcome for Mental Patients on First Admission’, Psychiatric Quarterly, 2, (1930), 295-323.

_____________, and Mary Johnston, ‘The Duration of Hospital Life for Mental Patients’, Psychiatric Quarterly, 5, No. 3, (1931), 552-582.


_____________, ‘Seeking Refuge: Why Asylum Facilities Might Still be Relevant for
'Died Today' Bibliography

Mental Health Care Services Today', *Health and History*, 11, No. 1, (2009), 24-45.


Harman, Bronwyn, ‘Out of Mind, Out of Sight: Women Incarcerated as Insane in Western Australia 1858-1908, *(MA Thesis, University of Western Australia, 1993).*


‘Died Today’ Bibliography

Hegadoren, Kathy, ‘Should inpatient psychiatric wards be gender segregated?’, *Cross Currents*, 12, No. 3, (Spring 2009), 20.

Heiberg, Poul, ‘Variations in the Number of Reported Cases of Syphilis and in the Number of Deaths from General Paresis’, *Psychiatrica Scandinavica*, 7, No. 2, (Jun 1932), 188-199.

Hetherington, Penelope, *Paupers, Poor Relief & Poor Houses in Western Australia 1829-1910*, (Perth: University of Western Australia Publishing, 2009).


Hawk, Angela, ‘Going “Mad” in Gold Country: Migrant Populations and the Problem of Containment in Pacific Mining Boom Regions’, *Pacific Historical Review*, 80, No. 1, (2011), 64-96


Hetherington, Penelope, *Paupers, Poor Relief and Poor Houses in Western Australia 1829-1910*, (Perth: University of Western Australia Press, 2009).


‘Died Today’ Bibliography


Kimberly, Warren Bert, History of West Australia, (Melbourne: F.W. Niven, 1897).


‘Died Today’ Bibliography


Maude, Phil, 'Treatment of Western Australia's Mentally Ill during the Colonial Period, 1826-1865', *Australasian Psychiatry*, 21, No. 4, (2013), 397-401.


Meier, Marietta, ‘Creating order: A quantitative analysis of psychiatric practice at the Swiss mental institutions of Burghölzli and Rheinau between 1870 and 1970’, *History of Psychiatry*, 20, (2009), 145


‘Died Today’ Bibliography


‘Died Today’ Bibliography


Rorie, James, ‘Statistics of Six Thousand Cases of Insanity Admitted into Dundee Royal Asylum from 1st April, 1890, to 2nd November, 1898’, British Journal of Psychiatry, 46, (1900), 205-207.


Schluger, Neil W., ’The Pathogenesis of Tuberculosis. The First Hundred (and Twenty-Three ) Years’, American Journal of Respiratory Cell and Molecular Biology, 32, No. 4, (2005), 251-256


'Died Today' Bibliography


Snow, Dudley, The Progress of Public Health in Western Australia, (Perth: University of WA Press, 1982).


‘Died Today’ Bibliography


Waterford Museum, ‘Desperate Haven – The Famine in Dungarvan. The Workhouse Diet 1850-1900’
[Retrieved 14/4/2014].

Watzka, Carlos, ‘Die Landesirrenanstalt Feldhof bei Graz und ihre Patienten vor 1914. Übersicht und neue historisch-soziologische Forschungsergebnisse’ in Eberhard Gabriel and Martina Gampfer (eds), Psychiatrische Institutionen in Österreich um 1900, (Vienna: Verlaghaus der Ärzte, 2009), 143-159.


